Quality Child Care for Infants and Toddlers:

Case Studies of Three Community Strategies

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CONTENTS

EXECUTIVE SUMMARY

The quality of child care can be a critical influence on the well-being of infants and toddlers. Extensive research has shown that variations in quality are associated with a broad range of child outcomes across a wide age spectrum (Love et al. 1996; NICHD Early Child Care Research Network 2000; Peisner-Feinberg 2001; and Zill et al. 2001). Good-quality child care can influence positively the developmental outcomes of infants and toddlers. However, finding and paying for good-quality care—child care in a safe, healthy environment that meets professional standards for good care and promotes healthy child development—can be especially challenging for low-income families with infants and toddlers.[1]

To address the increasing child care needs of low-income families in the wake of welfare reform, federal and state governments have responded in recent years with increased funding for child care and for initiatives to improve quality. Some of these initiatives have been designed specifically to address the unique challenges of infant-toddler care. In addition, policymakers and program operators have begun to collaborate across programs and systems to address the child care and child development needs of young children whose parents are working. At the state and local levels, many efforts are underway to increase collaboration, develop partnerships, and coordinate services (Kagan et al. 2000; Ochshorn 2000; and Schumacher et al. 2001). In response to the growing interest in collaboration and partnership strategies, several studies in recent years have examined early childhood partnerships and documented a variety of strategies for developing them (Kagan et al. 2000; Ochshorn 2000; Sandfort and Selden 2001; and Schumacher et al. 2001). However, these studies have not necessarily focused on the unique challenges faced by partnerships that focus on infant-toddler care.

[1]Professional standards include the accreditation criteria of the National Association for the Education of Young Children (NAEYC 1998), the Head Start Program Performance Standards (Administration for Children and Families 1996), and the guidelines of the American Public Health Association and the American Academy of Pediatrics (1992).

THE STUDY OF COMMUNITY STRATEGIES FOR INFANT-TODDLER CARE

In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) obtained funding from the Child Care Bureau of the U.S. Department of Health and Human Services (DHHS) to conduct an in-depth study of collaborative community initiatives and partnerships designed to improve low-income families' access to good-quality infant-toddler care. An interim report released in March 2002, *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families*, presents findings from the study's first year about promising strategies for building such community collaborations and partnerships. This executive summary highlights findings from the study's final report. At its heart is a set of in-depth case studies of three types of collaborative infant-toddler child care initiatives located in four diverse communities. The information used to develop these case studies was collected during intensive three-day site visits to the case study communities. Next, we describe each of the case study initiatives, the perspectives of parents participating in them, and key cross-site themes that emerged from the case study analysis.

THE CASE STUDY INITIATIVES

The Community Consolidated Child Care Pilot Services Program in El Paso County, Colorado. In 1997, the Colorado General Assembly created the child care pilot initiative, which directed the Colorado Department of Human Services (DHS) to designate 12 pilot communities and charge them with developing models for seamless service systems that could provide full-day, full-year early care and education services to children from low-income families. The General Assembly also authorized DHS to waive any state rule, regulation, or law that impeded the pilot communities from implementing a seamless service system. In El Paso County, various government agencies, child care providers, and other community partners formed a pilot steering committee to develop the initiative and create models for increasing access to quality child care. Drawing on a wide range of community partners and funding sources, El Paso County has developed and implemented four types of models to build its early care and education system: (1) models for increasing the number of child care slots available to low-income families, (2) models for increasing families' access to child care options, (3) models for improving child care quality, and (4) models for supporting children with special needs in child care.

State-Sponsored Early Head Start Programs in Kansas City, Kansas, and Sedalia, Missouri. In recognition of low-income families' increased need for quality infant-toddler child care, the states of Kansas and Missouri have sponsored Early Head Start programs modeled after the federal program. Through partnerships with community child care providers, state grantees must follow federal program performance standards and must provide child care to families who need it. To meet families' child care needs, Project EAGLE in Kansas City, Kansas, and the Children's Therapy Center in Sedalia, Missouri, have developed intensive partnerships with community child care providers, including child care centers and family child care homes. The programs pay for children's care at rates that are higher than state child care subsidy rates, provide training and technical assistance

through regular visits to child care providers, and provide developmentally appropriate toys and equipment. Participating providers agree to work toward meeting the Head Start program performance standards and to implement developmentally appropriate practices.

Mountain Area Child and Family Centers in Buncombe County, North Carolina. In the early 1990s, responding to a lack of affordable, good-quality child care in the area, a community group made up primarily of retirees launched a grassroots effort that resulted in the opening of the Mountain Area Child and Family Centers (MACFC) in January 2001. Spanning nearly a decade, this effort mobilized extensive community resources to design, build, and begin operating a state-of-the-art child care center in an underserved area of rural Buncombe County. Since its inception, the organization has remained committed to providing high-quality child care and parenting resources, serving children with special needs, and enrolling families from a mix of income levels. In addition, the center has opened its doors to provide hands-on learning opportunities for early childhood education students and professionals. Developed and implemented by a private community organization, MACFC is an innovative initiative that may not be easily replicated elsewhere. Nevertheless, it provides an important set of lessons that can inform the efforts of other private-sector child care initiatives, such as those launched by business communities, faith-based organizations, community foundations, and other private organizations.

PARENT PERSPECTIVES

During focus groups conducted in each of the case study communities, parents described the barriers they faced to accessing good-quality infant-toddler care and the characteristics of child care providers and settings they associated with high-quality care. Across the four case study sites, several common themes emerged from parents' experiences. In all the sites, parents identified an inadequate supply of regulated infant-toddler slots, the high cost of infant-toddler care, and inadequate quality of many arrangements they could afford as the three main barriers low-income families in their communities faced. Parents also discussed their own definitions of quality child care and described the aspects of quality they sought in child care arrangements for their infants and toddlers. Parents said they sought providers who created a welcoming environment for children and parents, provided developmentally appropriate learning activities, implemented rigorous health and safety procedures, and provided continuity of care for children over time. Parents also expected high-quality interaction between providers and children, as well as close communication between providers and parents. Finally, parents in several communities noted that willingness to care for children with special needs and teaching children to value diversity were also signs of good quality.

CROSS-SITE THEMES

Two overarching themes surfaced across the initiatives we studied: (1) how to pay for infant-toddler child care, and (2) how to ensure the provision of good-quality care. These themes certainly are not unique to infant-toddler child care; funding and quality also are important issues for preschool-age and school-age child care. Nevertheless, the challenges

of funding and quality are especially pressing issues for infant-toddler care. Child care for infants and toddlers is more expensive to provide than care for preschoolers or school-age children, and providing good-quality child care is more difficult for this age group than for older children. Below, we describe the lessons gleaned from a cross-site analysis of the case studies under the themes of funding and quality, with an emphasis on those aspects that are especially relevant to infant-toddler care.

FUNDING GOOD-QUALITY INFANT-TODDLER CHILD CARE

Providing infant-toddler care is expensive, in large part because providing the intensive care and supervision that infants and toddlers need requires lower child-caregiver ratios than for older children. Staff need training in infant-toddler care and development to ensure that their practices and expectations are age-appropriate and promote healthy development. Infant-toddler child care providers also need adequate space for crawlers and walkers, as well as special equipment such as cribs, high chairs, strollers, developmentally appropriate toys, and age-appropriate outdoor play equipment. Consequently, the fees charged for good-quality infant-toddler care were beyond the means of low-income families in the communities we visited. Identifying funding sources to pay for good-quality infant-toddler child care thus emerged as a central activity for each of the initiatives we studied.

In two of three case studies, state child care subsidies were accessible to low-income families, but subsidy funds alone were not sufficient to cover the cost of care. Parents described searching for infant-toddler providers who would accept the state subsidy; and most reported either that providers in the community would not accept subsidies or that the quality of care their children received from providers willing to accept the subsidy was inadequate. In the third case study, a long waiting list precluded most families from obtaining a subsidy unless their child had special needs.

Child care providers also cited the challenge of funding infant-toddler child care with state subsidy payments. In El Paso County, Colorado, the area's largest nonprofit child care provider described the difficult decision to close its last infant room, as covering the cost of infant-toddler care had depleted the organization's reserve fund. In North Carolina, staff and board members of the Mountain Area Child and Family Center reported that even the fees charged to higher-income families did not cover the true cost of providing infant-toddler care, and state subsidy reimbursement rates were well below tuition rates for paying families.

When providers were not able to cover their costs with state subsidies, they reduced or eliminated infant-toddler slots. Consequently, in all the communities we visited, the supply of infant-toddler care was inadequate to meet the demand for regulated care. This section describes cross-site lessons from the case studies about funding a stable supply of good-quality infant-toddler care.

- **Child care providers in the case study sites said they must combine multiple funding streams to cover the cost of offering good-quality infant-toddler care for low-income families.**

Although each community took a different approach to blending funding streams to pay for infant-toddler care, key stakeholders in each community emphasized the necessity of combining funds. In Colorado, child care providers formed partnerships with Early Head Start to help pay for child care. For example, a school district operating an on-site child care center at an alternative high school reported that without the Early Head Start partnership, the district could not afford to continue operating its infant-toddler rooms. The district also relied on state subsidies and a variety of other funding sources to pay for the care. In addition, the county welfare office in El Paso County, Colorado, supported providers' efforts to open infant-toddler rooms by providing guaranteed funding for these slots during an initial start-up period. In North Carolina, the Mountain Area Child and Family Center raised funds from foundations and private donors to supplement parent fees and state subsidies.

In Kansas and Missouri, Early Head Start-child care partnerships were funded primarily by state-sponsored Early Head Start initiatives. While these initiatives did not combine multiple funding sources (because families enrolled in these programs already received state funding for child care under Early Head Start, they could not access state subsidies), they did provide child care funding that exceeded the levels available through the state subsidy program. In addition to paying providers at rates that were higher than subsidy reimbursement rates, the initiatives paid for equipment and extensive training of staff.

All the case study initiatives further stretched the funds they had by taking advantage of other child care initiatives in their communities. For example, some providers participated in grant programs to purchase equipment; some accessed wage or health insurance supplement programs. Many took advantage of free or low-cost training opportunities or scholarships provided through state TEACH™ initiatives.

- **When assured of a steady cash flow and ongoing support, family child care providers in the case study sites proved to be a significant source of quality infant-toddler slots for low-income families.**

With the exception of North Carolina (where the initiative examined was a child care center), family child care providers participated in the case study initiatives. Key stakeholders in each of these sites reported that family child care homes provided an important source of good-quality infant toddler slots for low-income families. Initiatives were particularly successful in identifying and involving family child care providers in neighborhoods where families needed care and center-based infant-toddler slots were not available.

Stakeholders in the case study communities identified two kinds of support that were important to sustain the involvement of family child care providers. First, because they care for small numbers of children, family child care providers need a steady flow of cash. In Colorado, stakeholders reported that, because of the lag time between the provision of services and receipt of reimbursement, family child care providers often were reluctant to accept state child care subsidies. To remedy this problem, the child care pilot established the Home Network, which reimburses providers weekly. Early Head Start programs also provide prompt reimbursement to family child care providers.

Second, family child care providers were willing to work on quality improvement, but they needed ongoing support. Through Home Network and partnerships with Early Head Start, family child care providers received frequent technical assistance visits, including help with room arrangement, planning activities, communication with parents, and the business aspects of operating a family child care home. In some cases, providers also received such equipment as cribs, shelving, cubbies, and outdoor play equipment, in addition along with opportunities to network with other home-based providers.

- **Some regulatory barriers that deter child care providers from creating infant-toddler slots in existing facilities can be overcome without putting children's health and safety at risk.**

Regulatory requirements for infant-toddler child care are designed to safeguard the health of this vulnerable population. While stakeholders in the initiatives we studied agreed that these safeguards are essential, in some circumstances the safeguards could prevent potential expansion of infant-toddler slots in existing facilities. Especially in Colorado, providers were able to obtain waivers of some requirements by proposing alternative safeguards to protect the children. These waivers enabled providers to increase the number of infant-toddler slots available by using existing facilities; if the waivers had not been granted, the cost of extensive construction or renovation would likely have prevented providers from opening these slots.

- **Because funding good-quality infant-toddler slots requires the blending of funding and coordinating programs, building collaboration and partnerships was essential in all the case study sites.**

Stakeholders stressed the importance of building strong collaborative relationships with community partners to ensure effective communication and resource-sharing. They also emphasized the importance of sustained leadership by a core group of committed stakeholders to building and sustaining local initiatives. Continuity among core participants enabled key participants in the case study initiatives to build trust and thus establish a history of positive working relationships that they could draw on during difficult growth phases of the initiatives. In addition, frequent, effective communication at all levels—among key stakeholders at the local and state levels; between providers, funding agencies, and technical

assistance providers; and between providers and parents—was essential to forming partnerships and blended funding arrangements. In some communities, strong support from local government agencies, especially the welfare and child care administrators, has been essential to building local support, working out administrative barriers, and bridging temporary gaps in funding.

- **To fund the initiatives, new sources need to be cultivated, which can be accomplished through community outreach and education.**

Key informants in all the case study sites felt strongly that community education about the importance of high-quality child care for the healthy development of infants and toddlers has yielded increased support and investment in child care in their communities. The North Carolina initiative, in particular, has been successful in identifying new funders through a vigorous outreach and education campaign.

IMPROVING THE QUALITY OF INFANT-TODDLER CARE

Key stakeholders in the case study initiatives recognize the positive role that good-quality child care can play in the development of infants and toddlers; all the initiatives we examined emphasized the importance of improving the quality of infant-toddler child care in their communities. While increasing the supply of infant-toddler slots was an urgent need in these communities, most stakeholders felt strongly that initiatives should focus on developing good-quality slots rather than a larger number of slots that met minimal quality standards. As described below, all the initiatives have invested significant resources and staff time in their quality-improvement efforts.

- **Improving quality in the case study sites required offering sustained and intensive support to child care providers.**

Staff and organizations providing technical assistance through the case study initiatives emphasized the need for intensive support for child care providers. Most of the initiatives included regular visits (ranging from weekly to monthly) to family child care homes or infant-toddler classrooms in centers. During these visits, technical assistance staff checked on how the provider was doing, modeled developmentally appropriate caregiving, and provided guidance on implementing specific activities or curricula. When an initiative included Early Head Start-child care partnerships, technical assistance staff supported providers in implementing the Head Start performance standards.

- **Stakeholders also stressed that making the changes necessary for improving the quality of infant-toddler care could best be done incrementally, over time.**

Technical assistance staff emphasized that providing infant-toddler care is hard work and compensation is often low. Providers often became overwhelmed and discouraged if too many changes were expected at once. Instead, providers needed encouragement, positive reinforcement, and reassurance that changes could be made gradually over time. In most of the initiatives, technical assistance staff said that ensuring adherence to health and safety standards was their highest priority. After health and safety, most focused initially on improving the caregiving environment by purchasing equipment and toys and working with providers on room arrangement. Improving the quality of interactions between caregiving and children, however, usually happened more gradually.

- **Improving quality in the case study sites also required significant investments in provider training, provider compensation, and materials and equipment.**

In addition to regular technical assistance visits, all the initiatives supported child care providers in obtaining a Child Development Associate (CDA) credential or a higher degree in early childhood education. Early Head Start programs usually paid for this training, or provided it directly to their partner providers. Other initiatives offered free training or helped providers obtain scholarships.[2] In addition, initiatives offered additional training in infant-toddler care and development and on a range of broader child care topics. Some initiatives incorporated bonuses or wage supplements to serve as incentives for providers to obtain training. For example, a wage supplement pilot project in Kansas City, Kansas, offered higher wages to caregivers who obtained additional education. Similarly, the alternative licensing model implemented in El Paso County, Colorado, and the star rating system in North Carolina provided substantial financial incentives for meeting higher quality standards. Finally, most of the initiatives we examined invested in providing developmentally appropriate equipment and toys to child care providers. Early Head Start programs paid for setting up outdoor play areas at family child care homes and purchased cribs, rockers, and other needed equipment.

- **With adequate support, child care providers were able to accept and care for children with special needs.**

While inadequate supply of infant-toddler care was a significant barrier in the case study communities, finding care for infants and toddlers with special needs was an even bigger challenge. All the initiatives supported child care providers in caring for special needs children by fostering close working relationships with early intervention programs. Typically, early intervention providers worked with children in the classroom, offered

[2]Some of these initiatives were supported by Child Care and Development Fund (CCDF) quality-improvement funds.

technical assistance to caregivers in how to meet a child's needs, and coordinated with caregivers and parents to establish goals for the child in their child care setting. In Colorado, the child care pilot even established a program to support child care providers in caring for children with significant behavioral problems.

Although providing good-quality infant-toddler care is expensive and challenging, many child care providers in the case study sites were willing to add services for infants and toddlers or to expand the number of slots they offered once they were assured of sustained funding, technical assistance, and support. Thus, each of the case study communities was able to make progress in increasing the number of good-quality infant-toddler slots in its community, especially slots that were accessible to low-income families. Although the sites used a variety of strategies and their community contexts differed, all the case study initiatives made progress by pooling resources, coordinating services, and maintaining close communication among key stakeholders.

CHAPTER I

INTRODUCTION

The quality of child care can be a critical influence on the well-being of infants and toddlers. Extensive research has shown that variations in quality are associated with a broad range of child outcomes across a wide age spectrum (Love et al. 1996; NICHD Early Child Care Research Network 2000; Peisner-Feinberg 2001; and Zill et al. 2001), particularly for infants and toddlers (Love et al. 2000). Good-quality child care can influence positively the developmental outcomes of infants and toddlers. However, finding and paying for good-quality care—child care in a safe, healthy environment that meets professional standards for good care and promotes healthy child development—can be especially challenging for low-income families with infants and toddlers.[1]

To address the increasing child care needs of low-income families in the wake of welfare reform, federal and state governments have responded in recent years with increased funding for child care and initiatives for improving quality. Some of these initiatives have been designed specifically to address the unique challenges of infant-toddler care. For example, the Child Care and Development Fund (CCDF) has increased federal funding for child care, given states greater flexibility in spending the funds, and set aside funds for quality improvement. Some quality improvement funds are targeted to infant-toddler care. Similarly, Head Start, Early Head Start, and state-funded prekindergarten programs have expanded. In 2002, the Bush administration launched its *Good Start, Grow Smart* initiative, which aims to partner with states to develop guidelines for literacy promotion in child care and other early childhood programs, improve the quality of Head Start by training teachers in early literacy teaching techniques, and furnish parents and caregivers with more information on best practices in early childhood education.

[1]Professional standards include the accreditation criteria of the National Association for the Education of Young Children (NAEYC 1998), the Head Start Program Performance Standards (Administration for Children and Families 1996), and the guidelines of the American Public Health Association and the American Academy of Pediatrics (1992).

In addition, policymakers and program operators have begun to collaborate across programs and systems to address the child care and child development needs of young children whose parents are working. At the state and local levels, many efforts are underway to increase collaboration, develop partnerships, and coordinate services (Kagan et al. 2000; Ochshorn 2000; and Schumacher et al. 2001). These include partnerships between Head Start, child care, and public school systems. The federal government also has promoted collaboration and partnership development. For example, in late 1998, the Child Care and Head Start bureaus launched a training and technical assistance initiative—Quality in Linking Together: Early Education Partnerships (QUILT)—to help Head Start programs and child care providers develop partnerships. In response to the growing interest in collaboration and partnership strategies, several studies in recent years have examined early childhood partnerships and documented a variety of strategies for developing them (Kagan et al. 2000; Ochshorn 2000; Sandfort and Selden 2001; and Schumacher et al. 2001). However, these studies have not necessarily focused on the unique challenges faced by partnerships that focus on infant-toddler care.

THE STUDY OF COMMUNITY STRATEGIES FOR INFANT-TODDLER CARE

In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) obtained funding from the Child Care Bureau of the U.S. Department of Health and Human Services (DHHS) to conduct an in-depth study of collaborative community initiatives and partnerships designed to improve low-income families' access to good-quality infant-toddler care. An interim report released in March 2002, *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families*, presents findings from the study's first year about promising strategies for building such community collaborations and partnerships. The report also describes a set of preliminary operational themes that may be helpful for programs, communities, and state and federal policymakers who seek to develop, implement, and support partnership strategies. Because Early Head Start has been in the forefront of efforts to promote the development of community partnerships—especially those with child care providers—to help meet the unique needs of families with infants and toddlers, the report examines these Early Head Start-child care partnerships in detail.

This final report presents findings from Year Two of the study. At the heart of the report are a set of in-depth case studies of three types of collaborative infant-toddler child care initiatives located in four diverse communities (Chapters II, III, and IV). The first case study describes the Community Consolidated Child Care Pilot Project—a collaborative initiative implemented in El Paso County, Colorado that focuses on local planning. The second explores Early Head Start-child care partnerships developed as part of the Kansas and Missouri state-funded Early Head Start programs in two communities—Kansas City, Kansas, and Sedalia, Missouri. The third case study profiles the efforts of a private community group in Buncombe County, North Carolina, to develop, fund, and open a high-quality child care center in an underserved area of the county. Although the lessons of the North Carolina case study are in many ways unique to the community initiative we profiled, it nevertheless provides an important example of ways in which private sector entities—such

as employers, community foundations, or faith-based organizations—can increase low-income families' access to good-quality child care. Chapter V highlights the perspectives of parents whose infants and toddlers participate in these initiatives, based on parent focus groups conducted in each community. We present the perspectives of parents in a single chapter because of the similarities across all three communities in their child care experiences. Chapter VI explores cross-site operational lessons gleaned from the experiences of these case study sites. In the rest of this chapter, we describe the study's research questions, the main barriers faced by low-income families who need infant-toddler child care, and the data sources and methods we used to conduct the study.

RESEARCH QUESTIONS

This study was designed to identify a range of strategies that communities have used to increase the supply and enhance the quality of infant-toddler child care accessible to low-income families. The research questions that guided the study address five broad themes: (1) quality, (2) affordability, (3) state policy, (4) barriers faced by families, and (5) challenges to collaboration. Table I.1 lists the research questions associated with each of these themes, as well as the specific research topics we explored in each area. Under the themes of quality and affordability, we sought to learn about community strategies that have been implemented to help low-income families access good-quality infant-toddler child care and pay for it. Under the state-policy theme, we sought information about how state policies and child care funding have affected community collaborative efforts. We also examined the barriers faced by families, especially new barriers that have surfaced as a result of welfare reform. Finally, we identified the challenges communities faced in implementing collaborative partnerships and the strategies they tried for overcoming these hurdles.

BARRIERS FACED BY LOW-INCOME FAMILIES

Although many federal, state, and community initiatives across the country are working to address barriers to accessing good-quality child care, low-income families with infants and toddlers face significant challenges. Drawing on a literature review, telephone interviews, and focus groups conducted during Year One of this study and parent focus groups conducted during visits to case study sites in Year Two, this section provides context for the case study profiles that follow by summarizing the primary barriers families face:

1. ***Inadequate Supply.*** Many parents face long waiting lists because few infant-toddler slots are available in their communities. Regulated infant-toddler care—which is more likely to meet health and safety standards and be of high quality—is especially scarce in low-income neighborhoods. It also is scarce for families who need part-time care, care during nonstandard work hours, special-needs care, and care for children who are ill (Blank et al. 2001; Collins et al. 2000; Fuller

TABLE I.1

RESEARCH QUESTIONS AND TOPICS

Research Questions	Specific Research Topics
Quality	
What community strategies have been implemented to improve the quality of infant-toddler child care used by low-income families? What are the processes of collaboration, and how long does it take to form partnerships and address issues related to the quality of infant-toddler child care?	• Strategies developed for improving the quality of infant and toddler care in the community • Extent to which quality strategies are linked to collaborative community partnerships • Extent to which infant-toddler care is a focus of the community strategies • How the strategies have been implemented (steps, timelines, key players, funding) and the roles of key community members in carrying out the strategies • Processes of collaboration and steps in forming partnerships • Successes and challenges in implementing the strategies • Lessons for other communities and partnerships
Affordability	
What community strategies have been implemented to help families pay for good-quality child care? How do child care and other service providers navigate state child care subsidy systems, help families avoid breaks in child care caused by interruptions in subsidy payments, and help families pay for good-quality care when they cannot pay the difference between the subsidy and the cost of care?	• Strategies developed for helping families pay for good-quality infant and toddler care • Extent to which affordability strategies are linked to collaborative community partnerships • Extent to which infant-toddler care is a focus of the community strategies • How the strategies interact with the state child care subsidy system, and how they address interruptions in subsidy eligibility and long waiting lists • How the strategies have been implemented (steps, timelines, key players, funding) and the role of key community members in carrying out the strategies • Successes and challenges in implementing the strategies • Lessons for other communities and partnerships
State Policy	
How have communities worked with states to access funding and develop policies that address the needs of low-income families with infants and toddlers for affordable, accessible, good-quality child care?	• How state subsidy and other child care policies influence collaborative community partnerships and strategies to help low-income families find and pay for good-quality infant-toddler care • Use of state child care subsidies and other state funds by collaborative partnerships • How state quality-improvement initiatives can support collaborative community initiatives • How state funds are combined with other funding sources by collaborative partnerships • Community activities to influence state child care policies • Lessons on how states can support collaborative partnerships through funding and policy changes
Barriers Families Face	
What barriers do low-income families face in accessing good-quality child care for their infants and toddlers?	• Supply of child care for infants and toddlers • Cost of child care for infants and toddlers • Nature and availability of child care subsidies for infants and toddlers from low-income families, and any difficulties caused by subsidy policies and procedures

Research Questions	Specific Research Topics
	• Quality of child care for infants and toddlers • Availability of information and resources to help parents arrange good-quality child care for their infants and toddlers • Aspects of the community context that influence parents' child care needs (for example, work shifts of parents, availability of public transportation, location of child care providers, welfare rules) • Parents' infant-toddler child care needs and preferences, patterns of use, as well as experiences with finding and paying for child care
Challenges to Collaboration	
What challenges do community child care providers and other community service providers serving low-income families with infants and toddlers face in implementing collaborative initiatives and partnerships to increase families' access to good-quality infant-toddler child care?	• Nature of existing collaborative community partnerships that aim to help low-income families access good-quality child care for their infants and toddlers, including how they were formed, how they developed, and how they have changed over time • Key members of existing collaborative partnerships and their roles • Time and resources required to develop good collaborative relationships • Strengths and weaknesses of existing collaborative partnerships • Problems faced by existing partnerships and how they have been resolved • State and federal policies that pose challenges to collaborative partnerships • Community characteristics that pose challenges to collaborative partnerships • Lessons for federal and state policymakers and program administrators and communities on how they can support collaborative partnerships • Lessons for future collaborative efforts

et al. 1997; Fuller et al. 2000; General Accounting Office 1997; Lesser 2000; and Nadel 1998).

2. ***Inadequate Quality.*** Research indicates that a large proportion of child care for infants and toddlers is not of good quality. Low-income families in particular may have limited choices in child care providers because of cost and location constraints (Cost, Quality, and Child Outcomes Study Team 1995; Fenichel et al. 1999; Kisker et al. 1991; Kontos et al. 1995; Pungello and Kurtz-Costes 1999; Vandell and Wolfe 2000; and Whitebook et al. 1989). In case study sites, respondents reported that these constraints often led low-income families to use unregulated home-based arrangements for their infants and toddlers. However, research also indicates that some parents prefer informal kith-and-kin arrangements, especially when providers are trusted relatives or friends (Ehrle et al. 2001; and Porter 1998).

3. ***High Cost of Care.*** Low-income families are disproportionately affected by the high cost of infant-toddler care, because they often pay a higher proportion of their income for child care than higher-income families. Many low-income families without access to subsidies cannot afford to pay for regulated infant-toddler child care (Kirby et al. 2001; Mezey et al. 2002; and Southern Institute on Children and Families 2000).

4. ***Difficulties Accessing and Maintaining State Child Care Subsidies.*** Funding for state child care subsidies is insufficient to service all eligible children. Thus, states prioritize families to determine the ones that will receive assistance. Some eligible families have trouble obtaining and keeping subsidies due to lack of information about subsidy availability, transaction costs, administrative barriers, structure and level of copayments, job loss, and availability of providers who accept subsidies. Recent research indicates that the average duration of child care subsidy use is brief (approximately seven months), and that the proportion of families who cycle on and off subsidies is high (Adams et al. 1998; Adams et al. 2001; Collins et al. 2000; Meyers et al. 2002; and Peck and Meyers 2000).

5. ***Lack of Information About the Availability and Quality of Infant-Toddler Care.*** Although child care resource and referral agencies operate in many communities, states face constraints in providing adequate consumer information to parents. Low-income families who are not linked to the welfare system may not be aware of available referral services or may find access to information difficult, especially adequate information about the availability and quality of specific arrangements. In addition, language barriers prevent some families from accessing consumer information (Gong et al. 1999; and U.S. Department of Health and Human Services 1998).

6. ***Difficulties Arranging Transportation to Child Care Arrangements.*** Because infant-toddler child care is in especially short supply in low-income neighborhoods, many families need transportation to care settings. Transportation barriers can be severe for families in rural areas, where public transportation may not be available, and for parents who work late shifts and need transportation after public transit stops running (General Accounting Office 1997; Kirby et al. 2001; and Pungello and Kurtz-Costes 1999).

DATA SOURCES AND METHODS

Because collaborative community strategies for addressing the child care needs of low-income families with infants and toddlers have not been well documented in other research, this study is exploratory in nature. Using an iterative process to identify data sources and collect information for the study, we began in Year One by reviewing recent literature on the barriers faced by low-income families who need infant-toddler child care and relevant research on the strategies that have been implemented to address those barriers. We then conducted telephone interviews with a range of government officials, child care researchers, and other experts and conducted a series of seven focus groups with child care providers and Early Head Start staff. Based on this initial round of data collection, we identified promising community partnerships working to address the infant-toddler child care needs of low-income families. We interviewed key players in these partnerships and, in some cases,

interviewed other community members who were knowledgeable about the partnerships or participated in them.[2]

In Year Two of the study, we selected four communities—El Paso County, Colorado; Kansas City, Kansas; Sedalia, Missouri; and Buncombe County, North Carolina—that have implemented innovative initiatives for addressing the infant-toddler child care needs of low-income families and have developed in-depth case studies of each initiative. To gather information for the case studies, we conducted in-depth site visits to each community and conducted telephone interviews with state-levels officials. In the rest of this section, we describe the criteria used to select case study sites, the interviews and other activities we conducted during site visits, and the methods for analyzing the data collected.

Site Selection

We developed criteria for selecting case study sites to aid us in identifying initiatives likely to yield operational lessons for policymakers and other program operators (Table I.2). In particular, we examined characteristics of the initiatives to be studied, as well as the characteristics of the communities in which they had been implemented. We sought initiatives that were well implemented, that included a quality component, and that involved a broad range of partners. In addition, we sought a diverse set of communities that varied along key dimensions likely to influence families' child care needs and the barriers to finding good-quality infant-toddler care (Table I.3).

We used these criteria to evaluate the initiatives, primarily Early Head Start-child care partnerships, we identified in Year One of the study. Of these, we selected sites in El Paso County, Colorado; Kansas City, Kansas; and Sedalia, Missouri. All these sites met the criteria in Table I.2. Moreover, across the sites identified in Year One, the initiatives implemented in these communities appeared to have the strongest commitment to quality improvement, involved a broad range of community partners, and included both child care centers and family child care homes. They were strongly recommended by key informants—including government officials, technical assistance providers, and child care researchers—as communities that have implemented promising strategies. In addition, they varied in urbanicity, child care subsidy policies, and state child care regulations.

At the request of the Child Care Bureau, we conducted additional telephone interviews to identify initiatives in which Early Head Start was not a central partner that could serve as case study sites. After conducting interviews with key informants about initiatives in California, Maryland, North Carolina, and Virginia, we selected the Mountain Area Child and Family Center (MACFC) in Buncombe County, North Carolina. Of the initiatives identified during these interviews, this site proved to be the best fit with our site selection criteria. The initiative also has a strong commitment to quality and many community linkages. As a child care initiative developed and implemented by a private community organization, it differs

[2]For a more detailed discussion of the data sources and methods we used during the study's first year, see our report on Year One activities, *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families.*

TABLE I.2

CASE STUDY SITE SELECTION CRITERIA: CHARACTERISTICS OF INFANT-TODDLER CHILD CARE INITIATIVES

Criteria	Description
Sufficient Experience	Implementation should be far enough along to provide useful operational lessons. As a guide, we will identify initiatives that have been operating for at least two years.
Commitment to Quality	Initiatives should incorporate a commitment to improving the quality of infant-toddler child care. Specifically, initiatives should support child care providers in maintaining low child-teacher ratios and group sizes, work to increase teacher qualifications and provide training, and promote continuity of care for children over time.
Promising Strategies	The initiative should have implemented strategies that appear promising, based on information collected during preliminary telephone interviews and recommendations from government officials and other child care experts.
Involvement of Multiple Partners	Because this study seeks to learn about the processes of collaboration, initiatives should involve multiple organizations or service providers and should be linked with other community child care initiatives.
Extent of Early Head Start Involvement	Early Head Start is involved in infant-toddler child care initiatives in many communities. However, to ensure inclusion of the non-Early Head Start infant-toddler child care community in the study, at least one key initiative should not include Early Head Start as a central partner.
Types of Providers	Initiatives should consist of those who work with child care centers and family child care homes, either regulated or unregulated.
Types of Partnerships	At least one comprehensive and one subsidy enhancement partnership (as defined in year one of the study) should be among the key initiatives studied.[a]
Linkages with Other Initiatives	The group of initiatives studied across the case study sites should include or have links to the main types of infant-toddler child care initiatives identified in Year One: CCDF-funded initiatives, local planning strategies, initiatives to increase supply, initiatives to improve quality, Early Head Start-child care partnerships, and public-private partnerships.

[a]In year one of the study, we defined comprehensive partnerships as those that formally contracted with providers for child care slots, paid for the full cost of care, and maintained continuity of care. We defined subsidy enhancement partnerships as those that contracted for child care slots and provided funds to supplement state child care subsidies obtained for those children. For more details, see *Partnerships for Quality Improving Infant-Toddler Child Care for Low-Income Families* (Paulsell et al. 2002).

TABLE I.3

CASE STUDY SITE SELECTION CRITERIA: CHARACTERISTICS OF CASE STUDY COMMUNITIES

Criteria	Description
Urbanicity	Selected communities should include a mix of urban and rural sites so that the study can explore strategies implemented to address barriers faced by low-income families in both types of communities.
Child Care Subsidy Policies	Selecting communities that have implemented a variety of child care subsidy policies will facilitate examination of ways in which various aspects of the subsidy policies influence the strategies that communities implement.

Criteria	Description
State Regulations of Child Care Centers and Family Child Care Homes	Variation in state licensing requirements, such as ratio and group size limits and the extent to which family child care homes are regulated, will help us explore how these state policies influence community strategies to improve quality.

substantially from the other case study initiatives. In fact, it is in may ways a unique initiative that may not be easily replicated in other communities. Nevertheless, it provides an important example of a private sector effort to increase low-income families access to child care, thus enhancing variation across the four case study sites. Lessons gleaned from MACFC's experience can inform the efforts of a wide range of private sector entities, such as business communities, community foundations, and faith-based organizations.

Data Collection

Most of the information used to develop case studies was collected during intensive, three-day site visits conducted by a two-person team of researchers.[3] Prior to each visit, researchers developed detailed protocols for all interviews, focus group discussions, and other site visit activities (see Appendix A for site visit protocols and discussion guides). While plans for each visit were tailored to address local community issues and initiatives, a number of common themes were explored across all sites:

1. Community characteristics
2. Barriers to accessing good-quality infant-toddler care faced by low-income families in the community
3. Strategies for developing collaborative initiatives and partnerships to address these barriers
4. Successes and challenges of the initiatives and partnerships
5. Strategies for improving the quality of infant-toddler care used by low-income families
6. Strategies for helping low-income families pay for good-quality infant-toddler care
7. Collaboration across early childhood programs and initiatives

[3]We conducted a one-day site visit to Sedalia, Missouri. We added Sedalia as a fourth case study site to ensure that we included rural perspectives on implementing Early Head Start-child care partnerships in the study. Information collected in Sedalia is combined in a single case study with the Kansas City, Kansas, site, which also implemented an Early Head Start-child care partnership strategy.

Site visitors conducted a variety of interviews and activities while on site, including individual interviews, small group discussions, parent and provider focus groups, and semistructured observations of child care settings (Table I.4). Although the types of respondents varied somewhat by site, in all sites we interviewed or held group discussions with parents, child care providers, child care resource and referral staff, early intervention providers, and staff from early childhood initiatives—such as Early Head Start, Parents As Teachers, and CCDF-funded quality improvement initiatives. Most visits also included interviews with local child care subsidy and welfare administrators. Site visitors also conducted telephone interviews with state-level child care administrators and early childhood program staff about the case study sites either before or after each visit.

Both site visitors participated in almost all site visit interviews and in all focus groups. For individual interviews, one site visitor led the interview, while the other visitor had primary responsibility for notetaking. During focus groups, one site visitor led the discussion. The second visitor operated a tape recorder, took notes, and greeted latecomers. This approach ensured that site visitors were able to conduct high-quality interviews and discussions, as well as take detailed notes.

Table I.4

Site Visit Activities

Activity	El Paso County, Colorado	Kansas City, Kansas	Sedalia, Missouri	Buncombe County, North Carolina
Individual Interviews				
Local Child Care Administrator	X	X		X
Local Welfare Administrator	X	X		X[a]
Child Care Resource & Referral	X	X	X[a]	X
Staff from Local Quality Initiatives	X	X	X	X
Child Care Center Directors	X	X		X
Family Child Care Providers	X	X		
Child Care Center Teachers	X	X		X
Part C Providers	X	X	X	X
Child Care Network Coordinators	X	X	X	
Early Head Start Directors	X	X	X	X
Other Community Members[b]	X	X	X	X
ACF Regional Staff		X	X	
Focus Groups				
Parents	X	X	X	X
Child Care Center Providers		X	X[c]	
Telephone Interviews				
State Child Care Administrator	X	X	X	X
State Early Childhood Staff	X	X	X	X
Semistructured Observations of Child Care Settings				
Infant-Toddler Classrooms	X	X		X
Family Child Care Homes	X	X		

[a]Interview conducted by telephone after the site visit.

