March 30, 2026

COMMUNITY IMPACT
Policy Institute

Protecting Health in Child Care Expansion

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Executive Summary

New York State is in the midst of an ambitious effort to expand child care access — one of the most significant investments in early childhood infrastructure in the state's history. With more than $2.2 billion committed to expanding subsidies and slots, universal pre-K extending to younger children, and broad political support from the Governor, Legislature, and NYC Mayor and City Council, New York has made affordability and availability its primary focus. While these are the right goals, expanding seats without strengthening the health and safety systems that keep programs open, staffed, and trusted by families will produce a larger system that remains fragile.

This report makes the case that health readiness is an essential component of child care expansion. When children get sick and programs close, parents miss work and family stability suffers. When workers lack health coverage or paid sick leave, they come to work ill, exposing children and colleagues, and accelerating turnover. When facilities have poor ventilation, lead hazards, or inadequate emergency plans, they harm health and reduce trust.

$2.2B+ invested in child care expansion

Source: Office of Governor Kathy Hochul. "We Got It Done: Governor Hochul Celebrates Historic $2.2 Billion Investment in Child Care for New York Families." New York State Governor's Office, 2025.

A Three-Domain Framework

Child health readiness
Child health readiness means ensuring that every child entering a licensed program is vaccinated, screened for developmental and health needs, and safely accommodated if they have a chronic health condition. While New York is building upon a strong existing foundation— strong immunization requirements, enrollment health exams, and allergy protocols—gaps remain in developmental screening follow-up, referral pathways to early intervention, and the capacity of providers to manage children with complex health needs. These gaps become more worrisome as vaccination rates decline and childhood developmental diagnoses rise nationally.

Workforce health readiness
Workforce health readiness means ensuring that the adults who staff child care programs can stay healthy, show up reliably, and be supported in the physical and emotional demands of the job. Child care workers earn some of the lowest wages of any profession, and nearly half of their families receive public assistance. Most lack adequate health insurance or paid sick leave. The result is high absenteeism, high turnover, and chronic understaffing, conditions that directly compromise program quality and continuity. Addressing workforce health is essential to maintaining a reliable child care system.

Built environment health readiness
Built environment health readiness means ensuring that the physical spaces where children spend long hours are safe, well-ventilated, free of environmental hazards, and prepared for emergencies. The Covid pandemic demonstrated how dramatically indoor air quality affects program continuity. Climate change has added new urgency, with heat emergencies, wildfire smoke, and flooding already disrupting child care operations in New York. Many programs, particularly those operating in older urban buildings, lack the infrastructure to manage these risks reliably.

A Coordinated Policy Response

A recurring challenge in child care policy is what we refer to as the *high-expectations, low-commitment trap*: operators are held to exacting standards with any health or safety incident triggering intense public scrutiny, yet operational and infrastructure support needed to meet those standards are insufficient.

To translate this framework into durable policy and escape this trap, New York needs a permanent governance structure dedicated to child care health readiness, one that can coordinate across the Office of Children and Family Services, the Department of Health, and the Education Department—agencies that currently operate largely in parallel rather than in concert. Health readiness criteria must be embedded in capital grants, licensing standards, and inspection systems. The workforce must be supported through health coverage access and a funded sick leave stabilization structure. Training requirements must reflect the realities of caring for children with complex health needs in the context of infectious disease, behavioral challenges, and climate disruptions. And New York's Medicaid system, which covers a large share of children in licensed care, represents a potentially under-used lever for embedding health services and accountability directly into child care settings.

Many of these reforms can be initiated through executive action. The Governor and Mayor can establish interagency coordinating bodies, direct health departments and licensing agencies to update inspection protocols, prioritize health readiness in capital grant criteria, and use existing regulatory authority to strengthen ventilation and emergency preparedness standards. Other changes will require legislative action and budget appropriations. Throughout this report, we signal which recommendations fall primarily within executive authority and which require legislative partnerships, recognizing that the most durable systems will require both.

The Opportunity

New York is at an inflection point with growing political support to tackle the child care challenge. Will health readiness be built into expansion from the outset, or will it be retrofitted after the next crisis? This report provides a policy roadmap that embeds health and safety into the design, funding, regulation, and operations of New York's growing child care system, so that every child is safe, every educator is supported, and every facility is fit for purpose.

These recommendations will require dedicated state and city resources. While we do not attempt a comprehensive cost estimate in this report, the logic of the investment is sound: these measures will produce future cost efficiencies by preventing expensive disruptions, and they will protect the multi-billion-dollar public investments already committed to expansion. Illness-related closures, workforce attrition, and emergency facility repairs impose significant costs on families, employers, and the public sector. Proactive health readiness can reduce those costs over time. Health and safety infrastructure will help ensure that the pending expansion actually delivers the improved system that voters are demanding.

I. Introduction

Child care is increasingly recognized as essential infrastructure for New York's economy and educational system. In the past five years, New York State and City have launched efforts to greatly expand child care access. The State has invested over $2.2 billion to increase availability of child care subsidies and slots, along with $400 million to stabilize providers and expanded tax credits for families with young children[1]. New York City rolled out universal Pre-K for 4-year-olds, expanded to 3-year-olds, and recently announced plans for 2-year-olds[2]. These initiatives, championed by the Governor, Mayor, and a broad swath of the state legislature and NYC Council, reflect a broad consensus that affordable child care enhances workforce participation, family stability, and children's long-term development. Families cannot work if they cannot find reliable care for their children, and children develop socially, emotionally, and intellectually when given early learning opportunities.

Currently, almost 60% of New York census tracts are "child care deserts," with too few licensed slots for the children living there[3]. Even when slots exist on paper, staffing shortages mean thousands of them sit unused. And, even when there is a staffed seat available, many cannot afford it. For example, the average cost of child care now exceeds tuition at public college in New York[4].

Access Gap

60%

of New York census tracts are child care deserts

Source: Office of the New York State Comptroller. "Child Care in NY Challenged by Staff Shortages, High Prices and Too Few Slots." February 2025.

The average cost of child care now **exceeds tuition at public college** in New York.

Source: Empire Report New York. "To Strengthen the Economy, Integrate Child Care and Education."

