Investing in Quality:

A Survey of State Child Care and Development Fund Initiatives

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Melanie Pittard, Senior Policy Associate
National Association of State Child Care Administrators (NASCCA)

Martha Zaslow, Vice President for Research
Bridget Lavelle, Research Analyst
Child Trends

Toni Porter, Director
The Institute for a Child Care Continuum
Bank Street College of Education

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American Public Human Services Association
810 First Street, NE, Suite 500
Washington, DC 20002
Tel: (202) 682-0100
Fax: (202) 289-6555

Child Trends
4301 Connecticut Avenue NW, Suite 350
Washington, DC 20008
Tel: (202) 572-6000
Fax: (202) 362-8420

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Executive Summary

Background

The Child Care and Development Fund (CCDF) is a critical work support for low-income families, and a key component in national and state efforts to support early childhood development and promote school readiness. The program is structured as a block grant to states with combined federal and state expenditures of $9.4 billion in federal fiscal year (FFY) 2004. States use CCDF funds to subsidize the cost of child care for low-income families, including families receiving or transitioning off of public assistance, in order to allow parents to pursue work, education, or training opportunities. In addition, states are required to set aside a minimum of 4 percent of their CCDF grant for initiatives to improve the quality and accessibility of child care. Many states go beyond the required 4 percent set-aside in allocating funds for the improvement of child care quality. For FFY 2004, total state expenditures on quality initiatives, including some additional congressional earmarks for quality activities, equaled 10 percent ($920 million) of federal and state CCDF funds.

Although federal statute prescribes a minimum amount that states must expend on activities to improve child care quality and accessibility, the law gives states broad discretion on how to invest quality funding. States can design quality initiatives to address the specific needs of providers and families in their states and to build on the unique strengths and resources available in the state and local communities. The flexibility inherent in the CCDF block grant structure allows the implementation of quality initiatives that fit the diverse geographic, demographic, and cultural landscapes of each state.

In light of the wide diversity of strategies that states use to improve child care quality, the state agencies that administer CCDF programs decided to conduct a survey—the results of which are provided in this report—to more closely examine state quality investments. State child care administrators were particularly interested in describing the objectives of quality activities. Although state child care agencies have broad flexibility in determining the types of activities funded by the set-aside, state administrators were interested in identifying the common quality objectives among these diverse activities and examining patterns in state investments aimed at achieving these objectives.

With funding from the John D. and Catherine T. MacArthur Foundation, the National Association of State Child Care Administrators (NASCCA), an affiliate of the American Public Human Services Association (APHSA), and Child Trends, with the Bank Street College of Education, developed a methodology to describe state quality investments. Building on previous reports by Porter and colleagues (Porter, Habeeb, Mabon, Robertson, Kreader & Collins, 2002) and the U.S. General Accounting Office (2002), the current study attempts to create a more complete picture of quality expenditures and objectives by collecting information on each of the quality initiatives in responding states. The survey asked states to identify the objectives of their quality activities, based on a list of 17 objectives, each of which is grounded in child development research. The study also collected information regarding funding amounts and sources, target populations, and types and sources of data collected for each quality initiative in responding states. The resulting data provide an examination of priorities across states in terms of quality objectives and target populations.

Method

In 2005, child care administrators from every state and the District of Columbia were asked to provide information on every child care quality-improvement initiative with at least $1,000 from CCDF in FFY 2004. Thirty-five states submitted information on each eligible child care quality initiative, for a total of 339 initiatives. The on-line survey asked for information for each initiative

in four substantive areas: (1) objectives; (2) target populations; (3) funding levels and sources; and (4) data collection.

Summary of Findings

This report finds that although state child care agencies have broad flexibility under the block grant to implement activities to improve the quality of child care, states have chosen to focus activities on achieving a relatively small set of objectives that research suggests can contribute to child care quality. The confluence of objectives among states indicates that while there is variation in state initiatives in keeping with particular contexts and needs, state child care agencies are systematically investing quality funding to achieve a delimited set of goals that research has found to be linked with quality.

The survey also provides valuable information about the target populations, funding, and data collection efforts in the two-thirds of the states that responded. For example, the findings show that among those initiatives targeting child care providers, a nearly equal number of initiatives are aiming to serve regulated family child care and center care. The results also suggest a need to strengthen states' capacity for evaluation. While the objectives targeted by the states are aligned with what research shows can improve child care quality and most of the initiatives involved some data collection, data collection efforts to date are heavily focused on documenting the population served and the nature of the services rather than evaluating effects.

Key findings from each section of the survey are highlighted below.

Objectives

Promoting healthy and safe environments is a major focus of state quality activities. It was clear from multiple perspectives that health and safety were high priorities for the quality initiatives in these states. Health and safety was cited more often than any other objective. It was noted as one of the objectives for 51 percent of the quality initiatives. In addition, states' allocation of quality funding reflects a focus on healthy and safe environments. Twenty-three percent of the funds budgeted for initiatives documented in this survey were allocated to initiatives for which health and safety was the primary objective.

The survey suggests that health and safety are viewed as foundations for quality child care. States cannot focus on early learning without first ensuring that children are as protected as possible from physical harm and serious illness. In addition, an environment that provides safe areas for exploration provides a context in which learning can take place.

Professional development, including providing training and formal education for individual providers and programs, as well as strengthening professional development systems, is a major component of states' quality activities. Every state that responded to the survey had at least one initiative aimed at strengthening professional development systems. In addition, 97 percent of states had at least one initiative aimed at increasing formal education for caregivers, and 97 percent had at least one initiative supporting non–credit-bearing training for caregivers. One of the three objectives related to professional development was the primary objective for more than a third (35%) of the initiatives documented in the survey. Data on state funding for quality initiatives also reflect the priority placed on professional development, with 19 percent of funding budgeted for initiatives that focused on professional development systems, provider training, or provider education.

Research indicates that child care providers with more professional development, both education and training, tend to be in settings that provide care of higher overall quality (Tout, Zaslow & Berry, 2006). States appear to recognize that providing caregivers with additional professional development may improve their interactions with children, enhancing their understanding of children's individual needs as well as the value of age-appropriate activities.

The survey data indicate a balance in state child care quality initiatives between initiatives that aim to increase emotionally supportive and responsive caregiving and those that support early learning. This balance was apparent from several different perspectives. There was balance in the proportion of initiatives for which emotionally supportive and responsive caregiving and early learning were listed among the objectives—44 percent for emotionally responsive caregiving and 42 percent for early learning. In addition, there was a balance in the proportion of initiatives for which emotionally responsive caregiving and early learning were noted as primary objectives—6 percent for the former and 5 percent for the latter.

Research points to the importance of close and warm relationships as the primary context of children's early learning (Shonkoff & Phillips, 2000). Perhaps the equal focus on emotionally supportive and stimulating caregiving reflects an acknowledgment that these both need to happen to support children's early development.

Target Populations

CCDF-funded quality activities most often aimed to serve child care providers and child care programs or facilities. The child care quality initiatives funded through CCDF most often aimed to serve those working directly with children (providers and programs) rather than those one step removed (such as licensing staff, trainers, and resource and referral agencies). All 35 responding states had at least one initiative that aimed at supporting child care providers and all also had initiatives targeting child care programs. Child care providers were identified as a target population in 78 percent of the initiatives; programs or facilities in 71 percent.

State quality initiatives placed an equal emphasis on center-based providers and regulated family child care providers, but targeted family, friend, and neighbor caregivers less often. Of those initiatives whose primary target populations were child care providers, nearly equal proportions, about 85 percent, served center-based providers and regulated family child care providers. Only 37 percent, however, aimed to serve family, friend, and neighbor caregivers, who are legally exempt from regulation.

At first glance, these results appear to contrast with an earlier report (U.S. General Accounting Office, 2002) that found that substantially more state expenditures to improve child care quality were going to child care centers than to family child care homes. The present survey focuses, however, on target populations of initiatives rather than on expenditures to particular types of care. This perspective extends the picture by indicating that state child care quality initiatives emphasize both types of regulated care. However, the survey also shows that family, friend, and neighbor providers are served through this set of initiatives much less frequently than those who are regulated, although a number of states have developed initiatives to address quality in this kind of care. It will be interesting to note if the proportion of quality initiatives targeted to family, friend, and neighbor providers increases over the next several years as a result of growing public awareness that a large proportion of children, particularly infants, toddlers, and school-aged children, receive child care in these settings.

Parents are a target population for a substantial proportion of quality initiatives. A high proportion of states (97%) had at least one initiative that aimed to serve parents. Further, 39 percent of all initiatives in the survey cited parents as a target group. Many quality initiatives with parents as a target population provide information about the features of quality child care. Informed parents are better equipped to choose high quality care that meets the needs of their children.

Funding

Initiatives that supported health and safety, and those that supported accreditation or quality rating systems as their primary objectives, accounted for the largest proportions of total quality funding. Initiatives with these as their primary objectives accounted for 23 percent each of the total funding. These proportions are indicative of the priority many states place on these objectives

as well as the fact that health and safety and accreditation or quality ranking initiatives have, on average, comparatively large budgets.

The funding data reinforce evidence that professional development is a high priority for states. When initiatives that support professional development systems are added to those that aim to increase caregiver formal education and provide caregiver training, the resulting proportion of the total budgeted funding is 19 percent. These objectives were addressed by the majority of states and represented some of the most commonly cited initiative objectives.

The funding data also indicate that the largest proportions of quality budgets are spent on initiatives targeted to child care programs or facilities, child care providers, and parents. These findings closely resemble the priorities reflected in the proportion of initiatives aimed at each target group.

Data Collection

The majority of state child care quality initiatives are collecting data, with an emphasis on information about service delivery. Eighty-two percent of the initiatives in the survey collected some type of data related to the initiative. Administrative data with information about the number of participants and services provided was the most common data type, most likely because these types of data are comparatively straightforward to collect and provide some valuable information on how initiatives function.

Only 4 percent of initiatives in the study collected data on child outcomes. Although the ultimate outcome for all initiatives to improve child care quality is improved child outcomes, it appears that measuring these outcomes is not yet occurring on a regular basis. Most likely, the infrequent collection of child outcome data is related to budget limitations and the technical requirements of collecting child outcome data. To move forward on this issue might require further resources both in terms of funding and expertise.

For the majority of child care quality initiatives, the data collection design involved collecting data that focused on implementation, rather than an evaluation focusing on effects. But there are indications that some states are also attempting more rigorous evaluation approaches. Sixty-two percent of the initiatives in the survey that collect data focus on collecting data on implementation (such as type of service delivery agency, type of service, and participant satisfaction). However, about 10 percent of the initiatives that collect data use a pre-post design, a quasi-experimental design, or an experimental design. It is especially important to note that a small number of initiatives are being evaluated using experimental designs. These research designs provide more conclusive information regarding the initiatives' effects. It will be valuable to explore ways to strengthen state capacity to carry out these kinds of evaluations.

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In sum, the evidence here indicates that states are investing in child care quality, not only exceeding the minimum funding requirements of the 4 percent set-aside in many instances (as reported in previous research), but also launching initiatives with a set of objectives that research indicates can contribute to child care quality. There is substantial variation among states in terms of focus on specific objectives and target groups, as is appropriate for states that vary greatly in demographics, geography, and the most pressing needs identified within the state. However, this variation occurs within the framework of a relatively small set of research-based objectives. Further, there is evidence that among states, there is a consistent focus on certain goals, such as improving health and safety and strengthening the professional development of the early childhood workforce. To build upon states' focus on child care quality and strengthen future efforts, there is a need to learn from the range of initiatives through rigorous evaluation.

1. Background

The Child Care and Development Fund (CCDF) is the largest source of federal and state funding for child care for low-income families. CCDF was created as part of the 1996 welfare reform legislation that restructured state cash assistance programs as Temporary Assistance for Needy Families (TANF). The TANF program focused on the transition of individuals who were receiving public assistance to sustainable employment and put a time limit on cash assistance. Recognizing that providing TANF recipients access to safe, affordable child care would be critical to the success of welfare reform, Congress increased and streamlined child care funding. Since its inception, CCDF has evolved into more than a work support; it has become a key component in national efforts to support early childhood development and promote school readiness. States use funds not only to provide child care subsidies to low-income families, but also to help ensure that the child care provided is safe and developmentally appropriate.

CCDF is a block grant to states to offer child care subsidies to low-income families, including families receiving TANF or transitioning off of public assistance, in order to allow parents to pursue work, education, or training opportunities. In federal fiscal year (FFY) 2004, $4.8 billion in CCDF funding was made available to states, the District of Columbia, territories, and tribal grantees. With required state contributions and TANF funds transferred to CCDF, total CCDF expenditures were approximately $9.4 billion in FFY 2004.

All states spend a portion of their CCDF grant on activities to improve the quality of child care services. Federal law requires that states set aside a minimum of 4 percent of their CCDF grant for initiatives to improve the quality and accessibility of child care. In addition, Congress traditionally requires states to earmark some CCDF funding for child care quality activities as part of the annual appropriations process. In FFY 2004, a total of $290 million was earmarked for activities to improve the quality of infant and toddler care; to address the quality of care for school-aged children; for child care resource and referral activities; and for general quality enhancement. Many states go beyond the required 4 percent set-aside and earmarks when allocating funds for improving child care quality. In state child care plans for 2004, state estimates of quality set-asides ranged from 4 to 18 percent, with an average of 7 percent. For FFY 2004, total state expenditures on quality initiatives, including earmarks, equaled 10 percent ($920 million) of federal and state CCDF funds. In addition, some states use general revenue funds or public-private partnerships to increase quality expenditures.

Although federal statute prescribes a minimum amount that states must expend on activities to improve child care quality and accessibility, the law gives states broad discretion in how to invest quality funding. This flexibility has been essential to states' abilities to improve child care quality. States can design quality initiatives to address the specific needs of providers and families in their states and to build on the unique strengths and resources available in state and local communities. For example, a state aiming to increase the knowledge and skill level of child care providers may partner with community colleges to increase the availability of early childhood associate degree programs; create a provider scholarship program; offer wage increases for providers that meet certain educational requirements; work with local resource and referral agencies to provide community-based training sessions; or design a distance-learning program to meet the needs of rural providers. The flexibility inherent in the CCDF block grant structure allows implementation of quality initiatives that fit into the diverse geographic, demographic, and cultural landscapes of each state.

In light of the wide diversity of strategies that states use to improve child care quality, the National Association of State Child Care Administrators (NASCCA), an affiliate of the American Public Human Services Association (APHSA), decided to conduct a survey, the results of which are reported here, to more closely examine quality investments among states. State child care administrators were particularly interested in describing the objectives of quality activities. Although state

child care agencies have broad flexibility in determining the types of activities funded by the set-aside, state administrators were interested in identifying the common quality objectives among these diverse activities and examining trends in state investments aimed at achieving these objectives.

With funding from the John D. and Catherine T. MacArthur Foundation, NASCCA and Child Trends, with the Bank Street College of Education, developed a methodology to describe state child care quality investments. Building on previous reports by Porter and colleagues (Porter, Habeeb, Mabon, Robertson, Kreader & Collins, 2002) and the U.S. General Accounting Office (2002), the current study attempts to create a more complete picture of quality expenditures and objectives by collecting information on all of the quality initiatives in responding states. The survey asked states to identify the objectives of their quality activities, based on a list of 17 objectives, each of which is grounded in child development research and literature. For example, research has shown a linkage between child care quality and caregiver qualifications (Tout, Zaslow & Berry, 2006), providing a reasonable basis for aiming to improve caregiver education and training in efforts to improve the quality of care.

In addition to collecting data on quality objectives, this study attempted to create a more complete picture of quality initiatives by asking questions regarding funding amounts and sources, target populations, and types and sources of data collected for each quality initiative in responding states. The resulting data permit an examination of priorities among states in terms of quality objectives and target populations. This report documents the proportion of initiatives focused on particular objectives and target populations, as well as the proportion of funding invested in each. The report also examines state efforts to collect data and evaluate the effectiveness of quality initiatives. This information provides important insight into the manner in which federal and state funding is being spent to improve the quality of child care services.

This report finds that although state child care agencies have broad flexibility under the block grant to implement activities to improve the quality of child care, states have chosen to focus activities on achieving a relatively small set of objectives that research indicates can contribute to child care quality. States have focused particularly on activities aimed at increasing caregiver training and education and strengthening the state's professional development system. Ensuring healthy and safe environments is another common objective among state quality initiatives. States also have made substantial investments in helping providers achieve accreditation or a state quality rating; supporting early learning; and promoting emotionally supportive and responsive caregiving. Most state initiatives to improve the quality of child care are directed at child care centers and regulated family child care homes. The confluence of objectives among states indicates that while there is variation in state initiatives in keeping with particular contexts and needs, state child care agencies are systematically investing quality funding to achieve a delimited set of goals that are supported by research.

2. Method

Development

The members of NASCCA identified a need to document CCDF-funded quality-improvement initiatives within a common framework of quality objectives. In 2003, NASCCA created a preliminary draft of a child care quality objectives framework and piloted the approach. Researchers from Child Trends and Bank Street College of Education collaborated with NASCCA in the development of a survey based on this initial framework that would provide clear categorizations of initiatives' goals and that focused also on funding, target populations, and data collection. The research literature on the linkages among child care features, quality, and child outcomes provided the basis for the categorization scheme used in the survey.

The first draft of the survey was piloted in paper-and-pencil version. The survey was then revised and converted into an on-line survey, and re-piloted by four state administrators. The project team held debriefing calls with these administrators, and presented the revised survey draft at a NASCCA meeting in 2004. Feedback at this meeting and guidance from a steering committee of NASCCA members resulted in a final set of edits. All state child care administrators were invited to complete the final on-line survey beginning in January 2005.

Sample

Child care administrators from every state and the District of Columbia were asked to provide information on every child care quality-improvement initiative with at least $1,000 of funding from CCDF in FFY 2004. Thirty-five states submitted information on each eligible child care quality initiative, for a total of 339 initiatives. (Several more states submitted information on selected initiatives, but omitted others, so they are not included in the final sample for this report.) Discussions with child care administrators indicate that non-response was primarily due to time pressure. Some administrators also indicated that they experienced technical difficulties with the on-line survey format or did not have all of the information requested by the survey. While the report reflects responses from only two-thirds of states, the results nevertheless reveal important patterns about the child care quality initiatives funded by CCDF.