[b]Other: Colorado, School district official; Kansas, Community college official; Missouri, Parents As Teachers staff; North Carolina, MACFC Board Members

[c]Focus group participants included child care center directors and family child care providers.

Analytic Methods

Analysis of the case study data was based primarily on interview and focus group discussion summaries and detailed narratives prepared for each case study site. After each site visit or telephone interview, we created interview summaries organized according to the flow of topics contained in the discussion guides. Summaries of focus group discussions were created based primarily on tape recordings of the discussions. To ensure accuracy, one site visitor took the lead responsibility for drafting the summary; the second visitor reviewed the draft and compared it to her own notes. These summaries facilitated comparison of responses and perspectives across informants within particular communities, as well as triangulation of information across respondents and site visit activities.[4] Although the information collected was fairly consistent across respondents, in some cases, site visitors contacted respondents after the visits were completed to check the accuracy of notes on specific issues, resolve discrepancies in information provided by different respondents, or request clarifying information.

Interview summaries served as the foundation for preparing detailed case study narratives for each site. Both site visitors participated in analyzing the interview summaries and developing these narratives. To produce the narratives, site visitors summarized and synthesized the information collected from all sources, including individual interviews, focus group discussions, observations, and reviews of program documents. The narratives include both descriptive information (such as child care subsidy policies, description of each initiative's operations, and the roles of key community members) and judgments about the major implementation lessons gleaned from the site (such as key implementation successes, significant challenges faced by the community, and strategies developed to overcome them). Draft narratives were sent to key site visit participants in each community for their review and comment. Corrections provided by participants were incorporated into the final versions.

Finally, these detailed case study narratives were used to conduct cross-site analyses of key implementation lessons that can be useful for future programs, policies, and research. For example, we compared the successes and challenges experienced in each case study site. For common challenges identified across sites, we examined the strategies that different sites used to address the challenges and their assessments of the effectiveness of these strategies. We also examined the successes that sites achieved and tried to identify the similarities and differences in approaches across sites that contributed to these achievements. In addition, we examined differences in community context, such as child care subsidy policies or regulation, to determine whether these differences led communities to use different approaches for expanding supply or working on quality improvement.

The lessons derived from these analyses can provide valuable insights for policymakers and program operators who seek to implement collaborative strategies or partnerships for

[4]We did not code the interview notes using qualitative analysis software, because the number of sites and interviews was small enough that we could make comparisons manually using the interview summaries themselves.

helping low-income families access good-quality infant-toddler child care. Many communities are examining possibilities for enhancing collaboration, pooling resources, and forming early childhood partnerships. States are considering ways in which they can support and encourage implementation of collaborative strategies and partnerships at the local level. This exploratory study, however, does not provide a comprehensive accounting of the types of collaborative strategies implemented across the country. Rather, the in-depth case studies offer several models for developing and implementing such strategies in diverse communities, including detailed examples of the types of successes and challenges communities are likely to face, the variety of strategies communities can us to foster collaboration, and the relative usefulness of these strategies in a range of community contexts.

CHAPTER II

THE COMMUNITY CONSOLIDATED CHILD CARE PILOT SERVICES PROGRAM

EL PASO COUNTY, COLORADO

This case study describes the efforts of community partners in El Paso County, Colorado, to create a seamless system of full-day, full-year, high-quality early care and education services for children from low-income families. While El Paso County has worked to develop services for children ages birth to 5, this case study focuses on services for infants and toddlers (ages birth to 3). Community efforts to increase good-quality child care options that would meet the needs of low-income working families were set in motion as the county began planning for welfare reform in the mid-1990s, and accelerated when, in 1997, the county was designated by the state as 1 of 12 child care pilot communities. Based primarily on data collected during a site visit to El Paso County in May 2002, the case study describes the development of the county's pilot initiative, models created by the pilot for increasing access to quality infant-toddler care, implementation successes and challenges, and lessons learned from El Paso County's experiences.

COLORADO'S CONSOLIDATED CHILD CARE PILOT PROGRAM

In 1997, the Colorado General Assembly created the Community Consolidated Child Care Services Pilot Program. The authorizing legislation for this program was introduced in recognition of anticipated child care needs resulting from welfare reform. With the implementation of work requirements and time limits, many low-income parents with young children would need to work, thus increasing the need for quality child care options. Moreover, parents would need full-day, full-year services. The part-day options available at that time for children from low-income families would no longer be sufficient. For example, even if supplemental part-time care were available, low-income working parents would have difficulty leaving work in the middle of a shift to pick up their children from a part-day Colorado Preschool Program or Head Start program to transport them to another child care

arrangement. Programs might not be able to pay for transportation between program classrooms and child care providers.

To address this anticipated increase in the need for child care, the pilot legislation (Colorado Senate Bill SB97-174) directed the Colorado Department of Human Services to designate 12 pilot communities. Each of these communities was charged with developing models for seamless service systems that could provide full-day, full-year early care and education services to children from low-income families. Specifically, pilot communities were directed to:

1. Combine funding streams (in particular, funds from the Colorado Child Care Assistance Program [CCCAP], the Colorado Preschool Program [CPP], and the federal Head Start program) to create seamless service systems[1]
2. Increase collaboration among early care and education service providers and other local stakeholders
3. Provide high-quality early care and education services
4. Design services in response to the needs of low-income, working parents

The initial legislation did not authorize additional funding to support the work of the pilot communities. It did, however, authorize the Department of Human Services to waive any state rule, regulation, or law that impeded the pilot communities from implementing a seamless service system that met the needs of low-income working families. In addition, to ensure that the pilot communities had both support from key stakeholders and the flexibility to combine funding streams, the state required communities applying for pilot status to include the superintendents of schools (who administer CPP funds) and the county commissioners (who oversee administration of CCCAP and TANF funds) as pilot partners.

In the 1999 legislative session, the Colorado General Assembly authorized the addition of 6 pilot communities, bringing the total number of pilot sites to 18. The legislation, Colorado Senate Bill SB99-2226, also directed the pilot communities to develop training plans for early childhood professionals, credentialing systems for child care providers, and outcomes-based licensing models. In addition, it channeled quality set-aside funds allocated through the federal Child Care and Development Fund (CCDF) to the pilot communities. Finally, communities applying for pilot status were required to include Head Start grantees as partners in the pilot if Head Start or Early Head Start was already operating in the area.

The 1999 legislation also required the Colorado Department of Human Services to contract for an independent evaluation of the pilot program. The Center for Human

[1]In El Paso County, Colorado, CCCAP is funded through a combination of funds from the Child Care and Development Fund (CCDF) and Transitional Assistance for Needy Families (TANF) transfers.

Investment Policy at the University of Colorado-Denver conducted the evaluation and in 2001 released its findings. The study found that pilot communities have used waivers to increase the flexibility of funding streams and address barriers created by state child care licensing rules, increased collaboration at local and state levels, improved child care quality, and increased their focus on achieving school readiness (Garnett et al. 2001).

EL PASO COUNTY'S CONSOLIDATED CHILD CARE PILOT PROGRAM

In 1996, before the creation of the child care pilot, El Paso County's Department of Human Services (DHS) established several task forces comprising area service providers, members of the faith community, business leaders, public agencies, and other stakeholders to begin planning for welfare reform and to identify changes that would be needed in the county's service delivery system. One of these was a task force to plan for meeting the child care needs of low-income families under welfare reform. When the child care pilot legislation was passed in 1997, El Paso County DHS officials encouraged the local child care community to apply for pilot status. Working through its welfare reform child care task force, DHS took the lead on preparing and submitting an application.

After El Paso County received pilot status, the welfare reform child care task force and a separate task force created to oversee the child care pilot joined forces to form the Alliance for Kids (known as the Alliance). The Child Care Pilot Steering Committee (Pilot Committee) was established as a permanent subcommittee of the Alliance, which also conducts advocacy on early childhood care and education issues, parent education and information initiatives, and a child care provider support initiative. The Alliance depends for its operation on the volunteer contributions of its members. Although a coordinator for the child care pilot was hired in January 2002, the Alliance has no other paid staff to support its work.

Key Partners

By 2002, the Alliance had more than 30 member organizations, including the El Paso County DHS, several school districts, nonprofit and for-profit child care providers, associations of child care providers and other early childhood professionals, health and mental health care providers, Head Start and Early Head Start, and United Way. The key partners involved in the child care pilot are the El Paso County Board of Commissioners, El Paso County DHS, School District 11, Community Partnership for Child Development (the county's Head Start/Early Head Start grantee), Child Care Connections (CCC), Child Nursery Centers, Inc., Pikes Peak Family Child Care Association, and several for-profit child care centers. Table II.1 provides a detailed description of community partners involved in providing or enhancing infant-toddler child care services through the pilot.

Community Context

El Paso County has emerged as one of the fastest-growing regions in Colorado and in the United States. Between 1990 and 2000, the population grew approximately 30 percent, to 516,929 (U.S. Census Bureau 2001). Approximately 39,000 are children under age 5. More than 45,000 county residents live in poverty. Of these, nearly 44 percent (19,700) are children under age 18; more than 12 percent (5,580) are children under age 5 (U.S. Census Bureau 2001).

TABLE II.1

KEY PARTNERS FOR IMPLEMENTING INFANT-TODDLER MODELS
EL PASO COUNTY'S CONSOLIDATED CHILD CARE PILOT

El Paso County Department of Human Services (DHS)	• Administers the Colorado Child Care Assistance Program (CCCAP), Temporary Assistance for Needy Families (TANF), food stamps, Medicaid, Teen Self-Sufficiency, child welfare services, and other services for low-income families in El Paso County. • Works with a wide range of community partners—many of whom are co-located at the DHS office—including mental health workers, domestic violence counselors, early childhood specialists, and others. Its largest community partner, Goodwill Industries of Colorado Springs, provides case management for two-parent families and a range of employment-related services. • A transition team housed at the Pikes Peak Workforce Center provides postemployment assistance to approximately 2,000 families who are making the transition from TANF to self-sufficiency. • Has provided funds for pilot models, in-kind grant writing services, technical assistance, and leadership.
Child Care Connections (CCC)	• Affiliated with the Colorado Office of Resource and Referral Agencies (CORRA). • Provides resource and referral services in El Paso County. Parents can contact CCC by phone or meet with CCC early childhood specialists located on site at DHS or the Pikes Peak Workforce Center. • Also provides a range of training and support services for child care providers, educates the community about child care quality, and administers the Child Care Response Team and the El Paso County Licensing Model.
Child Nursery Centers, Inc. (CNC)	• The oldest child care agency west of the Mississippi (founded in 1897). Also the largest nonprofit child care provider in El Paso County, serving approximately 420 children, ages 6 weeks to 14 years, in six centers located throughout the county. • Has developed partnerships to provide Head Start, Early Head Start, Colorado Preschool Program (CPP) services in its centers. • Uses the Storybook Journey curriculum in all its centers to promote early literacy and learning; also provides nutrition, health, and family support services. • Administers the Home Network, a program that provides support services to 20 family child care providers. • Approximately half the families CNC serves participate in CCCAP, and half pay for child care based on a sliding fee scale.
Community Partnership for Child Development (CPCD)	• Founded in 1965 under the auspices of Catholic Charities to provide Head Start services; in 1987, became an independent nonprofit organization. • Provides Head Start services, CPP services to children in School District 11 and CPP and center-based Part B services (known as the Early Childhood Development Program) for the Harrison School District. CPCD began serving 75 Early Head Start children in 1996-1997 (Wave I).

Community Partnership for Child Development (CPCD) *(continued)*	• Has expanded to serve 135 Early Head Start children—107 in a combination model of home visits and center-based group activities, 24 in community child care centers (Child Nursery Centers and Tesla High School), and 4 in family child care homes that are members of the Home Network. • In 2002, had capacity to enroll 1,457 children across all programs.
School District 11	• As the largest school district in El Paso County, serves more than 32,000 children. • To meet the child care needs of students with infants and toddlers, provides on-site child care at three schools. At Pike Elementary School, serves up to 8 infants and 10 toddlers while their parents attend on-site GED preparation classes. At Hunt Elementary School, also serves up to 8 infants and 10 toddlers whose parents attend GED and ESL classes. At the Tesla Early Care and Education Center, located at Tesla Education Opportunity Center, offers care for 18 infants and 8 toddlers who are the children of teen parents attending the school. Also provides care to a few district employees if space is available. • All three child care programs have a family component in which parents work with their children on learning activities in the classroom.
Resources for Young Children and Families (RYCF)	• Provides service coordination for special needs infants and toddlers who are eligible for early intervention services. • Coordinates with the Resource Exchange, an organization that provides early intervention specialists and other therapists to provide individual therapies to special-needs children, as well as other community organizations, such as CPCD and CNC, that serve very young children with special needs.

Source: Site visit interviews conducted on May 28-30, 2002.

Employment. Services, retail trade, and government comprise the top three employment sectors in El Paso County. Most entry-level jobs fall within the service sector, particularly in the tourism and high-tech industries. Several companies operate large call centers that offer entry-level employment with some opportunities for advancement. This growing region also offers employment in construction. Entry-level positions, such as road flaggers, offer competitive starting wages; but these jobs are often seasonal. Other entry-level jobs available in the community include clerical positions and jobs in the health care field, such as certified nursing assistants. There is no heavy industry in the region.

TANF Program. El Paso County's TANF caseload has declined steadily since welfare reform began. The county's TANF caseload was 1,973 in 2001, compared with 2,867 in 1998. More than three-quarters of TANF cases remain open for less than 30 months (El Paso County DHS 2002). TANF recipients face a 60-month lifetime limit on cash assistance and must meet work requirements after 24 months of assistance. Parents of infants are exempt from work requirements for one year. According to DHS officials, however, as long as parents of very young children make progress toward goals in their Individual Responsibility Contracts (such as obtaining a GED), they are given some flexibility in meeting work requirements even after the one-year exemption ends. In addition, the county operates a Sanction Prevention Team to work with families at risk of sanction. As a result, according to DHS officials, the county rarely issues sanctions.

Child Care Demand and Supply. Parents, child care providers, county officials, and resource and referral staff reported that the supply of regulated infant-toddler child care slots accessible to low-income families falls substantially short of demand in the community.

Pilot partners report that available infant-toddler care is frequently either too expensive for low-income families or not of good quality. Consequently, several members of the Pilot Committee report that, despite the pilot's efforts to increase the number of good-quality, accessible infant-toddler slots, low-income families often do not have adequate choice in selecting child care options for their infants and toddlers. Most pilot partners attribute the shortage of accessible infant-toddler slots for low-income families to low CCCAP reimbursement rates. Because these rates do not cover the high cost of providing infant-toddler care, many providers choose not to care for low-income children under age 2.

Child Care Connections reported receiving more than 1,300 requests for information on available infant-toddler arrangements in the year preceding the site visit; more than half the families requesting this information were eligible for CCCAP. As shown in Table II.2, El Paso County has the capacity to provide infant and toddler care. Moreover, providers report an infant-toddler vacancy rate of 16 percent. According to Child Care Connections staff and other pilot partners, the recent economic downturn, particularly in the high-tech industry in El Paso County, has resulted in an increase in child care vacancy rates (because fewer parents are working). Many of the providers with vacant slots, however, do not accept CCCAP reimbursement and thus are not affordable for low-income families. Moreover, staff from Child Care Connections indicated that some of the vacancies are in centers or family child care homes that are not located in areas of the county where families need care.

When families need child care during nonstandard hours or have several children of different ages who need to be placed in the same child care setting, finding child care for infants and toddlers can be especially difficult. A handful of child care centers and some family child care providers offer child care during nonstandard hours. A few companies that operate 24 hours, such as call centers, have contracted with child care centers to offer evening or overnight care.

TABLE II.2

SUPPLY OF REGULATED INFANT-TODDLER CARE FOR LOW-INCOME FAMILIES IN JULY 2002
EL PASO COUNTY, COLORADO

Type of Care	Child Care Centers	Regulated Family Child Care Homes	Total
	Capacity		
Child Care Slots	18,293	4,565	22,858
Infant-Toddler Slots	2,351	1,083	3,434
	Vacancy Rates		
Child Care Slots	2,919 (16 percent)	1,010 (22 percent)	3,929 (17 percent)
Infant-Toddler Slots	206 (9 percent)	357 (33 percent)	563 (16 percent)

Source: Child Care Connections, El Paso County, Colorado.

Note: Not all providers with vacancies have contracts with DHS to accept CCCAP reimbursement. However, because Child Care Connections does not track the availability of subsidized slots, we were not able to obtain vacancy rates for subsidized slots.

In part because few regulated slots for low-income families are available, the use of unregulated child care providers is common, especially for infants and toddlers. DHS officials estimate that half of all child care options for infants and toddlers are with unregulated providers. These providers can receive CCCAP reimbursement and be exempted from state licensing standards as long as they care for children from no more than one family in addition to their own. Approximately 60 percent of providers in El Paso County with CCCAP contracts, about 700, are exempt providers. According to DHS officials, most are relatives or neighbors of the children in their care. Some pilot partners disagree with the DHS's policy of providing CCCAP reimbursement to exempt providers, primarily because of concerns about the quality of care. In addition, reimbursement funds for exempt providers are paid directly to families, rather than to providers. Some pilot partners speculate that not all families pay exempt providers the full CCCAP reimbursement amount, further limiting exempt providers' ability to provide good-quality care. However, some parents may prefer unregulated care provided by a trusted relative or friend, rather than a regulated child care provider whom they do not know.[2]

State Child Care Licensing Standards. Colorado requires child care providers caring for children from more than one family (in addition to their own) to be licensed. To become licensed, child care centers and family child care providers must meet a number of requirements. Generally, child care staff must be at least 18 years old, be certified in Cardio-Pulmonary Resuscitation (CPR) and first aid, pass a physical exam, undergo a criminal background check, complete required trainings and certifications, meet the requirements for educational and/or work experience, and pass initial and periodic facility inspections. Tables II.3 and II.4 provide licensing requirements for child-staff ratios and group sizes in child care centers and family child care homes. Colorado's maximum child-staff ratio for infants in centers is higher than in most states; however, Colorado ranks in the top half of states based on the maximum ratio for toddlers 18 months old. Among states that regulate group size, Colorado has relatively high group size limits (Children's Foundation 2002; and Azer et al. 2002).

The Division of Child Care (DCC) within the Colorado Department of Human Services is responsible for licensing child care providers. In El Paso County, state monitors from DCC monitor child care centers' compliance with licensing standards. The state contracts with Goodwill Industries of Colorado Springs to inspect and monitor family child care homes. According to El Paso County DHS officials, unless problems are reported to the state licensing authority, providers typically are inspected for compliance with licensing standards ranging from every 18 months to two years.

Availability of Child Care Subsidies for Low-Income Families. The El Paso County DHS administers CCCAP, which provides child care subsidies for low-income

[2]Because we did not speak directly with parents who use exempt care for their infants and toddlers or visit exempt providers, we were not able to explore parents' reasons for using exempt care or the quality of those arrangements.

TABLE II.3

COLORADO'S CHILD CARE LICENSING REQUIREMENTS
MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN CHILD CARE CENTERS

Age of Child	Maximum Child-Staff Ratios	Maximum Group Size
6 weeks	5 to 1	10
9 months	5 to 1	10
18 months	5 to 1	10
27 months	7 to 1	14
3 years	10 to 1	20

Source: National Child Care Information Center Web site, March 15, 2002.

TABLE II.4

COLORADO'S CHILD CARE LICENSING REQUIREMENTS
MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN FAMILY CHILD CARE HOMES

	Child-Staff Ratios	Group Size
Small Family Child Care Home	6 to 1	Group size and ratio vary based on the ages of children in care. Ratios and group sizes include the provider's own children.
Infant-Toddler Child Care Home	6 to 2	Two caregivers may care for six children from birth to age 3, with no more than three under 12 months, including the provider's children.
	4 to 1	One caregiver may care for four children from birth to age 3, with no more than two children under 12 months, including the provider's children.
Large/Group Family Child Care Home	6 to 1	Group size and ratio vary based on ages of children in care. Ratios and groups sizes include the provider's own children.

Sources: National Child Care Information Center Web site, March 15, 2002, and Quality in Linking Together Early Education Partnerships Web site, March 15, 2002.

families. The Colorado Department of Human Services allows counties to set income eligibility limits for CCCAP up to 225 percent of poverty (a recent increase from 185 percent). El Paso County has set its eligibility limit at 160 percent of poverty for initial eligibility and 185 percent for continuing eligibility. The county provides CCCAP subsidies to three categories of families: (1) low-income families who meet work and income requirements but are not on TANF, (2) TANF clients, and (3) families with special circumstances who meet income but not work requirements. For example, a family in which the mother needs child care while she attends mandatory counseling would qualify for

funding under the special circumstances category. According to DHS officials, in 2002, approximately 67 percent families on CCCAP were low-income working families, 28 percent were TANF families, and 5 percent were low-income families with special circumstances. Families participating in CCCAP who are not on TANF and who have incomes at 50 percent of poverty or higher must make a copayment to contribute a portion of the cost of care (Table II.5).

Between 1997 and 2002, the CCCAP budget in El Paso County has increased from $3 million to $12 million—$8 million from the CCDF funds allocated by the state and $4 million from TANF transfers (20 percent of the county's TANF allocation). In 2001, 7,206 children from 3,916 families received CCCAP subsidies (El Paso County DHS 2002). Approximately 5,500 children receive CCCAP subsidies in any given month. According to county DHS officials, El Paso County did not have a CCCAP waiting list in 2002, although state officials reported that waiting lists have emerged in several other counties.

CCCAP Reimbursement Rates. Colorado counties conduct market rate surveys at least every other year to help them set reimbursement rates for licensed providers with CCCAP contracts. Exempt providers also qualify for CCCAP reimbursement, although in El Paso County, DHS pays families directly to purchase exempt care. Table II.6 compares the market rates from El Paso County's 2001 survey to the CCCAP reimbursement rates for child care centers, family child care homes, and exempt providers.

Development of El Paso County's Child Care Pilot Models

Once El Paso County became a pilot site and the Alliance for Kids was established, the pilot subcommittee began the process of collecting input from stakeholders and developing a strategic plan for creating an early care and education system. One pilot partner said that the significance of the pilot designation was that it caused the community to develop a "master plan for building quality and full-day, full-year capacity for early childhood care and education in the county."

TABLE II.5

2002 COPAYMENT SCHEDULE FOR THE COLORADO CHILD CARE ASSISTANCE PROGRAM
EL PASO COUNTY, COLORADO

Income Level[a]	Copayment
Less than 50 percent of poverty	6 percent of household income
50 to less than 75 percent of poverty	7 percent of household income
75 to less than 100 percent of poverty	8 percent of household income
100 to less than 130 percent of poverty	9 percent of household income plus $5 per additional child
130 to less than 160 percent of poverty	10 percent of household income plus $10 per additional child
160 to less than 185 percent of poverty	11 percent of household income plus $15 per additional child

Source: El Paso County Department of Human Services.

[a]Families on TANF cash assistance who are not employed are exempt from paying the copayment.

TABLE II.6

2002 MARKET AND CCCAP WEEKLY REIMBURSEMENT RATES IN EL PASO COUNTY, COLORADO

	Centers		Family Child Care Homes		Exempt Providers	
Age Group	Market Rate	CCCAP Rate	Market Rate	CCCAP Rate	Market Rate	CCCAP Rate
Birth to 30 Months	$150.00	$120.50	$125.00	$102.60	NA	$61.25
31 to 60 months	$132.50	$94.35	$115.00	$83.05	NA	$49.25
Special-needs children (birth to 30 months)	NA	Up to $240.95	NA	Up to $205.20	NA	Up to $122.45
Special-needs children (31 to 60 months)	NA	Up to $188.70	NA	Up to $166.10	NA	Up to $98.50

Source: El Paso County Department of Human Services (rates effective January 2002), market rate survey completed in 2001. The CCCAP figures are weekly rates based on full-day, full-time care. The market rates survey collected information on rates for children ages birth to 24 months, 25 to 36 months, and 37 to 60 months. Market rates are set at the 75th percentile of the range of rates charged by providers. The response rate for the survey was 91 percent of licensed centers and 49 percent of licensed family child care homes. Market rates are not collected for special-needs children or exempt providers.

CCCAP = Colorado Child Care Assistance Program.

NA = Not available.

Pilot partners refer to the individual initiatives contained in their plan as "pilot models." The pilot subcommittee prioritized the models and implemented them as funding opportunities were identified. Models were prioritized according to goals established by the Alliance for Kids for El Paso County, largely reflecting the state's goals for the pilot initiative. Specifically, models were evaluated based on their potential to:

1. Demonstrate and test the feasibility of blending various early care and education funding streams to create a seamless delivery system in El Paso County.
2. Increase the degree of collaboration among area stakeholders in El Paso County's early care and education community.
3. Build child care capacity and increase the quality of care provided in El Paso County, as well as demonstrate the ability of these models to work in other communities.
4. Use the child care pilot waiver process to eliminate barriers to building a seamless system of early childhood services that meets the needs of low-income families in El Paso County.

After the initial set of models was designed and implementation was underway, the pilot committee occasionally created new models in response to new needs as they were

identified. Some models were eliminated because they did not work as anticipated or families' needs changed. For example, one model—part-day Head Start classrooms in an elementary school supplemented with on-site, wraparound child care provided by a for-profit child care center—was discontinued because most families did not use the wraparound services. According to school district officials, many families enrolled in this program were able to arrange care provided by relatives or friends at no cost, or did not need child care, during wraparound hours. Pilot partners reported that by 2002, they were focused primarily on monitoring implementation of the models, "tweaking" some that needed adjustment and working to identify funding sources to sustain the models into the future.

El Paso County's pilot developed four main types of models to build its early care and education system: (1) models for increasing the number of child care slots available to low-income families, (2) models for increasing families' access to child care options, (3) models for improving child care quality, and (4) models for supporting special-needs children in child care. In the rest of this section, we describe key models in each of these categories, focusing on models that address the supply and quality of child care for infants and toddlers. Figure II.1 shows how these models work together to increase quality infant-toddler child care options for low-income families.

Models to Increase the Number of Infant-Toddler Slots for Low-Income Families

According to the pilot partners who have implemented these models, the high cost of providing infant-toddler care, coupled with low Colorado Child Care Assistance Program (CCCAP) reimbursement rates and licensing requirements that require lower child-caregiver ratios for infants and toddlers, means that child care providers cannot cover the cost of providing infant-toddler care with CCCAP reimbursement alone. As a consequence, there are few regulated infant-toddler slots available to low-income families in El Paso County. The child care pilot sought to create models that eliminated these barriers by blending multiple funding sources to pay for care and seeking waivers from licensing requirements that prevented providers from opening infant-toddler rooms. Six models created to increase infant-toddler capacity are described below (Tables II.7, II.8, and II.9 provide information for each model about ratios and group sizes, waivers obtained, and funding sources).

Home Network. The pilot subcommittee developed a family child care model, known as the Home Network, to increase low-income families' choices of child care settings. It began operating in January 2000. The model seeks to increase the availability of CCCAP slots in family child care homes by addressing cash flow difficulties that often deter family child care providers from establishing CCCAP contracts. Administered by Child Nursery Centers, Inc. (CNC), the Home Network provides frequent reimbursement and technical assistance to a group of 20 family child care providers who agree to obtain CCCAP contracts and maintain a caseload of 50 percent CCCAP children. Typically, providers request CCCAP reimbursement after providing a month of service and are reimbursed between four

FIGURE II.1

CONSOLIDATED CHILD CARE PILOT, EL PASO COUNTY
MODELS AND INITIATIVES TO IMPROVE INFANT-TODDLER CARE FOR LOW-INCOME FAMILIES

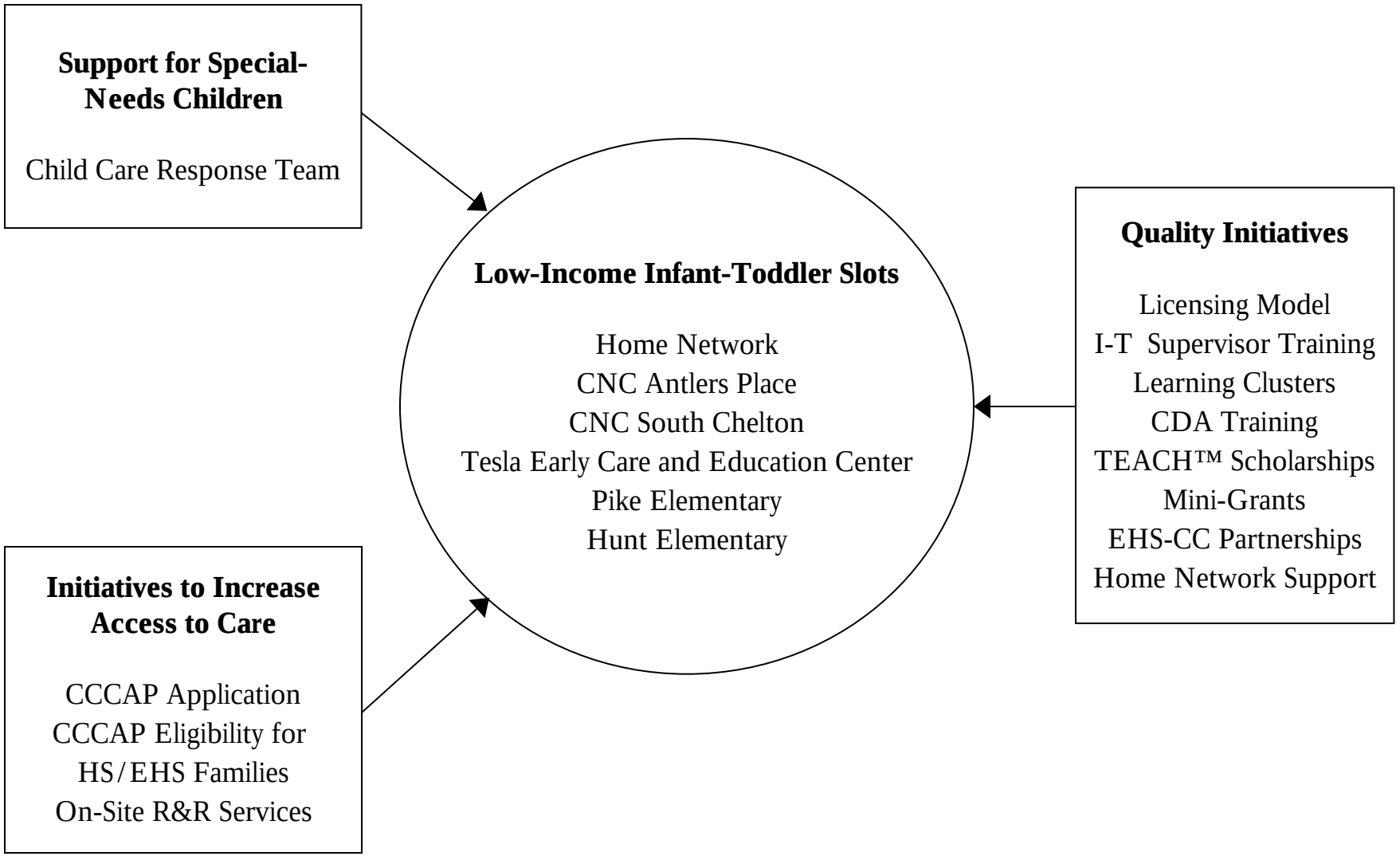

TABLE II.7

CAPACITY, CHILD-CAREGIVER RATIOS, AND HOURS OF OPERATION
CHILD CARE PILOT INFANT-TODDLER MODELS
EL PASO COUNTY, COLORADO

Model Program	Capacity	Child-Caregiver Ratio and Group Size	Hours of Operation
Home Network	40 infants and toddlers (2 per home)	6:1; 4:1 if all children are under age 36 months	Full-day, full year, hours vary
CNC Antlers Place	10 toddlers	10:2	6:30 AM to 6:00 PM
CNC South Chelton	8 infants and toddlers[a] 10 toddlers[b]	8:3 10:2	6:30 AM to 6:00 PM
Tesla Education Opportunity Program[c]	18 infants 8 toddlers	8:2, 10:2 8:2	7:30 AM to 4:30 PM
Pike Elementary	8 infants 10 toddlers	8:2 10:2	7:30 AM to 3:00 PM
Hunt Elementary	8 infants 10 toddlers	8:2 10:2	7:30 AM to 3:00 PM
Total	130 infant and toddler slots		

Source: Site visit interviews conducted May 28-30, 2002.

Note: Infants = birth to age 18 months; Toddlers = age 18 to 36 months.

CNC = Child Nursery Centers, Inc.

[a]Ages 6 weeks to 36 months.

[b]Ages 24 to 36 months.

[c]Ratios are lower when parent volunteers are included.

and six weeks after care is provided. CNC serves as the fiduciary agent for the Home Network, managing a pool of CCCAP funds loaned from DHS. CNC reimburses providers from this pool on a weekly basis and replenishes the funds when reimbursement is received from DHS. In addition, the Home Network provides weekly technical assistance visits, help with business management, and networking opportunities to participating providers. Since January 2002, five Home Network providers have begun partnerships with Community Partnerships for Child Development (CPCD) to care for a total of 16 Head Start and 4 Early Head Start children. These providers receive supplemental payments from CPCD that bring their total reimbursement up to 125 percent of market rates (an additional $41 per week for infants and toddlers), $100 a month for materials and supplies, equipment, technical assistance, and training.

CNC Antlers Place. This model was developed because the pilot wanted to open a toddler room in CNC's Antlers Place facility. The available room, however, had two steps at the exit, and thus violated state licensing requirements. The pilot applied for a waiver of this requirement on behalf of CNC. The waiver was approved, with the stipulation that CNC install hand rails at the exit, increase the staff-child ratio by one staff person, and practice fire

TABLE II.8

WAIVERS APPROVED FOR EL PASO COUNTY'S CHILD CARE PILOT PROGRAM INFANT-TODDLER MODELS

Need	Waiver	Models Affected
	Colorado Preschool Program	
Funding for low-income infants and toddlers who do not qualify for CCCAP	Broaden eligibility for CPP to infants and toddlers and allow children under age 4 to participate in the program for more than one year	Hunt Elementary
	Colorado Child Care Assistance Program	
Stable funding for infant-toddler care to promote continuity of care over time	For children in Head Start/Early Head Start, use the Head Start income eligibility determination to establish eligibility for CCCAP. Redetermine eligibility annually for both programs.	CNC South Chelton Tesla High School Home Network
	Licensing Regulations	
Insufficient capacity to serve toddlers from low-income families	License a room for children ages 18 months to 36 months in a ground-floor room with two steps at the exit. CNC agreed to install handrails at the exit, add an extra teacher to the classroom, and conduct more frequent fire drills.	CNC Antlers Place
Insufficient flexibility to place infants and toddlers in mixed-age rooms and avoid a back log of children in toddler rooms	Create an infant-toddler room with a mixed-age group ages 6 weeks to 36 months. Allow toddlers to remain in the room beyond age 18 months until space is available in a toddler room.	CNC South Chelton Hunt Elementary
Insufficient capacity to provide infant-toddler care for low-income families	Use a leather screen instead of constructing a wall to separate infants and toddlers	Pike Elementary

SOURCE: Site visit interviews conducted May 28-30, 2002.

TABLE II.9

FUNDING SOURCES FOR LOW-INCOME INFANT-TODDLER SLOTS
EL PASO COUNTY CONSOLIDATED CHILD CARE PILOT

Models	Private Funding*	CCCAP	Early Head Start	Title I	School District 11 Funds	Colorado Preschool Program	CDE Pilot Funds	CDE Non-Pilot Funds	Division of Child Care	Tony Grampsas Youth Services	TANF	CO State Mental Health Funds
Infant-Toddler Models												
Home Network	X	X	X				X		X			
CNC Antlers Place	X	X										
CNC South Chelton	X	X	X									
Tesla Early Care and Education Center		X	X	X	X							
Pike Elementary	X	X		X	X							
Hunt Elementary	X			X	X	X						
Quality Initiatives												
Learning Cluster Training	X	X			X			X				
Licensing Model					X		X	X				
Infant-Toddler Supervisor Training	X							X	X			
CDA Training	X						X		X			
TEACH™ Scholarships	X						X		X			
Mini-Grants	X								X			
Home Network	X						X		X			
Early Head Start-Child Care Partnerships			X									
Support for Children with Special Behavioral Needs												
Child Care Response Team	X						X			X	X	X

SOURCE: Site visit interviews conducted May 28-30, 2002.

CCCAP = Colorado Child Care Assistance Program; CDE = Colorado Department of Education; CNC = Child Nursery Centers, Inc.; CDA = Child Development Associate.

*Includes tuition, foundation grants, private contributions, and in-kind contributions.

drills more frequently than required under standard licensing rules. Families with toddlers in this classroom can pay for the care through CCCAP; if they do not qualify for CCCAP, payment may be made based on a sliding fee scale.

CNC South Chelton. CNC has partnered with CPCD to provide child care for eight Early Head Start children in its South Chelton center. CNC had once operated an infant room at this center but closed it in the mid-1990s after the agency spent a significant portion of its reserve funds to operate the room. CNC reopened the room in January 2002, with a waiver to serve children ages 6 weeks to 36 months in a single room, providing the center with more flexibility to care for children in appropriate groups and maintain continuity of care.[3] With a child-staff ratio of 8:3, CNC estimates a minimum cost of $225 per week per child. To pay for the care, DHS agreed to provide guaranteed CCCAP funding at the full-time rate ($24 per day) for all slots during the first year of operation. Through the Early Head Start partnership, CPCD provides an additional $25 per day; reimbursement from the Child and Adult Care Food Program (CACFP) accounts for almost $4 per day. In addition to funding, CPCD provides technical assistance, training, and equipment. CNC teachers use the *Storybook Journey* curriculum in the classroom and hold regular parent meetings and parent-teacher conferences.

