Financing Family-Centered Infant Child Care

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Better Care for the Babies Project

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Financing Family-Centered Infant Child Care

Overview State and local policymakers, administrators and practitioners alike face a serious challenge: pulling together enough funds to put high-quality, family-centered infant child care within reach, especially for low and moderate income employed parents.[1]

This paper is about ways to meet that challenge. It describes and analyzes:

A. the nature of family-centered child care for infants and toddlers;

B. the elements of a good financing strategy for family-centered child care;

C. nine sources of federal funds relevant to the family-centered approach to infant child care;

D. the value of four-way funding partnerships among:

- Part H of the Individuals With Disabilities Education Act (IDEA);
- Nutrition funds—The Child and Adult Care Food Program and the Special Supplemental Food Program for Women, Infants and Children (WIC);
- Medicaid;
- Child care funds under: the Family Support Act (FSA), the Child Care and Development Block Grant (CCDBG), Title IV-A At-Risk Child Care and the Social Services Block Grant (SSBG); and

E. what state governments can do to develop a state strategic plan (including a financing plan) for family-centered child care.

This paper concentrates on existing sources of funds and ways to combine or "piece" them together (Sugarman, 1991). However, it also embraces the perspective that we should increase our investment in the very early years of life—and particularly in a family-centered approach to the delivery of services to very young children (**ZERO TO THREE**/National Center for Clinical Infant Programs, 1992).

Most large scale research on early care and education services for low-income children demonstrates the outstanding effectiveness of these services (Berreuter-Clement Schweinhart, Barnettte, Epstein and Weikart, 1984; Copple, 1987; Lazar, Darlington, Murray, Royce and Snipper 1982; Zigler, and Valentine 1979). A $6 return for every $1 invested is associated with high-quality early care and education (Berreuter-Clement et al., 1984; Schweinhart and Weikart, 1992).

Much of the research described above is based on early care and education services for children above the age of 3 or 4. However, in the first few years of life, brain development and the emotional, social, moral and physical development of human beings are powerfully shaped (Harris, 1992; Szanton, 1992; **ZERO TO THREE**/National Center for Clinical Infant Programs, 1992).

Not surprisingly, therefore research is beginning to show positive outcomes associated with a high-quality, family-centered approach to the care and education of low-income children *in the first few years of life.* Specifically, this approach seems to:

- help parents make life decisions which enhance self-sufficiency (Provence and Naylor, 1983, Seitz, Rosenbaum, Apfel, 1985);
- result in significantly higher IQ scores and significantly fewer behavior problems (Infant Health and Development Program, 1990; Gross and Hayes, 1991);
- result in better school achievement later in life (Lally, Mangione, Honig and Wittmer 1988; Provence and Naylor, 1983; Seitz et al, 1985; Select Committee on Children, Youth and Families, 1990);
- result in less criminal behavior later in life (Lally, et al., 1988); and
- result in documented improvements in the physical and emotional aspects of family home environments (U.S. General Accounting Office, 1979).

In addition, research has long documented the positive impact of very early health and nutritional services (Select Committee on Children, Youth and Families, 1979). Thus, for low-income children and their families, the return on each dollar invested in family-centered care and education services for infants and toddlers may well be as high as the 6 to 1 return from the investment in services for children over 3 years of age—and perhaps even better.

A. The Nature of Family-Centered Child Care for Infants and Toddlers

Family-centered child care services aim to:

- nurture parent-child relationships;
- support and emphasize the strengths of both child and family; and
- enhance both the child and the family's optimal functioning.

Infant child care becomes a family-centered service when care and education are co-designed by parents and providers working in partnership. Family-centered infant child care can be provided within the family (relative care) and/or within the community (nonrelative care) (Morgan, 1991b). It can occur in the child's own

[1] In this paper, for simplicity's sake, the term "employed parents" includes employed trainee and/or student parents.

home; in the homes of relatives; in the homes of family child care providers; in child care centers; or in family resource and support centers with a child care component.

A family-centered approach to child care sees the parents of children (the people who take primary responsibility for parenting the child) as the most important people in a child's life. Services are then structured, under whatever auspices, not just to care for the child in absence of the parent(s) during the day, but to promote the parent-child relationship (Galinsky and Weissbourd, in press). In family-centered child care, the early childhood service provider works in partnership with parents.

She offers them opportunities to strengthen their skills as nurturers, educators, and/or advocates for their own children, and she, in turn, is prepared to learn from parents (Pizzo, 1990b). She provides the care that helps parents support their families with a stable, decent income—and parents in turn support the provider's need to earn a living wage.

In contrast, high-quality, child-centered care and education, while designed to foster the best possible child outcomes, is not necessarily planned to promote parent development and empowerment. Nor are child-centered services necessarily co-designed by parents. Practitioners of services, while deeply interested in the child's individual needs, strengths and unique developmental styles, do not typically set out to learn about and respond to the needs and unique coping styles of the child's family. This kind of learning may happen serendipitously, but is not a goal of the service.

In developing policy and practice that supports a family-centered approach, many important balances will have to be struck: (a) between workplace needs and child needs; (b) between nurturance of warm relationships and objective developmental assessment; (c) between caregiver needs and parent needs. There is a growing body of literature we can now draw on that describes the family-centered approach in different service delivery systems (Dunst et al., 1991; Galinsky and Weissbourd, in press; Kagan, et al., 1987; Pizzo; 1990a; Shelton, Jeppson and Johnson, 1987; Weiss and Jacobs, 1988). Time and space constraints forbid this discussion here.

Family-Centered Care of Infants and Toddlers by Relatives

For many families, relative care is the most family-centered care possible. A deeply devoted grandparent, aunt or uncle may recognize and respond well to the strengths and needs of both the child and his/her parents. Such a deeply devoted person may easily engage the child and enter into the reciprocal relationships described above (Zinsser, 1991). With a strong attachment to the parent as well, this relative may develop a relationship with the child which fuels her to communicate appreciation of the parent's competence, thus building parental confidence and further competence.

This is not always the case, of course. In some families, competition or other tension between the child's parents and members of the extended family may result in care that is not supportive of the parent-child relationship. And for the minority of families in which sexual or other forms of child abuse occurs, care by relatives may be family-centered but still deleterious to all concerned.

Relative care, however, is declining as a form of care chosen by parents—possibly because increasing numbers of relatives are now in the labor force themselves. In 1965, 33% of employed mothers used relative care; by 1990, only 19% did (Willer, Hofferth, Kisker, Divine-Hawkins, Farquhar and Glantz, 1991).

Family-Centered Care of Infants and Toddlers in Family Child Care Homes and Child Care Centers

When family-centered child care is provided in family child care homes and child care centers, relationships—between caregivers and children and between caregivers and parents—are defining elements. If infants and toddlers receive caregiving principally from the same sensitive and skilled adult, the caregiver is responsible for only a few children, the groups of children are kept small enough, and each group has a separate space, a warm, nurturing relationship between caregiver and child can develop (**ZERO TO THREE**/National Center for Clinical Infant Programs, 1992).

The quality of this relationship is one of the essential elements in determining whether infant child care is good quality care or not (Pawl, 1990; **ZERO TO THREE**/National Center for Clinical Infant Programs, 1992). Whether those relationships are developed in a family child care home or a good child care center is less important.