Child care should also be considered part of society's health and well-being system, where daily activities, environments, and relationships make healthy development possible—physically, emotionally, developmentally and socially. The Covid pandemic highlighted the challenge of maintaining access while simultaneously protecting the health of everyone who attends or works in child care settings[5]. Concerns from parents, child care workers, and operators about Covid transmission forced nationwide child care closures, led some parents to keep their children home, and led some staff to stop working. Many facilities adopted new protocols and enhanced respiratory and environmental hygiene measures, including some combination of health screening, exclusion of ill children, masks, testing, vaccination, and air filtration and ventilation. This experience taught parents, childcare operators, and public officials how important child care is to a functioning economy and society and how important health is to keeping child care facilities open, staffed, and attended. They also revealed how under-prepared the sector had been for a public health crisis. With childhood vaccination rates dropping and measles resurging nationally, the risk of further infectious disease disruptions is rising.

Other health issues have also been rising in importance among policy makers and parents. As diagnoses of autism-spectrum disorders and developmental delays continue to rise, parents and child health experts are calling for programs to detect these conditions earlier and accelerate the time to intervention. The death of a 3-year-old in 2017 from an unrecognized dairy allergy at a New York City preschool led New York lawmakers to pass "Elijah's Law," which mandates stringent allergy protocols in child care programs, and New York City will require all child care centers to stock emergency epinephrine auto-injectors (EpiPens) on site in 2026[6]. The death of a toddler at a Bronx daycare in 2023 – in which a toddler died after exposure to an illegal fentanyl stash – was an extreme outlier, but it shook public confidence and exposed oversight gaps[7]. In response, New York City passed new laws in 2025 to increase inspector training and require daycares to educate parents on safety rights[8,9].While this incident was criminal, it highlighted the sensitivity of policy makers to any threats to health and safety on child care facilities.

Staffing child care facilities remains an urgent challenge. In most states, hiring can take months, because child care workers must complete health examinations, background checks, and training. After they have been hired, many workers are unable to show up to work because of the same acute infections that children acquire or because of the physical and mental health strain. Climate change is also stressing the physical infrastructure, as operators seek to limit disruption from extreme temperatures, flooding, and wild fires.

In the first part of our series on expanding child care, *It Takes a Village: Opening Doors to Child Care Through Seamless Integration with the Education System*, we argued that high-quality, affordable child care is essential economic and educational infrastructure and proposed a coordinated strategy to expand access by integrating child care, early intervention, and early education into the public school system through co-location, regulatory streamlining, workforce development, and alignment with New York's P–20 framework.

This report builds on that foundation. Expanding seats without strengthening health readiness will create a larger system that is still fragile. New York's child care strategy must evolve from capacity alone to capacity plus health readiness to ensure programs can stay open, staffed, trusted by families, and safe for children. Protecting health in child care will require changes to standards, practices, and design across three domains: children, the workforce, and the physical environment. A weakness in any one of these can undermine the entire expansion effort.

In the sections that follow, we assess current policies in New York State, with particular focus on New York City, to identify gaps, and benchmark against best practices for child health, workforce health, and environmental health. We then present a policy roadmap for integrating health readiness into child care expansion. Our aim is to guide policy makers in creating a child care system where every child is healthy and safe, every educator is supported, and every facility is fit for kids – thereby truly delivering on the promise of early care and education as an engine for opportunity.

When child health systems falter, illness and unmet health needs reduce attendance, strain staffing and operations, and trigger closures, creating a negative feedback loop that further destabilizes access to care and education.

II. Child Health Readiness

To scale up safely, New York must ensure that children's health needs are met comprehensively in every program. This involves preventive health measures (e.g., immunizations, health screening), standard practices that keep children safe from illness and injury, and systems to detect and response to outbreaks, chronic conditions, and developmental needs. New York has important foundational elements in place already, such as state law and NYC health code requirements that all children to have a recent medical exam and be up to date on vaccines before enrolling in child care. Nevertheless, gaps and inconsistencies remain, especially as children under age 5 have unique vulnerabilities. In this section, we highlight key components of child-centered health readiness and recommend steps to strengthen them.

"To scale up safely, New York must ensure that children's health needs are met comprehensively in every program."

2.1 Infection Prevention and Control

Children are uniquely susceptible to infectious diseases, and child care settings bring large numbers of children and adults into close proximity, increasing the risk of disease transmission. For these reasons, New York State and New York City both mandate that children be vaccinated against high-priority infectious diseases before entry. The current list of required vaccinations includes: diptheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, and varicella[10]. In New York City, children are also required to receive the seasonal influenza vaccination annually.

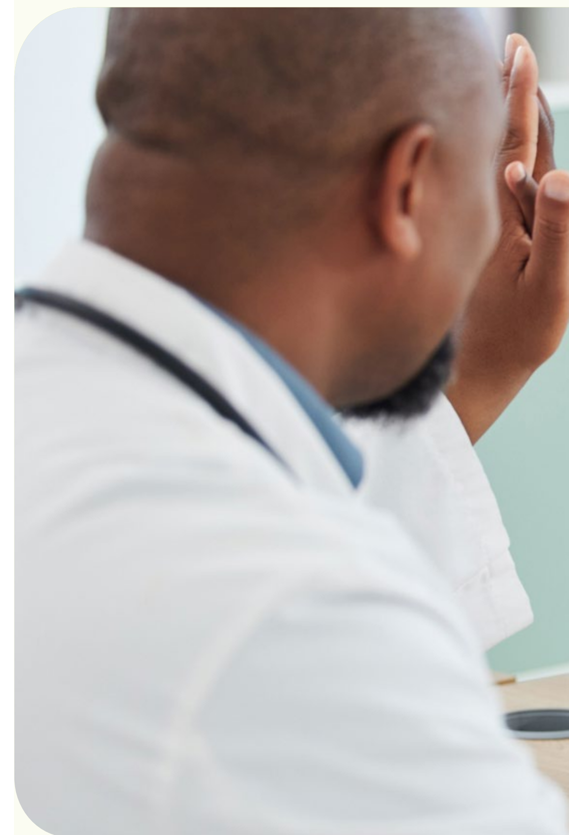
After a large measles outbreak in 2019, New York State modified its laws regarding exemptions, and parents can only exempt their children from vaccines for documented medical reasons, not for religion or personal belief. Parents must show proof of their child's up-to-date vaccinations within 14 days of the first day of child care.