Most of the initiatives in the survey were implemented prior to FFY 2004 and were ongoing throughout the fiscal year. Some, however, were only implemented during part of the year. The initiatives have been in operation for between zero and 32 years, with a median duration of four years. Note that this value underestimates the lifespan of initiatives due to the fact that the end date of initiatives still in operation cannot be captured.

Measures

The survey asked child care administrators to provide contact information as well as information for each initiative in four substantive areas: (1) objectives; (2) target populations; (3) funding levels and sources; and (4) data collection. Additional details on each component of the survey are provided in the results section.

Data Cleaning

The project team developed a detailed data checking protocol to ensure that all entries were accurate, with thorough review particularly of funding information, for which a problem was identified in the way the survey software recorded responses. Each state was contacted when any questions about the data were identified by the checking protocol. States with missing data were also contacted to collect final pieces of information (although small amounts of missing data remain).

Analysis

The project team developed an analysis plan oriented around key research questions. The NASCCA steering committee then reviewed the plan in detail. Survey data were cleaned and extracted from the on-line data collection tool into a data set for analysis. Following the analysis plan, basic descriptive analyses (for example, frequencies, means, medians, ranges) were used to answer the key research questions. Where there are missing data, analyses limit the sample to include only those initiatives or states with the relevant information. As a result, sample sizes for particular analyses vary.[1]

[1] Also note that numbers that appear on top of bars in graphs or as labels for "slices" in pie charts are rounded. This rounding sometimes results in slight differences between totals if summing across these numbers and totals reported in the text (e.g., summing across the numbers for "slices" in a pie chart may yield a sum slightly more or less than 100 percent due to rounding).

3. Quality Objectives

Because this project aims to describe the diversity of child care quality initiatives within a common framework, survey respondents were asked to categorize the quality-improvement goals of the initiatives using a list of 17 objectives. The list was developed by the project team to include features of child care settings or systems that are linked within the research to child care quality or children's outcomes and that could be addressed by state quality initiatives.

The overall list of objectives includes two types: (1) provider- or program-level objectives, and (2) systems-level objectives. Provider- and program-level objectives focused on improvements to child care quality that could occur within programs or in working with individual providers. This set of objectives included:

- Adequately small child-to-adult ratios
- Continuity in relationships between children and caregivers
- Emotionally supportive and responsive caregiving
- Healthy and safe environments
- Caregivers with sufficient formal education
- Caregivers with initial or on-going non–credit-bearing training
- Stimulating materials and supplies
- Activities that support early learning
- Communication with parents
- Family supports
- Higher overall quality for the purpose of achieving accreditation or other specific quality ranking

Systems-level objectives focused on improvements to child care quality that could occur through systems of administration or through dissemination of information. This set of objectives included:

- Widely disseminate information on child care quality
- Develop the regulatory system
- Assure sufficient payment levels within the subsidy system
- Support a system of professional development
- Coordinate service systems
- Create or improve data management systems

Respondents were asked to mark any objective served by an initiative, and then to select one objective as the initiative's primary objective. Respondents were also given an opportunity to write in an objective not already on the list.

See box on next page for examples of each frequently occurring primary objective.

The data on objectives are presented from three perspectives: the proportion of states that addressed each objective in at least one initiative; the proportion of initiatives for which each objective was identified as an initiative goal; and the proportion of initiatives for which each objective was identified as the primary objective.

Examples of State Initiatives Aimed at Achieving Each Frequently Occurring Primary Objective

Continuity in Relationships Between Children and Caregivers

- **Illinois'** Great START (Strategies to Attract and Retain Teachers) program promotes job stability and thereby diminishes disruptions in relationships between children and caregivers, by providing a wage supplement every six months to licensed family home and center-based child care providers that remain employed at the same program. The amount of the supplement is based on the caregiver's level of educational achievement. Interim results of an independent evaluation indicate that Great START is increasing provider retention.

Emotionally Supportive and Responsive Caregiving

- **Kansas'** Infant/Toddler Project promotes responsive caregiving by employing infant and toddler specialists at each of the state's 16 resource and referral agencies who provide training, technical assistance, and mentoring aimed at improving the quality of care for infants and toddlers.
- The Kids and Kin Relative Child Care Program in **Alabama** aims to support relatives in providing emotionally supportive and responsive care. Relative providers can obtain up to 20 hours of training on topics such as child development and positive guidance, while also receiving health and safety supplies and developmentally appropriate materials, through a voluntary certification program.

Healthy and Safe Environments

- Healthy Child Care **Iowa** aims to improve the health and safety of children in child care by supporting a network of nurse consultants that provide on-site assessments, consultation, and training for caregivers focused specifically on health and safety practices and environmental features. The campaign also provides health and safety information via a talkline and a web site.
- **West Virginia** operates a small grant program for family child care providers in order to help them meet health and safety requirements and improve the quality of care. Grants are used to purchase necessary items such as safety gates, smoke detectors, fire extinguishers, first aid kits, and curriculum materials.

Caregivers with Sufficient Formal Education

- One of the most common state strategies for increasing the level of caregiver formal education is to offer scholarships for providers. Many states, including **Michigan,** have implemented the T.E.A.C.H. Early Childhood® program, which provides financial support and rewards to child care providers pursuing Child Development Associate (CDA) credentials or associate or bachelor's degrees.
- **Montana** invests in caregiver formal education by funding institutions of higher education to provide early childhood degree and credential programs in communities where it was previously unavailable.

Caregivers with Initial or Ongoing Non–Credit-Bearing Training

- **New York** requires that all new family and group home day care providers complete, prior to licensure, a two-day comprehensive health and safety training program that covers topics such as developmentally appropriate practices, nutrition, physical plant, and infection control.
- The **California** School-Age Consortium works to increase the availability of training for providers of before- and after-school child care. The program uses a train-the-trainer model, teaching school-age care professionals to provide training

covering twelve content areas. The training is offered free on-site, is available in eight languages, and reaches up to 15,000 providers each year.

Stimulating Materials and Supplies

- Several states, including **Arkansas,** offer grants to help child care programs purchase developmentally appropriate materials. The Arkansas grant program establishes different priorities for funding each year and has been used to target needs identified by licensing inspections and to facilitate expansions of infant and toddler care.

Activities that Support Early Learning

- In **Ohio,** the Governor's Early Learning Initiative employs numerous strategies to disseminate and promote the usage of the state's Early Learning Content Standards. The initiative has created literacy toolkits for all child care settings; hired ten literacy specialists to work with caregivers; created a distance-learning literacy series; and piloted a core literacy curriculum for preschool that is aligned with the state's elementary school curriculum.
- A program funded by the **Colorado** CCDF agency works to improve the school readiness of young children receiving care in facilities in neighborhoods with poorly performing elementary schools and where more than 50 percent of children are from low-income families. Ten grantees work with these facilities to implement quality-improvement plans.

Family Supports

- A **New Jersey** initiative utilizing CCDF and other funding sources provides support to teen parents by offering case management, parenting classes, connections to health services, and academic support systems, in addition to child care services. The program operates in 12 school districts with high numbers of teen parents. More than 90 percent of participating parents graduate from high school and less than 3 percent have repeat pregnancies.

Higher Overall Quality for the Purpose of Achieving Accreditation or other Specific Quality Ranking

- The **Nevada** CCDF agency has helped child care centers and family child care homes receive national accreditation by offering observations, training, quality-improvement funds, grants for the cost of the accreditation process, and a one-time accreditation bonus. Since the program's inception in 2001, the number of accredited centers in the state increased from 12 to 29 and the number of accredited homes increased from one to 11.
- Several states, including **Tennessee,** use quality rating systems to encourage providers to achieve higher overall quality. Tennessee's Star-Quality program is a voluntary program in which licensed child care centers and group and family child care homes may earn up to a three-star quality rating. Participating providers earn a bonus, above the state's subsidy payment rate, of 5 percent for one star, 15 percent for two stars, and 20 percent for three stars.

Widely Disseminate Information on Child Care Quality

- Many states utilize child care resource and referral agencies to disseminate information on child care quality. The **Missouri** Child Care Resource and Referral Network provides information to families on how to choose quality child care, as well as listings of area providers. Information is given via a toll-free phone number and on-site at some state public assistance offices.

Develop the Regulatory System

- **Wyoming** has worked to improve the regulatory system by decreasing caseloads from more than 200 facilities per licensing specialist to a maximum of 60 facilities per licensor.

Assure Sufficient Payment Levels within the Subsidy System

- **Arizona** helps assure sufficient payment levels for center-based and family child care providers by paying an enhanced rate, up to 10 percent more than the regular state maximum rate, to nationally accredited providers.

Support a System of Professional Development

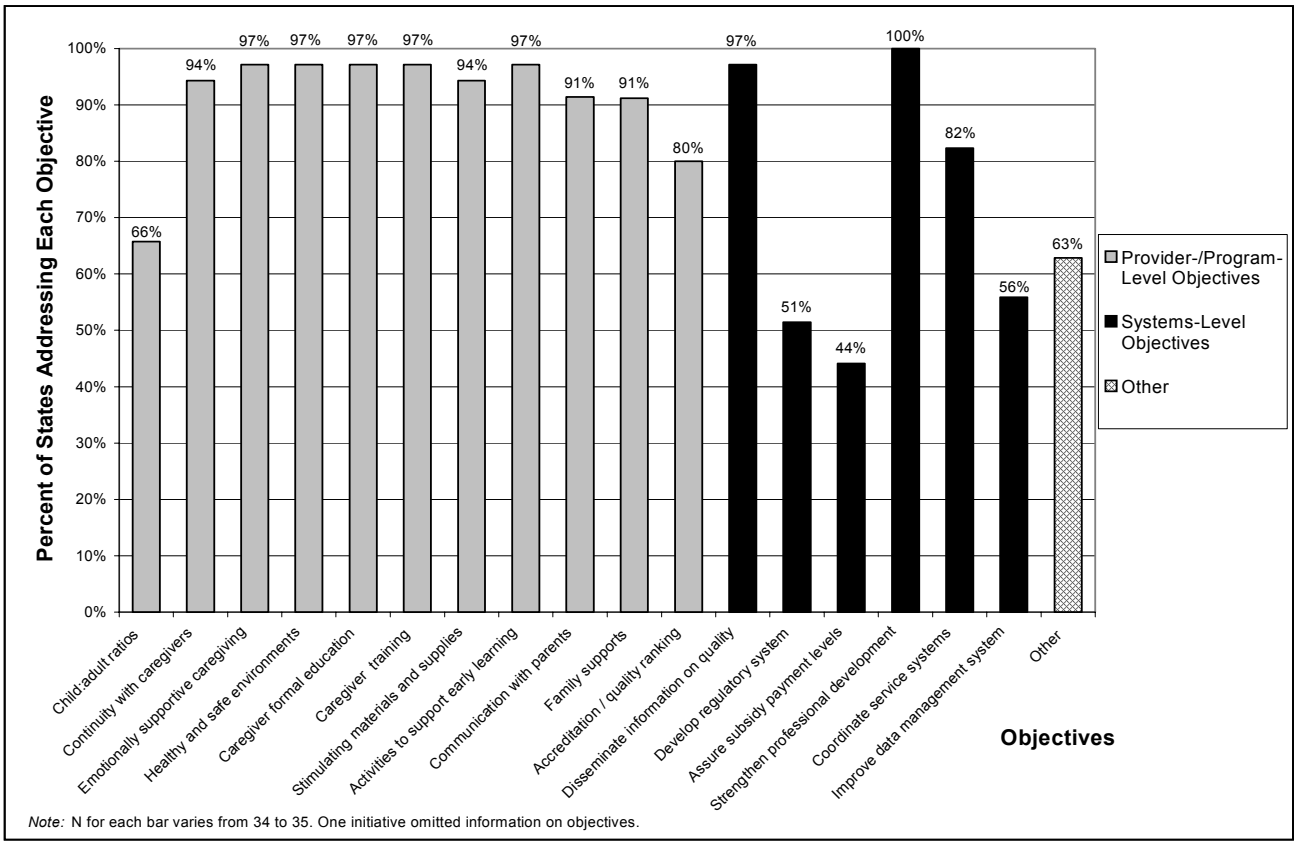
- The System for Early Education Development (SEED) in **Alaska** is a statewide initiative to develop a framework for professional development in early education. The SEED Council was instrumental in initiating the development of early learning guidelines, allocated funding for providers to seek university degrees in early childhood education (ECE) and other training, developed an eight-step career ladder, and initiated a professional development registry. SEED has assisted in the development of a statewide distance-delivered degree program for ECE.
- **Maryland** has supported professional development by creating the Maryland Child Care Credential, which recognizes child care providers for exceeding state licensing and registration requirements. There are six credential levels, each requiring a specific amount of training, experience, and professional activity.

Coordinate Service Systems

- **Washington's** Leadership Council for Quality Care and Education provides coordination and communication among state agencies responsible for child care and early education services. The council serves an advisory role for all state agencies responsible for early childhood programs, carries out an annual review of state programs, and makes recommendations to the agencies and legislature for maximizing funding and improving policy.
- The Keiki Care Project in **Hawaii** works to provide an integrated service system across state agencies for children ages three to five with special needs.

Note: No examples are provided for adequately small child-to-adult ratios; communication with parents; and creating or improving a data management system because these objectives were the primary objective for less than 1 percent of initiatives. These objectives are usually secondary to other quality initiative objectives.

3A. What Proportion of States Addressed Each Quality Objective?



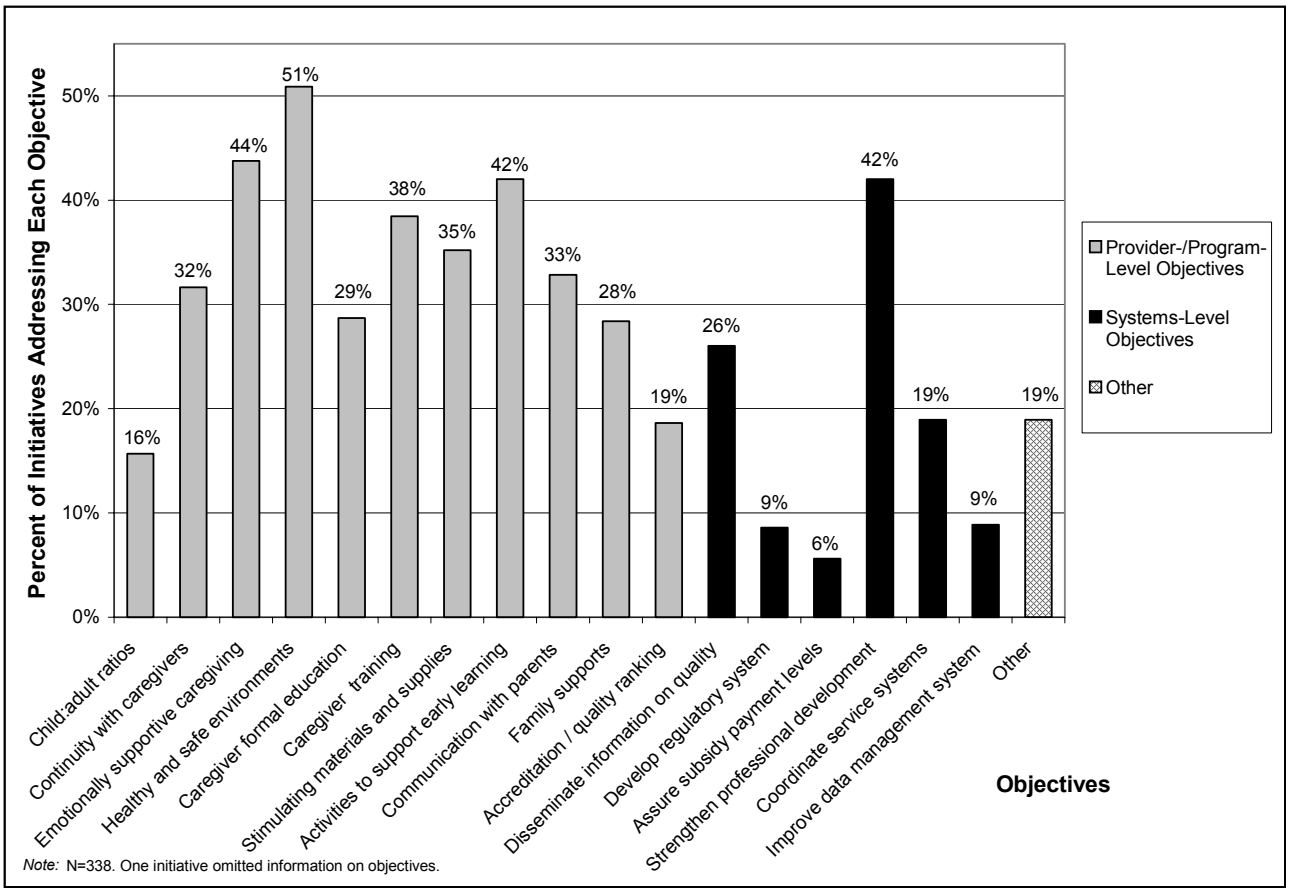
Note: N for each bar varies from 34 to 35. One initiative omitted information on objectives.

This figure presents the proportion of states that had at least one quality-improvement initiative that aimed to achieve each objective.

- The data indicate that states are addressing a wide range of quality objectives. With only one exception, at least half of the states had one or more quality initiative aimed at addressing each of the objectives.
- State quality initiatives are targeting objectives at the level of individual providers and programs (such as improving the health and safety of child care environments and increasing the availability of stimulating materials and supplies), as well as at the systems level (such as supporting a system of professional development).
- There was much more variation in the level at which states addressed system-wide objectives than objectives focusing on individual programs or providers. Most of the program- or provider-level objectives were addressed by 90 percent or more of the states in at least one initiative. Regarding systems-level objectives, only 51 percent of the responding states had implemented activities aimed at strengthening the child care regulatory system, and 56 percent had initiatives aimed at improving data management systems. However, all states had at least one initiative aimed at strengthening the professional development system, and 82 percent of states had at least one initiative aimed at coordinating service systems such as Head Start and child care.
- Professional development was especially likely to be addressed by at least one initiative. States addressed professional development objectives at the systems level as well as at the level of individual providers and programs. All responding states (100%) had at least one initiative aimed at strengthening the system of professional development, while in nearly all responding states at least one initiative aimed at improving quality through increasing caregiver formal education (97%) and caregiver training (97%).

