Quality Child Care for Infants and Toddlers: Case Studies of Three Community Strategies

Executive Summary
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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.
The Study of Community Strategies for Infant-Toddler Care

In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. 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 the 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. 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 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.

Notes

1Professional 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).

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

A reference list is available in the full report.