Programs must maintain proof of each child's immunizations, and program records are subject to inspection by public health and education officials. The combination of strict policy and enforcement has helped New York maintain high immunization levels in child care settings (often above 95%).

Child care settings are at high risk, however, of losing these high levels of immunization in New York, because of actions by the federal government and some states to reduce vaccine access and uptake and the resurgence of highly infectious vaccine-preventable infections, such as measles and pertussis[11].

While vaccines help reduce the risk of infection and severe illness after a child has been exposed to a microbe, child care centers are also required to have policies and practices to reduce overall exposure to microbes. Sanitation and hygiene practices must be rigorous. Licensing standards cover both basics—such as handwashing facilities and practices, toilet facilities, diapering procedures, toy sanitizing, cleaning schedules—and more complex protocols for screening and excluding ill children across a range of scenarios, such as when a child has a fever, when they are safe to return after a strep throat infection, and after exposure to lice or bed bugs. In New York State, these protocols must be codified in a facility's Health Care Plan (New York State's rules are adapted from the national "Caring for Our Children" guidance.)

Ensuring that these standards are followed correctly and consistently at all times is challenging. Standards are numerous and complex, new staff are constantly joining, existing staff are often overwhelmed by the number of children they need to care for, and there is a high incidence of all types of infectious diseases. To expand child care effectively and safely, New York must invest in building a large cadre of child health care consultants (CHCC). CHCCs are experts in health and safety who help staff at a facility improve their adherence to recommended protocols. CHCC's primary focus is helping the team to succeed in contrast to child care inspectors, whose focus is making a determination, with legal consequences, about whether a facility is adhering to regulations and should stay open or not. CHCCs answer questions from staff and administrators about supplies and systems, they observe routine operations and coach staff on how they can perform better, and they provide refresher training on proper handwashing, diapering, and adjudicating who should or should not be excluded. In a sector with high turnover and complex daily protocols, supportive coaching is one scalable way to promote adherence to standards between inspections. While CHCC are required in New York for Head Start / Early Head start programs, there is no current statewide mandate or dedicated line of funding in New York for all licensed providers in contrast to states such as Washington, Colorado, and North Carolina.



2.2 Health Screening and Developmental Support

Child care is a critical setting for monitoring and promoting child health and development. Regular health and developmental screenings ensure that issues are caught early, when interventions are most effective. Head Start programs have long been a gold standard in this regard: within 45 days of enrollment, every Head Start child receives vision, hearing, developmental, and behavioral screenings, and families are linked to medical and dental homes. This comprehensive approach could be an important model for New York to follow as it expands child care.

Currently, New York requires that each child have a physical exam (including proof of lead screening) before enrollment and periodically thereafter. This is typically documented on a standard form (such as NYC's Child Health Exam Form CH205). However, these exams are only useful when paired with follow-up. Child care providers should be equipped to support follow-up by informing families, reinforcing referrals, and knowing how to connect families to early intervention and specialty services. For example, if a pediatrician notes possible vision issues or elevated lead levels, the program could help the family connect with specialists. One way to strengthen this is by closer coordination with Early Intervention (EI) and Early Childhood Special Education services. Child care centers should know how to refer a child for an EI evaluation if they suspect a developmental delay, rather than waiting for the pediatrician alone. At minimum, every program should have a standardized EI referral protocol and a named point of contact at the local EI program. The state's expansion of developmental screening efforts (through pediatric practices and community programs) can be complemented by training child care staff to use simple screening tools or to partner with visiting specialists.

Through programs like the New York City Early Childhood Mental Health Network, some child care sites receive visits from mental health consultants who can observe classrooms and help identify children with behavioral or developmental challenges, then coach teachers and refer families to services. Expanding such programs citywide and statewide could greatly enhance health readiness. By having a pipeline from child care to early intervention and therapy services, more children get the support they need during the critical birth-to-5 window. The result is better school readiness and overall health when they start kindergarten.

"By having a pipeline from child care to early intervention and therapy services, more children get the support they need during the critical birth-to-5 window."

Additionally, children with chronic health conditions or special needs must be safely accommodated as the system grows. This includes children with asthma, food allergies, diabetes, seizure disorders, and other conditions that require management during the day. Regulations require child care providers to have individualized care plans for such children (e.g. an allergy action plan with instructions and medications like EpiPens). But not all providers feel equipped to handle them, leading some to turn families away or inadvertently put children at risk. The NYC epinephrine mandate (Local Law 2025/ Int. 895) is a positive step; child care facilities will have EpiPens available and staff trained to use them for any kid with a severe allergy. Similar approaches should be considered for other conditions: for instance, allowing child care staff to be trained by healthcare professionals to administer emergency asthma inhalers or glucagon for diabetic emergencies. As discussed above, CHCCs could help with children who have complex needs or the state could support a system of on-call nurses.

By bolstering screening, linking with health services, and equipping providers to handle health conditions, New York can make its expanded child care system an early touchpoint for promoting children's health and development.

2.3 Nutrition, Physical Activity, and Healthy Habits

In many child care settings, children consume a large proportion of their daily calories and engage in significant physical activity. These settings, therefore, play an important role in nutrition and obesity prevention.

New York City's Health Code already has strict rules regarding nutrition and physical activity in child care centers. These rules require that meals and snacks follow USDA nutritional guidelines and limit sugary drinks, such as prohibiting soda and only permitting juice in children over two years of age, as long as it is 100% fruit juice and supplied in small amounts. Toddlers and preschoolers in NYC centers must have at least 60 minutes of activity per day, including a portion of teacher-led structured play.

Ideally, New York City's standards should be maintained and extended during child care expansion. The key challenge will be funding. The US Department of Agriculture has historically operated a program that reimburses eligible providers for serving meals that meet strict nutritional guidelines. With the combination of funding cuts and added administrative requirements to many federal nutrition programs, it is unclear how stable and accessible this funding will be in the future[12].

An added challenge is ensuring that meals are prepared safely and account for the large number of children that may have food allergies, intolerance (e.g., gluten, lactose), or restrictions (e.g., vegetarian, halal, kosher). When expanding child care, policymakers will need to identify non-federal funding sources to support provision of safe and nutritious food. New York could reduce dependence on federal funds by offering a state supplement for qualifying meals and providing centralized administrative support so small providers can participate.

