

Assessing Child Care Development Fund (CCDF) Investments in Child Care Quality:

A Study of Selected State Initiatives Volume I



Institute for a Child Care Continuum
Bank Street College of Education
610 West 112th Street
New York, NY 10025

May 2002
Toni Porter
Sulaifa Habeeb
Sally Mabon
Anne Robertson
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The Issue

For many years researchers have been concerned about the impact of child care on children. Much of the research has yielded similar conclusions: good child care can benefit children's language and cognitive development as well as their social competence. These effects can last into children's early school years.

The Child Care and Development Fund (CCDF), the central federal child care subsidy program, provides support to states for child care subsidies for eligible families. In addition, it requires states to use 4% of the funding to improve child care quality and to expand child care supply. The CCDF quality set-aside is designed to address widespread concerns about the state of child care in the United States that are based, in large part, on discouraging findings about the quality of care that many children receive. These concerns are not limited to publicly funded services for low-income children. Rather, these issues are regarded as pressing for all but the wealthiest families. This situation places strong pressures on policy makers who are charged with the responsibility of allocating CCDF quality improvement funds. They face complex choices about the best use of these monies.

Purpose of The Study

In 2000, Bank Street College of Education, Abt Associates Inc. and the National Center for Children in Poverty of the Mailman School of Public Health began a joint study, "Assessing Child Care Development Fund (CCDF) Investments in Child Care Quality." A 3-year effort funded by the Administration of Children, and Families Child Care Bureau, it is intended to provide information for policy makers about how to make more efficient use of CCDF quality set-aside funding.

In the first phase of the study, we sought to answer the following questions:

What objectives do states aim to achieve with their CCDF quality improvement funds?

How do they design initiatives to meet their needs?

What kinds of strategies do they use to implement these program designs?

How do they measure the results of these initiatives?

This report, *A Study of Selected State Initiatives*, presents the results of the first year of our research. It is organized in two volumes. Volume One consists of our methodology; a summary of the research results; issues related to program design and implemen-

tation; initiatives' use of evaluation; and a conclusion. An appendix includes descriptions of specific national models and initiatives for improving child care quality. Volume Two consists of detailed profiles of the programs we selected for the study.

The Findings

Our report describes 104 initiatives that we selected from hundreds of CCDF quality improvement efforts across the country. While this set of programs does not represent a scientific sample of the universe of initiatives supported with CCDF quality set-aside funds, it demonstrates the rich and varied approaches states can, and do, use to improve quality in their states.

The study includes an initiative from every state with the exception of Virginia, which declined to participate. There are examples of programs that use different kinds of strategies to improve quality, including efforts that are based on national models such as T.E.A.C.H., national initiatives such as Healthy Child Care America, and generic approaches such as career development systems. The examples include initiatives that aim to serve different populations of children and those that are designed to serve different types of child care providers. The description of each initiative includes information about its start date, geographic scope, and funding level as well as the auspices of the program, recruitment strategies and implementation. Special attention was paid to evaluation components because this is the focus of the second year of our study.

Strategies States Use to Improve Quality

We selected initiatives that used different kinds of strategies for improving child care quality. The strategies include professional development, distribution of materials and equipment, compensation, accreditation/rating systems, recruitment/training, start-up, facilities improvement, and other approaches (technical assistance, linking health and child care, and miscellaneous approaches to improve quality).

Initiatives that use professional development to improve quality account for the largest number (29) of programs in our study. These include efforts to support academic or career advancement in the field. Initiatives that rely on recruitment and training—those that aim to increase the number of registered family child care providers, that offer workshops, or that train trainers—rank second, with 19.

Initiatives that provide materials and equipment to providers to

improve quality follow, with 12. Efforts that use compensation or accreditation/rating systems account for a relatively small proportion of the strategies, because we limited the number of efforts that represent national models or approaches. The study includes a small number of programs that provide funds for start-up, and only one program that uses funds to improve facilities.

Target Population of Children

In addition to quality improvement strategies, we used the population of children served as a dimension for selecting programs for the study. Populations of children include infants and toddlers, preschool children, school-age children, children with special needs, and children who need non-traditional hour child care. Most of the initiatives we selected serve more than one group of children: the vast majority of the initiatives serve infants and toddlers in addition to children in other age groups. Only a small proportion, one fifth, serve a single population of children exclusively, of which infants and toddlers, with 11, is the most common. Six programs serve school-age children exclusively; four limit services specifically to children with special needs. Only one program is exclusively intended for children who need non-traditional hour care.

Approximately one in five initiatives exclusively serve children who receive subsidies or those who live in low-income communities. Some initiatives exclusively serve subsidized children; others give preference to providers who provide care to children who receive child care subsidies; and still others use enrollment of subsidized children as a criterion for delivering services.

Type of Provider Served

The third dimension we used to select initiatives was type of provider—center-based programs, regulated family child care, and license-exempt child care (relatives and non-relatives who provide care that is legally exempt from regulation). Many of the initiatives in the study serve all types of providers. One third, however, are designed to serve particular providers, of which the largest number (18) is limited to centers. Five initiatives are designed specifically for license-exempt caregivers; three are intended exclusively for family child care providers.

Geographic Scope

Three quarters of the programs in our study are statewide. Most of them represent efforts to improve the child care infrastructure by providing professional development opportunities or increasing compensation. A significant number of recruitment and training initiatives as well as initiatives that distribute materials and equipment also serve providers across the state. The small proportion of initiatives that serve individual sites primarily include efforts to expand specific aspects of the child care supply through start-up funding or those that provide workshops to improve specific aspects of care. Several local initiatives represent pilot efforts.

Budgets

Initiatives that rely on compensation have the largest budgets,

with a median budget of \$1.3 million. Accreditation programs follow, with a median budget of \$1 million. Initiatives in the mid-range include professional development programs, programs that link health and child care, and recruitment and training programs. Initiatives that use materials and equipment, miscellaneous strategies and technical assistance represent the low-end of the budget range.

Use of Evaluation

Most of the initiatives we selected—three in four—have some kind of evaluation.

Many of the evaluations look at the number of participants that have enrolled in or completed the program. A large number also seek to determine participants' satisfaction with program services or to assess changes in participants' knowledge, skills or practice. Change in participants licensing status is another focus, especially for initiatives that use professional development, accreditation/rating systems or compensation to improve quality. By comparison, a few seek to measure outcomes such as changes in educational or income levels or staff retention and turnover.

The programs in our study use a wide variety of instruments to gather their data. Information on numbers served and other descriptive aspects of the initiatives are typically collected through reporting or monitoring records. Mail surveys or phone interviews are used to elicit participants' satisfaction with services. Pre- and post-tests are common strategies for measuring the extent to which participants use services or demonstrate changes in knowledge or skills, while directors and parents' reports are used to assess changes in practice. Some evaluations rely on standardized instruments such as environmental rating scales for pre- and post-tests.

Conclusion

Our study demonstrates the diverse and multifaceted ways policy makers at the state and community level use CCDF funds to improve child care quality or increase the availability of child care. It identifies some common themes about efforts to improve quality that can influence states' choice of initiatives. In addition, it provides detailed information about a wide array of programs to help them design their own efforts.

The study also highlights the importance of evaluating program results as a basis for using CCDF funds efficiently and effectively. Evaluation can provide valuable information about implementation issues that can be helpful for determining if changes are needed in program design. It can also provide information about longer-term results and broader impacts that can be helpful for assessing specific strategies and their effect on the quality of care overall. Policy makers want to make the best use of limited public resources for improving the quality of child care, and they want to know how to evaluate their results. In the second phase of our study, we will produce a tool kit of instruments to help them achieve this goal.

Background

Every day, millions of families in the United States turn to child care providers to care for their young children. Some experts place the number of children in care at thirteen million (Blank & Poersch, 1999). Nearly half of them are under six. Parents use a variety of child care arrangements when they are at work. Most young children of employed mothers—approximately 42%—are enrolled in classroom-based settings in child care centers. Another 21% are in regulated family child care with child care providers who care for children in their own homes. Eight percent are cared for at home by nannies or babysitters. The remaining 30% are cared for by relatives, mostly grandmothers (Brown-Lyons, Layzer, & Robertson, 2001).

In 1996, three in four women with school-age children between 6 and 17 were working or looking for work (U.S. Census, 1996). The proportion of women with very young children was almost as high, two thirds of women with children under six. Many of them returned to jobs when their babies were as young as twelve weeks.

Child care has received increasing attention as federal spending for child care has grown. Between 1980 and 2000, direct federal expenditures doubled. During the same period, child care spending for low-income families nearly tripled. There has been an almost equal growth in the number of children who receive child care subsidies (Collins, Layzer, Kreader, Werner, & Glantz, 2000).

The Issue

For many years researchers have been concerned about the impact of child care on children. Much of the research has reached similar conclusions: good child care can benefit children's language and cognitive development as well as their social competence (Caughy, DiPietro, & Strobino, 1994; Clarke-Stewart, 1991; Kagan, & Neuman, 1997; NICHD Early Child Care Research Network, 1997; Phillips, 1994; Ramey, & Campbell, 1991; Scarr, Eisenberg, & Deater-Deckard, 1994). These effects can last into children's early school years.

Assessments of child care quality generally examine two aspects of care: structure and process. Structural features include group size, child-staff ratios, physical space, teacher qualifications, wages and safety. Process features include caregiver-child interactions such as caregiver responsiveness and caregiver language as well as the appropriateness of learning activities (Cryer, 1999; Helburn & Howes, 1996; Love, 1997; Love, Schochet, & Meckstroth, 1996).

Research points to a moderate correlation between these two features. For example, studies show that two structural aspects of care—child-staff ratios and group size—are correlated with caregiver behavior for infants and toddlers, while two other structural features—caregiver training and education—are predictive for caregiver behavior with preschool children (Kontos, & Wilcox-Herzog, 1997; NICHD Early Child Care Research Network, 1996; Whitebook, Howes, & Philips, 1990). These aspects of care are associated with better outcomes in language and cognitive development even when income, ethnicity and parenting behavior are held constant (Lamb, 1997; NICHD Early Child Care Research Network, in press; Peisner-Feinberg, Burchinal, Clifford, Culkin, Howes, & Kagan, 1999; Peisner-Feinberg & Burchinal, 1997; Shonkoff & Phillips, 2000; Vandell & Wolfe, 2000).

Concerns about child care quality have escalated since the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the federal welfare reform program, which dramatically increased the availability of child care funding. In the first two years after the legislation was enacted, combined federal and state spending for child care assistance nearly doubled, rising from \$3.5 billion to \$6.3 billion (Greenberg, Lombardi, & Schumacher, 2000). Median state spending also rose, increasing by 78% between 1997 and 1999 (Collins et al., 2000).

The Child Care and Development Fund (CCDF), a component of the PRWORA, is the central federal child care subsidy program. It provides support to states for child care subsidies for eligible families. In addition, it requires states to use 4% of the funding to improve child care quality and to expand child care supply. States are also mandated to allocate an additional percentage to expand the supply and improve the quality of care for infants and toddlers.

The 4% quality set-aside is designed to address widespread concerns about the state of child care in the United States. They are based, in large part, on discouraging findings about the quality of care that many children receive. One recent national study of child care arrangements found that most care could only be rated "fair." Only a small proportion of the child care settings—9%—were considered excellent (Helburn & Howes, 1996). Another study produced even more disturbing results. It showed that nearly four in ten child care centers for infants provided poor quality care, that is, care that places babies' health and safety in danger (Helburn, Culkin, Howes, Byrant, Clifford, Cryer, Peisner-Feinberg, & Kagan, 1995).

Concerns about child care quality are not limited to publicly

funded services for low-income children. Rather, these issues are viewed as pressing for virtually all but the wealthiest families. The problem is perceived by some as a failure of the child care market to produce care that is socially optimal.

This situation places strong pressures on policy makers who are charged with the responsibility of allocating CCDF quality improvement funds. While some research points to several directions for improving quality, it does not indicate the relative effectiveness of specific strategies. As a result, policy makers face complex choices. Which aspects of quality should they address? What approaches should they use? What is the best use of their quality set-aside funds? How can they measure their results?

Purpose of the Study

In 2000, Bank Street College of Education, Abt Associates Inc. and the National Center for Children in Poverty of the Mailman School of Public Health began a joint study, “Assessing Child Care Development Fund (CCDF) Investments in Child Care Quality,” to seek answers to these questions. A three-year effort funded by the Administration of Children, Youth and Families Child Care Bureau, it is intended to provide information for policy makers about how to make more efficient use of CCDF quality set-aside funding. The project consists of two phases. In the first, we sought to better understand the objectives states aim to achieve with their quality set-aside funds, the kinds of programs they have created, and the ways in which they have evaluated them. In the second phase, we aim to develop and test instruments that policy makers can use to make decisions about the use of these funds.

This report presents the results of the first phase of the study. It describes 104 initiatives that we selected from hundreds of CCDF quality improvement efforts across the country. While this set of programs does not represent a scientific sample of the universe of initiatives supported with CCDF quality set-aside funds, it demonstrates the rich and varied approaches states can, and do, use.

The 104 initiatives include a wide variety of strategies to improve child care quality. Among them are grants and loans to start new child care programs, improve existing facilities or

recruit new family child care providers; distribution of materials and equipment; training workshops or academic programs; increased compensation, bonus or incentive payments; support for accreditation or rating systems that reward programs for achieving specific standards; and a category of other miscellaneous strategies to improve child care quality. These initiatives are intended to address quality in different kinds of child care settings—regulated family child care and center-based programs as well as license-exempt child care (child care provided by family, friends or neighbors who are legally exempt from regulation). They also aim to serve children in different age groups—infants and toddlers, preschoolers, and school-age children—as well as children with special needs and those who need child care during non-traditional hours (before 8 a.m. or after 6 p.m., evenings, nights, weekends, or shift hours).¹

We believe that the study will be a useful resource for several reasons. First, it describes a wide array of programs that can help states design initiatives to meet their own needs. Second, it provides insights into some common themes about quality improvement efforts that can influence states’ choices of initiatives. Third, it will stimulate discussion about how states can strengthen continuing efforts to improve quality. Finally, it can provide some directions about how they can evaluate their results.

