June 2014

West Virginia Measures of Success

Proposed Outcomes and Indicators for the State's Early Childhood System

Early Childhood Advisory Council of West Virginia

WEST VIRGINIA Early Childhood Planning TASK FORCE

Early Childhood Advisory Council of West Virginia

The Early Childhood Advisory Council of West Virginia is dedicated to creating a high-quality, coordinated system of services that support early childhood development. The Governor-appointed Council is comprised of state and community representatives of early childhood programs and is chaired Cabinet Secretary Kay Goodwin, West Virginia Department of Education and the Arts. www.wvearlylearning.org

WEST VIRGINIA Early Childhood Planning TASK FORCE

The West Virginia Early Childhood Planning Task Force was established by Governor Earl Ray Tomblin to create a development plan for the state's early childhood system. The Task Force is comprised of ten leaders from different sectors that have a stake in the future of our state's youngest children. The Task Force is chaired by Cabinet Secretary Robert Kiss, West Virginia Department of Revenue, and supported by grants from the Claude Worthington Benedum Foundation and other funders. www.wvecptf.org

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West Virginia
Measures of Success

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Introduction

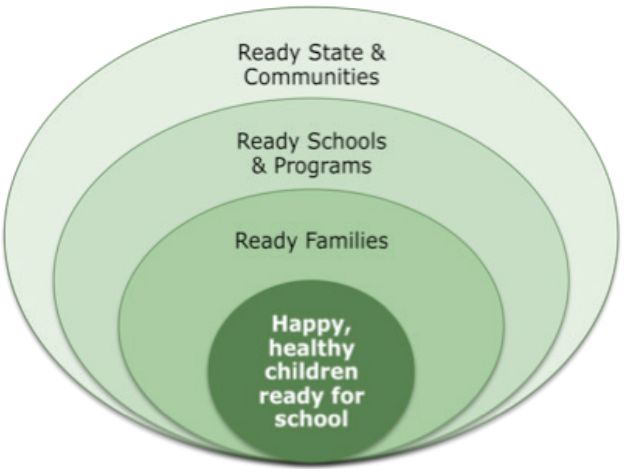
"Measures of Success" is a collaborative project of West Virginia's Early Childhood Advisory Council and Early Childhood Planning Task Force. The goal of the project is to develop population-based and system-level outcomes and indicators in order to:

- Track and improve child and family outcomes across programs;
- Signal the importance of key issues;
- Be accountable to funders, policymakers and the public;
- Engage multiple agencies and organizations in working toward the same outcomes;
- Integrate program-level initiatives into the broader work of the system; and
- Encourage reflection on progress made among partnering organizations.

The Project's Work Group includes representatives of the state's major early childhood programs and other allied organizations. The group views the ultimate goal of an effective early childhood system as "happy, healthy children who are ready for school." Achieving this goal requires the combined efforts of a broad range of people and organizations. Essential players include families, service providers, schools and communities that support early development. Another key ingredient is state support for policies and programs that promote the well-being of pregnant woman, young children and their families.

The Work Group relied on numerous resources to inform its work, including the experiences of other states, the recommendations of national groups, and the findings of surveys, forums and study groups convened by the Early Childhood Planning Task Force on what West Virginians want from an effective early childhood system. (See Appendix I.)

Child well-being and school readiness: A shared responsibility



Adapted from WV Dept. of Education definition of school readiness

The Work Group's strategy was to focus on a manageable number of highly predictive measures. When selecting indicators, the group used three criteria proposed by Mark Friedman, the developer of Results-Based Accountability.

- **Communication Power:** Does the indicator communicate to a broad range of audiences? Is it easily understood by the lay public, policy makers, and media? Does it measure or reflect something that is widely understood as a problem or remedy?

- **Proxy Power:** Does the indicator say something of central importance about the result? Does the indicator also reflect associated factors and risks? For example, infant mortality is an indicator considered to be a reflection of maternal and infant health, of low birth weight or premature birth, and of access to a healthy environment and quality health services.

- **Data Power:** Are data routinely available on a timely basis? Are these data reliable and standardized? Do we have both a valid numerator and denominator for calculating rates? If not, is the need for this indicator feasible and important enough to be put on the agenda for data development? Do the indicators and methods of measurement remain consistent over time so that long-term effects can be identified?