Tesla Early Care and Education Center. This infant-toddler center, operated by School District 11 since fall 1999, is housed in the Tesla Education Opportunity Program, an alternative high school and middle school. It provides care for up to 26 infants and toddlers whose parents attend the school. Through a partnership with CPCD, 16 of these slots are reserved for the children of teen parents enrolled in Early Head Start. The center uses the *Creative Curriculum for Infants and Toddlers* (Bicker and Squires 1999) and assesses the children's development using the *Ages & Stages Questionnaires for Infants and Toddlers* (Dombro et al. 1997). In addition, all teachers have been trained in the *Parents As Teachers* curriculum. Teen parents must volunteer in the center two times a month for as many hours as they normally attend school; they must also attend a regular parenting class held at the school. According to School District 11 officials, the school district could not afford to continue operating the center without the supplemental funding provided by CPCD through the Early Head Start partnership. In addition to supplementing CCCAP funds, CPCD provided money to purchase equipment and supplies, paid for installation of a new playground, and provided CDA training to Tesla teachers, regardless of whether they are assigned to care for Early Head Start children.

Pike Elementary School. Located in a working-class neighborhood within School District 11, Pike Elementary has experienced declining enrollment for several years. To make use of available space in the school and increase infant-toddler capacity, the pilot facilitated a partnership between School District 11 and Goodwill Industries—a major DHS contractor that provides employment, education, and training services to DHS clients—to relocate some of its GED classes to the school and add a family literacy component. School

[3]According to Colorado's licensing requirements, the upper limit age for children in an infant room is 18 months.

District 11 converted available space at the school into infant-toddler classrooms (with capacity for 18 children) to provide child care while parents attend classes. The pilot was granted a waiver to use a leather screen, rather than a wall, to separate the infant and toddler rooms. Teachers use *The Creative Curriculum for Infants and Toddlers* to plan classroom activities. In addition, they have incorporated a family literacy component, in which parents work with their children on learning activities in the classroom. The infant-toddler classrooms are funded through a combination of CCCAP, School District 11, and Title I funds.

Hunt Elementary School. This school also has a partnership with Goodwill Industries to offer on-site GED classes, infant-toddler child care, and family literacy activities. The Hunt model, however, does not use CCCAP funding, because many families are immigrants and are not eligible for CCCAP. To fund this model, the pilot obtained a waiver to serve infants and toddlers with CPP funds and to serve children under age 4 for more than one year in CPP.

Models to Increase Access to Child Care Options

Although CCCAP has been available to low-income families without waiting lists, in the past the application and eligibility redetermination processes have posed barriers for families who could not leave work to attend appointments at the DHS office. To address the problem of these barriers and make information about available arrangements as accessible as possible to parents, the pilot subcommittee developed several models, including a new CCCAP application process, alignment of CCCAP and Head Start/Early Head Start eligibility periods for children enrolled in both programs, and on-site resource and referral services.

CCCAP Application Process. In consultation with the pilot subcommittee, DHS has streamlined the CCCAP application process to make the subsidy as accessible as possible to families. A face-to-face appointment at DHS is no longer required; initial intake, eligibility determination, and notification of eligibility are conducted by CCC, the local resource and referral agency. To apply, families can meet with CCC staff located on-site at DHS or the Pikes Peak Workforce Center. They can also apply on-site at participating child care centers and family child care homes, where staff have been trained to help families complete the application and submit the paperwork to CCC. Alternatively, parents can request an application packet from CCC or DHS, complete the packet, and return it by mail. The entire application process—from intake to official notification of eligibility—takes four to six weeks; payments are retroactive to the date of the application.

CCCAP Eligibility for Head Start/Early Head Start Children. Families who are eligible for Head Start and Early Head Start are considered income-eligible for CCCAP. To reduce the number of applications that families must complete and to increase the continuity of care, DHS accepts the Head Start application in lieu of a CCCAP application when children are enrolled in Head Start or Early Head Start. In addition, although CCCAP eligibility typically is redetermined every six months, Head Start families' eligibility redetermination is conducted annually for both programs. Thus, Head Start/Early Head

Start children can remain in their child care arrangements for at least one year without risk of losing their CCCAP funding.

Resource and Referral Services. CCC and DHS have collaborated in making information about available child care arrangements as accessible as possible to low-income families. In addition to providing resource and referral services by telephone, CCC staff provide on-site resource and referral services to families at the DHS office and the Pikes Peak Workforce Center. In providing information about available child care arrangements, CCC relies on a provider database that contains such information as location, types of care, ages of children accepted, and whether the provider has a CCCAP contract. Information on vacancies is updated every six weeks, thus enabling CCC staff to provide "hot referrals" that increase families' chances of securing an open slot. When CCC staff provide resource and referral information, they also offer child care quality checklists and provide information on other resources and services available.

Models to Improve the Quality of Care

A major goal of the child care pilot in El Paso County has been quality improvement. The pilot's approach to working on quality is to implement initiatives that offer support, technical assistance, training, and resources to child care providers who are interested in improving the quality of their child care settings. This section describes key quality improvement models administered by CCC, including El Paso County's Licensing Model, training initiatives for child care providers, and mini-grants for family child care providers with CCCAP contracts. In addition, as described earlier, both the Early Head Start-child care partnerships and the Home Network provide weekly technical assistance visits and other support to child care providers.

El Paso County Licensing Model. The 1999 pilot legislation authorized the Colorado Department of Human Services to work with pilot sites to develop alternative models for child care licensing. In 2000, the El Paso County pilot developed a licensing model that incorporates quality indicators from widely used environmental rating scales.[4] Pilot partners rewrote the child care licensing regulations by changing any item captured by the rating scales (such as room arrangement, display for children, and safety practices) with the description of a 3 rating on these scales.[5] These adaptations serve as benchmarks that enable providers to measure their progress in improving quality of care. If an item covered by licensing regulations was not covered in the scales, it remained unchanged. Ten child care centers (including several that provide infant-toddler care through the models described above) and five family child care homes participate voluntarily in the licensing model. State

[4]El Paso County drew from the Infant-Toddler Environmental Rating Scale (ITERS; and Harms et al. 1990), the Early Childhood Environmental Rating Scale (ECERS; and Harms and Clifford 1980), and the Family Day Care Rating Scale (FDCRS; and Harms and Clifford 1989).

[5]A rating of 3 is described as minimal quality on the environmental scales. Pilot partners selected the 3 rating because licensing regulations are intended to be minimum standards.

licensing specialists inspect these child care providers every six months (compared to every two years for providers not participating) and work closely with an Early Childhood Specialist assigned to the provider by CCC, to make any necessary improvements. In addition, the Early Childhood Specialists conduct assessments that include an environmental rating and a biannual review of teacher qualifications, develop improvement plans with teachers, provide on-site technical assistance at least monthly, and use the Educare criteria to assign a star rating twice a year.[6] Participating providers receive cash incentives that are used to offset quality improvement and professional development costs based on the rating scale results, accreditation status, and staff qualifications. According to CCC, typical incentives payments are in the range of $2,000 to $3,000 every six months.

Training Models. The pilot subcommittee has been diligent in taking advantage of opportunities to bring training resources into the county. CCC, the focal point for these activities, provides Infant-Toddler Supervisory Training, Learning Cluster training, CDA training, and TEACH™ scholarships. Infant-Toddler Supervisor Training is a statewide initiative funded primarily by the Colorado Department of Education through CCDF quality-improvement funds; it has been operating for two years. It provides 45 hours (6.5 hours over a period of seven Saturdays) of training on responsive infant-toddler caregiving. Learning Cluster training, also funded by the Colorado Department of Education, provides a series of training sessions that follow seven tracks: preschool, infant-toddler, school-age, multi-age, social skills, brain gym, and professional development. CCC also offers CDA training, as well as TEACH™ scholarships provided through funds from the Colorado Office of Resource and Referral Agencies (CORRA) to help providers pay for CDA and associate degree courses.

Mini-Grants. CCC administers a mini-grants program (also funded through CORRA) for family child care providers who accept CCCAP children. Start-up grants provide $125 for start-up costs, $125 for liability insurance, and reimbursement for required training for providers who agree to give CCCAP children enrollment preference for at least one year. Quality-improvement grants for established providers to use in purchasing materials and equipment range from $500 to $600. To qualify, providers must complete an assessment checklist and request funds for needed equipment and materials. Providers are selected based on the assessment checklist and the proportion of CCCAP children they care for.

Models to Provide Support for Children with Special Needs

According to pilot committee members, families with special-needs infants and toddlers face particular difficulties in finding and maintaining child care arrangements. Two

[6]The Educare Colorado Quality Rating System is a voluntary method of enabling parents to determine more easily the quality of child care that particular providers offer. Providers in participating counties are rated on a four-star continuum, with four stars being the highest quality indicator. Ratings are based on five key measures of quality: (1) classroom environment, (2) parent involvement, (3) staff credentials, (4) staff-to-child ratios, and (5) accreditation.

programs in El Paso County, the Child Care Response Team (CCRT) and Resources for Young Children and Families (RYCF), provide support for these children, their families, and their child care providers. The CCRT was developed as a pilot model in response to the growing realization among pilot partners that children with behavioral and developmental problems were getting "kicked out" of child care. RYCF provides Part C coordination services. Although RYCF was not developed as a pilot model, it is nevertheless an integral part of the infant-toddler early care and education system in El Paso County (see Table II.1 for details).

Child Care Response Team. Through discussions held during pilot subcommittee meetings, pilot partners realized that children with behavioral or developmental challenges were losing their child care arrangements with alarming frequency; many providers reported expelling two or three children every six months. In response, the pilot subcommittee developed and obtained funding for the CCRT, which intervenes at the request of child care providers or parents to prevent children from being expelled from child care. Administered by Child Care Connections, CCRT works simultaneously with the child, the family, and the provider. For example, an early childhood specialist does an initial development assessment with the child to identify potential disabilities or delays. The specialist visits parents at home, to guide them in managing their child's behavior, and conducts an environmental assessment of the child care setting to identify aspects of the setting that may be causing the child's behavior. For example, a classroom may not have sufficient toys, or a caregiver may expect children to participate in activities that are not developmentally appropriate, either of which can result in frustration and "acting out." As a condition of receiving CCRT services, child care providers must agree to an improvement plan based on the results of observation by an early childhood specialist. Frequently, CCRT staff provide technical assistance to the provider in implementing a social skills curriculum in the classroom. In addition, staff refer families to early intervention services or specialized counseling, if such is needed. The CCRT serves children ages birth to 8, for up to six months per child. From its inception in October 1999 through May 2002, CCRT has served 347 children.

SUCCESSES OF EL PASO COUNTY'S CHILD CARE PILOT

El Paso County's pilot subcommittee has worked to increase the county's capacity to provide infant-toddler child care and the variety of arrangements from which parents can choose, increase access to care for low-income families, improve quality, and enhance support for children with special needs. Although challenges remain, pilot partners believe that they have made progress in each of these areas.

Expanding the Supply of Infant-Toddler Care and Increasing Access to Subsidies

El Paso County's child care pilot created at least 130 new infant-toddler slots in the community. While key stakeholders concur that demand for infant-toddler care continues to exceed the supply, models developed by the pilot to increase the supply of infant-toddler care have demonstrated the feasibility of several strategies—the blending of funding sources,

using alternative approaches to meeting health and safety standards, providing increased support for family child care providers, and providing child care in public school facilities.

Blending CCCAP, Early Head Start, and Colorado Preschool Program funding has enabled El Paso County providers to offer good-quality center-based care to low-income families with infants and toddlers and to cover their costs. Pilot partners estimate that CCCAP reimbursement covers approximately half the cost of providing good-quality infant-toddler center care. In fact, several providers reported that, with CCCAP funding alone, they could not afford to offer center-based infant-toddler care. Partnerships with Early Head Start—which cover roughly half the cost of care and provide supplies, equipment, and training, as well as a waiver allowing Colorado Preschool Program funding to be used for infants and toddlers—have provided the funding necessary for providers to open or sustain infant-toddler rooms in centers.

Waivers to state licensing requirements have removed barriers to the creation of new infant-toddler slots while also safeguarding the health and safety of children in care. The pilot has enabled El Paso County to apply for waivers to specific state licensing requirements that have created barriers to increasing the supply of infant-toddler care. Key stakeholders agree that maintaining health and safety standards is essential to providing both quality care and safeguarding the welfare of young children. In some circumstances, however, alternative solutions have been found that remove barriers to increasing the supply and maintaining safeguards. For example, in El Paso County, providers developed special evacuation plans for a toddler room with two steps and increased child-staff ratios to create mixed-age rooms for infants and toddlers.

Increased support for family child care providers has enabled them to accept children from low-income families who pay for care using CCCAP subsidies. Many pilot partners cited the Home Network as one of the pilot's greatest successes. By providing weekly reimbursement, technical assistance, and other support, 20 family child care providers have opened their homes to CCCAP children. Prior to the implementation of the Home Network, some community members predicted that, because of concerns about maintaining their independence, family child care providers would not be interested in joining the Home Network. According to pilot partners, however, family child care providers enjoy the visits and support they receive from the home network. Indeed, more providers would like to join the network but, as a result of its funding limitations, cannot.

Public school facilities have implemented infant-toddler programs that meet the needs of teen parents and others enrolled in adult education programs. The pilot created 62 new infant-toddler slots in three public schools that serve teen parents and low-income parents through adult education programs. According to school officials, many teen parents would not attend school if they did not have access to on-site child care, and children in all three facilities would likely be cared for in unlicensed settings if school-based arrangements were not available. School officials take pride in the quality of care offered—one facility is nearing accreditation and all three participate in the licensing model. Moreover, school officials believe they are "starting where we need to start, instead of waiting until preschool."

Streamlining the CCCAP application process has increased the access of low-income families to child care subsidies. According to pilot partners, because of the changes made in the application process in recent years, applying for and obtaining CCCAP funds is no longer difficult for families. The most important change is that families are no longer required to have a face-to-face meeting at the DHS office in order to obtain CCCAP funds. Moreover, applications are readily available at DHS, directly from child care providers, or from the local resource and referral agency.

Improving Quality

Pilot partners believe that the new infant-toddler slots created through pilot models are of good quality, and that multipronged strategies to improve the quality of care more broadly are showing results.

Pilot partners believe they are increasing the quality of infant-toddler child care offered in El Paso County. They attribute improvements to the many training opportunities available to community providers and to the increased use of environmental rating scales in assessing quality and providing feedback to providers. For example, environmental ratings scales are used as assessment and technical assistance tools by Child Care Connections' grant programs, the El Paso County Licensing Model, the Child Care Response Team, and the Home Network. A number of training and technical assistance providers in the county have been certified as reliable observers on these scales by the Center for Human Investment Policy at the University of Colorado-Denver. One pilot partner reported that when the county began using the environmental rating scales in 1999, many providers had poor health and safety practices and typically scored in the 2-to-3 range on the ITERS. By 2002, observers had noted increased interaction between caregivers and children, as well as ITERS scores that are often in the 4-to-5 range.

Most providers welcome the support and incentives offered by quality improvement initiatives. Staff involved in the Home Network, the Early Head Start-child care partnerships, and the Child Care Licensing Model—as well as center staff and family child care providers—reported that most providers like receiving technical assistance, support, and resources that come from participation in these quality initiatives. For example, staff reported that family child care providers with Early Head Start partnerships feel proud to tell parents that they have lower caregiver-child ratios, frequent technical assistance visits, and a "pool of experts" to call on if special needs arise. Moreover, family child care providers appreciate the opportunity for adult contact with a visitor who understands the difficulties of their jobs. Financial incentives enable all types of providers to purchase new equipment and toys.

The Home Network has increased the professionalism of family child care providers. In addition to increasing the supply of good-quality child care for CCCAP families, the Home Network aims to increase the professionalism of family child care providers and reduce the isolation they often experience working alone in their homes. According to Home Network staff, many initially view themselves as "babysitters." Over time, however—as they obtain more education, improve their child care environments,

receive feedback and technical assistance, and learn more about quality caregiving—they begin to view themselves as professionals. In addition, some have developed professional relationships with each other by attending network meetings and events.

Support for Children with Special Behavioral Needs

Many Pilot Committee members cited the Child Care Response Team (CCRT) as one of the greatest successes of the pilot. Most thought that the CCRT's success rested on simultaneously addressing mental health and home and child care environmental needs. One local government official said the CCRT model is "very preventative" because it prevents children from viewing themselves as failures for being expelled from child care and may prevent self-esteem and behavior problems in the future. Staff from the Part C agency reported that CCRT has been effective in guiding child care providers on addressing behavior issues and in maintaining special-needs children in their child care placements.

CONTINUING CHALLENGES

El Paso County's child care pilot continues to face several significant challenges, many of them related to funding constraints. While pilot partners cited a number of difficulties they have faced along the way, the most persistent ones are the continuing shortage of infant-toddler care, the high cost of providing infant-toddler care, the "cliff effect" on families whose incomes exceed CCCAP eligibility limits, identifying funding sources to sustain pilot models, aligning requirements and expectations of various funding sources in blended funding arrangements, and replicating the models beyond El Paso County.

The demand for affordable infant-toddler care far exceeds the supply in El Paso County. All stakeholders cited the shortage of infant-toddler care as a significant community challenge. The shortfall is especially acute for low-income families (because many providers do not accept CCCAP subsidies) and for families who need slots for several children of different ages. Others cited the proliferation of exempt child care providers and the common practice of "patching" together several regular, informal arrangements as evidence of a significant capacity problem. Moreover, several neighborhoods in El Paso County have prohibited family child care homes through zoning restrictions, citing fears about increased noise and traffic. Pilot partners believe that these restrictions only serve to drive family child care homes "underground" and thus add to the number of unlicensed, unregulated providers in the community.

The cost of providing infant-toddler care is high; CCCAP reimbursement rates are not sufficient to cover the cost of good-quality care. Many pilot partners cited the high cost of providing infant-toddler care as the main reason for the community's shortage of care. Several child care providers, other pilot partners, and state administrators reported that CCCAP reimbursement alone does not provide sufficient funds to offer good-quality infant-toddler child care. For example, one provider said that funding infant-toddler care with CCCAP could be done only if the funds were used exclusively for salaries and equipment, with other sources of funding covering such overhead costs as utilities,

administrative staff, and janitorial services. State officials also reported that low reimbursement rates have led to a shortage of infant-toddler slots. They reported that some Colorado counties pay providers lower rates, which enables the providers to cover more children with CCCAP funds. This practice, however, tends to result in fewer providers being willing to offer infant-toddler care for CCCAP families. In contrast, counties that offer higher rates have experienced an increase in the number of slots. El Paso County raised reimbursement rates somewhat in 2001. However, several pilot partners who provide center-based infant-toddler care estimated that rates would have to be doubled to cover the cost of providing good-quality infant-toddler care. Like many child care administrators, officials in El Paso County reported that they must weigh the benefits of raising reimbursement rates against the benefits of raising eligibility limits. County officials reported that, while it is difficult to find infant-toddler care, low-income families are almost always able to find an arrangement eventually, often with an exempt provider who may be a relative or friend.[7] At the time of the site visit, county officials were focusing on whether they could raise the income limit for continuing eligibility, from 185 to 225 percent of the poverty level. This would reduce the severity of the "cliff effect" (see below), enabling families to participate in CCCAP for a longer period of time and accept raises and promotions without losing their child care.

The "cliff effect" that occurs when families exceed income eligibility limits for CCCAP puts good-quality care beyond the reach of most families and deters some from accepting promotions and pay raises. Once its income exceeds 185 percent of poverty, a family loses eligibility for CCCAP. Especially for families with more than one child in care, the loss of CCCAP increases child care costs dramatically. According to local government officials, most of these families can no longer afford to pay for regulated child care, so their only option is informal kith-and-kin arrangements. Officials also reported that some parents refuse pay raises and promotions to avoid losing eligibility for CCCAP. Some pilot partners felt that increasing the eligibility level to 225 percent of poverty and increasing the copayment amount would reduce the "cliff effect" by extending the time that families could receive CCCAP and lessening the impact of losing CCCAP funding.

Funding may not be available to sustain some of the pilot models. Pilot partners raised concerns about their ability to sustain some pilot models that are funded by grants, particularly the Home Network and the Child Care Response Team. In 2002, the pilot subcommittee was still searching for more stable sources of funding for these initiatives. Some raised concerns about the stability of state funding in a time of economic downturn and reduced state revenues. Others recognized that there is simply not enough funding to implement all the pilot's plans. One pilot partner felt that the subcommittee has at times tried to do too much. Out of a desire to serve as many children as possible, she felt that the pilot has often tried "to do a dollar's worth on a dime" and has stretched itself too thin.

[7]At the time of the site visit, approximately 60 percent of providers with CCCAP contracts were exempt providers.

Partnerships and blended-funding arrangements pose some coordination challenges. While pilot partners concur that blended-funding arrangements are essential to cover the cost of quality infant-toddler child care, aligning the goals, approaches, and procedures of different organizations and funding streams can be difficult. For example, child care providers who form partnerships with CPCD to serve Early Head Start children must adhere to the Head Start Performance Standards and mesh those standards with their agency's practices. Some providers reported that their interpretation of what is required to meet the performance standards sometimes differs from that of the CPCD staff. Others said that confusion about supervisory authority and who reports to whom in each organization can cause tension. CPCD requires all child care teachers to obtain CDAs and provides CDA training free of charge. However, CPCD offers training during hours when child care providers are caring for children, making it challenging for them to attend the classes. Finally, some providers said that initially, the rules and paperwork associated with the performance standards can seem overwhelming.

Pilot models, while successful, may be difficult to implement in other communities. State officials raised some doubts about the extent to which models developed by the pilot communities (including El Paso County and the other 17 pilots) can be replicated elsewhere. While clearly pleased with the pilots' achievements, these officials pointed out that the pilots were designed to address specific local barriers and needs, and what is a barrier in one community may not be a problem in another. In addition, many of the pilots involve a relatively small number of child care providers. Officials said that because of the scale, effective models in smaller communities may not translate to larger communities. Finally, for the licensing model, state monitors are responsible for a relatively small number of child care facilities, usually about 35. This low ratio significantly increases the cost of monitoring, which may make the model unattractive to policymakers facing budget constraints.

LESSONS FROM EL PASO COUNTY'S CHILD CARE PILOT

The experiences of El Paso County's child care pilot can provide valuable insight into policies and practices that facilitate local communities' efforts to build early care and education systems that meet the needs of low-income families with infants and toddlers. In addition, other communities seeking to strengthen their early care and education systems can learn from El Paso County's efforts. This section summarizes the lessons derived from El Paso County's pilot experiences—with a particular focus on infant-toddler child care—including lessons about collaboration and increasing the supply of quality infant-toddler care.

Collaboration

Allowing local communities to design pilot models can increase collaboration and involvement at the local level. State officials stressed that Colorado did not initiate the pilot program as a "blueprint" for how local communities should design their pilot models. Instead, the state empowered local communities to identify their own communities' barriers, then design strategies tailored to the local community's strengths and needs. All the

pilot partners we interviewed in El Paso County believe that the pilot has facilitated increased collaboration among members of the early care and education community. One partner said that stakeholders now have a forum for talking about issues that arise and deciding on a strategy to address them. Several pilot partners cited changes in the CCCAP application process and formation of the Child Care Response Team as two examples of solutions to challenges that came about through the work of the pilot subcommittee. In addition, pilot partners report increased collaboration in applying for grants. When requests for proposals are issued, the pilot subcommittee discusses community needs, votes on the most pressing issues, and devises a strategy to write the grant proposal about that need.

Sustained leadership on the pilot subcommittee has enhanced collaboration. Many pilot partners said that the leadership provided by several key stakeholders, including staff from Child Care Connections, the Child Nursery Centers, Inc., Community Partnership for Child Development, and the Department of Human Services has been invaluable for successful collaboration. In addition, several stakeholders pointed out that building collaboration takes time. The pilot subcommittee needed time to build and strengthen relationships and come to an agreement about the direction they wanted to take. Meeting regularly and maintaining stability among the key partners over time has been critical to building trust and establishing professional relationships.

Strong support from local government officials has sustained and strengthened the pilot models. In addition to providing leadership, El Paso County DHS has contributed significant resources to the pilot. For example, a DHS staff person has provided in-kind grant-writing services to the pilot subcommittee, raising more than $500,000 in grant funds since the pilot began. DHS has used CCCAP funds in flexible and creative ways to support the creation of new infant-toddler child care slots. Some examples are the establishment of a fund from which CNC can draw funds to pay Home Network providers, and funding guaranteed slots for the first year to help Early Head Start-child care partnerships become well established. Finally, at several points, DHS has used TANF funds to provide "bridge funding" to the CCRT, which has enabled it to continue providing services during short gaps between funding cycles.

A designated pilot coordinator may have increased the pilot subcommittee's ability to develop and fund models. From its inception until January 2002, El Paso County's pilot was operated solely by volunteers. Early on, the pilot subcommittee decided to put all available resources into services, rather than hire a staff coordinator. Some pilot partners, however, said that this decision placed a tremendous burden on subcommittee members, who dedicated significant time to the pilot, in addition to continuing to perform their "day jobs." Finally, pilot members took turns attending state-level pilot coordination meetings, rather than sending a designated contact who could build sustained relationships with state contacts.

Increasing the Supply of Quality Infant-Toddler Care

Some regulatory barriers that deter child care providers from creating infant-toddler slots can be overcome without putting children's health and safety at risk.

Regulations about facilities for providing infant-toddler care can pose barriers to creating more slots. While all pilot partners agreed that such regulations are both important and necessary for protecting young children, they can also prevent communities from meeting families' child care needs. For example, because of internal steps and staircases, Child Nursery Centers' main building cannot house infant-toddler slots. The prohibition on caring for mixed ages in a single room is another barrier. Children may not remain in an infant room beyond age 18 months; however, a factor that frequently prevents children from transitioning out of rooms for 18- to 36-month-olds is potty training. Often, a backlog of toddlers develops, and providers do not have sufficient flexibility to combine age groups when necessary until transitions can be made. In El Paso County, the pilot subcommittee obtained waivers to such regulations for some facilities by proposing alternative solutions to safeguarding the children's health and safety.

Providers must be able to combine funding streams to cover the cost of offering quality infant-toddler care for low-income families. Virtually all the pilot partners agreed that CCCAP funding is not sufficient to cover the cost of good-quality infant-toddler care, especially in child care centers. While pilot partners praised DHS for its efforts to help fund infant-toddler care and make CCCAP funds accessible to families, all recognized that providers are not willing to create infant-toddler slots unless supplemental funding sources are available.

Flexibility on eligibility, programmatic, and reporting requirements can ease the difficulties of combining funding streams to pay for quality infant-toddler care. To simplify the process of combining funding sources to pay for infant-toddler care and ease the burden on service providers, program administrators should consider ways of aligning eligibility rules, performance standards and other programmatic requirements, and reporting requirements. For example, in El Paso County, the pilot subcommittee obtained a waiver enabling them to use Colorado Preschool Program funds to serve infants and toddlers, thus filling a funding gap at a specific facility. Similarly, DHS accepts Head Start and Early Head Start applications in lieu of CCCAP applications, to reduce the paperwork burden and to bring the eligibility periods for both programs in line with each other.

Family child care homes can be a significant source of quality infant-toddler slots for communities, but providers need a steady flow of cash and support to work with state child care assistance programs. According to several pilot partners, many parents prefer family child care in a home setting for their infants and toddlers. Offering quick-turnaround reimbursement to family child care providers, support in reporting and financial management of subsidy contracts, and other incentives can increase the number of family child care providers who are willing to accept child care subsidies. In El Paso County, the Home Network provides these services to providers. Other incentives for CCCAP providers—such as discounts on bulk food purchases through the local family child care provider association, and an opportunity to obtain quality-improvement grants—provide further incentives for family child care providers to maintain CCCAP contracts.

CHAPTER III

KANSAS AND MISSOURI EARLY HEAD START PROGRAMS

KANSAS CITY, KANSAS, AND SEDALIA, MISSOURI

This case study describes efforts by the Kansas and Missouri Early Head Start programs to increase the number of good-quality infant-toddler child care slots available to low-income families in grantee communities. It focuses on the experiences of two grantees—Project EAGLE, in Kansas City, Kansas; and the Children's Therapy Center, in Sedalia, Missouri. These state-sponsored programs follow the same program performance standards as federally funded programs. However, instead of providing all services directly, the programs supply most child development services through partnerships with community child care providers who agree to care for Early Head Start children in compliance with the performance standards. Based primarily on data collected during site visits to Kansas City, Kansas and Sedalia, Missouri, in April 2002, this case study provides an overview of each state's program and then describes the programs' partnerships with community child care providers, other community child care initiatives that support the partnerships, implementation successes and challenges of the partnerships, and lessons learned from these initiatives.

We combined these two sites into a single case study, for several reasons. As state-sponsored Early Head Start programs, they have much in common: both deliver child development services through partnerships with community child care providers, both follow the federal Head Start performance standards, both pay child providers directly for child care, rather than rely on state child care subsidies, and both have a strong focus on supporting providers to work on quality improvement. Nevertheless, each program has taken a somewhat different approach to developing the partnerships. In addition, one program is located in an urban area, while the other operates in a rural setting. By discussing similarities and differences across the two sites in one case study, we can highlight promising

or innovative approaches, as well as describe how approaches to various aspects of the partnerships developed in response to the community context of each program.

THE STATE EARLY HEAD START PROGRAMS

The federal Early Head Start program, which began in 1995, extended Head Start services to low-income pregnant women and families with infants and toddlers up to age 3. As a comprehensive, two-generation program, it focuses on enhancing children's development while strengthening families. Early Head Start programs must adhere to the Head Start Program Performance Standards, which took effect in January 1998 (Administration for Children and Families 1996). These standards lay out the requirements for the quality of early childhood development and health services, family and community partnerships, and program design and management; they also establish a set of expectations for the quality of services provided in child care settings. For example, the standards require that care be developmentally appropriate and that it promote the formation of secure relationships through continuity of care. Within one year of hire, child care teachers must have a Child Development Associate (CDA) credential or higher degree. Children must be cared for in groups of no more than eight, with at least one teacher for every four children. The Head Start Bureau expects Early Head Start programs to help arrange child care for all families who need it. Moreover, programs must require that their child care arrangements, whether in a program-operated child care center or through a community child care provider, adhere to relevant performance standards. The rest of this section describes the state Early Head Start programs in Kansas and Missouri and the grantees we visited in each state.

KANSAS

In 1998, the governor of Kansas signed into law a five-year Early Head Start initiative, funded at $5 million annually through a transfer of TANF funds into Kansas' Child Care and Development Fund (CCDF). Development of the initiative was spearheaded by the governor's office in recognition of the increased need for quality child care as TANF work requirements went into effect. To design the program, the state worked closely with the federal Administration for Children and Families' (ACF) Region VII office, the state Head Start Collaboration Office, and representatives from local Head Start programs. Kansas requested applications from Head Start programs that served 3-to-5-year-olds throughout the state and that agreed to comply with the federal performance standards for infant-toddler services and to provide child care to families who needed it through partnerships with community child care providers. An evaluation panel made up of representatives from the Kansas Department of Education, the Kansas Department of Social and Rehabilitation Services, and the ACF Region VII office reviewed applications and awarded grants to 13 of 14 applicants. By August 1999, all grantees had begun serving families. By July 2002, Kansas had invested more than $27.5 million in its Early Head Start program, while providing quality child care to 2,875 children through the program.

In the initiative's first year, grantees faced challenges in planning for children's transitions out of Early Head Start at age 3. Because many Head Start and other preschool programs do not enroll children until they reach age 4, many families were confronted with a one-year gap in services as they made the transition out of Early Head Start. To address this problem, in 2000 the governor approved an additional appropriation of $2.5 million dollars to serve children in Early Head Start between the ages of 3 and 4.

The federal Head Start Bureau has partnered with Kansas to support its Early Head Start programs. Initially, the Head Start Bureau provided federal funding at approximately 10 percent of the state's contribution, to cover programs' professional development costs. The Head Start Bureau invested an additional $200,000 in the region's Quality Improvement Center (QIC), to provide technical assistance to state grantees. By 2002, the federal contribution had increased to 35 percent of the state contribution.

Project EAGLE, in Kansas City, Kansas

Project EAGLE, located in Kansas City, Kansas, was founded in 1989 as a program of the University of Kansas Medical Center, whose mission it was to serve low-income families with infants and toddlers. Later, the agency added programs that serve older children. At the time of our site visit, Project EAGLE served approximately 400 children and pregnant women annually through several different programs (including Early Head Start and others). Families are drawn from several communities in Wyandotte County, including Bonner Springs, Edwardsville, Kansas City, and Piper. The agency's offices are located near the Department of Social and Rehabilitative Services, the local child care resource and referral agency, Part B and C providers, and the medical center, thus enhancing the staff's ability to coordinate services for families.

With a staff of 36 full-time employees, Project EAGLE operates several programs for families and children. The agency serves 200 children and pregnant women annually through the state and federal Early Head Start programs. Of these, 120 are funded with federal dollars, 64 with state dollars, and 16 with Kansas City, Kansas, municipal dollars. Initially, Project EAGLE served 34 children in its state Early Head Start program. When the program was extended to serve children through age 4, the agency expanded its program to serve 64 children. Project Hope, a teen pregnancy and parenting program funded by the Kansas Department of Health and Environment, serves 65 to 90 teenage parents annually, supporting them in completing their education and developing parenting skills. Project EAGLE also operates the federally funded Healthy Start program, serving 35 to 40 families a year. Finally, the agency provides supportive services to 75 adolescents each year through Health, Education, Assessment, and Resources for Teens. Many of the children served by this program are older siblings of Early Head Start children.

MISSOURI

Using Kansas's Early Head Start program as a model, Missouri developed its own Early Head Start program. In 1998, the Missouri legislature passed H.B. 1519, which allocated a

portion of state gaming revenues to an early child care and development fund administered jointly by the state Departments of Elementary and Secondary Education (DESE) and Social Services (DSS).[1] The state recognized that the most pressing need for quality child care rested with the birth-to-3 population, and decided to channel $5.5 million of the gaming revenues to a state-funded Early Head Start program. Key officials from the Missouri Department of Social Services, the Missouri Department of Health (the agency responsible for licensing child care providers), and state Head Start directors developed the program; other state agencies played an advisory role.

The state distributed a request for proposals to all Head Start programs in the state to provide Early Head Start services through partnerships with community child care providers. As was the case in Kansas, Missouri required grantees to follow the federal Head Start Program Performance Standards. In 1999, the state, in consultation with ACF Region VII, selected 11 out of 18 applicants. Most grantees began serving families in 2000, after a one-year planning period; a few began serving families in 1999.

Grantees participating in the Missouri Early Head Start program received the same training and technical assistance from the ACF Region VII office as those in Kansas. Missouri also received, from the Head Start Bureau, funding that initially matched 10 percent of the state's contribution. The federal contribution has since increased to 45 percent, which can be used for staff development and any program components that promote good-quality care for infants and toddlers.

Although the state Early Head Start programs in Kansas and Missouri are very similar, some key differences are evident. The state Early Head Start program in Missouri serves only children from birth to age 3 and pregnant women; it does not fund services for 3-year-olds. Moreover, although the Kansas legislature funded the program for a set dollar amount for five years, the authorizing legislation for the Missouri program allows for a budget that depends primarily on gaming revenue; a smaller portion comes from TANF transfers. Thus, the amount of Missouri's Early Head Start funding can fluctuate from year to year if gaming revenues are not sufficient to fully fund the program's budget. As of July 1, 2002, the state had invested more than $16.8 million in the program, increasing the availability of comprehensive services and quality child care to more than 2,000 low-income infants and toddlers and pregnant women. According to the Missouri Early Head Start director, the state Early Head Start-child care partnerships have created 652 new child care slots for children ages birth to 3.

The Children's Therapy Center in Sedalia, Missouri

The Children's Therapy Center was founded in 1956 to meet the needs of families who traveled from outlying areas to the hospital in Sedalia to obtain services for children with

[1]The Department of Elementary and Secondary Education administers all programs targeting the preschool population, while the Department of Social Services focuses on birth to age 3.

disabilities. Today, the agency's mission is to meet the needs of adults and children with disabilities in the community. In April 2002, the Center had a staff of 260, 43 of whom worked exclusively on early childhood programs for children ages birth to 5 and their families. The rest of the staff provide services for adults with disabilities, including sheltered workshops, assisted living, home care, and other support services.

Services for young children and their families are provided through the Children's Therapy Center's Family and Child Development Department. Through this department, the agency provides Part C services in an eight-county service area. The board of directors decided to begin providing good-quality child care and comprehensive services because some families receiving Part C services needed services that were more comprehensive and because the board felt that good-quality child care could help prevent developmental delays in young children. The Children's Therapy Center received a federal Early Head Start grant in fall 1999 to serve 70 families—20 in a child care center operated by the agency and 50 through home-based services. With funding from the Missouri Early Head Start program, the Center serves an additional 40 families through partnerships with community child care providers. Although most providers are located in or near Sedalia (Pettis County), the program also partners with child care providers in Moniteau County.

COMMUNITY CONTEXT

Kansas City, Kansas, and Sedalia, Missouri, are examples of some of the variety in communities where state Early Head Start programs have been implemented: one community is urban, the other rural. There are differences as well in the communities' demographic makeup, their child care markets, their welfare programs, and their child care subsidy systems. Wyandotte County, Kansas, has a population of nearly 158,000, most of whom live in Kansas City (U.S. Census Bureau 2001). Approximately 18 percent of county residents live in poverty. The county is home to a growing number of Hispanics—16 percent of the population. Nearly 13,000 county residents are younger than 5. The poverty rate among children is high: approximately 39 percent of residents under age 14 live in poverty (Kansas Action for Children 2002). Moreover, staff from Project EAGLE estimated that nearly a third of the 2,400 infants born annually in Wyandotte County are eligible for Early Head Start services because their families live below the poverty line.