This report is organized in two volumes. Volume I, which consists of seven chapters, presents the research findings. Chapter II describes the approach we used to select the initiatives as well as the kind of data we collected. Chapter III summarizes the research findings. The next three chapters discuss specific characteristics of the quality improvement initiatives we examined. Chapter IV addresses issues related to program design; Chapter V, those related to program implementation; and Chapter VI, initiatives’ use of evaluation. Chapter VII summarizes our conclusions. The Appendix includes descriptions of specific national models and initiatives for improving child care quality. Volume II of the report consists of detailed profiles of the 104 initiatives.

¹This study does not include two basic approaches—regulatory policy and consumer education—that states can use to improve quality, although they represent strategies for managing the child care market.

The research for this report consisted of two stages. In the first, we aimed to select approximately 100 quality initiatives from a wide pool of efforts undertaken by the states. In the second, we collected and analyzed data about these programs to gain a better understanding of their program design, implementation and evaluation.

Selection of the Initiatives

The selection of initiatives involved several steps. The first was a review of existing data on state efforts that were supported with CCDF quality improvement funds. To obtain this information, we analyzed 1999 CCDF plans from 45 states; research conducted by other organizations such as the Children's Defense Fund, Zero to Three, and the Child Care Bureau; and data from the 17 states that were the focus of the National Study of Child Care for Low-Income Families. Our initial scan produced a list of 445 initiatives.

To narrow the pool, we sent each state child care administrator the names of the programs we had identified in his or her state, with questions about the accuracy of the list and requests for additions, deletions and contact information for each program. The administrators' responses resulted in a set of 404 initiatives from 49 states. Virginia declined to participate.

We categorized these 404 efforts by three dimensions. The first was the type of strategy that states used to improve quality or expand supply. These included funding for program start-up; recruitment of family child care providers and training (workshops and train-the-trainer programs); materials and equipment; improving child care facilities; professional development activities (credential and degree programs, credit-bearing courses, financial aid for these purposes, and career development systems); compensation, including salaries and benefits; accreditation or ratings to improve quality; and other approaches (technical assistance, planning or evaluation, linking health and child care services, and miscellaneous). Another dimension was target population of children: infants and toddlers, preschool children, children with special needs, school-age children and children who need child care during non-traditional hours. The third was the type of child care setting: regulated family child care, center-based care and license-exempt child care.

We used several criteria to choose the initiatives for the research. First, we sought to ensure that the study included at least one example from each state, each quality improvement strategy, each target population, and each child care setting. To include a wide

variety of approaches in each strategy for improving quality, we decided to limit the number of examples that represented national models to enhance professional development and compensation like the T.E.A.C.H. Early Childhood® Project (Teacher Education and Compensation Helps), and those that represented accreditation by the National Association for the Education of Young Children (NAEYC), the National Association of Family Child Care (NAFCC) and the National School-Age Child Care Alliance (NSACA). In addition, we chose only a small number of examples of national initiatives like Map to Inclusive Child Care (Map) and Healthy Child Care America. At the same time, we selected only a few examples of generic approaches for improving quality like career development systems and differential reimbursement rates.

We used two other criteria as well. We excluded programs that were in the planning stages or those that had not been implemented before March, 2001, because we wanted examples of initiatives that had been operating for some time. We also looked for some evidence that there had been an effort to evaluate some aspect of the initiative because we planned to focus on evaluation in the second phase of the study.

The process resulted in a set of 104 initiatives, which reflect the wide range of approaches that states use to improve the quality of child care. These initiatives do not represent the universe of state quality improvement efforts, because we did not attempt to collect a scientifically random sample. Nor do they represent a compendium of "best" efforts, because effectiveness was not one of our criteria. Rather, the initiatives in this study serve as examples of the many ways that states use CCDF improvement funding to support quality child care for the children they serve.

Data Collection

We gathered data on individual initiatives through phone interviews with program administrators. In many cases, they were state child care administrators, who sometimes invited other staff to participate in the discussion. In other cases, they were individual program directors to whom the state administrators had referred us. On average, the interviews were 45 minutes to an hour. Many respondents provided written program descriptions and other materials.

The phone interviews focused on several sets of questions. One was related to the initiative's scope and scale, including the size of the budget as well as additional funding sources, the start date, and the geographic reach. Another set addressed implementation

issues. These included outreach or recruitment strategies, program design and delivery, and staff qualifications. We also collected data on the number of individuals served. Although we did not ask specific questions about goals for individual programs or how these goals related to overall strategies for improving quality, the respondents often shared some of this information with us.

The third set of questions was related to program outcomes and program evaluation. These were designed to gather information about whether and how states attempt to assess program efficacy.

We asked about the types of evaluation; whether the evaluation was conducted by the state, the program or an outside organization; and how states used the results of the evaluation.

We entered the data into a web data base to sort information across several variables. They include programs by state, by strategy, and by existence of an evaluation. We used these variables to identify general themes about how states use their funds, design and implement their programs, and how they evaluate them.

This chapter summarizes some of the characteristics of the 104 initiatives we selected for our study. It provides information about the geographic scope of the programs and the strategies they use to improve quality as well as the target populations of children and providers they aim to serve. In addition, it presents information about the duration of the initiatives based on the dates they were funded initially, the relative funding levels and some observations about their evaluation components.

Strategy

The largest proportion of the programs we selected use professional development activities to improve quality. Initiatives that rely on recruitment and training represent the second largest, followed by those that provide materials and equipment and those that use “other” approaches to improve quality. Programs that use compensation or accreditation/rating systems account for a relatively small proportion of the strategies, because we limited the number of initiatives that represented national models or approaches. There are also a small number of programs that provide funds for start-up. We selected only one program that uses funds to improve facilities.

Target Population

Most of the initiatives in the study serve more than one group of children. This reflects the large number that rely on professional development, compensation and accreditation/rating strategies as well as programs that link health and child care. The vast majority of the initiatives we selected serve infants and toddlers in addition to children in other age groups. (The emphasis on infants and toddlers may be the result of the CCDF infant/toddler earmark.) Only a small proportion, one fifth, serve a single population of children exclusively. Initiatives that specifically focus on infants and toddlers are the most common, with 11. Six programs serve school-age children exclusively; and four limit services specifically to children with special needs. Only one program serves children who need non-traditional hour care.

Approximately one in five of the programs we chose exclusively serve children who receive subsidies or those who live in low-income communities, according to information the respondents provided about outreach strategies or eligibility criteria.² Some initiatives exclusively serve subsidized children; others give preference to providers who provide subsidized care; and still others use it as one criterion for delivering services. A number of programs also limit recruitment to regulated caregivers who provide

subsidized care or those who serve low-income children.³ Others serve low-income communities where providers may or may not serve low-income families.

Type of Provider

We selected initiatives that provide services to all types of providers—regulated center-based programs and family child care providers as well as license-exempt caregivers. Approximately one third, however, are designed to serve specific providers. Initiatives that are limited to centers rank highest, with 18. Five initiatives are designed specifically for license-exempt caregivers; three are intended exclusively for family child care providers.

Start Date

Most of the programs we selected are relatively new or were developed in the past six years. Nearly one third of the initiatives were created in 2000 or 2001. Many of them seem to reflect an emphasis on strengthening infrastructure. Four of the five accreditation initiatives, for example, were funded for the first time during this period as were three of the seven programs that use compensation strategies to improve quality. Nearly a third of the 29 professional development initiatives and half of the six that support start-up activities were also funded in 2000. Other programs that started in 2000 include three of the six programs that rely on technical assistance as well as 3 of the 11 that use miscellaneous strategies.

Close to half of the programs in the study were created between 1996 and 1999. They include half of the 12 initiatives that use materials and equipment as a quality improvement strategy, half of the 19 recruitment and training programs, the other accredita-

² Federal regulations for CCDF funding require that states spend a significant portion of their funds on child care services or assistance for families earning 85% of the state median income or less (Greenberg, Lombardi & Schumacher, 2000). States fulfill these requirements through expenditures on grants and contracts to providers as well as vouchers for eligible families. These regulations do not apply specifically to the 4% that states must spend on quality improvement programs that aim to improve child care quality for low-income families.

³ Idaho's Training in a Manila Envelope (T.I.M.E.), for example, reaches out to providers who receive subsidies, while New Hampshire restricts participants in its Infant/Toddler Quality and Capacity Building program to licensed providers who are caring for low-income children. In New Mexico, providers are only eligible for AIM HIGH if 25% of children enrolled receive subsidies; a 30% enrollment of subsidized children is a requirement for Rhode Island's RiTe Care [sic] health insurance benefits.

tion/rating systems initiatives, the other technical assistance programs, and half of the miscellaneous programs. Ten professional development programs were also funded during this period.

A relatively large number of the initiatives initially funded between 1996 and 1999 are designed to support infants and toddlers or license-exempt caregivers. For example, five of the infant and toddler programs in the study were initiated in this period, as were four of ten programs for caregivers who are legally exempt from regulation.

The remaining programs in the study were established before 1996. They include half of the start-up initiatives, nearly a third of the recruitment and training programs, and three of the materials and equipment initiatives. Two of the five programs that link health and child care programs as well as two of those that use miscellaneous strategies were also created during this period as was the only facilities improvement program we selected.

Geographic Scope

Three quarters of the programs in our study are statewide. Typically, these represent efforts to improve the child care infrastructure by providing professional development opportunities. A significant number of recruitment and training initiatives and those that use materials and equipment are also statewide.

The small proportion of the initiatives that serve single or multiple sites rather than the entire state represent efforts to expand specific aspects of the child care supply through start-up funding or to improve specific aspects of care through workshops. In addition, several local initiatives are pilot efforts that use professional development strategies to improve quality.

Budgets

Budgets for the 104 initiatives in the study vary widely, ranging from \$36,000 for one professional development initiative to \$40 million for one compensation program. Efforts that aimed to strengthen the child care infrastructure have the highest median budgets, while those that address particular populations, specific

issues or local community needs are at the low end of the range. The exception is start-up programs, with a median budget of \$900,000, the third highest of the strategies, and a range of \$180,000 to \$3 million.

Among the strategies, initiatives that rely on compensation appear to have the largest budgets, with a median budget of \$1.3 million. Accreditation programs, with budgets ranging from \$95,000 to \$40 million follow, with a median budget of \$1 million. Initiatives that fall in the mid-range include the professional development programs, with a median of \$350,000; programs that link health and child care (\$301,000); and recruitment and training programs (\$300,000). Initiatives that use materials and equipment, miscellaneous strategies and technical assistance to improve quality represent the low end, under \$237,000.

Evaluation

Since one objective of our three-year project is to help state policy makers develop strategies for evaluating their efforts to improve quality, we tended to select programs that include an evaluation component. Approximately three in four of the initiatives in the study collect data about implementation. Many of these evaluations aim to answer questions about enrollment, participation and completion rates. Some focus on participants' satisfaction with or use of program services, while others look at the initiative's effects on participants' knowledge, skills or practice. Still other evaluations examine lessons learned. A few seek to understand the initiative's impact on broader issues related to child care quality such as retention and turnover.

In some cases, evaluations are part of statewide efforts to assess the results of quality initiatives. Many of the California programs in the study, for example, include evaluations because the state has developed a systematic approach for documenting the effectiveness of quality improvement efforts. Several evaluations of Minnesota's programs reflect a similar approach. They incorporate outcome indicators that the state has developed with child care stakeholders. Evaluations of North Carolina's programs, too, represent efforts to understand the impact of interrelated efforts across the state.

States face many choices in determining how to improve child care quality or expand child care supply. As policy makers seek to achieve these goals, they must make decisions about the objectives they aim to pursue. Should they seek to enhance children's health, safety and development by improving the quality of child care settings? Should they focus on supporting children's later success by enhancing caregivers' knowledge, skills or education? Should they aim to meet children's needs for stable, consistent care by improving staff retention?

The choice of objectives influences decisions about program design. Efforts to improve the child care environment, for example, require different approaches than those to improve caregiver training or those to reduce turnover. To create their programs, states have a variety of options. One is to develop their own initiatives to meet specific needs in particular communities or for particular populations of children. Another option is to replicate national models or adapt national initiatives. A third is to use initiatives or approaches that have been developed in other states.

States can, and do, often use multiple approaches in designing their programs. Some states—California, Minnesota, North Carolina, Wisconsin and Oklahoma, for example—have developed systematic plans for improving quality and have created comprehensive strategies to accomplish these objectives. Other states have developed an array of programs that are not necessarily linked in a coordinated effort. Distinctions among these approaches may be related to several factors, including the state's political culture, the presence and involvement of a strong child care constituency and the willingness to commit resources to child care.

MEETING SPECIFIC NEEDS

Programs for Children in Rural Areas

Among the programs we selected for the study are several examples of initiatives that aim to facilitate access to services for caregivers who would ordinarily have to travel long distances to obtain them. (Please see Volume II for full descriptions of these initiatives and others that are identified in the text.) Two are Alabama's Workshops on Wheels (WOW) Mobile and the Mobile Resource Library. Both use vans staffed with child care specialists to bring materials and equipment to caregivers in rural areas. Colorado's Child Care Quality Expansion Project and Nebraska's Infant Toddler Quality Initiative use a different

approach. Both fund substitute caregivers to enable rural providers to participate in training, in addition to providing support for other services.

Two initiatives in our study rely on distance delivery education programs to address the needs of rural caregivers. Wyoming's Infant Toddler Credential uses the internet, among other options, to offer the required courses. It also locates field placement sites within 20 miles of participants' homes. Idaho offers Training in a Manila Envelope (T.I.M.E.), a program for providers who work with children with special needs, as a correspondence course. T.I.M.E. instructors send participants weekly modules as well as comments on the previous week's assignment.⁴

We also included several examples of state initiatives that use local collaborations to provide services for caregivers who live in rural areas. One is Arizona's Coordination of Tribal Child Care Services Project, which relies on the Inter-Tribal Council's Early Childhood Working Group to deliver services. The Working Group, which includes representatives from 21 tribes as well as from different social service agencies, aims to establish a broad spectrum of services, because the Tribal Council cannot meet all of the needs of the tribes individually.

Addressing Language Issues

We selected several examples of initiatives that aim to support child care providers, children, and families whose first language is not English. Some focus exclusively on providers. Washington's Phase II Quality Enhancement Project uses two approaches in its Twilight Support Group: it provides written information in Spanish and uses bilingual translators who speak Vietnamese, Arabic, and Eastern European languages in its training sessions. Nebraska's Infant Toddler Quality Initiative, which works with Early Head Start, has also translated materials into Spanish. Like the Washington program, it uses also bilingual staff, who make home visits to offer technical assistance to providers.