The quality of the relationship between parent and caregiver is one of the essential elements in determining whether good quality child-centered care becomes family-centered (Galinsky and Weissbourd, in press; Pawl, 1990). The degree of caregiver sensitivity to the parent's feelings, capacities and needs and the attention paid to the family's strengths and needs (including health needs) largely determine whether child care is family-centered or not. Support of the relationship between infant and parent and of the different ways in which parents can relate to, become involved with and shape the child's experience of child care are also key elements in family-centered care.

Reciprocity (parents caring about the caregiver) is also important. No care can be family-centered if caregiver turnover is high, driven up by inadequate wages and benefits, poor working conditions, and inconsiderate treatment from parents.

Knowledge and Time as Essential Ingredients of Family-Centered Child Care—Low-Income Employed Families

All families can benefit from family-centered child care. For low-income employed families beset with both

economic and time pressures, child care that acknowledges and responds to the range of a family's circumstances is particularly valuable. Low-income employed parents are likely to lead hurried lives. Meeting even the basic nutritional and health needs of children and adults may be difficult.

Many parents using publicly funded child care have no health insurance. One-third of the children under 6 whose family incomes fall below the poverty level (and about 23% whose family incomes are between 100% to 200% of poverty) presently have no health insurance—neither private nor Medicaid insurance (Klerman, 1991). Of the 8.3 million uninsured children under 18, about two-thirds have at least one parent who works full-time. Another 13% have a parent who works part-time (National Commission on Children, 1991).

As a result, an emergency room or a general hospital may be the only source of health care for an ill child—and there may be no accessible source for preventive health care. Low-income families are likely to live in neighborhoods remote from physicians' offices and hospitals, as well as from sources of inexpensive, healthy foods. They must often travel long distances to and from work on public transportation and may work long and/or irregular hours, with no sick leave.

Familiar, respectful staff in a child care setting may be the ideal people to explore child health, nutritional, and other family needs with parents and to help parents connect to available resources. However, staff need both knowledge and time to respond to families' needs, either within the child care setting or through family-supportive referrals to health and social services.

The knowledge involved is threefold: (1) of best practices in infant health and nutrition as well as infant development and family support; (2) of the best and most accessible services in the surrounding community, including health, nutritional, employment, training and social services; and (3) of the sources of relevant financing, if needed, to enable parents to pay for these services.

Perhaps the greatest barrier faced by current practitioners of child-centered infant child care who wish to develop a more family-centered service is time. Providers involved with the care of several infants and toddlers have little time for the kind of unhurried conversation required for partnership-building, exploration of family needs and co-design of services. Directors of programs have very little time with which to locate and piece together funds from multiple funding streams.

Parents of infants in child care, juggling workplace and family needs, also have very little time. Family-centered child care services may have to establish working relationships with parents during weekends or other hours when the parent does not have to be in the workplace. Some employers may also permit the formation of family support groups which meet during lunch hours, for example, at the workplace. But all this outreach to families involves time.

Financing strategies designed to encourage family-centered infant child care must recognize that both the acquisition of knowledge—about families' circumstances and appropriate community resources—and the preservation of time—for relationship-building, planning and piecing together funds—require financial support.

Costs and Benefits of the Family-Centered Approach to Care and Education Services for Infants and Toddlers

The full cost of high-quality, family-centered care for infants has not yet been documented. In 1990, the full cost of high-quality child-centered care in child care centers ranged from $6,364 to an estimated $8,345 per child annually (Willer, 1990).

Paying the full cost of quality care requires sufficient financing to pay decent wages and benefits to skilled and sensitive caregivers who care for only a few children (Galinsky and Friedman, no date; Willer, 1990). Good quality child care is intellectually, physically and emotionally demanding work, reflective of the time and skilled attention young children need in order to thrive.

In centers serving primarily infants, the full cost of good *child-centered infant care* may well be higher than the figures cited above for centers, since the staff-child ratios should be tighter (fewer children per caregiver). To provide *family-centered infant child care*, additional resources will have to be brought into child care. Thus the financial obstacles to developing truly family-centered infant child care are formidable—not insurmountable, but formidable.

The funds provided, however, will be well-invested, with substantial cost-savings likely throughout the lives of both child and parent.

B. Elements of a Good Financing Strategy for Family-Centered Child Care

Three elements must be part of a good financing strategy for family-centered infant child care:

1. Federal, state and local government should assure:

   (a) levels of appropriate funding based on the full cost of care (Willer, 1990); and

   (b) supply subsidies (financing that increases the supply of good services, e.g. grants) as well as demand subsidies (financing that increases the purchasing power of consumers, e.g. vouchers) (Galinsky and Weissbourd, in press).

However, demand subsidies (which enhance consumer control) are not needed for consumer-controlled or consumer-driven programs financed by supply subsidies (e.g. Head Start).

The trend in early care and education services is toward an emphasis on demand subsidies (e.g., vouchers). This is unfortunate because low and moderate

income communities in the initial stages of developing infant child care services chiefly need supply subsidies. Start-up, planning and development costs cannot be assured by demand subsidies in communities where the economic base is limited, housing is deteriorating and banks don't provide loans.

In low- and moderate-income communities, vouchers simply give parents funds to help them buy into what is already there. They don't create a supply of a variety of quality options from which parents can choose.

2. State and local governments should assure:

   (a) advance funding as well as reimbursement financing [Advance funds (e.g., a grant to or contract with a provider at the beginning of each program or fiscal year) help providers plan and assure a stable continuous core of service over time. Reimbursement funds (e.g., funds paid on a monthly or quarterly basis, only after the family has received the service) preserve some funding for actual delivery of service.]; and

   (b) interagency agreements that make applying for and using funds from multiple sources feasible for child care providers.

To be effective, these interagency agreements should establish state umbrella agencies, governor's offices or interagency "bridge" offices to locate and piece together funds (see Figure 1. At the State Capitol).

Interagency agreements can be arrived at voluntarily. In crisis-ridden governments, however, interagency agreements are more likely to be accomplished if they are mandated by the state legislature, and provide a specific appropriation to support staff who (1) identify, analyze and publicize funds and (2) help child care resource and referral agencies and providers learn how to apply for and obtain funds from these multiple sources (See Figure 1. At the State Capitol).

3. Corporations, private foundations and the private sector should:

   (a) propose public-private partnerships wherever possible (rather than work in isolation from the public sector); and

   (b) use private sector dollars as local match required to bring in public sector funds wherever possible, rather than use private funds for services that can be primarily or even partly financed with public funds (see Figure 1. At the State Capitol).

Currently, no one funding stream is available to help practitioners transform their child-centered infant child care services into family-centered services. Even the demonstration projects known as Comprehensive Child Development Programs (CCDPs) must develop interagency agreements and supplement their own core funding.

These interagency agreements help CCDPs piece together the health, nutrition, social service, and child care services required to offer low-income families full-day, full-year health, nutrition, and family support services; vocational training, adult education and substance abuse education and treatment; and developmentally appropriate child care and education for children (see Figure 2. Comprehensive Child Development Programs—One Model).

There is some movement of family resource and support services into early care and education settings—a trend well worth encouraging (Galinksy and Weissbourd, in press; Shelby Miller, personal communication, 1992). But joint child care/family resource and support services are still the exception rather than the rule.