- States also demonstrated a strong focus on supporting and communicating with the parents of children receiving or seeking child care services. In a very high proportion of states, at least one initiative aimed at communicating with parents (91%), providing family supports (91%), and disseminating information on quality to consumers (97%).

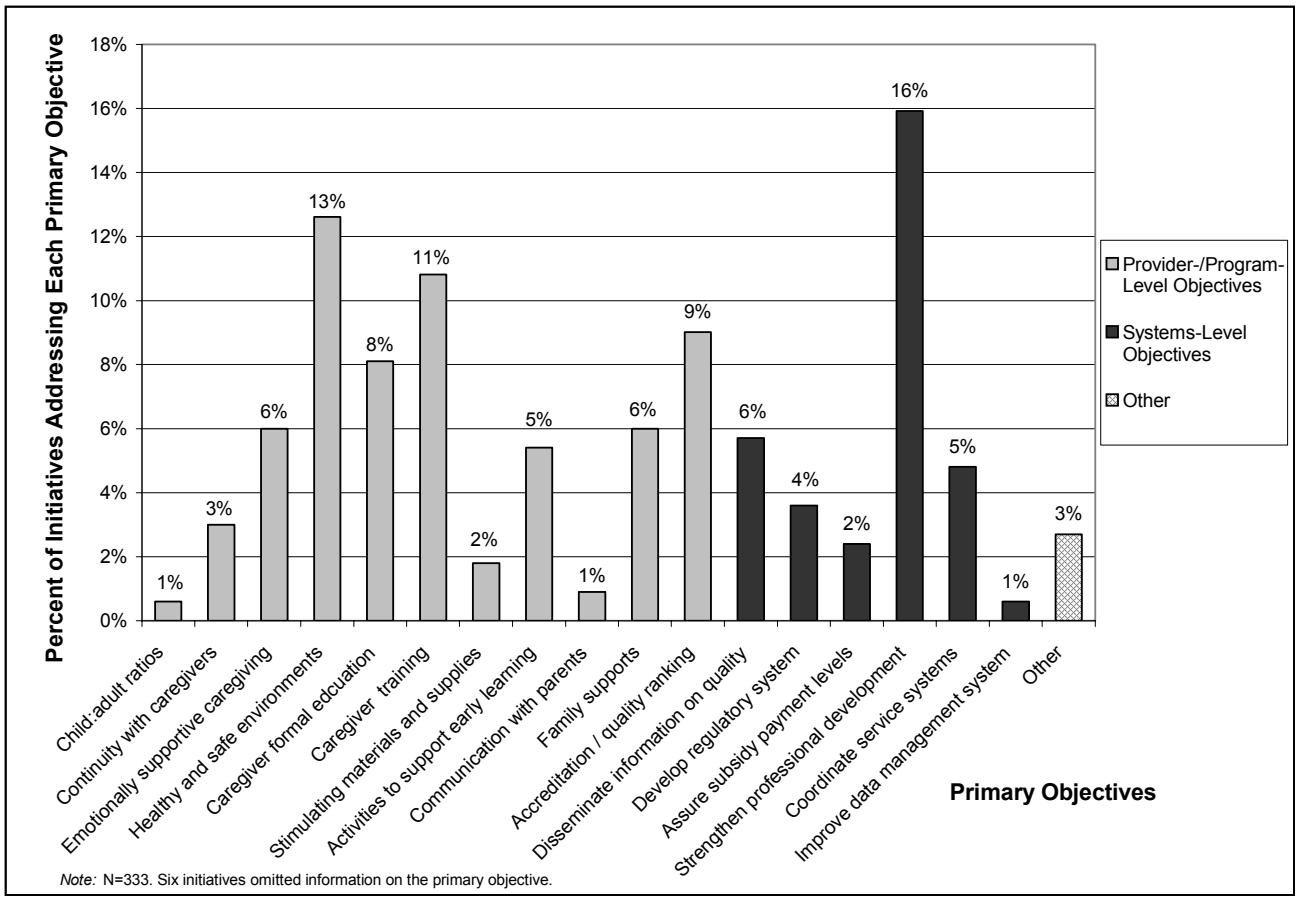
3B. What Proportion of Initiatives Addressed Each Quality Objective?



One can also view the information on objectives from the perspective of the proportion of *initiatives* addressing each objective, rather than the proportion of *states* addressing each objective. Responding states provided profiles for 339 child care quality initiatives. Respondents were asked to identify all of the objectives each initiative sought to address, and then each initiative's primary objective. When respondents were asked to indicate *all of the objectives* that each initiative sought to address, a subset of objectives emerged as particularly salient.

- Health and safety was the objective most often noted across these initiatives. In about half of the initiatives (51%), this was an objective.
- Strengthening emotionally supportive caregiving and the stimulation for learning available in the caregiving environment were both noted for a substantial proportion of the initiatives. There was a nearly even balance between these two objectives. Emotionally supportive caregiving was identified as an objective for 44 percent of the initiatives, while activities to support early learning was noted as an objective for 42 percent.
- Strengthening the system of professional development was also frequently identified as an objective, noted for 42 percent of the initiatives.
- Only a small proportion of the initiatives had as objectives developing the regulatory system (9%), assuring subsidy payment levels (6%), or improving data management systems (9%).
- The list of objectives captured the large majority of states' quality objectives: 19 percent of initiatives cited "other" as an objective.

3C. What Proportion of Initiatives Noted Each Objective as the Primary Objective?



Note: N=333. Six initiatives omitted information on the primary objective.

Responding states were also asked to identify the *primary objective* for each of their quality initiatives. The responses total 100 percent because there was only a single primary objective for each initiative.

- There was wide variation among objectives; while improving child-to-adult ratios was noted as the primary objective for about 1 percent of initiatives, strengthening the system of professional development was indicated as the primary objective for 16 percent of initiatives.
- Professional development was the most frequently identified primary objective. In addition to the 16 percent of initiatives for which strengthening the professional development system was noted as the primary objective, for 11 percent of the initiatives, providing caregiver training was noted as the primary objective, and for a further 8 percent, providing formal education for caregivers or teachers was the primary objective. Altogether more than a third of the initiatives (35%) noted one of these as the primary objective.
- For 13 percent of the initiatives, strengthening the health and safety of caregiving environments was the highest priority objective.
- Helping facilities achieve national accreditation or a higher quality rating was noted as the primary objective for 9 percent of the initiatives. In addition, disseminating information on quality was noted as the primary objective for another 6 percent of the initiatives, and initiative descriptions indicate that these activities often involved disseminating information on how facilities fit within a quality rating system (such as gold, silver, and bronze).
- About 6 percent of initiatives noted emotionally supportive caregiving as the primary objective, while another 5 percent noted activities to support early learning as the highest priority. The information on initiatives' primary objectives points to a near balance of emphasis on cognitive stimulation and emotional support.

4. Target Populations

The survey asked about the target populations for each initiative. The survey defined target population as the organizations, programs, or individuals that the initiative aimed to affect directly. While all initiatives eventually aim to benefit children, the focus here was on the organizations, programs, or individuals each initiative aimed to serve directly.

Just as in the section on objectives, respondents were asked first to identify all target populations for the initiative, and then to identify the primary target population for the initiative. The choices were:

- Individual child care providers
- Child care programs/facilities
- Parents
- Licensing staff
- Trainers, consultants, and developers of educational or curriculum materials
- Institutions of higher education
- Resource and referral agencies

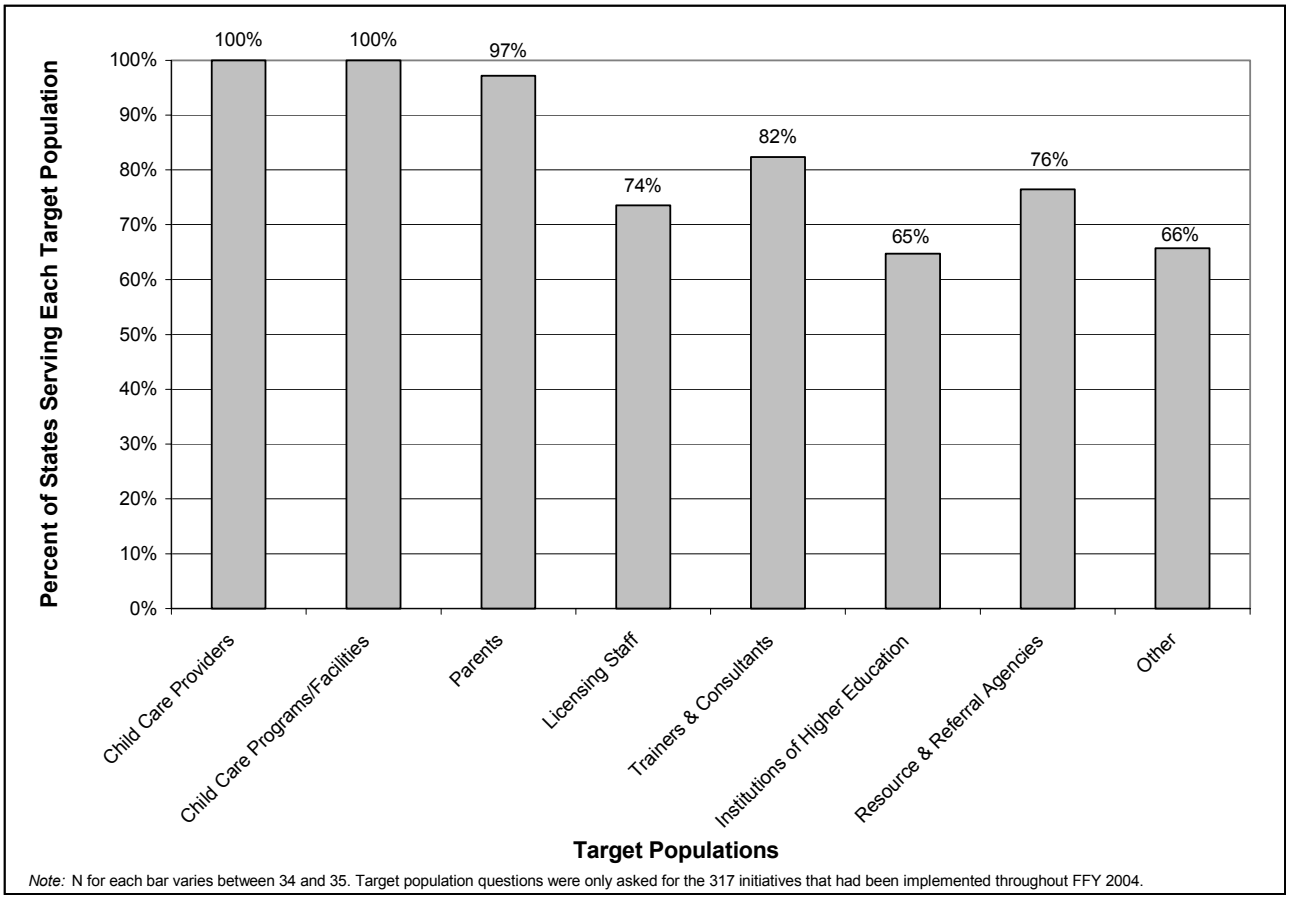
Respondents could also respond "other" and identify a different target population.

For some of the target populations there were follow-up questions to obtain further information.

- When the primary target population was an *individual child care provider,* the survey asked which types of individual providers were targeted: center teachers or assistant teachers; regulated family child care providers; home-based family, friend, and neighbor caregivers; or in-home nannies and babysitters.
- When the primary target population was a *child care program or facility,* the follow-up question asked which types of programs or facilities were targeted: child care centers; regulated family child care homes; home-based family, friend, and neighbor care; or other, including in-home nanny or babysitter care.

The data on target populations are presented from three perspectives: the proportion of states that addressed each target population in at least one initiative; the proportion of initiatives that identified each group as a target population; and the proportion of initiatives that identified each group as the primary target population. In addition, further detail is provided regarding the types of individual providers and child care facilities most often targeted by quality initiatives. Finally, the primary objectives for initiatives that targeted different populations are examined.

4A. What Proportion of States Aimed to Serve Each Target Population?

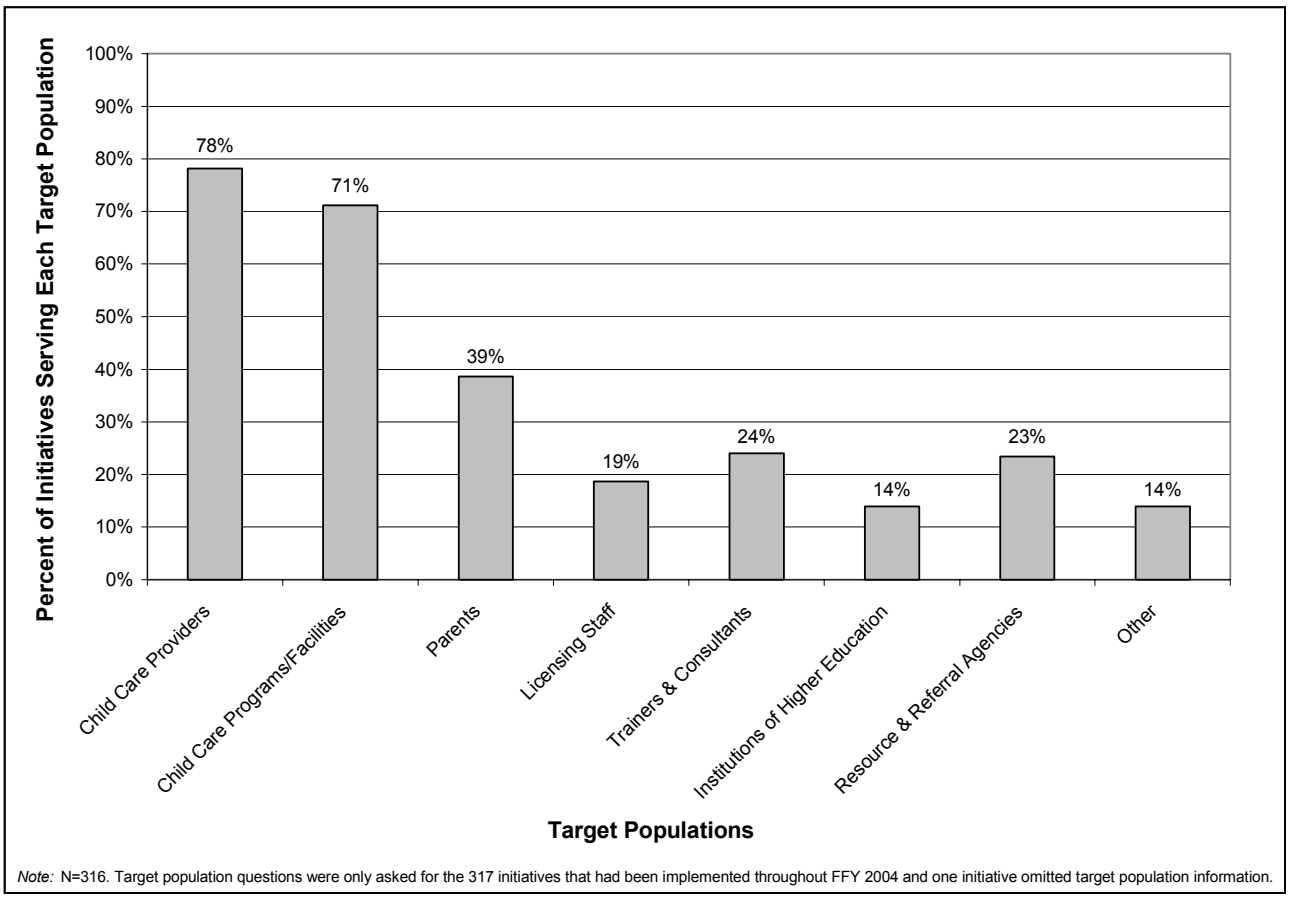


Note: N for each bar varies between 34 and 35. Target population questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004.

This figure presents data on the proportion of states that aimed to serve each target group through at least one quality initiative.

- All of the responding states had child care quality activities aiming to serve individual child care providers and child care programs or facilities.
- Nearly all of the responding states (97%) had at least one quality initiative aiming to serve parents.
- A somewhat smaller proportion of responding states had initiatives aiming to serve licensing staff (74%), trainers and consultants (82%), institutions of higher education (65%), and resource and referral agencies (76%).
- About two-thirds of the responding states identified target groups beyond those listed. These included tribal child care, health professionals, welfare recipients, businesses, and public schools.

4B. What Proportion of Initiatives Aimed to Serve Each Target Population?