The study includes several programs that provide training on language issues for providers who serve non-English-speaking children or their families. California's Fostering and Assessing the Development of a First and Second Language is an example. Designed to train teachers and directors who serve children with limited English proficiency, it includes topics on first and second

⁴ The other distance delivery education program, Massachusetts's Distance Learning Course, is designed for urban as well as rural caregivers.

language acquisition, assessing preschool language development, and teaching practices to support oral language. Two other programs—Minnesota’s Cultural Dynamics Education Project (CDEP) and Hawaii’s Getting Children Ready to Succeed—use a different approach. Both incorporate topics on language into broader curricula—CDEP in a training program that aims to promote culturally appropriate, anti-bias, disability-aware practice; Hawaii’s program provides support to license-exempt caregivers.

Meeting the Needs of License-Exempt Caregivers

Ten of the programs we selected for the study represent initiatives to support quality in license-exempt child care. They fall into two categories: those that are exclusively intended for license-exempt providers and those that include license-exempt providers as well as regulated family child care providers.

Six programs—Alabama’s Kids and Kin, Hawaii’s Getting Children Ready to Succeed, Iowa’s Child Care Home Consultant, Maryland’s Informal Provider Program, Massachusetts’s In-Home Relative Care Program and Michigan’s Better Kid Care/Joining Forces Program Phase II—are in the former category. Hawaii’s, Maryland’s and Massachusetts’s rely on materials and equipment as a primary strategy to enhance caregivers’ capacity to support child development and to provide safe, healthy environments for children. Each limits services to providers who receive state payments for providing care to eligible families. Getting Children Ready to Succeed mails packets about health, safety, child development and school readiness to participants each month. The Informal Provider Program distributes kits with art materials, while the In-Home Relative Care Program’s kits consist of safety equipment such as smoke detectors and a packet with information about well-child pediatric visits.

Three programs for license-exempt caregivers—Alabama’s, Iowa’s and Michigan’s—aim to help them become regulated family child care providers. These programs aim to serve license-exempt providers who receive state payments for child care as well as those who do not. Alabama’s Kids and Kin offers the 12 hours of training that are required for caregivers who want to become certified (regulated) family child care providers, while Iowa’s Child Care Home Consultant program uses three home visits to help providers comply with licensing requirements and complete the licensing process. Michigan’s Better Kid Care/Phase II consists of two components: training of trainers and recruitment and training of caregivers as regulated family child care providers.

Four initiatives—Minnesota’s Starting Out Successfully (SOS), Pennsylvania’s Home-based Providers Association Program, Ohio’s Ready to Learn, and Michigan’s R.E.A.D.Y. (Read, Educate and Develop Youth)—aim to serve both regulated family child care providers and license-exempt caregivers. Three use training as a primary strategy. The Minnesota and Pennsylvania programs focus on providers who serve children with special needs, while Ohio’s program provides workshops on using television as well as viewer guides and activity sheets. Michigan’s

R.E.A.D.Y., on the other hand, offers kits—audiotapes of children’s songs, children’s books, child development information and learning activities in both English and Spanish—to anyone who cares for children including license-exempt providers, regulated family child care providers, and parents.

Research, Planning or Evaluation

The study includes four examples of initiatives that represent state efforts to identify needs, develop strategic plans or evaluate existing initiatives. One is Washington state’s A Case for Culturally Relevant Care for Children and Families in King County, in which funding was used to identify the needs and interests of immigrant and license-exempt caregivers. Another is Delaware’s Early Success Program, a 10-year comprehensive statewide effort with strategic planning and evaluation components.

Two other initiatives represent efforts in which states have used quality funding for specific evaluation projects. In its Evaluation of the Infant Toddler Quality Enhancement Project, Mississippi funded an effort to measure the effect of Temporary Assistance for Needy Families (TANF) funding for materials and equipment on quality. California’s Quality Improvement Evaluation, on the other hand, consists of a systematic effort to evaluate the effectiveness of a large number of initiatives.

Institutionalizing or Expanding Programs

Several of the initiatives we selected are examples of institutionalizing pilot programs or extending existing programs. Eight initiatives in our study began as pilots. One example of institutionalizing a pilot program is California’s Training of TANF Recipients as Child Care Providers, a two-and-a-half year program of coursework and field placements. Initiated in 1997, it was funded in three sites. Three years later the state used CCDF funding to expand the program to 11 sites. Another is Tennessee’s Regional Child Care Resource Centers. The program, which provides materials and equipment as well as free workshops, was based on a local effort for children with special needs developed by United Cerebral Palsy and the Junior League in Chattanooga. It is now offered for providers in all counties across the state.

There are also several examples of states’ use of quality set-aside funding to strengthen existing programs. One is California’s Beginning Together. Created in 1999, it is designed to prepare qualified infant and toddler trainers to work with providers who serve children with special needs. A second example is Michigan’s Better Kid Care Satellite Training/Phase I and Better Kid Care Phase II/A Joining Forces Program. In the first phase of the project, funding was used to create videotapes and modules for training prospective family child care providers. The second phase focuses on recruiting and training them.

DRAWING FROM OTHER STATE OR NATIONAL EFFORTS

Replicating National Models

As we indicated in the methodology section, we selected a few

examples of initiatives that use national models to improve quality. We included four models in the study: T.E.A.C.H. and the Department of Labor Child Care Specialist Apprenticeship Program, both of which use professional development to improve quality; WestEd's Program for Infant/Toddler Caregivers (PITC), a train-the-trainer program for caregivers; Child Care Plus, a model inclusion program for children with special needs; and accreditation granted by national organizations. (Please see Appendix A for full descriptions.)

T.E.A.C.H. Early Childhood® Project (Teacher Education and Compensation Helps)

North Carolina's T.E.A.C.H. Early Childhood® Project has been replicated by numerous states. Its goals are to reduce turnover among child care workers by providing educational scholarships and increasing compensation. The examples we selected are the original T.E.A.C.H. program and two others—Florida's T.E.A.C.H. and the city of Seattle's Project Lift-Off. North Carolina's program has been active for 11 years; more than 13,000 child care providers have participated. Florida's T.E.A.C.H. began in 1995 as a pilot program, and was expanded statewide in 1998. Project Lift-Off includes T.E.A.C.H. as one component of a broad initiative intended to create quality early care, education and out-of-school-time activities for children and adolescents.

The U.S. Department of Labor's (DOL) Apprenticeship Program

The Department of Labor (DOL) has applied its apprenticeship program to the child care field. Child care apprenticeship programs, like others registered with the DOL's Bureau of Apprenticeship and Training, adhere to standards that require a combination of organized instruction and supervised on-the-job training, as well as progressively increasing wages. In addition to West Virginia's Child Care Specialist Apprenticeship Program, which served as the basis for the model, we selected two others: Vermont's and Nevada's.

WestEd Program for Infant/Toddler Caregivers (PITC)

The study includes four examples of WestEd's Program for Infant/Toddler Caregivers (PITC), a train-the-trainer program designed to improve the quality of child care for infants and toddlers, in addition to the original effort, which was developed and used extensively in California. Two examples—North Dakota's Infant/Toddler Enrichment Program and South Dakota's Infant/Toddler Training Initiative—have WestEd's infant toddler training series as the core of their professional development activities, while Florida's Infant Toddler Quality Enhancement Program includes PITC training as one of several training options.

Child Care Plus

Two programs in the study are replications of aspects of Child Care Plus, a multi-faceted program developed by the Center on Inclusion in Early Childhood at the University of Montana. They are Idaho's T.I.M.E. and Maine's Child Care +ME, both of which draw from the Center's work to improve child care for children with special needs.

National Accreditation

Accreditation granted by NAEYC, NAFCC and NSACA represents another national model for improving quality. It can serve as a primary strategy or as one component of a broader effort that includes multiple approaches. Accreditation is often linked to rating systems, which reward programs for achieving higher levels of quality.

We included six examples of initiatives where accreditation is the primary strategy for improving quality: Arkansas's School-Age Accreditation Project; Connecticut's School Readiness Program; Georgia's Black Child Development Institute (BCDI)-Atlanta Affiliate Early Childhood Leadership Mentoring Project; North Carolina's Quality Improvement Grants; Washington's Regional Action Program (WRAP); and Wisconsin's Quality Improvement and Staff Retention Grants. Two initiatives—Kentucky's Quality Rating System and North Carolina's Five-Star Rated License System—use accreditation as one component of their rating systems.

Implementing National Initiatives

National initiatives differ from national models because they represent general approaches rather than defined program designs. We used four in the study: Healthy Child Care America, Map to Inclusive Child Care, Out-of-School Time, and career development systems. Healthy Child Care America aims to improve children's health and safety in child care; Map to Inclusive Child Care supported inclusive child care; Out-of-School Time focuses on child care for school-age children; and career development systems, to create systematic approaches for providing professional development opportunities for child care providers.

Healthy Child Care America/Nurse Consultants

The Healthy Child Care America (HCCA) Campaign, a joint initiative of the federal Child Care Bureau and the federal Maternal and Child Health Bureau, stimulates collaborative efforts of the public health and early childhood communities in partnership with families. Its Blueprint for Action outlines ten action steps that states and communities can adapt to meet HCCA goals.

Creating cadres of child care health consultants—one of the recommended action steps—has offered states and communities a structure for providing a variety of health and safety training activities as well as direct support to child care providers and families. Three programs in the study, all of which rely on nurse consultants, are based on HCCA. Two are statewide efforts, Healthy Child Care Iowa and Healthy Child Care Missouri; and one is county level, the Community Health Nurse Consultation Program in Pierce County, Washington.

Map to Inclusive Child Care

The goal of Map to Inclusive Child Care (Map) was to provide technical assistance to states and to expand quality inclusive child care options for children (birth to 12) with special needs. Funding was provided by the federal Child Care Bureau. The project was coordinated by the Division of Child and Family Studies at the University of Connecticut.

Participating states assembled a diverse team of stakeholders. After assessing barriers, these teams developed, with assistance from Map, strategies for implementing inclusive child care in their states. Six of the seven programs in the study that serve children with special needs are Map programs. They are Alaska's Inclusive Child Care Initiative, Arizona's Coordination for Tribal Child Care Services, California's Child Development Training Consortium, Connecticut's School Readiness Program, Massachusetts's Child Care in the Neighborhood and West Virginia's Child Care Specialist Apprenticeship program.

Out-of-School Time

Several interrelated national efforts are dedicated to improving the availability, quality, and viability of programs serving children ages 5 to 14 when they are not in school. Notable among them are the National Institute on Out-of-School Time (NIOST) at Wellesley College, the National School-Age Care Alliance (NSACA), and the Finance Project's Out-of-School Time (OST) Project.

For more than two decades, NIOST has worked to improve care for school-age children through research, evaluation, and consultation; policy development and public awareness; training; and curriculum development. Among NIOST's pioneering projects was the development of a self-study guide, *Advancing School-Age Quality*. NSACA, the national membership organization of school-age programs, based its Standards of Quality School-Age Care and its accreditation system on NIOST's work. OST was launched in 1999 to provide information and technical assistance to assist state and community leaders in developing financing strategies for out-of-school time initiatives. In the study, North and South Dakota's school-age programs represent examples of state initiatives that rely on this approach.

Career Development Systems

Across the country, states are building systems that define the education and experience required for progressively more responsible positions in early care and education programs. Explicitly or implicitly linking wage and/or benefit increments to each step on the ladder, these systems aim to encourage practitioners to make early childhood education a lifelong career. Many of them are based on concepts of career systems generated by Wheelock College's Center for Career Development in the early 1990s. Two examples in the study include Georgia's *Advancing Careers through Education and Training (ACET)* and Washington state's *Statewide Training and Registry System (STARS)*.

Nationwide Approaches

In the past several years, a large number of states have developed initiatives that rely on rating systems and differential reimbursement rates to improve child care quality. Rating systems link reimbursement rates to changes in the child care environment, staff education or training, or accreditation status. Our study includes seven examples. Some, like North Carolina's *Five-Star Rated License System* and Kentucky's *Quality Rating System for Child Care*, use rating systems as a primary strategy. Others, like Utah's *Career Ladder/Provider Achievement*

Awards, use it as one of several strategies.

Differential reimbursement rates—providing higher payment levels for programs that serve specific populations of children or those that have attained higher quality levels—is another approach that has been widely used nationwide. Three of our examples are Missouri's system, which provides differential rates for providers who serve children with special needs; New York's, which provides higher reimbursement rates for providers who care for children during non-traditional hours; and Utah's, which reimburses accredited programs at higher levels than those that have not achieved this status.

Approaches From Other States

Several of the programs we selected represent approaches based on other states' efforts to improve quality. Some aim to reduce turnover in the field by increasing compensation or benefits. The North Carolina T.E.A.C.H. Early Childhood® Health Insurance Program, for example, mirrors Rhode Island's RItE Care, which provides subsidized health insurance for child care providers. Wisconsin's R.E.W.A.R.D. program and Utah's Career Ladder Provider Achievement Program are based on North Carolina's WAGE\$, which provides salary increases for staff who remain with their current programs.

Others use different kinds of strategies. One example is the Illinois Director Credential Program, which uses professional development as an approach to improve quality. It is based, in part, on California's Early Childhood Mentor program, which has served as a model for many mentoring programs. Among them is Oregon's Mentoring Project, another initiative in our study.⁵ Started in 1998, it recruits experienced child care providers, trains them as mentors, and then pairs them with providers to help them achieve annual goals.

Developing Collaborations

In some cases, quality initiatives reflect objectives that are shared by two or more organizations. Some partnerships represent collaborations between child care agencies and other public agencies, each of which contributes to funding and program implementation. Other programs are public-private partnerships, in which funding is shared, but the initiative is implemented by the public agency.

Public Partnerships

Several of the programs we selected rely on joint funding from state agencies. The Connecticut School Readiness Program, for example, depends upon funding from the Department of Social Services and the Department of Education, while Vermont's Child Care Apprenticeship Project is supported by the state's Department of Employment and Training as well as the state's

⁵ Several other programs in our study—Pennsylvania's Home-based Provider Association, California's Child Care Training for TANF Recipients, Oklahoma's Scholars for Excellence in Child Care, the District of Columbia's Higher Education Scholarships—also rely on mentors in some capacity.

Department of Education, and the federal Department of Labor.

In addition to the Healthy Child Care America programs, there are two other examples of public partnerships that aim to address health issues for children in care. One is Massachusetts's Collaborative Model for On-Site Mental Health Services, which responds to children's mental health needs. The pilot program is a partnership of the Division of Medical Assistance (DMA) and the Office of Child Care Services (OCCS), which work together to provide mental health services to children in child care. The cost for the mental health care is covered by DMA and OCCS, depending on where the care is provided.

