



# BETTER FOR BABIES

A STUDY OF STATE INFANT AND TODDLER  
CHILD CARE POLICIES

AUGUST 2013



CHARTING PROGRESS FOR  
BABIES IN CHILD CARE



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CLASP's *Charting Progress for Babies in Child Care Project* links research to policy ideas and examples that support the healthy growth and development of infants and toddlers in child care settings. The project provides resources to help states make the best decisions for infants and toddlers in child care. The central tenet of the *Charting Progress for Babies in Child Care Project* is that state child care subsidy, licensing, and quality enhancement policies that promote the quality and continuity of early childhood experiences can positively impact the healthy growth and development of babies and toddlers. For more information on *Charting Progress*, visit: <http://www.clasp.org/babiesinchildcare>.

# Introduction



The earliest years of life are a period of incredible growth. Infants need a number of important inputs to properly shape their brains and build a healthy foundation for life, including consistent relationships with caring adults and adequate health and developmental supports. Research is clear that high-quality child care with warm, responsive, and skilled caregivers; healthy and safe environments; and linkages to community supports help promote healthy development for infants and toddlers and create a strong base for the future.<sup>1</sup> Yet, far too many infants and toddlers lack access to child care environments that foster healthy outcomes. When state policies and services that help children grow and thrive are lacking, an incredible prevention opportunity is missed.

State policies can promote the quality and continuity of early childhood experiences and positively impact the healthy growth and development of babies and toddlers in all child care settings. These policies can not only advance basic health and safety, but also increase the likelihood that those who care for infants and toddlers have the tools to: stimulate early learning and development; identify health and developmental issues; and potentially link families to necessary supports. This paper presents data from a recent state survey of child care subsidy, licensing, and quality enhancement policies. It provides a national picture of infant-toddler child care, including information on both center and home-based child care.

The findings are conclusive: while some states have implemented strong infant and toddler child care policies, most fall far short in meeting the needs of the country's young children and their families, and states are struggling to provide quality child care that families can afford. States play a critically important role when they take the lead in planning and funding better policies that promote optimal infant-toddler development and support families.



## *Key Federal Funding Streams for Infants and Toddlers*

**The Child Care and Development Block Grant (CCDBG)** is the primary source of federal funding for child care subsidies for low-income working families and improvements to child care quality. Each state receives a set amount of federal funds and can receive additional funds by spending more state money on child care subsidies and quality initiatives. Annual CCDBG appropriations include an earmark for investments in infant-toddler care. Approximately 29 percent of children receiving CCDBG-funded assistance are infants and toddlers.

**The Temporary Assistance for Needy Families (TANF)** block grant was established in 1996 by the Personal Responsibility and Work Opportunity Reconciliation Act (commonly known as welfare reform). States have broad discretion when using their block grant funds and designing their TANF programs. States may provide child care assistance to families directly through TANF funds. A state may also choose to transfer up to 30 percent of its TANF funds to CCDBG.

**Early Head Start (EHS)** began in 1995 when Congress reauthorized the preschool Head Start program and launched a new program to serve infants, toddlers, and pregnant women. Participants and their families receive comprehensive early care and education services. All programs are required to meet Head Start Program Performance Standards, which include mental and physical health, dental, family, and social services. The Early Head Start program is funded through a set-aside within the Head Start budget. Fewer than 4 percent of eligible infants and toddlers are currently served by EHS.

**The Title V Maternal and Child Health Block Grant to State Programs** is a federal-state partnership designed to strengthen local public health initiatives for young children and their mothers. Title V provides access to medical care in underserved areas and for uninsured and underinsured families. In addition, Title V provides funds for family support services, including respite care for families with children with special needs. States disperse Title V funds according to the results of a needs assessment, which is required every five years.

**Medicaid** is a federal-state partnership primarily providing health insurance to low-income individuals. It is administered by the states, which set eligibility and service guidelines. Medicaid covers one-third of all births in the U.S. Federal Medicaid regulations require that states provide a comprehensive and preventive set of services for children, known as the Early and Periodic Screening and Diagnosis and Treatment benefit (EPSDT), which includes preventive health and developmental screening, vision, dental, hearing, and other health care services.

**The State Children's Health Insurance Program (SCHIP)**, gives states additional federal funds and flexibility to provide health care services to children and pregnant mothers with incomes higher than Medicaid eligibility. States have the option of operating separate SCHIP programs, using SCHIP dollars to expand eligibility for their Medicaid programs, or doing a combination of both. Eligibility and other SCHIP program details are determined by individual states.

**The Individuals with Disabilities Education Act (IDEA) Part C** supports services for infants and toddlers with developmental disabilities and delays. When a child is determined eligible for Part C, the family and the Part C agency develop an Individualized Family Service Plan (IFSP), which outlines the goals for the child and the services available.

**The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**, one of several federal nutrition programs, provides access to nutritious foods, nutrition education, and improved health care for vulnerable mothers and young children with or at risk of malnutrition.

**The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program** has made grants available to states and tribes to deliver voluntary home visitation services to promote a range of positive outcomes for eligible children and families. These outcomes include improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and families' socioeconomic status, along with reductions in child abuse, neglect, and injuries.

## The State of Infants and Toddlers

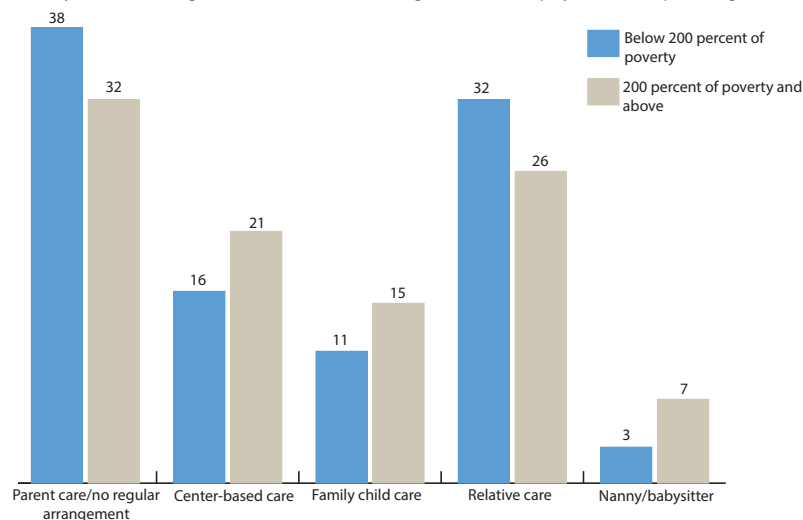
The United States is home to more than 12 million infants and toddlers under age 3.<sup>2</sup> In 2011, over a quarter (26 percent) of these young children lived in poor families, defined as those whose income was less than 100 percent of the federal poverty threshold. Forty-nine percent of children under the age of 3 were living in low-income families (living at or below 200 percent of the federal poverty level).<sup>3</sup> Children under three have the highest poverty rates of any age group in the country, and poverty is a strong predictor of negative child outcomes. Negative experiences related to poverty can be especially detrimental for infants and toddlers, as their brains are developing rapidly during this phase of life and laying the foundation for future growth and development. Children living in poverty are less likely to be successful in school and less likely to be gainfully employed over their lifetimes. And the longer children live in poverty, the worse their adult outcomes are likely to be, including employment and earnings.<sup>4</sup>