Proposed Outcomes and Indicators

For the purposes of this project, the Work Group defined an outcome as a desired condition of well-being for children, families or communities, and an indicator as a measure of progress toward a desired condition. An indicator can measure risk (e.g. percent of pregnant women who smoke), process (e.g. percent of programs that meet quality standards) or outcomes (e.g. percent of children who are proficient in reading by the end of third grade).

The Work Group identified four broad outcome areas: prenatal and child heath; social and emotional development; family engagement and well-being; and early learning and development. For each area, the group developed an outcome statement and selected four indicators, which are provided on the following page.

Currently available data sources for each indicator are listed in Appendix II. Indicators without readily available data sources will be included in the Early Childhood Advisory Council's data development agenda. Appendix III provides supporting research about the meaning and importance of each indicator.

The Work Group also recommends that, whenever possible, the data for each indicator be broken down by family income and by race in order to identify and address disparities in child well-being and school readiness.

West Virginia Measures of Success
Outcomes and Indicators

Outcome Area 1

Prenatal and child health

Outcome statement:
Children are born healthy and grow up healthy.

1.1. Infants with low birth weights
1.2. Child health status at school entry
1.3. Child death rate under age 5 (infant mortality and deaths of children ages 1-4)
1.4. Prenatal smoking and substance abuse

Outcome Area 2

Family engagement and well-being

Outcome statement:
Families are thriving.

2.1. Births to mothers under age 18
2.2. Births to mothers with less than a 12th grade education
2.3. Children under age 6 living in families that are poor (under 100% of Federal Poverty Level) or low-income (100%-200% FPL)
2.4. Early childhood programs that promote Strengthening Families protective factors

Outcome Area 3

Early learning and development

Outcome statement:
Children have positive early learning experiences.

3.1. Children under age 5 in at least one quality early learning program
3.2. Children ready for kindergarten
3.3. Children proficient in reading by the end of the 3rd grade
3.4. Early learning programs that meet quality standards

Outcome Area 4

Social and emotional development

Outcome statement:
Children live in safe, stable and supportive families and communities.

4.1. Young children who exhibit positive social behaviors when interacting with peers and with adults
4.2. Early childhood programs that promote "universal practices" for social and emotional development
4.3. Substantiated cases of child abuse and neglect of children under age 5
4.4. Families that screen positive for domestic violence

Appendix I

References

National resources

Murphey, David. “Early Childhood Indicators: Making the Most of Measurement.” Child Trends (2010)

Preskill, Hallie, Nathalie Jones and Afi Tengue. “Markers that Matter: Success Indicators in Early Learning and Education.” FSG (2013)

Project THRIVE. “State Indicators for Early Childhood.” National Center for Children in Poverty, Columbia University. (2008)

Resources from other states

California: First 5 California Evaluation Indicators

Colorado: Early Childhood Colorado Framework and Data Development Agenda

Michigan: Great Start Blueprint and Early Childhood Dashboard

Vermont: Early Childhood Action Plan – Population Accountability

Washington: Thrive by Five, State Early Learning Plan Indicators

West Virginia resources

Early Childhood Advisory Council: “Essential Policy Questions for West Virginia”

Early Childhood Planning Task Force:

- *Stakeholder Survey and Discussions: Summary of Findings (Collective Impact, LLC)*
- *Phase I Finding and Recommendations*

WV KIDS COUNT Data Center

Appendix II

Indicator Data Sources

Indicators by Outcome	Available Data Sources
Outcome Area 1: Prenatal and child health	
1.1. Infants with low birth weights	WV DHHR, Health Statistics Center*
1.2. Child health status at school entry	WVDE kindergarten entry health data
1.3. Child death rate under age 5 (infant mortality and deaths of children ages 1-4)	WV DHHR, Health Statistics Center
1.4. Prenatal smoking and substance abuse	*Add to data development agenda*
Outcome Area 2: Family engagement and well-being	
2.1. Births to mothers under age 18	Data available on births to 15- to 19-year-olds from CDC and Census Bureau*
2.2. Births to mothers with less than 12th grade education	WV DHHR, Health Statistics Center*
2.3. Children under age 6 living in families that are poor (under 100% of FPL) or low-income (100%-200% FPL)	Census Bureau - American Community Survey
2.4. Early childhood programs that promote Strengthening Families protective factors	*Add to data development agenda*
Outcome Area 3: Early learning and development	
3.1. Children under age 5 in at least one quality early learning program	*Unduplicated count not currently available*
3.2. Children ready for kindergarten	WV Pre-K Child Assessment System
3.3. Children proficient in reading by the end of 3rd grade	WV Educational Standards Test 2 (WESTEST 2)
3.4. Early learning programs that meet quality standards	*Add to data development agenda*
Outcome Area 4: Social and emotional development	
4.1. Young children who exhibit positive social behaviors when interacting with peers and with adults	*Add to data development agenda*
4.2. Early childhood programs that promote "universal practices" for social and emotional development	*Add to data development agenda*
4.3. Substantiated cases of child abuse and neglect of children under age 5	WV DHHR, Bureau for Children and Families*
4.4. Families that screen positive for domestic violence	*Add to data development agenda*

