



State CCDBG Plans to Promote Opportunities for Babies & Toddlers in Child Care

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About this Project

CLASP's *Charting Progress for Babies in Child Care* project highlights state policies that support the healthy growth and development of infants and toddlers in child care settings, and provides online resources to help states implement these policies. The foundation of the project is a policy framework comprised of four key principles describing what babies and toddlers in child care need and 15 recommendations for states to move forward. The project seeks to provide information that links research and policy to help states make the best decisions for infants and toddlers.

CLASP analyzed state Child Care and Development Block Grant (CCDBG) plans for FFY 2008-2009 through the lens of the project policy framework. A policy brief of this report and additional information may be found on the [CLASP Child Care and Early Education](#) webpage.

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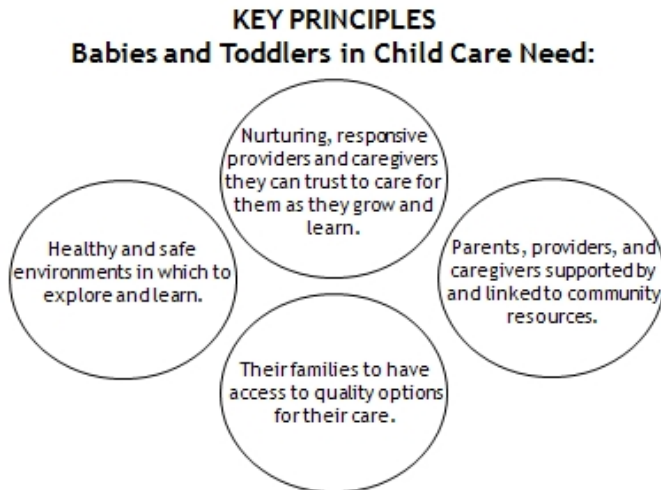


By Teresa Lim and Rachel Schumacher

State child care policies can promote the quality and continuity of early childhood experiences and foster the healthy growth and development of babies and toddlers in all child care settings, especially if they are informed by research. The quality of the relationship between children and those who care for them influences every aspect of young children's development, including intelligence, language, emotions, and social competence. Research has found that children in both child care centers and family child care homes benefit when their providers are sensitive and responsive to their individual needs.¹ Moreover, a secure attachment relationship between infants and their child care providers can complement the relationship between parents and young children.²

The Child Care and Development Block Grant (CCDBG) is the largest source of federal funding for child care available to states and touches the lives of many low-income infants and toddlers and their families. Twenty-nine percent of children who receive child care paid with CCDBG funds are under age 3—nearly 500,000 children in an average month in fiscal year 2007.³ The infant/toddler earmark in CCDBG, \$99.5 million in fiscal year 2009, is an important source of funding for many innovative state investments to improve the supply of high-quality infant/toddler child care, and supports programs and initiatives for children and families who receive a subsidy and those who do not.⁴ Every two years, states must lay out their plans for using CCDBG funds to help low-income families access child care and to improve the quality of child care for all children, including infants and toddlers. What do state CCDBG plans reveal about state policies that can promote opportunities for babies and toddlers in child care to experience the positive care that will help them thrive?

This policy report analyzes what the 50 states and the District of Columbia reported in their state CCDBG plans for FFY 2008-2009 using a Policy Framework that guides the Center for Law and Social Policy's *Charting Progress for Babies in Child Care* project. The framework is based on a set of key principles that establish what all babies and toddlers in child care need:



To achieve the four principles of the framework, CLASP offers 15 policy recommendations to help state leaders progress toward achieving these principles in their states. This report analyzes state CCDBG plans through the lens of this framework, highlighting promising policies and initiatives for babies and toddlers. Information presented in this paper is not meant to be representative of all state activities to support babies and toddlers, but is designed to give a sense of the types of actions and policies reported in the CCDBG plans. This paper provides examples of quality improvement activities funded by the CCDBG infant/toddler earmark as well as some licensing and subsidy policies reported in state plans that improve infant/toddler care. Additional states may have been doing some of the activities or policies described in this paper through CCDBG or other funding sources, but may not have explicitly mentioned these activities within their state plan for FFY 2008-2009. The examples in this paper illustrate how states are meeting many of the 15 policy recommendations but could take more action in several areas.

For each key principle of the *Charting Progress for Babies in Child Care* policy framework, this report provides:

- A brief discussion of the importance of this principle for babies and toddlers
- Policy recommendations for achieving the principle
- Key CLASP findings on whether state CCDBG plans reported activities that support the recommendations
- Specific examples of related state activities reported in the CCDBG plans, including links to online state information where possible

Principle: Babies in child care need nurturing, responsive providers and caregivers they can trust to care for them as they grow and learn.