The earliest years, from birth-to-age-three, are critical for young children’s healthy development. Experiences during infant and toddler years shape the architecture of the brain—including cognitive, linguistic, social, and emotional capacities—at a phenomenal rate and lay the foundation for future growth and learning.<sup>5</sup> During these formative years, many young children spend significant time being cared for by individuals other than their parents. Forty-two percent of infants and 52 percent of toddlers have at least one weekly non-parental child care arrangement in a center or home-based setting.<sup>6</sup> Children are cared for in a variety of settings, including centers or center-based, family child care homes, with relative care providers, or in their own home (See Figure 1). Fifty-five percent of mothers with children under 3 are in the labor force,<sup>7</sup> and 38 percent of children under the age of 3 who have an employed mother spend more than 35 hours in care each week.<sup>8</sup> Unfortunately, across the country, quality infant-toddler child care is in short supply and unaffordable for many families.<sup>9</sup>

The quality of care is critically important for infants and toddlers. A body of evidence shows the positive impact that high-quality child care programs can have on very young children, in particular low-income and other vulnerable young children.<sup>10</sup>

**Figure 1. Where do Infants and Toddlers Spend Their Time?**

Primary child care arrangements for children birth-to-age-three with employed mothers (percentage)



Note: Percentages may not add to 100% due to rounding.

Source: Jeffrey Capizzano and Gina Adams, *Children in Low-Income Families are Less Likely to be in Center-Based Care*, Urban Institute, 2003.

The Child Care and Development Block Grant (CCDBG) is the primary source of federal funding for child care subsidies to low-income working families and for improving child care quality. Twenty-nine percent of children receiving child care subsidies funded by CCDBG are infants and toddlers.<sup>11</sup> While infants and toddlers are often cared for in home-based settings—including family child care and license-exempt family, friend, and neighbor care—research indicates that infants and toddlers receiving child care assistance are more likely to be in center-based care.<sup>12</sup>

## Methodology

To learn and share how states are meeting the challenge of providing quality infant-toddler care, CLASP launched the *Charting Progress for Babies in Child Care Project*. The foundation of *Charting Progress* is a Policy Framework comprised of four key principles describing what babies and toddlers in child care need:

- Nurturing, responsive providers and caregivers they can trust to care for them as they grow and learn.
- Parents, providers, and caregivers supported by and linked to community resources.
- Families that have access to quality options for their care.
- Healthy and safe environments in which to explore and learn.

Based on the *Charting Progress* framework and corresponding research, CLASP gathered information on key infant-toddler child care policies, including: child care subsidy; child care licensing; child care quality; workforce and professional development; health; family support; and infant-toddler initiatives. Data in this report were collected through a survey sent to state child care administrators in all states and the District of Columbia, as well as from publicly available data sources.<sup>13</sup> State administrators and others were contacted by CLASP staff for follow-up

information. Due to the extensive nature of this study, data were collected throughout 2012; therefore, state policies reported here do not reflect a single point in time. And because state child care policies are subject to change, some states may have changed policies since this information was collected. CLASP has made every attempt to ensure that the information in this report is timely and accurate.

It is important to note that policies widely vary from state to state based on many factors. States define infants and toddlers differently, and make policy decisions based on those definitions. As a result, not all data are directly comparable, especially when reported by age grouping.

While the policies covered in this report are not an exhaustive list of state policy options to improve the quality of infant-toddler care, collectively they offer a baseline of policies important for babies in child care.



Key policies in this report are organized by topics within the four key principles outlined above. Each principle can be supported by additional policies not covered here.<sup>14</sup> The report outlines the research basis for supportive policies, key findings from the state survey and other publicly available data sources, and state policy examples for states looking to improve their policies. Note that links to relevant resources are embedded in the text. Please see the online version of this report.



## Key Findings



Overall, states have displayed good intentions by creating and implementing policies that support infants and toddlers. However, the data gathered show that state policies for licensing, subsidy, and quality enhancement are not yet meeting the needs of infants, toddlers, and their families.

**Infants and toddlers need healthy and safe environments in which to explore and learn.** In the earliest years of life, babies naturally seek out interactions with their environment and those who take care of them so that they can begin to understand their world. If the baby's needs are met, the infant forms a secure attachment to his or her caregiver that creates a foundation for healthy development in early childhood and beyond.<sup>15</sup>

- In most states, child-to-provider ratios and group sizes exceed national expert recommendations. Further, a handful of states do not regulate group size at all. Small group sizes with low child-to-provider ratios are linked to better-quality child care environments and more positive caregiving interactions between providers and children.
- Only six states require specific infant-toddler training for licensing and monitoring staff. Regular monitoring of child care settings can ensure children's safety. When information from monitoring visits is coupled with technical assistance, providers can get help complying with licensing standards. Specific infant-toddler training can improve implementation of health and safety standards particular to babies.