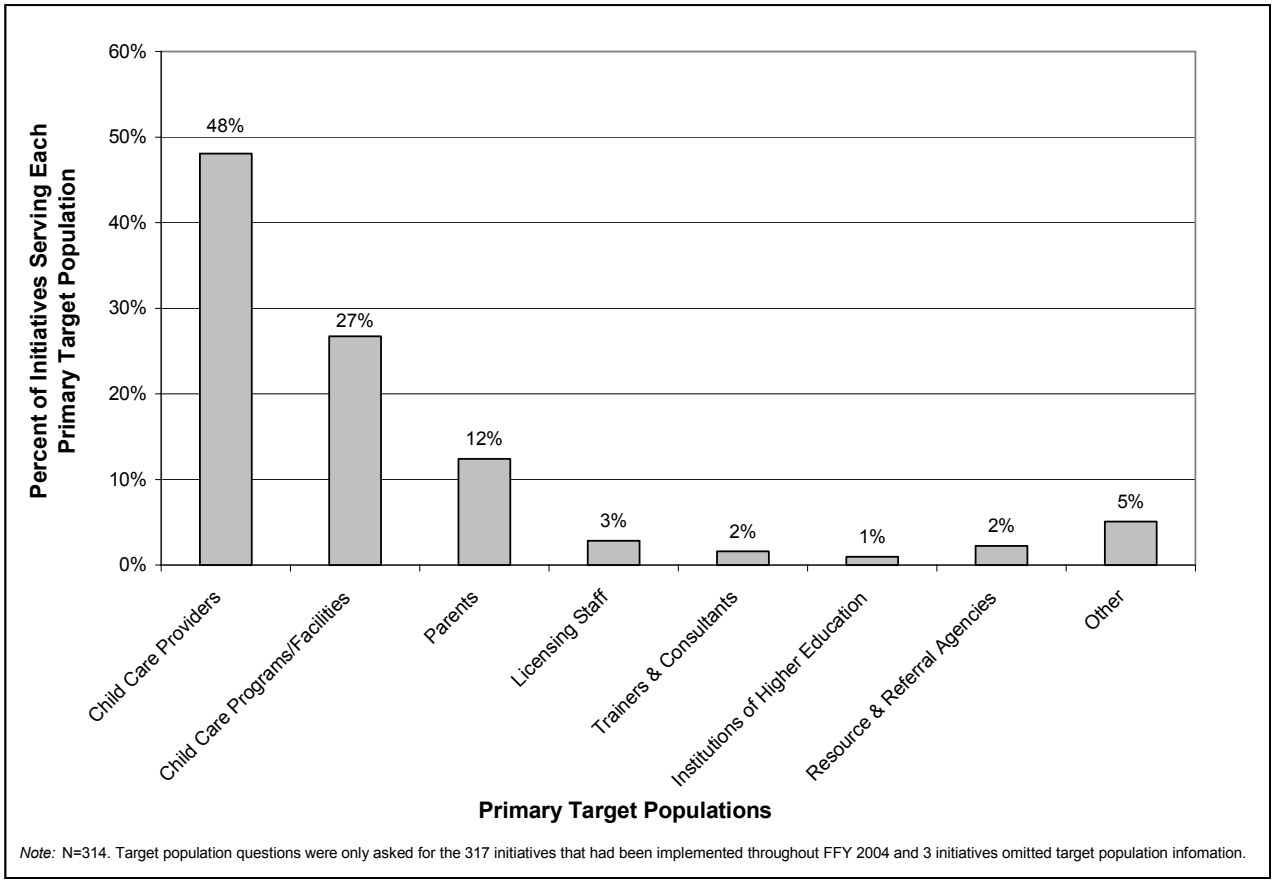


Note: N=316. Target population questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004 and one initiative omitted target population information.

While the preceding summary focused on the proportion of *states* aiming to serve each target group, it is also possible to ask what proportion of the *initiatives* aimed to serve each target population. The following summary provides the picture that emerges when respondents were free to note *all* of the target populations an initiative aimed to serve.

- The most frequently noted target populations were child care providers (78%) and child care programs and facilities (71%).
- Parents were the next most frequently noted target group. They were identified as a target population for 39 percent of initiatives.

4C. What Proportion of Initiatives Noted Each Target Population as the Primary Target?

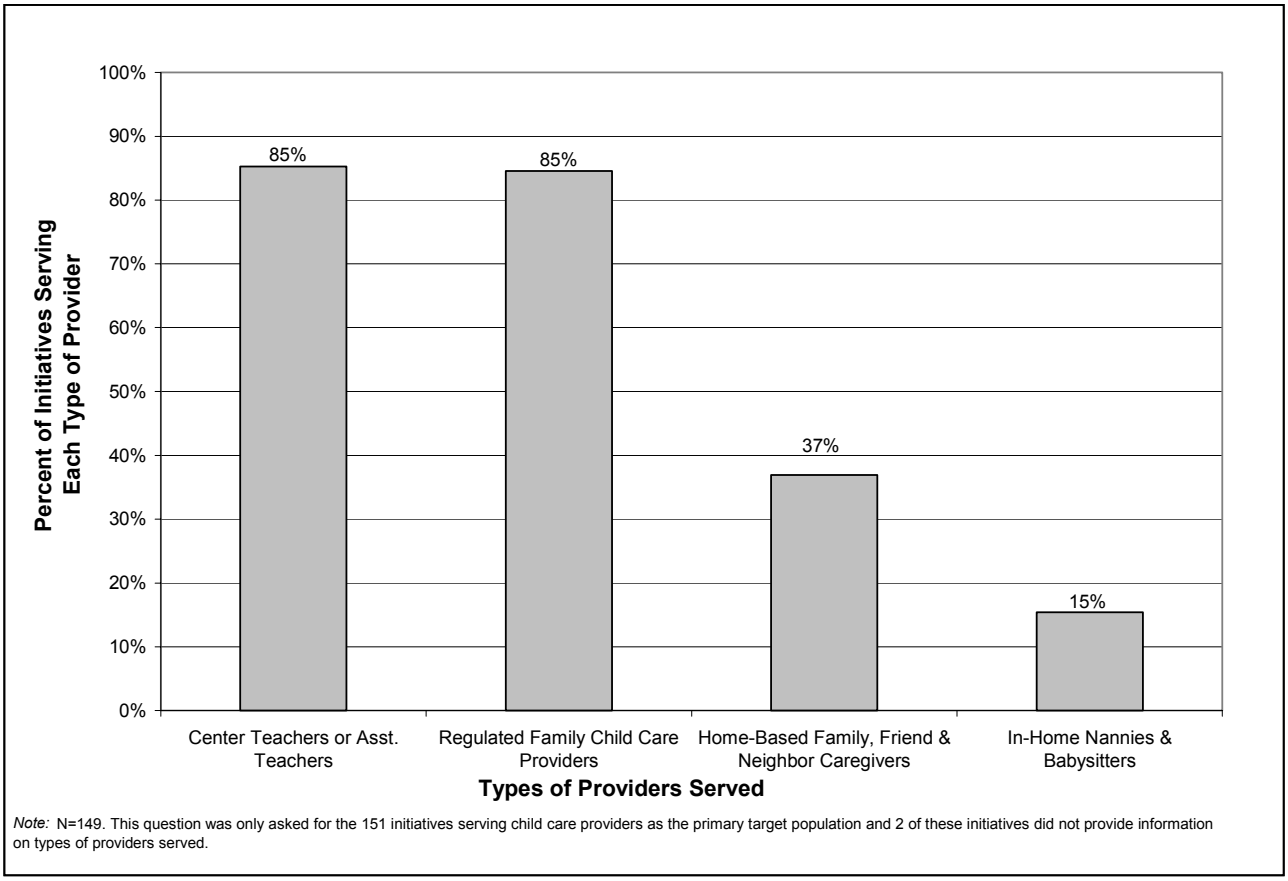


Note: N=314. Target population questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004 and 3 initiatives omitted target population infomation.

When respondents were asked to note the *primary* target population for each initiative, child care providers, child care programs and facilities, and parents again emerged as the most frequently noted target populations. In this figure the proportions total 100 percent as only one primary target population was noted for each initiative.

- Child care providers were identified as the primary target population for 48 percent of the initiatives.
- Child care programs and facilities were identified as the primary target population for 27 percent of the initiatives.
- Parents were identified as the primary target population for 12 percent of the initiatives. Programs with parents as the primary target group involved educating parents about child care programs and resources, educating parents on children's development, parent activities in the context of comprehensive programs, and linking child care with adult-focused programs like welfare programs.
- Very small proportions of initiatives had as their primary target populations licensing staff (3%), trainers and consultants (2%), institutions of higher education (1%), and resource and referral agencies (2%).

4D. For Initiatives Noting Child Care Providers as the Primary Target Population, What Types of Providers Were Targeted?

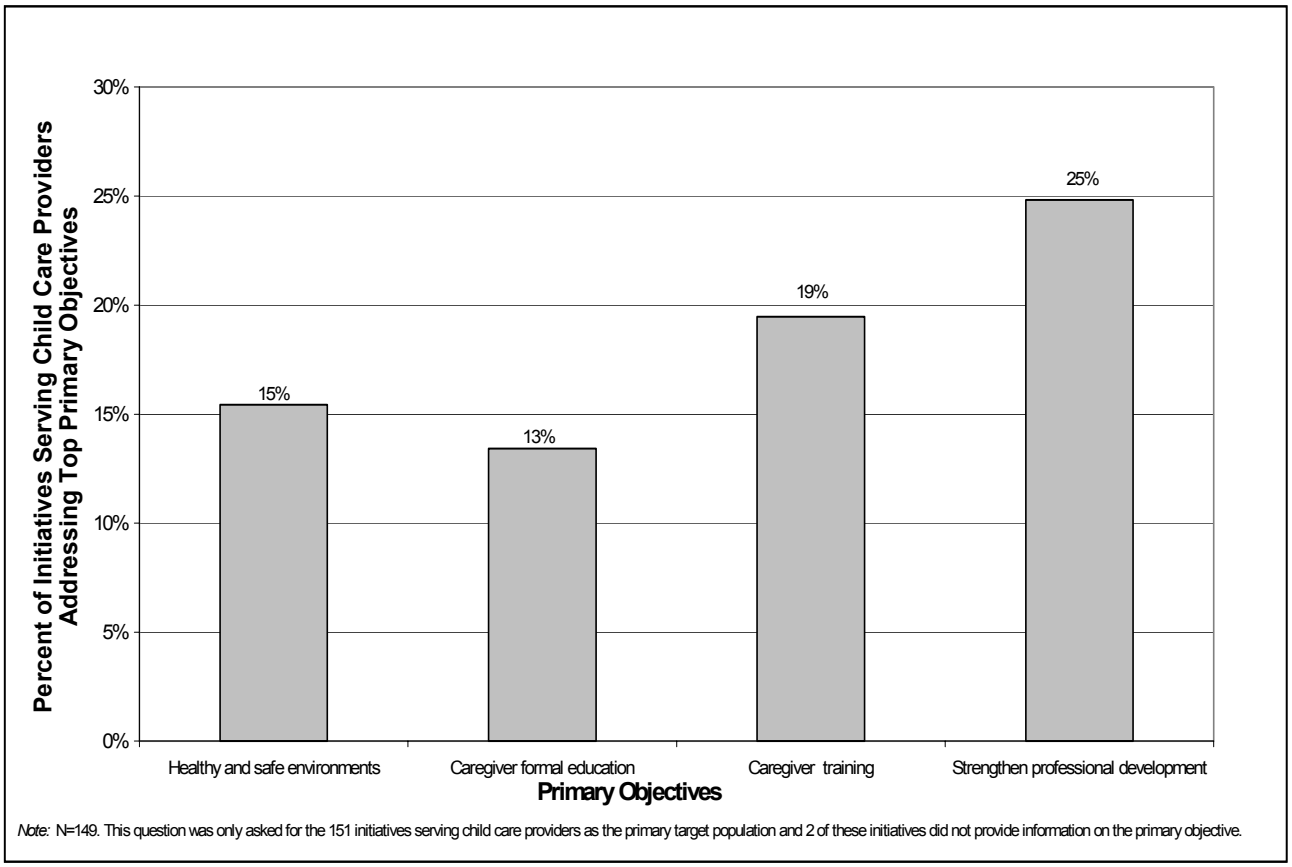


Note: N=149. This question was only asked for the 151 initiatives serving child care providers as the primary target population and 2 of these initiatives did not provide information on types of providers served.

When the primary target population for a quality initiative was identified to be child care providers, follow-up questions asked about the types of providers served. Each state answered the questions based on their state's definitions for different categories of providers. State definitions and policies vary greatly for both the types of providers that are required to be licensed or regulated and the standards that are applied to them.

- Of the initiatives with a primary target group of child care providers, 85 percent reported serving center teachers or assistant teachers.
- The same proportion of these initiatives, 85 percent, aimed to serve regulated family child care providers.
- Only a little over a third of initiatives targeting child care providers aimed to serve home-based family, friend, and neighbor caregivers (37%), and an even smaller proportion (15%) of initiatives targeting child care providers aimed to serve in-home nannies and babysitters.

4E. For Initiatives Noting Child Care Providers as the Primary Target Population, What Were the Most Common Primary Objectives?

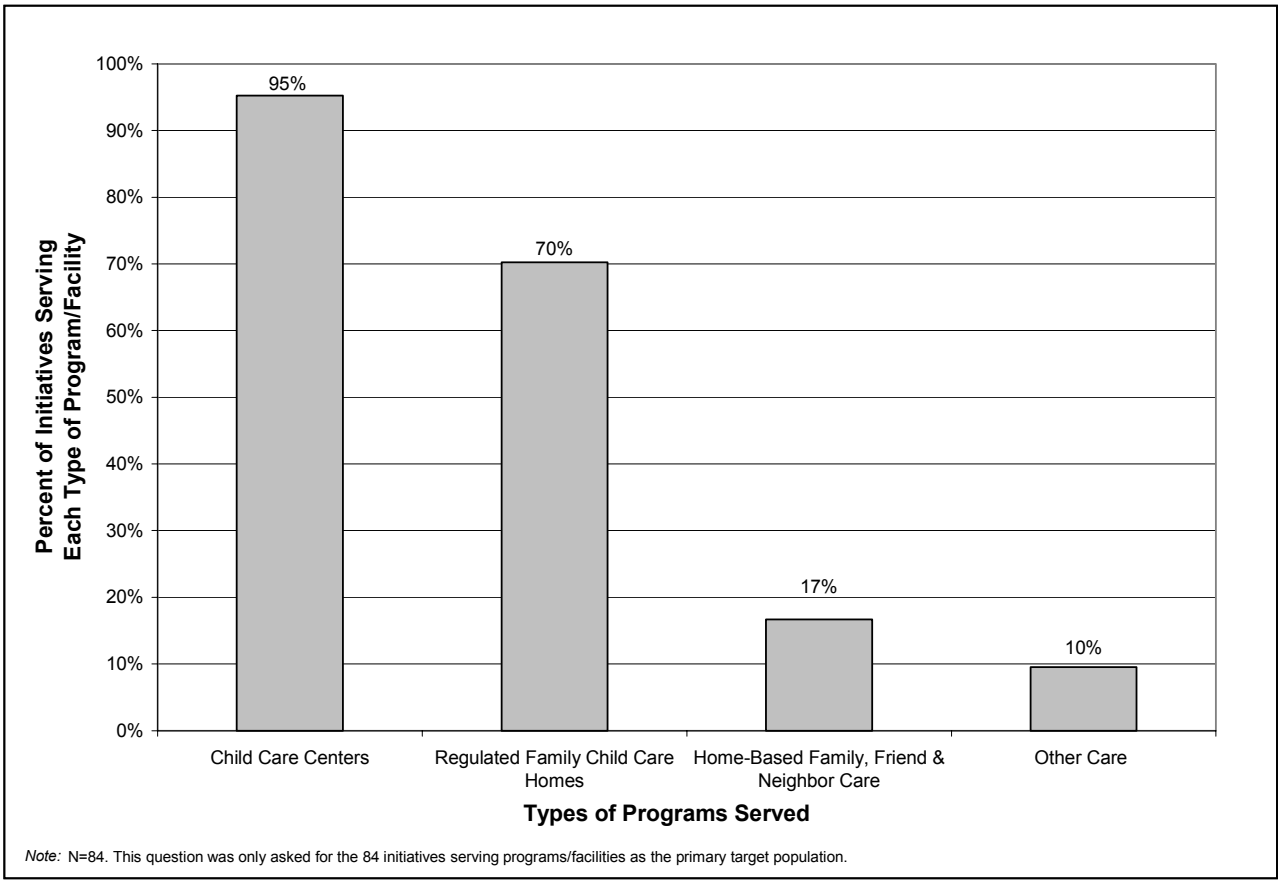


Note: N=149. This question was only asked for the 151 initiatives serving child care providers as the primary target population and 2 of these initiatives did not provide information on the primary objective.

It is possible to look at the primary objectives of quality initiatives serving specific target populations, such as individual child care providers. As noted in figure 4C, child care providers were identified most often as the primary target population.

- The majority of initiatives targeted at providers had a primary objective related to professional development. Strengthening the professional development system was the primary objective for 25 percent of quality initiatives aimed at providers, while increasing caregiver training was the objective for 19 percent of these initiatives, and encouraging caregiver formal education was the objective for 13 percent. Altogether, 58 percent of initiatives noting caregivers as the primary target population had a primary objective related to increasing or strengthening professional development.
- Promoting healthy and safe environments was also a commonly cited primary objective (15%) for initiatives aimed at providers.

4F. For Initiatives Noting Child Care Programs and Facilities as the Primary Target Population, What Types of Programs and Facilities Were Targeted?

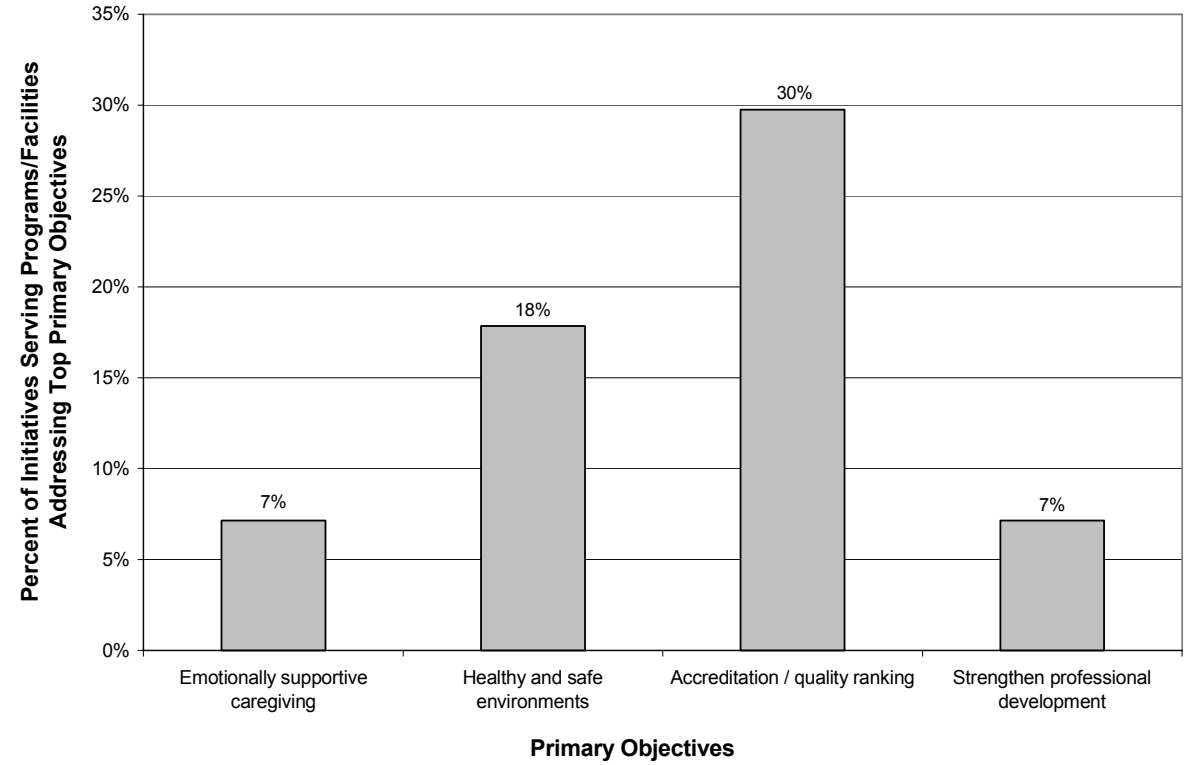


Note: N=84. This question was only asked for the 84 initiatives serving programs/facilities as the primary target population.