Many child care centers are stand-alone facilities that have limited space for children to run, climb, and play. Policymakers should ensure that expansion grants for new facilities include provisions for indoor and outdoor play areas or partnerships with local parks and play streets. As described in our *It Takes a Village* report, shared use of school facilities can help: co-locating child care in under-utilized school buildings often gives access to gyms, playgrounds, and cafeterias.

A system's resilience is only as strong as the health of its workforce. A health ready workforce means child care centers stay open with personnel fit for duty and skilled in promoting health and safety for adults and children.

III. Workforce Health Readiness

The core infrastructure of child care is staff, i.e., the teachers, assistant teachers, and other adults that determine the number of "seats" available. Compensation levels, professional recognition, and workload distribution have remained misaligned with the responsibilities these roles require. Across the nation, the Covid pandemic exacerbated an exodus of child care workers, many citing low wages, health concerns, and overall burnout. Expanding child care capacity requires addressing three major domains for the workforce:

1. **Compensation and benefits**
2. **Training and professional development**
3. **Occupational health and safety**

3.1 Compensation and Benefits

Child care workers earn wages that put many of them near or below the poverty line. In the U.S., the median wage for early educators is lower than 97% of all other occupations, and about 43% of families of child care providers receive Medicaid, SNAP, and/or housing assistance[13]. New York has taken steps recently to boost compensation, e.g. the one-time Workforce Retention bonuses funded in 2024, which provided bonuses and hiring incentives to ~150,000 child care workers[14].

Policymakers should explore ways to boost sustained compensation and benefits. There are a number of models policymakers could explore. Similar to plans some states have tried, New York could use subsidy dollars or other funds to create a health insurance pool for child care workers. For instance, Washington State and New Mexico have experimented with covering a portion of premiums for child care employees. New York could leverage its large size - perhaps allowing child care staff to buy into the state employee health plan or a state-sponsored plan with substantial subsidies. In a high intensity, close contact setting such as child care, the health of adults is linked directly to the health of children.

Economic Vulnerability

43%

of families of child care providers receive Medicaid, SNAP, and/or housing assistance

Source: Georgetown University Center for Children and Families, National Association for the Education of Young Children, and Center for Law and Social Policy. "Medicaid is a Critical Support for the Early Childhood Education Workforce." April 21, 2025.

Workforce Support

~150,000 child care workers

received bonuses and hiring incentives in 2024

Source: New York State Office of Children and Family Services. "Child Care Workforce Retention Grant."

Child care providers inevitably get sick, because of their workplace exposures. If they lack paid sick leave, they face a cruel dilemma: lose income or come to work ill, where they suffer themselves and endanger staff and children. Paid sick leave reduces the incentive for sick staff to work, which lowers workplace transmission and stabilizes staffing, as demonstrated by workforce studies, epidemiologic modeling, and exclusion policy research. New York City law already requires paid sick leave for even small employers (and a 2021 Council bill expanded sick leave specifically for child care workers in certain city programs). Statewide, child care centers should be encouraged or mandated to offer a minimum sick leave benefit. The state could subsidize a sick leave fund for small providers to backfill the cost of a substitute when staff are out ill.

The emotional toll of caring for young children, especially in understaffed conditions, is high. Many providers report symptoms of depression or anxiety[15]. New York must build on teacher wellness initiatives, including community-based counseling services and peer support networks to help the social and emotional conditions of staff. As described in our *It Takes a Village* report, developing professional pathways for child care workers to enter the school teaching workforce can also improve overall morale.

A healthier, more secure workforce is able to provide better care and more stable programs. The Georgetown analysis found that, in a national survey, educators who had health insurance and other benefits were significantly more likely to intend to stay in the field, whereas those without were more likely to consider leaving. Improving access to health care and sick leave could reduce overall absenteeism and turnover, increase job satisfaction, improve the quality of work performed, and reduce disease transmission to children.

The biggest challenge: this is expensive. These costs, however, are already embedded in the system, absorbed inefficiently through high turnover, intermittent closures, and workforce disruptions when programs lack adequate staffing.

"Paid sick leave reduces the incentive for sick staff to work, which lowers workplace transmission and stabilizes staffing, as demonstrated by workforce studies..."

3.2 Training and Professional Development in Health & Safety

Working with young children requires knowledge and vigilance about health and safety, as we described in the section about children's health. In New York, child care workers are mandated to complete 30 hours of training every two years, which includes safety, first aid, child abuse identification, and health practices. Some staff are also required to be trained in CPR. Ensuring quality and consistency in these trainings is a challenge, especially as the workforce grows. Key areas for enhanced training include:

- **Infection Control and Disease Prevention**
  The pandemic showed that many educators had to learn on the fly about personal protective equipment, quarantine, isolation, hygiene, and other approaches to limiting infectious disease transmission. Incorporating more robust infection control training into pre-service and annual training can help reduce the number of days that children and staff must stay home due to respiratory, gastrointestinal, and skin infections. The state can collaborate with public health experts to develop training specifically for child care providers and support child health care consultants with on-the-job coaching and teaching.

- **Medication Administration and Special Health Needs**
  Some states require a specific training for child care providers on administering medication to children (New York State OCFS encourages but does not mandate a full training course unless a provider opts to administer meds). Given the growing prevalence of asthma, severe allergies, and other chronic conditions in early childhood, New York should expand and standardize training in medication administration, especially for emergency medications, and clarify when and how trained staff can administer clinician-prescribed treatments. The state could incentivize providers to get Medication Administration Training certification and possibly require it for certain roles. This goes hand in hand with accommodating special needs as discussed: staff should also be trained on inclusive practices for children with disabilities or developmental delays, some of which overlap with health (e.g., understanding sensory needs or feeding techniques for a child with feeding therapy).

- **Trauma-Informed Care and Mental Health**
  The workforce should be prepared to deal with children who have experienced trauma or have behavioral health challenges. This affects health readiness because such children may have emotional or behavioral outbursts that can endanger themselves or others if not handled properly, and staff stress can skyrocket. Training in calming techniques, recognizing signs of stress or trauma in children, and de-escalation can make classrooms safer and more supportive. New York City's recent focus on "Healing-Centered" schools could be incorporated into child care settings as well. Equipping educators with these skills could reduce suspensions and expulsions in early childhood.