Babies and toddlers develop in the context of relationships. When early relationships are nurturing, individualized, responsive, and predictable, they increase the odds of desirable outcomes—building healthy brain architecture that provides a strong foundation for learning, behavior, and health.⁵ Babies and toddlers need providers and caregivers who understand the social, emotional, cognitive, and physical processes of their growth and development and can provide continuous care and support. Highly trained providers and caregivers who receive adequate compensation are a key factor to quality early care and learning environments. A study of highly-trained center-based teachers found that those who earned higher wages were more likely to remain in their jobs after four years than those who earned lower wages.⁶

To achieve this principle, CLASP has recommended a set of policy actions that can help increase access to the kind of providers and caregivers babies in child care need:

- ✓ *Establish core competencies.*
- ✓ *Provide access to training, education, and ongoing supports.*
- ✓ *Promote continuity of care.*

- ✓ *Promote competitive compensation and benefits.*
- ✓ *Support a diverse and culturally competent workforce.*

FINDING: All states reported having a variety of initiatives and resources to ensure that providers and caregivers had the knowledge and skills to care for infants and toddlers, including establishing what they needed to know about infant/toddler development, providing professional development and training activities, and/or offering competitive compensation and benefits. However, states reported no significant activities in their CCDBG plans to support continuous relationships between providers and the children they cared for, and very few reported initiatives to recruit, maintain, and support diverse and culturally sensitive infant/toddler providers. State leaders could strengthen efforts to ensure that infants and toddlers have nurturing, responsive providers and caregivers by focusing some attention on these two latter issues.

Establish Core Competencies. Some states reported using CCDBG funds to establish core expectations of what providers should be expected to know and the kind of skills they should demonstrate in order to care for babies and toddlers. Strategies states reported included:

Establishing core competencies for infant/toddler providers, specialists, and consultants: **Minnesota** planned to design a core competency guide for infant/toddler caregivers and providers. The guide would identify the skills and knowledge most important for infant and toddler care and be intended to supplement the state's broader [Minnesota Core Competencies for Early Education and Care Practitioners](#), which cover competencies for children from birth through age 8. **Washington** reported that the state had a collaborative team that had developed [core competencies](#) for infant/toddler specialists and consultants.

Developing early learning guidelines for infants and toddlers: Some states had taken or were taking steps to establish early learning guidelines that considered the developmental needs of infants and toddlers. In varying stages of development, implementation, or revision, states reported using CCDBG funds to:

- **Establish early learning guidelines for infants and toddlers:** **Oklahoma** reported that the state had taken initial steps to create early learning guidelines for infants and toddlers. A committee had been established to begin developing the guidelines.
- **Include infants and toddlers in existing early learning guidelines:** At the time that the CCDBG plan was submitted, **Wisconsin** was in the process of revising the state's [early learning guidelines](#), which focused on the developmental growth of children from age 3 through the end of kindergarten. In response to feedback from the child care workforce, the state planned to broaden the guidelines to address very young children, beginning at birth.
- **Train providers and caregivers on early learning guidelines:** A few states, such as **Arkansas, Georgia, Maine, and Michigan**, reported that they had early learning guidelines for infants and toddlers and were training or beginning to train providers on how to utilize them. For instance, **Arkansas** offered three four-hour [training sessions](#) to prepare providers on the state's [Framework for Infant and Toddler Care](#); both center-based and family child care providers participated in the sessions. In addition, the state planned to develop a web-based curriculum for infant/toddler providers based on the framework. **Maine** reported that the state was in the initial stages of providing training on the state's recently completed early learning guidelines, [Supporting Maine's Infants and Toddlers: Guidelines for Learning and Development](#). The state planned to offer training during the next two years.

Provide Access to Training, Education, and Ongoing Supports. States reported having an array of

programs and trainings available to infant and toddler providers to improve their skills and knowledge, such as:

Access to the Program for Infant/Toddler Care (PITC):

A number of states, such as **Hawaii, Indiana, Iowa, Louisiana, Minnesota, South Carolina, South Dakota, and Tennessee**, reported that they participated in the [Program for Infant/Toddler Care](#) (PITC) developed by WestEd or had incorporated elements of the PITC into existing state programs. The PITC provides training to trainers and others who work with providers to improve the quality of infant/toddler care. Some states, such as Hawaii, reported that training was available to both center-based and family child care providers. States utilized the program in different ways:

- **Customized PITC programs to fit state or community needs:** **Minnesota** reported that the state was working to improve its Infant Toddler Training Intensive [curriculum](#) based on PITC. Improvement efforts included customizing the core content of the training for use in specific cultural communities. **Indiana** reported that the state provided a set of trainings called [Better Baby Care](#), which incorporated WestEd modules as part of the program. Over 6,000 providers received training through the program in FFY 2006.
- **Expanded PITC program:** In **California**, stipends were available to child care staff and family child care providers who completed 25 hours of PITC training for children, birth to three years of age. The state expanded these PITC trainings to offer two Academies for Infant/Toddler Program Directors, a PITC Institute for Partners for Quality Trainers, and a PITC Graduate Conference.
- **Implemented provider service requirements for PITC participants:** In **South Dakota**, participants in the train-the-trainer module of the [South Dakota PITC](#) were required to provide up to 80 hours of training for child care providers in their communities. At the time that the CCDBG plan was submitted, over 152 trainers had participated in the WestEd curriculum for infant and toddler providers.