* Included in WV KIDS COUNT Online Data Center

Appendix III

Supporting Research for Indicators

Outcome 1: Children are born healthy and grow up healthy.

1.1. Infants with low birth weights

Birth weight of less than 5.5 pounds is considered low birth weight. Compared to infants of normal weight, low birth weight infants may be more at risk for many health problems. Some babies may become sick in the first six days of life or develop infections. Other babies may even suffer from longer-term problems such as delayed motor and social development or learning disabilities.

A pregnant woman may increase her chances of having a low birth weight baby if her lifestyle includes any of these risk factors:

- Smoking
- Drinking alcohol
- Lack of weight gain
- Younger than 15 years and older than 35 years
- Social and economic factors, including low income, low educational level, stress, domestic violence or other abuse, and unmarried.
- Previous preterm birth
- Exposure to air pollution (both indoor and outdoor) and drinking water contaminated with lead, which are considered environmental risk factors.

(Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking, http://ephtracking.cdc.gov/showRbLBWGrowthRetardationEnv.action)

1.2. Child health status at school entry

Health impacts early development and school learning in a variety of ways, including:

- When children have a medical home for ongoing care and immunizations needed to keep them healthy, they are more prepared for school. When children are sick, they can access immediate care and return to program activities. Time spent learning leads to academic success.
- Children with healthy teeth are better able to eat, speak, and focus on learning. Children need ongoing oral health care from a partnership between families and oral health professionals (a dental home).
- Activities that get children moving build large and small muscles. Strong large and small muscles support later reading, writing, and math skills. Children need daily exercise to be fit in both mind and body
- Eating nutritious food at every meal helps children stay healthy and have energy to learn.
- Screening (vision, hearing, developmental and behavioral) helps determine whether a child needs extra help. Early identification puts children on track for success in school.
- Early intervention and treatment for children with special health needs or disabilities helps them develop strategies for learning.

(Source: "Healthy Children Are Ready to Learn," by National Center for Health, prepared for US Dept. of Health and Human Services, Administration on Children and Families, Office of Head Start, http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/center/physical-health/individual-wellness-plans/healthy-children-ready-learn.pdf)

1.3. Child death rate under age 5 (infant mortality and deaths of children ages 1-4)

Among infants, the leading causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birth weight, and sudden infant death syndrome. Unintentional injuries are the leading cause of death among children and youth, accounting for nearly a third of all deaths among children ages one to four, five to nine, and 10 to 14. Along with the direct impact of a child's death, the child or infant death rate in a community can be an important indicator for researchers or policymakers. A high rate can point to underlying problems, such as poor access to prenatal care, violent neighborhoods, or inadequate child supervision. It can also point to inequities: for example, in access to health care or safe places to play, or exposure to environmental toxins. While not a nuanced measure, rates of child deaths are highly accurate, and allow comparisons both within and across countries.

Children are much more likely to die during the first year of life than they are at older ages. For example, in 2010 the death rate for children under age one was more than 12 times higher than the death rate of children ages 15 to 19, the group with the next highest rate (623 and 49 per 100,000, respectively).

(Source: "Infant, Child and Teen Mortality," Child Trends Data Bank, 2013, http://www.childtrends.org/wp-content/uploads/2012/11/63_Child_Mortality.pdf)

1.4. Prenatal smoking and substance abuse

Multiple individual, family, and environmental factors—such as nutritional status, extent of prenatal care, neglect or abuse, socioeconomic conditions, and many other variables—make it difficult to determine the direct impact of prenatal drug use on the child. Still, a number of drugs can have negative consequences, as summarized below.