Follow-up questions provided a more detailed picture of the specific types of programs and facilities most commonly served by state child care quality initiatives.

- Like the initiatives that targeted individual child care providers, initiatives that targeted programs or facilities focused on regulated settings. Ninety-five percent of the initiatives that targeted programs and facilities aimed to serve child care centers and 70 percent aimed to serve regulated family child care homes.
- Only 17 percent of initiatives serving programs and facilities aimed to serve home-based family, friend, and neighbor care settings, and 10 percent aimed to serve other types of programs (such as care provided by nannies and babysitters).

4G. For Initiatives Noting Child Care Programs and Facilities as the Primary Target Population, What Were the Most Common Primary Objectives?

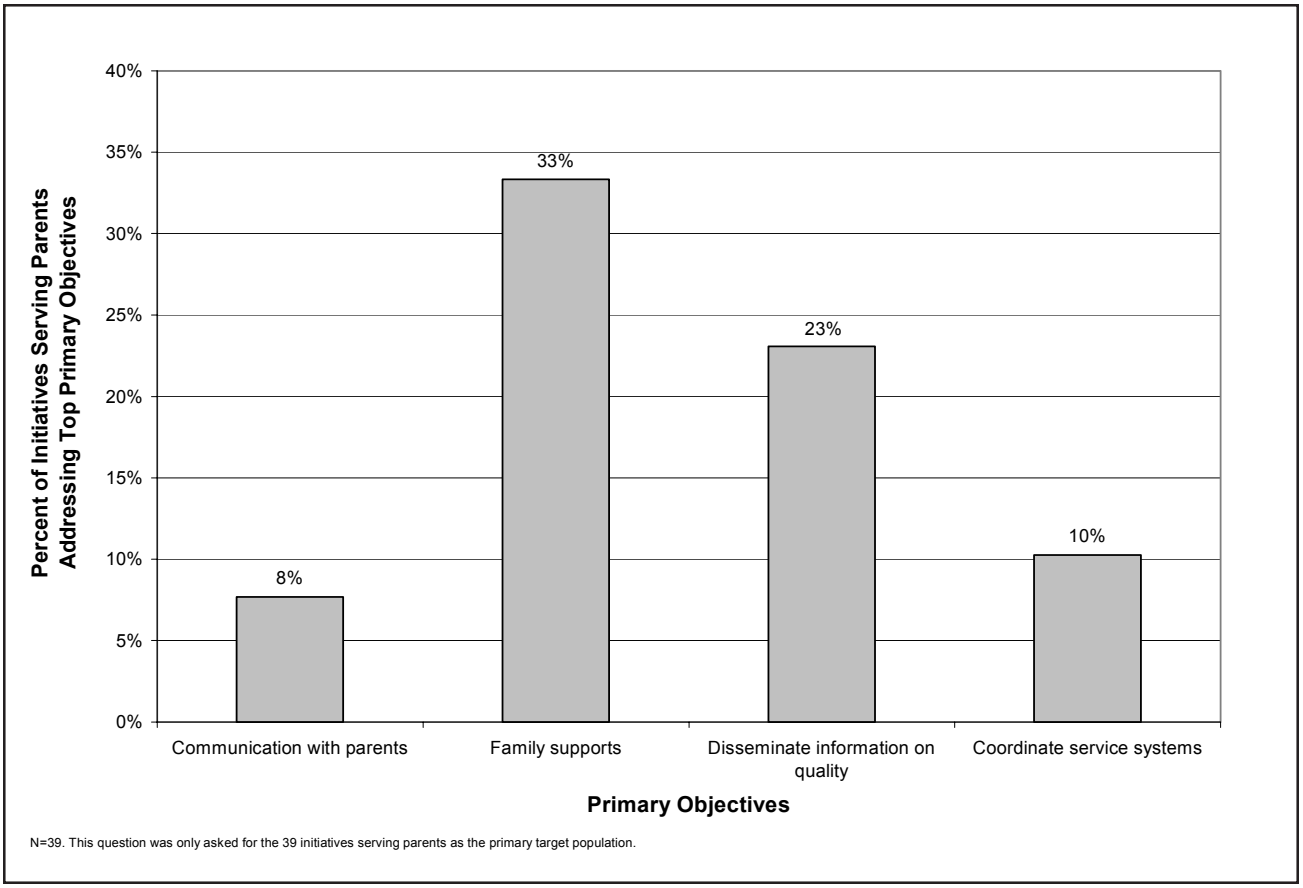


Note: N=84. This question was only asked for the 84 initiatives serving programs/facilities as the primary target population.

This figure examines the primary objectives of state quality initiatives directed at child care programs and facilities.

- The most frequently occurring primary objective for quality activities aimed at child care programs and facilities was supporting movement toward accreditation or a higher rating in a quality rating system (30%).
- The second most commonly cited primary objective for initiatives targeting programs and facilities was creating and ensuring healthy and safe environments (18%).

4H. For Initiatives Noting Parents as the Primary Target Population, What Were the Most Common Primary Objectives?



N=39. This question was only asked for the 39 initiatives serving parents as the primary target population.

Two quality objectives stood out as the most frequently occurring primary objectives in initiatives targeting parents.

- For 33 percent of initiatives directed at parents, provision of family supports was the primary objective.
- For 23 percent of these initiatives, the primary objective was dissemination of information on quality.
- Coordinating service systems (10%) and communicating with parents (8%) were also frequently occurring primary objectives for activities aimed at parents.

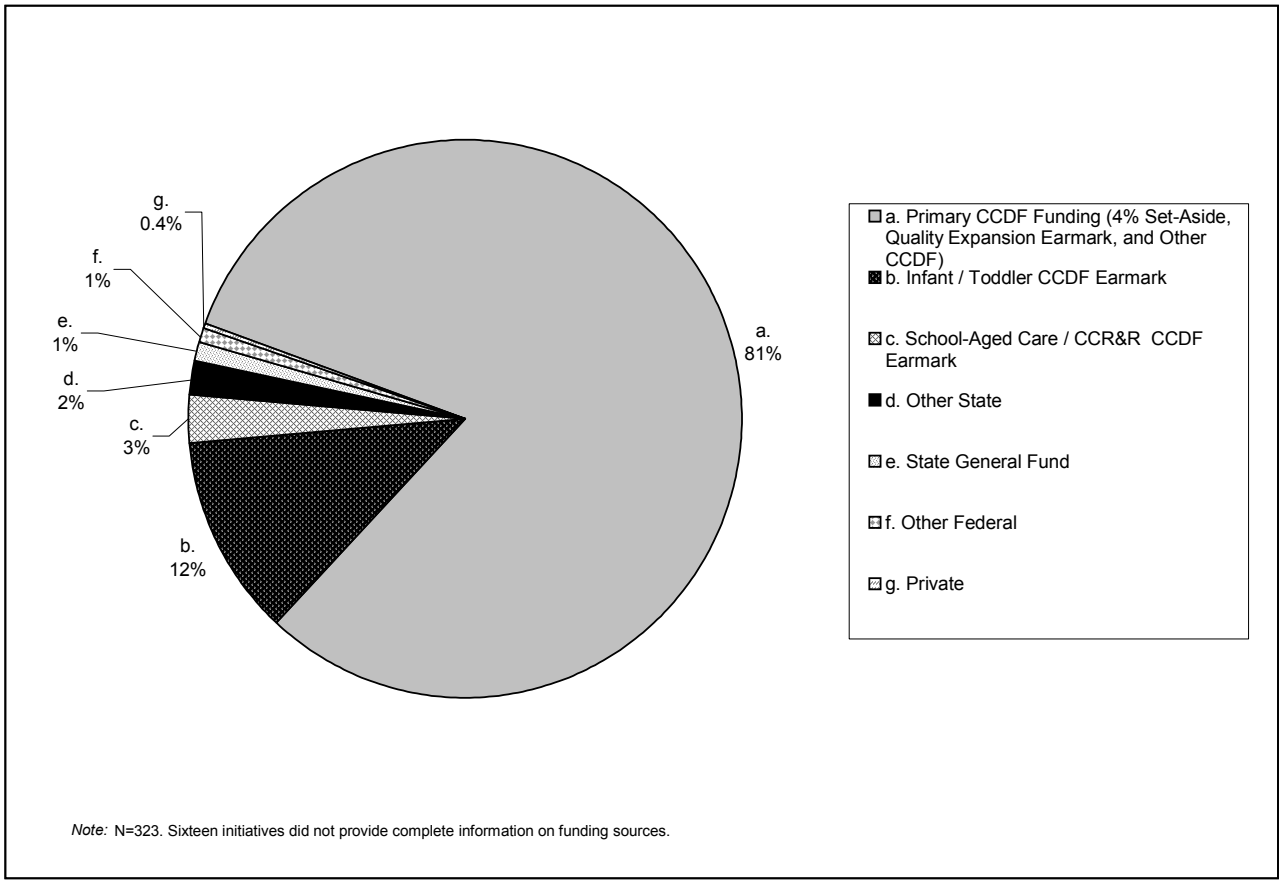
5. Funding

The survey asked a series of questions about the funding for each initiative during FFY 2004 (October 2003 through September 2004). The focus was on budgeted funding level rather than on expenditures during the fiscal year.

- The survey asked for the total funding level, in dollars, for each initiative, in FFY 2004.
- The survey also asked for a breakdown of the funding by source. Respondents provided the funding for the initiative, in dollar amounts, from each of the following sources:
  - Primary CCDF funding (4 percent quality set-aside, quality expansion earmark, and other CCDF)
  - Infant and toddler CCDF earmark
  - School-aged child care and child care resource and referral CCDF earmark
  - Other federal funds
  - State general fund
  - Other state (e.g., tobacco money, taxes)
  - Private (e.g., foundations, United Way)
- For initiatives that had been in place for at least one year, the survey asked whether funding for the initiative had been cut during FFY 2004.

Analyses presented include the proportion of total funding across all initiatives that came from each funding source; the proportion of total funding for all initiatives reported on that went to initiatives with each primary objective; and the average funding level for initiatives with each primary objective. Data are also presented on the primary objectives of initiatives with at least some funding through the infant and toddler earmark and through the school-aged child care and resource and referral earmark, and the proportion of total funding for all initiatives reported on that went to initiatives that targeted each primary target population. Finally, the proportion of initiatives in place for at least one year for which funding was cut during FFY 2004 is presented.

5A. What Proportion of Quality Initiative Funding Was Allocated from Each Source?

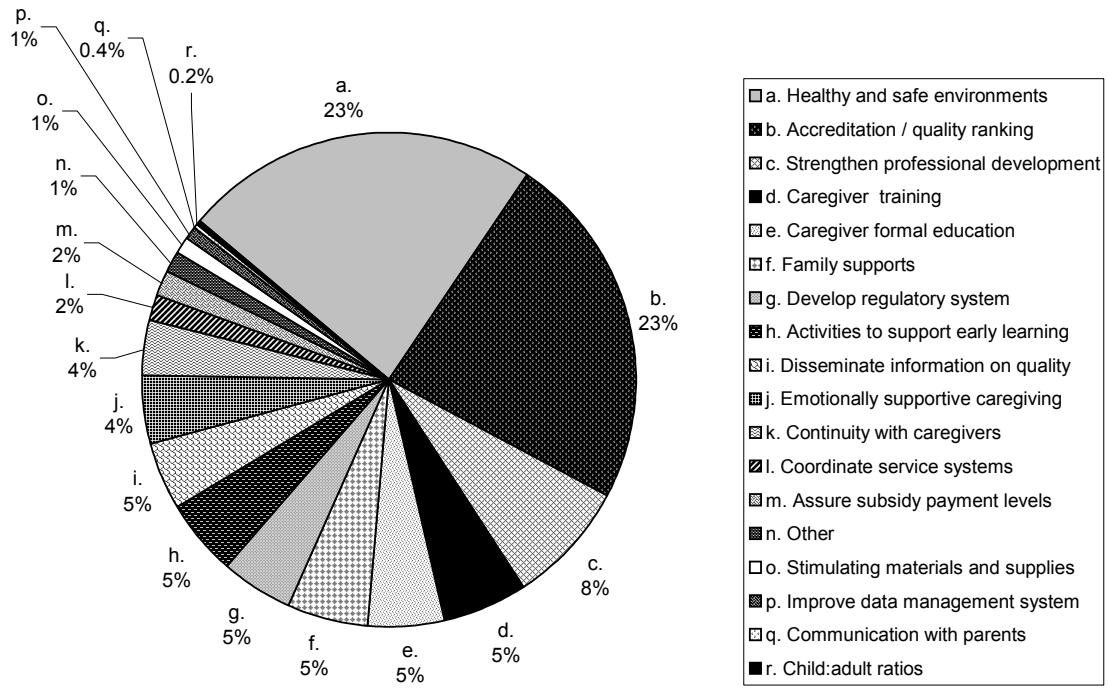


Note: N=323. Sixteen initiatives did not provide complete information on funding sources.

This figure presents the sources of funding for state child care quality initiatives included in this survey. States were asked to provide survey information only on quality activities that were funded with at least $1,000 from CCDF. Because many states have initiatives funded entirely with state or private funds that would not have been captured in the survey, non-federal sources of funding are most likely underrepresented here.

- The largest single source of funding for this set of state child care quality-improvement activities is the CCDF, including transfers from TANF to CCDF. When the quality earmarks are included, CCDF, which consists of both federal and state funding, accounts for 96 percent of budgeted quality funding.
- Looking separately at the infant and toddler earmark, and the school-aged child care and child care resource and referral earmark, these account for 12 percent and 3 percent, respectively, of budgets for initiatives in this survey.
- State funding, including both state general fund and other state funding sources, accounts for another 3 percent of the budgeted amount for these initiatives. Over a third of the responding states, about 34 percent, had some funding from these state sources.

5B. What Proportion of Quality Initiative Funding Was Allocated for Initiatives with Each Primary Objective?

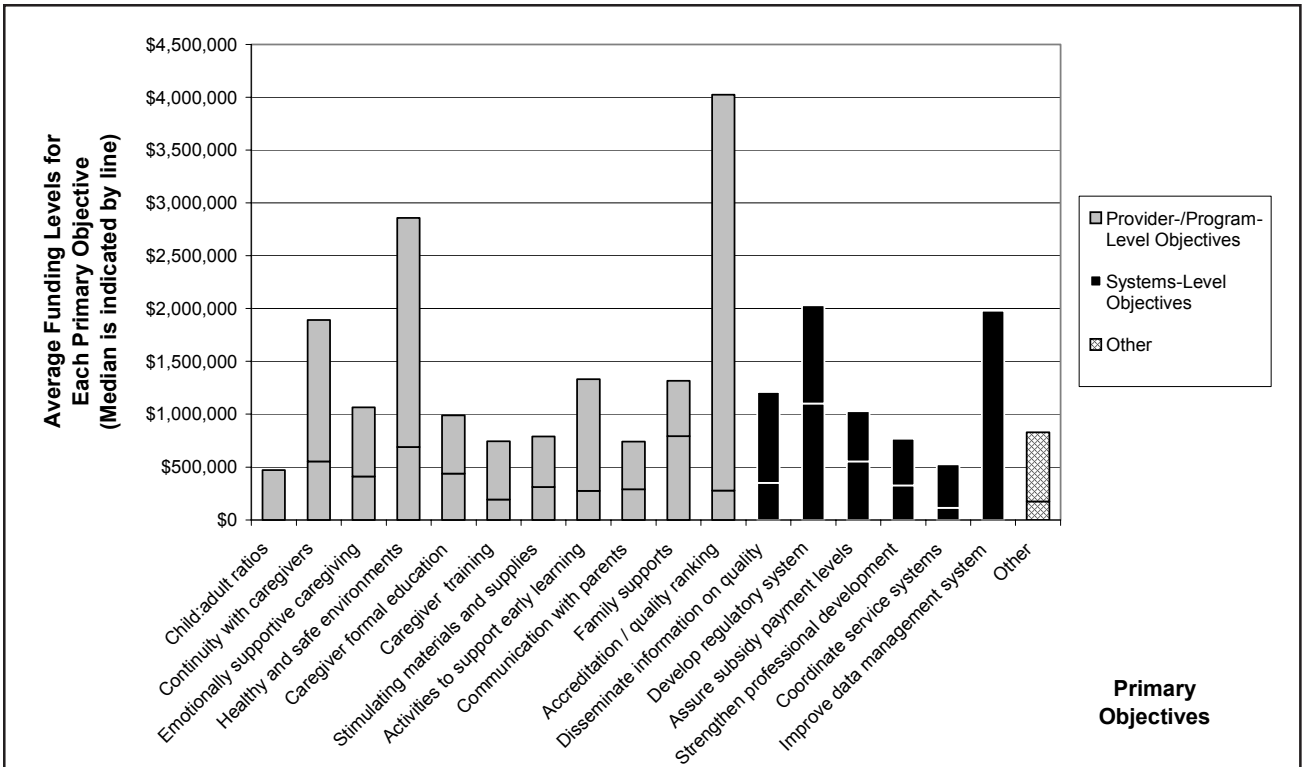


Note: N=330. Six initiatives omitted information on the primary objective and 3 omitted funding information.

The proportion of funding allocated for each primary objective is a reflection of both the number of initiatives aimed at these objectives and the relative cost of initiatives aimed at achieving particular objectives.