Creating other intensive infant/toddler training programs:

Some states offered intensive training programs focused on infant/toddler care. The trainings came in a variety of forms. For instance, **Tennessee** reported that the Tennessee Early Childhood Training Alliance (TECTA) offered a free [Orientation Program](#) that provided 30 clock hours of training to providers and was available in five different specializations, one of which was infant/toddler care. Completion of the Orientation Program satisfied a provider's annual training requirement for two years. **Rhode Island** offered an [Infant-Toddler Academy](#), which was a 12-week training program consisting of 30 hours of instruction and eight hours of practical classroom application. The program was offered at least once a year. **Maine** offered a rigorous summer institute for infant/toddler providers. Providers who completed the program received college credit and equipment grants of \$1,000. At the time that the state's CCDBG plan was submitted, 180 providers had participated, resulting in the creation of 300 additional infant/toddler slots. An advanced level course was in development.

Supervisor training: **Colorado's** state Department of Education operated an intensive training program called [Expanding Quality in Infant/Toddler Care](#). The program consisted of 48 hours of training and was designed for individuals interested in becoming infant/toddler supervisors in child care facilities; licensing specialists and others who wanted intensive preparation on child development could also participate. The program offered an option for participants to become a certified trainer in a local community and a mentor to infant/toddler providers. In the state's CCDBG plan, Colorado reported that since 2000, 111 participants had become local trainers.

Specialized infant/toddler studies: At least a handful of states reported that they were collaborating with colleges and universities to offer specialized coursework or training in infant/toddler care. Students were given formal recognition for completing these infant/toddler studies. While similar in intent, state initiatives used different nomenclature, such as:

- **Infant/toddler certificates or credentials:** In **Montana** and **North Carolina**, students received

a certificate in infant/toddler care for completing a set of infant/toddler-specific courses. Similarly, **South Carolina** and **Wisconsin** awarded an infant/toddler credential for completing an infant/toddler course of study. In the latter state, the credential had been awarded to over 500 child care professionals since 1999. **Oregon** reported that the state had finished developing core coursework for an infant/toddler credential and were offering the coursework as 21 training sessions for a total of 62 hours of training. The state was in the process of incorporating the credential into the Oregon Registry Steps and the Oregon Registry Trainer Program. **Illinois** also planned to offer an infant/toddler credential and had finished developing core knowledge and benchmarks for the credential at the time that the state's CCDBG plan was submitted.

- **Infant/toddler endorsements:** **Virginia** awarded students who completed a series of infant/toddler-specific training an endorsement comparable to an infant/toddler credential or certificate. **Arkansas** also offered an Infant/Toddler Endorsement with the state's Child Care Specialist Certificate; providers had to complete 60 hours of infant/toddler study for the endorsement. **Delaware** piloted a 60-hour infant and toddler course that built on its general core competencies for providers. The course included training on the social and emotional development of infants and toddlers and forming relationships with children and their families. Participants who completed the course received an infant and toddler endorsement. The state planned to make the course a regular professional development offering.

Distance learning: A few states increased access to higher education opportunities by making available online courses. These courses aimed to improve training and education among hard-to-reach infant/toddler providers, such as those who lived in rural communities. Among states that reported online offerings:

- **Providing online courses and training:** **Nebraska** offered an online training program

First Connections. The program was developed for infant/toddler providers, particularly those in rural and remote areas. The curriculum was based on the Child Development Associate Credential competencies and granted three hours of college credit in any of the state's community colleges. Since the program's launch in 2001, over 2,050 participants had enrolled, with 564 registrations occurring within the past year that the CCDBG plan was submitted. **Massachusetts** also offered a distance learning course, *A Caring Curriculum for Infants and Toddlers*, for those with limited access to college courses. The purpose of the course was to increase knowledge in infant/toddler development.

Infant/toddler specialists and ongoing support and mentoring for providers: Some states reported that they had infant/toddler specialists (also called consultants, mentors, coaches, or TA providers) who provided one-on-one assistance and support to all levels of staff, from directors to providers, to improve the quality of care for very young children. Services provided to infant/toddler providers included:

- **ITERS assessments and consultations:** **North Carolina** ran a program called the Infant-Toddler Enhancement Project, which funded 25 infant/toddler specialists across 18 child care resource and referral (CCR&R) regions. The infant/toddler specialists provided consultations to providers on the Infant Toddler Environment Rating Scale (ITERS). As of 2006, 4,712 consultations had been conducted, and 723 infant/toddler spaces showed improvements in quality as measured by pre- and post- ITERS-R scores. In **North Dakota**, infant/toddler specialists also provided ITERS consultations to providers through two different programs, the *Quality Enhancement Project* and *Right From The Start*. **Alabama** offered a mentoring program called the *Infant/Toddler Teacher Support* project. A mentor completed an ITERS assessment with a provider and then worked with the provider to develop an action plan. **Indiana**

reported having a similar program called the *Infant Toddler Mentoring Project*.

- **General technical assistance and onsite support:** **West Virginia** had full-time infant/toddler specialists, located in each of the state's six CCR&Rs, who provided at least six hours of onsite technical assistance to providers who had gone through the through the Caregiver's Module of the West Virginia Infant/Toddler Professional Development Program (WVITP). In addition, the state's CCR&R ran a program called the Traveling Resource and Information Library System (TRAILS), which provided onsite assistance and materials to providers to support quality learning environments.