The other is Washington state's Partners in Child Care, which aims to strengthen disease prevention in child care settings. The program—a partnership between the County Health Department, the state child care agency, and a child care resource and referral (CCR&R) agency—offers training on healthy environments and illness prevention to child care providers.

Public-Private Partnerships

Eight of the programs we profiled are collaborations of public and private organizations. In many cases, the non-public partner is a private foundation. One example is the Illinois Director Credential Program, which receives significant funding from the McCormick Tribune Foundation and the American Business Collaborative for Quality Dependent Care in addition to public funds. The McCormick Tribune Foundation funded the planning phases and the pilot project; it continues to contribute funding for its implementation.

Another foundation, the Bush Foundation in Minneapolis, has also played a major role in collaborations with state child care agencies. It funded the pilot for North Dakota's Infant/Toddler Enrichment Program and the Infant/Toddler component of its Tribal Consult Program as well as a three-year grant for South Dakota's Infant/Toddler Training Initiative.

Foundations also contributed to the development of two California programs that we included in the study. The Packard Foundation and the United Way funded the pilot phase of the Early Childhood Mentor Program as well as its expansion statewide, while Bank of America provided the seed money for the Child Care Initiative Project (CCIP) and supported it until it was funded by the state.

Illinois's Child Care Development Program is an example of a different kind of public-private partnership. The Illinois Facilities Fund, which manages the initiative, raised \$2 million from the Chicago Community Trust for collateral financing and the debt service reserve account to finance new child care facilities. Other foundations provided support for the loan component. Public funds are paying off the bonds that were issued for the loans.

We also selected one example of a collaboration with local businesses, Indiana's Business Partnership Pilot Project. It aims to build relationships with local businesses to leverage funds to cover the cost of child care for their employees. The program does not receive additional funds for its operational costs; rather, it seeks to involve local businesses in child care financing.

PROFESSIONAL DEVELOPMENT

Initiatives that use professional development strategies to improve quality represent the largest share of programs we selected. They account for 29 entries, nearly a third of the programs in the study. It is likely that the size of this category is related to several factors. One is the process that we used for selecting programs. As we indicated in Chapter II, we chose only a small number of programs that were based on national models or initiatives, because they are relatively common approaches for improving quality. As a result, the number of programs in the professional development category is higher than any other category in the study.

Another factor may be our definition of professional development: efforts that promote academic or career advancement in the field. States may fund initiatives that support these objectives, because research findings point to caregiver education as a predictor of child care quality.

Professional development initiatives consist of certificate as well as credential and degree programs and credit-bearing courses; financial aid programs to enhance access to these kinds of education; and structural initiatives that support career development systems. This category includes all of the initiatives that identified professional development as a primary strategy, although they may use other strategies as well. Volume II provides full descriptions of each of the programs.

Strategies

Certificate, Credential and Degree Programs

Seven initiatives offer certificates, credentials, degrees and credits. They are: Alabama's Kids and Kin; California's Training Program for TANF Recipients as Child Development Teachers Project; Illinois's Director Credential Program; New York's Infant Toddler Certificate Credential Program and its School-Age Child Care Credential; Pennsylvania's Delaware Valley Child Care Council's Leadership and Mentoring Project; and Wyoming's Infant Toddler Credential.

We selected two initiatives that lead to a certificate. They are New York's Infant Toddler Certificate Credential program and Alabama's Kids and Kin. The former, a 12-hour college credit program linked to the Child Development Associate (CDA) credential, is provided in 28 locations. The latter offers license-exempt relative providers a four-month workshop series, with a

\$200 incentive in materials and equipment for completion. The two credential programs in the study are New York's School-Age Child Care Credential and Wyoming's Infant Toddler Credential. The New York program, a pilot, is based on the U.S. Army's competency-based credential. It consists of 120 hours of classroom training or independent study, a portfolio and a resource file. Wyoming's Infant Toddler Credential is offered as a CDA program, a credit-bearing program or as WestEd training.

The three degree programs we selected include the Delaware Valley Child Care Council's Leadership and Mentoring Project in Pennsylvania, the Illinois Director Credential Program, and California's Child Care Training Program for TANF Recipients. The Delaware Valley program offers five workshops that lead to an associate's degree. Participants can apply the workshops toward the first five weeks of a bachelor's or master's degree program at East Stroudsburg University.

The Illinois Director Credential Program offers two options: participants can enroll in an institution of higher education approved by the Illinois Credential Commission or they can complete a portfolio that documents their degrees, management coursework, experience and professional contributions to the field. California's Child Care Training program for TANF Recipients aims to help welfare recipients obtain a college degree and employment in a child care center. The program's classroom instruction and paid placement meet welfare-to-work requirements; mentors provide support to participants throughout the program.

Apprenticeship Programs

As we indicated earlier, we selected three U.S. Department of Labor's Child Development Specialist Apprenticeship Programs. The oldest is West Virginia's, which began in 1989. Nevada's program was implemented in July, 1999. Vermont's program began to recruit participants in the fall of 2000.

There are some differences among them. In West Virginia, the program is part of a career system: participants who receive a certificate reach level five of the state's eight-level career path. Nevada's program requires a minimum \$6 hourly wage and 50 cent hourly increases in the second year. In West Virginia there is no specific mandated wage increase, while in Vermont, apprentices receive a wage increase of 25 cents an hour, which then increases to 50 cents after they have completed the first component of the training. Nevada's program provides technical assistance to center sponsors, while Vermont's initiative requires 12 hours of additional training.

Credit-bearing Courses

In addition to the Wyoming Infant Toddler Credential, six initiatives in the professional development category represent efforts to increase providers' educational levels through credit-bearing courses.⁶ They are California's Fostering and Assessing the Development of a First and Second Language, Idaho's T.I.M.E., Ohio's Ready To Learn, Massachusetts's Distance Learning Courses, Minnesota's Inclusive Child Care/On-Site Consultation Program, and New Hampshire's Infant Toddler Quality and Capacity Building Program. Four offer college credits and two offer continuing education credits.

Participants in Idaho's program can earn college credit from the University of Idaho for their coursework, while those in Minnesota's can earn college credit for completion of a 16-hour series that is based on Sonoma State University's Project Exceptional curriculum (which is also used in California's Beginning Together program). The New Hampshire program consists of a week-long graduate seminar that is offered by Wheelock College; participants also receive grants for equipment to enhance their capacity to serve infants and toddlers. The California program offers the option of one unit of community college credit.

Massachusetts's Distance Learning Courses offers continuing education credits for completion of three four-unit courses on infants and toddlers, inclusion and school-age child care. Continuing education credits are also offered for successful completion of Ohio's Ready to Learn workshops.

Financial Assistance

Six of the initiatives we selected offer financial support to help providers obtain a certificate, a CDA credential, or a degree. They include Alabama's Statewide Leadership Scholarship; California's Child Development Training Consortium; the District of Columbia's Higher Education Scholarship; New Mexico's AIM HIGH; Tennessee's Even Start Family Literacy Program; and Texas's Train Our Teacher (TOT).

There are some differences among these efforts. Alabama and Texas provide financial support for individuals. Alabama provides tuition for a full-year program that it defines as two semesters and a summer term. Its scholarships cover transportation and substitutes as well. Texas's funding is limited to \$1,000, which can be used for tuition, books and transportation to community colleges; Tennessee subsidizes the partial costs of a CDA program for Even Start instructional staff.

By contrast, California's Child Development Training Consortium (CDTC) and the District of Columbia provide financial support directly to the institution of higher education in which participants are enrolled. CDTC Community College Reimbursement funds can be used for tuition reimbursement, instructor fees, and tutorial or translation services for providers who are enrolled in courses required for a permit. In addition, the CDTC provides

funds for fees for first-time permits, renewals, or upgrades. AIM HIGH funds can be used for tuition for college courses or for other training activities such as workshops. Many providers take advantage of the program to complete training to progress on the state's career lattice.

New Mexico and the District of Columbia provide support in addition to scholarships. AIM HIGH includes program development specialists, who help providers locate the training they want and need, while the District's program provides mentors, often former scholarship recipients, who meet with students throughout the year.

T.E.A.C.H.

There are some distinctions in the implementation of the three T.E.A.C.H. models in the study—North Carolina's, Florida's, and Seattle's Project Lift-Off. North Carolina's T.E.A.C.H. does not require enrollment in a degree program. Its scholarships are available for providers who enroll in the state's Early Childhood Administrator or CDA programs, in addition to the associate's or bachelor's degree programs and the Early Childhood Model/Mentor Teacher program. Providers who participate must remain in their current program for a year after they complete the training, for which they receive increased compensation. Florida offers scholarships for regulated providers who enroll in community college courses as well as CDA programs. Participants must commit to remaining with their current programs for six months to a year.

Career Development Systems

We selected four initiatives that use career development systems to improve quality. These efforts include four basic components: a defined set of core competencies; approved courses or workshops that enable participants to acquire related knowledge and skills; a registry of trainers who have been approved to offer these courses; and a practitioners registry of completed training.

Three initiatives—Georgia's Advancing Careers through Education (ACET), Montana's Early Care and Education Program, and Washington's State Training and Registry System (STARS) use career systems as a primary strategy. ACET, which was established in 1993, is the oldest career development system we profiled. In addition to the basic elements, it manages Georgia's wage supplement program, INCENTIVE\$, which is designed to improve retention in the field.

Montana's program began in 1995 as part of the state's Best Beginnings program. In addition to a core knowledge base, a practitioners registry, and a trainers approval system, the program provides scholarships for providers who are seeking NAEYC or NAFCC accreditation.

Created in 1999, STARS is designed to link licensing requirements and training. All licensed providers in the state must comply with its guidelines. The program also provides some scholarship support for providers who demonstrate financial need.

The other career development initiative, Utah's Career Ladder

⁶ Casper College offers the credit-bearing courses for Wyoming's Infant Toddler Credential.

and Provider Achievement Awards, incorporates a rating system linked to compensation in its career ladder. The program is described in the Compensation section, below.

Auspices and Outreach

States often turn to state institutions of higher education like community, technical, two-year or four-year colleges to offer professional development services. For example, community colleges offer the courses for New York's Infant Toddler Certificate Credential, Wyoming's Infant Toddler Credential and California's TANF Child Care Training program. Higher education institutions—Montana State University is one example—typically are responsible for managing career development systems, while state child care agencies operate financial aid programs.

Child care resource and referral (CCR&R) agencies often play a role in credential or degree programs as part of a collaboration or as the oversight agency. The two New York programs, for example, represent partnerships between CCR&Rs and other agencies—Empire State College in the Infant Toddler program, and Cornell Cooperative Extension Service in the School-Age Credential. The Illinois Network of Child Care Resource and Referral Agencies operates the Director Credential Program.

Many of the professional development programs recruit participants through mailings to providers on licensing lists, presentations at conferences, or announcements on their websites. Some programs also recruit participants through college catalogues. New York, for example, uses college catalogues and CCR&R videoconferences to inform providers about the Infant Toddler Certificate Program, while California sends mailings about the TANF training project to subsidized families and makes announcements about the program at community college classes.

Budgets

Budgets for professional development programs rank fourth in median budgets in the study. They range from \$36,000 in the Wyoming Infant Toddler Credential Program to \$4 million in the New York Infant Toddler Certificate Credential Program. Programs in the low range—\$36,000 to \$200,000—are all statewide initiatives that include the distance learning programs in Idaho and Massachusetts as well as the apprenticeship programs in Vermont, Nevada, and West Virginia. Also included in the low range are the two programs that support leadership training for directors—the Illinois Director Credential Program and the Pennsylvania Leadership and Management Program.

Budgets at the high end of the category range from \$1 million to \$4 million. They include scholarship programs like North Carolina's T.E.A.C.H., Project Lift-Off and the Tennessee Family Literacy Program.

RECRUITMENT AND TRAINING

We have divided the 19 recruitment and training programs we selected for the study into three subcategories. The first consists

of initiatives that focus on reaching out to prospective family child care providers and providing them with various supports they may need to complete the licensing process. The second consists of training workshops that are intended to improve quality by enhancing providers' knowledge without the option of academic credit. The third, and largest, subcategory consists of train-the-trainer programs.

Strategies

Recruitment of Family Child Care Providers

Recruitment programs typically aim to increase child care supply in areas with few child care options, particularly those in low-income areas. We selected a small number of initiatives that aim to achieve this goal. They are California's Child Care Initiative Project (CCIP); Iowa's Child Care Home Consultant Program; Michigan's Better Kid Care Phase II/A Joining Forces Program; Nebraska's Infant Toddler Quality Initiative; and Washington's Building Blocks. (Please see Volume II for program profiles.) Typically, these programs intend to help caregivers comply with licensing and related health and safety standards by providing technical assistance, materials and equipment, and/or home visits.

Three programs—Iowa's, California's, and Nebraska's are statewide, although services are offered at the community level. Iowa uses home visits to assess providers' homes and practices and to provide business as well as other technical support. Occasionally, it provides incentives like carbon dioxide detectors and fire extinguishers. Staff also helps providers throughout the registration process.

The California Child Care Initiative Program (CCIP), on the other hand, emphasizes training. One of the oldest initiatives in the study, it serves as the model for many similar efforts across the country. CCIP training generally focuses on child development, business operations, child safety and licensing requirements, although it is tailored for individual sites.

Nebraska's Infant Toddler Quality Initiative is part of its Early Head Start program. Each site recruits providers who serve very young children and assesses their care with the Infant Toddler Environmental Rating Scale (ITERS) and the Family Day Care Rating Scale (FDCRS). Early Head Start staff provide training to meet their needs.

The other two recruitment programs—Washington's and Michigan's—focus on a small number of communities. Washington state's Building Blocks is an outgrowth of Family to Family, a family child care recruitment and training program that began in the early 1990s with corporate support. It offers workshops that are required for all family child care providers who seek to become licensed. The Michigan initiative was discussed in an earlier section.

Workshops

Five of the programs in the recruitment and training category consist of single workshops or a workshop series. They include two programs in Massachusetts—the Domestic Violence Training Program and Child Care in the Neighborhood—as well as two in

Minnesota—Starting Out Successfully (SOS) and the Cultural Dynamics Education Project. Washington’s Partners in Child Care is the fifth. Each focuses on a single issue. (Please see Volume II for program profiles.)