- Smoking during pregnancy is associated with a range of adverse outcomes for the fetus, newborn, and the individual as he/she develops. The adverse effects of smoking during pregnancy can include increased risk for stillbirth, infant mortality, Sudden Infant Death Syndrome, preterm birth, respiratory problems, slowed fetal growth and low birth weight. Smoking during pregnancy can also affect cognition and is associated with behavioral problems. Smoking more than a pack a day during pregnancy nearly doubles the risk of the child becoming addicted to tobacco if he or she starts smoking.

  Even second-hand exposure to cigarette smoke can cause problems. For example, strong associations have been found between second-hand smoke and low birth weight and premature birth. Exposure during the postnatal period has been associated with a number of physical health outcomes, including Sudden Infant Death Syndrome, respiratory illnesses (asthma, respiratory infections, and bronchitis), ear infections, cavities, and increased medical visits and hospitalizations.

- Drinking during pregnancy can cause brain damage, leading to a range of developmental, cognitive, and behavioral problems, which can appear at any time during childhood. Fetal Alcohol Spectrum Disorders (FASD) is the umbrella term for the different diagnoses, which include Fetal Alcohol Syndrome, partial Fetal Alcohol Syndrome, Alcohol-related neurodevelopmental disorder, and Alcohol-related birth defects. People with FASD often have difficulty in the following areas: coordination, emotional control, school work, socialization and holding a job as an adult.

- Cocaine, marijuana, and other illicit drug use during pregnancy has been associated with a variety of adverse effects, though more research is needed to draw causal connections. Effects may be subtle, and generally range from low birth weight to developmental deficits affecting behavior and cognition.

  (Source: "Prenatal Exposure to Drugs of Abuse," National Institute of Drug Abuse, http://www.drugabuse.gov/publications/topics-in-brief/prenatal-exposure-to-drugs-abuse)

Outcome 2: Families are thriving.

2.1. Births to mothers under age 18

Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.

- Teen pregnancy and childbirth accounted for nearly $11 billion in 2008 in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers.

- Pregnancy and birth are significant contributors to high school drop-out rates among girls. Only about 50% of teen mothers receive a high school diploma by 22 years of age, versus approximately 90% of women who had not given birth during adolescence.

- The children of teenage mothers are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.

These effects remain for the teen mother and her child even after adjusting for those factors that increased the teenager's risk for pregnancy, such as growing up in poverty, having parents with low levels of education, growing up in a single-parent family, and having poor performance in school.

(Source: "Teen Pregnancy," Centers for Disease Control and Prevention, http://www.cdc.gov/teenpregnancy/aboutteenpreg.htm)

2.2. Births to mothers with less than a 12th grade education

Research has consistently shown that the education level of a child's mother is a good predictor of many child outcomes. Consequently, children born to women who have not graduated from high school face tough odds. The infant mortality rate is higher for births to women with less than 12 years of education than for women who finish high school. Women who do not get a good formal education are often less likely to provide the kind of educational and intellectual stimulation that their children need. In addition, parents with less education are less likely to be effective advocates for their children when they enter school or encounter problems with other institutions or public systems. Finally, mothers with less than 12 years of education are more likely to smoke during pregnancy and to receive inadequate prenatal care.

(Source: "The Right Start for America's Newborns," Child Trends and KIDS COUNT Working Paper, http://eric.ed.gov/?id=ED462477)

2.3. Children under age 6 living in poor or low-income families

Family economic hardship is one of the chief risk factors linked to academic failure and poor health. Children who live in families with incomes less than the federal poverty level are considered "poor." Children who live in families with incomes less than 200 percent of the federal poverty level are considered "low-income." In West Virginia, nearly half of all children live in poor and low-income households, and the rates are significantly higher for African-American and Hispanic children.

As early as 24 months, children in low-income families have been found to show lags in cognitive and behavioral development compared to their peers in higher-income families. Other risk factors, such as living in a single-parent family or low parent education levels, especially when combined with poverty, can markedly increase children's chances of adverse outcomes. Children affected by multiple risks – three or more risk factors – are the most likely to experience school failure and other negative outcomes, including maladaptive behavior.

(Source: "Young Children at Risk: National and State Prevalence of Risk Factors," National Center on Children in Poverty, http://www.nccp.org/publications/pdf/text_1073.pdf)

2.4. Early childhood programs that promote Strengthening Families protective factors

Strengthening Families is a research-based, cost-effective strategy to increase family strengths, enhance child development and reduce child abuse and neglect. It focuses on building five Protective Factors that also promote healthy outcomes: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.