- Initiatives with the primary objective of ensuring healthy and safe environments and initiatives supporting accreditation or a higher quality rating each accounted for 23 percent of the total allocated quality funding.
- Funding for professional development combined with that for caregiver formal education and caregiver training (categories c, d, and e) accounted for nearly one-fifth (19%) of the total.
- Initiatives with a primary objective of supporting emotionally supportive caregiving and those with a primary objective of supporting early learning activities accounted for approximately equal though smaller proportions of the total—4 percent and 5 percent, respectively.
- Smaller proportions of funding were also directed toward initiatives with a primary objective of providing family supports (5%), developing the regulatory system (5%), disseminating information on quality (5%), and continuity with caregivers (4%).

5C. What Were the Average and Median Budgets for Initiatives with Each Primary Objective?



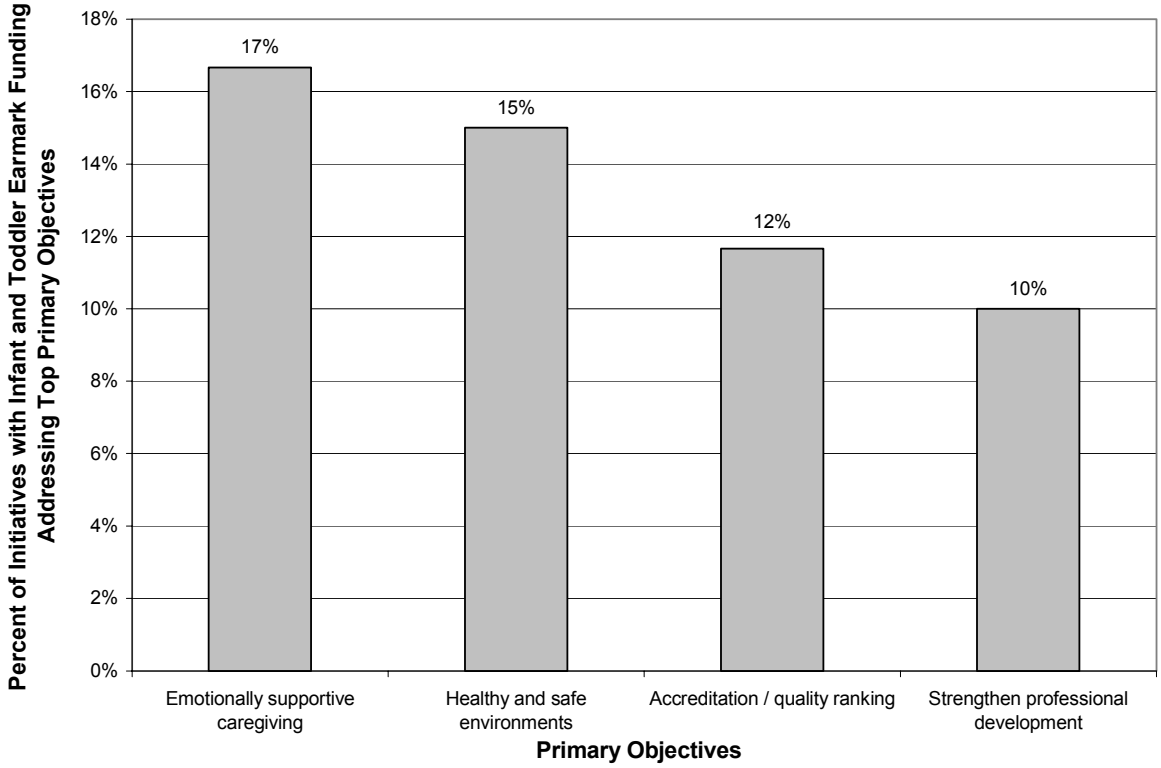
Note: N=330. Six initiatives omitted primary objective information and 3 omitted funding information. No median line is indicated for "child:adult ratios" or "improve data management system," because the mean and median were equal for these two types of initiatives.

This figure provides data on the average and median annual funding levels for state quality initiatives directed at each of the primary objectives. The full bar indicates the average funding level; the line within the bar indicates the median funding level.

- Initiatives with the primary objective of supporting child care programs in attaining accreditation or a higher quality rating had the largest budgets on average, $4 million, but also the greatest range—$5,000 to more than $50 million. The median for initiatives with this objective indicates that half had budgets of $278,000 or below. Thus, the high average funding level reflects the fact that a few initiatives had substantial budgets. While initiatives with the primary objective of supporting progress toward accreditation or a higher quality rating had the largest average budgets, accounting for 23 percent of the total budgeted amount, this was the primary objective for only 9 percent of initiatives.
- The primary objective of initiatives with the second largest average budget ($2.9 million) was ensuring healthy and safe environments. As for initiatives focusing on accreditation or other quality rankings, initiatives supporting healthy and safe environments had a large range of funding ($42,000 to $46 million), and a median significantly smaller than the average funding level ($690,000). Healthy and safe environments accounted for almost a quarter (23%) of total funding, and this objective was the second most common primary objective (13%).
- The primary objectives of other initiatives with high average budgets included two with systems-level objectives—developing the regulatory system ($2 million) and improving data management ($2 million). These two objectives also had relatively high medians ($1.1 million and $2.0 million, respectively). Developing the regulatory system, with the third highest average budget, accounted for only about 5 percent of the total budgeted amount and 4 percent of the primary objectives, while initiatives that had the primary objective of improving data management represented 1 percent of both the total budgeted amount and primary objectives.

- Initiatives with the primary goal of increasing continuity with caregivers had average budgets of close to $1.9 million, but accounted for only about 4 percent of the total budgeted amount and 3 percent of the primary objectives. Initiatives focusing on continuity of caregivers had a large range, from $155,000 to $7.5 million, and median of $552,000.
- Initiatives with the primary objective of strengthening professional development systems, with an average budget of almost $800,000, accounted for 8 percent of the total budgeted amount and 16 percent of primary objectives. The median funding level for these initiatives was somewhat smaller ($325,000), again reflecting the high-budget initiatives that ranged up to $10 million.

5D. For Initiatives with Funding from the Infant and Toddler Earmark, What Were the Most Common Primary Objectives?

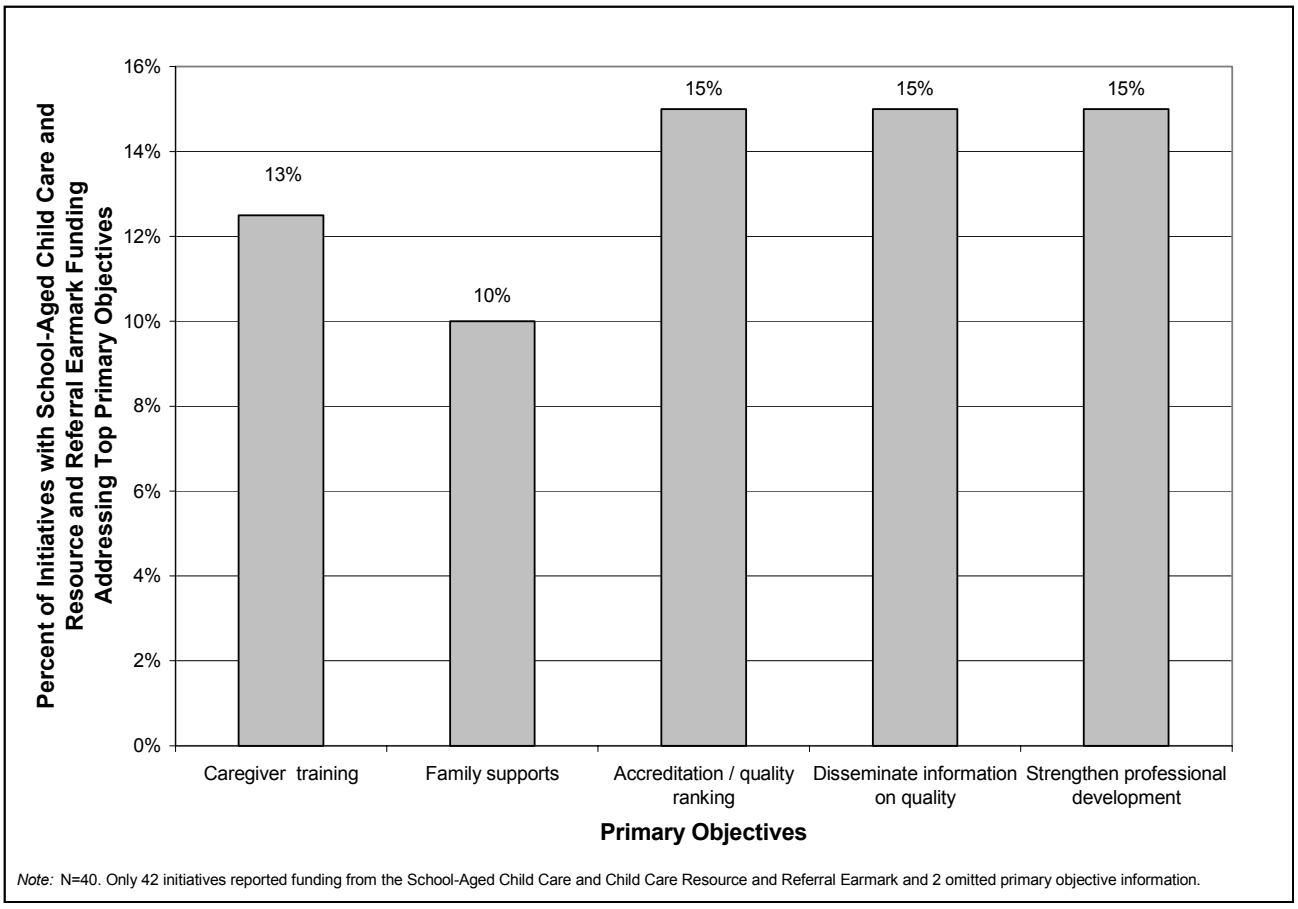


Note: N=60. Only 61 initiatives had funding from the Infant and Toddler Earmark and one initative omitted information on the primary objective.

The infant and toddler earmark is CCDF funding that states must use for activities to improve the quality of child care provided to infants and toddlers. Sixty-one of the 339 state quality initiatives included in the survey (18%) reported some funding from the infant and toddler earmark. Among these initiatives, four primary objectives were commonly noted.

- Quality initiatives with at least some funding from the infant and toddler earmark most often cited providing emotionally supportive and responsive caregiving as their primary objective (17%). Providing emotionally supportive caregiving appears to be particularly salient in initiatives involving very young children.
- The next most commonly noted primary objective of initiatives with funding from the infant and toddler earmark was healthy and safe environments (15%).
- Helping programs achieve accreditation or a quality rating was the primary objective for 12 percent of quality-improvement initiatives funded with the earmark. Strengthening the professional development system was the main objective for an additional 10 percent.

5E. For Initiatives with Funding from the School-Aged Child Care and Child Care Resource and Referral Earmark, What Were the Most Common Primary Objectives?

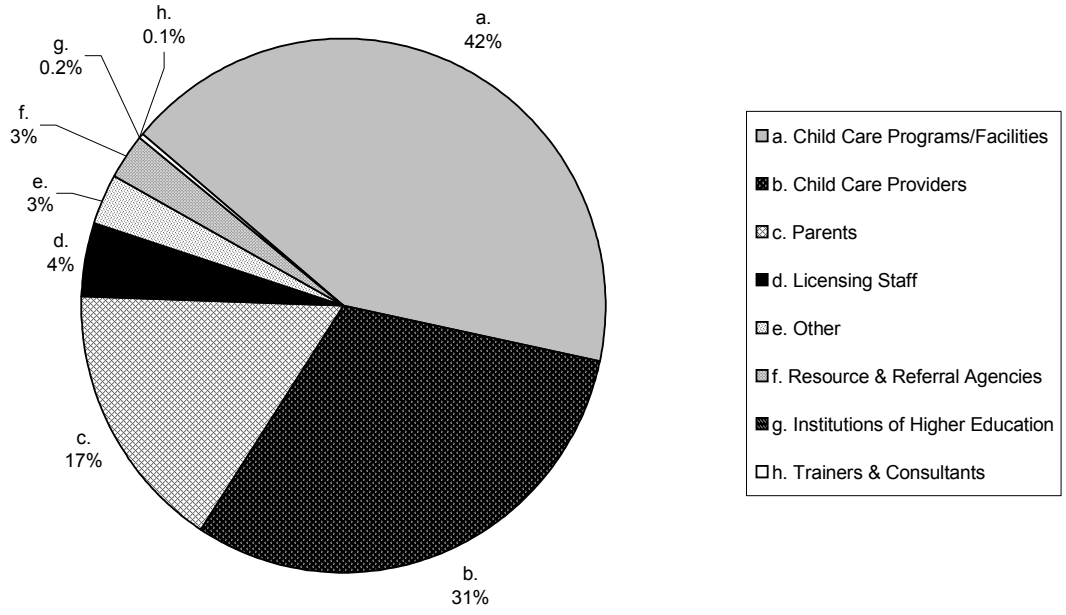


Note: N=40. Only 42 initiatives reported funding from the School-Aged Child Care and Child Care Resource and Referral Earmark and 2 omitted primary objective information.

The school-aged child care and child care resource and referral earmark is CCDF funding that states must use for activities to expand or improve the quality of before- and after-school care and to provide information to parents regarding child care providers. Forty-two of the 339 state quality initiatives included in the survey (12%) reported some funding from this earmark. This figure summarizes the most frequently cited primary objectives for these initiatives.

- Quality initiatives with at least some funding from the school-aged child care and resource and referral earmark were equally likely to have as their primary objectives supporting programs in reaching accreditation or a higher quality rating (15%), dissemination of information on quality (15%), and strengthening the professional development system (15%).
- Caregiver training (13%) and family supports (10%) were also frequently occurring primary objectives of initiatives with some funding from this earmark.

5F. What Proportion of Quality Initiative Funding Was Allocated for Initiatives Aiming to Serve Each Primary Target Population?

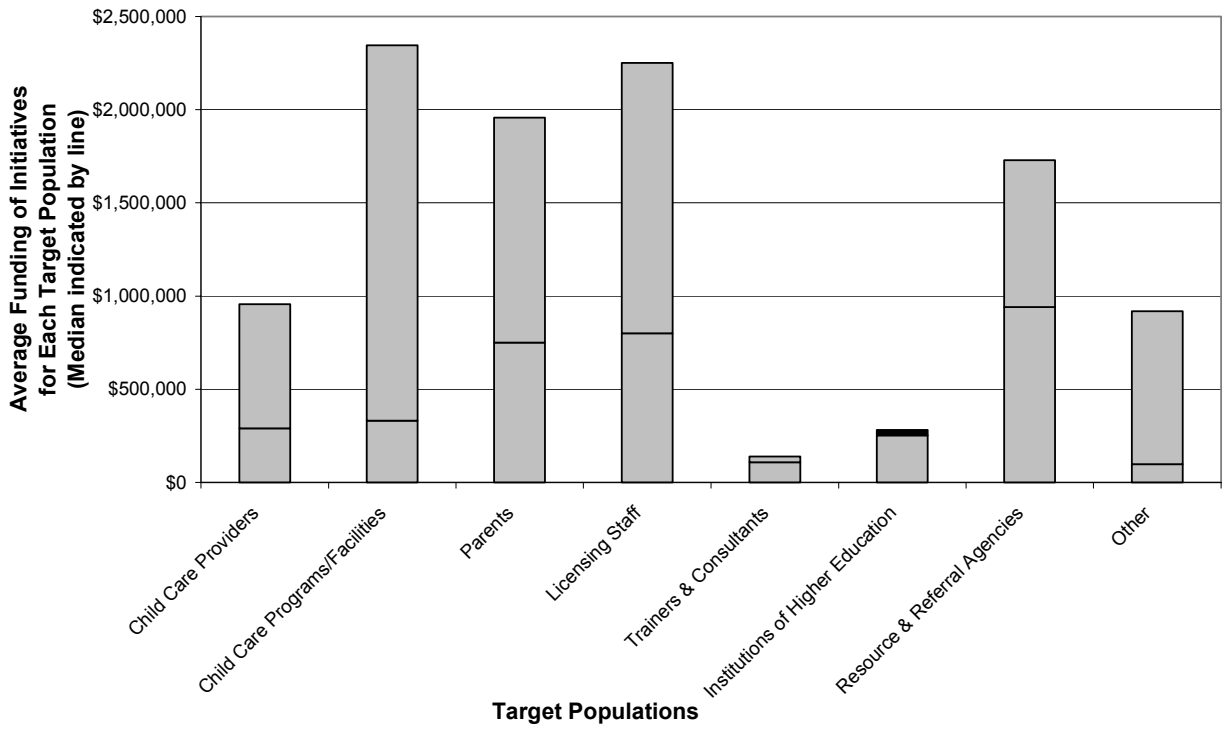


Note: N=311. Target population questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004. Of these, 3 omitted primary target population information and 3 omitted funding information.

The percentage of total quality funding dedicated to services for each target population is a reflection of the number and scope of initiatives aimed at each population, as well as the relative cost of the types of initiatives aimed at each target population.

- The greatest portion of the total budgeted quality funding was allocated toward initiatives with child care programs and facilities as the target population (42%). The most common objectives for initiatives targeting programs and facilities were supporting the attainment of accreditation or a higher quality rating and ensuring healthy and safe environments, the two objectives with the highest average budgets.
- The second largest proportion of funding was allocated for initiatives with child care providers as the target population (31%), followed by initiatives targeting parents (17%).
- A total of 89 percent of the total budgeted amount was allocated toward initiatives with these three primary target populations (programs, providers, and parents).
- The remaining 11 percent of the total funding was allocated to initiatives in which the primary target population was licensing staff (4%), resource and referral agencies (3%), institutions of higher education (0.2%), trainers and consultants (0.1%), and other (3%).

5G. What Were the Average and Median Budgets for Initiatives Aiming to Serve Each Primary Target Population?