While Head Start funds support the family-centered approach, currently Head Start programs for infants and toddlers typically do not offer full-day, full-year services, even if some of the families involved need this type of care in order to sustain employment. Consequently, pieces of funds must be stitched together from a variety of federal sources.

A strategy for piecing together funds

To understand piecing together as a strategy for child care financing it helps to conceptualize the funding needed for a child care home or center as a quilt. Currently this quilt fails to keep warm the children and families involved in the child care service (including the caregiver and her children, if any). This is principally due to one or a combination of three factors:

(1) The funds are available to cover only part of the day or part of the year, making the funding quilt too short to cover the full length of the children and families. It needs to be lengthened.

(2) The funds are available to cover a full-day, full-year service, but they don't really cover anywhere near the actual costs, principally because parents can't pay the full costs and/or because either the per-child or per-program funding (or both) is too limited to adequately pay for the sufficient number of staff or for supplies, equipment and services. In this case, the funding quilt is long enough, but too narrow to actually cover all the children and families. It needs to be widened.

(3) The funds are available to cover only one aspect of what children and families need (e.g. sensitive interaction between caregivers and children), but not enough to cover all of the aspects involved in good family-centered care (e.g., outreach to health and nutritional services, family-supportive interactions with parents). In this case, the funding quilt is too thin and threadbare, even if it is long and wide enough. It needs warm lining all across its width and length in order to be an adequate quilt.

To "piece" together the needed funds, policymakers, administrators and practitioners should learn and use the special language unique to each particular funding

stream. For example, in Medicaid parlance, an infant child care program which provides family support services to help low-income Medicaid eligible families obtain health, educational and social services is providing "case management services" and may be eligible for Medicaid reimbursement for doing so.

This same program may also provide regular developmental assessment for babies with developmental delay. This may be an "early intervention service," partially reimbursable under Part H of IDEA (Public Law 101-476, formerly Public Law 99-457). Or developmentally appropriate care for a medically complex infant may be provided. If delivered under a plan developed by a nurse, for a baby with medical needs, it may be "medical day care," reimbursable under Medicaid.

But in each case, policymakers, administrators and practitioners should first analyze whether the services they are currently providing or wish to provide are "a good fit" both with the needs of child and family and with the services reimbursable under a particular funding stream. Then they should use the technical language of that funding stream, not the language of the early childhood services field, to describe the activities.

Types of federal funding streams

Policymakers, administrators and practitioners also need to master the distinctions among open-ended entitlement, capped entitlement, and discretionary grant-in-aid federal funding streams (see Figure 3. Types of Federal Funding Streams).

The most direct result of learning these distinctions is to understand that for fiscally strapped states, some federal funding streams are more desirable than others. The most desirable federal funds, from the point of view of a local provider or state policymaker, concerned with financing good family-centered infant child care are:

- open-ended entitlements that require no state match;
- open-ended entitlements with relatively low requirements for state matching funds; and
- discretionary grant-in-aid funds that require no state match and are backed by relatively significant federal appropriations.

The least desirable funds, from the local and state perspective are:

- grant-in-aid programs with very limited appropriations;
- capped entitlement programs with relatively limited federal funds and state match requirements; and
- federal discretionary or entitlement funds attached to federal regulations that inhibit quality assurance or quality improvement.

States must currently piece together the least desirable funds with the most desirable funds in order to provide sufficient funds to reach both children and families and assure good quality, family-centered services. States can make optimal use of this situation by using part of their state appropriations (e.g., for early intervention services or for prekindergarten services) as the state match for open-ended entitlements such as Medicaid and the Family Support Act (see Figure 1. At the State Capitol).

Like quilting, piecing together funds requires skill, art, resourcefulness, and patience, and lends itself to collaborative effort. By piecing together funds, child care providers may be able to help pay for the time, special knowledge and skills that caregivers need to provide a more family-centered service. This kind of financing strategy may also help pay the salaries of additional family support staff who can form partnerships with parents to help them obtain the health, nutrition, social, educational and employment and training services that they need.

C. Nine Sources of Federal Funding and the Family-Centered Approach to Infant Child Care

At least nine sources of federal funds can be brought into early childhood and child care programs seeking to become more family-centered (or into resource and referral agencies which support the development of family-centered early childhood programs in their communities) (see Table 1).

1. Federal Funds for Family-Centered Infant/Toddler Services under the Head Start Act of 1990

Overview

In 1991, almost 17,000 infants and toddlers participated in Head Start. Most early childhood specialists are used to thinking of Head Start as a program for 3-to-5 year olds. But the 1990 reauthorization of Head Start expanded the authority for Parent Child Centers, which by 1992 numbered 106 instead of the 37 that existed between 1967 and 1990. In addition, funds expanded for migrant Head Start, where infants and toddlers have traditionally been cared for on a full-day basis, as a deterrent to the high rates of death experienced by migrant babies taken to the fields.

Eligibility

Grants to local entities to provide Head Start programs are authorized under the Head Start Act. Head Start services are primarily available to families whose incomes are below the poverty line. However, 10% of the families may have incomes above the poverty line and 10% of the Head Start spaces must be available to children with disabilities. All programs must provide a 20% match (which can be in-kind) and operate their services according to the Head Start Performance Standards, the operating standards which define the core of the Head Start service for grantees. Final Head Start

Performance Standards specific to the needs of infants and toddlers are not published at this writing.

Parent-Child Centers

Most Parent-Child Centers (PCCs) are part-time early intervention and family support services. Some of these services are delivered at a center; some PCCs are home visitor programs. The core of a good quality PCC is often already family-centered to some degree. As Head Start programs, Parent-Child Centers offer infant health, mental health and development services combined with family support services designed to enhance family strengths. As Head Start programs, Parent-Child Centers are also designed to be consumer driven, operated under the direction of policy councils which have a majority membership of parents.

In addition to the Head Start programs' emphasis on parent involvement, parents participating in the PCCs have traditionally been required to be present with their babies for at least fifty percent (50%) of the time their infants and toddlers participate. Thus while PCCs have a strong emphasis on nurturing the parent-infant relationship, they do not wholly meet the needs of low-income families with infants and toddlers who, as a result of participation in education, training or employment, require half-time or full-time infant care. However, at the present time, some part-day Parent-Child Centers can be "wrapped around" with full-day, full-year infant child care financed with other federal funds.

In the years ahead, the need for half-time or full-time infant care among low-income employed, trainee or student families will have to be reconciled with the traditional part-time nature of the Parent-Child Centers. This reconciliation needs to be done in such a way that a high degree of parent presence and involvement with their children is combined with support to parents seeking to hold down workplace or educational commitments.

The 1990 Head Start legislation clearly permits the use of Head Start funds to support full-day, full-year Parent-Child Centers. Thus, one way to create these services would be to support any Parent-Child Center that requests full-day, full-year funds and retain a 50% parental presence requirement. These Parent-Child Centers serving infants and toddlers full-day and full-year would then be available to parents with a twenty hour per week involvement in employment, training and/or school.

Another way is to pilot some full-day, full-year Parent-Child Centers with variations in the requirements for parental presence on-site, ranging, for example, from 5% to 50%. The impact of these pilot programs on the emerging parent-infant relationship could then be evaluated. The resulting information could be used to shape future policy for the PCCs.