### *Infants and Toddlers and the Child Care and Development Block Grant (CCDBG)*

CCDBG is the primary source of federal funding for child care subsidies for low-income working families and for improving child care quality. CCDBG provides child care assistance to children from birth to age 13. In FY 2011, more than 564,000 infants and toddlers received CCDBG-funded child care assistance in an average month, comprising approximately 29 percent of all children receiving CCDBG.<sup>16</sup>

Just 18 percent of federally eligible children actually receive child care assistance through CCDBG. For infants (children age 0), this number is 15 percent, and for toddlers (children age 1-2), 29 percent of federally-eligible children receive assistance.<sup>17</sup> Families with infants and toddlers who participate in the child care subsidy system utilize center care at higher levels than the national average. Sixty-four percent of infants and 68 percent of toddlers receiving CCDBG are cared for in centers. Twenty-five percent of infants and 22 percent of toddlers receiving CCDBG are cared for in family homes, which include licensed and license-exempt settings.<sup>18</sup>

Federal CCDBG funding includes dedicated funding to improve the quality of care for infants and toddlers. In FY 2012, dedicated infant-toddler funding totaled \$107 million, or approximately 2 percent of federal CCDBG funds. States use the infant-toddler dedicated funding for a range of services, including technical assistance; training or education for infant and toddler child care providers; financial incentives such as scholarships, wage supplements, or higher reimbursement rates; grants for specialized equipment and supplies for programs serving infants and toddlers; support for infant-toddler specialists or health consultants; support for parent and consumer education initiatives; and collaborations with Early Head Start. Four states report they make additional, dedicated funds available specifically for infants and toddlers outside of the CCDBG infant-toddler set-aside.<sup>19</sup>

## **Infants and toddlers need nurturing, responsive relationships with caring adults, including child care providers and caregivers they can trust to care for them as they grow and learn.**

Caring relationships are at the core of quality infant-toddler care. In order for infants and toddlers to benefit from such relationships, providers and caregivers need a set of skills and knowledge that enables them to best support young children.

- Almost all states (45) have early learning standards or developmental guidelines for infants and toddlers and, of the states that do not, many are in the process of approving them. Early learning standards provide information to programs and providers<sup>22</sup> on what children should know and do at different stages of development. These standards play a key role in supporting children's development in early education.
- While more than half of states (30) reported having specific infant-toddler training for providers, most state requirements for number of hours are minimal, and the content of training curricula related to infants and toddlers is limited. Although most states provide targeted technical assistance (TA) to infant-toddler providers, method and content vary tremendously. Twenty-six states reported that they funded a network of infant-toddler specialists to support infant-toddler child care providers and increase their knowledge and skills. Improving the knowledge and skills of infant-toddler caregivers through training or targeted TA is closely related to improving the quality of care for infants and toddlers.<sup>23</sup>
- Twenty-five states reported that they have established core knowledge or core competencies specific to infant-toddler child care providers. Infant-toddler child care providers and caregivers need information and knowledge specific to the age of the children for whom they care, along with the skills and practices to apply this information and knowledge. Less than half of states (22) reported having an infant-toddler credential for the child care workforce. Eighteen states reported that their credential is credit-based. Providers with higher levels of education and credentials in fields related to early childhood education are linked to higher-quality child care environments and caregiver sensitivity.
- Thirty-nine states reported that they provide financial supports for the high costs of training or education of infant-toddler providers. Many of these states provide those supports through Teacher Education And Compensation Helps (T.E.A.C.H.) grants.<sup>24</sup>
- Twenty states have compensation initiatives available for infant-toddler providers to help programs attract and retain qualified staff to work with young children.
- Twenty-one states report licensing standards that require a consistent primary caregiver for infants and toddlers in care. A few additional states encourage continuity of care through other means, including regulations, policies, or waivers. Providers and caregivers who regularly care for very young children can have a positive impact on child development by forming continuous, strong attachments with children.

**Infants' and toddlers' families need to have access to quality options for their care.** For low-income families, child care assistance is essential to affording the high costs of infant and toddler care. State child care subsidy policies can determine whether and how parents with very young children can get and retain assistance and access quality care.

- Only three states (Arkansas, Hawaii, and New York) set their standard subsidy reimbursement rate for a one-year-old in center-based care at the federally recommended rate, which allows providers to better meet the high costs of infant care and allows families access to more child care options.<sup>25</sup>
- Twenty-two states report offering rate differentials or higher payment rates for infant-toddler care. Higher payment rates for infant-toddler care can offset higher costs and support quality enhancements.
- Forty-one states reported that they pay child care providers for days when a child is absent, a policy particularly important since infants and toddlers have more frequent illnesses and require more frequent doctor visits than older children.
- Half the states (25) set their maximum eligibility period for child care assistance at 12 months. The remaining states limit eligibility to shorter periods of time. Longer eligibility periods for subsidies may support continuity of care for infants and toddlers.
- Fourteen states reported using direct contracts with child care providers that can increase the supply or improve the quality of subsidized infant-toddler care.
- Thirty-five states with Quality Rating and Improvement Systems (QRIS) reported that they include quality requirements specific to infant-toddler care in their QRIS standards. Specific infant-toddler standards in QRIS can improve the quality of infant and toddler care and help parents better identify and secure quality care.
- Twenty-one states reported providing monetary and/or non-monetary assistance for family child care networks to provide administrative and quality support and services to meet the needs of child care providers.
- Thirty-three states report that they support (through play-and-learn groups, supports to become licensed, health and safety trainings, etc.) FFN providers who care for infants and toddlers to encourage higher-quality care.

### Infants and toddlers need parents, providers, and care-givers supported by and linked to community resources.

Parents and families require personal and economic resources to provide for their infants' and toddlers' basic needs. Programs and policies that support families (for example by reducing economic hardship, promoting healthy parent-child relationships, or treating parental health conditions) also promote infants' and toddlers' healthy development.

- Mental health consultation for child care providers makes available the training and tools providers need to foster healthy child development and support children with special needs. Thirty-two states offer infant-toddler mental health consultation to child care providers.
- Four states make additional, dedicated funds available specifically for infants and toddlers outside of the CCDBG infant-toddler set-aside.
- Twenty-three states have at least one initiative that builds on the federally-funded Early Head Start program to extend its comprehensive model to more children and families.<sup>26</sup>





## Detailed Findings

### Infants and toddlers need healthy and safe environments in which to explore and learn

Research shows that lower ratios and smaller group sizes are among the strongest predictors of positive infant-toddler caregiving.<sup>27</sup> Sufficient child-to-provider ratios and small group sizes are linked to higher-quality child care environments and more positive caregiving interactions between providers and children.<sup>28</sup> **Optimal ratios and group sizes** would follow the nationally recognized, high-quality standards in *Caring for Our Children*, the seminal report of the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care. The report recommends that infants in center-based programs are cared for in groups no larger than six, with ratios of no more than 3:1, and that toddlers are cared for in groups no larger than eight, with ratios of no more than 4:1. In family homes, *Caring for Our Children* recommends that group size not exceed six children (including all children related to the provider) and that no more than two children under age two are cared for by a family child care (FCC) provider at one time.<sup>29</sup>

**Infant-toddler training for providers and licensing and monitoring staff** also contributes to creating and maintaining healthy and safe environments. Infants and toddlers are vulnerable to illness and injury and need providers and caregivers who are knowledgeable and can accurately and consistently implement health and safety practices to ensure their well-being. Licensing and monitoring staff who are knowledgeable about infant and toddler development are better able to use that knowledge as they monitor and license the centers and providers to ensure that children are getting what they need. State child care licensing agencies can signal the importance of having specialized knowledge about infants and toddlers by requiring licensors who monitor that care to have a certain amount of specialized training, coursework, or individualized consultation on infant-toddler care.