Massachusetts’s Domestic Violence training program, a pilot program in six sites, is designed to help providers understand the impact of domestic violence on children and how to make referrals to appropriate organizations. Mental health and domestic violence experts teach the workshops, which are offered as one-day, two half-day or three evening sessions and can be applied towards licensing training requirements.

Massachusetts’s Child Care in the Neighborhood and Minnesota’s SOS focus on children with special needs. The centerpiece of the Massachusetts’s program is a videotape about inclusion that can be used in training and is available on loan to providers. SOS uses a more common approach. It provides training through four visits during a six-month period to help providers identify children who need services and refer them to appropriate organizations.

The two other workshop programs, Minnesota’s Cultural Dynamics in Education (CDEP) and Washington’s Partners in Child Care, both of which were described earlier, focus on different topics. CDEP provides training on cultural competence and anti-bias practice, while Partners in Child Care relies on health professionals to teach workshops on disease prevention.

Train-the-Trainer

Training trainers to offer workshops to enhance providers’ knowledge and skills is a relatively common strategy. Nine of the programs we selected for the study use this approach. They include the four programs based on WestEd: California’s Program for Infant Toddler Caregivers (PITC), North Dakota’s Infant/Toddler Enrichment Program, South Dakota’s Infant/Toddler Training Initiative, and Florida’s Infant Toddler Quality Enhancement; as well as California’s Beginning Together (Special Needs Training for PITC Trainers) and its Early Childhood Mentor Programs; North Carolina’s Basic School-Age Child Care Training; Michigan’s Better Kid Care Phase II; and Pennsylvania’s Home-based Provider Association Program. (Please see Volume II for program descriptions.)

The four WestEd programs focus on preparing caregivers to work with infants and toddlers, while the other train-the-trainer programs focus on different issues. Two—California’s Beginning Together and Pennsylvania’s Home-based Provider Association, both of which were described earlier—prepare trainers to teach providers who work with children with special needs. North Carolina’s Basic School-Age Care Training addresses issues related to school-age children, while California’s Early Childhood Mentor Program trains child care professionals to serve as mentors to new practitioners.

Auspices and Outreach

Three recruitment initiatives rely on CCR&Rs to deliver services. California’s extensive CCR&R network manages CCIP; Iowa’s

Child Care Home Consultant Program is operated by CCR&R staff across the state; and Washington’s Building Blocks is provided by CCR&Rs in 17 sites. Michigan’s Better Kid Care Phase II, on the other hand, is managed by Michigan State University, and Nebraska’s program is operated by Early Head Start sites.

In general, these initiatives use similar approaches to reach participants. In CCIP, CCR&Rs recruit participants for family child care training at local welfare agencies, schools and community organizations. Better Kid Care Phase II reaches out to potential participants through organizations that are located in the low-income neighborhoods where it aims to expand the supply of regulated family child care. Building Blocks recruits prospective providers through licensing orientations. The Nebraska program, however, uses various strategies including building trusting relationships between the Early Head Start staff and prospective participants.

CCR&Rs also play a major role in three workshop programs—the two Massachusetts initiatives and the Washington program. Minnesota’s SOS, on the other hand, is provided by a community action agency, Anoka County Community Action; CDEP by the Early Childhood Resource Center within the state’s Department of Children and Families.

The CCR&Rs and SOS agencies recruit participants through provider networks and their own registries. CDEP recruits providers with flyers that it posts at local organizations and child care centers.

CCR&Rs manage several train-the-trainer programs as well: they provide the WestEd training in all four sites. Institutions of higher education are responsible for the other train-the-trainer initiatives. Sonoma State University provides Beginning Together training; the 4-H Youth and Development Department at North Carolina State University offers the Basic School-Age training; and Michigan State University provides training for Better Kid Care.

Several train-the-trainer programs—Beginning Together, the Home-based Providers Association, and Better Kid Care—recruit participants from lists of registered providers. Beginning Together turns to qualified PITC trainers; the Providers Association relies on licensing lists for its mentees; and Better Kid Care uses direct mail to providers as well as ads in newspapers. North Carolina’s School-Age training program uses a different strategy. It recruits providers through word of mouth and its web site.

Budgets

The five workshop programs’ budgets are among the smallest in the recruitment and training category. They range from \$120,000 for Child Care in the Neighborhood to \$356,000 for Partners in Child Care. Budgets for the three other workshop programs—SOS, CDEP, and Domestic Violence—are \$100,000, \$200,000, and \$240,000 respectively.

Budgets for the recruitment programs vary widely. They range

from \$146,000 for Nebraska's Infant and Toddler program to \$1.5 million for CCIP. The budget for Washington's Building Blocks was \$184,000; Better Kid Care Phase II, \$270,180; and Iowa's, \$300,000.

Train-the-trainer programs comprise the middle and high-end of the spectrum for the recruitment and training budgets. Budgets for the four WestEd programs extend from \$600,000 and \$800,000 for the North and South Dakota programs respectively to \$1.5 million for California's PITC and \$2.6 million for Florida's Infant Toddler Quality Enhancement Program. There is also wide variation in the budgets for the other train-the-trainer programs. The budget for Beginning Together is \$250,000, while the budget for the Providers Association program is \$449,000. The Early Childhood Mentor program's budget is \$2.2 million.

MATERIALS AND EQUIPMENT

Like training, distributing materials and equipment is a relatively common strategy among the programs we selected. Twelve initiatives in the study rely on this approach. They include three Alabama programs—Caring for the Caregiver, the Mobile Resource Library, and the WOW Mobile; Hawaii's Getting Children Ready to Succeed; Maine's Child Care +ME; Maryland's Informal Provider Program; Massachusetts's In-Home Relative Child Care Program; Michigan's R.E.A.D.Y.; Tennessee's Regional Child Care Resource Centers; Texas's Middle Rio Grande Workforce Board Quality Initiatives for Child Care; and two Washington State programs—the MiniGrant Program and the Quality Growth Plan. (Please see Volume II for program profiles.)

Strategies

The types of materials and equipment that these programs distribute vary. Some initiatives, such as Michigan's R.E.A.D.Y., Alabama's Mobile Resource Library, and Washington's Quality Growth Plan, provide books as well as audiotapes or games to support child development. Others, like Texas's program, distribute computers and age-appropriate software. Maine's Child Care +ME provides a wide variety of materials, including adaptive equipment, to facilitate the classroom participation of children with special needs.

Several programs distribute materials that are only on loan. In Texas, for example, the computers are on permanent loan to centers and family child care homes providing that they maintain their licensed status. In Alabama, the Mobile Resource Library lends materials as a means of maintaining connections with providers.

Almost all of the programs that distribute materials and equipment provide some additional supports for participants. Some, like Tennessee's Regional Child Care Resource Centers and Hawaii's Getting Children Ready to Succeed, offer training workshops. Others, like Washington's Quality Enhancement Mini-Grant Program and Maryland's Informal Provider Program, provide consultations through home visits.

Auspices and Outreach

Most of the programs that use materials and equipment as a quality improvement strategy turn to CCR&Rs to deliver services. In Alabama, for example, CCR&Rs are responsible for providing materials to providers in the Caring for the Caregiver, WOW Mobile and Mobile Resource Library programs. Maryland's Informal Provider Program is also offered by CCR&Rs, as are Massachusetts's In-Home Relative Child Care Program and Washington's Mini-Grant Program.

A few programs rely on other kinds of organizations. Two initiatives, Hawaii's and Maine's, are offered by institutions of higher education—the University of Hawaii and the Center for Community Inclusion at the University of Maine. R.E.A.D.Y. is operated by the state child care office. Washington's Quality Growth Plan is offered by the Puget Sound school district.

Agencies use a wide variety of strategies to recruit participants. In addition to mailings, these include flyers, newsletters, or presentations. Maine's Child Care +ME, for example, informs potential providers through presentations at meetings like the statewide Health and Safety, and Association for the Education of Young Children (AEYC) conferences. Alabama's Mobile Resource Library publicizes its services through a quarterly newsletter and training calendars, while Washington state disseminates information about the Quality Enhancement Mini-Grant through presentations at state licensing orientations and early childhood education college programs.

Budgets

Budgets for the 12 programs in this category range from \$45,000 for the Mobile Resource Library to \$2.5 million for R.E.A.D.Y. Initiatives at the low end include Texas's program, at \$73,000; Alabama's Caring for the Caregiver, at \$80,000, and the two Washington programs—the Quality Growth Plan, \$120,000 biennially and the Mini-Grant, \$86,897. Mid-range programs include Child Care +ME, at \$350,000, the Informal Provider Program, \$400,000, and Getting Children Ready to Succeed, at \$475,000. The programs at the high end of the range have seven figure budgets. R.E.A.D.Y. and the Regional Child Care Resource Centers have budgets of \$1.1 million.

ACCREDITATION PROGRAMS **NAYEC, NAFCC, NSACA Credential**

We selected six programs for the study that use accreditation as a recognizable and tangible means of defining quality. They include Arkansas State University's School-Age Accreditation Project; Connecticut's School Readiness Program; Georgia's Black Child Development Institute (BCDD)-Atlanta Affiliate Early Childhood Leadership Mentoring Program; Kentucky's Quality Rating System for Child Care; North Carolina's Quality Improvement Grants; Washington's Regional Action Project (WRAP); and Wisconsin's Quality Improvement and Staff Retention Grants. (Please see Volume II for program profiles.)

Strategies

Three programs use accreditation as a primary strategy: Georgia's BCDI-Atlanta Affiliate Early Childhood Leadership Mentoring Project focuses on NAEYC accreditation. Arkansas's School-Age Accreditation Program and Washington's WRAP focus on the NSACA credential. The Georgia program assigns mentors to aspiring centers that have African-American directors and serve large proportions of African-American children. The program also pays for NAEYC validation visits. WRAP provides grant funds to family child care providers and centers for self-study, training or technical assistance. Unlike the other initiatives, Connecticut's School Readiness program aims to support both NAEYC and NAFCC accreditation. It requires all providers that receive funding to acquire accreditation within three years.

North Carolina and Wisconsin's programs use accreditation, among other strategies, to improve quality. North Carolina's also relies on professional development, while Wisconsin's links accreditation with compensation. Funds from the Quality Improvement component can be used to pay for accreditation fees, while the Staff Retention component rewards providers and centers that become accredited. (Please see Compensation, below.)

A few programs in the study provide support for the accreditation process, although they do not use accreditation as a primary strategy. The Washington Mini-Grant Program, which relies on materials and equipment as a primary strategy, provides funds for self-study towards the NSACA credential. New Mexico's AIM HIGH scholarship program pays fees for providers who express an interest in accreditation.

Auspices and Outreach

The accreditation initiatives are managed by a variety of organizations. The Atlanta Affiliate of the Black Child Development Institute, a national organization, operates the Georgia program, while Arkansas State University operates the Arkansas school-age child care project. School's Out, a not-for-profit organization, offers Washington's accreditation program. Connecticut relies on its local School Readiness Councils to deliver its program, and Wisconsin uses CCR&Rs to distribute information.

The accreditation programs concentrate on reaching centers and providers that have demonstrated an interest in attaining this standard of quality. They use a variety of strategies to inform providers about these programs. The BCDI-Atlanta Affiliate Early Childhood Leadership Mentoring Project, for example, reaches out to potential participants through licensing lists, while WRAP recruits through CCR&Rs as well as lists provided by the Department of Social and Health Services. The Connecticut School Readiness Councils distribute requests for proposals to child care centers and family child care providers.

Budgets

Budgets for the four programs that use accreditation as a primary strategy range from \$95,000 for Arkansas's School-Age Child Care

Accreditation Program to \$40 million for Connecticut's School Readiness Program. WRAP (\$150,000), the BCDI-Atlanta Affiliate Early Childhood Leadership Mentoring Project (\$230,000), and Wisconsin (\$1.4 million) fall in the middle.

RATING SYSTEMS

We included three examples of states that use rating systems to improve quality. Two programs in this category—Kentucky's Quality Rating System and North Carolina's Five-Star Rated License System—use rating systems as a primary strategy, while the third, Utah's Career Ladder/Provider Achievement Program, links rating to its career development system, a professional development strategy, where we have categorized it. (Please see Volume II for program descriptions.) These systems rate programs on a combination of factors that include program standards, staff education levels, licensing records, and staff-child ratios. Accredited providers and centers usually receive the highest ratings. Rating systems are often linked to existing career ladders; in some instances, the rating system serves as the career ladder. Rating systems are also frequently tied to approaches to increase compensation.

Strategies

In Kentucky's Quality Rating System for Child Care, a pilot program, providers and centers that achieve the three highest ratings are eligible for a one-time cash bonus. The highest quality rating—four—is defined by accreditation standards. By contrast, North Carolina's Five-Star Rated License Program offers a voluntary option of exceeding the minimum one-star rating standard that is associated with licensing. Providers who achieve higher ratings are rewarded with an increased number of subsidized child care spaces.

Utah's rating system is integrated with its career ladder and its licensing system. Ratings are based on levels that providers achieve on the career ladder as well as the number of years they have been licensed. Providers are rewarded for higher ratings through the state's Provider Achievement Awards program, which is described in the Compensation section, below.

Auspices and Outreach

Like the accreditation programs, the three rating systems are managed by different kinds of agencies. Utah's Workforce Board operates its program, while the State Early Childhood Development Authority manages Kentucky's system and the Department of Child Development operates North Carolina's. Utah recruits participants through information distributed by CCR&R mailings and a training newsletter. The State also distributes training calendars through the mail to prospective participants. Centers volunteered to participate in the pilot phase of Kentucky's Quality Rating System. In North Carolina, outreach to providers is coordinated by the central office located in Raleigh.

Budgets

Budgets for the three rating systems are among the largest in the study. Of the three, Utah's initiative, at \$70,000 for the Career Ladder and \$52,000 for the Provider Achievement Awards is the lowest in this category. North Carolina's Five-Star Rated License System, at \$2.3 million, falls in the mid-range; and Kentucky's Quality Rating System for Child Care, at \$10 million, is the largest.

COMPENSATION

Seven of the programs we selected for the study use compensation as a primary strategy. They are Missouri's Differential Rates; New York's Odd-Hour Care and Child Care Retention programs; North Carolina's WAGE\$ and T.E.A.C.H.[®] Early Childhood Health Insurance Program; Rhode Island RIte Care; and Wisconsin's Rewarding Education With Respect for Dedication (R.E.W.A.R.D.). Two other programs, Wisconsin's Quality Improvement and Staff Retention grants and Utah's Provider Achievement Awards, also include compensation as a strategy. (Please see Volume II for program profiles.)