In contrast to Kansas City, with its urban density, Sedalia, Missouri is a small town in a rural area. The minority population is relatively small, under eight percent. Pettis County (where Sedalia is located) contains about 39,000 people and covers 686 square miles. More than 13 percent of the population lives in poverty, including nearly 2,000 children under age 18 (U.S. Census Bureau 2001). In the rest of this section, we describe each community's employment opportunities, TANF program, child care demand and supply, child care licensing standards, and child care subsidy program.

Employment Opportunities

The Wyandotte County, Kansas Economic Development Council cites services (primarily in retail trade and government jobs) and manufacturing as the top non-agricultural employment sectors in the county. According to officials at the Kansas Department of Social and Rehabilitative Services (SRS), low-skilled workers typically find jobs in the service sector. Entry-level positions with customer service companies offer the best wages ($10 an hour) and benefit packages. Fast-food chains offer $7 an hour. House-cleaning jobs and entry-level jobs in the health sector (such as home health aides) also are common. In addition, some low-skilled workers find jobs in warehouses and in light manufacturing, which typically pay $7 to $9 an hour. During the site visit, SRS officials noted that since the events of September 11, 2001, the local economy has declined, wages have fallen, and the number of job openings has declined.

Missouri also had a struggling economy in the month preceding the site visit. As of December 2001, the unemployment rate had jumped to 7.6 percent, up from 4.0 percent only two years earlier (Missouri Economic Research and Information Center 2002). The Missouri Department of Economic Development lists, as the dominant employment fields in the county, local government, retail trade (especially in restaurants and general merchandise), health and social services, business services, secondary education, trucking, and construction. An official at the Children's Therapy Center noted that many low-income parents in Sedalia have second-shift jobs in factories, mostly in the food- and poultry-processing industries.

TANF Programs

In Wyandotte County, Kansas, the welfare caseload has fallen considerably. According to SRS, there were 1,700 adults on TANF in Wyandotte County in 1994; by May 2002, there were 800. Moreover, fewer than 20 percent of those adults had received TANF for more than 36 months. A local SRS official estimated that 50 to 70 percent of TANF families have infants and toddlers. Kansas limits TANF cash assistance to 60 months and imposes work requirements after two years (although clients must participate in work activities immediately unless they are exempt). When families have been on TANF for 48 months, an interagency team meets monthly to determine why they remain on public assistance, to develop service plans, and to take all possible steps to help them find employment before they reach the five-year lifetime limit. According to local SRS officials, sanctions are infrequent in the county; no more than 10 percent of TANF clients receive them.

Kansas exempts parents of infants from working during the first year of the child's life. Up to that point, SRS staff focus mainly on skills assessment. After children reach age 1, SRS often refers parents to one of several life skills courses as a first step toward employment and helps them find child care if needed. SRS staff reported that, due to the availability of unregulated child care providers, they rarely grant time-limit extensions because of inability to find child care. When the parents want only regulated arrangements for their children, SRS will consider granting a temporary extension, but this rarely occurs.

In Missouri, the Department of Social Services (DSS) provides consolidated service delivery in some rural counties, including Pettis, because of small caseloads in the rural areas. A single caseworker handles TANF, child care subsidies, food stamps, and other social programs. As in Kansas, the TANF caseload has declined in Missouri. The number of clients receiving cash assistance has fallen 41 percent—from 1,389 in January 1993 to 818 in June 2002 (Missouri Department of Social Services 2002). Also, TANF recipients in Missouri are subject to a five-year lifetime limit on receipt of cash assistance and face work requirements after two years. Parents with infants under age 1 are exempt from work requirements.

Child Care Demand and Supply

In both communities, stakeholders report that the number of regulated child care providers, especially good-quality providers and those who accept child care subsidies, falls short of meeting the demand for infant-toddler child care.

Kansas. Heart of America Family Services, the local resource and referral agency, received 817 requests in 2001 for help finding infant-toddler child care. Approximately half these children were eligible for a state child care subsidy. Many families, however, do not contact resource and referral agencies when looking for child care; therefore, demand for infant-toddler care may be considerably higher.

According to an SRS official in Kansas City, the area has child care capacity for half the children age birth to 5. A United Way survey commissioned by SRS in 2001 indicates that the supply of regulated child care is inadequate in low-income neighborhoods, particularly in eastern Wyandotte County. Heart of America Family Services has identified only 13 child care centers located in these zip codes. A local SRS official reported that community-based organizations and churches have expressed interest in opening child care facilities in these neighborhoods, but that obtaining a license and meeting state standards is too costly. In fact, several faith-based providers closed down during the year preceding the site visit because the child care subsidy payments from SRS did not cover their operating costs. Further, the official noted that, while various licensed providers in the community have infant and toddler slots, the better-quality ones frequently have waiting lists. During the site visits, staff from several community service providers reported that parents who cannot find good-quality, affordable licensed care for infants and toddlers usually rely on registered providers (family child care providers who care for six or fewer children and are not required to obtain a license), relatives, or neighbors. In other cases, parents choose to use relatives or friends as child care providers because they prefer such arrangements.

Table III.1 shows the supply of child care in the county for *all* age groups. Staff at Heart of America Family Services reported that licensed family child care providers offered most of the community's regulated infant-toddler slots. According to Project EAGLE, there are 111 licensed family child care providers, 45 group family providers, 24 child care centers, and 16 registered family child care providers in Wyandotte County who will care for children under 18 months. Although staff from Heart of America Family Services noted that many

TABLE III.1

REGULATED CHILD CARE SUPPLY IN AUGUST 2002
WYANDOTTE COUNTY, KANSAS

	Child Care Centers	Family Child Care Homes	Group Family Child Care Homes	Registered Family Child Care Homes	Total
Child Care Slots for Ages Birth to Five					
Number of Slots	3,307	1,470	752	165	5,694
Number of Vacant Slots	440	442	241	42	956
Vacancy Rates	13%	30%	32%	25%	17%

Source: Heart of America Family Services, Kansas City, Kansas.

Note: Not all providers with vacancies have contracts with SRS to accept child care subsidy reimbursement.

parents—particularly those from low-income families—work second shifts, few providers offer care during nonstandard hours, and parents have trouble finding care during alternative hours. Most providers who offer care during nonstandard hours are licensed family child care providers; only two child care centers in the Kansas City area offer this service.

Missouri. Parents of infants and toddlers in Sedalia and the surrounding area also have a limited supply of affordable, good-quality providers to choose from. Staff from the Children's Therapy Center noted that it is especially difficult to find slots in infant rooms, even among providers who partner with the agency. While there is one accredited child care center in Sedalia, it accepts only children ages 2 to 5. According to program staff, most families rely on kith-and-kin care for their infants and toddlers, either because they prefer it or because they cannot find regulated arrangements. There is virtually no regulated child care available during nonstandard hours. A few licensed child care centers have attempted to offer care during second shifts but, according to a program staffer, have found it too difficult. Table III.2 displays information on the supply of infant-toddler slots and vacancy rates in Pettis County. Relative to total child care slots, vacancy rates for infants and toddlers are extremely low.

State Child Care Licensing Standards

Kansas. The Kansas Department of Health and the Environment contracts with local county health departments to regulate and monitor licensed and registered providers. Family child care providers who care for no more than six children and meet minimal health and safety standards are required to register with the state, but they are not required to obtain a license. Providers who care only for related children do not have to register with the state; all other providers must obtain a license to provide child care. In order to monitor adherence to licensing standards, a licensing surveyor from the health department visits providers annually, or more often if a complaint is filed. Registered providers must submit

TABLE III.2

REGULATED CHILD CARE SUPPLY IN APRIL 2002
PETTIS COUNTY, MISSOURI

	Child Care Centers	Family Child Care Homes	Group Family Child Care Homes	Total
All Child Care Slots				
Child Care Slots	661	219	47	927
Vacant Child Care Slots	56	27	9	92
Vacancy Rates	8%	12%	5%	10%
Child Care Slots for Infants and Toddlers				
Infant-Toddler Slots	77	50	8	135
Vacant Infant-Toddler Slots	1	3	1	5
Vacancy Rates	1%	6%	13%	4%

Source: Central Missouri State University, the child care resource and referral agency for Pettis County.

Note: These figures include only providers who have responded to a survey conducted by Central Missouri State University, the local child care resource and referral agency. There are 42 licensed providers in Pettis County. Of those, 38 responded to the survey, including 12 child care centers, 24 family child care homes, and 2 group family child care homes. Not all regulated providers accept child care subsidies. Of those providers who responded to the survey, 7 of 12 child care centers, 18 of 24 family child care homes, and 1 of 2 group family child care homes reported accepting child care subsidies.

an annual self-assessment to the health department, but they are not visited unless a complaint is filed. To maintain their status, licensed and registered providers must submit to child-abuse screenings, obtain first aid training, participate in required hours of annual training (5 for family child care providers, 10 for teachers in child care centers), and adhere to health and sanitation codes. Tables III.3 and III.4 display the ratio and group size limits for the various categories of providers. Kansas is 1 of only 4 states with maximum child-staff ratios for infants in centers as low as 3 to 1, and its maximum group sizes for infants and toddlers in centers are in the middle of the range among states that regulate group size (Children's Foundation 2002; and Azer et al. 2002).

Missouri. The Bureau of Child Care within the Missouri Department of Health is responsible for monitoring compliance with child care licensing standards. There are three categories of providers in Missouri: (1) licensed, (2) license-exempt, and (3) unregulated. Home-based and center-based facilities that care for more than four unrelated children must obtain licenses and meet health, safety, and training requirements. Some providers are license-exempt, but they must still undergo fire and sanitation inspections and meet general health and age requirements. Frequently, these are religious organizations that operate preschools or nursery schools for less than five hours a day, as well as family child care homes and centers operated by school districts. According to Central Missouri State University (CMSU), the local resource and referral agency, there are four license-exempt providers in Pettis County. Providers who care for four or fewer unrelated children are not required to obtain a license; CMSU is aware of 69 unregulated providers in the

TABLE III.3

MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN CHILD CARE CENTERS

	Kansas		Missouri	
Age of Child	Child-Staff Ratios	Group Sizes	Child-Staff Ratios	Group Sizes
6 Weeks	3:1	9	4:1	8
9 Months	3:1	9	4:1	8
18 Months	5:1	10	4:1	8
27 Months	7:1	14	8:1	16
3 Years	12:1	24	10:1	Not Regulated

Source: National Child Care Information Center Web site, March 15, 2002.

TABLE III.4

MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN FAMILY CHILD CARE HOMES

Type of Arrangement	Child-Staff Ratios	Group size
		Kansas
Licensed Small Family Child Care Home	3:1 or 6:1	Child to staff ratio of 6 children to 1 provider, with no more than 3 children under 18 months. The ratio is 3 to 1 if all children are under 18 months.
Licensed Group/Large Family Child Care Home	5:1	Maximum number of children to staff varies by the age of the child. For example, a total of 10 children may be cared for by 2 providers if 4 children are under 18 months, 4 children are 19 months to kindergarten age, and the remaining children are kindergarten age or older.
Registered Family Child Care Home	6:1	Maximum number of children is 6, with no more than 3 children under 18 months.
		Missouri
Small Family Child Care Home	4:1 or 6:1 or 10:1	Each provider may be licensed for up to 6 children, with a maximum of 3 children under age 2, or up to 10 children, with a maximum of 2 children under age 2. If only 4 children are present, all may be under age 2. If the provider has an assistant, the home may be licensed for up to 10 children, with a maximum of 4 children under age 2 or for 8 children of any age.
Group/Large Family Child Care Home	10:1	Can care for 11 to 20 children with 2 adult caregivers.

Source: Quality in Linking Together Early Education Partnerships Web site, March 14, 2002, and the Kansas Department of Social and Rehabilitative Services, 2002.

county. Tables III.3 and III.4 display the ratios and group size limits for the various categories of regulated providers. Missouri is 1 of 33 states with maximum child-staff ratios of 4 to 1 for infants in centers and 1 of 15 states with this maximum ratio for toddlers in centers. Missouri ranks in the top third of states when ranked according to maximum group

sizes for infants in centers and in the top half of states when ranked according to maximum group sizes for toddlers in centers (Children's Foundation 2002; and Azer et al. 2002).

Child Care Subsidy Programs

Kansas. There has not been a waiting list for child care subsidies in Wyandotte County for more than five years. For a family to be eligible for a subsidy, family income must be below 185 percent of poverty, unless the parent is enrolled in TANF or the food stamp work program, has an open child protection case, or is a teen parent under age 18. Subsidies are provided for the hours in which parents are working or attending work activities for TANF; parents over age 18 cannot obtain a subsidy to cover child care costs while they attend education programs. Families with incomes at 100 percent of poverty or higher must make a copayment based on income and family size (Table III.5). Families making the transition off TANF, however, have a two-month grace period before they must begin making copayments. Most families who receive child care assistance are working families rather than TANF clients. For example, according to SRS officials, in March 2002, the agency spent approximately 80 percent of its subsidy funds on working families and 20 percent on TANF families.

In recent years, SRS has simplified the subsidy application process. SRS uses one generic application form for all its services (for example, food stamps or WIC), and clients complete only those pages that are applicable. Families can complete and submit the application in person at the SRS office, or they can mail it in. The county no longer requires parents to attend a face-to-face interview or provide a social security card and proof of residency. TANF recipients and families with open protective services cases can obtain subsidies through their caseworker without filling out an application. In addition, some child care centers and family child care providers make applications available on-site.

TABLE III.5

KANSAS CHILD CARE ASSISTANCE PROGRAM
MONTHLY COPAYMENTS BY INCOME LEVEL AND FAMILY SIZE IN MAY 2002
(IN DOLLARS)

Income Bracket (Percent of Federal Poverty Level)	Family Size			
	2	3	4	5
Up to 99 Percent	0	0	0	0
100 to 109 Percent	18	22	27	31
110 to 119 Percent	46	58	70	82
120 to 129 Percent	63	79	95	112
130 to 139 Percent	84	106	127	149
140 to 149 Percent	110	138	166	194
150 to 159 Percent	141	177	213	250
160 to 169 Percent	165	207	249	291
170 to 179 Percent	175	220	265	310
180 to 184 Percent	186	233	281	329
185 Percent	197	243	293	343

Source: Kansas Department of Social and Rehabilitative Services.

SRS redetermines eligibility annually and does not increase the copayment amount at redetermination unless family income has increased more than two income brackets (Table III.5). This policy is intended to help families increase their disposable income without having to pay more for child care. Parents who are not employed at redetermination lose child care assistance.

SRS will provide subsidies for care provided by licensed or registered child care providers and for out-of-home care provided by relatives, including grandparents, aunts and uncles, as well as adult siblings who do not live in the same household as the child. At the time of the site visit, SRS had 390 subsidy agreements in place with providers; of these, 65 were with relatives. To obtain a subsidy for an unregulated provider who is a relative, parents must tour the home and complete a safety checklist, and sign consent forms for emergency medical care and for the provider's discipline policy. Providers and others living in the home must pass a check with the abuse and neglect registry.

Kansas reimburses child care providers for the hours children attend child care based on an hourly rate for each type of care (Table III.6). These rates are set based on the results of market rate surveys conducted in each county. In February 2002, SRS implemented a provider rate adjustment based on the 2000 market rate survey. Using these survey results, the state assigned each county to one of three groups, according to similarities across counties in child care rates charged to families that pay privately. For each of these groups, the state set subsidy reimbursement rates at the 65th percentile of market rates for licensed child care centers and family child care homes, and at the 60th percentile for registered family child care providers and unregulated relative providers.[2] This means that in 2000, 65 percent of licensed providers charged privately paying families rates that are at or below the subsidy reimbursement rates. For example, hourly reimbursement rates for center-based infant care are $4.48 for counties in group one, $3.36 in group two (the group to which Wyandotte county is assigned), and $2.10 in group three.

Missouri. Since welfare reform, the use of child care subsidies in Pettis County has increased, from 265 children in 1996 to 343 in 2000 (Citizens for Missouri's Children 2001). At the time of the site visit, Pettis County did not have a waiting list for obtaining a subsidy.

Missouri's child care subsidy program is administered by the Division of Family Services within the DSS. For applicants not on TANF, the division determines eligibility for child care assistance based on household income. Families with incomes at or below 121 percent of poverty are eligible (Table III.7). According to a state DSS official, the state set a very low income threshold for the program because its goal is to provide the subsidies to as many poor families as possible. Families can receive a subsidy for hours in which parents are working, attending an education program, or participating in a job training program.

[2]Kansas offers lower child care subsidy reimbursement rates to registered providers and unregulated relative providers to encourage licensure.

TABLE III.6

HOURLY MARKET AND MAXIMUM CHILD CARE SUBSIDY REIMBURSEMENT RATES IN FEBRUARY 2002, WYANDOTTE COUNTY, KANSAS (IN DOLLARS PER HOUR)

Child Age	Maximum Subsidy Reimbursement Rates
Licensed Child Care Centers	
Birth to 12 Months	3.36
13 to 29 Months	2.88
30 Months to 5 Years	2.20
Licensed Small and Group Family Child Care Homes	
Birth to 7 Months	2.22
8 months to 5 Years	2.00
Registered Family Child Care Providers and Unregulated Relative Providers	
Birth to 17 Months	2.02
18 Months to 5 Years	2.00

Source: Kansas Department of Social and Rehabilitative Services and Heart of America Family Services' community market rate survey.

Note: These rates are set based on the results of market rate surveys conducted in each county. In February 2002, SRS implemented a provider rate adjustment based on the 2000 market rate survey. Using these survey results, the state assigned each county to one of three groups, according to similarities across counties in child care rates charged to families that pay privately. For each of these groups, the state set subsidy reimbursement rates at the 65th percentile of market rates for licensed child care centers and family child care homes, and at the 60th percentile for registered family child care providers and unregulated relative providers.

TABLE III.7

MISSOURI CHILD CARE ASSISTANCE PROGRAM CHILD CARE INCOME ELIGIBILITY LIMITS AND COPAYMENT RATES BY INCOME AND FAMILY SIZE IN FEBRUARY 2000 (IN DOLLARS)

Income Eligibility Limits by Family Size					Daily Copayment per Child
1	2	3	4	5	
Up to 417	Up to 545	Up to 674	Up to 802	Up to 930	0
418–500	546–654	675–808	803–962	931–1,116	.50
501–583	655–763	809–943	963–1,122	1,117–1,302	.75
584–667	764–872	944–1,078	1,123–1,283	1,303–1,488	1.00
668–750	873–981	1,079–1,212	1,284–1,443	1,489–1,674	2.00
751–834	982–1,090	1,213–1,347	1,444–1,604	1,675–1,860	2.00
835–917	1,091–1,199	1,348–1,482	1,605–1,764	1,861–2,046	3.00

Source: Missouri Department of Family Services, February 2000.

Families on TANF must make a copayment of $1 a year; other families make copayments based on income and type of care. DSS redetermines eligibility annually. The department has made the process relatively easy for parents, who need only to complete a one-page form and submit it by mail.

To supply subsidized care, the state contracts with licensed providers, license-exempt providers, unlicensed providers caring for four or fewer children, or out-of-home relative providers. Unlicensed providers and relatives must be at least 18 years old, pass a tuberculosis test, pass criminal and child-abuse screenings, and inform parents as to whether they have a working telephone.

Missouri uses market rate surveys conducted every two years to set reimbursement rates. Because of budget constraints, however, the state has not increased reimbursement rates since 1996. In addition, Missouri has implemented a tiered reimbursement system. Providers who care for certain populations or offer specific types of care in high demand receive enhanced subsidy payments. For example, providers receive a 30 percent increase in their reimbursement rate if more than half the children in their care qualify for subsidies. They receive a 25 percent rate increase for any child with a diagnosed special need. To promote quality, DFS offers a 20 percent rate increase to accredited providers. Finally, providers who offer weekend care receive a 15 percent rate increase.

STRATEGIES FOR DEVELOPING PARTNERSHIPS

The two state Early Head Start grantees described in this profile—Project EAGLE in Kansas City, Kansas, and the Children's Therapy Center in Sedalia, Missouri—have implemented partnership strategies for meeting the child care needs of low-income families with infants and toddlers enrolled in their programs and for improving the quality of infant-toddler care provided in the community. In response to the community contexts in which they operate and the strengths of their respective organizations, the two grantees designed different partnership models and took distinct approaches to coordinating services for families and helping child care partners with quality improvement. In this section, we describe the model for partnering with child care providers implemented by each grantee. We compare and contrast their approaches to recruiting child care partners, developing partnership agreements, and working with providers on quality improvement. We also describe the other community initiatives that each grantee draws upon to enhance the support available to partner child care providers and families.

Overview of Partnership Models

Project EAGLE and the Children's Therapy Center operate both state and federal Early Head Start programs. In designing their state programs, both agencies integrated the two programs to some degree and developed plans for drawing on the expertise of specialists and other staff already working in their federally funded programs. However, they took different approaches to staffing the key tasks of providing comprehensive services to families and supporting partner child care providers.

Project EAGLE. In Kansas City, Project EAGLE has recruited and developed partnership agreements with numerous community child care providers. At the time of the site visit, the agency had established partnerships with 14 child care centers and 11 family child care homes. A child care coordinator oversees support for these partnerships. She is responsible for recruiting partners, developing partnership agreements, coordinating a CDA training program, keeping track of vacancies (to facilitate matching families with providers), and supervising two child care specialists who support the providers.

One child care specialist serves as the program liaison for child care centers, while the other focuses on family child care providers. These specialists visit each child placed with the providers in their caseload twice a month, usually once during an active time of day (when the child is awake), and once during nap time. During these visits, the specialists observe the child, offer feedback and technical assistance to the child's teacher, help out in the classroom if needed, and model developmentally appropriate caregiving. The specialists also use these visits to bring equipment and supplies and to address any needs or issues related to the partnership that have arisen since their last visit.

Family advocates serve as the program's primary contact for families and are responsible for coordinating all the services that families receive. They conduct home visits (initially, weekly, then bimonthly or monthly) to families receiving child care through the partnerships, periodically assess children's development, and work with families to develop family partnership agreements that include the parents' goals for their infants and toddlers. Family advocates coordinate with the child care specialists on issues related to child care families receive through the partnerships. For example, they coordinate with the specialists to enroll families in child care, share information about services provided in the home and in child care, and coordinate if any child care-related problems arise.

The Children's Therapy Center. At the time of the site visit, the Children's Therapy Center had seven child care partners—five child care centers and two family child care homes. Like Project EAGLE, the Children's Therapy Center employs a child care coordinator to oversee the partnerships with child care providers. At the Children's Therapy Center, however, the child care coordinator also oversees services for families. She is responsible for recruiting partners, developing partnership agreements with providers, and supervising the work of four Partner Advocate Liaisons (PALs).

Three of the PALs are responsible for providing support and technical assistance to a caseload of child care providers; they visit centers and family child care homes weekly for one and a half to three hours. Unlike Project EAGLE's child care specialists, however, the PALs also provide services to families, primarily during monthly home visits. During these visits, PALs work with parents to develop individual learning plans for children, complete regular developmental assessments using the *Ages & Stages Questionnaires* (Bricker and Squires 1999), and provide other family development services.

The fourth PAL does not have a caseload of providers or families. Instead, she provides specialized services to child care partners as needed. For example, she can spend several days at child care center shadowing a child to address specific behavior problems

(such as biting), serve as a substitute, care for a family child care provider's children while she meets with another PAL, or provide one-on-one training for new child care teachers.

Staffing to Support the Partnerships

Both these staffing models have advantages and drawbacks. For example, one advantage of assigning a single PAL to both child care providers and the families is that the PALs can facilitate efficient communication between them when problems arise. During the site visit, however, PALs said that while they liked the staffing arrangement, they did not always have enough time to work with families. In contrast, Project EAGLE's family advocates can focus on serving families, while child care specialists focus on serving providers. This division of labor allows staff to focus intensively on serving either families or providers; however, maintaining communication among all those involved with a particular family can be challenging. For example, some child care partners reported that communication sometimes is inefficient because so many staff (family advocates, child care specialists, child care teachers) are involved. At times, parents talk with one staff member about an issue, then assume that the others know—when, in fact, they do not. If staff do not share information frequently, confusion and miscommunication can occur.

Recruiting and Selecting Child Care Partners

Project EAGLE and the Children's Therapy Center have developed strategies for recruiting child care partners based on the child care needs of families and the supply of child care available in the community. This section describes the methods used by the two agencies to recruit potential child care partners, as well as their criteria for selecting partners.

Because Project EAGLE had longstanding relationships with several community child care providers before it began the Kansas Early Head Start program, it did not have to recruit heavily to find providers when the state program started. To recruit new partners, the child care coordinator relies primarily on word of mouth. For example, licensing monitors from the Kansas Department of Health sometimes tell good-quality family child care providers about the state Early Head Start program during facility inspections and encourage providers to contact the child care coordinator. The coordinator actively recruits new partners when specific needs arise, for example, if families need providers in specific areas of the county or during nonstandard work hours. In these circumstances, she calls the child care providers to assess their interest in joining the partnership.

Unlike Project EAGLE, the Children's Therapy Center had no previously established partnerships with community child care providers when the state program began. To recruit providers, the child care coordinator posted flyers and placed an advertisement in the local newspaper, inviting child care providers to attend an orientation session to discuss the partnership. Afterward, the child care coordinator met individually with interested center directors and family child care providers to discuss the details of the partnerships. In particular, she emphasized the benefits of the partnerships for providers and tried to assuage their concerns about meeting the Head Start Program Performance Standards.

Project EAGLE and the Children's Therapy Center both require partners to have state licenses and to be in good standing with the licensing agency. While neither agency requires providers to provide high-quality care when they begin the partnership, providers must be willing to work toward improving quality and meeting the performance standards. In addition to these requirements, the child care coordinator at Project EAGLE makes decisions about forming partnerships based on the needs of families. For example, the coordinator may choose to form a partnership with a family child care provider located in a neighborhood where many families need care, rather than a provider located in an area where few families live or work.

Both agencies reported that most partnerships have worked well. However, both have ended a few partnerships because providers were unwilling to work on meeting the performance standards. In some of these cases, the providers decided not to continue with the partnerships because they did not want to implement some requirements contained in their partnership agreements with the programs.

Partnership Agreements

Project EAGLE and the Children's Therapy Center develop formal partnership agreements, or contracts, with their child care partners. These agreements document in writing the expectations of both partners, the resources each partner will bring to the partnership, and the activities each partner agrees to carry out through the partnership.

Partnership agreements detail the standards that child care partners must work toward meeting. Because state Early Head Start programs must operate in compliance with the federal Head Start Program Performance Standards, the agreements focus heavily on those requirements and how the partnership will achieve compliance with them. Specifically, the partnership agreements developed by Project EAGLE and the Children's Therapy Center must meet the following requirements:

1. **State Licensing.** Partners must comply with all state licensing requirements and be in good standing with the licensing agency.

2. **Participation in Visits by Early Head Start Staff.** Providers must allow program staff to visit regularly, as well as provide needed technical assistance.

3. **Implementing Developmentally Appropriate Practices.** Partners must implement developmentally appropriate practices, such as holding infants while bottle-feeding them and putting them down on the floor to play. Programs discourage providers from using restrictive equipment, such as swings and walkers. In addition, Project EAGLE requires providers to conduct self-assessments using the Infant-Toddler Environment Rating Scale (ITERS) or the Family Day Care Rating Scale (FDCRS).

4. **Compliance with the Head Start Program Performance Standards.** Partners must work toward compliance with the performance standards, such

as implementing developmentally appropriate practices, family-style dining, toothbrushing and other health and safety procedures, requirements for teacher credentials, and ratio and group size limits (four children per teacher and eight children per group). Neither program requires progress in a particular time frame or outlines minimum thresholds. Program staff expects regular progress, but the progress seems to be relative to each individual provider. They are willing to work with providers to raise their quality-of-care standards as long as providers show improvement and dedication. The Children's Therapy Center does, however, include a probation policy in its partnership contract, and Project EAGLE uses a Child Care Action Plan when corrective action is needed.[3]

5. **Teacher Credentials.** Lead teachers must obtain a Child Development Associate (CDA) credential or have a higher degree within one year of hire or the start of the partnership. Both programs provide training and support for obtaining a CDA. The Children's Therapy Center also requires child care teachers to complete infant-toddler cardiopulmonary resuscitation (CPR) and first aid training.

6. **Monitoring Children's Development.** Child care teachers must maintain, for each child, daily log sheets that track eating and sleeping patterns and record regular observation notes. They also must maintain portfolios of each child's log sheets, service plans, assessments, and artwork or other projects. Teachers must develop lesson plans that incorporate developmentally appropriate activities and collaborate with program staff and parents in working on children's individual learning goals. The Children's Therapy Center requires teachers to use the *Creative Curriculum for Infants and Toddlers* (Dombro et al. 1997) for lesson planning. During the site visit, Project EAGLE staff said they planned to begin requiring providers to use the Creative Curriculum in July 2002. Some of Project EAGLE's partners also perform regular developmental screenings using the *Ages & Stages Questionnaires* (Bricker and Squires 1999).

7. **Communication with Parents.** Both programs require child care partners to communicate regularly with parents. Project EAGLE requires child care teachers to lead two parent-teacher conferences a year at the child care facility. The teachers also must participate in two home visits per year that are led by a family advocate. In addition, Project EAGLE requires child care partners to hold a monthly group activity for parents and children.

[3]The Children's Therapy Center and the provider work together to draft a corrective plan of action (CPA), which is reviewed monthly by program staff for signs of improvement. While, *technically*, a CPA can result from a failure to comply with the Head Start Program Performance Standards, program staff understand that it takes time for caregivers to implement quality improvements. Providers have six months in which to address any outstanding issues once a CPA is activated. Project EAGLE uses the Child Care Act plan to identify goals, steps that staff must complete toward the goals, and deadlines for completing these steps.

8. **Recordkeeping.** Both programs require providers to maintain attendance and other administrative records.

To support child care partners in their efforts to improve quality and comply with the Head Start Program Performance Standards, Project EAGLE and the Children's Therapy Center provide partners with reimbursement for child care services, equipment and supplies, and training and technical assistance. Partnership agreements describe the level of support that child care partners receive from the programs, including the following:

1. **Reimbursement.** Project EAGLE and the Children's Therapy Center purchase slots for Early Head Start children from partner providers. They reimburse providers at higher rates than those paid by state child care subsidy systems and provide reimbursement more quickly. Both programs negotiate rates with each child care partner individually, rather than setting standard rates. In addition, both programs pay for days when children are absent; state subsidy systems do not.

2. **Bonuses.** The Children's Therapy Center pays higher rates to accredited providers. In the year preceding the site visit, the agency also provided incentive bonuses to partners that met quality improvement goals. Project EAGLE provides a $400 mini-grant to providers when teachers complete CDA training, which can be used to purchase equipment.

3. **Equipment and Supplies.** Both programs purchase equipment (such as changing tables, rockers, and cribs), indoor and outdoor play equipment, and toys that providers need to implement developmentally appropriate practices and comply with the performance standards.

4. **Lending Libraries.** Both programs maintain lending libraries for providers that include curricula and lesson planning materials, children's books, toys, and health and safety materials and equipment.

5. **CDA and other training.** Both programs provide CDA training free of charge, pay for the cost of applying for the CDA credential, and pay for substitutes while teachers attend CDA or other training. In addition, Project EAGLE pays teachers for the time they spend in CDA classes and pays for transportation to CDA classes. Both programs invite child care teachers to attend other in-house trainings; some providers have attended conferences with program staff.

TECHNICAL ASSISTANCE AND TRAINING FOR CHILD CARE PROVIDERS

Project EAGLE and the Children's Therapy Center provide intensive training, technical assistance, and support to partner child care providers to help them work toward quality improvement and compliance with the Head Start Program Performance Standards. Most

technical assistance is provided by Early Head Start staff who visit partner providers regularly. The programs also provide substantial training to child care teachers through their CDA programs. This section describes in detail the technical assistance and training that child care partners receive.

Technical Assistance from Program Staff

Although staff from both programs visit partner providers regularly, Project EAGLE and the Children's Therapy Center take different approaches to conducting these technical assistance visits. Child care specialists from Project EAGLE visit each Early Head Start child in child care twice a month; thus, the focus of their visits to child care partners is on the services provided to a particular child. Child care specialists observe the child, talk with the teacher about how the child is doing, and, if appropriate, make suggestions about caring for the child in compliance with the performance standards. In contrast, PALs from the Children's Therapy Center visit providers weekly, regardless of how many Early Head Start children are in care. Their visits focus on providing technical assistance to the child care teachers and working to implement the performance standards, rather than on the services provided to an individual child.

Staff who visit child care partners in both programs are highly qualified. All of them have substantial education in the early childhood field. They also have professional experience working in child care or with infants and toddlers. Staff in both programs said, and child care providers confirmed, that their experience in the child care field gives them credibility in the eyes of child care providers and helps them gain the trust of the teachers they visit.

The primary focus of technical assistance visits in both programs is to work toward meeting the performance standards. Child care specialists and PALs stressed the importance of working incrementally to implement them. Providers become overwhelmed if they are expected to make too many changes at once. In addition, all staff stressed the importance of giving supportive, positive feedback and suggestions to providers, rather than correcting them or pointing out what they are doing wrong. The first priority for both programs has been to implement health and safety standards, then work on the room arrangement and the caregiving environment. All staff agreed that making changes in the environment is fairly straightforward and that most providers are willing to make these changes fairly quickly.

Implementing other standards that require changes in caregiving practices, however, takes more time. Child care specialists and PALs said they try to introduce one new standard at a time and gradually work with providers on ideas for implementing it. They encourage providers to implement practices that foster children's development and self-help skills, and that promote positive relationships between children and their caregivers. For example, both programs work with providers on holding infants while giving them bottles, implementing family-style dining with toddlers, talking more to children and giving them individual attention, giving infants opportunities for floor play, planning age-appropriate activities throughout the day, individualizing them to address the specific needs of each child, and maintaining close communication with parents.

Both programs incorporate quality assessments of the technical assistance they provide to child care partners. In Sedalia, the PALs conduct an annual observation using the ITERS or FDCRS to gauge providers' progress in improving quality. In Kansas City, child care specialists do not conduct formal observations, but they distribute the ITERS or FDCRS to providers twice a year and ask them to conduct their own self-assessments and identify weak areas on which they need to focus.

Child Development Associate (CDA) Training Programs

Both programs have implemented CDA training programs for child care teachers, and both help teachers apply for the CDA credential and pay the cost of the application. However, the programs have taken different approaches to providing the training. Project EAGLE partners with the Kansas City Community College to offer an intensive series of weekend classes. The Children's Therapy Center offers classes in-house during regular working hours.

Project EAGLE. In 1998, Project EAGLE and Kansas City Community College began a CDA preparation program exclusively for child care providers that partner with Project EAGLE. The classes are offered once a month, from February through October on Friday evenings and all day Saturday, and include Fundamentals of Early Childhood Education, Infant and Toddler I, and Infant and Toddler II. Upon completion of each class, students receive three college credits (nine total for the program) that can be applied toward an associate's degree in early childhood education. To enroll in the program, teachers must have a high school diploma or a GED. A few teachers who did not have a GED were able to obtain it and then enroll in the CDA program.

CDA students receive intensive support while they are in the program. A part-time instructor teaches the course. A program coordinator from the community college administers the program; she handles all program logistics, helps students who need tutors obtain them from the Learning Resource Center, helps students enroll in English as a Second Language (ESL) courses if needed, obtains college identification badges for the students, takes them to the college bookstore, and helps them access college computer labs. She also serves as the academic adviser for all the students.

The child care coordinator at Project EAGLE attends all the CDA classes and serves as a mentor for the teachers. Throughout the program, the coordinator observes the teachers in their classrooms and provides feedback to ensure that they are translating what they learn in the CDA classes into their work with children.

At the end of the coursework, the community college coordinator helps students assemble and submit all needed paperwork for the CDA application. To obtain the CDA credential, students must complete 120 hours of coursework, prepare a portfolio, pass an oral and written exam, write an autobiography, become certified in CPR and first aid, and pass an observation by a CDA examiner. At the time of the site visit, the program boasted a 95 percent success rate for students who had enrolled in the program. By May 2002, 65 teachers had obtained CDAs.

The Children's Therapy Center. The professional development coordinator at the Children's Therapy Center teaches CDA classes for child care teachers on staff and from partner child care providers. Classes are held for three hours on two afternoons a week. The coordinator has designed the coursework by drawing on the Caring for Infants and Toddlers curriculum, as well as West Ed's Program for Infant and Toddler Caregiver training. During the first year, classes were offered in three-week segments, with a week off between each two segments. However, in part because of high staff turnover in partner child care sites, few students finished the coursework. In addition, some center directors sent staff to training on a rotating basis, so that all teachers had an opportunity to attend training. As a result, teachers from these centers did not attend sufficient hours for them to apply for the CDA credential. At the time of the site visit, the coordinator reported that 2 of 10 students enrolled in the CDA program were expected to complete all the requirements and obtain their CDA. In addition to teaching the classes, the staff development coordinator serves as the students' mentor. She conducts observations in teachers' classrooms and provides feedback; she also helps students assemble their portfolios and prepare all materials for their CDA application.

During the site visit, the coordinator said that she planned to offer courses in six-week blocks in the coming year and to allow providers to commit to each block separately. She will also ask centers to select only one or two teachers to enroll in each block, to ensure that they accumulate enough hours to apply for the credential.

At the time of the site visit, students did not receive college credit for completing the CDA course. The local community college, however, was planning to begin offering an associate's degree in early childhood development. Staff at the Children's Therapy Center reported that, as a result, the community college will offer CDA training courses.

COMMUNITY INITIATIVES THAT SUPPORT THE PARTNERSHIPS

Without the contributions of other community initiatives, local grantees could not be as effective in their efforts to promote good-quality care for infants and toddlers and provide comprehensive services to families. Collaborations with and access to numerous resources help supplement the state Early Head Start programs through additional training, technical assistance, and bonuses for child care providers. The rest of this section summarizes other community initiatives that support the state Early Head Start programs in Wyandotte County, Kansas, and Pettis County, Missouri.