#### Findings:

- Most states fail to meet the *Caring for Our Children* standards for ratios and group size. For infants in centers, states reported ratios of children to providers ranging from 3:1 to 7:1. Three states (Kansas, Maryland, and Massachusetts) meet the 3:1 recommendation for infants based on their state's definition of an infant. For toddlers in centers, states reported ratios ranging from 4:1 up to 12:1.<sup>30</sup> Fourteen states meet the recommendation of 4:1 for at least the youngest toddlers in care.<sup>31</sup>
- Group sizes widely vary. Twelve states reported that they did not regulate group sizes for infants, and 11 states reported that they did not regulate group size for toddlers. Among states that do have such regulations, Maryland reported a maximum group size of 6 infants, while South Dakota reported a maximum group size of 20 infants. Other states regulating group sizes fall in between. Regulations also vary for toddlers, with states reporting maximum group sizes ranging from 8 to 22.

- For infants and toddlers in FCC homes, ratios and group sizes vary and depend on a number of factors, including ages of the children, number of providers, and whether or not the children are mobile. Due to the complexity of the standards, it is difficult to quantify ratios and group sizes from FCC homes. Only seven states (Connecticut, Maryland, New York, Oregon, Utah, Vermont, and West Virginia) and the District of Columbia meet the recommendation of two children under age two for one FCC provider, as recommended in *Caring for Our Children*. South Dakota has the least restrictive policy and allows a maximum of 12 children under age 2 to one FCC provider.
- Only six states require specific infant-toddler training for licensing and monitoring staff. Regular monitoring of child care settings can ensure children’s safety. When information from monitoring visits is coupled with TA, providers can get help complying with licensing standards. Specific infant-toddler training can improve implementation of health and safety standards particular to babies.



### State Example:

#### *Specific Infant-Toddler Training:*

In Florida, all licensing staff is required to complete the Child Growth and Development module of the state-mandated 40-hour *Introduction to Child Care Course*. The six-hour module addresses infant-toddler development.

## Infants and toddlers need nurturing, responsive providers and caregivers they can trust to care for them as they grow and learn.

In order to provide nurturing and responsive caregiving for infants and toddlers, **providers need access to training, education, and ongoing supports**. Infants and toddlers in child care need providers and caregivers with both the sensitivity and skills to respond to their cues and needs and the knowledge of how infants and toddlers develop. When infants are cared for in a center setting, providers with more formal education have been observed to have higher-quality care practices; when cared for in a family child care setting, infants benefit when their providers have specialized training in child development.<sup>32</sup> While it’s not clear from research whether a minimum level of higher education, such as a Child Development Associate (CDA), associate’s, or bachelor’s degree, is necessary to promote quality and effectiveness of care for infants and toddlers, it is clear that improving the knowledge and skills of infant-toddler caregivers is closely related to improving the quality of care for infants and toddlers.<sup>33</sup>

Providers need ongoing support. One way to offer that support is through targeted technical assistance, which many states use to provide information and written materials, training, and on-site consultation. Most states provide targeted technical assistance to providers on infant-toddler care, but their methodology varies. States provide technical assistance to providers on a range of different substantive areas through multiple supports related to QRIS, licensing, and subsidy systems. In a study completed by the National Association for the Education of Young Children (NAEYC), it was suggested that policies should focus on the integration of multiple technical assistance strategies including mentoring, coaching, and consulting.<sup>34</sup>

An additional consideration when it comes to education and training for providers is cost, which is a critical barrier to attaining higher education for the child care workforce. Data suggest that 31 percent of center providers and 35 percent of family child care and other home-based caregivers are low-income (living below 200 percent of the federal poverty line), making the high costs of post secondary education prohibitive.<sup>35</sup>

Appropriate infant-toddler guidelines that incorporate all aspects of development help to shape caregiver practice and create a positive learning environment for infants and toddlers. States can train providers, caregivers, and parents on developmentally and culturally appropriate early learning guidelines that explain what infants and toddlers need, how they learn, and what they are able to do.

State-established **core competencies for infant-toddler caregivers** are an agreed-upon body of knowledge, skills, and expertise that providers and caregivers need in order to give babies and toddlers quality care, based on current research on social, emotional, cognitive, and physical development. The National Association for the Education of Young Children's (NAEYC) guidelines for developmentally appropriate practice state that prepared providers must have knowledge about: child development and learning; the traits of the individual child, including strengths, interests, approaches to learning, and abilities based on prior experiences; and the social and cultural contexts in which a child lives.<sup>36</sup> All professionals and caregivers should have a base level of core knowledge before working with and caring for young children. Building from this core knowledge base, states can develop core competencies, which describe what child care providers should be able to do (i.e., the observable skills they should have) prior to working with young children.

**Adequate compensation and benefits for infant-toddler caregivers** are important to attract and retain qualified staff to work with young children. Promoting competitive compensation linked to education and experience, in addition to health care benefits, will help attract and retain highly skilled infant-toddler providers.

For infants and toddlers, development occurs within the context of relationships, including relationships between young children and their parents and primary caregivers. Providers and caregivers who regularly care for very young children can have a positive impact on their development by forming continuous, strong attachments. Caregivers who are attuned to each child's unique needs and personality can effectively support, nurture, and guide their growth and development.