Some initiatives reward providers who care for special populations in order to increase the child care supply. Others reward providers who attain a specific level of professional standing and/or positive quality rating with sustained wage increases, bonuses, or benefits.

Strategies

Sustained Wage Increases, Differential Rates

The two differential rate programs in the study are Missouri's and New York's. In Missouri, providers who are paid through state subsidy are entitled to receive a percentage increase if they care for children during odd hours or for children with special needs. New York State's Odd-Hour Care program uses the same approach for providers who serve children during non-traditional hours.

Bonus

Four career development initiatives offer bonuses as incentives for providers to enhance their education or to remain in the child care field. For example, in Utah, the Provider Achievement Award is based on the career ladder level and years of licensed experience. Wisconsin's R.E.W.A.R.D. and North Carolina's WAGE\$ reward providers who reach specific educational levels and also indicate their intentions to remain in the field. New York's Child Care Retention Program provides a bonus to providers if they remain at the same program for six months, and in the field for 18 months.

Benefits

Wisconsin's Staff Retention Grants allow providers and centers who have achieved specific quality standings to use grant money for such benefits as wage increases, bonuses, vacations, retirement plans or health insurance, while Rhode Island and North Carolina offer health coverage to family child care and center providers. In Rhode Island, the RIte Care program provides health insurance to centers, regulated family child care providers and their families if they care for a specific proportion of subsi-

dized children. The North Carolina T.E.A.C.H. Early Childhood[®] Health Insurance Program reimburses participating providers for one third of the cost of health insurance.

Auspices and Outreach

With the exception of North Carolina's programs, the compensation programs in our study are operated by state child care agencies, because these programs are tied to state reimbursement levels. Recruitment focuses on providers who have attained some form of professional standing in the child care field and have a credential or degree. For example, Wisconsin's R.E.W.A.R.D. recruits potential participants through mailings to all licensed providers who are registered with the Wisconsin Career Registry and have a bachelor's degree in early childhood education. Utah uses a similar approach in its Provider Achievement Award Program by recruiting participants who have reached a specific level on the Utah Early Childhood Career Ladder.

Budgets

Overall, the seven programs that use compensation as their primary strategy have the largest budgets in the study. They range from \$1 million for New York's Incentive Grants for Odd-Hours Care Program to \$40 million for its Child Care Professional Retention Program. In addition to New York's Odd-Hours Program, three other programs—R.E.W.A.R.D., RIte Care, and North Carolina's Health Insurance program—have budgets in the \$1 million range. WAGE\$'s budget is \$6.3 million.

START-UP FUNDING

Strategies

We selected six programs that use start-up funding as a principal strategy. Three—Minnesota's School-Age Grant Program, North Carolina's School-Age Child Care Services Project, and South Dakota's Out-of-School Time—serve school-age children. Utah's Expansion of Infant Toddler Space or Expansion of Existing Space focuses on very young children. The other two—North Carolina's Child Care Revolving Loan Fund and the Illinois Facilities Fund—provide support for new programs for children in all age groups. (Please see Volume II for full descriptions.)

Grants in the Minnesota and North Carolina programs can be used to create additional spaces through hiring staff, purchasing equipment, and recruiting children. North Carolina's program also provides planning grants to develop applications for funding. South Dakota accords preference to applications that indicate evidence of community collaboration with a commitment from local school systems to implement the program. In Utah, the Expansion of Infant and Toddler Space or Enhancement of Existing Space provides grants to centers that score above 60 on a 100-point scale. The funding can be used to pay for personnel costs, training, and equipment.

Grant levels across the programs are similar. All have a minimum grant of \$10,000, but the maximum varies. The ceiling for Minnesota grants is \$50,000, while the maximum in North

Carolina is \$60,000. South Dakota awards grants as large as \$100,000. Utah's grants average between \$25,000 and \$43,000.

Unlike the grant programs, the North Carolina Child Care Revolving Loan Fund provides low-interest loans. Providers can use them to comply with basic licensing standards and regulations for outdoor play equipment or to meet voluntary licensing standards and to create new spaces.

The Illinois Facilities Fund, which was described earlier, is the study's only example of a program that awards grants for start-up of new programs rather than the expansion of existing programs. It provides funding to child care providers, child welfare agencies, and community development organizations for child care center construction. After the centers are built and the debt is paid off, the Illinois Facilities Fund turns deeds for the centers over to the organizations that operate the programs.

Auspices and Outreach

A variety of organizations manage start-up programs. Minnesota relies on CCR&Rs, but North Carolina's program is operated by the 4-H Department of North Carolina State University, the same institution that offers its school-age child care training. State offices—Utah's Office of Child Care and North Carolina's Division of Child Development—manage their start-up initiatives. South Dakota's OST is managed by the Department of Social Services.

Mailings are a common outreach strategy. For example, North Carolina recruits family child care providers and centers for the Child Care Revolving Loan Fund through mass mailings to licensing lists and to providers in CCR&R databases. Minnesota's School-Age Grants Program also uses mailings, sending out requests for proposals through all CCR&Rs in the state. Both states use their websites to publicize these programs as well.

Budgets

Among the strategies, the six start-up programs ranked third in median budgets. They range from \$180,000 for Utah's program to \$3.1 million for the Child Care Revolving Loan Fund. Budgets for the two school-age child care programs—Minnesota's (\$620,000) and South Dakota's (\$800,000)—fall in the mid-range. The Illinois Facilities Fund has a budget of \$1.4 million.

OTHER STRATEGIES

Approximately a fifth of the programs we selected for the study, 22, do not fit into any of the principal strategies that states use for improving quality. As a result, we have identified them as "other" strategies. Initiatives in three subcategories—technical assistance, linking health and child care, and planning/evaluation—account for nearly three quarters. The remaining programs use miscellaneous strategies to improve quality.

TECHNICAL ASSISTANCE

Six programs in the study offer technical assistance to child care

providers to help them improve the quality of their programs. They include: Alaska's Inclusive Child Care; New Jersey's First Steps; South Carolina's Child Care Monitoring Program; Oklahoma's Scholars for Excellence in Child Care; Kansas's Regional Support Teams; and Texas's Intensive Technical Assistance (TA) Mentoring Project. (Please see Volume II for program profiles.)

There are variations in the objectives and kinds of technical assistance that these initiatives offer. New Jersey's First Steps, for example, aims to help programs that serve infants and toddlers by using environmental rating scales to identify areas for improvement and then providing the requisite support. South Carolina's Child Care Monitoring Program uses technical assistance to help child care programs meet basic licensing standards, while Kansas's Regional Support Teams initiative aims to engage child care stakeholders in strategic planning for child care. Alaska focuses on children with special needs, relying on CCR&R specialists to link children with providers who can serve them.

Two programs—Oklahoma's and Texas's—use mentors to provide technical assistance. Oklahoma's program is an integral part of the state's broader effort to strengthen the child care workforce. The Scholars for Excellence coordinators, who are based at community colleges throughout the state, provide a wide range of supports for students who enroll in child care certificate or degree programs. Community college early childhood departments receive a bonus for each student who completes the program and remains in the field. The Texas Mentoring program provides individual visits that offer staff or director training to centers that need support.

Auspices and Outreach

Two of the technical assistance programs, Alaska's and New Jersey's, rely on CCR&Rs to deliver services. South Carolina's is managed by the state child care office; Oklahoma's child care office coordinates its program. Texas and Kansas rely on the Regional Workforce Board and CCR&Rs respectively.

Unlike other strategies, several technical assistance programs do not recruit caregivers. South Carolina and Texas licensing officials identify the centers for which technical assistance will be provided, while New Jersey relies on self-referrals from the providers the program serves. CCR&Rs distribute information about the Alaska program's services. Because its program is new, Oklahoma uses presentations to publicize the effort.

Budgets

Budgets for the six technical assistance programs range from \$70,000 to \$1 million. Three have budgets that are \$100,000 or less. They include New Jersey's First Steps with \$70,000, Texas's with \$96,000, and Alaska's Inclusive Child Care Initiative (\$100,000). The budgets for the three other programs are significantly higher. At \$800,000, Kansas's is the lowest of the three; the two others—Oklahoma's and South Carolina's—have \$1 million budgets.

HEALTH AND CHILD CARE PROGRAMS

Five programs in the study aim to link health and child care. Three are Healthy Child Care America (HCCA) initiatives: Healthy Child Care Iowa; Missouri's Nurse Consultation Program; and Washington's Community Health Nurse Consultation Program. (Please see Volume II for program profiles.) Another is Massachusetts's Collaborative Model for On-Site Mental Health Services, which was discussed in a previous section. The fifth is California's Healthline, a free call-in service for child care providers and parents.

Auspices and Outreach

All three HCCA programs are managed by county health departments. Two of them—Iowa's and Washington's—collaborate with CCR&Rs to advertise their training and technical assistance, while Missouri makes presentations about the program at child care meetings. The Healthline also uses presentations as does the Massachusetts program.

Budgets

Budgets for the five health and child care programs range from \$118,000 for Washington State's Community Health Nurse Consultation Program to \$400,000 for the California Child Care Health Line. The two other HCCA programs, Iowa's and Missouri's, have budgets of \$351,000 and \$252,000 respectively. No budget information is available for Massachusetts's mental health program.

EVALUATIONS/PLANNING

The third subcategory consists of the four initiatives in the study that use quality set-aside funding to plan or evaluate programs. The initiative we selected from Delaware represents the use of these funds to support a ten-year plan for quality improvement, while Washington's A Case for Culturally Relevant Care used funds to conduct a needs assessment for services. The two other initiatives use funding for evaluation: California's Quality Improvement Program Evaluation, for evaluations of a broad range of quality initiatives; and Mississippi's Infant Toddler Evaluation for a single program. (Please see Volume II for full descriptions.)

Auspices and Outreach

Three initiatives in this subcategory are managed by state agencies. The exception is the Washington study which was conducted by a collaboration of community agencies. These initiatives did not engage in recruitment activities.

Budgets

The budgets for planning and evaluation initiatives vary widely. They range from \$140,000 for Delaware's program and \$185,000 for Washington's to \$800,525 for Mississippi's and \$900,000 for California's.

MISCELLANEOUS

The seven remaining programs in the "other" category use miscel-

laneous approaches. They include Arkansas's Bright Opportunities Program; Arizona's Coordination of Tribal Child Care Services; Colorado's Child Care Quality Expansion Project; the Indiana Business Partnership; North Dakota's Tribal Consult; Oregon's Mentoring program; and Washington State's Substitute Bank. The Arizona, Colorado, Indiana and Oregon programs were described earlier. Arkansas's program, which is based on North Carolina's Bright Beginnings, uses a model classroom to demonstrate good early childhood practice; Washington's program provides substitute caregivers for staff who need coverage for illness, time to attend courses, or respite. Like the Arizona program, North Dakota's aims to address child care issues on reservations.

Auspices and Outreach

Arkansas's program is managed by the Department of Human Services, while Arizona's Coordination of Tribal Child Care Services is managed through the Inter Tribal Council of Arizona. The Indiana Business Partnership is coordinated by the Indiana Association of Child Care Resource and Referral Agencies.

Recruitment varies. In Arkansas, licensing specialists mail invitations to providers to observe the Bright Opportunities classroom. The Tribal Early Childhood Working Group in Arizona is responsible for contacting providers and programs from their own tribes. Indiana relies on CCR&R project specialists to identify local child care needs and to recruit local businesses to participate in the program.

Budgets

Budgets for miscellaneous programs range from \$38,000 for Arkansas's program and \$49,999 for Arizona's to \$500,000 for Indiana's and \$1.6 million for Colorado's project. Budgets for the other initiatives fall between \$86,000 and \$165,000.

FACILITIES IMPROVEMENT

We selected only one program, Louisiana's Repair and Improvement Program, whose main strategy is facilities improvement. It makes funds available to child care providers for improvements and repairs that are required by licensing standards. Funding is limited to providers who document that these changes are specifically intended to comply with regulations. Centers and regulated family child care providers can also apply for funds to cover costs they have already incurred. Half of the applications fall in this category. Grants for centers range from \$100 to \$3,500; the maximum for regulated family child care providers is \$100.

Auspices and Outreach

The program is delivered by the Office of Family Support within the Department of Social Services, which provides information about the grant through handbooks for subsidized providers, provider networks, lists, meetings, and "word of mouth" among center directors.

Budget

The budget for the program is \$75,145.

Overview

How do states determine if the initiatives they have funded have improved child care quality? What results do they expect to find? How do they measure whether these effects have been achieved?

Most of the initiatives selected for the study—three in four—have some kind of evaluation. With the exception of facilities improvement, all of the strategies have at least one program that include an evaluation. Of the 29 professional development initiatives, 23 have an evaluation component as do 16 of the 19 recruitment and training programs. Nine of the 12 initiatives that distribute materials and equipment, four of the six start-up initiatives, and 12 of the 22 programs that use “other” approaches include evaluations as well. There are also evaluation components in six of the ten initiatives that use accreditation or rating systems initiatives and two of the seven compensation programs.

Some states routinely include evaluations in their quality improvement efforts. Six of the seven North Carolina initiatives in our study assess program effectiveness as do all but one of the California programs. The Minnesota programs are expected to use common statewide indicators.

What States Evaluate

Many of the evaluations look at program results in terms of the number of participants served, recruited, enrolled, and levels of completion. Florida’s Infant Toddler Quality Enhancement program tabulates data on the number of participants who complete the training as well as the number and content of the trainings, while Maryland’s Informal Provider Program tracks the number of caregivers who received kits, and Georgia’s BCDI accreditation program collects a large amount of information about the participating centers.

Evaluations of satisfaction levels are also a common evaluation strategy. Michigan’s R.E.A.D.Y and Alabama’s WOW Mobile distribute surveys to learn whether participants like the materials and equipment provided. Washington uses surveys to gauge responses to the STARS program, as does New Mexico for AIM HIGH, New Hampshire for its Infant Toddler Initiative, and North Carolina for Smart Start. Texas asks center staff about their reaction to the technical assistance that its Intensive Mentoring Program provides; satisfaction with the start-up grant process is an element in South Dakota’s Out-of-School Program and Washington’s Mini-Grant Program for family child care and center providers.