PCCs will probably expand over the coming years. As funds are made available, the Administration for Children, Youth and Families in the U. S. Department of Health and Human Services publishes a Request for Proposals (RFP) in the Federal Register and sends grant applications to those who request them. Existing community-based programs might consider applying for the funds to offer a Parent-Child Center at their sites.

Migrant Head Start for Infants and Toddlers

In 1991, Head Start migrant programs served 26,000 children under the age of 6 with full-day, family-centered care and education services. Of these, 35%—or 9,100—children were under the age of 3.

For the most part, Migrant Head Start services are full-day, but not full-year. They serve children from 8 weeks to 4 years, during the growing season. Migrant Head Start mainly serves children "upstream," near the fields where their parents labor. Some Migrant Head Start programs also serve children at "the home base," the communities to which children and parents return during the winter months. However, typically, infants and toddlers participate in upstream programs, not in the home base programs.

Like PCCs, Migrant Head Start programs are expanding. As noted above, performance standards specific to Head Start programs serving infants and toddlers still need to be published. Since Migrant Head Start has had to offer its infant/toddler services for many years without the benefit of standards specific to this age group, program changes and adjustments which increase the costs (and the benefits to later development) of these services will be made during the next few years. An important issue for Migrant Head Start for infant and toddlers, therefore, will be the degree to which the Head Start community strongly supports the funding increases necessary to enable Head Start programs to make these needed program improvements.

A future issue for Migrant Head Start will be whether the home base programs offer infant and toddler services during the winter months, when families are in the home base communities. Continuation of Head Start during these months may be important for the very young migrant child's nutrition and good development, as well as for healthy parent development.

This kind of continuation may also be particularly important for continued support to good infant health. Unlike children over 3, infants and toddlers need frequent immunization and preventive health care visits as well as frequent visits for the treatment of mild illnesses. Full-year Migrant Head Start for infants and toddlers could help the family obtain these essential health and nutritional services.

II. Federal Funds for Family-Centered Child Care under the Family Support Act of 1988

Overview

Open-ended federal funds are available for child care for every child eligible for Aid to Families with Dependent Children, (AFDC) whose family meets the conditions set forth in the Family Support Act (FSA) of

1988. Between 50% and 78% of the allowable cost of the service is paid for by the federal government. This law modifies Title IV-A of the Social Security Act.

Eligibility

These child care funds are available as part of a broader program, whose purpose is to provide incentive and support to AFDC families who participate in employment or training. The part of FSA which most directly affects infants and toddlers is the requirement that parents between the ages of 16 and 20 who have not yet finished high school participate in full-time educational activities, regardless of the age of their children.

The new law also requires parents of children aged 3 and up to participate in employment and training as a condition for participation in Aid to Families with Dependent Children. States may impose the identical requirement on AFDC families with children aged 1 to 3, but are not required by federal law to do so. Finally, parents of children of any age may access this federal source of support for child care if they volunteer to participate in employment or training.

These Title IV-A or Family Support Act (FSA) funds can be given either to eligible child care providers or to eligible parents, who then are expected to pay the providers. There is no cap on Title IV-A funds appropriated every year. Thus, the federal government can provide, on an open-ended basis, federal matching funds for every eligible child who participates in child care that meets the requirements of state and federal law.

However, these funds are typically made available by states as per-child reimbursement for day-to-day child care services. Reimbursements cannot exceed the market rate in each locality, defined in the FSA regulations as the 75th percentile of the going rate in communities. These limitations mean that FSA funds will need to be pieced together with other funds in order to finance a high-quality, family-centered child care service.

FSA funds can be used to provide a wrap-around service to early intervention, family resource and support or Head Start services which are currently part-day. In a wrap-around, these funds are used to lengthen the day or otherwise lengthen the time that the services are available so that the AFDC parents can fulfill the requirements of the Family Support Act.

In addition, FSA authorizes funds for grants to states to help them improve licensing, monitoring and (as of 1990) training. However, this provision, reauthorized in 1990 at $50 million, is not currently funded.

III. Federal Funds for Family-Centered Child Care under Title IV-A At-Risk Child Care

Overview

Up to $300 million in federal funds are available each year under a recent provision of Title IV-A of the Social Security Act. Authorized in 1990, this funding stream has become known as "Title IV-A At-Risk Child Care."

Like FSA funds, Title IV-A At-Risk funds (like the older "Title XX" funds) are an entitlement. Unlike FSA funds, however, Title IV-A At-Risk funds are a capped entitlement, not an open-ended one. Thus, states are typically allocated a certain amount of federal matching funds each year. States may draw down matching funds for every child whose family meets the eligibility requirement, until the states's allocation level is reached. The federal match is between 50% and 78% of the allowable costs.

Eligibility

Within the limits of the cap, Title IV-A funds are available for every child whose family is at-risk of becoming dependent on Aid to Families of Dependent Children (AFDC) and needs child care in order to continue to participate in the labor force.

States can make Title IV-A At-Risk funds available to parents in the form of vouchers or certificates or to providers in the form of grants or contracts. As with FSA funds, states can use Title IV-A At-Risk funds to finance child care up to the "market rate," also defined as the 75th percentile of the going rate in communities. As with FSA, the limitation means that these funds too will need to be pieced with other funds to provide family-centered infant child care.

Like FSA funds, Title IV-A At-Risk funds can be used to provide a wraparound service to eligible families participating in early intervention, family resource and support or Head Start programs which are part-day and/or part-year. The final federal regulations clearly authorize states to use funding requirements to assure some key health and safety practices in license—exempt child care. These minimal requirements are small but essential steps towards improving the quality of license-exempt child care. In addition, the final federal regulations for Title IV-A make it clear that Child Care and Development Block Grant (CCDBG) funds can be used to help bring funds for Title IV-A At-Risk child care to the 75th percentile of the going rate in communities.

IV. Federal Funds for Family-Centered Child Care under the Child Care and Development Block Grant (CCDBG)

One hundred percent (100%) federal funds (funds which do not require a state match) are available to states under the Child Care and Development Block Grant (CCDBG). Authorized in 1990 as part of the Omnibus Budget and Reconciliation Act (OBRA), the CCDBG provides grants to states so that they can fund child care services for families at or below 75% of the state's median income.

Unlike the Title IV-A funds, CCDBG funds are not an entitlement. They are grant-in-aid funds, whose level must be set each year. The FY 1992 appropriation is $825 million. From this appropriation, each state has been allocated a certain amount of funds, based on a formula in the law.

Seventy-five percent (75%) of these funds are earmarked for child care services, although states may use up to 15% of this set-aside for administration and/or quality improvement. States can make funds available to parents in the form of vouchers/certificates or to providers in the form of grants/contracts, but parents must be given the choice first of either receiving a voucher/certificate or having their child enrolled at a center or family child care home of their choice that receives a CCDBG grant or contract.

In dispersing this 75% set-aside, states must set reimbursement rates that are:

- sufficient to assure equal access for eligible children to comparable child care services used by other parents in the state or community; and
- based on variations in the cost of care related to setting, age and special needs of the children served.

Of the remaining 25% of the total appropriation, states must use:

- 20% (or 5% of the total appropriation) for quality improvement activities;
- 75% (or 18.75 % of the total appropriation) for early childhood development programs (including start-up costs for infant child care) and before and after school programs; and
- 5% (or 1.25% of the total appropriation) for either purpose.