Training Requirements

30 hours

of training required every 2 years from New York child care workers

3.3 Occupational Health and Safety for the Child Care Workforce

Child care workers face unique occupational health and safety risks that directly affect staffing stability, absenteeism, and program continuity. Key components of workforce occupational health and safety include:

- **Illness Prevention and Management in the Workplace**
  Child care workers experience high rates of exposure to respiratory, gastrointestinal, and skin infections due to sustained close contact with young children. Clear, standardized workplace protocols for symptom recognition, exclusion, return-to-work decisions, and access to substitutes are essential to prevent avoidable transmission and reduce pressure on staff to work while ill.

- **Injury Prevention and Physical Health Protection**
  The physical demands of child care, including lifting children, repetitive motion, and prolonged standing, contribute to musculoskeletal injuries and chronic pain. Training in safe lifting and ergonomics, appropriate classroom equipment and furniture, and reasonable staff-to-child ratios can reduce injury risk and extend workforce longevity.

- **Mental Health, Burnout Prevention, and Psychological Safety**
  As noted above, chronic understaffing, behavioral challenges in classrooms, and limited backup support place significant psychological strain on child care workers. Occupational health strategies should include access to mental health services, peer support, and supervisory structures that allow staff to raise concerns without fear of reprisal. Psychological safety is critical to retention and quality.

- **Data, Monitoring, and Continuous Improvement**
  State and local agencies should track workforce absenteeism, injury-related exits, and illness-related closures as indicators of occupational health stress. These data can inform targeted interventions, guide funding decisions, and help identify practices that improve workforce stability.

Poor building conditions create a cascading effect: higher illness rates, operational disruptions, and reduced public confidence.

IV. Built Environment Health and Safety

The third domain of health readiness concerns the built environment of child care. Buildings, playgrounds, and indoor air actively shape children's health, safety, and development, particularly given the long hours of close contact in child care facilities. As New York expands child care capacity, policymakers must ensure that decisions about design, renovation, and oversight prioritize health from the outset and are sustained through routine maintenance and inspection.

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4.1 Facility Safety: Designing and Maintaining Healthy Spaces

Whether child care capacity is expanded through new construction or renovation of existing space, facility design should explicitly emphasize health and safety. New centers offer an opportunity to incorporate evidence-based components such as sufficient natural light and non-toxic building materials. Practical design choices can reduce disease transmission, such as handwashing sinks placed at classroom entrances, touchless faucets and toilets, and easily cleanable flooring.

Facilities can also plan for illness in a realistic and humane way. Most child care centers do not have a nurse's office, but a small, quiet space where a sick child can be supervised while awaiting pickup can reduce exposure to others while providing comfort and supervision for the child. Similarly, quiet rooms for breastfeeding, sensory regulation, or calming overstimulated children can promote an inclusive, developmentally appropriate environment.

In urban areas, child care programs often operate in aging buildings, including converted brownstones, former schoolhouses, or ground-floor commercial spaces.

Capital funding, including state and federal child care facilities grants, should prioritize improvements that directly affect health and safety. Examples include installing child-height sinks, modernizing HVAC systems, replacing worn carpeting with easy-to-clean surfaces, adding door alarms to prevent children from exiting unnoticed, and upgrading lighting and security systems. Health and safety criteria should be explicitly weighted when governments allocate funding for capital improvements.

Outdoor space is another essential component of a healthy built environment. Daily outdoor play supports physical activity, mental health, and social development. In dense urban areas, this may require creative approaches, such as rooftop play spaces with appropriate safety features, shared use of nearby parks during designated times, or well-designed indoor gross motor rooms during inclement weather. As the city incentivizes new child care sites, access to outdoor play should be considered. Programs that lack on-site outdoor space should be required to demonstrate equivalent opportunities for physical activity or receive support in securing nearby options.

Facility safety requires ongoing monitoring and adaptation. As buildings age, new health evidence develops, or diseases emerge, standards must evolve. State agencies can support child care providers by providing clear maintenance standards, technical assistance, and simple tools such as seasonal safety checklists that prompt preventative action before problems escalate.

"Health and safety criteria should be explicitly weighted when governments allocate funding for capital improvements."

4.2 Indoor Air Quality and Environmental Health

One of the most important lessons from the Covid pandemic was about the importance of indoor air quality for health. Good ventilation and air filtration reduce the spread of airborne viruses and improve overall wellness by lowering exposure to allergens and pollutants. New York has an opportunity to make child care a model for healthy indoor environments. Many older child care sites rely only on windows or on HVAC systems that do not filter small particles. In New York City, public schools underwent substantial improvements to indoor air quality during the pandemic, including the upgrading of HVAC systems to include MERV-13 filters, installation of standing room air purifiers in classrooms, and modification of windows to allow natural ventilation.

During child care expansion, basic ventilation standards should be incorporated into licensing and health codes, with phased implementation to allow time for upgrades. These standards should include requirements for mechanical ventilation or operable windows, use of portable air purifiers in rooms below certain size or occupancy thresholds, and simple tools such as carbon dioxide monitors that help providers assess ventilation. These measures are low-cost relative to their health benefits and can significantly reduce disruption from illness.

"During child care expansion, basic ventilation standards should be incorporated into licensing and health codes, with phased implementation to allow time for upgrades."

Ongoing attention to hazards such as lead, mold, and chemical exposures is also essential. New York has strong lead prevention policies, including required water testing in child care facilities and routine blood lead screening in young children. However, older buildings still pose risks from peeling paint or poorly managed renovations. Mold, particularly in basements or flood-prone spaces, can trigger respiratory symptoms and can be addressed through moisture control, ventilation, and early detection. Facility staff should be trained to recognize warning signs and know when to seek remediation support.

Cleaning products, art supplies, furnishings, and pest control methods can all introduce harmful substances. Clear guidance on child-safe cleaning products, strict adherence to integrated pest management requirements, and limits on pesticide use when children are present are critical protections.