Some evaluations look at the efficacy of the initiative in terms of its usefulness for the providers. The evaluation of California’s Beginning Together Program surveys participants about whether the training has been useful in their workshops for providers. South Dakota uses the same approach with its Infant Toddler Initiative, as does Arizona’s Coordination of Tribal Child Care Services. Maine’s Child Care +ME, Alabama’s Mobile Resource Library and Maryland’s Informal Provider Program all send questionnaires to participants about how they use the materials and which they prefer.

Other evaluations examine providers’ use of community resources. One example is Minnesota’s SOS, where the evaluation examines family child care providers’ use of community resources for children with special needs. Hawaii is also assessing how participants use the services that are discussed in its workshops.

A number of evaluations seek to determine the program’s effects on participants, particularly in terms of changes in knowledge, skills or practice. Idaho’s T.I.M.E. is evaluating changes in participants’ attitudes toward and knowledge about children with special needs. South Dakota used the same approach for the evaluation of the infant and toddler training program, while Ohio’s Ready To Learn attempts to determine its effect on providers’ use of television. North Carolina’s T.E.A.C.H., California’s Early Childhood Mentor program and Connecticut’s School Readiness Program, on the other hand, look at changes in practice.

Changes in licensing status is another focus for evaluations, especially for initiatives that use professional development, accreditation/rating systems or compensation to improve quality. Nevada collects these data for its Apprenticeship program as does North Carolina in WAGE\$.

Some evaluations seek to understand how the initiative works. Minnesota’s Cultural Dynamics Education Program aimed to identify the aspects of the design that contributed to the program’s success, while the evaluation of California’s Early Childhood Mentor program examined the program’s strengths and weaknesses and the effectiveness of its outreach strategies. Illinois looked at key factors that contributed to the success of the Facilities Fund.

A number of programs seek to measure specific program outcomes, particularly provider retention and effects on compensation. North Carolina’s T.E.A.C.H. and WAGE\$ as well as Georgia’s BCDI program, for example, look at this issue. Other evaluations, such as those in California’s TANF training program, Wisconsin’s R.E.W.A.R.D., and Vermont’s Apprenticeship program, seek to measure changes in income.

Some evaluations compare the results of one program with other similar efforts. For example, Nevada is comparing the Apprenticeship Program with its Quality Enhancement Project. The evaluation of California's Early Childhood Mentor program seeks to determine the effectiveness of the mentor approach compared to the more traditional master teacher approach for preparing early childhood teachers, while the evaluation of Georgia's BCDI-Affiliate NAEYC Accreditation program seeks to assess the impact of a culturally specific approach on accreditation rates.

A few of the initiatives we selected use evaluation to address a broad range of questions. North Carolina's T.E.A.C.H. is examining the program's impact on child care staff educational levels and compensation as well as retention in the field, while its Child Care Revolving Loan Fund evaluation is looking at the relationship between loan forgiveness and changes in program quality. Connecticut's School Readiness Program and Kansas' Regional Support Teams, both of which use multiple strategies to achieve multiple goals, also evaluate several kinds of results. Connecticut's School Readiness is the only evaluation in the study that assesses the program's effects on children.

What Kinds of Evaluation Instruments States Use

The kinds of instruments that the programs we selected use are related to the objectives of the evaluation. Data on numbers served and other descriptive aspects of initiatives are typically collected through reporting or monitoring records. Surveys or phone interviews are used to elicit participants' satisfaction with services. Pre- and post-tests are common strategies for measuring the extent to which participants use services or demonstrate changes in knowledge or skills, while directors' and parents' reports are used to assess changes in practice. Some programs also use videotapes to measure this outcome.

Standardized instruments are common for programs in our study that use rating systems or accreditation to improve quality. Often these programs use environmental ratings scales such as the ECERS, ITERS, and the FDCRS to measure program effects through pre- and post-tests.

The only other standard instruments that programs we selected use are those in the evaluation of Connecticut's School Readiness program. In addition to the ECERS, the evaluators, the Families and Work Institute and the School of Family Studies at the University of Connecticut, use observation instruments such as the Child Observation Instrument and the Arnett Scale of Caregiver Behavior. Standardized child assessments such as the Social Skills Rating Scale and the Bracken Basic Concept Scale are also employed to assess the program's effects on children.

Who Conducts Evaluations

Many initiatives rely on internal evaluations that are developed by program staff. Nearly four in ten, however, use outside evaluators, most of whom are state institutions of higher education. For example, the Frank Porter Graham Child Development Center at the University of North Carolina is responsible for North Carolina's Quality Improvement Smart Start, Child Care Revolving Loan Fund, and Five-Star Rated License program evaluations; the University of Nevada-Reno is conducting the evaluation of Nevada's Apprenticeship program; and Oklahoma University is responsible for the study of Scholars for Excellence in Child Care.

In other cases, programs retain independent organizations, including child care organizations, to evaluate their efforts. For example, the Child Care Services Association is conducting the North Carolina T.E.A.C.H. evaluation, while the Center for the Child Care Workforce was responsible for the California Early Childhood Mentor study. Other outside evaluators are consulting firms that specialize in program evaluation. Northnode conducted the evaluation of Massachusetts's Domestic Violence Training Program; Research and Evaluation Associates is conducting the Vermont Apprenticeship program evaluation; the American Institutes for Research is responsible for several California evaluations; and Abt Associates is responsible for Michigan's Better Kid Care Phase II evaluation.

How States Use Evaluation Results

When states include an evaluation as part of efforts to improve quality, how do they use the results? Some of the initiatives in our study used findings to recommend program expansion or modifications. After the evaluation of the Domestic Violence Training Program indicated a high degree of satisfaction, for example, Massachusetts aimed to extend the program to other parts of the state. Similarly, California used the successful results of the Training for TANF Recipients pilot program to expand the program statewide.

Other initiatives used evaluation results to modify programs. Oregon uses mentor satisfaction surveys to modify the content of its mentor training, while Alabama relies on providers' responses to questionnaires to select the materials for the Mobile Resource Library. Maryland required participant surveys for the second round of funding for the Informal Provider Program after the evaluation of the pilot showed that an initial survey of participants' interest resulted in a more successful program.

Some evaluations are intended to develop new approaches for improving quality. For example, Colorado plans to use the local evaluations of its Child Care Quality Expansion Program to design models for meeting specific program needs. Delaware has a similar goal in the evaluation of its Early Success plan.

This study demonstrates the diverse and multifaceted ways policy makers at the state and community level use CCDF funds to improve child care quality or increase the availability of child care. At the same time, it indicates the complex nature of the decisions policy makers face about how to use these funds efficiently and effectively. Our research underscores the importance of understanding individual program results as well as their impact on the overall quality of care.

Assessing program effects can serve multiple purposes. Evaluations of efforts to improve quality can provide valuable data for policy makers. They need to know not only if individual programs have achieved their goals, but also the extent to which these results have affected child care quality in general. This kind of information can be helpful for determining if current policies should be maintained, modified, or expanded, or if they should be abandoned in favor of other alternatives. To make these decisions, policy makers need basic information about program implementation—whether the program succeeded in reaching the anticipated number of participants, the level of satisfaction with the kinds of services that were offered, the extent to which participants used these services, and the initial effects. These data can help policy makers make changes in the program design, improving aspects that are weak and enhancing those that are effective.

Data about the longer-term results and broader impact of these efforts can also be useful. Policy makers need to know if providers who receive materials and equipment, for example, have continued to offer child care; whether providers who have taken advantage of professional development programs have remained in the field; or whether programs that have become accredited have maintained this status. They also need to know the extent to which initiatives that are intended to improve children's health and safety result in a decrease in illness, harm or

injury; whether those that are designed to enhance providers' knowledge and skills have an effect on providers' interactions with children; and if initiatives to reduce staff turnover increase retention in the field. This kind of information can help policy makers assess the impact of specific strategies, and how, if at all, these strategies can be integrated into a more systematic approach for achieving their goals.

Efforts to evaluate child care supply can produce similar benefits. For example, evaluation can reveal the net effect of efforts to increase a particular type of care. This can provide valuable information about the number of spaces that were lost during the same period that spaces were added, which, in turn, can guide decisions about whether states should continue to support expansion policies or whether they should focus on supporting existing providers. Assessment of the net effect of supply-building programs can also help policy makers understand particular results—the communities in which the efforts were most successful and the factors that contributed to this success. This kind of information is especially important for policy makers who aim to expand the supply of care in low-income communities or for families who are eligible to receive child care subsidies.

The programs we selected demonstrate a range of evaluations policy makers use to gauge the results of their efforts. While some of their findings can be generalized to other similar programs, the specific effects of one initiative may not be the same in one community or another, because each child care market is unique. For this reason, policy makers need more information about how to assess their efforts to make better use of their funds. They want to know the kinds of evaluations that are useful for particular programs, the type of data that would be meaningful, and the designs that would be most practical. We aim to provide some answers to these questions in the second phase of our project.

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NATIONAL MODELS

The T.E.A.C.H. Early Childhood® Project

The Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood® Project was created by the North Carolina Child Care Services Association in 1990 to address the issues of inadequate education, poor compensation and high turnover among North Carolina's early childhood workforce. T.E.A.C.H. seeks to improve child care quality by offering scholarships to providers in regulated child care programs. The program's philosophy is that, "children will ultimately benefit as they are able to bond with a provider who has made a commitment to the field, who is a specialist in early childhood education, who understands child development and who is sensitive to the needs of the very young. Providers benefit by increasing their knowledge and compensation."⁷ It uses funding from foundations, the United Way, corporations, the Child Care and Development Fund and the North Carolina General Assembly as well as contributions from recipients and their sponsoring child care programs.

The T.E.A.C.H. Early Childhood® Project offers scholarships to study early childhood education at all 58 North Carolina community colleges and six four-year institutions of higher education. Child care providers can contract for a minimum of one class to earn the North Carolina Early Childhood Administration credential, a minimum of two classes to earn the North Carolina Early Childhood credential, or can work toward a certificate, diploma, associate's or bachelor's degree in early childhood education. One course for undergraduate or graduate credit is also offered to master teachers to train them to mentor beginning teachers. Most participants attend classes part-time. To attract early childhood professionals to the child care field, the T.E.A.C.H. Early Childhood® Scholars Program provides scholarships to full-time students who are finishing their four year degree in child development.

All T.E.A.C.H. Early Childhood® scholarships link continuing education with increased compensation and require that recipients and their sponsoring child care programs share the cost. In general, every T.E.A.C.H. program has four components. They are scholarships, education, compensation, and commitment. The scholarship usually covers partial costs for tuition and books or assessment fees. Many scholarships require that the recipient

receive paid release time and a travel stipend. In return for receiving a scholarship, each participant must complete a certain amount of education, usually in the form of college coursework, during a prescribed contract period. After completing the educational requirement, participants are eligible to receive increased compensation in the form of a bonus ranging from \$100 to \$700 or a raise, 4% or 5%. Participants must then honor their commitment to remain in their child care program or the field for six months to a year.

The North Carolina Child Care Services Association has focused from the outset on collecting data on participants. Each licensee is required to maintain a database to track and evaluate the initiative's activities. Child Care Services also requires quarterly reports from the licensees. It plans to conduct a cross-site evaluation of the entire project.

More than 19,000 child care providers in North Carolina have participated in the program. According to state reports, taxpayers benefit by saving \$7 for every \$1 spent on high quality programs for young children. In 1999-2000, 4,300 teachers, directors and family child care providers received T.E.A.C.H. Early Childhood® Project scholarships. For more information on T.E.A.C.H. Early Childhood® Project, please visit <http://www.childcareservices.org>.

Child Care Apprenticeship Programs

The idea of using the Department of Labor (DOL) apprenticeship model for training practitioners in the child care field was conceived in 1989 by the West Virginia State Director of the U.S. Department of Labor (USDOL) Bureau of Apprenticeship and Training. The initial effort involved contacting leaders in the Department of Health and Human Resources, the Department of Education, and vocational schools to build support and funding for the program. It offers participants time in the classroom, time with children, the tutelage of seasoned professionals, and a national certification equivalent to the Child Development Associate (CDA) credential.

While there is some variability in the components of the 39 DOL child care apprentice programs across the country, all must adhere to the basic apprenticeship standards set forth by USDOL's Employment and Training Administration. They include: full and fair opportunity to apply for apprenticeship; a schedule of work processes in which an apprentice receives training and experience on the job; organized instruction designed to provide apprentices with knowledge in technical subjects related

⁷ *Child Care Services*. Retrieved September, 2001, from the World Wide Web: <http://www.childcareservices.org/TEACH/T.E.A.C.H.%20Project.htm>

to their trade; a progressively increasing schedule of wages; proper supervision of on-the-job training with adequate facilities to train apprentices; evaluation of the apprentice's progress, both in job performances and related instruction; and no discrimination in any phase of selection, employment, or training.

Every apprentice participating in a registered program enters into an agreement that incorporates the Apprenticeship Standards. A minimum of 144 hours of related instruction annually is required for each occupation. It may be provided in a classroom; through trade, industrial or correspondence courses of equivalent value; or other forms of self-study approved by the registration/approval agency.

The on-the-job component is structured supervised on-the-job training consisting of a minimum of 2,000 hours. The apprentice is supervised by a skilled craft worker. Upon entry into the program, apprentices are paid a progressively increasing schedule of wages. As they demonstrate satisfactory progress in both the on-the-job training and related instruction, they advance in accordance with the wage schedule.

West Virginia's Apprenticeship and Child Development Specialists (ACDS) program is one of three state child care apprenticeship models highlighted for replication under the "Quality Child Care Initiative" by the U.S. Department of Labor. In March 1999, the federal government published a notice that funds were available to replicate programs like it. For more information on the USDOL apprenticeship program, please visit: http://www.doleta.gov/atels_bat/setprgm.asp.

WestEd

WestEd is a nonprofit research, development, and service organization. It traces its history to 1966 when Congress created a network of regional educational laboratories. In 1995, two of the original laboratories—Far West Laboratory for Educational Research and Development and Southwest Regional Laboratory—joined forces to form WestEd.

WestEd defines its mission as a commitment to improving learning at all stages of life from infancy to adulthood, both in school and out. It has developed a range of services that include: tailoring effective assessment strategies for states and districts; working with administrators and teams of school and district leaders to help bring about school-wide change; enhancing teachers' career-long professional development; and finding ways for community-based groups to collaborate and solve problems.