Scholarships: A number of states offered general scholarships for pursuing higher education in the early childhood field. States reported that infant/toddler providers were among those that utilized these scholarships:

- **CDA Scholarships: Arkansas and Rhode Island** offered a scholarship for Child Development Associate (CDA) credentialing. The credentialing included an option to specialize in infant/toddler care.
- **T.E.A.C.H. scholarships:** T.E.A.C.H. scholarships were a source of financial assistance to infant/toddler providers in a number of states, such as **Kansas, Ohio, Nevada, North Carolina, Minnesota, Montana, South Carolina, and Wisconsin.**

Promote Competitive Compensation and Benefits. To promote a stable, highly-trained workforce, states reported that they offered stipends, salary enhancements, and other financial incentives to encourage professional development and increase retention rates among infant/toddler providers. These incentive programs included:

Salary stipends/enhancements: **Wisconsin** reported that the state used CCDBG infant/toddler set-aside dollars to

fund the R.E.W.A.R.D. Stipend Program. The program aimed to increase retention and compensation rates in the early childhood workforce by awarding providers with salary stipends based on educational attainment and experience in the field. At the time that the CCDBG plan was submitted, the state could not yet report on results of the program. The state planned to establish measurable outcomes and goals of the program within the next two years.

Grants to improve retention: **Minnesota** offered a workforce retention program called Retaining Early Educators Through Attaining Incentives Now (R.E.E.T.A.I.N.), which distributed grants that recipients were free to use as they chose. The purpose of the grants was to increase retention rates and quality in the early childhood field. The state targeted 75 percent of R.E.E.T.A.I.N. grants for infant/toddler providers. From 2005-2006, infant/toddler providers comprised about 85 percent (160 of 188 providers) of R.E.E.T.A.I.N. grantees. **California** had two programs that aimed to improve retention rates: the CDE Child Care Staff Retention Program and the Matching Funds for Retention incentive program. Evaluations conducted by the state revealed that 12,594 center-based and family child care providers had received stipend awards from the programs, of whom 5,181 worked with infants and toddlers.

Support a Diverse and Culturally Competent Workforce. A handful of states reported efforts to increase the cultural and linguistic sensitivity of providers, or support the quality of care of diverse providers and caregivers. Some examples of state activities were:

Adapting early learning guidelines to address diverse children and providers: **Minnesota** reported that the state addressed the cultural and linguistic diversity of families in the state's early learning guidelines for infants and toddlers. **Arkansas'** Framework for Infant and Toddler Care included strategies for working with children of limited English proficient (LEP) families as well as children with special needs. Similarly, **South Dakota** included strategies for addressing the needs of bilingual learners in the state's early learning guidelines.

Making intensive infant/toddler training appropriate for diverse communities: **Minnesota** planned to adapt the core content of the state's Infant Toddler Training Intensive, which is modeled on PITC, for use in specific cultural communities.

Professional development for infant/toddler providers in Spanish: **Florida** reported support for developing a state-approved Infant and Toddler Florida Child Care Professional Certificate Program in English and Spanish.

Principle: Babies in child care need healthy and safe environments in which to explore and learn.

In the earliest years of life, babies seek out interactions with their environment and those that take care of them, so that they can begin to understand the world. Child care providers and caregivers who are attuned to each child's unique needs and personality can support, nurture, and guide the child's growth and development. To create quality learning environments in which infants and toddlers can explore and learn, there needs to be sufficient numbers of providers to ensure both the quality and safety of children's care. Moreover, providers need an adequate understanding of health and safety issues specific to the developmental needs of babies and toddlers. State licensing, monitoring, and technical assistance policies should be designed intentionally to establish critical protections for the youngest children in child care settings.

To achieve this principle, CLASP recommends the following policy actions to create healthy and safe environments for babies in child care:

- ✓ *Improve center ratios and group sizes.*
- ✓ *Improve family child care ratios and group sizes.*
- ✓ *Promote health and safety.*
- ✓ *Expand monitoring and technical assistance.*

Promote Health and Safety. To ensure the healthy growth and development of babies and toddlers, a handful of states reported activities to support licensing provisions

FINDING: Over half of states reported using CCDBG funds to provide training on health and safety issues critical to the care of infants and toddlers. In addition, states reported offering grants and other supports to providers for making facility improvements that enhance and improve the safety of the child care environment. Very few states reported efforts to improve the capacity of state licensing agencies to monitor or provide technical assistance to infant/toddler providers, although states mentioned other technical assistance activities. CLASP found no examples of states explicitly working to reduce group size and improve provider to child ratios in centers and family child care homes. By increasing attention to licensing and monitoring, as well as group size and provider-to-child ratios, states can improve the health, safety, and quality of care environments for infants and toddlers.

that set minimum health and safety standards for their care. States reported using CCDBG quality funds to support monitoring efforts and assist providers meet licensing requirements related to infant/toddler care, such as:

Requiring preparation on health and safety issues: Some states reported in their CCDBG plans that they had training requirements related to the care of infants and toddlers. Two common requirements were:

- **Preparation in safe sleep practices, Sudden Infant Death Syndrome (SIDS), and shaken baby syndrome:** **West Virginia** reported that the state had strengthened licensing requirements related to infant/toddler care for family care homes that received subsidy payments. Prior to caring for infants, all child care staff had to complete a self-study guide on Sudden Infant Death Syndrome (SIDS) and Shaken Baby Syndrome or participate in an approved training on the two issues. The state had infant/toddler specialists, funded by the infant/toddler set-aside, to assist providers meet this licensing

requirement. **North Carolina** also required in [licensing rules](#) that providers in both centers and family child care homes complete training in infant/toddler safe sleep practices and SIDS within four months of becoming employed and working with infants and toddlers. Providers have to update their training every three years in order to maintain their license. North Carolina reported that the state used the CCDBG infant/toddler earmark to fund the Infant/Toddler Safe Sleep and SIDS Risk Reduction (ITS-SIDS) Project. The project facilitated an online train-the-trainer module to infant/toddler specialists, child care health consultants, and others, who then administered ITS-SIDS training to providers.