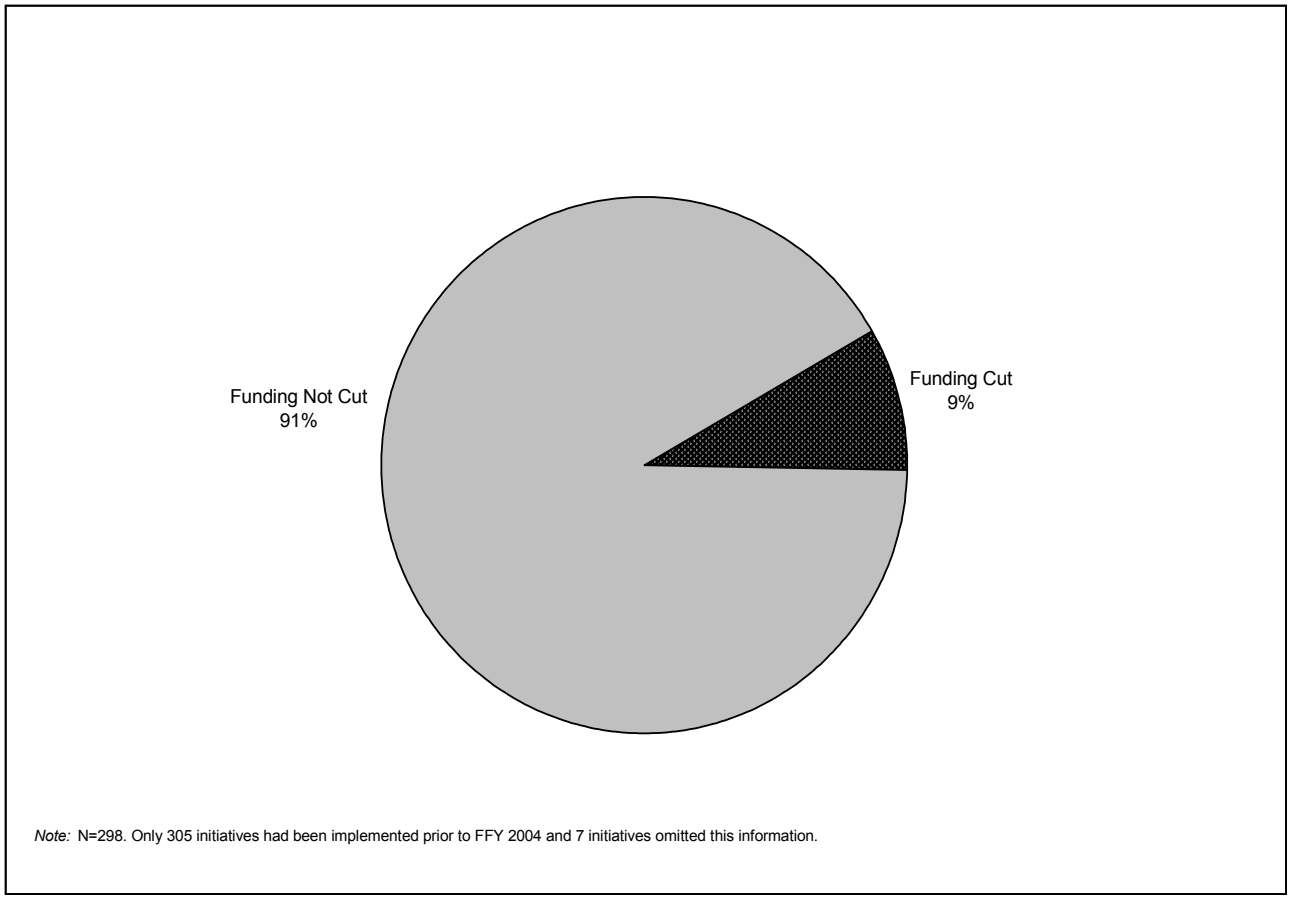


Note: N=311. Target population questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004. Of these, 3 omitted primary target population information and 3 omitted funding information. For "institutions of higher education," median was slightly higher than mean; bottom of bold line indicates mean funding level and top of bold line indicates median funding level.

This figure presents data on the average and median annual funding levels for quality activities aimed at each primary target population. The full bar indicates the average funding level and the line within the bar indicates the median funding level.

- The average budget for initiatives with programs and facilities ($2,346,000) as the primary target population was higher than that for any other primary target group. Because of the great range in funding levels for these initiatives—$3,000 to $52 million—the median funding level was much lower than the average, at $331,000.
- Initiatives with the second largest average budgets were those with licensing staff as the primary target population ($2,252,000). The range in funding levels was somewhat smaller than for programs and facilities—$189,000 to $7.7 million—but the median was quite a bit higher, at $800,000. Unlike child care programs and facilities, however, licensing staff was an infrequent target population for quality activities.
- On average, initiatives targeted at parents ($1,957,000) and resource and referral agencies ($1,729,000) had larger budgets than those targeted at providers ($957,000). Similarly, the medians for those initiatives targeting parents ($750,000) and resource and referral agencies ($941,000) were greater than for those targeting providers ($291,000).

5H. What Proportion of Initiatives Experienced a Funding Cut During FFY 2004?



Note: N=298. Only 305 initiatives had been implemented prior to FFY 2004 and 7 initiatives omitted this information.

States were asked whether or not funding for the initiative was reduced in 2004 compared to the previous year.

- Respondents reported that funding was cut during FFY 2004 for 9 percent of the initiatives that had been implemented for more than one year. However, no information on the reason for the funding reductions was collected. The impetus for the cuts could have included statewide budget reductions, a shift in quality priorities, or concerns about the effectiveness of particular initiatives.

6. Data Collection

Respondents were asked whether data had been collected about each initiative. When data had been collected, the survey asked about the type of data collected, the data source, and the data collection design. When data had not been collected about an initiative, the survey asked for the reasons why.

The survey asked whether the following *types* of data had been collected:

- Number of participants enrolled, participating, or having completed participation
- Characteristics of participants
- Number of programs accredited or going through the process
- Number of programs meeting higher quality standards other than accreditation (e.g., star rating system)
- Observation of quality to measure changes in child care programs
- Parent report of change in experience of care or satisfaction
- Retention and turnover of caregivers
- Change in caregiver qualifications (e.g., training or education completed)
- Assessment of caregiver knowledge or skills
- Data on compensation or benefits
- Data on physical setting or materials
- Child outcome data

Respondents could also specify if some other type of data had been collected.

The survey asked which of the following had been *sources* of data:

- Observations of the child care environment
- Direct child assessments
- Parent or caregiver report about a child's development
- Surveys completed and returned by respondents
- Interviews carried out in person or over the phone
- Focus groups
- Administrative data

Respondents could also specify if some other source had been relied upon.

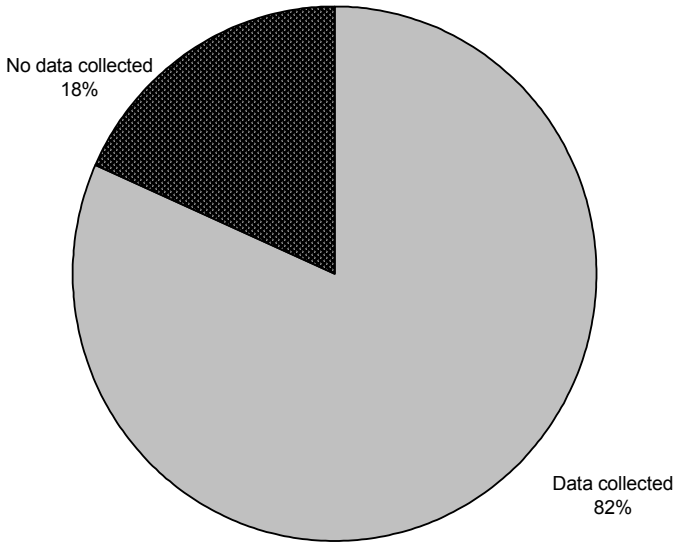
The survey asked which of the following best described the data collection design used:

- Collection of data focusing on implementation (e.g., type of service delivery agency, type of service, participant satisfaction)
- Tracking key outcome indicators (like staff retention) over time
- An evaluation involving pre-test and post-test before and after an intervention to improve quality
- Quasi-experimental
- Experimental

Respondents could also specify if another data collection design had been used.

If there was no data collection for an initiative, respondents were asked to indicate why, choosing from a list of possible reasons. These included: did not have enough funding; did not have sufficient expertise; could not locate a researcher; did not have enough time; initiative is too new; and other (with a request to specify).

6A. What Proportion of Initiatives Collected Any Data?

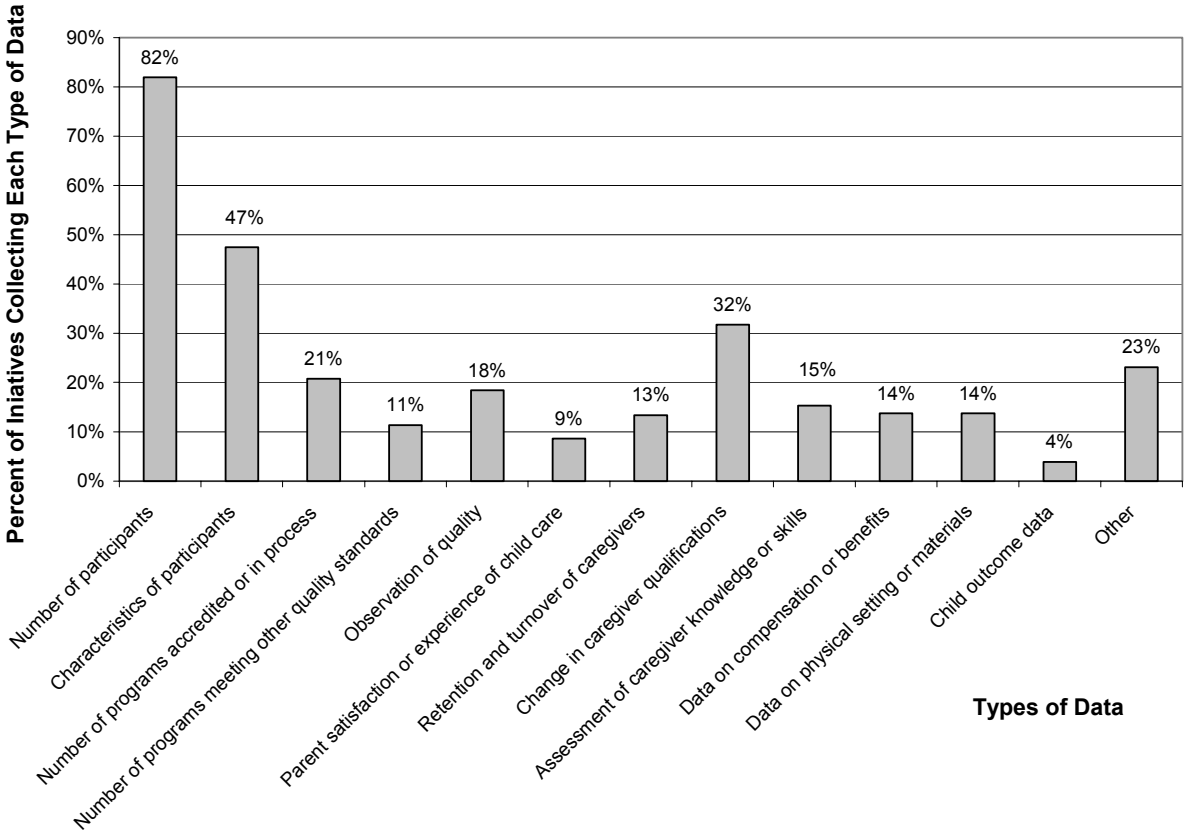


Note: N=314. Data collection questions were only asked for the 317 initiatives that had been implemented throughout FFY 2004 and 3 initatives omitted data collection information.

The survey asked states if they collected any data, ranging from basic participation data to child outcomes, on each quality initiative.

- The large majority of initiatives (82%) collected some data.

6B. For Initiatives that Collected Data, What Proportion Collected Each Type of Data?

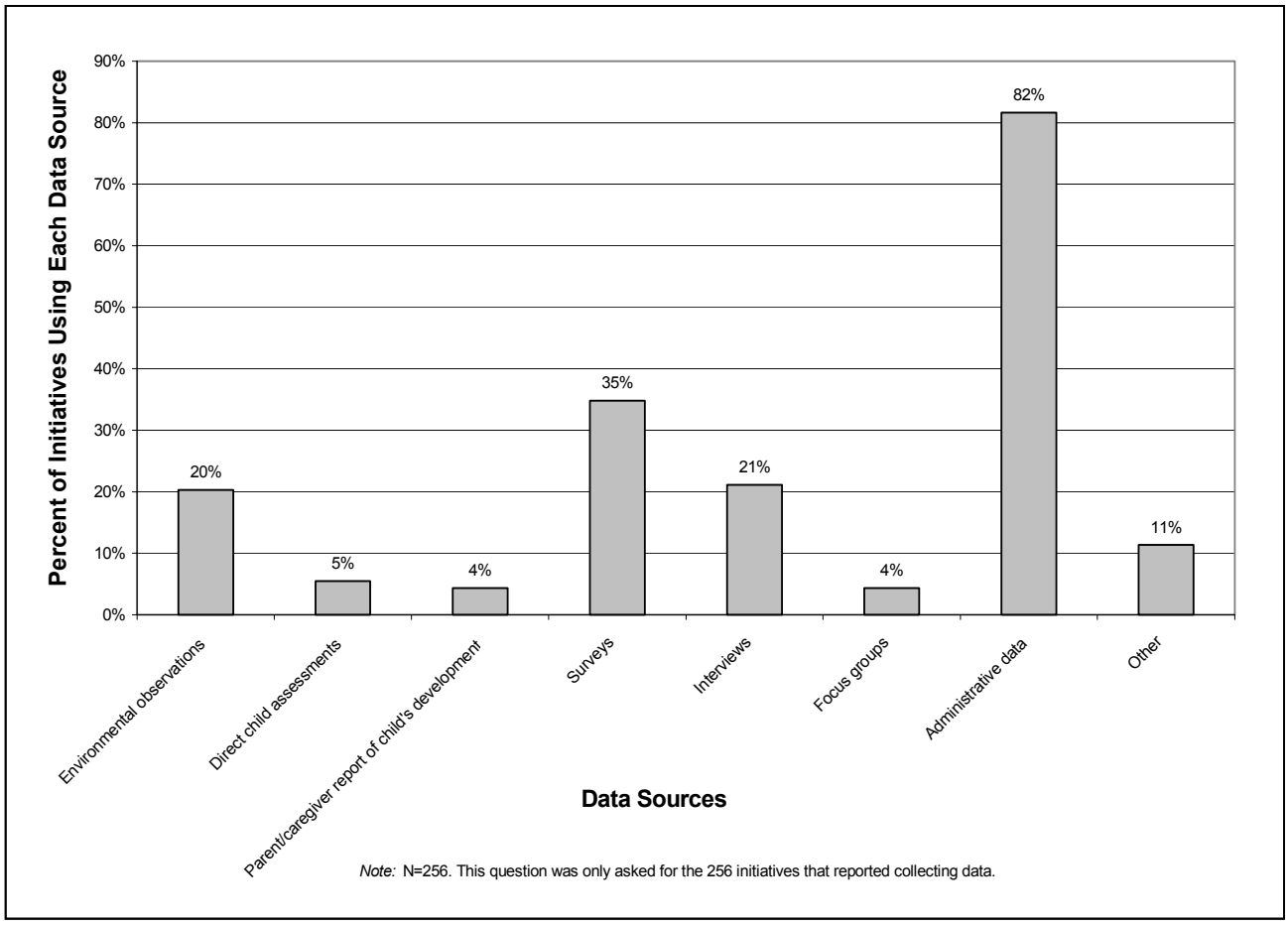


Note: N=255. This question was only asked for the 256 initiatives that reported collecting data and one omitted information on types of data collected.

This figure presents the types of data collected by state quality initiatives. Not all of the types of data listed would be appropriate for all types of initiatives. For example, data on changes in caregiver qualifications would probably be collected for initiatives with objectives related to professional development, but not for initiatives aiming to increase family supports or to coordinate service systems.

- By far, the most frequently collected types of data involved the number and characteristics of participants. Eighty-two percent of initiatives with any data collection collected data on number of participants and 47 percent of these initiatives collected data on characteristics of participants.
- Beyond this, change in caregiver qualifications (32%) was the type of data most often collected.
- Eighteen percent of quality initiatives that collected data involved observations of quality.
- In contrast, only a small proportion of those initiatives that collected any data focused on parent satisfaction (9%) or child outcomes (4%).

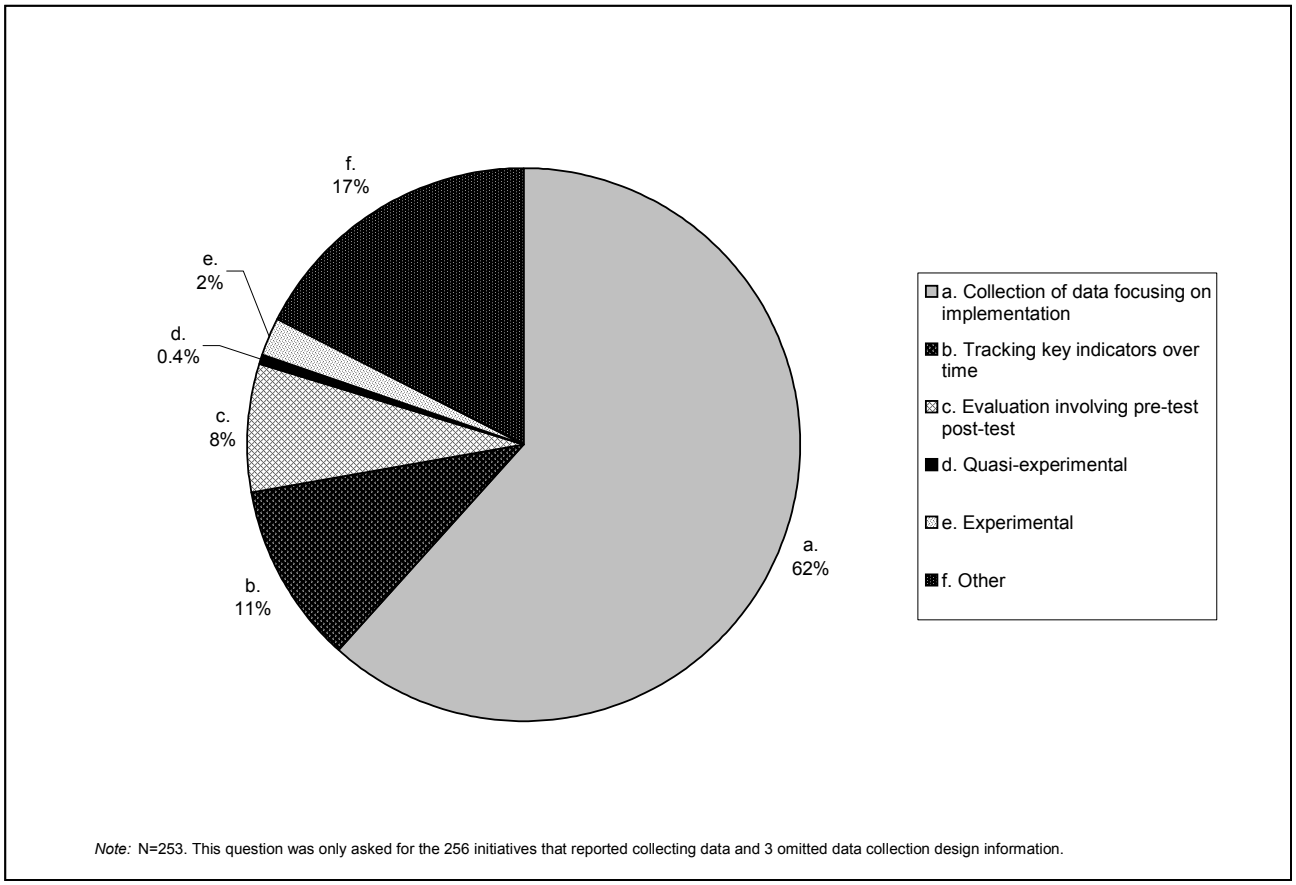
6C. For Initiatives that Collected Data, What Proportion Relied on Each Data Source?