Wyandotte County, Kansas

Project EAGLE and its child care partners receive support from the following community programs:

1. ***Heart of America Family Services.*** This nonprofit agency provides child care resource and referral and other services to families in the greater Kansas

City area. As a member of the Kansas Association of Child Care Resource and Referral Agencies (KACCRRA), the agency administers a range of support initiatives for child care providers funded through KACCRRA and other sources:

- ***The Infant-Toddler Project.*** Funded through KACCRRA by a grant from SRS, this program has as its goal to improve the quality and supply of infant and toddler care. An infant-toddler specialist on staff at Heart of America organizes provider trainings, on-site technical assistance, quality assessments using the ITERS and FDCRS, and outreach to encourage providers to add infant-toddler slots. During the site visit, however, staff from Project EAGLE and KACCRRA noted that at that time, the Infant-Toddler Project had provided assessment and technical assistance services to only a few of the providers who partner with Early Head Start.

- ***TEACH™ Scholarships.*** The Teacher Education and Compensation Helps (TEACH™) program offers scholarships to child care providers as an incentive to encourage professional development in the child care field. Funded through the KACCRRA by an SRS grant, the scholarships cover 80 percent of tuition costs. Students also receive three hours of compensated time (TEACH™ and the providers each pay $4 an hour for a substitute) and mileage reimbursement. To qualify, scholarship recipients must commit to remaining in their current position for one year after completing coursework. After receiving a CDA or associate's degree, family child care providers receive a $300 bonus, and staff from child care centers receive either $300 or a 2 percent salary increase. Staff from several of Project EAGLE's child care partners have obtained TEACH™ scholarships to pursue associate's degrees in early childhood development, often after completing Project EAGLE's CDA program.

- ***Child Care WAGES Project.*** The WAGES initiative aims to reduce child care teacher turnover and promote professional development by providing salary supplements to teachers who meet experience and/or and education requirements. For example, assistant teachers with a CDA earn between $8.00 and $9.75 an hour, while lead teachers with a bachelor's degree in early education or child development earn between $11.00 and $13.00. In 2000, Wyandotte was one of three Kansas counties to receive a $250,000 competitive Smart Start grant funded through the state's tobacco settlement. The grant pays a wage supplement based on education and experience. Participating counties designated a target wage of $9 per hour for child care teachers and equalized wages for all three counties to minimize turnover caused by teachers moving to jobs in counties with higher wages. Providers apply for funds through a Smart Start committee led by United Way; preference is given to accredited providers or those in the process of

obtaining accreditation. At the time of the site visit, seven pilot sites received Smart Start funds in the Kansas City area; six of these sites were partners with Project EAGLE.

- ***Quality Improvement Enhancement Project.*** This project offers training opportunities for family child care providers to share strategies in making their child care business profitable and communicating more effectively with parents. Also available through the Heart of America Family Services are family child care provider grants, which offer additional funding to providers for purchasing equipment and supplies to improve their child care environments.

2. ***Accreditation Project.*** Through this initiative, 14 full-time staff provide technical assistance to providers working on obtaining accreditation. The program also provides grants for equipment purchases and facilities improvements, ranging from $5,000 to $25,000, to providers undergoing accreditation. The project is funded by a range of private sources. Several Project EAGLE partners have obtained accreditation assistance.

3. ***Foster Grandparents.*** This program is administered by Catholic Charities and funded by the Corporation for National and Community Service's Senior Corps. Foster grandparents serve as volunteer classroom assistants in several partner child care centers. They help teachers with feeding and rocking infants, reading to children, cleaning, and other tasks. Project EAGLE provides training for the foster grandparents who volunteer in partner centers.

4. ***The Infant-Toddler Program.*** Project EAGLE and its child care partners work closely with the Infant-Toddler Program, Kansas City's early intervention program for infants and toddlers with special needs (Part C). Over the past several years, the Infant-Toddler Program has expanded services to children in child care settings. Staff from the program work on-site in partner child care centers to serve Early Head Start children with special needs, and coordinate with Project EAGLE and child care staff to develop and implement individual family service plans.

Pettis County, Missouri

As a rural community, Pettis County has fewer support initiatives for child care providers than Wyandotte County, Kansas. However, Children's Therapy Center collaborates closely with three community initiatives to enhance support for families and providers:

1. ***EduCare.*** Funded by the state Department of Social Services, this initiative has as its primary mission to prepare low-income children for kindergarten. An organization called the Pettis County Community Partnership provides technical assistance and support services to 62 child care providers (primarily

family child care homes) to promote implementation of developmentally appropriate practices. Four of these providers are Early Head Start partners. EduCare co-hosts an annual provider appreciation dinner with Children's Therapy Center and serves on the agency's Early Head Start Policy Council.

2. ***Parents As Teachers.*** This parent education and family support program collaborates with the Children's Therapy Center to provide child development and parent education services to Early Head Start families. Families are dually enrolled in Early Head Start and Parents As Teachers and receive monthly visits from Parents As Teachers staff. The visits focus on child development activities that involve both parent and child.

3. ***First Steps.*** Also administered by the Children's Therapy Center, First Steps is the early intervention program (Part C) in Pettis County for infants and toddlers with special needs. Staff from Early Head Start and First Steps work closely to identify and assess children with special needs and to plan and coordinate services across the two programs. First Steps staff provide on-site therapies to children in their child care settings and in families' homes.

SUCCESSES OF THE PARTNERSHIPS

Project EAGLE and the Children's Therapy Center have developed promising approaches to partnering with community child care providers to increase low-income families' access to good-quality infant-toddler care. Specifically, strategies implemented by these state Early Head Start grantees have shown promise for improving quality, increasing low-income families' access to care, supporting special-needs children and their families, educating parents, and increasing community collaboration.

Improving Quality

Program staff and child care partners believe that the quality of care provided in partner child care sites has improved as a result of the Early Head Start-child care partnerships. Program staff report that child care partners have made significant strides in numerous aspects of quality, especially in those of health and safety. In Missouri, PALs reported that, in contrast to practices in place when the partnerships began, teachers now hold children in rocking chairs while giving them bottles, and no longer use walkers or swings. They follow sanitary diaper-changing procedures and have instituted regular hand-washing and tooth-brushing routines. Other community service providers who work with the partner child care sites reported that teachers generally implement higher-quality practices, compared to other community child care providers. For example, they put infants down on the floor to play on mats, take children outside daily, and interact more with the children. In Kansas, community partners reported that the state Early Head Start program had increased the continuity of care for some children by providing stable child care arrangements, along with a stable source of funding to pay for the care.

Program and partner staff believe they are increasing quality for many non-Early Head Start children who receive care from the partner child care providers. State officials and program staff in both states believe non-Early Head Start children receiving care from the partner providers benefit from quality improvements made through the partnerships with Early Head Start. For example, when teachers receive CDA training, all children in the classroom benefit from the teacher's new skills. All children enjoy new toys, equipment, and improvements to outdoor play areas provided through the partnerships. Similarly, reductions in group size and child-teacher ratios benefit all children in the classroom.

Program and partner staff attribute increases in quality to the training and support providers receive through the partnerships. Community partners in Kansas observed that teachers who have participated in the CDA training program implement what they learn in their classrooms. In particular, one community partner noted that regular observations and feedback from Project EAGLE's child care coordinator were crucial to helping teachers translate what they learned during training into their daily practice with children in their care. By May 2002, Project EAGLE's partnership with Kansas City Community College had produced 65 teachers with a CDA credential (95 percent of teachers who enrolled in the program). In Missouri, center directors and community partners credited the supportive attitude and intensive coaching provided by the PALs with helping providers implement quality practices.

Training, especially that for the Child Development Associate credential, has increased the sense of professionalism among partner child care teachers. Regular visits from Early Head Start staff, CDA training, WestEd training, and opportunities to attend professional conferences and workshops provided through the Early Head Start-child care partnerships have helped teachers in the partner sites view themselves as professionals in the field of early childhood education, rather than as "babysitters." In Kansas, program staff noted that as more child care teachers in the community have received CDAs, other community members have begun to view child care as more of a "profession."

Increased Access to Good-Quality Infant-Toddler Care for Low-Income Families

The Early Head Start-child care partnerships have increased the supply of regulated infant-toddler slots in their communities. In Kansas and Missouri, partner providers have increased the number of infant-toddler slots offered. Moreover, program staff reported that providers were willing to expand once knew they had a stable source of funding from the state Early Head Start program.

In Kansas, teen parents attending school who are income-eligible for the state child care subsidy but cannot receive the subsidy because they are not working can access infant-toddler care through the Early Head Start-child care partnerships. Parents are not eligible for a state subsidy to pay for child care while they attend school if they are over age 18. The state Early Head Start program, however, can cover these costs. Many teenage parents in Project EAGLE's program would not have access to child care while they attend high school if they were not in the program.

Support for Children with Special Needs and Their Families

The Early Head Start-child care partnerships have improved support for special-needs children and their families, especially in child care settings. Part C providers in both communities report that support from Early Head Start has increased partner providers' receptivity to Part C children. Moreover, they believe that the CDA and other training that partner providers receive has enabled them to better meet the needs of special needs children in their care. In addition, Early Head Start staff are available to provide support to parents of children with special needs and help them obtain the services their children need.

Parent Education

The state Early Head Start programs have increased parents' awareness of the importance of quality child care. Parents have learned what to look for in a child care setting and the quality practices that providers should implement. For example, during parent focus groups conducted during the site visits, parents talked about the importance of teacher-child interaction, activities to promote language development, upholding health and safety standards, and frequent communication between parents and teachers.

Increased Community Collaboration

Program staff and community partners believe that the state Early Head Start programs have increased collaboration among service providers. Program staff and providers reported that the state Early Head Start programs and child care partnerships have raised community awareness of the importance of quality child care and increased collaboration between programs, providers, and other community child care initiatives. Program staff and providers reported participating in more cross-agency meetings and community collaborations that address the quality and affordability of child care.

ONGOING CHALLENGES

Despite these successes, Project EAGLE and the Children's Therapy Center continue to face a number of challenges, many of them related to the high cost of providing good-quality infant-toddler care and the complexity of coordinating comprehensive services for children and families. In this section, we describe the challenges associated with improving quality, dealing with teacher turnover, meeting CDA requirements, assigning additional duties to teachers, working with Early Head Start families, and handling coordination and communication.

Improving Quality

Several aspects of the performance standards have been particularly challenging to implement. Program staff and partner providers reported that implementing the Head Start Program Performance Standards takes significant effort and time. Teachers, especially those without formal training in early childhood development, need time and support in order to implement new curricula in the classroom and learn how to individualize activities for children. In addition, it takes time for programs to supply all the equipment that providers needed, especially for outdoor play areas. Some requirements, such as family-style dining, have required significant changes to programmatic systems and routines.

Reducing child-teacher ratios to meet the performance standard requirements has been the most significant challenge, especially in family child care homes. Even though state licensing standards permit higher ratios, Early Head Start programs must comply with the 4-to-1 child-teacher ratios required by the performance standards. Programs in both states report that reducing child-teacher ratios to 4 to 1 has been especially challenging. Even though Early Head Start programs offer higher reimbursement rates than providers receive from the state child care subsidy programs, they cannot afford to compensate providers fully for the revenue they would lose by adhering to these ratios. For example, in Missouri, state licensing rules for child care centers require a ratio of only 8 to 1 for children ages 6 weeks to 18 months, twice that of the Head Start Program Performance Standards. This is an especially difficult challenge for family child care providers because of the small groups of children they serve. A related difficulty with reducing teacher-child ratios is the unmet need for infant-toddler child care in the community. Providers find it difficult to turn away families who need care when licensing regulations would permit them to accept additional children.

Changing familiar practices and habits takes time. Program staff who provide direct support to child care teachers reported that changing old and comfortable habits can be difficult, that it simply takes time. Clearly outlining expectations and the rationale for making changes, so that teachers understand how new practices will benefit the children, helps to encourage teachers to make the changes. In addition, program staff report that teachers are more receptive to changing their practices once they begin CDA training and learn more about how children develop.

Teacher Turnover

Frequent teacher turnover has made sustaining gains in quality a challenge for some partner providers. Especially in Missouri, several partner providers have experienced high teacher turnover. Program staff and center directors reported that other entry-level jobs in the community, even some jobs in the fast-food industry, offer higher wages than child care. Frequent turnover has made it hard to sustain continuity of care for children and improvements in quality caregiving practices. For example, staff told the story of one teacher who completed her CDA coursework and portfolio, then made the difficult decision to accept another job because it offered higher wages. Although she did not want to leave

her position at the child care center, economic realities prevented her from staying in the child care field.

Meeting the CDA Requirement

Finding a time when teachers can attend classes regularly, as well as teacher turnover, pose barriers to meeting the CDA requirement. In Missouri, because partners did not want to attend classes on evenings and weekends, the program offered CDA training during regular working hours. It has been challenging, however, to get teachers to attend classes regularly and obtain sufficient hours to apply for the credential. To provide equal opportunity for all teachers to attend training, some centers set up a rotating schedule for staff to attend training. As a result, few teachers completed the coursework within a year. In Kansas, center directors reported that some teachers were reluctant to attend CDA training because of family responsibilities on weekends and because they do not have strong literacy skills. These directors suggested that a self-study option for obtaining the CDA may be a viable alternative for these teachers.

Difficulty finding substitute teachers poses another obstacle to completing CDA training. In Missouri, the Early Head Start program paid for substitutes while teachers attended CDA training. Nevertheless, center directors reported that they have struggled to find qualified substitutes who were available to work while teachers attended the training.

Extra Duties for Teachers

Partner providers and teachers have had difficulty finding the time for completing additional activities required by the partnerships. As a result of the partnerships with Early Head Start, child care teachers have taken on additional duties. For example, they must maintain more-detailed documentation of children's activities and progress, as well as lesson plans and observation notes. Teachers must also conduct parent-teacher conferences with Early Head Start parents. Some teachers have been overwhelmed by these additional duties, especially the increased paperwork.

In Kansas, conducting home visits has been a particularly challenging obstacle for some teachers. Partner teachers and family child care providers must hold two of four required parent-teacher conferences in the families' homes. Although some teachers said they enjoyed conducting these home visits, most expressed reluctance about them. Further, while the Early Head Start programs paid them overtime to conduct these visits, teachers said that they did not have time after work because of family responsibilities or that they were too tired after a full day of caring for children.

Working with Early Head Start Families

Some providers have had to learn about working with new populations of families as a result of the Early Head Start partnerships. For example, some providers

reported that they began working with teenage parents and their children for the first time after forming the partnership and needed to learn about their unique needs and challenges. In addition, some providers began working with a culturally and linguistically more diverse group of families and faced communication challenges.

Coordination and Communication

Ensuring efficient and effective communication between families, program staff, and providers has at times been challenging. In Kansas, some center directors reported having been confused initially about lines of communication between the program, providers, and families. In some cases, providers or program staff assumed that all relevant persons knew about a particular family situation, when in fact they did not. In other situations, it was difficult to coordinate across family advocates, child care specialists, and center teachers. At times, parents approached program staff about child care-related concerns without first approaching the caregivers. Directors preferred that parents speak directly to the teacher so that their concerns could be addressed quickly.

When multiple programs work with a single family, program staff must invest significant time in ensuring smooth coordination. In Missouri, families in Early Head Start work with a PAL who visits them at home, a Parents As Teachers home visitor, their child care providers, and in some cases, other community service providers (such as Part C). Program and community partner staff reported that, while services were fairly well coordinated, at times it was challenging to keep all service providers abreast of what was happening with families. In addition, because each program has different goals and requirements, it was sometimes difficult to negotiate the logistics of service coordination and meet all requirements.

Blending funding streams can be difficult because fiscal years and reporting requirements differ. While programs welcome the opportunity to receive funding from the federal Head Start Bureau, the state program, and other local funding sources, blending various funding sources is challenging because each source has its own reporting requirements. For example, in Missouri, staff reported that they had to contend with two different fiscal years in completing required financial reports.

LESSONS FROM STATE EARLY HEAD START PROGRAMS

The experiences of Project EAGLE and the Children's Therapy Center can inform the efforts of other states seeking to implement similar initiatives. They also can be useful to Early Head Start grantees and other community organizations that work in partnership with child care providers on quality improvement and increasing low-income families' access to infant-toddler care. This section highlights several lessons derived from the grantees' experiences implementing the Kansas and Missouri Early Head Start programs.

Changes necessary for meeting the Head Start performance standards and improving quality are best made incrementally. Program staff and partners agreed that

it is not realistic to expect child care providers to make multiple changes in their environments and caregiving practices in a short time. Instead, they need to work through one change at a time, building on what they have accomplished to achieve new goals. Staff in both programs reported that they placed top priority on achieving health and safety standards, and then began working with providers to obtain equipment and materials for improving the caregiving environment. Other changes in caregiving practices—such as implementing family-style dining, implementing curricula, and conducting parent-teacher conferences—have been made gradually.

Improving quality requires sustained effort and significant investment in teacher compensation, training, and materials and equipment. Program staff and child care partners believe they have made significant improvements in the quality of care they provide, but only through sustained effort of participating in regular technical assistance visits, obtaining CDA credentials, and working step by step to implement the performance standards. In addition, child care partners stressed they could not have made many of the changes without the substantial resources invested by the state Early Head Start programs. For example, the programs have provided equipment and furniture, renovated playgrounds, offered intensive training programs, provided one-on-one coaching, and ensured a stable source of funding for infant-toddler rooms.

Funding provided through the state Early Head Start programs may not be sufficient to pay for the low ratios and group sizes required by the performance standards, especially in family child care homes. Both Project EAGLE and the Children's Therapy Center pay their partners at higher rates than those of their state child care subsidy programs. They also offer more stable funding, because they pay for care when children are absent. These differences, however, are not enough to compensate providers for lost revenue associated with reducing ratios and group sizes to required levels (4 children per teacher and 8 children per group). This is especially true for family child care homes, because the reduction in group size of even one child reduces the provider's income substantially. While most providers reported that they have moved closer to the ratio and group size requirements contained in the performance standards, several had not fully achieved the standards because they could not afford to do so.

Although providing good quality infant-toddler care is expensive and challenging, many child care providers are willing to add infant-toddler slots if they are guaranteed sustained funding and support. Project EAGLE and the Children's Therapy Center both reported that child care partners expanded the number of infant-toddler slots they offered after the partnerships were established. Despite the intensity and high cost of providing infant-toddler care and the additional work associated with the partnerships, many providers were willing to maintain or even expand their infant-toddler slots with assurances that reimbursement and support from Early Head Start would continue.

Partnerships require strong communication systems. Communication was a recurring theme during the site visits, perhaps because the state Early Head Start programs require coordination among multiple parties to function effectively. Parents stressed the

need for daily communication with child care teachers. Teachers emphasized their need to be kept up to date about changing family circumstances that could affect the child's participation in the child care setting. Program staff described the various strategies they used for keeping service providers and families informed about needs, goals, services, and concerns. All involved in the partnership underscored the importance of having up-to-date information and knowing whom to contact as circumstances changed or new issues arose.

CHAPTER IV

MOUNTAIN AREA CHILD AND FAMILY CENTERS

BUNCOMBE COUNTY, NORTH CAROLINA

This case study describes the efforts of local community members in Buncombe County, North Carolina, to develop a high-quality child care center to serve area children ages birth to 5. In the early 1990s, responding to a lack of affordable, good-quality child care in the area, a community group made up primarily of retirees launched a grassroots effort that resulted in the opening of the Mountain Area Child and Family Center (MACFC) in January 2001. Since its inception, the organization has remained committed to providing high-quality child care and parenting resources, serving children with special needs, and enrolling families from a mix of income levels. Nearly half of MACFC's 76 slots are reserved for infants and toddlers; approximately half of enrolled children come from low-income families. Based primarily on data collected during a site visit to Buncombe County in June 2002, the case study describes the history and development of MACFC, the services provided children and families, support for teachers' professional development, other community initiatives that support MACFC, planning for sustainability and expansion, implementation successes and challenges, and lessons learned. The lessons from this unique community-based endeavor can be useful for a wide range of private-sector entities—such as business communities, faith-based organizations, community foundations, and other private organizations—that seek to improve infant-toddler child care in their communities.

COMMUNITY CONTEXT

Buncombe County, North Carolina, has more than 200,000 residents, most of whom live in the city of Asheville. The county comprises approximately 650 square miles; other major towns (with populations ranging from 4,000 to 8,000) include Black Mountain, Weaverville, and Swannanoa. The overwhelming majority of the population is white, although the number of Hispanics has grown rapidly over the past decade—almost 400 percent—from 1,173 in 1990 to 5,730 in 2000 (U.S. Census Bureau 2001). According to program staff, approximately 1,200 children in the county are eligible for Early Head Start

services, with 20 percent of the county's children living in poverty. In addition, Buncombe County has become a popular retirement community; as more retirees have purchased homes in the county, housing costs have increased.

Employment Opportunities

The top three employment sectors in Buncombe County are services, retail trade, and manufacturing. Manufacturing jobs, however, have declined dramatically in recent years, with most factories eliminating second and third shifts. Retail jobs have held steady, and employment in the service industry has increased (North Carolina Department of Commerce 2002). Tourism-related positions—such as those in restaurants, hotels, and resorts—are especially plentiful during the spring, summer, and fall. Other entry-level jobs can be found in fast food restaurants and health care facilities. In addition, there is a high concentration of tobacco farms in the region.

Local Welfare Program

The Department of Social Services (DSS), within the North Carolina Department of Health and Human Services (DHHS), administers the state's TANF program. In Buncombe County, DSS served 1,184 TANF clients in September 2002. In its TANF program, DSS has implemented a work-first approach; assisting TANF clients in securing employment quickly is the agency's top priority. After attending an orientation and job readiness course, TANF clients must participate in work activities through a program called Work First Employment Services. These activities may include short-term job training, job coaching, and immediate employment. Parents of infants are exempt from TANF work requirements until the child reaches age 1, although the welfare administrator in Buncombe County noted that 10 percent of TANF clients with infants choose to work or enroll in a job training program before their exemption ends. The federal government has imposed a five-year lifetime limit on TANF cash assistance. However, clients can receive TANF for only two years continuously in North Carolina; to reestablish eligibility, they must remain off TANF for three years. According to the local DSS office, about 5 percent of TANF clients are sanctioned each month, typically because of noncompliance with their individual mutual responsibility agreement.

Child Care Demand and Supply

Buncombe County Child Care Services (BCCCS), the local resource and referral agency, receives 150 to 200 calls per month from parents looking for child care. Demand for child care is highest in the summer months, when employment in the tourism industry peaks. BCCCS reported that the county has a sufficient supply of care for preschool-age children, but the demand for infant-toddler slots is higher than the number available. As of October

2002, Buncombe County had 59 licensed family child care homes and 130[1] licensed child care centers, offering a total of 3,950 slots (Table IV.1). According to BCCCS staff, approximately half the centers accept infants and toddlers; the total number of center-based infant-toddler slots is 1,883. Overall, local officials said that families seeking infant-toddler care have few options as they search for affordable care; families often accept any available infant-toddler slot.

Supply is especially low for families who need care in certain regions of the county, for families seeking Spanish-speaking providers, and for children with special needs. Often, the location of available openings does not match up with the areas where the need for care is greatest. For example, according to BCCCS, West Asheville has an ample supply of child care facilities—especially centers operated by churches and other faith-based groups. The supply of care, however, is lower and thus the demand for care is much higher in other areas of the county. BCCCS staff also reported an increase in calls from Spanish-speaking families, but there are few child care providers in the county who speak Spanish. Finally, there are not enough providers in the county who can provide care for children with special needs. Many providers are willing to try; but some children with special needs have had as many as three or more providers because none can meet their needs without supplemental funding. Children with behavioral problems, such as aggressive and disruptive behavior, frequently have difficulty maintaining child care placement.

TABLE IV.1

REGULATED CHILD CARE SUPPLY IN BUNCOMBE COUNTY, NORTH CAROLINA
OCTOBER 30, 2002

Type of Care	Child Care Centers (slots)	Family Child Care Homes (slots)	Total
	Capacity[a]		
Child care slots (0 to 5)	3,655	295	3,950
Infant-toddler slots (0 to 2)	1,883	NA	NA
	Vacancy Rates		
Child care slots (0 to 5)	737 (20%)	NA	NA
Infant-toddler slots (0 to 2)	424 (23%)	NA	NA

Source: Buncombe County Child Care Services. Not all providers with vacancies accept child care subsidy reimbursement.

[a]"Capacity" is defined as the number of slots that providers are willing to offer, not necessarily the maximum number for which they are licensed.

NA = not available.

[1]BCCCS reported that 27 of the 130 centers are licensed for after-school-age children only.

Child Care Licensing Standards

North Carolina's Division of Child Development (DCD), within DHHS, regulates child care and monitors compliance with licensing standards. All child care centers and family child care homes must obtain licenses, except for the following: programs that operate for four hours or less per day, programs offering limited on-site child care services for parents (such as health clubs), care provided by a relative, seasonal programs that operate less than four months a year, and family providers caring for one or two children. DCD consultants are mandated to conduct annual monitoring visits to licensed providers.

To receive a license, family child care providers must be at least 21 years old, have a high school diploma or GED, undergo a criminal background check, meet annual requirements for training in child development and cardiopulmonary resuscitation (CPR), complete first aid training every three years, meet basic health and safety standards, provide age-appropriate activities and toys, provide nutritious meals and snacks, and pass a tuberculosis test. In addition to these requirements, child care centers must comply with additional requirements for staff qualifications, facility specifications, and health and safety guidelines. Tables IV.2 and IV.3 display the ratio and group size limits for child care centers and family child care homes. These maximum child-staff ratios for infants and toddlers in centers are higher than in many other states, while the maximum group sizes are in the middle of the range across states that regulate group sizes (Children's Foundation 2002; and Azer et al. 2002).

In addition to meeting minimum licensing requirements, providers can voluntarily meet higher quality standards through North Carolina's star rating system (Table IV.4). North Carolina assigns ratings of one to five stars to licensed child care providers. The ratings are based on providers' achievement of various quality indicators in the areas of program standards, staff education, and compliance history. In 1999, North Carolina implemented the star rating system to help families determine the quality of care that providers offer as they make child care choices. In addition, providers with higher star ratings receive recognition and higher subsidy reimbursement rates (see below). For the first six months of operation, all new facilities receive a temporary license, indicating that they meet minimum standards for licensing, and are reimbursed at the one-star rate.

TABLE IV.2

MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN CHILD CARE CENTERS
BUNCOMBE COUNTY, NORTH CAROLINA

Age	Child-Staff Ratios	Group Size
0–12 months	5 to 1	10
13–24 months	6 to 1	12
25–36 months	10 to 1	20
Over 26 months	15 to 1	25

Source: National Child Care Information Center Web site, March 15, 2002.

TABLE IV.3

MAXIMUM CHILD-STAFF RATIOS AND GROUP SIZES IN FAMILY CHILD CARE HOMES
BUNCOMBE COUNTY, NORTH CAROLINA

	Child-staff ratios	Group size
Small Family Child Care Home	8 to 1	Provider may care for up to five preschool-age children, including infants. Each provider may care for an additional three school-age children up to a maximum of eight children, including the provider's own preschool-age children.
Large/Group Family Child Care Home	NA	NA

Source: Quality in Linking Together Early Education Partnerships Web site, March 15, 2002.

TABLE IV.4

NORTH CAROLINA'S STAR RATING SYSTEM: SUMMARY OF REQUIREMENTS
AT EACH POINT LEVEL

Points	Program Standards	Staff Credentials	Compliance History (Previous 3 Years)
		Child Care Centers	
1	Meets licensing standards	Meets licensing standards	60% compliance
2	Meets voluntary program standards	Director has Level I Administration Credential and 2 years experience; Lead Teachers have NCECC, and 75% have 3 ECE credit hours or 1 year experience; 50% of teachers have 2 ECE credit hours or 1 year experience	65% compliance
3	Meets voluntary program standards; average score of 4.0 or higher on environmental rating scale	Director has Level I Administration Credential and 2 years experience; Lead Teachers have NCECC, and 75% have 3 ECE credit hours or 2 years experience; 50% of teachers have 4 the NCECC or ECE credit hours or 3 years experience	70% compliance
4	Meets voluntary program standards; average score of 4.5 or higher on environmental rating scale	Director has Level II Administration Credential and 2 years experience; Lead Teachers have NCECC and 75% have 9 ECE credit hours and 2 years experience; 50% of teachers have NCECC or 4 ECE credit hours or 5 years experience	75% compliance
5	Meets voluntary program standards; average score of 5.0 or higher on environment rating scale; reduced child-staff ratio	Director has Level III Administration Credential and 4 years experience; Lead Teachers have NCECC, and 75% have an AA degree in ECE or an AA degree in any major with 12 ECE credit hours, and 2 years experience; 50% of teachers have NCECC and 4 ECE credit hours and 2 years experience	80% compliance

Points	Program Standards	Staff Credentials	Compliance History (Previous 3 Years)
		Family Child Care Homes	
1	Meets licensing standards	Meets licensing standards	Meets licensing standards
2	Meets licensing standards; written operational policies	FCC Credential or at least 4 ECE credit hours or 10 years experience and 14 hours annual training	No more than 1 substantiated complaint about licensing violations in past year and no substantiated abuse/neglect complaints
3	Meets licensing standards; written operational policies; score of 4.0 or higher on FDCRS or national accreditation	FCC Credential and 5 years experience or FCC Credential and 3 ECE credit hours and 1 year experience, or 6 ECE credit hours and 1 year experience, or an AA or BA with 6 ECE credit hours and 6 months experience, or an AA or BA in ECE and 3 months experience	No more than 1 substantiated complaint about licensing violations in the past 3 years and no substantiated abuse/neglect complaints
4	Meets licensing standards; written operational policies; score of 4.5 or higher on FDCRS or national accreditation; membership in a professional organization	FCC Credential, 6 ECE credit hours, and 2 years experience; or 9 ECE credit hours and 2 years experience; or AA or BA degree with 9 ECE credit hours and 18 months experience; or an AA or BA degree in ECE and 1 year experience	No substantiated complaint about licensing violations in the past 3 years and no substantiated abuse/neglect complaints
5	Meets licensing standards; written operational policies; score of 4.5 or higher on FDCRS or national accreditation; membership in a professional organization; no more than 5 children age 5 or younger; no more than 3 children under age 1	AA or BA with 12 ECE credit hours and 2 years experience or an AA or BA in ECE and 18 months experience	No substantiated complaint about licensing violations in the past 3 years, no substantiated abuse/neglect complaints, and no violation of ratio/group size or supervision requirements in past year

Source: North Carolina Division of Child Development Web site, September 4, 2002.

Note: Providers receive one to five points for meeting the requirements in each of the three rating categories. Providers receive licenses based on earning points as follows: one star = 3 to 4 points, two stars = 5 to 7 points, three stars = 8 to 10 points, four stars = 11 to 13 points, and five stars = 14 to 15 points.

NCECC = North Carolina Early Childhood Credential; ECE = Early Childhood Education; AA = Associates Degree; BA = Bachelors Degree; FDCRS = Family Day Care Rating Scale.

Child Care Subsidy Program

In addition to the Buncombe County DSS, the DCD contracts with six agencies to provide child care services or to purchase such services from other providers in the area. BCCCS administers the child care subsidy program, provides child care resource and referral services, and oversees the operation of 18 after-school programs and three child care centers (all three centers provide infant-toddler care). When parents call BCCCS for help with child care, parent counselors determine whether they need help finding child care, paying for child care, or both. Parent counselors also provide resource and referral services. Child care social workers help parents complete subsidy applications and determine eligibility for new and continuing cases. BCCCS also administers child care subsidies for Work First clients;

child care social workers placed in the DSS office assist Work First employment services clients who need child care assistance.

According to local officials, BCCCS provides child care subsidies to approximately 1,425 families (about 2,400 children) each month. An estimated 25 to 30 percent of these are working-poor families who do not receive any other form of public assistance. To fund the child care subsidy program, BCCCS pools the county's subsidy allocation from DSS and the Smart Start initiative into one fund. The income limit for subsidy eligibility is $2,852 per month for a family of three, 225 percent of the federal poverty guidelines and about 75 percent of state median income. Families must make a copayment equal to 8 to 10 percent of their income, depending on family size. Families must reapply for subsidized child care annually and report any changes affecting their eligibility to the agency as they occur.

The level of funding for child care subsidies is not sufficient to meet the need for child care assistance in the county. BCCCS staff said that they have maintained a waiting list for subsidies for many years. At the time of the site visit, approximately 650 children were on the list. Each county that has insufficient funds to serve all families must establish priorities for serving families that are waiting. Some examples of how counties may establish priority include (1) families with an open child protective services case, including children in DSS custody; (2) teenage parents enrolled in high school; and (3) TANF recipients who are employed or participating in Work First. Buncombe County has designated children with special needs as a fourth priority group. Families in these priority groups do not have to wait to obtain a subsidy. Families on the waiting list may wait weeks to months before receiving assistance.

Child Care Subsidy Reimbursement Rates

North Carolina establishes market rates for subsidy payments at the 75th percentile using the data collected from a survey of all regulated child care providers in the state. Providers are asked to report the rates they charge parents who pay privately. Providers participating in the Subsidy Program can be paid the rate they charge privately paying parents or the market rate, whichever is lower. Rates are established for different age groups and for each of the star-rated license levels in the state (one to five stars). Providers who meet minimum licensing standards are issued a one-star license, while those who choose to apply to meet higher standards may be issued a two- through five-star license (Table IV.5).

The current market rates in Buncombe County were established in 1999 and are based on legislation that required the assignment of a state market rate if there were not at least 75 children reported in an age group. The current market rates in the county include a mixture of state and county rates and in some instances the county market rates are less than what providers are charging patients. This presents a problem in that parents are faced with paying the difference in the subsidy payment rate and what the provider charges, and this may affect a parent's ability to afford higher-quality care.

About 153 licensed child care providers participate in the child care subsidy program, well over 90 percent of licensed providers in the county. Unregulated providers can receive subsidy reimbursement if they are at least 18 years old and meet certain health and safety standards. However, reimbursement rates for these providers are set at half the one-star rate for family child care homes, making this an unattractive option. In June 2002, only 11 unregulated providers participated in Buncombe County's subsidy program.

HISTORY OF THE MOUNTAIN AREA CHILD AND FAMILY CENTER

MACFC has emerged from the concerns of community members who want to address the county's unmet need for good-quality child care. Its development spanned nearly a decade, from the initial efforts of community members in 1992, to the opening of the child care center in January 2001. This section tells the story of how a small group of concerned citizens mobilized extensive community resources to design, build, and operate a state-of-the-art child care center in an underserved area of Buncombe County. Figure IV.1 provides a timeline of key events in the center's development.

TABLE IV.5

BUNCOMBE COUNTY'S CHILD CARE SUBSIDY PROGRAM
MONTHLY REIMBURSEMENT RATES FOR
LICENSED PROVIDERS, BASED ON STAR RATINGS SYSTEM

	Infants and Toddlers		2-Year-Olds		3-to-5-Year-Olds	
Star Rating	Centers	Family Child Care Homes	Centers	Family Child Care Homes	Centers	Family Child Care Homes
One Star	$368	$368	$346	$346	$325	$325
Two Stars	$386	$386	$363	$363	$341	$341
Three Stars	$585	$405	$414	$381	$383	$358
Four Stars	$600	$414	$424	$389	$392	$366
Five Stars	$614	$423	$435	$398	$401	$374

Source: North Carolina Division of Child Development, effective September 1, 2000. Rates are per month and represent market rates at the 75th percentile.

FIGURE IV.1

TIMELINE OF KEY EVENTS: MOUNTAIN AREA CHILD AND FAMILY CENTER

Date	Event
Fall 1992	Leadership Swannanoa Valley held at Warren Wilson College
Fall 1993	Head Start classroom opens at W. D. Williams Elementary School
1993	Local survey indicates high need for good-quality child care in Buncombe County
1993	Swannanoa Valley Voice for Children (SVVC) formed
1995	SVVC hires a design consultant and an architect to design child care center
1996	Warren Wilson College grants a renewable lease at one dollar a year for 40 years
May 1996	Board hires fundraising consultant and launches capital campaign to raise $3.5 million

Date	Event
April 1997	$1.0 million in donations received
February 1998	Board changes name to Mountain Area Child and Family Center
June 1999	Capital campaign goal met; $3.6 million raised
July 2000	Board hires executive director
Sept 2000	Warren Wilson College students and community volunteer build playground
January 2001	MACFC begins providing child care
September 2001	MACFC obtains EHS grant
September 2002	MACFC begins EHS program and opens a satellite center in southwestern Buncombe County

The Swannanoa Valley Voice for Children

In 1992, Warren Wilson College, a private liberal arts school located in Buncombe County, offered a course for community members, called Leadership Swannanoa Valley, to help local residents develop leadership skills and plan community projects. By means of this course, students researched local resources and community needs. During one class, an elementary school principal spoke about the unmet needs of families in the community and how these needs interfered with children's learning in school. She told the story of a student who had responsibility for caring for younger siblings after school because child care was not available. When several students approached her about what they could do to help, she suggested that, as a first step, they work to establish a Head Start classroom at her school. Over the next year, a group of volunteers, most of them retirees, worked with Head Start and the school district to open a Head Start classroom, including conducting door-to-door recruiting of eligible families.

This achievement of opening the Head Start classroom gave the group confidence and a track record. Their next step was to focus on broader child care needs in the Swannanoa Valley, an area of approximately 105 square miles within Buncombe County (but outside the city of Asheville). To begin documenting the need for child care, the group worked with the social work department at Warren Wilson College to develop and distribute a survey asking about child care needs to area doctors, dentists, clergy, educators, schools, and others who provided early education or other services to children. After the questionnaires were mailed, the group contacted respondents by phone, encouraging them to complete the questionnaire and requesting a face-to-face meeting. The response was positive, especially from doctors, dentists, and educators. After the survey results were compiled, one member of the group met with the director of every agency that serves children and families in the valley, to discuss community child care needs and what the group could do to address them. Agencies responded positively to the group's efforts and offered support and encouragement for developing a child care center.