- **Preparation in infant/child CPR and first aid:** **Wisconsin** sent out child care nurse consultants to provide training and technical assistance to providers on the health and safety of children. The state's child care program performance standards required that providers have training in child health and safety issues, which included infant/child CPR. The state revised licensing rules in 2004 to require that both center and family child care providers be certified in infant/child CPR by September 2005 or within six months of hire; the certification had to be maintained thereafter. **Wyoming** reported that all providers, both licensed and legally exempt, who received [subsidy payments](#) have to maintain current certification in infant/child CPR and first aid.

Providing resources to improve the health and safety of child care settings: To assist providers in improving the health and safety of their facilities as well as their understanding of issues affecting infants and toddlers, states provided various forms of assistance and service. Examples included:

- **Offering facility grants:** In **South Dakota**, [health and safety grants](#) were available to providers to help them meet child health standards and improve the quality of care. Infant/toddler capacity building was prioritized. The state reported that most funding was used to install fire safety devices, egress windows for

safety, and fences. New providers had some limited funding available to them for new equipment, such as cots, mats, and changing tables.

- **Increasing provider knowledge on health and nutrition issues:** **Kansas** offered a program called [EXCEL](#), which employed infant/toddler specialists to work with providers on improving the quality and availability of infant/toddler care. In 2007, the specialists targeted obesity prevention and health and nutrition as two key issues to focus on with EXCEL participants.

Expand Monitoring and Technical Assistance.

For the most part, states did not report activities to improve the capacity of licensing agencies to monitor and provide technical assistance to infant and toddler providers, although many states mentioned technical assistance projects located elsewhere. One specific example that merits mention is:

Training licensing staff on infant and toddler development:

To better serve the mental health needs of infants and toddlers in child care, **Arizona** reported that child care licensing staff received training on infant mental health. In 2006, licensing staff received 16 hours of training from the Arizona Infant Toddler Institute.

Principle: Babies in child care need parents, providers, and caregivers supported by and linked to community resources.

For babies and toddlers, early learning experiences occur within the context of their physical and mental health and the relationships they have with their families and other caregivers. Good health is essential for positive child development. Access to quality health care and early intervention services can help reduce early childhood impairments and their impacts on later years. Neuroscience suggests that early interventions for vulnerable children should begin at birth or even prenatally, since earlier interventions are more likely to affect the entire trajectory of a child's life.⁷ Although

families at all income levels are vulnerable when they experience challenges that put children at risk for unhealthy development, such as domestic violence, child maltreatment, substance abuse, and depression, many challenges are disproportionately prevalent among low-income families. Parents, who are key figures in informing a child's understanding of the world, require personal and economic resources to provide for their infants' and toddlers' basic needs.

Many vulnerable, low-income babies and toddlers and their families who could benefit from comprehensive services can be reached through their child care settings. The majority (73 percent) of children under age 3 with employed mothers have a regular, nonparental child care arrangement.⁸ Similar rates of child care use exist for infants and toddlers with employed mothers in low-income families.⁹ Programs and policies that support the full range of child development (including health and social-emotional development) and parents and families (for example, by reducing economic hardship and promoting healthy parent-child relationships) can better promote the health and development of vulnerable babies and toddlers.

To achieve this principle, CLASP recommends the following policy actions to link parents, providers, and caregivers to comprehensive community resources:

- ✓ *Promote family engagement.*
- ✓ *Promote access to appropriate screenings.*
- ✓ *Promote access to comprehensive services.*

Promote Family Engagement. CCDBG plans reflected that states were using multiple approaches to team up with parents and increase their knowledge of infant/toddler development and care. These strategies included:

Media outreach: States such as **Alabama, Arkansas, and Maine** reported working with television networks and other public media to increase awareness among parents about infant/toddler care and services and supports available to them.

FINDING: Nearly half of states reported using various methods and approaches to increase parents' understanding of early childhood development and skills in infant/toddler care. In addition, states reported implementing multiple kinds of screenings to identify infants and toddlers with or at risk for health or developmental delays. While referral services were provided to address these delays, no state reported actively providing or linking necessary services for vulnerable babies and toddlers to child care settings. States can enhance their partnerships with parents by looking at additional ways to connect families with infants and toddlers in child care to needed comprehensive services.

Toolkits for parents of newborns: In **South Dakota**, every parent with a newborn infant received a [parent/infant welcome box](#) containing a broad range of information on topics related to the well-being of young children. This included information on infant health, early brain development, and choosing child care. Other states, such as **Arizona and Virginia**, provided comprehensive toolkits to new parents to educate them on health care, child development, and infant safety. Virginia reported distributing approximately 100,000 toolkits, which included a toll-free number for child care referrals, at the time that the state's CCDBG plan was submitted.