A “continuity of care” approach for infants and toddlers can enhance the relationship between caregivers and young children in center-based child care programs by keeping young children within the same setting and with the same team of providers for an extended period, usually for the first three years of their lives. When very young children transition from room to room or teacher to teacher according to pre-determined developmental stages or ages, they can experience high levels of stress. Young children are less likely to exhibit behavior problems in child care when they experience fewer changes in caregivers—both in the course of a day and over longer stretches.<sup>37</sup> Research shows that the longer infants and toddlers were with the same provider, the more likely they were to form a secure attachment; 91 percent of infants and toddlers who had been with their provider for more than one year had a secure attachment relationship.<sup>38</sup> Researchers have also found that while many child care centers support the idea of continuity of care for infants and toddlers, implementation is challenging.<sup>39</sup>

### Findings:

- Most states have minimal requirements for pre-service and ongoing training for licensed child care providers, and training materials are often limited in content specific to caring for infants and toddlers. Thirty states reported that they require pre-service and/or specific, ongoing infant-toddler training for providers on things like: health and safety procedures and requirements; Sudden Infant Death Syndrome (SIDS); mental health; and infant-toddler development. The training required, including hours and type, varies by state.
- Forty-nine states reported that they provide targeted technical assistance for child care providers on infant-toddler care.
- Twenty-two states reported that they have an infant-toddler credential. Of those 22 states, 18 reported that their credential is at least partially credit-based or a combination of credit and non-credit.
- Thirty-nine states reported that they provide financial supports for the training or education of infant-toddler providers. Many of these states provide financial supports through T.E.A.C.H. grants.
- Twenty-six states reported that they fund a network of infant-toddler specialists, with the size of the network and number of specialists varying significantly.
- Forty-five states reported having early learning standards or developmental guidelines. Of the states that have no current guidelines for infants and toddlers, many are in the process of developing or approving them.
- Twenty-five states reported that they have established core knowledge or core competencies specific to infant-toddler child care providers.
- Twenty states have compensation initiatives available for infant-toddler providers.
- Twenty-one states report requiring a consistent primary caregiver for infants and toddlers in care.
- A few additional states encourage continuity of care through other means, including regulations, policies, or waivers. One way states encourage care is through policies created by the state subsidy agency.



## State Examples:

### *Training and Technical Assistance:*

In **Minnesota**, pre-service and ongoing training in safe sleep practices and shaken baby syndrome is required. Additionally, half of the in-service training completed by a staff person each year of employment must pertain to the age of children for whom the person is providing care. All child care center lead teachers and all family child care providers participating in **Parent Aware**, Minnesota's QRIS, must complete at least eight hours of approved training on the Early Childhood Indicators of Progress (the state's early learning standards) specific to the age group for which they are responsible (birth to three or 3-5 years).

In **Iowa**, child care consultants employed by child care resource and referral (CCR&R) agencies, and funded through a contract between the CCR&R agency and the Department of Human Services, provide on-site technical assistance and consultation to child care programs. These consultants have received training on infant-toddler care.

### *Infant-Toddler Credential:*

**Virginia** provides two different infant-toddler credential opportunities. The state offers both the **Virginia Infant-Toddler Certificate**, which has been approved by the Office of Head Start to meet the CDA requirements defined in the Head Start Act for Early Head Start staff, and the **Virginia Department of Social Services (VDSS) Infant and Toddler Endorsement**. VDSS is developing two additional endorsement programs to cover more advanced knowledge for working with infants, toddlers, and preschoolers. These are called the Early Childhood Endorsement I and II. All VDSS programs will be available online or in the classroom. The endorsement requires approximately 50 hours of training and provides a basic knowledge of working with infants and toddlers and/or preschoolers.

### *Financial Supports:*

In **Oklahoma**, a scholarship to attend community college is available to eligible child care providers. Oklahoma also has vouchers available for child care providers to attend conference trainings.

**Washington** State provides tuition reimbursement for providers who complete its basic STARS 20-hour training, along with required continuing education training that aligns with the state core competencies. Additionally, the state provides funding to its partner, Washington State Child Care Resource & Referral Network (WSRRN), to administer the **Washington Scholars** program, which provides tuition reimbursement, release time, and other associated costs to providers who are completing a Child Development Associate Credential, an associate's degree, or—in some cases—a bachelor's degree.





## Indiana Promotes Continuity of Care

Indiana's Bureau of Child Care released Interpretative Guidelines in 2007 to provide examples of how a center may demonstrate a reasonable effort to achieve continuity of care, including:

- Moving the teacher with their children to another classroom as the children mature;
- Modifying the classroom as the children mature;
- Creating mixed age groupings of children, ages 6 weeks to 36 months; or
- Creating intentional transitions that prepare children as they move into the next age classroom.

Child care center directors were among both the strongest proponents and most vociferous opponents of the continuity of care rule. Its adoption was made more feasible by allowing existing centers to take one year to meet the new standard and tempering the requirement to one of "reasonable effort" to achieve continuity of care. Indiana adopted its continuity of caregiver regulation as part of a comprehensive overhaul of its child care center regulations, recognizing that the benefits of continuity of care depend also on a commitment to a **primary caregiver and a small group size**. In addition to embedding its continuity of care rule in an overall policy approach to infants and toddlers, Indiana has invested in developing the quality of infant-toddler care. Indiana's Child Care and Development Fund State Plan provides for funding a statewide **network of infant-toddler specialists** in each of the state's 11 child care resource and referral agencies.

The continuity of care regulation has been a catalyst for infant-toddler specialists and problem-solving licensing consultants to create a vibrant learning community focused on advancing high-quality infant-toddler care. Purdue University's Department of Child and Family Studies' evaluation of the **4C of Southern Indiana**, the child care resource and referral agency, found that promoting implementation of the continuity of care regulation contributed to higher levels of quality among infant-toddler child care providers, as measured by the ITERS and Family Day Care Rating Scale (FDCRS) environmental rating scales.

Source: *Indiana: Requiring Continuity of Care in Licensing State Example*, *Charting Progress for Babies in Child Care Project*, CLASP (2009).

### Infant-Toddler Specialist Network:

Washington has 35 infant-toddler specialists. The state Department of Early Learning (DEL) funds each of its ten Early Learning Regions to provide infant-toddler interdisciplinary child care consultations to licensed family child care homes and centers, and to coordinate an infant-toddler consultant network within each region. The DEL also hosts regular statewide interdisciplinary infant and toddler consultation networking meetings.

### Early Learning Guidelines:

Washington has developed birth-to-age-5 guidelines that integrate cultural competency standards and has conducted outreach to educate providers and parents on those provisions.<sup>40</sup>

### Compensation Initiatives:

In Minnesota, **R.E.E.T.A.I.N.** (Retaining Early Educators Through Attaining Incentives Now) is a rewards program designed for child care professionals who have earned a degree or CDA. Twenty-five percent of total funding is set aside for infant-toddler practitioners.

**INCENTIVES** is a statewide supplement program in Georgia designed to encourage and reward eligible early care and education professionals for earning a credential or degree in the field and for tenure with their employer. Eligible applicants may receive two payments per education level, ranging from \$250 to \$1,250 per payment.

### Continuity of Care:

In Alaska, the Child Care Assistance Program (CCAP) supports timely renewal of participating providers and families to ensure continuity of care is maintained with a parent's chosen and eligible provider.