4.3 Regulatory Standards and Inspections

New York maintains detailed regulatory requirements for child care facilities across multiple oversight systems, including state regulations and city health codes. These standards cover square footage, fire safety, sanitation, outdoor play areas, and storage of hazardous materials. As capacity expands, the challenge is applying these standards uniformly when there is a temptation to waive or loosen requirements during rapid expansion. The goal should be to streamline approvals without compromising safety. This could involve aligning regulations across agencies and cross-training and certifying inspectors to reduce confusion and duplication. Achieving this requires extensive cross-agency coordination, shared inspection frameworks, and inter-agency agreements with clear directives from state, county, or city executives. Inspectors must be adequately trained in traditional safety requirements and in identifying environmental health risks and emerging hazards. Training should encompass issues such as mold, lead paint compliance, playground safety, fire hazards, and emergency preparedness. Digital tools can help standardize assessments, flag high-risk issues, and ensure follow-up across agencies. A persistent gap in the current system is the fragmentation of inspection records across agencies; a provider that has failed a health inspection may not be flagged during a subsequent fire or licensing review, and vice versa. Addressing this gap requires both better technology and shared governance and accountability.

"As capacity expands, the challenge is applying these standards uniformly when there is a temptation to waive or loosen requirements during rapid expansion."

A central policy question is how to strengthen health readiness in family-based and other informal settings without inadvertently regulating them out of existence. Policymakers should explore tiered or graduated approaches that preserve baseline safety expectations across licensed settings while creating supportive pathways for smaller providers to build capacity over time. Options could include funded technical assistance, shared health resources, infection prevention training, and access to Child Health Care Consultant support. The broader aim would be to raise standards in a sustainable way so that expanded oversight does not unintentionally reduce supply in communities that rely most on flexible, home-based care.

4.4 Emergency Preparedness and Climate Resilience

New York City and other parts of the state have already experienced extended heat emergencies, flash flooding events, and air quality alerts that forced school and program closures. With climate change, child care facilities must develop protocols for managing emergencies they may not have previously worried about, such as prolonged and intense heat waves, flooding, power outages, and wildfires, as well as pandemics, which they have had to deal with before. Providers should have clear shelter-in-place and evacuation plans, protocols for power loss, and access to timely information during emergencies.

State and local agencies can support this through toolkits, technical assistance, and, where appropriate, provision of equipment such as portable air purifiers during smoke events. Local emergency management agencies should formally include child care providers in alert systems, evacuation planning, and emergency resource distribution. Integrating child care providers into broader community emergency planning ensures that children are not overlooked when disasters occur.

"Integrating child care providers into broader community emergency planning ensures that children are not overlooked when disasters occur."

4.5 Co-Location as a Health-Promoting Strategy

How and where child care capacity is added matters as much as how much is added. A central recommendation of *It Takes a Village* is to co-locate child care in existing public facilities, particularly schools. This approach directly addresses many built-environment challenges. Schools are already constructed to rigorous safety standards. They have fire suppression systems, emergency plans, established inspection processes, and often on-site health supports. Many schools also have superior ventilation systems and outdoor play areas compared with stand-alone child care sites. In New York City, hundreds of school buildings operate below capacity, representing an underused asset for safe expansion. Co-location can, therefore, be both a capacity strategy and a health readiness strategy that raises baseline safety, improves air and space quality, and connects programs to existing emergency systems compared with other approaches.

V. Integrating Health Readiness Into Policy

New York's child care expansion represents a critical opportunity to embed health readiness into policy, funding, regulation, and operations across three domains: children, workforce, and the built environment. Building on our report, *It Takes a Village: Opening Doors to Child Care Through Seamless Integration with the Education System*, this framework extends the case for integrated systems by elevating health and safety as core infrastructure within expansion efforts. Together, these approaches advance a child care system that better protects children's health, supports educators, and ensures facilities are safe and prepared for the realities of climate change, infectious diseases, and other emerging public health threats.

One of the biggest challenges to making childcare policy is that it falls into a trap of high expectations and low commitment. Child care operators are expected to uphold high standards for their workforce, facilities, and daily operations. Even one health or safety incident in a child can prompt widespread public outrage, extensive media attention, and heated political discourse. At the same time, the level of public commitment—as expressed through funding and staffing—is rarely sufficient to meet these high expectations. Effectively integrating health readiness into child care systems will require government and public to reckon with this historical mismatch and commit to a sustained infusion of funding and resources.

This section synthesizes our recommendations into a coordinated policy roadmap. While grounded in New York State's governance structure, the framework is designed to be adaptable for other states seeking to scale child care safely, sustainably, and in alignment with broader education and workforce systems.

Policy Recommendation 1.

Create a permanent early childhood health governance structure

New York policymakers should establish a standing Early Childhood Health Readiness Task Force, jointly led by the Office of Children and Family Services and the Department of Health, with participation from the State Education Department, Medicaid leadership, and external experts in pediatrics, public health, and early childhood education. In recent years, Governors have convened child care and early childhood task forces and advisory bodies to address affordability, workforce stabilization, and post-pandemic recovery. While these efforts have been important, they have generally been time-limited and advisory in nature, rather than permanent governance infrastructure focused specifically on health readiness.

The Task Force should be established by executive order or legislation with a defined governance structure, including a clear mandate, a designated chair within state government, and authority to issue binding recommendations to Office of Children and Family Services and the Department of Health and health-related regulatory updates. It should be advisory to the Governor and Legislature but empowered to compel agency responses to its findings within a defined timeframe.

Within its first year, the Task Force should produce a model Health Readiness Plan that specifies the minimum policies, protocols, and staffing supports a licensed provider must have in place across each of the three domains addressed in this report: child health, workforce health, and the built environment. All licensed providers should be required to adopt the model Health Readiness Plan, or an approved equivalent, within 18 months of the Task Force issuing it.

The Task Force should publish an annual Health Readiness Scorecard and issue model standards and implementation guidance that agencies adopt through regulation, contracts, and grant criteria. It should also oversee development of a statewide system to monitor serious injuries, illness outbreaks, emergency responses, and health-related closures in child care.

Policy Recommendation 2.

Integrate health infrastructure into child care expansion investments

As New York expands child care seats, policymakers should explicitly integrate health infrastructure into capital planning and operational design. To ensure health and safety improvements are treated as core components rather than optional upgrades, New York should require that a minimum of 15 percent of any child care capital expansion grant be dedicated to health and safety infrastructure. Eligible uses should be specified in grant criteria and should include, at minimum:

1. **HVAC upgrades and ventilation improvements meeting or exceeding MERV-13 filtration standards.**
2. **Lead paint assessment and remediation in pre-1978 buildings.**
3. **Handwashing infrastructure, including child-height sinks installed at classroom entrances.**

Grants that do not include a compliant health and safety component should not be approved. Health-related criteria should be clearly weighted in the scoring of facility grants and expansion initiatives, particularly in child care deserts and high-need communities. Expansion strategies should encompass both physical upgrades and operational readiness, including necessary supplies, environmental monitoring tools, staff training, and emergency response planning, ensuring that new capacity is both larger in scale and stronger in health resilience.