Parent education courses: **South Dakota** offered a [parent education course](#) called *Responsive Parent* for families of children from birth to age 3. The course was a six-week training that taught parents about child development and how to respond to children's needs. Child care was provided during the training sessions so that parents could attend. In SFY 2006, 56 courses were offered, and 458 adults participated, affecting 868 children.

Home-based parent education programs: **New Mexico** reported that that state was collaborating with New Mexico State University to offer a program for families called the *In Home Infant Child Care* program. The program allowed parents with infants who were eligible

for child care assistance to stay at home and receive a subsidy that would have otherwise been paid to a provider for their child's care. As part of the program, parents participated in a 45-hour course to increase their infant care skills and understanding of early childhood development.

Accessible Early Learning Guidelines and other informational materials: States such as **Arkansas, Connecticut, and Delaware** reported that they were working to ensure that Early Learning Guidelines were accessible to parents. Informational materials were also available for parents on critical health and safety issues. **Indiana, Kentucky, Massachusetts, and New Hampshire** had initiatives to increase parental awareness of Sudden Infant Death Syndrome (SIDS). Some of these states reported that they translated materials in Spanish.

Promote Access to Appropriate Screenings. A number of states reported that they had health consultants, coordinators, or teams that monitored and provided technical assistance to providers on health and other related issues. These individuals and groups worked with providers to identify health or developmental delays among vulnerable babies and toddlers. Some actions states reported taking to support screenings included:

Coordinating and planning cross-agency health screening systems: **Minnesota** reported that the state's lead agency in overseeing CCDBG funds coordinated with other agencies, such as the state's health department, to provide health screening services. At minimum, state legislation required mandatory mental health screening for children from birth to age 3, who were in child protection services. The agencies developed a framework for a comprehensive health and developmental screening system funded by the state's Early Childhood Comprehensive Systems grant. The main target of the grant was to screen young children for various health risks at an early age and on a regular basis. Families were connected to culturally appropriate services and supports in their community as needed. **Georgia's** child care agency similarly coordinated with other state agencies to screen infants for health-related concerns. For instance, the agency worked with the state's public health

department to promote a free vision screening program called **InfantSEE** that targeted young children from ages six months to twelve months.

Providing comprehensive screenings and services for developmental delays: **Kansas** had a **language intervention toolkit**, which was used to assess and monitor infants and toddlers with language developmental delays and direct parents to infant/toddler Part C services. In **Tennessee**, a Health, Safety, and Inclusion Coordinator worked with the state's early intervention system to help parents of infants and toddlers with special education needs find resources. **Nevada** also worked with child care providers to offer speech screenings, consultations, and transition services for parents of developmentally delayed infants and toddlers.

Providing nurse health consultations: In **New Jersey**, registered nurses were assigned to twenty-one counties to evaluate health care services for children in child care, particularly infants and toddlers. The nurses provided technical assistance to providers to improve the quality of health-related services. Training on CPR, First Aid, and other issues was provided.

Promote Access to Comprehensive Services. CCDBG plans reflected that at least a few states were taking some steps to connect vulnerable infants and toddlers and their families to health care and other needed services, such as:

Training providers in infant mental health: **Oregon** sought to improve provider understanding of early childhood mental health needs and interventions by offering an **Infant/Toddler Mental Health Certificate Program**, a distance learning program offered by Portland State University. Oregon Community Foundation, a partner organization, provided financial assistance for some providers to participate in the program.

Streamlining social service agencies: **Arizona's** Department of Economic Security housed most of the state's social services programs in one agency, thus making it easier for families to apply for multiple services. Programs housed in the department included

child care assistance, employment services, food stamps, and the Early Intervention Program for Infants and Toddlers with Disabilities.

Providing community-based systems of support: **New Hampshire** had 14 interagency, regional Infant Mental Health Teams that identified gaps in services and responded to the particular needs of each region. The teams had representation from multiple fields, including mental health, early intervention, and CCR&R agencies. In **Pennsylvania**, infant/toddler specialists worked with local communities through an initiative called the [Infant Mental Health Consultation Project](#) to create comprehensive systems of mental health services and supports for infants and toddlers.

Principle: Babies in child care need their families to have access to quality options for their care.

Across all types of child care settings, high-quality infant care is characterized by sufficient provider-to-child or staff-to-child ratios; small group sizes; compassionate child-rearing beliefs of providers and caregivers caring for babies; and safe, clean, and stimulating environments. For low-income families, however, fewer resources are available to pay for quality care, and many cannot afford the price of licensed care for babies and toddlers.¹⁰ Licensed infant and toddler care is costlier for providers to offer than care for older children and consequently in shorter supply, especially in economically disadvantaged communities.¹¹ Key features required by licensing for infant/toddler care are expensive to provide, such as more adults per child, more space per child, special equipment such as cribs, and additional health and safety requirements such as sanitary areas for diaper changing. Families that receive a subsidy to help pay for child care may face limitations on what care they can choose based on those willing to accept this form of payment and the rules and rates of payment attached. State policy choices on how often families must reapply for subsidies, how much to pay infant/toddler providers, and how stable provider payments and policies are all have an impact on whether providers choose to care for infants and toddlers

receiving subsidy and on parents' ability to maintain subsidy support for their provider of choice.