At that point, the group formed a membership organization called "The Swannanoa Valley Voice for Children" and appointed a board of directors. Members contacted local religious groups and civic clubs to make presentations about community child care needs and the mission of their organization. Through membership fees, funds were raised to support the group's work.

The group envisioned a high-quality child care center in the community that would serve children ages birth to 5 from diverse economic backgrounds and would include children with special needs. A program committee of the board identified four core components of the center:

- High-quality child care to help children reach their full potential through developmentally appropriate, culturally sensitive, family-friendly education
- Family support and parent education services
- Education for students of early childhood education, including experiential learning opportunities in a high-quality child care environment and continuing education for professionals working with young children
- Health services with which to model strategies for keeping children in child care as healthy as possible and to teach healthy lifestyle practices to children, parents, and staff

Community Collaboration

The Swannanoa Valley Voice for Children pursued community collaboration from its inception. In addition to conducting a vigorous community education and outreach campaign to gain support for its goal of establishing a child care center, the organization turned to institutions in the community for specific contributions. For example, the group consulted extensively with BCCCS on how to develop the child care center and which experts could provide advice at various stages of the center's development. The group also succeeded in garnering the support of community volunteers; more than 200 community volunteers and college students participated in building the center's three playgrounds.

Early on, the group identified Warren Wilson College as an ideal partner for helping the group meet its goal for the center: providing education for the broader early childhood community. With a working farm, the college has ample land in the Swannanoa Valley. In addition, the college uses a service learning approach to educating its students, requiring them to serve on campus work crews and complete 100 hours of community service before graduation. Moreover, the school had a history of interest in child development, with a Head Start classroom on campus and a significant proportion of students majoring in elementary education.

Recognizing that the child care center could provide an excellent fieldwork site for students, board members with connections to Warren Wilson College approached the college to request land for the child care center site. After more than a year of study by the college, in 1996, Warren Wilson granted a 40-year, renewable lease on 3.34 acres of land for $1 a year.

The Capital Campaign

Once the lease was secured from Warren Wilson College, the group began a capital campaign. First, they hired a fundraising consulting firm to conduct a feasibility study for their project. Based on the results of the study, a goal of $3.5 million was set for the campaign. To initiate the campaign, board members from Swannanoa Valley Voice for Children, accompanied by staff from BCCCS, approached a major foundation in Asheville. The foundation pledged $500,000 for the child care center, with the stipulation that the group raise an equal amount in matching funds within two years. Soon after, a wealthy community member pledged another $500,000. With these two gifts as leverage, the group began an aggressive fundraising campaign, receiving donations ranging from $25 to $50,000. Several other foundations also contributed, such as the Duke Endowment, the Thom's Health Services Foundation, and the Eckerd Foundation. To better convey a broader mission of serving families and educating child care providers beyond the Swannanoa Valley, in 1998 the group changed its name to the Mountain Area Child and Family Center. By 1999, the organization had raised $3.6 million to construct and operate the center.

Designing the Center and Planning Services

Another important strategy that board members used during the center's development was to seek the advice of experts at various stages of the planning process. At the suggestion of BCCCS, MACFC hired a design consultant with expertise in child development to develop a design concept that broadly defined how the new building could provide a child-centered program and meet the goals set by the board. An architect was hired who was willing to design the building according to the specifications of this design concept. In addition, the board hired a playground designer, as well as consultants and experienced staff, to develop the center's program. Groundbreaking and construction of the center began in 1999. In 2000, MACFC hired an executive director.

CENTER OPERATIONS AND SERVICES

Capacity and Types of Families Served

In January 2001, MACFC opened, with three classrooms serving 23 children from 6:30 A.M. until 6 P.M., Monday through Friday. Within six months, the center was enrolled at its projected capacity of 76 full-time children. By June 2002, 85 children were attending the center, including some who attended part-time. MACFC has full-time slots for 36 infants and toddlers ages 6 weeks to 36 months, and 40 preschoolers. An infant room serves 8 children ages 6 weeks to 20 months, two toddler rooms serve 8 children each, and a third toddler room serves 12 children. Two preschool rooms serve 20 children each. In June 2002, MACFC had a waiting list of approximately 90 children, more than half of whom were infants or toddlers.

In keeping with the board's vision that MACFC serve a diverse group of families, the center maintains a split of approximately half low-income and half privately paying families.

As of June 2002, fees ranged from $150 a week for infants to $115 for 5-year-olds. MACFC also gives preference to children with disabilities and serves children with a wide range of special needs (approximately 15 percent of enrolled children at the time of the site visit). MACFC also gives preference to children referred by child protective services. Approximately 20 children are from families who are affiliated with Warren Wilson College, either as students or staff. MACFC offers limited scholarships to families who need financial aid, usually to cover gaps in child care subsidy coverage or while the families are on the subsidy waiting list. At the time of the site visit, MACFC had a $400,000 endowment fund, of which 5 percent could be used for scholarships.

Staffing

MACFC has a large staff, including a management team that provides support to teachers and families. An executive director oversees all aspects of the program, and an operations manager is responsible for day-to-day management and staff supervision. A parent services specialist manages enrollment and a volunteer program, organizes parent-involvement activities and parent meetings, and refers families to needed services. A curriculum/disabilities specialist supports teachers in implementing the *Creative Curriculum for Infants and Toddlers* (Dombro et al. 1997), developing lesson plans, assessing children's development, and coordinating early-intervention providers for children with special needs. A registered nurse keeps track of children's immunizations, provides on-site care when children are sick, arranges for a variety of health screenings on-site for children and families, and provides education on health, safety, and nutrition topics. Among other administrative staff are a community outreach and development officer, a special services coordinator, a finance officer, a receptionist, and a cook.

MACFC employs 18 teachers. In infant-toddler rooms, the center maintains ratios of four children per teacher. Two "floating" teachers work with two classrooms each to ensure coverage at all times and to provide the flexibility to increase staffing as needed. Lead teachers must have an associate's or bachelor's degree in early childhood education or a related field, such as education or psychology. If the degree is in a related field, teachers must take two state credentialing courses to gain a knowledge of early childhood development and developmentally appropriate activities. However, MACFC will hire assistant teachers without these credentials if they are in an early childhood education program or working on a Child Development Associate (CDA) credential.

Facilities

MACFC was designed to be a child-centered facility. It has many windows, and visual displays are at the children's level. Classrooms are spacious and light; many have lofts to provide quiet areas within the rooms. Furnishings are child-sized. The center has two preschool classrooms; four infant-toddler rooms; an art room; a multipurpose room for indoor play and other group activities; a conference room for meetings, classes, and educational events; administrative offices; a full kitchen; and a staff lounge. In addition, it has a family resource room containing books, videos, and information pamphlets addressing

a wide range of childrearing, health, and other family issues. This room is used by parents whose children attend the center and by early intervention providers and others as a place to meet with families and children.

MACFC has an acre of outdoor space enclosing three playgrounds—one each for infants, toddlers, and preschoolers. The infant playground has ample shade, plantings of edible herbs, planters where infants can dig, and low benches. The other two playgrounds have play equipment, shade structures, and sandboxes that have been modified for easy access by children with physical disabilities. Students from Warren Wilson College have constructed a nature path behind the playground. Finally, the infant room has a screened porch adjacent to the playgrounds, allowing infants and toddlers to get fresh air when weather does not permit outdoor play.

Services Provided

MACFC provides developmentally appropriate child care, family support and parent involvement opportunities, health services for children and families, services for special-needs children, support and continuing education for staff, and a range of educational opportunities for students from area colleges.

Good-quality child care and early education services. Teachers at MACFC use the Creative Curriculum as a guide to provide developmentally appropriate early education services. Teachers also develop weekly lesson plans, taking into account the developmental goals for each child, input from specialists and parents, and the children's ages, interests, and developmental levels. MACFC takes a child-centered approach to implementing its curriculum. Thus, if a child asks a question or becomes interested in another topic, such as a butterfly found on the playground, teachers follow the children's lead rather than adhere to planned activities. MACFC follows the state's limit of a maximum two-year age span in classrooms. As children get older and move to new rooms, some of the teachers move up with the children, in order to provide continuity. Teachers who are especially skilled at working with specific age groups remain in their classrooms to work with new children.

Teachers develop individual goals for each child, which are updated regularly. These goals are based on results of regular developmental assessments using the Ages & Stages Questionnaires, observations, and the children's interests. Teachers also maintain, for each child, portfolios that contain artwork, photographs, observation notes, developmental assessments, and other information, such as children's likes and dislikes and parent input. If developmental assessments conducted by the teachers indicate a potential problem, the curriculum/disabilities specialist conducts another assessment using the Denver II Developmental Screening Test, then discusses the concerns with the child's parents and, if appropriate, makes a referral to early intervention services.

Teachers have individual parent-teacher conferences with each child's parents every three months. During these meetings, they review the child's portfolio, discuss any concerns they have, and suggest activities that the parents can do at home. For example, one teacher

works with children who are not yet talking, using basic sign language to get them to communicate their needs; she also teaches these signs to parents during conferences.

Family support and parent involvement. MACFC provides services to parents and other family members through a family resource room, parent meetings and involvement activities, and referrals. As described previously, the center's family resource room, located near the building's entrance, contains books, videos, and resource materials on a broad range of topics of interest to families. For example, parents can obtain information on topics such as job search strategies, services for victims of domestic violence, finding a speech therapist, or children's developmental stages. In this room, they can also use e-mail and the Internet, access the United Way's directory of services, and consult with teachers and other specialists.

The parent services specialist organizes parent meetings about once a month, either for the entire center or organized by individual classroom. She arranges for speakers to come and talk with families on parenting topics during some of these meetings. To ease the transition to kindergarten, she has also worked with area public schools to arrange tours and meetings with kindergarten teachers and principals. At the parents' initiative, she has organized a clothing exchange and other parent projects.

In addition, the parent services specialist provides referrals and information to parents on a range of topics. She has helped parents with assessing job skills, looking for job openings, and preparing for job interviews. Other parents have asked for information about discipline strategies, children's developmental stages, and services for children with special needs.

Health services. In keeping with the board's emphasis on health services, MACFC employs a full-time registered nurse who delivers basic medical care, tracks immunization records, provides health resource and referral services to families, and notifies parents when they need to make well-child appointments for their children. She also arranges for a variety of on-site health screenings—for example, dental, hearing, and vision screenings for children; and blood pressure and glucose checks for adults. In addition, she trains MACFC's teachers on health, safety, and nutrition topics.

Services for special-needs children. MACFC serves children with a variety of special needs. For example, they have enrolled several children who were born prematurely or are "failure to thrive" babies. Other children have developmental delays or disabilities such as vision problems, speech delays, autistic tendencies, Down's syndrome, dwarfism, cerebral palsy, fetal alcohol syndrome, and behavioral problems related to high activity level and inattention. The curriculum/disabilities specialist and nurse work closely with families to refer them for early intervention assessments and services and participate in service planning. Service coordination and most therapists who work with children enrolled at MACFC are provided by the Blue Ridge Center in Asheville. Once services begin, therapists come into the classrooms to work with children and to train teachers in working with children. Teachers adjust their routines and activities to incorporate a focus on the skills a child needs to work on; they help parents learn to implement these activities at home.

Staff development and support. Board members have sought to make MACFC the "employer of choice" for early childhood professionals in the community by providing a competitive compensation package and supporting ongoing professional development. According to program staff, MACFC's staff retention rate in 2001 was 85 percent, compared to 50 percent for child care centers statewide.

MACFC provides an attractive compensation package for teachers. Lead teachers receive $12.00 to $12.50 an hour; assistant teachers receive $8.00 to $10.00 an hour. Teachers also receive full health insurance coverage, a $50,000 life insurance policy, disability insurance, paid vacation and sick days, paid holidays, and 50 percent off the cost of child care at MACFC for their own children. Teachers may also contribute to a retirement account and receive matching contributions from MACFC. They also receive tuition assistance for obtaining CDA credentials, as well as associate's and bachelor's degrees.

MACFC also provides numerous professional development opportunities for teachers. MACFC's goal is for all lead and assistant teachers to have at least a two-year college degree. Management staff said that during interviews with teacher candidates, they stress that teachers will be expected to participate in training and, if necessary, attend courses in the evenings. At the time of the site visit, MACFC had supported seven assistant teachers without associate's degrees in obtaining a CDA credential. In June 2002, one teacher had received her credential, and six were preparing for final tests and observations the following month. MACFC paid for teachers to obtain the credential, and was helping six of them apply for TEACH™ scholarships (see below) to support work toward an associate's degree in early childhood education.

When teachers join MACFC, they complete an initial self-assessment of their strengths and training needs and participate in a 10-hour orientation. Management staff observe each new teacher in the classroom and determine those areas in which the new teacher needs additional training. MACFC closes for four days each year for professional development workshops, and sponsors other training workshops in the evening. For example, MACFC sponsored, during three weekly evening sessions, a training series about integrating music into the curriculum. It also sponsored a 10-week Spanish course for staff. In addition to in-house training, MACFC sends teachers to trainings sponsored by BCCCS and to regional conferences and workshops for child care teachers.

Education and training for early childhood educators. MACFC has opened its doors to offer on-site educational opportunities for students of early childhood development. Students from Asheville-Buncombe County Technical and Community College, Mars Hill College, UNC-Asheville, Warren Wilson College, and Western Carolina University participate in classes, do research projects, and complete internships at the center. For example, nursing students from Western Carolina University visit weekly during the academic year to complete their pediatric rotation. The students also do special projects at the center, such as shadowing a special-needs child and writing a paper about the child, or preparing parent education booklets on various topics for the family resource center.

Warren Wilson College has a faculty member on-site at MACFC who serves as liaison between the two institutions. She teaches classes at MACFC for Warren Wilson students on

early childhood development and education. In addition, she oversees the placement of two students as part-time workers, arranges for child development and social work classes to visit the center and observe classrooms, and arranges for Warren Wilson College work crews to do projects at MACFC.

SUPPORT FROM SMART START AND OTHER COMMUNITY INITIATIVES

MACFC leverages its resources by drawing on numerous community resources and collaborating with local organizations to enhance the services it provides. Community organizations have donated everything from funds to handmade quilts. Volunteers visit the center to organize special events and activities, read to the children, and do other work at the center. As described previously, the center collaborates with Warren Wilson College and other higher education institutions to support the education of future early childhood educators. MACFC teachers access training provided by BCCCS on a wide range of child development and early education topics, and support for special-needs children from the Blue Ridge Center.

MACFC also benefits from collaboration with Buncombe County's Smart Start initiative. Initiated in 1993, Smart Start is a statewide public-private initiative that provides local communities with funding to support programs that promote young children's healthy development and school readiness, such as quality child care, family support services, and health care. Funding is allocated locally by partnerships that include broad community representation. Buncombe County began its Smart Start partnership in 1996, focusing on four areas: (1) child care quality, accessibility, and affordability; (2) family support; (3) health care; and (4) capacity-building. MACFC benefits from a number of Smart Start-funded initiatives in Buncombe County, including:

- ***Health Insurance Supplement.*** Smart Start provides up to $200 per month to cover a portion of health insurance costs for child care teachers who meet specific education criteria and work at least 30 hours a week with children ages birth to 5. Employers also must cover a portion of the cost. MACFC accesses these funds to provide health insurance for its teachers.

- ***Teacher Education and Compensation Helps (TEACH™).*** This initiative encourages professional development by paying 50 to 80 percent of child care teachers' tuition for early childhood college courses. At the time of the site visit, MACFC was helping six assistant teachers who wanted to pursue an associate's degree in early childhood education to apply for TEACH™ scholarships. MACFC planned to pay the remaining 20 to 50 percent of their tuition costs.

- ***Child Care Health Consultants.*** With support from Smart Start, the Buncombe County Health Center has registered nurses on staff who provide consultation on health issues and child development to child care providers. At MACFC, health consultants visit periodically and have conducted vision and hearing screenings on site.

- ***Early Childhood Dental Care.*** A dental care project, also funded by Smart Start and operated by the Buncombe County Health Center, has conducted dental screenings and education on preventive dental care at MACFC.

- ***Private Sector Grants.*** Buncombe County Smart Start also supplies child care providers with opportunities to apply for private sector grants. Through this initiative, MACFC received grants totaling $50,000 from an area bank in 2001.

- ***Special Needs Assistance Program (SNAP).*** With funding from Smart Start, BCCCS provides child care providers serving special-needs children with funds to purchase adaptive equipment and hire additional staff, as well as on-site consultation for teachers. At the time of the site visit, MACFC was accessing SNAP funds to pay part of the cost of a teacher with a background in psychology to work one-on-one with a toddler.

- ***Child Care Quality Enhancement Project.*** Operated by the Orelena Hawks Puckett Institute in Asheville, this initiative provides on-site training and technical assistance to child care providers, giving priority to providers that have or are willing to add infant slots and are committed to increasing their star rating. This project has conducted some on-site trainings at MACFC.

SUSTAINABILITY AND GOALS FOR THE FUTURE

During the site visit, one board member said that despite highly successful fundraising efforts, MACFC is "constantly swimming upstream" because of the disparity between what families can afford to pay and the cost of high-quality child care. Despite the costs, however, the board and staff remain committed to providing high-quality care and paying for the services that children enrolled at the center need. At the time of the site visit, the board had initiated a campaign to raise $1.5 million for an endowment fund by 2004. As of June 2002, they had raised $400,000.

In September 2001, MACFC received a federal grant to provide Early Head Start services to 48 infants and toddlers and 12 pregnant women. Many of MACFC's administrative staff and specialists are former Head Start staff who are familiar with the program's requirements and performance standards. Initially, staff designed the center and services based on a Head Start model, hoping eventually to obtain an Early Head Start grant. At the time of the site visit, MACFC was nearing the end of its planning year and was to begin serving Early Head Start families in September 2002. Board members and staff reported that obtaining the Early Head Start grant had relieved some financial pressure on the center by adding a stable source of funding for low-income children. With this new grant, MACFC is funded in roughly equal shares by family fees (including state child care subsidies), Early Head Start funds, and funds from foundations and other donors.

MACFC also was in the midst of expansion efforts during the site visit. To sustain the board's vision of serving an economically diverse group of families, MACFC planned to serve roughly one-third of the Early Head Start families at its original center and to serve the

other families at two satellite sites. The first satellite center was to open in September 2002 in the Montmorenci United Methodist Church in the Enka-Candler area of southwestern Buncombe County. MACFC's operations manager was overseeing renovation and planning for the new facility, which would consist of four classrooms. Similar to the main site, MACFC envisions that this new site will serve about half low-income families and half privately paying families. Staff expect to serve many Spanish-speaking families who live in the area; most are former migrant workers who have settled permanently in the community.

A second expansion site was being planned for spring 2003. MACFC expects to open three classrooms in a new YMCA building in the South Buncombe community. Other groups have approached MACFC about opening additional sites; but at the time of the site visit, the board had made no commitments beyond the first two satellite sites. During the visit, staff were enthusiastic about further expansion, noting the large unmet need for quality child care in the community. Board members, however, had more diverse views of expansion. While some were eager to expand, others cautioned that MACFC should expand more gradually.

SUCCESSES

Through the efforts of concerned community members, MACFC has succeeded in building broad community support for developing a high-quality child care center by drawing on a range of community leaders, experts, and early childhood experts to build and begin operating the center. This section describes the main successes achieved by MACFC in three areas: (1) increasing access to care, (2) promoting high-quality child care, and (3) strengthening community collaboration.

Increased Access to Good-Quality Infant-Toddler Care

MACFC has expanded the supply of quality infant-toddler care accessible to families in rural communities outside the Asheville city limits. Families in Buncombe County face limited infant-toddler child care options, especially if they need care outside Asheville. While some families prefer to use informal kith-and-kin arrangements, MACFC has increased families' choices by offering a high-quality child care option for infants and toddlers outside Asheville for families who prefer center-based care. The addition of Early Head Start and two satellite centers, also located in underserved communities outside Asheville, will further expand families' choices.

MACFC has expanded the supply of quality infant-toddler child care accessible to low-income families. The board of MACFC is committed to serving families at a range of income levels. Staff try to maintain enrollment at approximately 50 percent low-income families and 50 percent privately paying families. MACFC accepts state child care subsidies and has limited funds available for scholarships. These are used primarily to tide families over during gaps in subsidy eligibility or while they are waiting to move to the top of the subsidy waiting list. The board is attempting to raise $1.5 million for an endowment fund, which would increase the amount of scholarship funds available for low-income families.

MACFC has expanded the supply of quality infant-toddler child care for children with special needs. MACFC gives priority to enrollment of children with special needs, and makes whatever accommodations are necessary to integrate special needs children into its classrooms and ensure that they can participate fully in center activities. A nurse and a curriculum/disabilities specialist work closely with early intervention service coordinators and therapists to arrange for all needed services and support teachers in implementing recommended activities. MACFC also hires specialists when needed to work individually with children. Teachers develop individual goals for children and tailor lesson plans to focus on the skill areas recommended by therapists.

Promoting Quality

The board and staff of MACFC are committed to investing the resources necessary to provide high-quality child care. Since its inception, the board of MACFC has been committed to providing high-quality child care. To ensure that they constructed a high-quality facility, board members consulted with child development and design experts during the center's development. Since the center opened, MACFC has continued to invest in quality. For example, the center maintains low child-teacher ratios that allow time for conducting developmental assessments, setting individual goals for children, creating weekly lesson plans, and holding regular parent-teacher conferences. A management team of specialists provides support and guidance to teachers and access to many services and resources beyond child care. In addition, the center invests substantial resources in teachers' professional development. According to board members, the cost of operating MACFC and providing all these quality enhancements costs even more per child than the full tuition rates for privately paying families, making ongoing funding a necessity.

Sufficient funding has enabled MACFC to implement policies and practices that lead to high levels of teacher retention and greater continuity of care for children. As part of its commitment to quality, the MACFC has implemented policies and practices designed to hire and retain skilled child-care teachers. For example, MACFC offers above-average wages, health insurance coverage, vacation and leave time, pension benefits, and child care discounts. The center has been able to attract teachers with degrees in early childhood education and has supported those without degrees in returning to school. In addition, MACFC provides all staff with opportunities for ongoing professional development. The center had high retention rates during its first year of operations. In addition to retaining teachers, MACFC ensures continuity for children by moving some teachers with their classes as they transition between infant, toddler, and preschool rooms.

MACFC serves as a model for high-quality child care in the community. At the time of the site visit, only three child care centers and one family child care provider in the Swannanoa/Black Mountain area of Buncombe County had four- or five-star ratings. With a limited number of high-quality child care centers in that part of the county, MACFC serves as an important model for high quality in the community (the center received a four-star rating in July 2001). MACFC has opened its doors to students from several colleges to provide a setting for experiential learning about child development and early childhood education. MACFC also serves as a site for Smart Start-sponsored trainings and receives

frequent visits from other organizations interested in developing high-quality centers. Finally, several organizations in the community have contacted MACFC about partnering to set up satellite sites in other areas of the county.

Strengthening Community Collaboration

MACFC has raised community awareness of the importance of high-quality child care for children's development. During MACFC's development phase, board members effectively articulated the importance of high-quality child care for children's development to the Buncombe County community. Many individuals, civic organizations, churches, businesses, service agencies, schools, and foundations learned about the importance of quality and contributed to the center's development. At the time of the site visit, board members said they were focused on raising awareness of the high cost of providing quality child care, especially within the business community. Also, board members and program staff continue to bring groups to visit the center and showcase its facilities and services.

MACFC supports local higher education institutions by providing a hands-on learning experience for students in a high-quality environment. MACFC provides students from area colleges with an opportunity to volunteer, complete an internship, work, and take classes at the center. These students benefit from hands-on experience in a high-quality child care environment; at the same time, their contributions support the mission of the center. One success noted by staff is that the presence of students has increased the number of men who work with children at the center.

CHALLENGES

As a fledgling child care center and organization in transition, MACFC faces ongoing challenges. Sustaining the funding levels necessary to care for children from low-income families who cannot afford to pay tuition while maintaining high-quality care are ongoing challenges. Other challenges relate to the center's transition from the development to the operational phase, as well as the changes that have come with plans for expansion.

Funding

The state child care subsidy system does not provide adequate funding to meet the needs of low-income families who need child care. MACFC aims to serve an enrollment of approximately half children from low-income families and half from families who can pay the private tuition. The waiting list for state child care subsidies is long, however, and reimbursement rates are low compared to the cost of providing care. As a result, the center must provide scholarships to some low-income families while they wait for a child care subsidy and must use private funds to cover the difference between the subsidy rates and the cost of care. Although the Early Head Start grant will defray some of these

costs, ensuring adequate funding for low-income families whose children attend the center remains a challenge.

Covering the cost of providing high-quality child care requires ongoing fundraising efforts. Even MACFC's private tuition fees ($645 per month for an infant), paid by about half the enrolled families, do not cover the cost of care at the center. MACFC's board and staff, however, remain committed to maintaining the high quality standards that drive up costs, such as hiring skilled teachers, providing attractive teacher compensation, and maintaining low teacher-child ratios.

Staff and board members must make difficult choices between maintaining high quality standards and serving more children. During the site visit, staff talked about the tension between upholding high quality standards and expanding to serve more children. The unmet need for good-quality infant-toddler child care in the county is large, and staff feel a sense of urgency about serving more children from low-income families. At the same time, they have a strong commitment to upholding high quality standards and are unwilling to compromise the quality of care they provide in order to increase the number of children served. While the choice is difficult, staff and board members agree that they must choose high quality over expansion, unless funds are available to serve more children without lowering standards.

Change

The transition from planning to operating a child care center has been a learning process for board members, as they have become less involved in day-to-day decision making. MACFC board members were actively involved in making decisions about the center during the planning and design phases. After the board hired an executive director to begin planning its program, there was confusion and some disagreement about how involved the board should be in making operational decisions. In fact, this conflict led to the departure of the first executive director. Gradually, as the board has gained experience and confidence in the new executive director and management team, its role has come to focus more on setting policy and supporting the staff. During our visit, several board members said that, over time, they have learned to turn daily operations over to staff.

As opportunities for expansion have arisen, staff and board members have had to reconcile diverging visions for MACFC. The board hired management team members with extensive experience in operating early childhood programs. When expansion opportunities arose, staff felt confident in their ability to expand the program successfully. Moreover, they had a strong desire to address more of the unmet need for child care in the community. Board members held a range of views on expansion and had divergent ideas about how best to fulfill MACFC's mission. Although some members endorsed plans to expand and extend services to more low-income families, others viewed operating the original center as MACFC's core mission. Furthermore, some thought the organization's mission of promoting high-quality child care could best be achieved by providing professional development opportunities for practitioners and students at MACFC's model center. Others urged caution, wanting instead to defer expansion until the center gained

more experience. After much discussion, the board and staff agreed to move forward with two expansion sites, while deferring decisions on additional sites. At the time of the site visit, discussions about the future direction of MACFC were continuing. Several participants in these discussions observed that reconciling the opinions and agendas of various stakeholders is an ongoing collaborative process.

Some parents have expressed concerns about changes in MACFC that could result from implementation of Early Head Start. Some parents have worried that as MACFC expands, it may compromise on quality. In particular, some feared the center would increase teacher-child ratios to accommodate more children. Others have expressed concern that Early Head Start children may have more behavioral problems and needs that will lower the quality of care received by the children currently enrolled. Staff responded to these concerns by holding several meetings with parents to discuss their concerns, reassure parents of MACFC's commitment to uphold high quality standards, and underscore the center's mission of serving families from diverse economic backgrounds. Staff expressed optimism that, once the new program was implemented and parents saw that quality was not compromised, their concerns would diminish.

LESSONS FROM THE MOUNTAIN AREA CHILD AND FAMILY CENTERS

Community Collaboration and Fundraising

MACFC has developed a broad base of support for its mission by educating the community about the importance of high-quality child care and opening its doors to serve as a training site for the early childhood education field. MACFC's board members have worked effectively to educate the community about the importance of high-quality child care for children's development by meeting with key community leaders and speaking to numerous community groups about its mission. Since its beginning, the center has opened its doors to the community and served as a model for high-quality caregiving. For example, it serves as a training site for college and nursing students, early-childhood professionals, and others throughout the community and state who are interested in learning how to provide high-quality child care. Through these activities, MACFC continues to garner the public and philanthropic support necessary for sustaining its mission and supporting its expansion plans.

Gaining the support of key community leaders early on helped MACFC gain credibility in the community and raise funds to build the center. At the early stages of the center's development, MACFC board members invested substantial time and effort in meeting with a broad range of community members about their vision for a high-quality child care center in rural Buncombe County. These meetings enabled them to learn more about community child care needs, obtain input and advice from service providers and experts, and educate key community members about their plans to build the center. When the group launched its capital campaign, board members were able to call on these key stakeholders to accompany them on visits to foundations and donors, write letters of support for grant proposals, and provide other public endorsement and support for the mission of MACFC.

Providers must blend funds from various public and private sources to sustain high-quality care. Because of the disparity between the cost of providing high-quality care and the fees that families can afford to pay for it, MACFC board members believe that a sustained fundraising effort will be needed to pay for the center's operation. Even though MACFC's fees are among the highest in the county, tuition payments from privately-paying families and state child care subsidies obtained by low-income families are not enough to cover the cost of operating the center. At the time of the site visit in June 2002, MACFC was preparing to begin operating an Early Head Start program. Staff expected the center to be funded by roughly one-third Early Head Start funds, one-third family fees (including subsidy payments), and one-third foundation funds and private donations.

Planning and Implementation

Obtaining the advice of experts at key points in the planning process was essential to the project's success. For example, rather than begin a fundraising campaign on their own, the board hired a fundraising consultant to explore the feasibility of a capital campaign, set a goal for the campaign, and designed a step-by-step strategy for raising the funds. The board hired a design consultant with expertise in early childhood education to develop a design concept for the center that would support a high-quality program, then hired an architect who was willing to follow that concept in drawing up plans for the building. Similarly, a playground consultant worked with the center to design its three playgrounds.

Hiring experienced staff enabled MACFC to implement services quickly and begin expanding within a year of opening its doors. MACFC's executive director and key management team members had substantial experience in the early childhood education field when they were hired by MACFC. Several had worked in child care or with Head Start/Early Head Start programs in neighboring communities. This experience gave the team members confidence in their own abilities to provide quality services, enabled them to reach consensus fairly rapidly about their goals and approach, and allowed them to get the center up and running quickly.

CHAPTER V

PARENT PERSPECTIVES

This chapter highlights reflections of low-income parents who live in the case study communities about their experiences in finding and using child care for their infants and toddlers. We collected this information during parent focus groups held in each of the four case study communities. Thirty-one parents participated in these groups—9 in Colorado, 11 in Kansas, 9 in Missouri, and 2 in North Carolina. In three of the four groups, a total of eight fathers participated; teenage mothers also attended at several sites. Parents were recruited to participate by key participants in the main initiatives we profiled; many were enrolled in Early Head Start. All parents in the focus groups had infants or toddlers enrolled in the initiatives and were generally pleased with the care their children were receiving. Therefore, this chapter does not include the views of parents who have not been able to access good-quality infant-toddler care. In the sections that follow, we present the barriers that parents described to arranging care, the characteristics of child care providers and settings that parents associated with high-quality care, and parents' recommendations for making good-quality infant-toddler care more accessible to low-income families.

BARRIERS TO ACCESSING GOOD-QUALITY INFANT-TODDLER CARE

Parents described the barriers they faced to obtaining care before they enrolled in the case study initiatives, as well as the experiences of other parents they knew in the community. The three main barriers parents identified were inadequate supply of infant-toddler slots, the high cost of care, and the inadequate quality of arrangements they could afford. Difficulty accessing and maintaining state child care subsidies did not surface as a significant barrier, perhaps because turnout for the parent focus group was low in Buncombe County, the only site we visited that had a long waiting list for subsidies.[1]

[1]Only two parents participated in the focus group in Buncombe County. One had children with special needs and thus received priority for a child care subsidy. The other mother paid for her child care directly. She did not qualify for a child care subsidy, because she was living with her mother, whose income was included in the income eligibility determination for the subsidy.

Inadequate Supply of Infant-Toddler Slots

Before securing their current child care arrangements, most parents in the focus groups said they struggled to find an infant-toddler slot for their child. According to parents, none of the four communities offered low-income families an adequate supply of quality child care for children under age 3. In Kansas City, parents reported that, while it was possible to find infant-toddler child care, it was extremely difficult to find care that was both affordable and of good quality. In contrast, parents in Colorado Springs said that finding an open infant-toddler slot of *any* quality was very difficult in their community.

Parents identified several circumstances that further complicated the task of arranging infant-toddler child care. For example, parents in Colorado Springs and Sedalia reported having difficulty finding providers who would accept state child care subsidies; many accepted only direct payments for care and charged fees that were higher than the subsidy reimbursement rates. A handful of parents noted that finding openings for multiple children of different ages could be particularly difficult, especially when one child was an infant or toddler. Parents in some communities reported that affordable care during nonstandard hours, such as evenings and weekends, was almost nonexistent. For example, parents in Sedalia knew of only one family child care provider who offered weekend care, but her fees far exceeded what parents could afford.

Across all sites, parents reported that waiting lists for infant-toddler slots were the norm. Waiting time on these lists ranged from about three months in Kansas City to as long as 15 months in Colorado Springs. A parent in Sedalia reported waiting six months for an infant slot. While they waited for a slot to open up, parents said they relied on family members or other informal providers. A mother in Kansas City postponed returning to work until she could place her infant with a Project EAGLE child care partner.

In addition, many parents felt there was a mismatch between the type of care they wanted for their infants and toddlers and the types of infant-toddler care available in their communities. According to parents, most infant-toddler slots were offered by family child care providers, both regulated and unregulated. One mother commented that there were, on a list generated by the local child care resource and referral agency, "pages and pages" of home providers who accepted infants and toddlers, but very few child care centers. Some parents in the focus groups used family child care and expressed a high level of satisfaction with these arrangements. Many, however, expressed a preference for center-based care, because they believed centers maintained higher standards of quality and were monitored more regularly by state licensing officials and by parents and others who visit centers during the day.

> *We tried to get [child care with] state pay [subsidies], but no one was taking any more state pay babies at that time. We called everyone, and they were like, "Try program so and so, maybe they can help you." Everyone just said they could put us on a waiting list. We first tried to get [child care with] state pay when our son was about 3 months old. Early Head Start finally helped us get a spot.*

The High Cost of Infant-Toddler Care

In all four sites, parents said that infant-toddler care in their communities was very expensive; some characterized the fees as "outrageous." According to parents, market rates for good-quality infant-toddler child care were out of reach for low-income families in their communities. One father compared monthly child care fees to the cost of a mortgage payment. Another said that if he had to pay market rates, more than half his earnings would go toward child care. In Kansas City, one father declared, "It makes no sense for you to work when you have to turn around and turn over your whole check to them. Good quality infant-toddler care is $160 a week at least, even $200. Some places I called were $200 to $225 a week. Any person who does not have a regular job would not be able to afford that. They won't be able to work either. If you work, you'd have to give them your check." In North Carolina, parents remarked that while low-income households could afford the fees charged by some providers, the quality of care offered by these providers was minimal.

Related to affordability, parents in Colorado Springs and Buncombe County discussed income-eligibility limits for state child care subsidies. In Colorado Springs, some parents said that they could not accept salary increases for fear of exceeding income limits and losing their child care subsidies. Similarly, in Buncombe County, North Carolina, one parent suggested that the state reassess subsidy eligibility limits so that parents like her would not feel "trapped" at their income level because of fear of losing their child care subsidy.

> *If it wasn't for state pay or the Early Head Start program, there would be no sense in going to work, because there would be no paycheck. Ninety dollars a week for one kid, just for a toddler! I had two toddlers, and I want to say it was $150, 160 a week just for those two, plus I had my daughter. Without state pay I could forget it. I might as well be a stay-at-home mom. It is expensive, very expensive.*

Inadequate Quality

Focus group participants also discussed their views about the quality of infant-toddler care accessible to low-income families in their communities. Their observations were based primarily on child care arrangements they used or facilities they visited before finding their current arrangements through the case study initiatives. Parents in several communities cited large group sizes and inadequate child-teacher ratios as indicators of poor quality. For example, one parent described a visit to a family child care home in which the provider cared for a dozen children of mixed ages, including infants. Another parent compared her child's current provider to others in the community: "The ratios in other places are so much. I mean, there are so many kids to one person, to a point where there is no way that I myself could keep an eye on that many children at that age. How can anybody else?"

In addition, many parents cited a low level of interaction between providers and children as a sign of poor-quality care. For example, a mother in Missouri remarked, "Every day when I got there, they had her asleep in a swing, with a bottle propped in her mouth." Several parents described caregivers who appeared to ignore the children and instead had personal conversations among themselves. Parents in Colorado Springs speculated that

some family child care providers had placed their children in front of the television for most of the day and took them outside to play only right before parents arrived to pick them up. Similarly, a mother who used a family child care provider during evening work hours said that she arrived at the home to find the children unsupervised and watching television in the dark without an adult in the room.

Parents also said that they and their children were not made to feel welcome in previous child care settings or during visits to prospective child care providers. For example, one parent said, "A lot of the day cares I went to, you walk into a place and you expect someone to tell you 'Hi,' you know, to say 'Hello, welcome.' You didn't get nothing; they looked at you like, 'Oh, another baby.'" A father in Colorado described a provider who he felt did not provide a welcoming environment for children or parents. He said, "They don't look at it like there are kids involved, and they just treat it like a business. You don't feel warm when you talk to these people." Other parents cited their children's unhappiness about going to child care and their eagerness to leave at the end of the day as signs that their children did not feel welcome and were not well cared for.