Using the Strengthening Families approach, over thirty states (including West Virginia) are shifting policy, funding and training to help programs working with children and families build Protective Factors with families. Many states and counties also use the Protective Factors Framework to align services for children and families, strengthen families in the child welfare system and work in partnership with families and communities to build Protective Factors.

(Source: Center for the Study of Social Policy, http://www.cssp.org/reform/strengthening-families)

Outcome 3: Children have positive early learning experiences.

3.1. Children under age 5 in at least one early learning program

This indicator focuses on the participation of eligible children in the five major state-sponsored early learning programs, as identified by the Early Childhood Planning Task Force and represented on the Early Childhood Advisory Council. The programs are Birth to Three, child care subsidies, Head Start, home visiting, and Pre-K for all four-year-olds and for three-year-olds with Individual Education Plans (IEPs). Participation is voluntary for all five programs, and some have eligibility requirements related to income, age and/or special needs. Some families enroll their young children in private early childhood programs for which data are not available.

According to the National Association for the Education of Young Children (NAEYC), "Access to child care, particularly high quality child care, remains out of reach for many families. Programs outside of K-12 public education have the greatest difficulty in meeting the criteria of good quality, equitable compensation, and affordable access. Unlike K-12 education -- a publicly financed system with a relatively stable funding base -- most early childhood care and education services operate in a very price-sensitive market financed primarily by fees from families and supplemented by public and private contributions. Many families cannot pay the full cost of quality care, and the ongoing commitment from public and private contributions is seldom guaranteed. For other children, there are insufficient numbers of child care providers trained in or connected to others who can help support their special educational or other needs to develop to their full potential." (http://www.naeyc.org/policy/excellence)

3.2. Children ready for kindergarten

In West Virginia, school readiness is measured using the WV Pre-K Child Assessment System, which is based on Pre-K child data collected from:

- Early Learning Scale, which focuses on children's development over time, informs intentional teaching, and is user-friendly to facilitate parent communication.
- WV Early Learning Standards Domains, capturing evidence based on individual children's developmental progression and WV Early Learning Standards Framework.
- Child Health information, collected from HealthCheck documentation provided by the student's medical home.
- English Language Learner data (if applicable)
- Special Education reporting data (if applicable)

(Source: "An Overview of the WV Pre-K System of Child Assessment," WV Department of Education, Office of Early Learning, https://static.k12.wv.us/oel/docs/WV%20Pre-K%20Child%20Assessment%20System%20Overview%201%2012.pdf)

3.3. Children proficient in reading by the end of the 3rd grade

Research shows that proficiency in reading by the end of third grade enables students to shift from learning to read to reading to learn, and to master the more complex subject matter they encounter in the fourth grade curriculum. Most students who fail to reach this critical milestone falter in the later grades and often drop out before earning a high school diploma. Yet two-thirds of U.S. fourth graders are not proficient readers, according to national reading assessment data. This disturbing statistic is made even worse by the fact that more than four out of every five low-income students miss this critical milestone.

The WV Department of Education has joined the national Campaign for Grade-Level Reading to improve third grade reading proficiency among the state's children. The Campaign focuses on helping communities and policymakers promote school readiness and quality teaching, tackle chronic absence, and improve summer learning, as well as engage parents as their children's first teachers.

(Source: Campaign for Grade-Level Reading website, http://gradelevelreading.net)

3.4. Early learning programs that meet quality standards

This indicator relates to the number of programs that meet program-specific quality indicators, as well as the alignment of quality standards across programs. NAEYC recommends that all states develop a system of early childhood care and education with appropriate regulatory, governance, finance, and accountability mechanisms so that --

- All children have access to a safe and accessible, high quality early childhood education that includes a developmentally appropriate curriculum, knowledgeable and well-trained program staff and educators, comprehensive services that support their health, nutrition, and social well-being, in an environment that respects and supports diversity.

- All early childhood professionals are supported as professionals with a career ladder, ongoing professional development opportunities, and compensation that will attract and retain high quality educators.

- All families have access to early care and education programs that are affordable and of high quality, and are participants in the education and well being of their children through family involvement in programs and schools, as well as opportunities to increase their educational attainment.