## Infant and toddlers' families need to have access to quality options for their care.

Many parents face challenges in finding care for infants and toddlers that meet the child's and family's needs, especially low-income parents with fewer resources to pay for care. The licensed infant-toddler care supply is inadequate, particularly in certain geographic areas like rural communities. According to analysis of census data, poor and non-metropolitan areas are less likely to have an adequate supply of licensed child care center slots.<sup>41</sup> Key features of high-quality infant-toddler care, such as higher child-to-provider ratios and smaller group sizes, make infant care more costly. Without stable funding, most child care providers—especially those in low-income or rural areas—cannot afford the qualified staff, equipment, and facilities that good program standards require. State policies can help build the supply of high-quality child care settings for all infants and toddlers, with a special focus on underserved communities—including those in low-income, rural, or immigrant and language-minority communities.



An additional factor that influences access to quality child care options for families is creating subsidy policies that **promote stable, quality care**. Low-income parents' decisions about who cares for their infants are influenced by preferences, but also by significant constraints—such as personal financial resources, employment schedules and stability, transportation issues, and supply of care choices in their neighborhoods, as well as problems accessing and maintaining child care assistance.<sup>42</sup> State subsidy policies can determine:

- The extent to which families have a full range of child care options in their community;
- When and how a family may receive a subsidy or be put on a waiting list;
- How often families are required to recertify their eligibility; and
- How changes in job and family status affect eligibility.

All of these policies have ramifications for parents' ability to access high-quality, continuous care for their children.<sup>43</sup> Qualitative researchers have found evidence that subsidy policies tied closely to current parental work hours and requiring significant paperwork may increase child care instability, as parents' frequent changes in eligibility status and related loss of subsidy lead to changes in arrangements.<sup>44</sup>

States determine the rate to be paid to child care providers and caregivers participating in the subsidy system. Federal guidance recommends rates be set at a level equal to the private cost of at least 75 percent of care available in their communities, referred to as the 75th percentile of a current child care market rate study. Setting payment rates lower not only reduces the funds available for providers to invest in quality care, but also restricts the child care options available to parents using a subsidy. If payment rates are too low, some child care providers may be financially unable to care for children receiving subsidies and opt not to participate in the subsidy system.<sup>45</sup>

Many infants and toddlers are cared for by license-exempt providers, including relatives and friends. States may support FFN providers through many means, including offering training opportunities and funding local hubs to support FFN caregivers. Some states also provide additional supports for FFN providers, including play-and-learn groups, licensure training/supports, health and safety trainings, and other activities.

CCDBG allows states the option of providing care through vouchers, as well as through direct contracts with child care providers. Contracting directly with child care providers for high-quality infant and toddler care is one way of building the supply and improving the quality of infant-toddler care. Contracts also offer providers a consistent level of revenue, which may improve their financial stability and ability to serve children with subsidies. Contracts guarantee a number of infant-toddler child care spaces with a particular provider and, importantly, may require and support higher quality standards beyond basic health and safety provisions of state licensing regulations, thereby increasing the supply and quality of available care.<sup>46</sup>

Compared to older children, infants and toddlers have immature and developing immune systems and engage in behaviors that make them particularly vulnerable to illness. As a result, infants and toddlers are more likely to be absent from care due to illness or doctor visits. Infants also require more regular, routine doctor visits as compared to older children. Payment for absent days ensures children maintain their slot with their child care provider or in their child care center and that providers and centers can afford to run their business and get paid regardless of a child's sickness or need to be absent for care.



Some states use QRIS as a tool to improve the quality of child care and many make linkages between QRIS and their subsidy systems. Specific infant-toddler standards in QRIS can improve the quality of care and help parents with very young children better understand and find quality care.

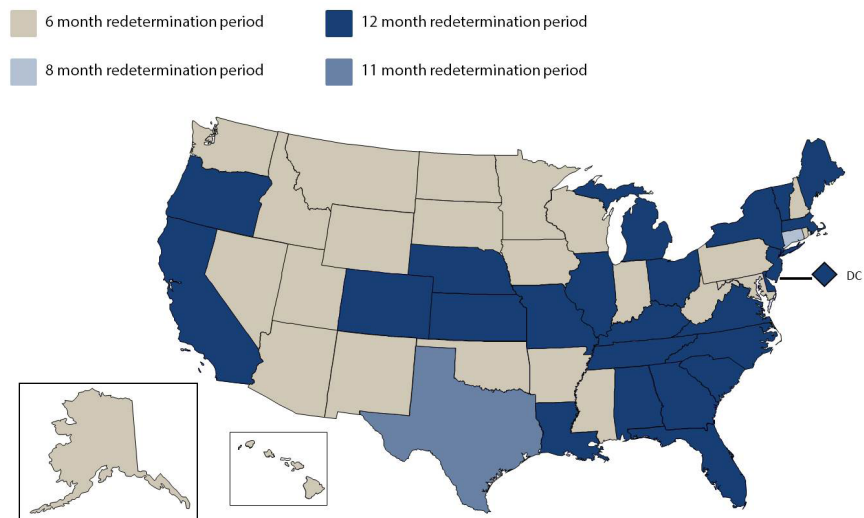
A family child care network or system is a formal group, association, or program that provides administrative and quality support and services to meet the needs of FCC providers. Family child care networks may be free-standing agencies or organizations, or may be housed within a larger private or public agency, such as a resource and referral agency, a child care service delivery agency, or a community development agency. In states where FCC networks manage subsidies, a portion

of the subsidy rate may be held at the network level to cover the costs of their administrative and quality support work with individual providers. An evaluation of family child care networks in Chicago found that those that employed a coordinator who had special training in infant development and fostered supportive interactions and techniques with providers achieved higher environmental rating scores and higher levels of provider sensitivity.<sup>47</sup>

## Findings:

- Twenty-five states set their maximum subsidy eligibility determination period at 12 months for most families. The remaining states extend shorter authorization periods to families before requiring redetermination of eligibility. Four states (Illinois, Nevada, New York, and South Dakota) allow longer eligibility periods for children receiving subsidies who also attend Early Head Start, which is allowable under CCDBG regulations.<sup>48</sup> (See Figure 2.) In practice, all families may not be authorized for the maximum eligibility period. All states require families to report changes, such as those in employment or income, which would impact their eligibility status between periods of redetermination; however, some states have taken steps in recent years to limit what families are required to report and how often.<sup>49</sup>
- According to what states reported in this survey and a 2012 analysis by the **National Women’s Law Center** (NWLC), only three states (Arkansas, Hawaii, and New York) set their standard reimbursement rate for a one-year-old in center-based care at the recommended 75th percentile of a current market rate survey.<sup>50</sup>
- Thirty-two states have tiered reimbursement rates. Of those, approximately 80 percent still have a reimbursement rate for center-based care that is below the 75th percentile of current market rates.<sup>51</sup>
- Twenty-two states reported offering differential rates for infant-toddler care. What this means varies by state. For example, in California, according to the 2012-2013 **state plan**, contracted child care centers caring for infants receive a 70 percent higher rate above the standard reimbursement rate and those caring for toddlers receive a rate 40 percent higher. For infant and toddler caregivers in family child care homes, the adjustment factor is 20 percent.