"New York should require that a minimum of 15 percent of any child care capital expansion grant be dedicated to health and safety infrastructure."

Policy Recommendation 3.

Stabilize the child care workforce through health policy alignment

Workforce health is inseparable from child health. A child care worker who lacks health insurance, cannot afford to stay home when sick, or is experiencing untreated depression or burnout is a risk to both children and program continuity. New York must move from aspirational language to specific, funded commitments. On health coverage, New York should explore concrete ways to lower costs and expand coverage. For example, the state could authorize child care workers employed by licensed providers to buy into the plan that covers state employees (New York State Health Insurance Program) with premium subsidies calibrated to provider size and revenue. New York, with its large state workforce infrastructure, is well-positioned to adopt a buy-in model rather than creating a separate pool.

For paid sick leave, the state should consider a Child Care Sector Sick Leave Stabilization Fund, modeled on the Paid Family Leave infrastructure already in place, that reimburses small providers for the cost of a qualified substitute when a staff member takes illness-related leave. This removes the financial disincentive that currently causes sick workers to come to work, exposing children and colleagues to infection. New York City's existing paid sick leave law provides a floor. This fund would extend meaningful protection to the many small and home-based providers operating statewide for whom the mandate is difficult to fulfill in practice.

Both mechanisms should be piloted in the first two years, with evaluation data used to inform permanent program design. The state should set a target of reducing illness-related staff absences and closures by 20 percent within three years of full implementation.settings, creating a durable framework that embeds health readiness into the state's long-term child care expansion strategy.

Recommended Target

Reducing illness-related staff absences and closures by 20% within 3 years of implementation

Policy Recommendation 4.

Strengthen training requirements with a health and safety core

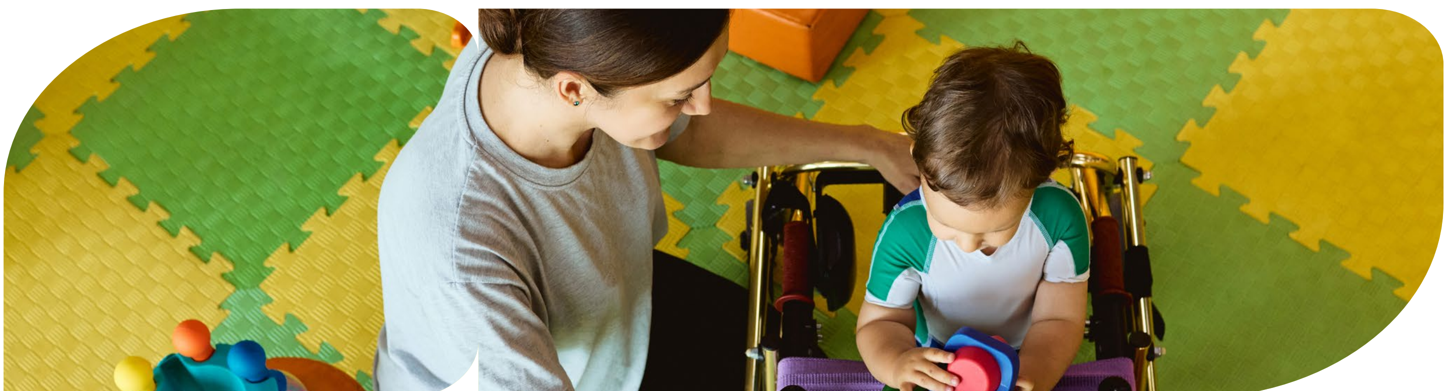
The state should require that a defined portion of mandated professional development hours focus on health readiness, including infection prevention and control, medication administration, trauma-informed care, and emergency response. Medication Administration Training should be expanded and incentivized, particularly as more children with asthma, allergies, diabetes, and other chronic conditions enter child care settings. Early childhood degree and certificate programs within SUNY and CUNY should include substantive coursework on child health, developmental screening, and inclusion of children with special needs.

As part of this effort, New York should support Child Health Care Consultants (CHCCs) for all licensed child care settings. CHCCs will focus on coaching and training, rather than regulation, related to infection prevention and control (e.g., hygiene, exclusion policies), medication administration, and management of children with special health needs. Experience from other states shows that CHCC programs can reduce illness-related closures, improve compliance, and build workforce confidence. New York could also develop regional CHCC networks or centers of excellence housed within local health departments, academic centers, or nonprofit partners. Ideally, CHCCs will function as the primary operating system for maintaining and strengthening health readiness working to reduce the number of days closed due to outbreaks or staff illness.

Policy Recommendation 5.

Integrate child care with Medicaid and public health systems

Given that a large share of children in licensed child care are Medicaid-enrolled, New York should leverage existing Medicaid authority to embed health readiness supports directly into child care settings. The primary vehicle should be a Section 1115 Medicaid Demonstration Waiver, which would allow New York to test and claim federal matching funds for services that fall outside traditional Medicaid billing, such as: consultative nursing visits, developmental screening follow-up conducted in child care settings, and chronic condition care coordination for children with asthma, diabetes, or severe allergies. As a near-term step that does not require a waiver, the state should also explore whether existing Medicaid billing codes, including those for care coordination, preventive services, and FQHC-delivered services, can be used to reimburse Child Health Care Consultants or visiting nurses who provide structured, documented services in licensed child care programs. Together, these Medicaid linkages would reduce fragmentation between the health and child care systems, improve early identification of developmental delays, and generate data on health outcomes that currently go unmeasured.



Policy Recommendation 6.

Deploy a unified digital inspection and compliance platform

New York's child care inspection system spans multiple agencies—fire, health, buildings, and licensing— each operating with its own checklists, timelines, and records systems. This fragmentation creates gaps. A facility can pass a fire inspection while failing a health inspection that no other agency sees, and violations can go unremediated because no single agency has a complete picture. As New York's licensed child care system grows, this fragmentation becomes a larger risk.