Several parents told stories about the use of inappropriate disciplinary techniques or overly restrictive practices. One parent told about seeing a child shaken. Another, whose son had a problem with biting as a toddler, said that a caregiver threatened to bite her child in an attempt to stop him from biting. In Sedalia, a mother described what she considered to be an overly restrictive environment in their child's toddler classroom, "At my old day care, I felt like every time I would go in there it was time to put the toys up, and I felt like, 'When do they play?' That's what they need to do to learn. . . . Every time I'd go in there . . . she'd be yelling at them, and if they took a toy off the shelf she'd yell at them to put it back and sit on the line. I understand some structure, but they have to play, they have to learn and communicate with each other."

Health and safety practices were also of concern to parents. Parents expressed concern about accidents and unexplained bumps and bruises. Cleanliness was also a major issue for many parents. Several commented that in some child care settings their children were not kept as clean as they should be; they had dirty clothes and faces at the end of the day and their noses were not wiped when they had colds. Others told stories about the lack of adequate processes to safeguard health. For example, one father said, "One of the places I was at, I walked in, and . . . I went in to get my son and take his bottle and give it to him since it was his bottle time. [The caregiver] pulled open the refrigerator door and said, 'Here, this isn't his bottle, but there's some milk in it, here you go.' It was winter, you know, flu was going around. . . . That was why I left."

> *It was extremely difficult to find good child care. Even on the [Department of Social and Rehabilitative Services'] list, if you go to half the houses, you would never send your child. At one house I went into, the lady kept 10 kids. Okay, she said, "You are more than welcome to come around." I went in her house, I about fell out. I said, "What are you doing? This is supposed to be a day care?" She said, "Yes." I said, "Well could you tell me what you do with the children all day?" "Well, they sit in the play pen." "You don't interact?" "Well, no, I don't have time, I have 10 infants." Well, I said, "You're not getting my child."*

PARENTS' OPINIONS ABOUT QUALITY

During the focus groups, parents talked about their own definitions of quality child care and the key elements of what they thought would constitute a good-quality child care setting. Often, parents described positive aspects of the child care settings they were currently using. Not surprisingly, these items correspond with many characteristics of child care settings that early education experts think are indicators of quality. The following section describes the characteristics of infant-toddler child care settings that parents said were important, including a welcoming environment, quality interactions with children, developmentally appropriate learning activities, proper health and safety procedures, good communication with parents, continuity of care for children, the ability to care for children with special needs, and a philosophy that teaches children to value diversity.

Welcoming Environment

Parents described an ideal child care setting as one that was warm, cheerful, calm, and inviting for both children and parents. A father in Colorado Springs felt that teachers at the center his child attended were like members of his extended family; other parents voiced similar feelings about their children's caregivers. In fact, one parent claimed to have difficulty sometimes getting out of his child's center to get to work on time because staff were so friendly and engaging. A mother remarked that staff at one particular center remembered her name when she made return visits to possible providers. This personal touch impressed her. She said that she believes children can sense when their parents do not feel comfortable and welcomed in a child care center, which could affect their degree of comfort in that facility. Some parents described the relief of seeing that their children were happy and emotionally close to their caregivers; a few even said their toddlers called their teachers "Mom."

> *My son, he loves to go to school. If one day I can't take him to school or something, he will get mad at me. He says, "No mama, I want to go to school, I have to go to school." We had spring break and all he talked about was going to school, but I'm like, "Honey, there's nobody at school." So it was pretty funny, he really wanted to go to school, and I knew he enjoyed his class.*

Quality Interactions Between Caregivers and Children

During the discussions, parents overwhelmingly associated good-quality care with individualized attention provided to their children from enthusiastic, professional, and personable caregivers. They expected providers to become familiar with the children's personalities and the specific likes and dislikes of each child. Parents in Kansas praised the care and attention their children received in the infant room at a particular center because the teacher constantly talked with the infants, even those who were only a few months old. About this teacher, one parent said, "I've never seen a lady that talks so much. Any time she touches them, she's talking. She talks to them the whole time she's caring for them. . . . She greets them and tells them what we are getting ready to do, like 'we are going to go and change your diaper.' You can go in there any time and she's talking or reading books. Even

with infants 6 weeks old she's reading books." Another mother using a family child care provider said she appreciated the small group size in the provider's home (six children) and the individualized attention that her child received there. Finally, some parents noted that continuity of care was important for ensuring quality interactions. Parents recognized the importance of low staff turnover and maintenance of predictable routines for their children. In North Carolina, parents liked the fact that some of their children's teachers would change classrooms with them as they got older.

> *Kids see the same faces, are greeted by the same receptionist, and it's that stabilizing factor which I think we all need, especially children, because they need to know what they can count on.*

Developmentally Appropriate Activities

Parents also emphasized the importance of stimulating, age-appropriate activities for their children in an environment of learning, not merely a place where they "are just stuck in a play pen." Participants from all the focus groups likened the child care settings to school. For example, a mother in North Carolina appreciated that her toddlers have learned the alphabet, songs, colors, bugs, animals, the phrases "please" and "thank you," and how to sit quietly and listen to books read aloud. Similarly, parents enrolled at a center in Colorado liked the way in which teachers incorporated age-appropriate educational activities into the daily schedule through the *Storybook Journey* series.[2] They also were pleased that the children were learning self-help skills, such as how to brush their teeth, clean up, and use good manners.

Several parents who used family child care homes emphasized that even though their children were cared for in a home, they also received developmentally appropriate educational activities. For example, one mother said that her child's provider had a sand and water table just like a center. She valued the combination of a more intimate home setting for her child and stimulating educational activities.

> *It is important for him to learn things, and he has just learned so much. I wish everyone had a place like this where they could take their children. It's just a big relief to know . . . that I can go to work and focus on my work. And I know that he is having a blast here.*

Health and Safety Practices

All focus group participants stressed that child care facilities should be clean, and that providers should meet the highest standards for health and safety, including offering healthy meals. Not only should the area be spacious and clean, with minimal clutter, but the children should have a clean appearance. Parents also stressed that they wanted assurance

[2]Each month, a classroom focuses on one book and uses song, art projects, and other activities to supplement the book.

from providers that procedures were in place to prevent injuries. Many said that they liked the hand-washing and tooth-brushing routines implemented in their children's child care settings. One mother said, "They have a family structure like what I do at home. I set the table, and they're in there washing their hands, and they wash their hands here. Every classroom has toothbrushes marked with their names on them, every time after they eat, they are brushing their teeth. Before they sit down to eat, they're doing hands inspections." The mother of an infant commented on the care her child's teacher took to maintain a healthy environment in the classroom, "She washes the babies' hands. . . . The first day I saw it I couldn't believe it. My son was three months old, and she had time to bring him to the sink and wash his hands. . . . I use a wipe after I change him, but she takes him to the sink and washes his hands. She's very clean, toy-wise. If a kid is finished with a toy, she radars and goes, 'Okay, I got to wipe that off in case another kid comes.' I love it in there." Finally, parents with children in Early Head Start felt reassured that program staff visited child care partners regularly to work on quality improvement and ensure that health and safety standards were met.

Good Communication and Feedback

Open, honest communication between parents and providers was critical for focus group participants. Parents appreciated receiving daily updates from child care providers, daily record sheets that summarized children's eating and sleeping patterns, calendars of upcoming classroom themes or activities, and parent-teacher conferences. Some parents said that if issues arose and they could not speak directly with teachers, they exchanged notes. Parents also appreciated information caregivers provided about their children's achievements and developmental milestones. For example, one mother described how her family child care provider took digital pictures of activities and accomplishments so that she could feel linked to what happened during the day when she was away from her daughter.

Parents were especially pleased whenever providers took the initiative to ask questions about their children, such as "How do you feel her speech is going?" or "Do you think maybe you should have the pediatrician examine that?" A mother in Missouri was very impressed that a teacher called her at home to check on her sick child. Careful monitoring and followup regarding the child's development and well-being demonstrated to parents that caregivers were involved with their children and cared about them.

Parents also wanted opportunities to express concerns and appreciated providers who were open and receptive to these discussions. For example, one parent in Kansas noted that the director of the center consulted parents frequently. She said, "The director goes around and checks on all the kids and all the classrooms, and she sits down and she asks the parents if they have any concerns. So I think communication she does really well." Other parents said child care providers must allow parents to visit freely without giving prior notice; they appreciated caregivers who welcomed them to observe classrooms and participate in activities. Finally, parents said they wanted to be informed about any problems that arose and expected to receive accident reports if their children had falls or other accidents. For example, a parent in Colorado Springs expressed appreciation for how an incident with her son was handled. Her son wandered away from an outside playground back inside the

center. Even though he was not hurt, his teacher was suspended because she was not providing adequate supervision. When the mother arrived to pick up her child, the center director informed her about the incident and the disciplinary action she had taken. This candid account by the director impressed her; she believed that some providers would have tried to cover up the incident.

Finally, some parents cited aspects of Early Head Start-child care partnerships that facilitated good communication between parents and providers. Program staff (such as family advocates or child care specialists) were available to serve as intermediaries or advise parents about how to address their concerns. A few parents noted that their participation on policy councils gave them a forum for sharing ideas and addressing concerns about the care their children received.

Capacity to Care for Special-Needs Children

Parents of special-needs children emphasized the importance of finding a child care setting that could address their children's needs effectively. Some focus group participants had children enrolled in early intervention services; others had children with special health or emotional needs. Child care providers used by some participants collaborated with early intervention service providers to coordinate services for the children in the child care setting. For example, the mother of a toddler with developmental delays described how the child's teacher and a physical therapist from early intervention worked together to help her learn to improve her diet and gain weight. Another mother expressed her appreciation for a child care provider who accommodated her son's asthma treatments: "He had to have a breathing treatment every hour. I was willing to stay home with him, but they were like no, bring him. They gave him all the attention he needed, plus they attended to the other children. . . . It's just remarkable, its wonderful. I don't know if me being a child care provider, if I could have done that for someone else's child. I mean, really, it takes a lot." Finally, a focus group participant expressed gratitude for support from her son's teacher in helping him cope with her recent divorce.

Teaching Children to Value Diversity

Parents in Colorado Springs also expressed their appreciation for their child care providers' attitude toward diversity and the values their children were learning about it. For example, several parents noted that their children did not focus on racial differences, and they attributed that to role modeling done by teachers. In addition, one mother who used a family child care provider was particularly impressed by the children's attitude toward one child with muscular dystrophy. She said, "They had to help her get to the table, and help her wash her hands, but they didn't see it as a handicap, and I thought that was great. And it was my son who most often helped her, and I thought that was great, because he doesn't even help his sister like that."

SUGGESTIONS FOR CHANGE

While focus group participants were generally satisfied with their child care arrangements, they offered several recommendations for improving access to good-quality infant-toddler care. In every focus group, parents emphasized the need to increase funding for child care—to make it more affordable and accessible to low-income families and to improve quality. In particular, some parents felt that the wages of caregivers should be increased to reduce staff turnover and to motivate them to do their best for the children. Several parents suggested increasing income eligibility limits for child care subsidies so that more working families could qualify for assistance. Finally, some parents said that providers should be encouraged to offer care during nonstandard hours, such as evenings and weekends, and that child care centers should have "sickrooms" where ill children could be cared for so that parents did not have to miss work.

CHAPTER VI

CROSS-SITE THEMES

In this chapter, we focus on common challenges and lessons from the three case studies. In particular, two overarching themes surfaced across the initiatives we studied: (1) how to pay for infant-toddler child care, and (2) how to ensure the provision of good-quality care. These themes certainly are not unique to infant-toddler child care; funding and quality also are important issues for preschool-age and school-age child care. Nevertheless, the challenges of funding and quality are especially pressing for infant-toddler care. Child care for infants and toddlers is more expensive to provide than for preschoolers or school-age children, and providing good-quality child care is more difficult for this age group than for older children. Next, we describe the lessons gleaned from a cross-site analysis of the case studies under the themes of funding and quality, with an emphasis on those aspects that are especially relevant to infant-toddler care. We also include some steps that federal and state governments can take to support such community-based collaborative efforts as those profiled here.

FUNDING GOOD-QUALITY INFANT-TODDLER CHILD CARE

Providing infant-toddler care is expensive, largely because providing the intensive care and supervision that infants and toddlers need requires lower child-caregiver ratios than for older children. Staff need training in infant-toddler care and development to ensure that their practices and expectations are age-appropriate and promote healthy development. Infant-toddler child care providers also need adequate space for crawlers and walkers, as well as special equipment such as cribs, high chairs, strollers, developmentally appropriate toys, and age-appropriate outdoor play equipment. Consequently, the fees charged for good-quality infant-toddler care were beyond the means of low-income families in the communities we visited. Identifying funding sources to pay for good-quality infant-toddler child care thus emerged as a central activity for each of the initiatives we studied.

In two of the three case studies, state child care subsidies were accessible to low-income families, but subsidy funds alone were not enough to cover the cost of care. Parents described searching for infant-toddler providers who would accept the state subsidy; and most reported either that providers in the community would not accept subsidies or that the

quality of care their children received from providers who did was inadequate. In the third case study, a long waiting list prevented most families from obtaining a subsidy unless their child had special needs.

Child care providers also described the challenges of funding infant-toddler child care with state subsidy payments. In El Paso County, Colorado, the area's largest nonprofit child care provider described the difficult decision to close its last infant room, because covering the cost of infant-toddler care had depleted the organization's reserve fund. In North Carolina, staff and board members of the Mountain Area Child and Family Center reported that even the fees charged to higher-income families did not cover the true cost of providing infant-toddler care, and state subsidy reimbursement rates were well below tuition rates for paying families.

When providers were not able to cover their costs with state subsidies, they reduced or eliminated infant-toddler slots. Consequently, in all the communities we visited, the supply of infant-toddler care was inadequate to meet the demand for regulated care. This section describes cross-site lessons from the case studies about funding a stable supply of good-quality infant-toddler care.

- **Child care providers in the case study sites said they must combine multiple funding streams to cover the cost of offering good-quality infant-toddler care for low-income families.**

Although each community took a different approach to blending funding streams to pay for infant-toddler care, key stakeholders in each community emphasized the necessity of combining funds. In Colorado, child care providers formed partnerships with Early Head Start to help pay for child care. For example, a school district operating an on-site child care center at an alternative high school reported that, without the Early Head Start partnership, the district could not afford to continue operating its infant-toddler rooms. The district also relied on state subsidies and a variety of other funding sources to pay for the care. In addition, the county welfare office in El Paso County, Colorado, supported providers' efforts to open infant-toddler rooms by providing guaranteed funding for these slots during an initial start-up period. In North Carolina, the Mountain Area Child and Family Center raised funds from foundations and private donors to supplement parent fees and state subsidies.

In Kansas and Missouri, Early Head Start-child care partnerships were funded primarily by state-sponsored Early Head Start initiatives. While these initiatives did not combine multiple funding sources (families enrolled in these programs could not obtain state subsidies, as they already received state funding for child care under state-sponsored Early Head Start), they did provide child care funding that exceeded the levels available through the state subsidy program. In addition to paying providers at rates higher than those for subsidy reimbursement, the initiatives paid for equipment and extensive training of staff.

Participants in all three case studies described some difficulties with blending funding streams and forming partnerships, such as coordinating across programs to ensure that all program standards and fiscal reporting requirements were met. Particularly in Early Head Start child care partnerships, some child care providers found meeting the Head Start Performance Standards challenging. Nevertheless, nearly all stakeholders in the case study initiatives emphasized the necessity of combining multiple funding streams to pay for good-quality infant-toddler care. All the case study initiatives further stretched the funds they had by taking advantage of other child care initiatives in their communities. For example, some providers participated in grant programs to purchase equipment; some accessed wage or health insurance supplement programs. Many took advantage of free or low-cost training opportunities or scholarships provided through state TEACH™ initiatives.

- **When assured of a steady cash flow and ongoing support, family child care providers in the case study sites proved to be a significant source of quality infant-toddler slots for low-income families.**

Except in North Carolina (where the initiative examined was a child care center), family child care providers participated in the case study initiatives. Key stakeholders in each of these sites reported that family child care homes provided an important source of good-quality infant toddler slots for low-income families. In particular, initiatives were successful in identifying and involving family child care providers in neighborhoods where families needed care and center-based infant-toddler slots were not available.

Stakeholders in the case study communities identified two kinds of support that were important to sustain the involvement of family child care providers. First, because they care for small numbers of children, family child care providers need a steady flow of cash. In Colorado, stakeholders reported that family child care providers often were reluctant to accept state child care subsidies because of the lag time between the provision of services and receipt of reimbursement. To remedy this problem, the child care pilot established the Home Network, which reimburses providers on a weekly basis. Early Head Start programs also provide prompt reimbursement to family child care providers.[1]

Second, family child care providers were willing to work on quality improvement, but they needed ongoing support. Through Home Network and partnerships with Early Head Start, family child care providers received frequent technical assistance visits, including help with room arrangement, planning activities, communication with parents, and the business aspects of operating a family child care home. In some cases, providers also received

[1]In cases where family child care providers must meet the group size and ratio requirements of the Head Start Performance Standards (8 children per group and 4 children per teacher), providing steady cash flow was not sufficient to achieve compliance with the performance standards. For example, in Kansas and Missouri, reimbursement rates provided by Early Head Start were not high enough to achieve the lower groups sizes and ratios in family child care homes.

equipment, such as cribs, shelving, cubbies, and outdoor play equipment, in addition to information on training opportunities, encouragement to develop professionally, and opportunities to network with other home-based providers.

- **Some regulatory barriers that deter child care providers from creating infant-toddler slots in existing facilities can be overcome without putting children's health and safety at risk.**

Regulatory requirements for infant-toddler child care are designed to safeguard the health of this vulnerable population. While stakeholders in the initiatives we studied agreed that these safeguards are essential, in some circumstances the safeguards could prevent potential expansion of infant-toddler slots in existing facilities. Especially in Colorado, providers were able to obtain waivers of some requirements by proposing alternative safeguards to protect the children. These waivers enabled providers to increase the number of infant-toddler slots available by using existing facilities. Had the waivers not been granted, the cost of extensive construction or renovation would likely have prevented providers from opening these slots.

- **Because funding good-quality infant-toddler slots requires the blending of funding and the coordination of programs, building collaboration and partnerships was essential in all the case study sites.**

Stakeholders stressed the importance of building strong collaborative relationships with community partners to ensure effective communication and resource-sharing. They also emphasized the importance of sustained leadership by a core group of committed stakeholders to building and sustaining local initiatives. Continuity among core participants enabled key participants in the case study initiatives to build a history of trust and positive working relationships they could draw on during difficult phases of the initiatives' growth. In addition, frequent, effective communication at all levels—among key stakeholders at the local and state levels; among providers, funding agencies, and technical assistance providers; and between providers and parents—was essential to forming partnerships and blended-funding arrangements. In some communities, strong support from local government agencies, especially the welfare and child care administrators, has been essential to gaining local support, working out administrative barriers, and bridging temporary budget gaps. In Colorado Springs, stakeholders said that, by supporting local communities in designing initiatives tailored to their specific strengths and needs, the state's child care pilot initiative had increased local collaboration and fostered a sense of local ownership.

- **To fund the initiatives, new sources need to be cultivated, which can be accomplished through community outreach and education.**

SUPPORTING COLLABORATIVE COMMUNITY INITIATIVES

While the case study communities achieved notable successes in increasing supply and improving quality, key stakeholders reported that the supply and quality of infant-toddler care remained woefully inadequate in their communities. In each site, participants in the initiatives hoped to expand their services by increasing the level and extent of community collaboration and by seeking additional funding sources. The sections below describe ways in which federal and state governments, even without additional resources, can support communities in their efforts to collaborate, develop partnerships, and blend funding.

- **Increase coordination at the federal and state levels, to align program standards and requirements for infant-toddler child care services.**

Coordinating rules and procedures across programs and funding streams can help support partnerships by reducing the number of requirements and rules that must be met. For example, aligning quality standards and regulations across initiatives could help underscore the importance of meeting these standards and eliminate confusion at the local level about which set of requirements to follow.

- **Coordinate and streamline recordkeeping and reporting requirements, to ease the paperwork burden associated with combining funding streams.**

When service providers blend funding streams—such as state child care subsidies, public school funds, state funds, or Early Head Start funds—they must adhere to the record-keeping and reporting requirements of several funding sources. Simplifying and aligning financial management requirements would reduce paperwork and avoid duplication of effort in reporting to each funding source.

- **Align eligibility periods and requirements for state child care subsidy and other programs, to promote continuity of care for children and ensure stable funding sources for child care initiatives.**

When eligibility periods and requirements differ substantially across programs, families can lose eligibility for a portion of their funding, thus jeopardizing continuity of care for the child and stable funding for the provider. Aligning eligibility across programs, such as state child care subsidies and Early Head Start, can eliminate this potential source of instability for families and providers.

- **Provide a full-day child care subsidy or pay for guaranteed slots for children enrolled in programs that pay for a portion of the cost of care to help to cover the high cost of providing good-quality infant-toddler care.**

Some states provide only a partial-day subsidy for children when Early Head Start or other grant funds pay for part of the cost of child care. In these situations, child care subsidy funds frequently are used to pay for "wraparound" child care services, which often are of lower quality because the subsidy is insufficient to pay for good-quality services. In other communities, however, families remain eligible for a full-day subsidy that can be combined with other funding sources to pay for higher-quality care. Similarly, in some communities child care subsidy funds can be used to purchase guaranteed child care slots. This arrangement guarantees funds for infant-toddler slots, regardless of whether a child is out sick or a family loses eligibility for the subsidy, thus increasing the stability of funding for the provider. However, with limited resources to fund child care subsidies, states must make difficult trade-offs between providing higher reimbursement rates to pay for the cost of higher-quality care, versus providing lower reimbursement per child so that funds can be stretched to serve more children.

Key informants in all the case study sites felt strongly that community education about the importance of high-quality child care for the healthy development of infants and toddlers has yielded increased support and investment in child care in their communities. The North Carolina initiative, in particular, has been successful in identifying new funders through a vigorous outreach and education campaign.

IMPROVING THE QUALITY OF INFANT-TODDLER CARE

Key stakeholders in the case study initiatives recognize the positive role that good-quality child care can play in the development of infants and toddlers; all the initiatives we examined emphasized the importance of improving the quality of infant-toddler child care in their communities. While increasing the supply of infant-toddler slots was an urgent need in these communities, most stakeholders felt strongly that initiatives should focus on developing good-quality slots rather than on creating a larger number of slots that met minimal quality standards. As described below, all the initiatives have invested significant resources and staff time in their quality improvement efforts.

- **Improving quality in the case study sites required offering sustained and intensive support to child care providers.**

Staff and organizations providing technical assistance through the case study initiatives emphasized the need for intensive support for child care providers. Most of the initiatives included regular visits (ranging from weekly to monthly) to family child care homes or infant-toddler classrooms in centers. During these visits, technical assistance staff checked on how the provider was doing, modeled developmentally appropriate caregiving, and provided guidance on implementing specific activities or curricula. When an initiative included Early Head Start-child care partnerships, technical assistance staff supported providers in implementing the Head Start performance standards.

- **Stakeholders also stressed that making the changes necessary for improving the quality of infant-toddler care could best be done incrementally, over time.**

Technical assistance staff emphasized that providing infant-toddler care is hard work and compensation is often low. Providers often became overwhelmed and discouraged if too many changes were expected at once. Instead, they needed encouragement, positive reinforcement, and reassurance that changes could be made gradually over time. In most of the initiatives, technical assistance staff said that ensuring adherence to health and safety standards was their highest priority. After health and safety, most focused initially on improving the caregiving environment by purchasing equipment and toys and working with providers on room arrangement. Improving the quality of interactions between caregivers and children, however, was usually more gradual.

- **Improving quality in the case study sites also required a significant investments in provider training, provider compensation, and materials and equipment.**

In addition to regular technical assistance visits, all the initiatives supported child care providers in obtaining a Child Development Associate (CDA) credential or a higher degree in early childhood education. Early Head Start programs usually paid for this training, or they provided it directly to their partner providers. Other initiatives offered free training or helped providers obtain scholarships.[2] In addition, initiatives offered additional training in infant-toddler care and development and on a range of broader child care topics. Some initiatives incorporated bonuses or wage supplements to serve as incentives for providers to obtain training. For example, a wage supplement pilot project in Kansas City, Kansas, offered higher wages to caregivers who obtained additional education. Similarly, the alternative licensing model implemented in El Paso County, Colorado, and the star rating system in North Carolina provided substantial financial incentives for meeting higher-quality standards. Finally, most of the initiatives we examined invested in providing developmentally appropriate equipment and toys to child care providers. Early Head Start programs paid for setting up outdoor play areas at family child care homes and purchased cribs, rockers, and other needed equipment. Child Care Connections, in El Paso County, Colorado, offered grants to providers to purchase equipment. Several of the initiatives focused on purchasing floor mats and other equipment that could help caregivers phase out inappropriate, restrictive equipment such as walkers or infant swings.

- **With adequate support, child care providers were able to accept and care for children with special needs.**

While an inadequate supply of infant-toddler care was a significant barrier in the case study communities, finding care for infants and toddlers with special needs was an even bigger challenge. All the initiatives supported child care providers in caring for special-needs children by fostering close working relationships with early intervention programs. Typically, early intervention providers worked with children in the classroom, offered technical assistance to caregivers in how to meet a child's needs, and coordinated with caregivers and parents to set goals for the child in the child care environment. In Colorado, the child care pilot even established a program to support child care providers in caring for children with significant behavioral problems.

Although providing good-quality infant-toddler care is expensive and challenging, many child care providers in the case study sites were willing to add services for infants and toddlers or to expand the number of slots they offered once they were assured of sustained funding, technical assistance, and support. Thus, each of the case study communities was

[2]Some of these initiatives were supported by Child Care and Development Fund (CCDF) quality-improvement funds.

able to make progress in increasing the number of good-quality infant-toddler slots in their communities, especially slots that were accessible to low-income families. While the community context, needs, and resources differed across the sites, some common themes emerged. Obtaining sufficient funding to pay for care and improving the quality of care available were the two greatest challenges in all the sites. Although the sites used a variety of strategies, all of them made progress by pooling resources, coordinating services, and maintaining close communication among key stakeholders.

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APPENDIX A

PROTOTYPE SITE VISIT PROTOCOLS[1]

State Child Care Administrator

State Early Childhood Education/Early Head Start Director

Local Child Care Administrator

Local Welfare Administrator

Parent Group Discussion

Child Care Resource and Referral Agency

Child Care Teacher/Family Child Care Provider

Part C Provider

Community College Staff/Staff Development Coordinator

Early Head Start Program Director

Child Care Coordinator

Child Care Specialists/Partner Advocate Liaisons/Network Coordinator

Informal Observation of Child Care Setting

[1]These protocols served as the basis for planning site visits and conducting interviews in all sites. We customized the protocols prior to the visits according to the community context and specific initiatives we planned to examine at each site.

STATE CHILD CARE ADMINISTRATOR TELEPHONE INTERVIEW

CHILD CARE ADMINISTRATION

1. Can you describe the administrative structure for the subsidized child care program at the state level?
   - Is it administered within the same department as TANF?
   - How does the state's subsidized child care program relate to TANF administration and other children's services?
2. At the local level, how does the service delivery structure for the subsidized child care system work?
   - Who authorizes child care at the local level (specialized child care workers, TANF workers, employment service workers)?
   - Are other entities, such as Child Care Resource and Referral Agencies, involved with the administration or delivery of subsidies?
3. Do you operate an integrated subsidy system based on income, or is your system organized according to specific populations, such as TANF recipients, those transitioning off of TANF, and non-TANF families who are income eligible?
   - Do families need to reapply for assistance under different categories as their TANF or income status changes?
   - Have you maintained a transitional child care program?
   - If so, is it for 12 months?

CHILD CARE FUNDING

4. Has the level of state funding for child care significantly increased to pull down all federal matching funds available under the Child Care and Development Fund (CCDF), or was state funding already sufficient to maximize federal funding available?
5. Does the state contribute state funds in excess of the dollars needed to maximize full federal funding? If so, how much does the state contribute in excess?
6. Do you transfer funds from the TANF block grant to pay for child care assistance? If so, how much? Do you use any Social Services Block Grant (SSBG) funds for child care assistance?
7. Do you expect state funding levels for child care to remain at about the current level, to increase, or to decrease in the near future?

CHILD CARE POLICIES

Eligibility and Redetermination

8. What are the eligibility requirements for child care assistance? What is the income eligibility requirement? Do you have any extended eligibility once families begin receiving assistance?

9. How often is eligibility redetermined? Can you describe the eligibility redetermination process?

10. What work-related activities does child care assistance cover? Work, education, training?

11. Some states have tried to set eligibility consistent with funding levels in order to serve all eligible families that seek assistance. What was the rationale for the choice of income eligibility levels in your state?

12. Do you have a sense of the proportion of eligible families who receive subsidies?

13. What priorities have been set to determine which families receive assistance?

    - How are priority groups determined?
    - Do local offices have any discretion in determining priority groups for subsidies in their area?

14. Do you maintain waiting lists for families wishing to receive assistance? Do you have a sense of how many families are on waiting lists now?

Reimbursement Rates and Family Fees

15. How is the child care subsidy delivered?

    - Income disregard, vouchers, or contracts with providers?
    - Does this vary by type of work or work-related activity?
    - By whether families receive TANF cash assistance?
    - Do families have a choice about the form of subsidy they receive?

16. How are provider reimbursement rates determined? In general, what is the feedback you receive from providers and/or families about the adequacy of reimbursement rates in providing access to care?

17. Do you pay differential or tiered rates to providers who exceed state quality standards by some measure or who are accredited?

    - Do you pay differential rates for infant-toddler care?
    - For nonstandard hours care?

- For other special populations or types of care?
- If so, have these policies seemed to make a difference in the supply of care?

18. At what income level do family copayments apply? Are TANF recipients required to make any copayment? What kinds of factors were considered when setting the fee schedule? REQUEST SCHEDULE.

Licensing

19. What entity is responsible for licensing child care providers? REQUEST REQUIREMENTS.
20. Could you describe your system for monitoring different types of child care settings, such as the frequency and announcement of inspections?
21. What are the requirements for unlicensed providers in order to provide child care for families who receive state subsidies? Health and safety standards, registration, form of payment, background check? What types of relatives *cannot* be paid for care?

QUALITY AND INFANT-TODDLER CARE INITIATIVES

22. What do you feel are the greatest gaps in child care available for low-income families? What state initiatives are underway to address these gaps?
23. How does the state spend its CCDF quality set-aside funds?
24. Are there specific initiatives in place to improve quality or increase the supply of infant-toddler care? To address the care needs of infants and toddlers with special needs?
25. Does the state provide assistance to TANF recipients and other low-income families in arranging child care and selecting what type of care to use? What type of arrangements are used most often for infants and toddlers? Least often?

[CONSOLIDATED CHILD CARE PILOT/STATE EARLY HEAD START INITIATIVE]

26. Do you coordinate the child care subsidy program with the [child care pilot/state-Early Head Start initiative]? How and why?

27. What do you think are the main successes of the [child care pilot/state Early Head Start initiative]?

28. Do you think the initiative has improved quality of care for infants and toddlers? In what ways?

29. Has the initiative increased the supply of infant-toddler care? Improved low-income families' access to infant-toddler care? How?

30. What have been the greatest challenges of the [child care pilot/state Early Head Start initiative? Meeting quality/performance standards? Community collaboration? Others?

WRAP UP

31. Is there a significant child care policy or program in your state related to infant-toddler care that we have not discussed?

STATE EARLY CHILDHOOD INITIATIVE/EARLY HEAD START DIRECTOR

TELEPHONE INTERVIEW

STATE CONTEXT AND PROGRAM DEVELOPMENT

1. When did the state begin developing the concept of [the early childhood/Early Head Start initiative]?

2. What factors led the state to develop the program?

   - What were the child care needs of low-income families with infants and toddlers?
   - Supply and quality of infant-toddler care?
   - Other state quality initiatives?
   - Was welfare reform a factor?

3. Who were the key players involved in the program's development?

   - State officials?
   - ACF regional office?
   - Head Start Bureau?
   - State collaboration office?
   - Child care community?
   - Local early childhood or Head Start programs?

4. How was the program developed and how long did it take? Who wrote the RFP for the program, and when was it issued?

5. Why did the state decide to operate the program through partnerships with community child care providers?

6. How is the program funded? How was the decision made to use this funding source, and who was involved?

7. When was your position developed? What is your role in administering the program?

PROGRAM OPERATIONS

8. What are the eligibility requirements for grantees? How many applications did you receive when the RFP was issued?

9. How many grantees have been funded? How were they selected? Who was involved in the selection process?

10. When were the first grantees funded? When did grantees begin enrolling families? Have all grantees continued participating in the initiative?

11. What are the eligibility requirements for families? How often is eligibility redetermined?

12. How many families are enrolled annually? How many have been served through the program since its inception?

13. Describe the key services provided through the initiative. Does the initiative follow specific quality standards or the Head Start Program Performance Standards? All of the standards or specific sections of the standards? Additional state standards?

14. How are participating child care providers selected? Do the providers have to meet specific criteria?

15. How is the initiative monitored? How often? Who is involved in the monitoring process? What have you learned about program operations through the monitoring process?

16. Does the state provide grantees with technical assistance or other support? What kinds of technical assistance are provided? Who is involved?

17. What are the mechanisms for communication between the state and the grantees? Does the state convene meetings of grantees? What kinds of issues are discussed?

18. How much funding does the program receive annually? How much does the state spend per child? Is this level of funding sufficient to meet the quality or performance standards?

COLLABORATION

19. Does the state [early childhood/Early Head Start initiative] collaborate with other state programs? In what ways?

    - Welfare?
    - Child care subsidy program?
    - State quality initiatives?
    - CCR&Rs?

- State licensing agency?
- Head Start/Early Head Start

20. Are there other child care initiatives operating in the state that support the initiative? Training programs? Other quality initiatives? Supply-building initiatives?

21. How has the child care community responded to the initiative? Are child care providers eager to participate in the program, or has recruitment been difficult? How does the child care community's response vary across communities?

22. How does the state collaborate with the ACF regional office? Head Start Bureau? Other federal agencies or programs?

23. Does the state collaborate with other states to share ideas on program development, monitoring, or other issues? If so, has this collaboration been helpful?

SUCCESSES

24. What are the initiative's key successes?

25. Do you think the initiative has improved child care quality? In what ways? Have you been able to document these improvements?

26. Do you think the initiative has increased the supply of infant-toddler care? Improved low-income families' access to infant-toddler care? How?

27. Are there other benefits of the initiative for children and families?

28. What are the benefits for child care providers?

CHALLENGES

29. What has been challenging about implementing the initiative?

- Recruitment of child care providers?
- Enrolling families?
- Monitoring?

30. What has been challenging for child care providers about improving the quality of care they offer? Which quality/performance standards have been the most challenging to meet? Why?

31. Have any aspects of collaboration with other federal, state, or community agencies been challenging?

FUTURE OF THE INITIATIVE

32. What is the initiative's future? Is there support in the state for continuing it?

33. Will funding continue? What impact will changes in TANF funding or the TANF caseload have on the initiative's funding?

34. Does the state have any plans to expand the initiative?

35. Does the state have any plans to evaluate the initiative's effectiveness?

WRAP-UP

36. Are there other lessons the state has learned from its experience operating the initiative that we have not discussed?

37. Is there anything else I should know about the state's [early childhood/Early Head Start program]?

38. Can you connect me with other state administrators I would like to interview?

    - State child care administrator
    - State welfare administrator
    - Local child care administrator
    - Licensing agency

LOCAL CHILD CARE ADMINISTRATOR INTERVIEW GUIDE

ORGANIZATION OF CHILD CARE ADMINISTRATION

1. Can you describe where child care fits within the office structure?
2. Is child care assistance handled by specialized child care workers or by eligibility or employment service workers?
3. How would you describe the connection between welfare services and child care assistance for families? Do families on TANF receive information about the availability of child care assistance and their eligibility for child care assistance?

CLIENT PROFILE

4. What is the general profile of families who seek child care assistance?
   - Are there more families connected to the welfare system than not?
   - Are there more families with younger children, or is there a broad range of children's ages?
   - Are the families that receive child care assistance and are not on welfare generally those at the lower end of the eligible income range, or do you see a range of income levels under the eligibility requirement?
5. How long do families typically receive child care assistance?
6. What are the most common reasons that families leave the child care assistance program?
   - Increases in income?
   - Job loss?
   - Failure to meet recertification requirements?
   - Other administrative problems?

PROGRAM GOALS AND IMPLEMENTATION

7. What are the major goals or priorities of your child care program in serving low-income families?
8. What is your assessment of the emphasis placed on child care assistance as a work support versus an opportunity for child development?

9. Are families with infants and toddlers, in particular those on TANF, generally able to find child care?

10. What types of child care arrangements do families typically use for their infants and toddlers? What is the type of care used more frequently? Least often?

11. How easy would you say it is for families to receive child care assistance:

    - Thinking first in terms of accessibility, do families "get lost" in the referral process, or do most families find it relatively easy to get to the office and make an application for assistance?
    - What is your opinion of how available subsidies are to families seeking assistance? Are there waiting lists? If so, can you estimate the percentage of families who seek assistance that receive assistance?

12. Can you describe the redetermination process? How often do families have to recertify? Do families lose their subsidy for failure to recertify?

13. What are the priorities that determine which families receive child care assistance when there are waiting lists?

    - Is there a waiting list now?
    - Can you estimate how many families are on it?

14. What is your policy on paying for informal or unregulated child care?

    - Is informal care promoted as an option, especially for infants and toddlers?
    - Are there other options for families with infants and toddlers who seek child care assistance?

SUPPLY

15. How would you characterize the availability of infant-toddler child care in your community? Does it vary by age of child or type of care?

16. Is there an adequate supply of infant-toddler care available in low-income neighborhoods?

17. Is there an adequate supply of infant-toddler care during nonstandard hours, particularly in low-income neighborhoods? For infants and toddlers with special needs?

    - Do regulated providers maintain waiting lists for infants and toddlers? What would you say is the typical length of time families spend on waiting lists before obtaining an infant-toddler slot?
    - How would you say the supply of infant-toddler care in low-income neighborhoods compares with the supply in higher-income areas?