This figure presents the sources of data that states relied upon when collecting data on quality initiatives.

- Findings regarding the data sources relied upon were consistent with those for types of data collected. By far the most frequent source of data was administrative records, used as a source in 82 percent of initiatives that included some data collection.
- Consistent with the finding that only a small proportion of initiatives collected child outcomes data, direct child assessments were infrequently used as a data source in these initiatives (5%).
- Surveys were used as a source in just over a third of initiatives that collected some data (35%).
- Environmental observations (20%) and interviews (21%) were each used as data sources in approximately one-fifth of the initiatives that collected some data.

6D. For Initiatives that Collected Data, What Proportion Used Each Data Collection Design?

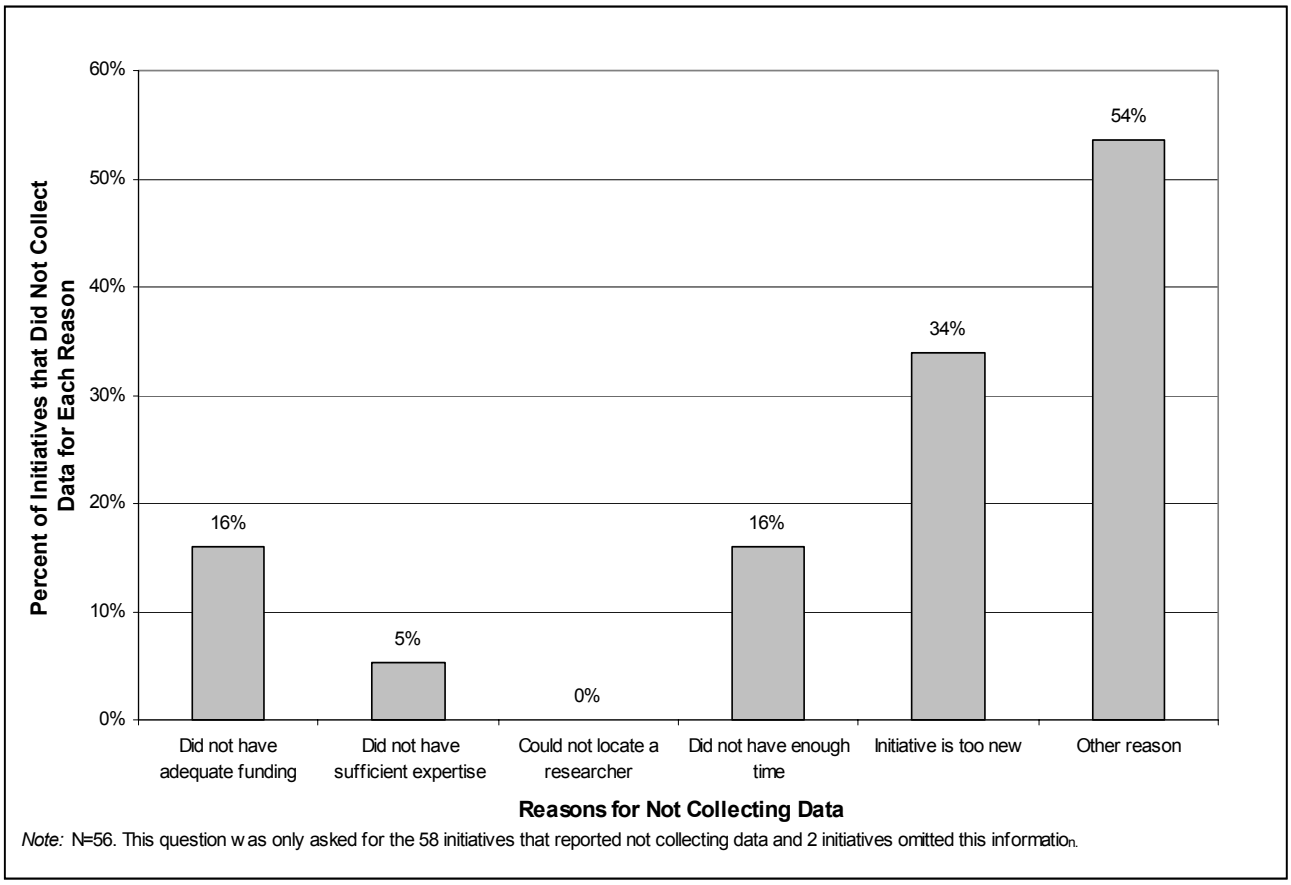


Note: N=253. This question was only asked for the 256 initiatives that reported collecting data and 3 omitted data collection design information.

States use a variety of data collection designs to track implementation progress and measure the effectiveness of quality initiatives.

- When data were collected on initiatives, the most common data collection designs involved collecting data on implementation (62%) and tracking key indicators over time (11%).
- Only a small proportion of initiatives that collected some data used comparative designs, about 10 percent. Eight percent used a pre-post design, less than 1 percent used a quasi-experimental design, and 2 percent used an experimental design.
- The initiatives studied through quasi-expermental or experimental designs most often focused on supporting child care programs or facilities in reaching accreditation or a higher overall quality rating.
- The initiatives studied with pre- and post-test designs most often focused on improving the emotional supportiveness of caregiving.

6E. For Initiatives that Did Not Collect Data, What Were the Most Common Reasons for Not Collecting Data?



Note: N=56. This question was only asked for the 58 initiatives that reported not collecting data and 2 initiatives omitted this information.

For the 18 percent of initiatives that did not collect data, respondents were asked to provide additional information about the reasons that data were not collected.

- A range of "other" reasons were most often cited for why data were not collected for an initiative. These included not having an initiative conducive to data collection; not knowing what data should be collected; data collection procedures being developed but not yet implemented; and not having enough staff to support data collection.
- In addition, respondents were likely to indicate that an initiative was too new (34%), or that they lacked time (16%) or funding (16%) as the reasons that data were not collected.

7. Summary of Findings

This survey represents the first comprehensive effort by states to provide a descriptive portrayal of each of the child care quality initiatives that they support with CCDF funding. The fact that state child care administrators actively participated in developing the survey, that it was guided by the earlier work of Porter and colleagues (2002), and that 35 states completed the first round of data collection, suggests that this is a viable and well-grounded approach that could be used in the future.

The survey provides valuable information about objectives, target populations, funding, and data collection efforts for the two-thirds of states that responded. The findings on the 339 reported initiatives demonstrate that states fund a wide range of quality-improvement activities. The flexibility inherent in CCDF has allowed states to work toward their objectives through programs that reflect their unique needs and resources. Yet the fact that states were able to describe the goals of their initiatives using a common set of objectives, grounded in child care research, indicates that state variation existed within a common framework.

The results also point to important next steps in states' evolving efforts to improve child care quality. For example, they suggest a need to strengthen the capacity for evaluation. While the objectives states have targeted are aligned with what research shows can improve child care quality and most of the initiatives involved some data collection, data collection efforts to date focus heavily on documenting the population served and the nature of the services rather than on evaluating effects.

An overview of key findings from each section of the survey follows.

Objectives

The framework for categorizing objectives appears to capture the range of objectives addressed by state initiatives to improve the quality of child care. The list of 11 program- and provider-level objectives and six systems-level objectives was sufficient to describe the large majority of initiatives. Only 3 percent of initiatives aimed to address an "other" objective as the primary objective.

A majority of states addressed most of the quality objectives in the framework. Of the 17 quality objectives included in the framework, 16 were addressed through at least one initiative in over half of the responding states. Eleven of the objectives were addressed by more than 90 percent of states.

The survey identified objectives at the program and provider levels, and at the systems level. Program- and provider-level objectives were addressed by initiatives more often than systems-level objectives. Close to two-thirds of the initiatives identified provider- and program-level types of objectives as their primary objective. Although the survey did not collect any information on why states chose to address particular objectives, the focus on program- and provider-level objectives may be because these aspects of quality are thought to have a more direct and immediate impact on children.

Promoting healthy and safe environments is a major focus of state quality activities. It was clear from multiple perspectives that health and safety were high priorities for state quality initiatives. The goal of improving health and safety was noted as one of the objectives for 51 percent of the quality initiatives, more often than any other objective. In addition, promoting health and safety was the second most common primary objective of quality initiatives, noted as the primary goal of 13 percent of initiatives. The way states allocate quality funding also reflects a focus on healthy and safe environments. Twenty-three percent of the funds budgeted for initiatives in this survey were

allocated to initiatives for which health and safety was the primary objective. Only initiatives aimed at achieving accreditation or higher quality rankings received a comparable proportion of funding.

The survey suggests that health and safety are viewed as a foundation for quality child care. States cannot focus on early learning without first ensuring that children are as protected as possible from physical harm and serious illness. In addition, an environment that provides safe areas for exploration provides a context in which learning can take place.

Professional development, including providing training and formal education for individual providers and programs, as well as strengthening professional development systems, is a major component of states' quality activities. Every state that responded to the survey had at least one initiative aimed at strengthening professional development systems. In addition, 97 percent of states had at least one initiative aimed at increasing formal education for caregivers, and 97 percent had at least one initiative supporting non–credit-bearing training for caregivers. Supporting a system of professional development was also the most commonly named primary objective for child care quality initiatives, with 16 percent of initiatives listing this as the primary objective. Caregiver training was the primary objective for 11 percent of initiatives and caregiver formal education was the main objective for an additional 8 percent of quality initiatives. Combined, these three objectives related to professional development were the primary focus of more than a third (35%) of the initiatives in the survey. Data on state funding for quality initiatives also reflect the priority placed on professional development, with 19 percent of funding budgeted for initiatives that focused on professional development systems, provider training, or provider education.

Research indicates that child care providers with more professional development, both education and training, tend to be in settings that provide care of higher overall quality (Tout, Zaslow & Berry, 2006). States appear to recognize that providing caregivers with additional knowledge about child development may improve their interactions with children, enhancing their understanding of children's individual needs as well as of the value of age-appropriate activities.

The survey data indicate a balance in state child care quality initiatives between initiatives that aim at increasing emotionally supportive and responsive caregiving and those that support early learning. This balance was apparent from several different perspectives. The same very high proportion of states, 97 percent, had at least one objective aimed at increasing the supportiveness and responsiveness of care and at supporting early learning. There was also balance in the proportion of initiatives for which emotionally supportive and responsive caregiving and early learning were listed among the objectives—44 percent for emotionally responsive caregiving and 42 percent for early learning. Finally, there was a balance in the proportion of initiatives for which emotionally responsive caregiving and early learning were noted as primary objectives: 6 percent for the former and 5 percent for the latter.

Research points to the importance of close and warm relationships as the primary context of children's early learning (Shonkoff & Phillips, 2000). Perhaps the equal focus on emotionally supportive and stimulating caregiving reflects an acknowledgment that these both need to happen to support children's early development.

Target Populations

There is a wide range in the groups or individuals that the initiatives aimed to serve. Target populations included individual child care providers, child care programs or facilities, parents, licensing staff, trainers, institutions of higher education, and resource and referral agencies.

Among these different target populations, CCDF-funded quality activities most often aimed to serve child care providers and child care programs or facilities. All 35 states had at least one initiative that aimed at supporting child care providers and all also had initiatives targeting child care programs. Child care providers were identified as a target population in 78 percent of the initiatives; programs or facilities in 71 percent.

The child care quality initiatives funded through CCDF most often aimed to serve those working directly with children (providers and programs) rather than those one step removed (such as licensing staff, trainers, and resource and referral agencies). The findings regarding target population correspond closely with the finding summarized above indicating that objectives at the program or provider levels are more often noted than those at the systems level.

State quality initiatives placed an equal emphasis on center-based providers and regulated family child care providers, but aimed to serve family, friend, and neighbor caregivers less often. Of those initiatives with a primary target population of child care providers, nearly equal proportions, about 85 percent, served center-based providers and regulated family child care providers. Only 37 percent, however, aimed to serve home-based family, friend, and neighbor caregivers.

At first glance, these results appear to contrast with an earlier report (U.S. General Accounting Office, 2002) that found that substantially more state expenditures to improve child care quality were going to child care centers than to family child care homes. However, the present survey focuses on target populations of initiatives rather than expenditures to particular types of care. This perspective extends the picture by indicating that state child care quality initiatives are emphasizing both types of regulated care. However, the survey also shows that unregulated providers are served much less frequently than those who are regulated, although a number of states have developed initiatives to address quality in this kind of care. It will be interesting to note if the proportion of quality initiatives targeted to family, friend, and neighbor providers increases over the next several years as a result of growing public awareness that a large proportion of children, particularly infants, toddlers, and school-aged children, receive child care in these settings.

Parents are a target population for a substantial proportion of quality initiatives. In a high proportion of states (97%) at least one initiative aimed to serve parents. Further, 39 percent of all the initiatives included in the survey cited parents as a target group. Many quality initiatives with parents as a target population provide information about the features of quality child care, acknowledging that parents play a critical role in the child care system. Informed parents are better equipped to choose high quality care that meets the needs of their children and to act as advocates for maintaining or improving the quality of care provided to their children.

Funding

CCDF funding was the major source of funding for this set of state child care quality initiatives. CCDF funding, including both federal and state CCDF dollars; earmarks for quality expansion, infants and toddlers, and school-aged child care and child care resource and referral; and TANF transfer dollars, accounted for 96 percent of the budgeted funding for initiatives in the survey. The remaining 4 percent came from state general funds, other federal and state sources, and private funding. The findings may under-represent the total amount of funding budgeted for quality-improvement efforts from other sources, because only those initiatives with a minimal amount of CCDF funding were included in the survey and some states fund quality initiatives entirely with state or private funds.

Initiatives that supported health and safety, and those that supported accreditation or quality rating systems as their primary objectives, accounted for the largest proportions of total quality funding. Initiatives with these as their primary objectives accounted for 23 percent each of the total funding. These proportions are indicative of the priority many states place on these objectives as well as the fact that the health and safety and the accreditation and quality ranking initiatives are comparatively expensive.

The funding data reinforce evidence that professional development is a high priority for states. When initiatives that support professional development systems are added to those that aim to increase caregiver formal education and provide caregiver training, the resulting proportion of the

total budgeted funding is 19 percent. These objectives were addressed by the majority of states and represented some of the most commonly cited initiative objectives.

The funding data also indicate that the largest proportions of quality budgets are spent on initiatives targeted to child care programs or facilities, child care providers, and parents. These findings closely resemble the priorities reflected in the proportion of initiatives aimed at each target group.

Data Collection

A majority of state child care quality initiatives are collecting data, with an emphasis on information about service delivery. Eighty-two percent of initiatives collected some type of data. Administrative data with information about the number of participants and services provided was the most common data type, most likely because this type of data is comparatively straightforward to collect and provides some valuable information on how initiatives function. Specifically, the most common types of data collected were the number of participants and participant characteristics. Data on caregiver qualifications and the number of programs that obtained accreditation, or were working toward accreditation, were also often collected. This is consistent with the emphasis states place on initiatives aimed at providing professional development and helping programs become accredited.

These types of data parallel the data sources that were relied upon. Among the data sources were administrative data, surveys, interviews, environmental observations, and direct child assessments, with administrative data collection and surveys being the most commonly used sources.

Only 4 percent of initiatives in the study collected data on child outcomes. Although the ultimate outcome for all initiatives to improve child care quality is improved child outcomes, it appears that measuring these outcomes does not yet occur on a regular basis. Most likely, infrequent collection of child outcome data is related to budget limitations and technical requirements. To move forward on this issue might require additional resources both in terms of funding and expertise.

For the majority of child care quality initiatives, the data collection designs focused on implementation rather than effects. But there are indications that some states are also attempting more rigorous evaluation approaches. Sixty-two percent of the initiatives in the survey that collect data focus on collecting data on implementation (such as type of service delivery agency, type of service, and participant satisfaction). However, about 10 percent of the initiatives that collect data use a pre-post design, a quasi-experimental design, or an experimental design. It is especially important to note that a small number of initiatives use experimental evaluation designs. These research designs begin to provide a more conclusive evaluation of the initiatives' effects. It will be valuable to explore ways to strengthen state capacity to carry out these kinds of evaluations.

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In sum, the evidence here indicates that states are investing in child care quality, not only exceeding the minimum funding requirements of the 4 percent set-aside in many instances (as reported in previous research), but also launching initiatives with a set of objectives that research indicates can contribute to child care quality. There is substantial variation among states in terms of focus on specific objectives and target groups, as is appropriate for states that vary greatly in demographics, geography, and the most pressing needs identified within the state. However, this variation occurs within the framework of a relatively small set of research-based objectives. Further, there is evidence that across states, there is a consistent focus on certain goals, such as improving health and safety and strengthening the professional development of the early childhood workforce. To build upon states' focus on child care quality and strengthen future efforts, there is a need to learn from the range of initiatives through rigorous evaluation.

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