New York should invest in a shared inspection and compliance infrastructure that allows inspectors from each agency to record findings in a common system, access each other's records, and flag high-risk sites for coordinated follow-up. While the ideal would be a single inspector doing all inspections, a more feasible solution is to create a single data environment in which each agency can see the full compliance profile of a facility. Deciding which facilities to inspect first and how quickly to require remediation should be based on risk rather than geography or administrative ease. This infrastructure should be governed by the Early Childhood Health Readiness Task Force proposed in Recommendation 1, which should set data standards, oversee interoperability, and report annually on compliance trends.

Policy Recommendation 7.

Accelerate co-location of child care in public facilities

Local governments should aggressively pursue co-location of child care in under-utilized public buildings, particularly schools, because it will both build capacity and improve health readiness. As detailed in *It Takes a Village*, school buildings offer significant health and safety advantages over stand-alone child care sites. They are built to rigorous safety codes, include fire suppression systems, established inspection processes, and often superior ventilation systems and outdoor play areas. Co-location can simultaneously expand seats and raise the baseline of safety, indoor air quality, and emergency preparedness for participating programs.

Where feasible, co-location agreements should allow child care programs to access existing school health personnel, including nurses, to support younger children and integrate health services more seamlessly. Localities should prioritize co-location in neighborhoods designated as child care deserts, where the need is greatest and the health readiness baseline is often lowest.

"Localities should prioritize co-location in neighborhoods designated as child care deserts, where the need is greatest and the health readiness baseline is often lowest.

Policy Recommendation 8.

Strengthen emergency preparedness and indoor air quality standards for all licensed providers

Climate change has made emergency preparedness a routine operational concern for all facilities in New York. Child care providers have already been disrupted by extended heat emergencies, wildfire smoke events, and flash flooding. All licensed providers should be required to maintain current emergency plans that address the full range of climate-related and public health emergencies. Local emergency management agencies should formally include child care providers in alert systems, evacuation planning, and emergency resource distribution, ensuring that children in these settings are not overlooked when disasters occur.

On indoor air quality, the state and city should incorporate clear, enforceable benchmarks into licensing and inspection criteria. At minimum, these should require functional mechanical ventilation, operable windows, deployment of portable air purifiers in rooms below defined occupancy or ventilation thresholds, and use of carbon dioxide monitors as a practical proxy for ventilation adequacy. These standards should apply to all licensed providers and should be phased in with technical assistance and capital support for providers who need to upgrade.

Finally, as health-related mandates evolve, localities should pair new requirements with the infrastructure and accountability systems necessary to make them workable, including bulk purchasing mechanisms, standardized training curricula, and incident reporting systems that inform continuous policy updates.

"All licensed providers should be required to maintain current emergency plans that address the full range of climate-related and public health emergencies."

Table

Indicators to measure health readiness of the child care system at county, city, or state level

This table includes a list of indicators that could be collected at the program level for quality improvement and then reported publicly, in aggregate, at the county, city, or state level. The goal is not to rank individual providers, but to assess whether child care expansion is producing a system that remains open, safe, and trusted over time.

Indicator	Definition (Geographic Level)	Why It Matters
Continuity		
Illness-Related Closure Days	Average number of full or partial closure days per 100 licensed programs within the jurisdiction due to infectious disease, environmental hazards, or health-related staffing shortages.	Measure system fragility and disruption to families' ability to work.
Workforce Absenteeism Rate	Percentage of scheduled staff days missed due to illness or health-related leave across licensed programs in the jurisdiction.	Leading indicator of workforce strain and transmission risk.
Annual Staff Turnover Rate	Percentage of staff exiting employment within licensed programs in the jurisdiction during the calendar year.	Stability correlates with predictable operations and sustained program quality.
Safety		
Outbreak-Related Closure Rate	Percentage of programs within jurisdiction requiring closure (full or partial) due to infectious disease outbreaks during the calendar year.	Measures effectiveness of infection prevention, vaccination compliance, and response systems.
Core Health & Safety Compliance Rate	Percentage of programs within the jurisdiction meeting defined priority health standards at inspection, e.g., immunization records, medication plans, exclusion policies, ventilation standards.	Indicates consistency of safety implementation across the system.
Emergency Preparedness Completion Rate	Percentage of programs within the jurisdiction with updated emergency plans, documented drills, and required staff training completed.	Reflects readiness for climate events, fire, smoke, and other emergencies.

Trust		
Family Confidence Index	Average annual survey-based measure of family perception of safety, health responsiveness, and communication within jurisdiction's child care system.	Trust sustains enrollment and political support for expansion.
Staff Support Index	Average annual survey measure of whether staff in the jurisdiction feel supported in managing illness, behavioral challenges, and emergencies.	Psychological safety predicts retention and workforce stability.
Enrollment Stability Rate	Percentage of programs within the jurisdiction operating at ≥85% licensed capacity across the year.	Stable enrollment signals confidence in safety and operational predictability.

About the Author

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Acknowledgements

The Community Impact Policy Institute extends its sincere appreciation to Dr. Jim Malatras, Director of the Institute and Chief Strategy Officer and Senior Vice President for Education at Fedcap, for his leadership, strategic guidance, and extensive contributions to the development of this report. His insights, thoughtful critique, and hands-on engagement—including substantive comments, edits, and rewrites—were instrumental in strengthening both the analysis and overall clarity of this work.

We are equally grateful to Bill Nichols, Fellow of the Institute and Editor of Spotlight on Poverty and Opportunity, whose editorial expertise, careful review, and commitment to precision significantly enhanced the report. His contributions helped refine the narrative, elevate the quality of the writing, and ensure the report's accessibility to a broad audience.

About The Community Impact Policy Institute

The Community Impact Policy Institute is the thinktank and research arm of Fedcap, conducting leading research to provide solutions in breaking down barriers to economic well-being. The Institute, and its partners, have conducted groundbreaking analysis and solutions to many pressing needs including building wage and wealth for disadvantaged communities, effects of minimum wage increases, early childhood education, employment opportunities for individuals with disabilities, socially responsible investing, immigration and its impact on the economy, and more.

The Community Impact Policy Institute also provides technical assistance and training, products and hands on support to government agencies and community-based providers working to change their delivery of services and enhance the community integration of people with individuals with barriers to employment.

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