The limitations on the use of funds for quality improvement inhibit state activities designed to promote a family-centered approach to infant child care. CCDBG appropriations are also insufficient to meet the need. Further, the final CCDBG regulations are not as supportive of differentiated rates as they should be. However, states may be able to use the reimbursement rate requirements to encourage higher quality and a greater degree of family-centeredness in infant child care, since rates must be sensitive to age-related needs.

Like Title IV-A funds, CCDBG funds can be used to provide a wrap-around service to part-day, part-year programs. However, since the CCDBG funds theoretically can be made available to families in most states who are above the poverty line, care should be taken to compare the income eligibility requirements, for example, of Head Start to those the state has set for CCDBG and to make sure that families receiving the wrap-around service are eligible for both Head Start and CCDBG.

V. Federal Funds for Family-Centered Child Care under the Social Services Block Grant (SSBG) or Title XX

Funding for child care is also authorized under Title XX of the Social Security Act as the Social Services Block Grant (SSBG). Like CCDBG, SSBG is a grant-in-aid with no state match required. The FY '92 appropriation is $2.8 billion.

States may use these funds to help provide certain social services for any family that is currently eligible under state policy. Usually these are families with very low incomes. One of the social services which the state may elect to fund is child care (each state decides how much money it will spend on each social service).

Like CCDBG, SSBG funds can be used as a wrap-around for part-day Head Start, early intervention and family resource and support programs.

VI. Federal Funds Related to Family-Centered Child Care under the Special Supplemental Food Program for Women, Infants and Children (WIC)

Overview and Eligibility

The WIC program provides food, nutrition screening and nutrition counseling to pregnant women, new mothers, infants and children under 5 who demonstrate nutritional risk and live in households with incomes below 185% of the poverty line. Anemia, inadequate diet or abnormal weight are all considered signs of nutritional risk. The FY '92 appropriation is $2.6 billion. No state match is required. Nineteen states also invest state funds in WIC.

Under federal policy, two sets of activities should be carried out with WIC funds: (1) food assistance and (2) outreach, nutrition education and counseling as well as program administration. In general, states use about seventy-five percent (75%) of the WIC funds for food assistance and about twenty-five percent (25%) for outreach, education and counseling and program administration.

States can contract with specific agencies—mostly state and local public health clinics—who conduct outreach, determine eligibility and provide either food or vouchers as well as health and nutritional counseling.

The Importance of Coordination between Infant Child Care and WIC

Child care providers in low-income communities know that some children arrive at child care hungry and express fear of weekends and holidays as times when there isn't enough to eat at home. In addition, early childhood service providers often witness the negative impact on women and children of scarce protein and iron-rich food. Children and parents may arrive at child care, for example, chronically fatigued from anemia. Research shows that these children (and their pregnant and postpartum mothers) will benefit greatly from participation in the WIC program.

Possible Points of Juncture between Infant Child Care and WIC

Child care and other early childhood service providers, who have daily contact with parents, are often in an excellent position to provide WIC-related outreach. Therefore, reimbursed outreach for the Special Supplemental Food Program for Women, Infants and Children (WIC) is the most logical point of juncture. It is

important to note, however, that while outreach is an allowable cost under WIC, it is not known whether state and local agencies currently devote much WIC funding to outreach—or whether they would agree to contract with child care providers to do outreach.

Nationally, WIC funds are insufficient to meet the needs of the eligible population. WIC is not an entitlement. Funds must be appropriated by Congress each year. Currently, at least two of every five individuals eligible for the program cannot be served because of insufficient funds. Consequently, local WIC agencies may be reluctant to subcontract with early childhood service programs to provide outreach. However, because adequate nutrition is so vital to the health and well-being of low-income infants, toddlers and their mothers, we have included a discussion of WIC funds in this paper.

Process of Applying

Child care program directors deeply interested in helping parents access WIC services might point out to WIC agencies the advantages of conducting outreach through child care. By reimbursing child care providers for WIC outreach, rather than establishing a separate outreach effort (which is intended to reach many of the same parents using child care), WIC agencies may actually save monies.

VIII. Federal Funds Related to Family-Centered Child Care under the Child and Adult Care Food Program (CACFP).

Overview

Authorized under the National School Lunch and Child Nutrition Act, the Child and Adult Care Food Program (CACFP) is an open-ended entitlement—with no state match required. It is administered at the federal level by the U.S. Department of Agriculture (USDA). At the state level it is administered by the Department of Education, the Department of Human Resources (or Social Services) or the Department of Health.

The costs of purchasing, preparing and serving nutritious food to infants and toddlers can be offset by funds from the Child and Adults Care Food Program. Outreach funds are also available to CACFP program sponsors.

Eligibility

All children in nonprofit child care centers and sponsored family child care homes (whether full or part-time programs) are eligible for some type of reimbursement. In family child care homes, all children qualify for the same reimbursement. However, in centers, children in the higher end of the income ranges qualify for only a slight reimbursement while children in the lower income ranges qualify for a more substantial reimbursement.

For-profit centers are eligible for participation in CACFP if their total child population is comprised of at least 25% low-income children, currently defined in law as children participating in Title XX. Recent official guidance by the USDA loosens this eligibility requirement to accommodate the reality that low-income children now participate in child care funded under a variety of federal programs, not just Title XX (Blank, 1992).

The Importance of Coordination between Infant Child Care and the Child and Adult Care Food Program

All infants and toddlers undergo such rapid physical and mental development that their need for food with appropriate caloric and nutritional content is acute. In addition, mealtimes for infants and toddlers are essential moments in the development of a baby's emotional health and capacity for social interaction. Therefore staff need to have unhurried feeding times with babies and toddlers. In low-income employed families, nutritious food may not be affordable. Thus, if there is insufficient good food at home, low-income infant and toddlers may derive their primary nutrition from the food served by the child care provider. For these infants and toddlers, coordination between infant child care and CACFP is particularly essential.

CACFP funds also provide an incentive to quality improvement in child care, especially family child care. Child care providers must become licensed or approved to qualify for these funds. In addition, family child care providers must be sponsored by an intermediary organization and participate in training. Thus, because of requirements specific to this program, CACFP funds can draw unregulated family child care providers into a support network, provide some training and encourage licensure or approval.

In 1990, an estimated 668,000 to 1.2 million family child care providers in the United States served 4 million children (Willer et al., 1991). Yet in March, 1992, only 156,060 family child care providers participated in CACFP (Coddington, personal communication, 1992).

CACFP is an open-ended entitlement with 100% federal funding (no state match required). Furthermore, every family child care home that meets the requirements can participate in CACFP. Thus even states experiencing fiscal problems can improve both the family-centeredness and the quality of family child care with an outreach campaign that results in many more family child care CACFP participants.

States can now draw down CACFP outreach funds that sponsors can use to offset the costs of recruiting family child care homes serving low-income or rural children (Campaign to End Child Hunger, no date). States who wish to increase family child care home participation in better nutrition services, training and a support network—as well as either licensure or approval—can now plan a concentrated federally-funded CACFP outreach.