In 1985, WestEd created the Program for Infant/Toddler Caregivers (PITC), which develops training materials based on sound theoretical principles for caregivers and caregiver trainers. PITC Module Training Institutes help caregivers and professionals responsible for training infant and toddler caregivers to interact with infants in ways that support their discovery, learning, and self-esteem; develop sound program practices and policies; and design safe, interesting, and developmentally appropriate environments. The training is divided into four modules: Social-

Emotional Growth and Socialization; Group Care; Learning and Development; and Culture, Family and Providers.

To obtain a WestEd certificate for each module, participants must complete all sessions and submit a certification paper. The certificate recognizes participants as trainers for the specific module they have completed.

The program also offers a series of 12 training videos produced in English, Spanish, and Cantonese. Various print materials are also available, including a series of guides on infant and toddler caregiving as well as trainers' manuals.

WestEd is conducting a comprehensive study of the PITC implementation. Findings from a survey of California PITC graduates and recommendations from an evaluation advisory panel provided the foundation for developing the sampling strategy and study design. An important component of the evaluation has been the development of the PITC Program Assessment Rating Scale, which is designed to provide data on the implementation of a wide range of PITC recommendations and guidelines.

National Association for the Education of Young Children (NAEYC) Accreditation⁸

The National Academy of Early Childhood Programs administers a national voluntary accreditation system for all types of preschools, kindergartens, child care centers and school-age child care programs. The Academy is a division of the National Association for the Education of Young Children (NAEYC), the nation's largest organization of early childhood educators. By fall 2000, more than 7,500 programs serving more than a half-million children had achieved NAEYC accreditation; an additional 7,500 programs were engaged in the process.

Accreditation criteria include: children attending the program appear generally comfortable, relaxed and happy as well as involved in play or other activities; there are sufficient numbers of adults with specialized training in early childhood development and education; adult expectations vary appropriately for children of different ages and interests; all areas of children's development are addressed equally, with time and attention devoted to cognitive, social, emotional and physical development; staff members meet regularly to plan and evaluate the program; and parents are welcome to observe, discuss policies, make suggestions, and participate in the work of the program.

To achieve NAEYC Accreditation, a program must complete a voluntary application and subsequent self-study based on the Academy's criteria for high quality early childhood programs. The accuracy of the self-study is verified by a team of trained volunteer validators who make a site visit. A three-member national commission of recognized experts in child care and early childhood education reviews the validated self-study. If the validated

⁸ *National Association for the Education of Young Children*. Retrieved September, 2001, from the World Wide Web: http://www.naeyc.org/accreditation/naeyc_accred/info_general.htm

self-study is judged to be in substantial compliance with the Academy's criteria, accreditation is granted for a three-year period. If the commission makes suggestions regarding areas needing improvement, the program must agree to act upon them and to submit annual written reports that document improvements and continued compliance.

The National Center for the Early Childhood Work Force evaluated the impact of NAEYC accreditation and summarized findings in NAEYC Accreditation as a Strategy for Improving Child Care Quality. The study examined 92 child care programs in three northern California communities between 1994 and 1996, assessing changes in program quality resulting from participation in the accreditation process; the impact of various support models on programs' achievement of accreditation; and the extent to which accreditation contributes to building a skilled stable early child care and education workforce.

With the caveat that the number of accredited programs studied is small (23), initial findings suggest that NAEYC accreditation achieves its primary goals of improving and recognizing program quality. Compared to nonaccredited programs within the community, accredited programs were six times more likely to be rated as good to excellent in quality. No accredited programs were rated as low quality. Intensive facilitated accreditation support projects help programs achieve accreditation at more than twice the rate of other centers seeking accreditation. Programs successfully pursuing accreditation made substantial improvements in classroom quality over time.

National Association for Family Child Care (NAFCC) Accreditation

The National Association for Family Child Care (NAFCC) is a national membership organization that works with more than 400 state and local family child care provider associations nationwide. These groups represent more than one million family child care providers caring for more than four million children. The Quality Standards for the NAFCC Accreditation system were developed through a two-year consensus-building process that included hundreds of providers, parents, and child care resource and referral staff members as well as other early childhood experts. Accreditation content areas include relationships, environment, activities, developmental learning goals, safety and health, and professional and business practices.

The accreditation process for family child care providers is similar to NAEYC's, because it consists of self-study and a site visit by trained validators. It begins with a self-study workbook that enables the provider to assess herself and her program. In preparation for an accreditation observation visit, providers design their own professional development plans and make the necessary improvements. They are encouraged to join a support group, obtain help from a mentor/advisor, and to involve the parents in the accreditation process.

After completing the self-study, the provider completes a self-observation and asks parents to complete surveys that are sent

to NAFCC for review. The final step in the process is a visit from an NAFCC observer whose report is reviewed by an NAFCC committee that makes the accreditation decision.

NAFCC developed its first accreditation system in 1988. A 1995 study of accredited providers by the Families and Work Institute concluded that accreditation increases providers' professionalism and self-esteem, improves quality of care, and develops leadership skills.

National School Age Care Alliance (NSACA) Accreditation⁹

National School Age Care Alliance (NSACA) accreditation is a competency-based national credential awarded to school-age programs that work with children and youth between the ages of 5 and 14 and that have met quality standards for school-age care. The standards, which were developed by NSACA and the National Institute on Out-of-School Time (NIOST), are divided into six categories: human relationships; indoor environment; outdoor environment; activities; safety, health and nutrition; and administration.

A program seeking accreditation engages in a self-study with the Advancing School-Age Quality (ASQ) team at its own pace. The self-study and improvement implementation phase can take from six months to a year. The program can then apply for an endorsement visit or continue to implement further improvements. Programs that successfully complete the process are accredited for three years and are responsible for submitting annual interim reports to maintain their status.

Eligible school-age programs must be licensed and have been in operation for one year at time of validation visit. Scholarships are available to cover the cost of the accreditation process.

NATIONAL INITIATIVES

Healthy Child Care America Campaign

A joint initiative of the federal Child Care Bureau and the Maternal and Child Health Bureau, the Healthy Child Care America (HCCA) Campaign stimulates the combined efforts of the public health and early childhood communities—together with families—to ensure that children are in healthy and safe child care environments. Launched in 1995 at a U.S. Department of Health and Human Services forum for health and early childhood professionals, HCCA has been coordinated by the American Academy of Pediatrics (AAP) since 1996. It implements the program through Community Integrated Service Systems/Health Systems Development in Child Care projects.

HCCA's "A Blueprint for Action" outlines ten action steps to expand existing public and private services or to create new services that link families, health care, and child care. They are: to promote safe, healthy, and developmentally appropriate environ-

⁹ *National School-Age Care Alliance*. Retrieved September, 2001, from the World Wide Web: <http://www.nsaca.org/accreditation.htm>

ments for all children in child care; to increase immunization rates and preventative services for children in child care settings; to assist families in accessing key public and private health and social service programs; to promote and increase comprehensive access to health screenings; to conduct health and safety education and promotion programs for children, families, and child care providers; to strengthen and improve nutrition services in child care; to provide training and ongoing consultation to child care providers and families in the areas of social and emotional health; to expand and provide ongoing support to child care providers and families caring for children with special health needs; to use child care health consultants to help develop and maintain healthy child care; and to assess and promote the health, training, and work environment of child care providers.

For each action step, the Blueprint identifies initial implementation strategies and suggests ways to enhance them through potential partnerships with local systems and organizations.

Examples of initiatives and an annotated bibliography of resources accompany each action step.

The HCCA campaign also allocates technical assistance funds to support collaborative initiatives in each of the 10 multi-state federal Health and Human Service regions. Each regional initiative has implemented at least 1 of the 10 action steps outlined in the Blueprint for Action. They serve as model programs that can be replicated by other regions, states, or communities.

In addition to working with the Coordinated Integrated Service Systems/Health Systems projects, the AAP provides the HCCA newsletter on a quarterly basis to more than 3,500 health professionals, child care providers, and families interested in working together to promote health and safety in child care. The University of North Carolina National Training Institute for Child Care Health Consultants, the National Resource Center for Health and Safety in Child Care, and Health Systems Research, Inc. also provide technical assistance to HCCA projects.

State	Name of Program	Strategy
Alabama	Caring for The Caregiver Kids & Kin Mobile Resource Library Statewide Leadership Scholarship WOW Mobile	Materials and Equipment Professional Development Materials and Equipment Professional Development Materials and Equipment
Alaska	Alaska Inclusive Child Care Initiative	Technical Assistance
Arizona	Coordination for Tribal Child Care Services	Other Strategies
Arkansas	ASU School-Age Child Care Accreditation Program Bright Opportunities	Accreditation/Rating Other Strategies
California	Beginning Together's Special Needs Training for PITC Trainers CA Early Childhood Mentor Program (Mentor Teacher/Director) Child Care Initiative Project Child Development Training Consortium; Fostering and Assessing the Development of a First and Second Language Program for Infant/Toddler Caregivers (PITC) Quality Improvement Evaluation Program Stipend for Child Development Permit The California Child Care Healthline Training TANF Recipients as Child Development Teachers Project	Recruitment and Training Recruitment and Training Recruitment and Training Professional Development Recruitment and Training Other Strategies Professional Development Health and Child Care Professional Development
Colorado	Child Care Quality Expansion Project	Other Strategies
Connecticut	School Readiness	Accreditation/Rating
Delaware	Early Success	Other Strategies
District of Columbia	Child Care Higher Education Scholarship Project	Professional Development
Florida	Infant Toddler Quality Enhancement T.E.A.C.H.	Recruitment and Training Professional Development
Georgia	Advancing Careers through Education and Training (ACET) BCDI-Atlanta Affiliate Early Childhood Leadership Mentoring Project	Professional Development Accreditation/Rating
Hawaii	Getting Children Ready to Succeed	Materials and Equipment
Idaho	Easter Seals-Training in a Manila Envelope (TIME)	Professional Development
Illinois	Child Care Facilities Development Program Illinois Director Credential Program	Start-up Funding Professional Development
Indiana	Business Partnership Pilot Project	Other Strategies
Iowa	Child Care Home Consultant Healthy Child Care	Recruitment and Training Health and Child Care
Kansas	Regional Support Teams	Technical Assistance
Kentucky	Quality Rating System for Childcare	Accreditation/Rating

State	Name of Program	Strategy
Louisiana	Repair and Improvement Grants	Facilities Improvements
Maine	Child Care +ME	Materials and Equipment
Maryland	Informal Provider Program	Materials and Equipment
Massachusetts	Child Care in the Neighborhood: Caring for Children with Disabilities Collaborative Model for On-site Mental Health Services Distance Learning Courses Domestic Violence Training for Child Care Professionals In-Home Relative Child Care Program	Recruitment and Training Health and Child Care Professional Development Recruitment and Training Materials and Equipment
Michigan	Better Kid Care Phase II/A Joining Forces Program Better Kid Care Satellite Training Series/ Phase I R.E.A.D.Y. Kits (Read, Educate and Develop Youth)	Recruitment and Training Recruitment and Training Materials and Equipment
Minnesota	Cultural Dynamics Education Project (CDEP) Inclusive Child Care/On-site Consultation for Child Care Providers School-Age Care Grants Program Starting Out Successfully (SOS)	Recruitment and Training Professional Development Start-up Funding Recruitment and Training
Mississippi	Infant Toddler Quality Enhancement Initiative Evaluation	Other Strategies
Missouri	Differential Rates Nurse Consultation	Compensation Health and Child Care
Montana	Early Care and Education Career Development	Professional Development
Nebraska	Infant Toddler Quality Initiative	Recruitment and Training
Nevada	Nevada Child Care Apprenticeship Program	Professional Development
New Hampshire	Infant/Toddler Quality and Capacity Building	Professional Development
New Jersey	First Steps 2001: Infant/Toddler Program Development Initiative	Technical Assistance
New Mexico	Aim High	Professional Development
New York	Child Care Professional Retention Program Incentive Grants for Off-Hours Care Infant Toddler Certificate Credential Program NYS School-Age Care Credential	Compensation Compensation Professional Development Professional Development
North Carolina	Basic School Age Care Training (BSAC) Child Care Revolving Loan Fund Child Care WAGE\$™ Project Five-Star Rated License Program Quality Improvement Grant Program/a SmartStart program School-Age Care Services Project T.E.A.C.H. Early Childhood® Program T.E.A.C.H. Early Childhood® Health Insurance Program	Recruitment and Training Start-up Funding Compensation Accreditation/Rating Accreditation/Rating Start-up Funding Professional Development Compensation
North Dakota	The North Dakota Infant/Toddler Enrichment Program Tribal Child Care Consult Program	Recruitment and Training Other Strategies
Ohio	Ready to Learn/Ohio Education TV stations	Professional Development

State	Name of Program	Strategy
Oklahoma	Scholars for Excellence in Child Care	Technical Assistance
Oregon	The Mentoring Program	Other Strategies
Pennsylvania	DVCCC Leadership & Management Project PA Home-based Providers Association	Professional Development Recruitment and Training
Rhode Island	RIte Care: Health Insurance for Child Care Providers in Rhode Island	Compensation
South Carolina	Child Care Monitoring Program	Technical Assistance
South Dakota	OST (Out of School Time) Program The South Dakota Infant/Toddler Training Initiative	Start-up Funding Recruitment and Training
Tennessee	Regional Child Care Centers Tennessee Family Literacy Program	Materials and Equipment Professional Development
Texas	Intensive TA Provider Mentoring Project Middle Rio Grande Workforce Board Quality Initiatives for Child Care Train Our Teacher (TOT)	Technical Assistance Materials and Equipment Professional Development
Utah	Career Ladder/Provider Achievement Awards Expansion of Infant and Toddler Space or Enhancement of Existing Space	Professional Development Start-up Funding
Vermont	Apprenticeship Program	Professional Development
Washington	A Case for Culturally Relevant Care for Children and Families in King County/Phase II Building Blocks: Laying the Foundation for Quality Family Child Care™ Community Health Nurse Consultation Program Mini-Grant Program Partners in Child Care Program Project Lift-Off Quality Growth Plan STARS (State Training and Registry System). The Child Care Substitute Bank Program WRAP (Washington Regional Action Project)	Other Strategies Recruitment and Training Health and Child Care Materials and Equipment Recruitment and Training Professional Development Materials and Equipment Professional Development Other Strategies Accreditation/Rating
West Virginia	Child Care Apprenticeship	Professional Development
Wisconsin	Quality Improvement and Staff Retention Grants R.E.W.A.R.D	Accreditation/Rating Compensation
Wyoming	Infant Toddler Credential Program	Professional Development