In addition, all parents of young children need information on infant/toddler development and quality child care. For parents with low literacy skills or limited English proficiency, finding understandable information can be a particular challenge. Limited English proficient (LEP) and immigrant families are often unaware of or unfamiliar with the availability of child care assistance. Many parents of infants and toddlers need individualized consultation, provided through bilingual and culturally competent staff, to understand the full range of child care options available to them.

To achieve this principle, CLASP recommends the following policy actions to expand access to quality options for babies in child care:

- ✓ *Build supply of quality care.*
- ✓ *Use subsidy policies to promote stable, quality care.*
- ✓ *Provide information on infant/toddler care.*

FINDING: At least half of states reported using CCDBG funds for grants to providers to help build the supply of high-quality infant/toddler care. Some grants were given particularly to increase infant/toddler slots; others were general quality improvement grants in which infant/toddler providers received priority. Another method states mentioned in their CCDBG plans was paying higher subsidy rates to both center and family child care providers serving infants and toddlers, with a few reporting that they contracted directly with infant/toddler providers to promote stable access to care. While a few states reported activities related to providing diverse families with culturally and linguistically appropriate information on choosing child care, their activities did not specifically target diverse families with infants and toddlers.

Build supply of quality care. CCDBG plans indicated that states used several common approaches to improve the availability of high-quality infant and toddler child care and child care in underserved communities. These common strategies included creating grant opportunities for providers and collaborating with CCR&R agencies:

Grant Opportunities: States reported that they had various grants available to support infant/toddler providers, such as:

- **Expansion grants:** **Nevada** offered mini-grants to increase the number of available infant/toddler slots and to make quality improvements in licensed child care facilities. Similarly, **North Carolina** offered expansion grants for infant/toddler slots. The state reported that as of June 2006, 245 new infant/toddler new slots had been created as a result of the expansion grants. All the grantees were in four and five star settings in the state's quality rating and improvement system (QRIS).
- **Facility/equipment improvement grants:** **New Hampshire** awarded up to \$4,000 in equipment grants for centers and up to \$1,500 for family child care homes for providers that participated in an Infant/Toddler Graduate Seminar at Wheelock College. The state reported that 30 center directors and lead infant/toddler teachers had participated since 2000. In **South Dakota**, regulated caregivers that completed 20 hours of [infant/toddler training](#) could apply for a \$200 mini-grant. The mini-grant could be used for the purchase of infant/toddler-specific resources.
- **Prioritized grants:** **Rhode Island** offered grants to providers to increase the supply of child care or participate in quality improvement activities. Priority was given to hard-to-find child care, such as infant and toddler care and child care in underserved communities, as well as to activities such as accreditation that improved the quality of care. **New York** also prioritized grants to providers seeking to increase infant/toddler slots.

Partnerships with CCR&R agencies: **Kansas'** child care agency partnered with the [Kansas Association of Child Care Resource and Referral Agencies](#) (KACCRRRA) to recruit providers to serve children who received child care subsidies. Infant/toddler specialists from KACCRRRA provided technical assistance and training to providers. The state also created recruitment materials to increase the supply of child care.

Use subsidy policies to promote stable, quality care. To promote stable, quality infant/toddler care, the majority of states had built higher subsidy rates into the subsidy payment systems for both center and family child care providers serving infants and toddlers. Some states reported that they had additional payment enhancements or incentives to help providers compensate for the higher costs of infant/toddler care. A few reported contracting with subsidy providers to deliver services and promote stability. Examples included:

Higher subsidy payment rates for infant/toddler care with additional payment enhancements: **Missouri** paid a higher [subsidy rate](#) for infant and toddler care compared to other age groups and added a 25 percent payment increase to the base reimbursement if a child had special needs. **New Mexico** reported that the state used the CCDBG infant/toddler earmark to pay a higher subsidy rate for infant and toddler care and added \$120 a month per child for nationally accredited providers.

Stable child care contracts: **Connecticut** spent about a quarter of CCDBG subsidy dollars to contract directly with licensed providers to offer child care slots for subsidy-eligible children, including infants and toddlers.

Conclusion

Based on CLASP's review of CCDBG plans for FFY 2008-2009, it is clear that states are implementing policies intended to support the healthy growth and development of babies and toddlers in child care through multiple levers such as child care licensing, subsidy, and quality enhancement policies. This review was conducted to cull

specific, illustrative examples of state policies, as well as identify opportunities and challenges for state policy in the future. When CLASP analyzed state CCDBG plans according to principles and policy recommendations of what babies and toddlers in child care need, we found states were addressing them to different degrees. States were:

Developing nurturing, responsive providers and caregivers:

All states reported activities to promote the nurturing and responsive nature of providers and caregivers, including initiatives to define core knowledge and skills; enhance education, training, ongoing support and consultation; and supplement compensation. CCDBG plans reflected minimal action by states to ensure that infants and toddlers were in continuous care relationships with their providers and caregivers during their critical years of growth and development. And, despite an increasingly diverse population under age 3, only a few states reported specific efforts to recruit, maintain, and support culturally and linguistically diverse providers and caregivers.

Ensuring healthy and safe environments: The majority of states reported that they had trainings and resources to improve providers' preparation on health and safety issues related to infants and toddlers and assist them in meeting licensing policies. However, no states explicitly indicated that they were taking specific steps to make certain that babies and toddlers were in sufficiently small groups with adequate numbers of providers or caregivers.