Process of Applying

The steps which providers of early childhood services must take to apply for reimbursement are different for centers than for home-based programs. Qualifying centers can apply directly to the administering state agency for reimbursement. Family day care homes must work through a nonprofit sponsoring agency, often a center or a resource and referral agency. The red tape of applying for reimbursement can be cumbersome to some center providers. Some centers are choosing to apply in ways similar to family child care homes, i.e., through an agency that takes responsibility for the paperwork.

VIII. Federal Funds Related to Family-Centered Child Care Under Medicaid

Overview

Medicaid is authorized under Title XIX of the Social Security Act. It provides open-ended federal matching funds for those eligible services that are provided to eligible individuals. The federal match is between 50% and 78%. Historically, children eligible for Medicaid were typically (although not always) of such low incomes that they participated in the state's Aid to Families of Dependent Children program. Now children of the working poor—the population of children served by child care programs for economically disadvantaged children—are increasingly eligible for Medicaid.

New Eligibility for Medicaid

As of April 1, 1990, states must include in Medicaid all pregnant women, infants and children up to age six whose families currently earn less that 133% of the federal poverty line ($14,045 for a family of 3 in 1991). All of these families are eligible for the full range of preventive health care, for medical treatment and for case management services, if the state has chosen to adopt case management services as one of its options. Note that this new mandate may make the children of many Head Start and child care providers eligible for Medicaid as well.

The Importance of Coordination between Infant Child Care and Medicaid

There are natural areas of overlap between child care and health care. In addition, there are often state and/or federal requirements for immunization or state requirements that children have physical examinations or health assessments in order to participate in child care. These are usually considered necessary safeguards to a child's health when being cared for in groups.

Thus, providers become aware of the child's immunization, health and developmental status. As parents undertake the search for basic health services—a search that can often be frustrating, particularly for low-income families—child care providers often try to help them and thereby come to know about the availability of health services in the community.

Some providers actively promote good health (as well as developmental) outcomes in the children they serve and search for ways to help parents strengthen the connection between the children and good health care providers. Medicaid reimbursement may be available to support the time of child care staff or consultants who help low-income families this way.

Possible Points of Juncture between Medicaid and Child Care

In all states, child care programs, family resource and support services, early intervention and Head Start programs that meet the qualifications can now apply for and receive Medicaid funds to enable them to provide to Medicaid-eligible children and families (1) information about, referral to and/or assistance with keeping appointments (outreach, in Medicaid terminology) while participating in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; (2) parts of the EPSDT screening and assessment; (3) remediation and treatment services; and (4) transportation to medical services (Chavkin and Pizzo, 1991; Chavkin and Pizzo, 1992).

In some states, child care programs, family resource and support programs, Head Start programs and child care resource and referral services that serve Medicaid-eligible families and meet the qualifications can now apply for and receive Medicaid funds to assist families in gaining access to needed medical, social, educational and other services. In Medicaid terminology, the service of assisting families in this way is called "case management services".

An optional Medicaid service such as case management must be specifically included by the state in its Medicaid plan before it can be generally funded (Chavkin and Pizzo, 1991; Chavkin and Pizzo, 1992). However, on a per-child basis, case management is mandatory for EPSDT-participating children who need this kind of health and social service coordination as a medically necessary treatment service (Chavkin and Pizzo, 1991).

Although a state match has to be supplied in order to draw down Medicaid funds for any purpose, states can use some of the funds appropriated by the state legislature for child care or prekindergarten services as the state match. In this way, the total funds available within the state for some health, family support and early intervention aspects of child care for low-income families can be multiplied. Using Medicaid to finance these program features will free up child care dollars for reducing infant-staff ratios, for training or for better compensation.

Process of applying

Child care resource and referral agencies, family child care networks, child care programs and family resource and support programs interested in becoming official Medicaid providers must first research their

state's requirements related to "qualified providers." Individuals with the appropriate qualifications must be on staff or on contract as consultants. The program must then approach the Medicaid agency in the state and request certification as an official provider.

If child care and family support services experience any denial of this request—despite evidence that they meet the requirements—they can remind the state Medicaid agency of the freedom of choice provisions in Medicaid law. These provisions, rooted in the strong belief that Medicaid clients must be able to freely choose from among qualified providers, buttress the right of qualified providers to be certified.

IX. Federal Funds Related to Family-Centered Infant Child Care under Part H of the Individuals With Disabilities Education Act (IDEA)

Overview and Eligibility

Part H of the Individuals With Disabilities Education Act (IDEA) provides discretionary grants-in-aid to states that elect to participate in Part H. Part H is intended to help states plan and implement statewide systems of early intervention services for infants and toddlers with disabilities over the course of 5 years. In FY 92, Congress appropriated $175 million for Part H.

Part H of IDEA requires states that elect to participate to develop statewide, comprehensive, interdisciplinary and interagency systems of early intervention services. Participating states must serve infants and toddlers who are developmentally delayed or have a physical or mental condition likely to result in developmental delay. (Participating states may also use the federal funds authorized under IDEA to provide early intervention services to infants and toddlers who are at risk of having substantial developmental delays for other reasons).

Early intervention services for children under 3 have been defined in this federal law as services designed to meet an eligible infant's or toddler's developmental needs and to enhance the family's ability to assist the child's development. States can opt to designate developmentally appropriate infant child care as an early intervention service. However, state-level differences in qualification requirements for personnel (e.g., bachelor or master's degree) may make such a designation unlikely.

However, many states may want to provide Part H services in child care. The law requires that "natural environments"—such as child care—be used to the maximum appropriate extent as a site for early intervention services.

The Essential Elements of the Part H Mandate for Participating States: Years 1 to 4

Part H of IDEA mandates participating states to plan a statewide system of early intervention services. By the fourth year a statewide system of early intervention services must be in place. During the fourth year, four elements of early intervention services must be provided for eligible infants, toddlers and their families:

(1) Multidisciplinary assessment of the child and identification of needed services;

(2) Family-directed assessment of the family's resources, priorities and concerns and identification of supports and services needed to enhance the family's capacity to meet the child's developmental needs;

(3) Development of an IFSP; and

(4) Service coordination [a service which facilitates implementation of the Individualized Family Service Plan (IFSP) and is analogous to case management under Medicaid].

States may apply for an extension of up to 2 years before entering the fifth official year of participation. This gives states more time to prepare for the change in mandate linked to the fifth year of participation.

The Essential Elements of the Part H Mandate for Participating States: Year Five

Once the fifth year is reached, the mandate changes. Those states that continue to participate must now also make available, for every eligible individual, the services which are named in the IFSP as "entitled" services. For some states the nature of this entitlement and the associated costs have proved difficult to estimate and plan for (Brown, 1991). Thus, states can apply for the extension mentioned above. Each year, funds are appropriated by Congress to help states defray the costs of these new mandates. States may also use Medicaid and other sources of funds to help finance the costs of identifying children through comprehensive health and developmental assessments and of providing some of the remediation and treatment services needed, including for example, medical day care (Chavkin and Pizzo, 1992).

The Importance of Coordination between Infant Child Care and Part H

Coordination between Part H and child care is needed because family child care homes, child care centers and Head Start programs for infants and toddlers are natural environments which are increasingly asked to enroll infants and toddlers with special needs. These special needs include developmental delay resulting from a physical or mental condition and developmental delay from causes still unknown.