- All communities are accountable for the quality of early childhood programs provided to all children, backed by the local, state, and federal funding needed to deliver quality programs and services.

(Source: "A Call for Excellence in Early Childhood Education," National Association for the Education of Young Children, http://www.naeyc.org/policy/excellence)

Outcome 4: Children live in safe, stable and supportive families and communities.

4.1. Young children who exhibit positive social behaviors when interacting with their peers and with adults

Social emotional development is a fundamental part of a child's overall health and well-being, as it both reflects and impacts upon the developing brain's wiring and function. It spans from how children interact with others to how they manage or cope with adversity and stress. Social emotional development within the first few years of life sets a precedent and prepares children to be self-confident, trusting, empathic, intellectually inquisitive, competent in using language to communicate, and capable of relating well to others.

Healthy social and emotional development refers to a child's emerging ability to:
- Experience, manage, and express the full range of positive and negative emotions;
- Develop close, satisfying relationships with other children and adults; and
- Actively explore their environment and learn.

A child's emerging social and emotional skills form a critical foundation for learning and wellness that will guide them into adulthood. The healthier a child's early experiences are, the more apt they are to enter school and life with a strong foundation of social-emotional skills. It is important to remember that these are the experiences and skills that will influence how they deal with both success and adversity across their lifespan.

(Sources: "The Social Emotional Development of Young Children," American Academy of Pediatrics and National Healthy Start Association, http://www.nationalhealthystart.org/site/assets/docs/NHSA_SocialEmotional_1.pdf)

4.2. Early childhood programs that promote "universal practices" for social and emotional development

The Pyramid Model for Promoting the Social and Emotional Development of Infants and Young Children provides a tiered intervention framework of evidence-based interventions for promoting the social, emotional, and behavioral development of young children. The model describes three tiers of intervention practice: universal promotion for all children; secondary preventions to address the intervention needs for children at risk of social emotional delays, and tertiary interventions needed for children with persistent challenges.

Universal promotion involves two levels of practices that are critical to promoting the social development of young children. The first level of practices is the provision of nurturing and responsive caregiving relationships to the child. This includes the family or primary caregiver and the caregiver or teacher within an early childhood program. In addition to a focus on the relationship to the child, this level of the pyramid also describes the need for developing partnerships with families and collaborative relationships among intervention or classroom team members.

The second level of universal promotion is the provision of supportive environments. Within home and community settings, this level of the pyramid refers to the provision of predictable and supportive environments and family interactions that will promote the child's social and emotional development. Universal practices for children with or at risk for delays or disabilities include receiving instruction and support within inclusive environments that offer the rich social context that is essential to the development of social skills and peer relationships.

(Source: Technical Assistance Center on Social and Emotional Development, http://challengingbehavior.fmhi.usf.edu/do/resources/documents/pyramid_model_fact_sheet.pdf)

4.3. Substantiated cases of child abuse and neglect of children under age 5; and

4.4. Families that screen positive for domestic violence

Adverse childhood experiences (ACEs), such as abuse and neglect and witnessing domestic violence, can have lifelong effects. Researchers believe that intense and prolonged traumatic experiences produce toxic levels of stress that disrupt brain development, which can cause social, emotional and cognitive impairments. These impairments increase the likelihood of health-risk behaviors, such as overeating, smoking and substance abuse, which can result in disease, disability, social problems and premature death.

Children from birth to 5 years old are at the highest risk for abuse and neglect, most often by parents or primary caregivers. In 2011, maltreatment rates were highest in the first year of life (21.2 per 1000); 47 percent of the reports involved children less than 5 years old; and 82 percent of maltreatment fatalities known to child welfare agencies involved children less than 4 years old. Children less than 5 years old are also more likely than older children to reside in homes with domestic violence, illustrating the extensive overlap between violence against a parent (most often the child's mother), and direct maltreatment.

This high prevalence of exposure to interpersonal violence in infancy and early childhood has stark implications for children across the age range because early experiences are most influential in shaping the structure and functioning of the brain, the quality of attachments and other relationships, and the child's readiness to explore and learn. The physical and mental health problems and learning difficulties of older children may have their roots in early victimization experiences that remain unidentified and unaddressed.

(Sources: Centers for Disease Control and Prevention, http://www.cdc.gov/features/dsaces/index.html, and "Child Exposure to Violence as a Public Health Emergency," ZERO TO THREE, 2013)