Figure 2. States’ Maximum Redetermination Periods for Child Care Assistance



Source: Child Care and Development Fund (CCDF) State Plans, FY 2011-2012.

- Fourteen states reported using contracts to increase the supply or improve the quality of infant-toddler care. States utilize different strategies when creating contracts. Some states contract directly with the child care providers, while others offer sub-grants to communities or other entities.
- Of the 37 states that currently have QRIS, 35 reported that they include quality standards specific to infant-toddler care, with guidelines specific to infants and toddlers across the social, emotional, physical, and cognitive domains.
- Forty-one states reported that they pay child care providers for days when a child is absent from care. These policies widely vary, with the number of allowable absent days deviating up to 10 days per month. One exception is Idaho, which does not limit the number of allowable absent days. According to a recent NWLC [fact sheet](#), many states are beginning to put stricter guidelines on their absent day policies by reducing the number of hours or days that are reimbursed.
- Twenty-one states reported that they provide varying monetary or non-monetary support for family child care networks.
- Thirty-three states reported that they support (through play-and-learn groups, supports to become licensed, health and safety trainings, etc.) the license-exempt FFN providers caring for infants and toddlers.



### State Examples:

#### *Redetermination:*

Colorado's 12-month eligibility policy allows parents to keep subsidies for a year, as long as they stay within federal eligibility rules. Parents are only required to report increases in income above federal eligibility levels—85 percent of State Median Income (SMI)—or a loss of work activity.

#### *Contracts:*

According to its 2012-2013 state plan, Illinois has contracts in place statewide and uses the contracted slots to increase the supply of all types of care, including infant-toddler, school-age, care for children with special needs, center-based, and family child care. In Illinois, contracted providers may accept and process child care assistance applications.





### *Absent Days:*

**Montana's** Certified Enrollment policy allows providers to receive payment for the hours or days when a child is temporarily absent from care in circumstances where private-pay parents are required to pay providers for those hours. Previously, providers were paid for up to 150 hours per state fiscal year per child participating in certified enrollment. This amount was reduced to 70 hours in 2012.<sup>52</sup> In addition, parents in the subsidy system are permitted to use their child care subsidy during

times when they need to leave work to attend medical appointments. The subsidy may be used to provide care for children who are not attending the medical appointment. These policies are supportive of parents with very young children, who must receive more regular medical checkups and are more often sick than older children. If an infant must attend a medical appointment, a sibling may still be served by a subsidy while the parent and baby attend the appointment.<sup>53</sup>

### *QRIS and Infant-Toddler Quality Standards:*

**Arizona's** QRIS, Quality First, addresses infant and toddler care standards in child care centers and family child care homes through use of the Infant-Toddler Environmental Rating Scale (ITERS) and the Family Child Care Environmental Rating Scale (FCCERS), as well as a points scale designating quality ratios and group sizes for infants and toddlers. This program is funded through First Things First, Arizona's state early childhood development and health board.

In **Indiana**, the QRIS includes standards specific to the care of infants and toddlers. Training is provided on these standards and other items, such as implementing continuity of care, primary caregiving, and safe sleeping practices. In addition, Indiana's QRIS trains providers using the Center on the Social and Emotional Foundations for Early Learning's (CSEFEL) **Infant-Toddler Modules**, which are designed to promote the social and emotional development of young children.

### *Support for FCC Networks:*

**South Carolina's** PITC Network offers on-site training and coaching to family child care networks and family child care providers who are not involved in networks. A key component of the PITC Network is establishment of a provider network. Family child care providers are also awarded scholarships to attend state early care and education conferences. In addition, the lead agency is providing support for a regional quality enhancement initiative that solely targets family and group child care homes. Providers are offered on-site consultation, training, program incentives, and scholarship opportunities to attend state-level conferences.

The West Virginia Department of Health and Human Resources' Division of Early Care and Education provides \$15,000 through West Virginia Training Connections and Resources to the newly created **West Virginia Family Child Care Association**. The West Virginia Family Child Care Association supports local FCC associations and promotes the professional development of family child care.

*Support for license-exempt family, friend, and neighbor (FFN) providers:*

In New York, legally exempt providers, caring for children of all years, who undertake 10 or more hours of training per year receive an enhanced subsidy payment rate.

In Indiana, Caring Safely is an infant-toddler health and safety training available in all communities and is specifically designed for FFN providers and entry-level child care staff. CCR&Rs implement local plans to identify and engage potential caregivers in order to increase the availability of quality care where supply is low. The Bureau of Child Care offers support and technical assistance to FFN providers to assist potential providers in becoming licensed.



### ***Massachusetts: Family Child Care System Contracts***

The Massachusetts **Department of Early Education and Care (EEC)** contracts with **family child care (FCC) systems** to ensure stable access to high-quality family child care throughout the state. Any FCC system in Massachusetts that agrees to provide EEC subsidized early education and care services through its affiliated providers must hold a contract with EEC. Family child care is a common type of child care for children under the age of three. According to **data** collected by the state's child care resource and referral agency, just over half of care (55 percent) requested by parents in 2008 was for infants and toddlers; 42 percent of families requested family child care. In 2009, more than a quarter (28 percent) of subsidized children in Massachusetts were infants and toddlers, and more than a quarter of subsidized children (28 percent) were cared for in family child care or group child care homes.

FCC systems are contractually required to provide an array of services and supports to families, children, and affiliated providers. As part of their **direct contract** with EEC, FCC systems must provide the following services:

- Provider recruitment;
- Eligibility and enrollment services;
- Substitute child care;
- Home visitor services (technical assistance services to providers);
- Family support services and referrals to community services;
- Reporting suspected child abuse and neglect;
- Administrative support;
- Transportation; and
- Collection of parent fees.