This increasing population of children with special needs in child care is in part due to state efforts to locate children eligible for early intervention services. It is also due to deep parent need for employment-related infant and toddler services. Rising medical and other expenses associated with the upbringing of children with special needs propel parents into the workforce—and into the search for child care.

Furthermore, the Americans with Disabilities Act (ADA) will result in increased participation of children with disabilities in child care. Under the terms of this

new civil rights law, as of 1992 child care providers may not deny access or discriminate due to disability. Although child care providers are not required to make accommodations that would be considered an undue burden in order to serve children with disabilities, they are required to attempt to accommodate.

Thus, parents searching for mainstreamed child care for their infants and toddlers with disabilities undertake this search with greater confidence, knowing that civil rights protections now back up their quest for inclusion.

Part H of IDEA, however, does not mandate states to provide developmentally appropriate child care. The IFSP mentions both the entitled and nonentitled services which the infant or toddler and his/her family will need. The IFSP can also name developmentally appropriate infant child care as an entitled early intervention service. However, since child care is not specifically mentioned in the federal law as an early intervention service, states may refuse to make infant child care available as an entitled service, even if it is specifically named in the IFSP. In cases like these, a determination as to whether developmentally appropriate infant child care can be construed as an entitlement for certain individuals under this law may have to be made by a court decision.

A better way for states to proceed is to conceptualize Part H as a "mobile"[5] service, which can be taken to and provided within natural environments like infant child care. The IFSP of each infant or toddler who needs developmentally appropriate child care should therefore include a statement that child care will be the "natural environment" in which early intervention services shall be provided.

Possible Points of Juncture between Infant Child Care and Part H

Providers of early childhood services can best cooperate with Part H by:

- participating in (or helping to provide) evaluation and assessment of the child;
- participating in the required family-directed assessment of concerns, priorities and resources and the identification of appropriate services;
- working with or assuming responsibility as service coordinators for the child and family;
- helping to develop a good IFSP; and
- providing developmentally appropriate infant child care as a natural environment to which early intervention services are brought.

Child care and resource and referral agencies can best cooperate with Part H by:

- helping to clarify for state agencies how child care (including family child care) can best serve as a natural environment in which early intervention services can be appropriately provided;
- working with the Child Find agency to help refer children whose parents or caregivers suspect developmental delay;
- working with providers and parents to identify child care settings where Part H participating infants and toddlers might receive early intervention services;
- providing (with IDEA funds), specialized training in identification and remediation of developmental delay to child care providers;
- informing child care providers about their rights and responsibilities under the Americans With Disabilities Act (ADA); and
- participating in local or state interagency councils that are designing services.

Early childhood providers that wish to participate in IFSP teams and possibly become service coordinators or service sites for the infants and toddlers eligible for Part H may be able to contract with the state or receive a grant to do so. Similarly, those providers that are qualified to provide part of the required multidisciplinary assessment (e.g., developmental assessment) may be able to contract with the state to receive a grant to do so.

Process of applying

Child care providers interested in providing early intervention services should contact the local interagency council for Part H (if there is one in their community). Providers can also contact the lead agency for Part H in their state.

They should try to identify state and local parent advocacy organizations concerned with special needs and make their interest in serving infants and toddlers with special needs known to these organizations. Child care resource and referral agencies can help early childhood program providers connect with the lead agency and with parent advocates for children with special needs. They can also help parents of infants and toddlers with special needs become aware of their options under Part H.

D. The Value of Four-Way Partnerships: Part H of IDEA, Nutrition, Medicaid and Child Care

The infancy-related mandate with the best-organized political support is Part H. With this law, the federal government has begun to back the principle that developmental delay in infants and toddlers should be identified and remediated in a family-centered manner.

[5]Kathleen Noonan of the Citizen's Committee for Children of New York describes Part H as a "mobile system" to illustrate a strategy of providing early intervention services to children by moving specialists to the children in their natural environment rather than moving the children to the specialists.

This principle is strongly supported by parent advocates of all income levels whose children have special needs and who strongly support family-centered services. The other funding sources summarized above have primarily time pressured, resource-scarce, low-income and working poor parents as their advocates. However, Part H also attracts advocates who have time, information, access to policymakers and other resources with which to support family-centered services for infants and toddlers: middle and upper income parents of children with developmental delay or at risk thereof.

From a strategic standpoint then, Part H might be supported as a lead effort around which other family-centered infant and toddler services could be organized at the state level.

However, Part H provides a very small amount of federal funds compared to the need. Furthermore, this situation is unlikely to change. Education has traditionally been viewed as primarily a local and state responsibility. From a fiscal perspective, Part H is intended to be a federal aid to state and local expenditures. It is assumed that the primary financial responsibility will fall on local and state government, not on the federal government.

The implications of this for child care, where large numbers of developmentally delayed infants and toddlers are undoubtedly (or probably) now receiving services, are twofold. First, most states will not use Part H funds to finance the full costs of developmentally appropriate infant child care as an early intervention service, because it would be viewed as too costly. Second, some states may be quite interested in *partially* funding developmentally appropriate infant child care with a combination of Part H and Medicaid funds, as a way to spread the financial responsibility for the early intervention services among Part H, social service and Medicaid systems. It is also a way to attend to the federal emphasis on natural environments. States may find it cost-effective to supply child care programs with the appropriate specialized services and equipment instead of financing start-up costs for brand new early intervention services. This is particularly the case with Medicaid-eligible infants and toddlers. Medicaid will pay for part or all of the costs of the early intervention services, depending on the degree to which those services are deemed remediation or treatment services. Thus, states are able to use their state appropriations for early intervention services as the state match for Medicaid, thereby multiplying the total funds available in the state for early intervention services for Medicaid-eligible infants and toddlers.

Therefore these three-way partnerships—among Part H, Medicaid and child care—may be valuable. Four-way partnerships among child care, child nutrition, Medicaid and Part H would add even more benefit. Particularly in low-income communities, bringing nutrition into this cooperative arrangement could help strengthen informal family child care, which serves the infants and toddlers of many low-income employed parents (Willer et al., 1991; Zinsser, 1991).

Although there is not at this writing a federal funding source specifically for family resource and support programs, some states appropriate funds for these services. To the extent that these services can be brought into this partnership, the resulting infant child care can become much more family-centered.

States seeking to increase the supply of developmentally appropriate natural environments for infants and toddlers might begin by developing a plan to finance specialized mobile professionals in infant nutrition, health, assessment and intervention who would work with both family child care providers and center-based providers, from the base of the R&R agency, the Child and Adult Care Food Program sponsors or local coordinating agencies. To pay for these specialists, states can package Child and Adult Care Food Program, Family Support Act, Child Care and Development Block Grant and other child care funds with Medicaid and some Part H funds.

R&R's and other outreach services could then publicize the availability of both child care funds and Child and Adult Care Food Program funds for those child care providers who become sponsored and enter whatever licensing or approval system the state has established. In addition, they could also publicize the availability of health, mental health and early intervention consultants who can provide information and on-site services, as appropriate, particularly for those child care providers participating in CACFP.

Thus, eligible family child care and center-based care providers could receive information and referral services, plus additional funds, plus specialized mobil early health, mental health and intervention services—as a result of this four-way partnership. In addition unregulated family child care providers would become either licensed or approved.