Linking parents, providers, and caregivers to comprehensive services: Almost half of states offered educational programs and resources to parents to increase their skills and understanding of infant/toddler care. Fewer states reported efforts to help parents with infants and toddlers in child care connect to other needed comprehensive supports and services.

Providing access to quality options for infant/toddler child care: Nearly all states paid higher rates for infant/toddler child care for center-based and family child care providers, and a handful reported

compensation, enhancement, and other incentive strategies to increase the stability of the infant/toddler workforce. A few also reported using grants or contracts to build the supply of stable, quality infant/toddler care. No state reported an initiative to provide culturally and linguistically appropriate information specifically on infant/toddler child care.

As most state leaders are well aware, planning for the future of state child care policy must always include an intentional focus on the needs of infants and toddlers. Based on this review, it is clear that states are implementing policies intended to support the healthy growth and development of babies and toddlers in child care using child care licensing, subsidy, and quality enhancement policies. However, CLASP's analysis of state CCDBG plans finds states addressing these policies to different degrees. A lack of reported initiatives in particular key areas, such as linking necessary services for vulnerable babies and supporting diverse providers and families, may be due to a shortage of knowledge of appropriate strategies, financial resources, or both. Policymakers at the state and federal level should consider how best to build state capacity to address the areas for which CLASP did not find examples.

States will have further impetus to examine their infant and toddler child care investment over the next two years, as they determine how best to use the additional CCDBG funding available to them from the American Recovery and Reinvestment Act (ARRA). The ARRA provides \$2 billion to states to use for child care on top of the current federal allocation for CCDBG. Of this amount, \$93.6 million is targeted for activities that improve the quality of infant/toddler care.¹² The *Charting Progress for Babies in Child Care* policy framework, and its supporting recommendations and technical assistance products, include [ideas](#) for utilizing ARRA funds that states may use to help identify the strengths and gaps in their current policies and to continue to build their efforts to expand access to high-quality child care for babies and toddlers in their states.

¹ Alison Clarke-Stewart, Deborah Lowe Vandell, Margaret Burchinal, Marion O'Brien, and Kathleen McCartney, "Do Regulable Features of Child Care Homes Affect Children's Development?" *Early Childhood Research Quarterly* 17, no. 1 (2002): 52-86; Susanna Loeb, Bruce Fuller, Sharon Lynn Kagan, and Bidemi Carrol, "Child Care in Poor Communities: Early Learning Effects of Type, Quality and Stability," *Child Development* 75, no. 1 (2004): 47-65.

² Carollee Howes, "Attachment Relationships in the Context of Multiple Caregivers," in *Handbook of Attachment: Theory, Research, and Clinical Applications*, ed. Jude Cassidy and Phillip R. Shaver, 1999, 671-687.

³ Hannah Matthews, *Infants and Toddlers in the Child Care and Development Block Grant Program: 2007 Update*, CLASP, http://www.clasp.org/publications/ccdbgp participation_2007babies.pdf.

⁴ U.S. Department of Health and Human Services, Administration for Children and Families, *Fiscal Year 2009 Federal Child Care and Related Appropriations*, http://www.acf.hhs.gov/programs/ccb/ccdf/approp_2009.htm.

⁵ *The Science of Early Childhood Development*, National Scientific Council on the Developing Child, 2007, http://www.developingchild.net/pubs/persp/pdf/Science_Early_Childhood_Development.pdf.

⁶ Marcy Whitebook, Laura Sakai, Emily Gerber, and Carollee Howes, *Then & Now: Changes in Child Care Staffing, 1994-2000, Technical Report*, Center for the Child Care Workforce, 2001.

⁷ *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, Center on the Developing Child at Harvard University, 2007, 3, http://developingchild.harvard.edu/content/downloads/Policy_Framework_ork.pdf. For other resources, see also

<http://developingchild.harvard.edu>.

⁸ Jennifer Ehrle Macomber, Gina Adams, and Kathryn Tout, *Who's Caring for Our Youngest Children? Child Care Patterns of Infants and Toddlers*, Urban Institute, 2001, <http://www.urban.org/url.cfm?ID=310029>.

⁹ *Ibid.*, Sixty-five percent of infants and toddlers living in poverty and 72 percent of infants and toddlers living between 100 percent and 200 percent of the federal poverty level with employed mothers have a regular, nonparental care arrangement.

¹⁰ National Association of Child Care Resource and Referral Agencies, *Parents and the High Price of Child Care: 2008 Update*, 2008, http://www.naccrra.org/docs/reports/price_report/Price_Report_2008.pdf.

¹¹ Diane Paulsell, Julie Cohen, Ali Stieglitz, Erica Lurie-Hurwitz, Emily Fenichel, and Ellen Kisker, *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families*, ZERO TO THREE and Mathematica Policy Research, Inc., 2002, <http://www.mathematica-mpr.com/pdfs/partnership.pdf>.

¹² U.S. Department of Health and Human Services, Administration for Children and Families, *Fiscal Year 2009 Federal Child Care and Related Appropriations*, http://www.acf.hhs.gov/programs/ccb/ccdf/approp_2009.htm.