FCC systems must make professional development opportunities available to affiliated FCC providers throughout the year. Massachusetts is developing standards for FCC systems to support best practices and greater consistency across systems. Currently, beyond the requirements specified in the contract, there are no other means of regulating the systems' operations. No further details are presently available on the status of these standards, including whether the new standards will be mandatory or voluntary, or how they will be enforced.

Source: *Massachusetts: Family Child Care System Contracts* State Example, *Charting Progress for Babies in Child Care Project*, CLASP (2011).

## Infants and toddlers need parents, providers, and caregivers supported by and linked to community resources.

For infants and toddlers, early learning experiences occur within the context of their physical and mental health and the relationships they have with their families and other caregivers, building brain architecture that lays the foundation for success later in life.<sup>54</sup> Quality health care and good nutrition, both for pregnant mothers and infants and toddlers, is essential for a child's healthy development and can help reduce early childhood health impairments.<sup>55</sup> Parents and families require personal and economic resources to provide for their infants' and toddlers' basic needs. Programs and policies that support families (for example by reducing economic hardship, promoting healthy parent-child relationships, or treating parental health conditions) also promote infants' and toddlers' healthy development.<sup>56</sup>



The sources of child care funding historically available to states have a limited supply and restrictions on allowable uses, and **comprehensive services are critical to the success of children**—especially those who are most at risk of developmental challenges and delays. States can secure additional and diverse funding for infants and toddlers designed to ensure they have access to and receive the care and services they need to grow and thrive. The most-used strategy is to establish partnerships between child care and Head Start. States can also use Early Head Start initiatives to partner with and enhance the quality of child care for infants and toddlers in the state.

Research studies find that young children who are at high risk of developing social-emotional or psycholog-



ical problems can be reliably identified as early as the first few years of life.<sup>57</sup> Further studies indicate that early identification and treatment are effective in preventing risk factors from having a harmful impact on children's development and can reduce problems, such as delinquency and school failure, that may emerge later in childhood. Mental health consultations can also have positive impacts on child care providers themselves and have been associated with decreased staff stress and turnover rates, as well as increased job satisfaction.<sup>58</sup> Mental health consultations can help equip child care providers who serve infants and toddlers with the tools and training needed to implement developmentally appropriate practices that foster healthy child development and support children with special needs.

### Findings:

- Four states make additional, dedicated funds available specifically for infants and toddlers outside of the CCDBG infant-toddler set-aside.
- To achieve diverse funding for infants and toddlers, states use a variety of sources, but the most-used strategy is to establish partnerships between child care and Head Start. Twenty-three states have at least one initiative that builds on the federally-funded Early Head Start program to extend its comprehensive model to more children and families.<sup>59</sup>
- Thirty-two states support infant-toddler mental health consultation for child care providers. States use many methods of support and funding to provide this.



### State Examples:

The Oklahoma Pilot Early Childhood Program combines public and private money to expand access to high-quality early care and education for children birth-to-age-three. The George Kaiser Family Foundation initiated the pilot in 2006 by matching state general revenue with private donations. Since that time, other private funders and providers have begun to contribute matching funds. In addition to Head Start and EHS grantees, child care centers, school districts, and community agencies are eligible to apply as long as they meet federal Head Start Performance Standards.

Since 1999, Nebraska's Early Head Start Infant/Toddler Quality Initiative has supported EHS and community child care partnerships to improve the quality and professionalism of infant and toddler care. EHS programs apply for funding to establish partnerships with center-based or home-based child care. The initiative has three options



of intensity, with the most intense option requiring EHS programs to enter into agreements with local child care centers and family child care homes; 52 such agreements by grantees are currently in place. Additional child care programs participate at the two less intense levels of involvement. Through these partnerships, federal EHS grantees provide professional development opportunities to home-based and center-based partners; assist in training and mentoring for their child care partners; and observe and report on the best outcomes and challenges for child care partners who participate in the initiative, as well as measures of quality within the partners' child care environments.

In Connecticut, the Department of Children and Families supports the Early Childhood Consultation Partnership, a mental health consultation project available at no charge to early care and education programs serving children birth-to-age-five.



### ***Louisiana: Mental Health Consultation (MHC) Program***

In July 2007, Louisiana's Department of Children and Family Services (DCFS) contracted with the **Tulane Institute of Infant and Early Childhood Mental Health** to launch a Mental Health Consultation (MHC) program for child care centers. Funded by the Child Care and Development Block Grant, the program's three main objectives are to:

- Promote the social and emotional health of young children;
- Support teachers' promotion of healthy child development within the classroom setting; and
- Refer young children exhibiting behavioral problems for treatment or design interventions to assist them.

The MHC model focuses on both the individual child and child care program. Mental health consultants (MHCs) provide case consultation to address the specific needs of a child, while helping programs as a whole become better prepared to support children's social-emotional development. The model emphasizes developing collaborative relationships between MHCs and teachers/directors. MHCs provide training to teachers on developmentally appropriate practices in classroom settings. This includes five interactive meetings that are designed to meet state child care licensing requirements for continuing education credits. MHCs also work with teachers on strategies for working effectively with parents.

Program eligibility child care centers are eligible to receive consultation services if they are participating in Quality Start, the state's QRIS. Participation is voluntary and incurs no cost for the center, and centers are free to terminate services at any time. Consultants are on-site at a center for one day every other week for 6 months (total of 12 visits). Consultation elements include:

- Classroom observations;
- In-class modeling;
- Individual meetings with teachers;
- Didactic group meetings;
- Meetings with families and parent education;
- Referrals to outside services; and
- Design of specific interventions for challenging behaviors.

Source: *Louisiana: Mental Health Consultation (MHC) Program State Example, Charting Progress for Babies in Child Care Project, CLASP (2011).*

# Conclusion



Child care programs can play a key role in supporting very young children and their parents. This report shows the urgent need for further investment and stronger policies to increase access to high-quality services for infants and toddlers. While particular state policies offer promise, no state has in place a comprehensive set that fully meets the needs of infants and toddlers.

State policies can promote the quality and continuity of early childhood experiences and positively impact the healthy growth and development of infants and toddlers in all child care settings. State child care policies can ensure basic health and safety while also making certain that those who care for infants and toddlers have the tools to stimulate early learning and development, identify health and developmental issues, and potentially link families to necessary supports. States must improve their quality, licensing, and subsidy policies to ensure that infants and toddlers receive the quality, developmentally appropriate care they need to grow and learn.

While states set many key policies that support quality infant-toddler child care, increased investments at all levels—federal, state and local—are imperative to give public agencies, child care providers, and programs the resources they need to make improvements in key policies that support our youngest children’s healthy development and future success.

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