QUALITY

18. What is your opinion of the quality of infant-toddler child care available? Does it differ by type of care (center-based or family child care home)? Does it differ by age of child?

19. How are providers monitored to ensure adherence to state standards and licensing requirements?

    - Do you feel this system works well in promoting quality in child care in your area? Do you feel that providers generally do a good job in adhering to state standards and licensing requirements?

    - Does the state provide grantees with technical assistance or other support? What kinds of technical assistance are provided? Who is involved?

20. What are the requirements for informal care in order to provide child care for families who receive state subsidies?

    - Are there any limits placed on the use of informal care by families?
    - What are the health and safety requirements?
    - In your opinion, what is the quality of this informal care?

21. Do you contract with the local child care resource and referral agency to provide parent education and help in selecting child care arrangements for families who receive child care assistance? For other activities to increase the placement of infants and toddlers in high-quality settings?

22. What other initiatives, by your agency or others, are in place to improve the quality of child care for low-income families with infants and toddlers?

COSTS AND SUBSIDIES FOR INFANT-TODDLER CARE

23. How would you characterize the affordability of infant-toddler care in centers and family child care homes in your area? Is it reasonable for most families, or out of reach for many low-income families?

24. What are your provider reimbursement rates?

25. To what extent do provider reimbursement rates for infant-toddler child care match the market cost of care? Is the level of child care assistance provided to families with infants and toddlers sufficient to make the care affordable and to provide choices in care arrangements for these families?

26. What is the market cost of infant-toddler care in your area?

27. Outside of the subsidy system, are there community initiatives underway to address the affordability of infant-toddler care for low-income families, such as foundation initiatives, or employer-subsidized centers?

CHALLENGES

28. Currently, what are the most challenging problems you face in delivering child care assistance to low-income families with infants and toddlers?

    - Adequacy of funding to meet families' needs?
    - Supply of infant-toddler providers who accept subsidies?
    - Affordability of care with the level of reimbursement rates?
    - Ensuring that children are in quality arrangements?
    - Ensuring consistency of assistance with changes in welfare and income status?

[CASE STUDY INITIATIVE]

29. Do you coordinate the child care subsidy program with the [case study initiative]? How and why? Has coordination been smooth? Challenging?

30. What do you think are the main successes of the [case study initiative]?

31. Do you think the initiative has improved the quality of care for infants and toddlers? In what ways?

32. Has the initiative increased the supply of infant-toddler care? Improved low-income families' access to care? How?

33. In your opinion, what have been the greatest challenges of the [case study initiative]?

WRAP-UP

34. Is there a significant child care policy or program in your community related to infant-toddler care that we have not discussed?

35. Is there anything else I should know about the [case study initiative]?

LOCAL WELFARE ADMINISTRATOR
INTERVIEW GUIDE

BACKGROUND

1. What are the general characteristics—such as age, number of children, education levels, and ethnicity—of the clients you serve? Can you estimate the proportion of families with infants and toddlers?

2. What types of job opportunities are available specifically for low-skilled workers? Who are the main employers?

3. How would you describe the availability of child care for low-income families with infants and toddlers? The availability of other services for families with young children?

4. What are the key challenges facing low-income families with infants and toddlers in your community?

VISION AND GOALS

5. Could you briefly describe the underlying philosophy and major goals of your community's welfare program?

6. As an office, do you have specific performance goals you are trying to meet?

   - If yes, what are they?
   - Who established the goals?
   - Do you think the goals are the right ones?
   - Are there other performance standards on which you would like to see your performance assessed?

7. How much discretion do you have in deciding how to implement your welfare program in your locality?

ORGANIZATIONAL STRUCTURE

8. Can you briefly describe the structure of your office?

9. What are the responsibilities of caseworkers?

   - Do they deal solely with TANF clients?
   - What is the approximate caseload of a case worker?

10. Can you describe how child care fits within the office structure? Is child care handled by specialized child care workers or by eligibility or employment services workers?

TANF POLICIES

Work Requirements and Exemptions

11. Can you give me a general description of the approach you are using to move welfare recipients into the labor market? What is the balance between education and training and immediate job placement?

12. Are parents of infants and toddlers exempted from work requirements?

    - If so, until the child reaches what age?
    - When the exemption period ends, how are these families engaged in work activities?
    - How is the process you just described for moving families into work different for parents of infants and toddlers?
    - Do caseworkers have discretion over the exemption of work requirements for parents of infants and toddlers? Can they grant a longer period than the time specified?

13. Has your office experienced challenges in requiring parents of infants and toddlers to meet work requirements? Do you feel that these challenges are any greater than challenges with other reforms you have implemented?

14. Do you have a general sense of how families with infants and toddlers have responded to the work requirements?

15. Overall for parents required to work or attend school, have any exemptions from work requirements been granted due to the inability to arrange child care? If so, do you have a sense of whether these exemptions are granted more often to parents of infants and toddlers compared to parents of older children?

Sanctions and Time Limits

16. What kinds of actions, or non-actions, typically trigger a sanction (for example, missing an orientation session, missing appointments, not keeping up with job search, other)?

17. Is there flexibility as to how many infractions may occur before a sanction is applied?

    - Are they applied on the first, second, or later occurrence?
    - How much discretion do caseworkers have in imposing sanctions?

18. What is your sense of how often sanctions are applied? Could you provide an estimate of the typical number of cases that enter into a sanction in a given month?

19. Are sanctions applied any differently to parents with infants and toddlers? Are there specific policies concerning school/training requirements for teen parents?

20. Can you describe your policy on time limits? Could you describe the implementation of this time limit policy, such as whether any exemptions apply specifically to parents with infants and toddlers?

21. How important are sanctions and time limits to your overall approach to moving recipients toward self-sufficiency?

22. Do you foresee any welfare policy changes in the near future that would specifically affect parents—either teen or non-teen—with infants and toddlers?

FUNDING

23. Has the state adequately supported your locality in implementing welfare reform?

24. In what areas is funding the most adequate, relative to the need for services? In what areas is funding least adequate?

STRATEGIES AND INITIATIVES FOR PARENTS WITH INFANTS AND TODDLERS

25. Can you describe any community initiatives or programs that offer specialized services to TANF recipients with infants and toddlers, such as specialized child care programs, infant-toddler development or intervention programs, or parenting classes?

26. Do you coordinate the TANF program with the [case study initiative]? If so, how and why?

27. Do you think the [case study initiative] has benefited TANF families participating in it? For example, has it improved the quality of infant-toddler care or increased supply?

28. Have there been challenges for state or local TANF officials in coordinating with the [case study initiative]?

WRAP-UP

29. What is your overall opinion about the success of the welfare program in helping recipients find employment and become self-sufficient? For parents with infants and toddlers?

30. Is there a significant policy or program in your community that affects TANF recipients with infants and toddlers that we have not discussed?

31. Is there anything else I should know about the [case study initiative]?

PARENTS
GROUP DISCUSSION GUIDE

INTRODUCTION

1. Introduce site visitors.
2. Describe purpose of discussion: talk about availability, affordability, and quality of child care for infants and toddlers and parents' experiences with child care.
3. Discuss the mechanics of taping.
4. Discuss confidentiality.
5. Ask participants to introduce themselves by giving their first name and telling about their children (first names and ages).

COMMUNITY CHILD CARE

1. How hard is it to find child care for infants and toddlers in this community?
2. What kinds of care are available (centers, licensed family child care homes, informal providers such as relatives, friends, and neighbors)?
3. Are there waiting lists for child care centers or family child care homes? How long are the lists?
4. Do any of you work on evenings or weekends? Where do you find child care during those hours?
5. In your opinion, what is the quality of child care available in the community? Why do you think the quality is good/poor?
6. Is child care for infants and toddlers in this community affordable? How much does it cost?
7. Are funds or subsidies available to help low-income families pay for child care?
   - How hard is it to get these subsidies? Do you know how long it takes?
   - Do you know what the requirements are to keep the subsidies? What kinds of information do families have to report to [subsidy administrator]?

CHILD CARE EXPERIENCES

8. What kind of child care arrangements do you use? How many use a child care center, a family child care home, or a relative or friend to provide child care?

9. Are your children in child care full-time or part-time?

10. How long have you used the same child care arrangement?

11. If you have ever changed child care arrangements, why did you decide to make the change?

12. Do any of you use more than one regular child care provider? If so, why? How many hours per week do you use the second child care provider?

13. How did you find your current child care provider? Did [case study initiative] help you?

14. Why did you pick this child care provider? What was it that you liked about this arrangement?

15. Did you have any other choices? How many other arrangements did you consider?

16. What do you like about your current child care arrangement? What do you think your child likes about it?

17. Is there anything you would change about it if you could? If yes, what would you change?

18. If you were not in [case study initiative], what kind of child care arrangement do you think you would be using now?

CHILD CARE QUALITY

19. What is most important to you about the way your child is cared for?

20. How well does your current child care provider meet these expectations?

21. Overall, how would you rate your satisfaction with your child care provider? (very satisfied, satisfied, somewhat satisfied, or not satisfied at all)

22. Can you describe your relationship with your child care provider?

    - Does she tell you about what happens during the day?
    - Can you talk to her about concerns you have about your child?
    - What happens during drop off and pick up?
    - Do you ever have meetings with your provider to talk about your child's development?

23. Can you describe your ideal child care provider?

WRAP-UP

24. Is there anything else about child care that you would like to share before we close the discussion?

CHILD CARE RESOURCE AND REFERRAL AGENCY INTERVIEW GUIDE

BACKGROUND ON ORGANIZATION

1. What is the major objective or primary mission of the resource and referral agency?
2. How long have you provided services in [case study community]?
3. What is the size of your organization?
   - How many staff do you have?
   - What is your annual operating budget?
   - What are your major funding sources?
4. Are you part of a statewide or national (NACCRA) organization for child care resource and referral agencies?
   - How long have you been part of this organization?
   - Can you describe how you coordinate your activities with this organization?
5. What are the characteristics of the families you serve in this community? (income levels, ethnicity, education levels, employment status)
6. Do you have a contract with the Department of Social Services to provide services to TANF recipients or other low-income families?
   - What services do you provide?
   - Do you administer subsidies or determine eligibility for subsidies?

COMMUNITY NEEDS FOR INFANT-TODDLER CARE

7. What are the major barriers that low-income families with infants and toddlers face in arranging child care?
8. What type of child care arrangements do low-income families with infants and toddlers typically use?
   - Which types of arrangements are used least often?
   - How common is the use of informal or unregulated care?
9. Do you have a sense of how many hours infants and toddlers from low-income families typically spend in child care on average per week?

10. Are parents with infants and toddlers generally satisfied with their child care arrangements? Are they satisfied with the level of quality?

QUALITY AND SUPPLY OF INFANT-TODDLER CARE

11. In general, how would you characterize the quality of infant-toddler child care available in the community?

    - For low-income families?
    - What are the major factors that influence the quality of infant-toddler care? (reimbursement levels, licensing requirements, staff training and education)

12. Is the supply of infant-toddler care in the community sufficient to meet families' needs? Does it vary by age of child or type of care? By families' income status?

13. Is there an adequate supply of infant-toddler care during nonstandard work hours and flexible care for shift-work or changing schedules, particularly in low-income neighborhoods?

14. In your experience, what factors influence low-income families' choice between using different types of care for their infants and toddlers?

    - Parents' preferences for specific types of care?
    - If yes, which factors are the most important to parents? (trust, location or convenience, affordability, quality of care, other?)
    - Supply of certain types of care?
    - Cost of care?

15. Do you encounter many families who find it difficult to find infant-toddler child care?

COSTS AND SUBSIDIES

16. How would you characterize the affordability of infant-toddler care in centers and family child care homes in your area? Is it reasonable for most families or out of reach for many low-income families?

17. What are the provider reimbursement rates in this community?

18. To what extent do provider reimbursement rates for infant-toddler child care match the market cost of care? Is the level of child care assistance provided to families with infants and toddlers sufficient to make the care affordable and to provide choices in care arrangements for these families?

19. What is the market cost of infant-toddler care in your area?

20. How easy would you say it is for families to receive child care assistance:

    - Thinking first in terms of accessibility, do families "get lost" in the referral process, or do most families find it relatively easy to get to the office and make an application for assistance?
    - What is your opinion of how available subsidies are to families seeking assistance? Are there waiting lists? If so, can you estimate the percentage of families who seek assistance that receive assistance?
    - Can you describe the redetermination process? How often do families have to recertify? Do families lose their subsidy for failure to recertify?

21. Outside of the subsidy system, are there community initiatives underway to address the affordability of infant-toddler care for low-income families?

RESOURCE AND REFERRAL SERVICES

22. Are there basic resource and referral services you provide to any family in the community who requests assistance? Please describe.

23. Do you provide specialized services to families on TANF, families receiving child care subsidies, or other low-income families? How are these families referred to you?

24. What efforts do you have in place to help parents identify and select good-quality providers?

    - Do you have written materials that explain indicators of quality? How are these disseminated, especially to low-income families?
    - Do you conduct classes or workshops on choosing child care? How do families hear about these workshops?
    - Do you have a public campaign to raise the general awareness about the importance of quality in child care?

25. Do you have any special efforts in place to help families with infants and toddlers locate or select child care arrangements?

26. Do you make referrals to specialized services offered by infant-toddler programs, such as Early Head Start, Part C, or other home visiting or parenting programs?

27. What are the major indicators of quality that you stress for parents with infants and toddlers when they choose a provider?

    - Do you recommend any type of arrangement over another (centers, family child care homes, relative care)?
    - Do you have a list of accredited or preferred providers that you recommend to families with infants and toddlers?
    - Do you take any steps to prevent parents from choosing poor-quality care, such as removing certain providers from your list?

[QUALITY INITIATIVE]

28. What are the major goals of [quality initiative]?

29. How long have you operated the initiative?

30. How is it funded?

31. Can you describe the services you offer to providers through the [quality initiative]?

    - Training
    - On-site technical assistance
    - Quality assessment
    - Toys and equipment
    - Curricula and other resources
    - Other services

32. How many providers are you currently working with [in the case study community]?

33. Can you describe any supply-building activities undertaken through the initiative?

34. What are the major successes of the initiative?

    - Do you think the initiative has improved quality? In what ways? Have you been able to document these improvements?
    - Do you think the initiative has increased the supply of infant-toddler care? How?
    - What are the benefits to providers?

35. What has been challenging about implementing the initiative?

PROFESSIONAL DEVELOPMENT INITIATIVES

36. We understand that your agency operates professional development initiatives for child care providers, including [scholarships, wage supplements, accreditation assistance, and training]. Are there others?

37. For each initiative, ask the following:

    - How long have you operated this initiative?
    - How is it funded?
    - Can you describe the main services provided through the initiative?
    - How many providers have participated?
    - What proportion of providers who receive services through this initiative provide infant-toddler care?
    - What have been the initiative's main successes so far, and what challenges have you encountered?

[CASE STUDY INITIATIVE]

38. Do you coordinate [quality, professional development or other initiatives] with the [case study initiative]? How and why? Has coordination been smooth? Challenging?

39. In your opinion, how have your programs benefited [the case study initiative]?

40. What do you think are the main successes of [the case study initiative]?

41. Do you think the initiative has improved quality of care for infants and toddlers? In what ways?

42. Has the initiative increased the supply of infant-toddler care? Improved low-income families' access to care? How?

43. In your opinion, what have been the greatest challenges of [the case study initiative]?

WRAP UP

44. Are there other infant-toddler child care initiatives operating in [the case study community] that we have not discussed?

45. Are there coordinating groups of community agencies that serve infant-toddlers that address infant-toddler child care issues? Groups of providers?

CHILD CARE TEACHERS/FAMILY CHILD CARE PROVIDER GROUP DISCUSSION GUIDE/INTERVIEW GUIDE

YOUR JOB AS A CHILD CARE TEACHER

1. FOR CENTER TEACHERS ONLY: Do you have children who are assigned to you, so that all children have primary caregivers?
   - How many children are "yours" for care each day?
   - In your opinion, how well does this system of assigning teachers work?
   - How long will you keep a child with you?
2. Can you describe a typical day?
   - How do you plan your activities and schedule?
   - How much planning time do you have each week?
3. Do you use a child development curriculum? If yes, which one? How do you implement it? Can you give me some examples?
4. Do you individualize any activities to meet the specific needs of each child?
5. Can you describe your interaction with parents?
   - Do you share information on a regular basis?
   - If yes, how often and what kind of information?
   - Do you have regular meetings with parents?

TRAINING AND TECHNICAL ASSISTANCE

6. Can you describe the training you have received in the past year?
   - Did you receive this training from [the case study initiative] or from another source?
   - Did you participate in CDA classes? If yes, do you have a CDA credential? If not, when do you expect to receive it?
   - Which training has been most helpful for your work with the children? Why?
   - Are there other topics on which you would like to receive training but have not?
7. Have you received other help from [case study initiative]? If yes, can you describe?
   - Visits from a program liaison?

- On-site training and consultation?
- Materials and equipment?
- Individual staff development plan?

8. Have you received guidance on implementing quality or performance standards?
   - If yes, what kinds of guidance did you receive? Training, written materials?
   - Which standards do you think are hardest to follow? Which are the easiest?
9. Do you think [case study initiative] has helped you do your job better? Improved the quality of care you provide? Why or why not?
10. What is challenging about working with [the case study initiative]?

EXPERIENCES WORKING IN CHILD CARE

11. How long have you been in this job?
12. Is working with children your chosen career? Do you see yourself continuing to work in child care in the future? If not, what are your career goals?
13. What is most challenging about your job? What do you like the least?
14. What do you like most about your job? What is most rewarding about working with young children?

WRAP-UP

15. Is there anything else about working in child care that you would like to share before we close the discussion?

PART C PROVIDER
INTERVIEW GUIDE

AVAILABILITY OF SERVICES IN THE COMMUNITY

1. How plentiful are services for infants and toddlers with disabilities in your community? What kinds of services are available?
2. What are the child care options for families with infants and toddlers with disabilities?
3. How are infants and toddlers with disabilities usually identified and referred to Part C in the community? Pediatricians? Child care providers? Others?
4. What kinds of community outreach do you do to promote identification and referral of infants and toddlers with disabilities to Part C?
5. How likely is it that the infants and toddlers you serve through [case study initiative] would be identified if they were not enrolled in the program?
   - What kinds of services would they likely receive?
   - Would the families be able to find child care?

OVERVIEW OF PART C SERVICES

6. Can you describe the families and children you work with who are referred to you by [case study initiative]?
7. What are the most common types of disabilities that children in [case study initiative] have? How severe are they?
8. Can you describe the services you provide to families and children referred to you by [case study initiative]?
   - Service planning?
   - Parent education?
   - Direct services to children?
9. Where do you usually provide services to families and children?
   - In their homes?
   - In child care? What kinds of services are provided on-site in child care?
   - At the Early Head Start program?
   - Other locations?

10. How long does it usually take to assess children once they are referred by [case study initiative]? If they are determined eligible for Part C services, how long typically does it take for services to begin?

WORKING WITH [CASE STUDY INITIATIVE]

11. Can you describe the process by which [case study initiative] refers children to Part C for assessment?

12. How do you coordinate the assessment and eligibility determination process with [case study initiative]?

13. Once children are determined to be eligible, do you coordinate with [case study initiative] on developing service plans?

    - Do you ever develop joint plans?
    - Which staff do you work with?
    - Are child care providers involved in service planning?
    - How do you involve parents?

14. Do you coordinate ongoing service delivery with [case study initiative]? Do you divide lead responsibility for providing specific services across participating agencies? How does this work?

15. Do you coordinate service delivery with child care providers? If yes, how?

16. How receptive have child care providers been to serving children with disabilities?

    - What kinds of accommodations do they typically have to make?
    - How receptive are child care teachers?
    - Have teachers needed special training to serve children with disabilities? If yes, who provides the training?
    - How receptive are child care partners to allowing Part C to provide on-site services to children?

SUCCESSES AND CHALLENGES

17. In your opinion, what are the benefits to families and children with disabilities of receiving child care through [case study initiative]?

18. In your opinion, what are the [case study initiative's] key successes, thinking particularly about children with disabilities?

19. Do you think the initiative has improved child care quality?

    - For children with disabilities in particular?

- In what ways?
- Have you been able to document these improvements?

20. What are the benefits of [case study initiative] for child care providers?

21. What has been challenging about providing Part C services to children in child care settings?

22. What is challenging about coordinating the services you provide with [case study initiative] and child care providers?

23. In your opinion, what has been most challenging for child care providers about serving children with disabilities? Why?

24. If you could, is there anything you would change about [case study initiative] or the services provided to children with disabilities?

25. Are there other important lessons you have learned about coordinating early intervention services with [case study initiative] and child care providers that we have not discussed?

COMMUNITY COLLEGE STAFF/STAFF DEVELOPMENT COORDINATOR INTERVIEW GUIDE

BACKGROUND ON CDA PROGRAM

1. How long has the [community college/agency] been providing CDA classes?
2. In addition to child care providers participating in [case study initiative], who typically takes these classes?
3. Are there any entrance requirements for participants?
4. How much college credit do CDA students receive?
5. How often are the courses offered?
6. Do you offer CDA courses during evening and weekend hours?

OVERVIEW OF CDA CLASSES

7. Can you give me an overview of the content of the CDA training curriculum? What are the main topics you cover?
8. Do students have to develop portfolios as part of the class? Complete other assignments?
9. Can you describe the requirements that students must meet to obtain the CDA credential?
10. Do you help students with the credential application process?
11. How long does it take a typical student to complete the coursework, apply for the credential, and obtain the credential? Can most students complete this process in one year?
12. What kinds of support do you provide to students?
    - Tutors or mentors?
    - Help with language for non-native English speakers?
    - On-site visits to providers' homes or classrooms?
    - Other kinds of support?
13. How do you coordinate with [case study initiative]?
    - Do you coordinate enrollment of students?
    - Curriculum?

- Instruction?
- Other?

SUCCESSES AND CHALLENGES

14. What do you think providers like most about the CDA training program? What do they dislike? Which portions of the training are most difficult for them?

15. Do you think [case study initiative], and the CDA classes in particular, have improved child care quality? In what ways? Have you been able to document these improvements?

16. What are the benefits of [case study initiative] for child care providers? Have any of the students continued working toward an A.A. degree after completing the CDA course? If so, approximately how many?

17. What has been challenging about providing CDA training to [case study initiative] participants?

18. In your opinion, what has been most challenging for child care providers about improving the quality of care they offer? Why?

19. If you could, is there anything you would change in the CDA training program?

20. Are there other important lessons you have learned about providing CDA training to [case study initiative] participants that we have not discussed?

EARLY HEAD START PROGRAM DIRECTOR
INTERVIEW GUIDE

BACKGROUND OF ORGANIZATION

1. How long has your organization provided services in [case study community], and what is its history?
2. What is your organization's primary mission?
3. What is the size of your organization?
   - How many staff do you have?
   - What is your annual operating budget?
   - What are your major funding sources?
   - How many families do you serve annually?
4. What are the main services you provide?
5. What is the geographic service area that your organization covers?
6. What are the main characteristics of the families you serve?
   - income levels and TANF receipt
   - ethnicity and proportion of non-English speakers
   - employment status and types of jobs
   - age of children

COMMUNITY NEEDS FOR INFANT-TODDLER CARE

7. What are the main barriers that low-income families with infants and toddlers face in arranging child care?
8. What type of child care arrangements do low-income families with infants and toddlers typically use?
   - Which types of arrangements are used least often?
   - How common is the use of informal or unregulated care?
9. Do you have a sense of how many hours, on average, infants and toddlers from low-income families typically spend in child care per week?

QUALITY AND SUPPLY OF INFANT-TODDLER CARE

10. In general, how would you characterize the quality of infant-toddler child care available in the community?

    - For low-income families?
    - What are the major factors that influence the quality of infant-toddler care (reimbursement levels, licensing requirements, staff training and education)?

11. How would you characterize the supply of infant-toddler care in the community? Does it vary by age of child or type of care? By families' income status?

12. Is there an adequate supply of infant-toddler care during nonstandard work hours and flexible care for shift-work or changing schedules, particularly in low-income neighborhoods?

COSTS AND SUBSIDIES

13. How would you characterize the affordability of infant-toddler care in centers and family child care homes in your area? Is it reasonable for most families, or out of reach for many low-income families?

14. To what extent do provider reimbursement rates for infant-toddler child care match the market cost of care? Is the level of child care assistance provided to families with infants and toddlers sufficient to make the care affordable and to provide choices in care arrangements for these families?

15. How easy would you say it is for families to receive child care assistance:

    - Thinking first in terms of accessibility, do families "get lost" in the referral process, or do most families find it relatively easy to get to the office and make an application for assistance?
    - What is your opinion of how available subsidies are to families seeking assistance? Are there waiting lists? If so, can you estimate the percentage of families seeking assistance who receive assistance?
    - Can you describe the redetermination process? How often do families have to recertify? Do families lose their subsidy for failure to recertify?

16. Outside of the subsidy system, are there community initiatives underway to address the affordability of infant-toddler care for low-income families?

EARLY HEAD START PROGRAM

17. Can you describe the basic structure of your Early Head Start program?
    - Do you serve families through a center-based option, home-based option, or combination option?
    - If more than one option, what factors determine which option families enroll in?
    - What services are provided to families?
18. When did you receive initial funding for the program? When did you begin enrolling families?
19. How many families are enrolled annually? Have many families have been served through the program since its inception?
20. What is your annual budget for the program?
    - Is this level of funding sufficient for meeting the performance standards?
    - Do you receive additional funding from other sources to operate the program? Head Start Bureau? Foundations? Other sources?
21. How is the program staffed?
    - Can you describe the major tasks of each position?
    - What are the qualifications of program staff?
    - In your opinion, what are the most important qualifications for staff who serve as liaisons with child care partners?
22. How did you develop the program's design? Did you consult with child care partners or other community organizations during the program's design phase?

COORDINATION WITH THE STATE, REGIONAL OFFICE, AND OTHER ORGANIZATIONS

23. Who is your main contact at the state level?
    - How do you communicate?
    - How often?
    - What kinds of issues do you discuss?
24. Does the state convene regular meetings with grantees?
    - What kinds of issues do you discuss during these meetings?

- Do you find the meetings helpful? In what way?

25. Does the state provide grantees with training and technical assistance? What types?

26. Do you communicate regularly with the regional office?

    - Which staff? QUIC?
    - How often?
    - What kinds of issues do you discuss?

27. Does the regional office provide grantees with training and technical assistance? What types?

28. Can you describe your collaboration with other community organizations that support your program? CCR&R? Community college? Community collaborative groups?

29. How has your program benefited from collaboration with these organizations?

CHILD CARE PARTNERSHIPS

30. How are child care providers selected to participate in the program? Do they have to meet specific criteria?

31. Can you provide an overview of how your program monitors and supports the quality of care provided through partnerships?

32. What lessons have you learned about forming partnerships with child care providers?

    - Are there provider specific provider characteristics that are important for forming successful partnerships?
    - Are there specific types of providers with whom you do not partner? Why?

33. Can you describe the ideal child care partner?

SUCCESSES AND CHALLENGES

34. In your opinion, what are the program's key successes?

35. Do you think the program has improved child care quality? In what ways? Have you been able to document these improvements?

36. Do you think the program has increased the supply of infant-toddler care? Improved low-income families' access to infant-toddler care? How?

37. Are there other benefits of the program for children and families?

38. What are the benefits for child care providers?

39. What has been challenging about implementing the program?

40. What has been challenging for child care providers about improving the quality of care they offer? Which performance standards have been the most challenging to meet? Why?

41. In your opinion, what is the program's future? Is there support in the state for continuing the program?

CHILD CARE COORDINATOR
INTERVIEW GUIDE

BACKGROUND

1. Can you describe your primary duties as child care coordinator?
2. Do you supervise other staff? Which ones?

CHILD CARE PARTNERS

3. How many child care partnerships do you currently have?
4. What are the characteristics of your partners?
   - Do you partner with centers, family child care homes, informal providers?
   - Do any of your partners provide care during nonstandard work hours?
   - Do any of your partners provide care for children with special needs?
   - In general, how much experience do your partners have in the child care field?
   - Are your partners able to meet family's needs for types, hours, and location of care?
5. How much turnover have you had in partnerships?
6. How long do partnerships typically last?

PARTNER RECRUITMENT AND SELECTION

7. How do you recruit partners?
8. Do you solicit recommendations from the CCR&R? From other community organizations?
9. Do you hold orientation meetings for potential partners?
10. How do you "sell" the benefits of partnership to providers? Which aspects of the partnerships are most attractive to providers? Least attractive?
11. What has been the response to your recruitment efforts? Are providers eager or reluctant to enter into partnerships? Why?
12. Do you have a waiting list for potential partners?

13. What are your selection criteria for partners? Are there minimum standards partners must meet?

14. In your experience, which criteria are most important? Can you describe the characteristics of an ideal partner?

15. Do you assess the quality of care partners provide before making a decision to partner? What tools do you use?

16. How is the final decision to enter a partnership made? Who is involved?

17. What lessons have you learned about recruiting and selecting partners?

PARTNERSHIP AGREEMENTS

18. What are the basic elements of your agreements with child care partners?

    - How much do you pay partners per child? Is this rate higher than the state child care subsidy?
    - Do you provide incentives for meeting specific quality standards, such as higher rates, salary enhancements, bonuses, or other incentives?
    - Do you provide equipment, toys, or other materials?
    - Do you pay for renovations?
    - Do you pay for CDA training? Compensate teachers for training time?
    - What standards do you require providers to meet in the agreements?
    - How soon after forming a partnership do you expect providers to comply with these standards?
    - Are there services other than child care, such as home visits or parent-teacher conferences, that providers must agree to provide?

19. In your opinion, does your program provide sufficient resources to providers to enable them to comply with the terms of the agreements?

20. What lessons have you learned about developing partnership agreements?

21. Based on your experiences with forming partnerships, are there aspects of your partnerships agreements that you would change?

TRAINING AND TECHNICAL ASSISTANCE

22. Can you describe the training and technical assistance you provide to child care partners?

23. Which staff provide on-site technical assistance? How often?

24. Do you collaborate with staff from other organizations to provide technical assistance?

25. How do you train providers on implementing quality or performance standards? Do you provide written materials or checklists?

26. Which quality/performance standards can providers meet most readily? Which standards are most difficult for providers? Why?

27. Do you develop individual development plans with child care teachers? What is the content of those plans? How often do you update them?

28. How do you provide CDA training to child care teachers? Do you provide it directly, or in partnership with another organization? If through a partnership, how does this work?

29. How challenging has it been for providers to meet the CDA requirement? Is teacher turnover a factor?

30. Do you provide other types of training?

31. Do you collaborate with other organizations to provide training or other professional development support to providers?

32. What lessons have you learned about providing training and technical assistance to child care providers?

SUCCESSES AND CHALLENGES

33. In your opinion, what are the initiative's key successes?

34. Do you think the initiative has improved child care quality? In what ways? Have you been able to document these improvements?

35. Do you think the initiative has increased the supply of infant-toddler care? Improved low-income families' access to infant-toddler care? How?

36. What are the benefits of the partnerships for child care providers?

37. What has been challenging about implementing the initiative?

38. What has been challenging for child care providers about improving the quality of care they offer? Which quality/performance standards have been the most challenging to meet? Why?

39. Are there other important lessons you have learned from its experiences working in [case study initiative] we have not discussed?

CHILD CARE SPECIALISTS/PARTNER ADVOCATE LIAISONS/CHILD CARE NETWORK COORDINATOR DISCUSSION GUIDE

PRIMARY RESPONSIBILITIES

1. Can you describe your primary duties as [child care specialist, partner advocate liaison, network coordinator]?
2. How many providers do you work with?
3. Do you work with families? If yes, how many families are in your caseload, and what services do you provide?
   - Do you participate in parent-teacher conferences? How often?
   - Do you do home visits? How often?
   - Do you participate in developmental assessments? How often are these done?
4. Do you participate in provider recruitment and selection? If yes, what role do you play?
5. Do you work with providers to develop partnership agreements? If yes, what role do you play?
6. Can you describe the training and technical assistance you provide to child care providers?

WORKING WITH CHILD CARE PROVIDERS

7. How often do you visit child care providers?
8. What do you do during a typical visit?
   - Do you observe in classrooms and family child care homes? Conduct quality assessments?
   - Provide formal training sessions?
   - Coach child care teachers in the classroom or family child care home?
   - Discuss the needs of particular children with teachers, center directors, or family child care providers?
   - Meet with individual teachers on professional development issues?
   - How long does a typical visit last?

9. How do you develop relationships with child care providers? How do you establish credibility and trust with them?

10. Do you work with providers on implementing a specific curriculum? If yes, which one do you use? What training do you provide on implementing it?

11. How do you train providers on meeting quality and performance standards?

    - Do you use checklists to monitor compliance?
    - Do you establish goal plans for meeting the standards?
    - Do you provide training on the standards?

12. How do you work with providers to address the needs of children from varied ethnic and cultural backgrounds?

13. Do you work with child care teachers to develop individual staff development plans?

    - What kinds of activities are included in these plans?
    - How are staff development needs identified?
    - How often do you review and update these plans?

14. Do you support child care teachers in obtaining CDAs? What role do you play?

15. What lessons have you learned about working with child care providers?

16. In your opinion, what are the keys to developing successful partnerships?

YOUR EXPERIENCE IN [CASE STUDY INITIATIVE]

17. How long have you been in this position? Did you work for the agency in another position before beginning this one? If so, what was it, and how long did you have that position?

18. What do you like about your job? What is rewarding about working with providers? With families?

19. What aspects of your job are challenging? What is challenging about working with child care providers?

20. Do you have enough time to do your job? Do you work evenings or weekends?

21. What support do you receive from [case study initiative] to help you do your job?

    - How often do you meet with your supervisor?
    - Do you have an opportunity to talk with your colleagues about your experiences working with providers?

22. Have you received training through [case study initiative]?

    - If yes, on what topics?

- Has the training helped you do your job? In what ways?

SUCCESSES AND CHALLENGES

23. In your opinion, what are the initiative's key successes?
24. Do you think the initiative has improved child care quality? In what ways? Have you been able to document these improvements?
25. What are the benefits for child care providers?
26. What has been challenging about implementing the initiative?
27. What has been challenging for child care providers about improving the quality of care they offer? Which quality or performance standards have been the most challenging to meet? Why?
28. If you could, is there anything you would change about the initiative?
29. Are there other important lessons you have learned about working with child care providers that we have not discussed?

INFORMAL OBSERVATION OF CHILD CARE SETTING

Facility Tour *(Ask for a tour of all the spaces in which caregiving occurs, both inside and outside. Also ask to see the daily schedule to look for evidence of the items listed below.)*	
Space: Room Arrangement	
1. Adequate space for walking, crawling, and playing	
2. Areas for quiet and active play are separated	
3. Traffic patterns do not interfere with activities	
4. Routine care areas conveniently arranged	
Space: Furnishings	
5. Adequate quantity of furniture for feeding and sleeping	
6. Highchairs or other seats for feeding have a footrest, adequate support, and a safety belt	
7. Child-sized furniture is available for toddlers (tables and chairs)	
8. Comfortable adult furniture is available for caregivers	
9. Children have adequate space to store personal belongings	
10. Open shelves with variety of accessible toys	

11. Cozy areas that provide softness and a quiet place for quiet time	
Space: Display for Children	
12. Colorful pictures and photographs displayed at children's level	
13. Mobiles and other hanging objects displayed	
14. Children's artwork displayed	
Safety and Hygiene	
15. Diapering area disinfected after each use	
16. Hand-washing after diapering and before meals (caregivers and children)	
17. Care given to children's appearance (face, hands, and clothes are clean)	
18. No indoor or outdoor equipment higher than the children	
19. All electrical outlets covered	
20. Outside play area fenced	
Materials	
21. Adequate books and pictures available	
22. Equipment for active play (outdoor play area used daily except in very bad weather)	

23. Adequate number and variety of toys for eye-hand coordination (toys rotated to provide variety)	
24. Art materials available daily for toddlers	
25. Musical instruments available, musical activities done daily	
26. Variety of blocks accessible	
27. Variety of toys for pretend play (dress up clothes, pots and pans, dolls, puppets, etc.)	
Schedule: Greeting and Departing	
28. Child and parent greeted warmly	
29. Greeting and departure used for information-sharing with parents	
30. Separation problems handled sensitively	
31. Written record of child's activities available to parents	
Schedule: Meals and Snacks	
32. Children fed separately or in small groups	
33. Infants held while bottle fed	
34. Children encouraged to feed themselves	

35. Caregiver sits and talks with children during meal times	
Schedule: Naps	
36. Each child has own crib or bed	
37. Naps are personalized by familiar practices, special blankets, or soft toys	
38. Toddlers eased into group schedules (can begin nap early if tired)	
39. Children helped to wind down (back rubbed, soft music, etc.)	
Observation of One Room *(Observe an infant/toddler room of the program's choice for at least 20 minutes. Count the number of caregivers and children in the room during the observation.)*	
Child-Teacher Interaction	
40. Children are assigned primary caregivers	
41. Positive interaction; caregiver responsive to child	
42. Frequent holding, patting, and physical warmth	
43. Caregivers sensitive to children's feelings and reactions; no hardness or yelling	
Language	
44. Caregivers respond verbally to children's crying, gestures, sounds, and words	
45. Caregiver names objects and actions	

46. Caregiver repeats and extends what toddlers say		
Discipline		
47. Program is set up to minimize discipline problems (duplicate toys available, smooth transitions)		
48. Children are redirected and removed from negative activity		
49. Caregivers react consistently to behavior		
50. Caregivers reinforce positive behavior		
51. Rules are simple and explained to toddlers		
52. No time out for child younger than 2		
Peer Interaction		
53. Interaction usually positive (watching, side-by-side play, smiling)		
54. Caregiver models and reinforces positive interaction		
55. Relaxed atmosphere; more smiles than crying		
Child-Teacher Count		Number of Children:

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