Four-way partnerships—among Part H, nutrition, Medicaid and child care—can benefit Parent-Child Centers, Migrant Head Start, family child care, child care centers, early intervention services and family resource and support services. The result: a greater supply of both higher-quality, more family-centered infant child care and early intervention services.

E. What State Governments Can Do

A Better, More Family-Centered Service System

State legislatures and governors' offices can make possible a better, more family-centered service system. They can:

- provide vision and leadership and communicate it in a state strategic plan;
- develop financing plans and strategies, including strategies for the allocation of increased funds to family-centered services;

- promote interagency planning at the state and local levels, organized around a vision of services that meet the needs of children and families—not the needs of the systems themselves; and
- improve both regulatory and nonregulatory approaches to quality assurance.

If a vision of services organized to meet the needs of children and families can become a hallmark of state and local community based policy planning, better-quality, more family-centered services will result (see Figure 1. At the State Capitol).

Making the "Piecing Together" of Funds More Possible

States can also facilitate the piecing together of funds by R&R agencies and other intermediaries. They can finance governors' offices, umbrella or bridge agencies to:

- produce and disseminate the state strategic plan (including financing plans) for early care and education services (see Figure 1. At the State Capitol);
- develop interagency agreements that commit diverse agencies to support the elements of family-centered infant care and education services appropriate to the funding streams administered by each of the agencies;
- identify and publicize both the possible points of juncture among the various funding streams and the process of applying;
- resolve conflicting eligibility requirements wherever possible;
- develop a single application form and procedure wherever possible; and
- provide ongoing technical assistance to the early care and education community.

In addition, states can also piece together regulatory, monitoring and training policies in order to promote the blending of funds by providers of high quality family-centered infant care. For example, wherever possible states can:

- develop a single set of improved health and safety requirements and apply them across *all* programs serving infants and toddlers, using, for example, the 1992 guidelines on out-of-home care produced by the American Public Health Association and the American Academy of Pediatrics;
- develop a single set of improved monitoring strategies and assessment tools and apply them across *all* programs serving infants and toddlers also using for example the 1992 guidelines of the APHA/AAP;
- develop joint statewide training plans with a career development focus, which benefit caregivers working with infants and toddlers whether they work within child care, Head Start, family resource and support, or early intervention settings (Costley, 1991; Lombardi, 1992; Morgan, 1991);
- promote collaborative financing of training by Head Start, child care, early intervention, family support services, child nutrition and, where possible, child health (Lombardi, 1992);
- promote co-location of health, early intervention, child care, family resources and support, and/or nutrition services sites; and
- promote the use of family resource centers and child care resource and referral agencies as sites where families can obtain support and information for a variety of needs.

Summary

Policymakers and providers who want to see more family-centered infant child care will need to continue to piece together funds for some time to come. However, the pioneers who do piece funds together to create and sustain a more family-centered approach to infant child care not only strengthen the development of children, parents and providers they also mobilize greater public acceptance and support of high-quality infant child care. The public will lend its support more to family-centered infant child care that is of high quality then it will to child-centered infant child care-even when it is good quality care.

From the point of view of the babies themselves, of course, 3 simple aspects of their lives matter most: (1) freedom from physical and emotional distress and discomfort; (2) deeply devoted families who remain devoted to them no matter what else competes for family time and resources; and (3) safe, healthy and stimulating care from stable, sensitive and skilled persons when their parents are away for awhile. Family-centered infant child care supports all 3 elements of a decent beginning for babies and their families. What could matter more?

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Figure 1

At the State Capitol: Developing a State Financing Plan for Family-Centered Infant Child Care

(With acknowledgment to the State of Florida, whose Strategic Plan for Prevention and Early Intervention serves as a model for many of these recommendations)[2]

A state financing plan for family-centered infant child care is best developed within the context of a state strategic plan for family-centered early childhood (0-6) services. The following steps will help:

(1) Establish, preferably by state legislative mandate, a State Coordinating Council that includes parents and key public and private sector leaders concerned with:

- health and mental health;
- nutrition;
- family support (including employment and training); and
- early care and education services for children under 6 and their families;

(2) Require (in legislation) this Council to develop a strategic plan for family-centered early childhood services, including two financing plans (0-3 and 3-6 services). Set a timetable for its activities;

(3) Develop a vision of the kind of family-centered early childhood services most desired by the state's citizens;

(4) Establish agreed-on principles that will govern the delivery of early childhood services;

(5) Document the numbers of children in the state aged 0-3 and 3-6, including:

- AFDC children with parents required to complete high school; required (or volunteering) to make the transition from AFDC to education, employment or training;
- children in families with incomes below 100%, 133% and 185% of the poverty line, as well as below 75% of the state median income;
- children 0-3 diagnosed with developmental delay or with physical/mental conditions highly likely to cause developmental delay;
- children 0-3 living in environments associated with developmental delay or with the risk of abuse and neglect; and
- children 3-6 with disabilities and with developmental delay;

(6) Document the health, mental health, nutritional and family support needs of children aged 0-6 and their families (including employment and training needs);

(7) Analyze and document the costs and benefits of meeting those needs;

(8) Agree on a few program goals—the results intended to meet these needs in a family-centered manner;

(9) Agree on a few system goals—the policy and administrative practice changes that will help providers and parents achieve the program goals (e.g. the development of a career development-focused state training plan for providers);[3]

(10) Establish, for each program and each system goal, specific intervention strategies, outcome indicators and benchmarks (short-term progress expected by a certain date);

(11) Document, for children aged 0-3 and 3-6 and their families, the types and amounts of funds available to meet health, nutrition, family support and early care and education needs (along with related restrictions and eligibility requirements), including:

- state appropriations;
- state-administered federal funds currently available and any state match required;
- locally-administered federal funds (e.g. Head Start) currently available and any local match required; and
- private sector support (e.g., United Way, private philanthropies, etc.) available to help local communities.

(12) Develop, in concert with the appropriate leadership, five mini-plans[4] for maximizing private sector and federal funds within (not just to) the state that would:

- use private sector funds wherever possible for local match for federal funds;
- support and augment locally administered federal funds while preserving local administration (e.g., helping Head Start grantees connect with private sector sources of local match);
- use federal open-ended entitlement funds that do not require state match (e.g., The Child and Adult Care Food Program funds) to the maximum extent possible;
- use part of state appropriations wherever possible to supply the state match for federal entitlement funds (e.g., the use of state funds for prekindergarten as the state match for Family Support Act and/or Medicaid in order to fund early care and education services meeting health, mental health, family support and child care needs); and
- use state-administered federal grant-in aid funds (e.g., the Child Care and Development Block Grant and/or IDEA) to fund, wherever possible, the remaining needed services;

(13) Highlight the aspects of the State Strategic Plan that support family-centered infant child care; develop a state financing plan for using/supporting existing funds; document remaining need and develop a plan for securing additional funds;

(14) Develop a similar financing plan for family-centered care and education for 3 to 6 year olds; and

(15) Ratify, in the state legislature, the State Strategic Plan, including the two financing plans with modifications as needed. Mandate its implementation and set a timetable.

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[2]See *Strategic Plan for Prevention and Early Intervention as Required by Chapter 411, F.S.*, by the Florida Department of Health and Representative Services and the Florida Department of Education (November 1991) for an example of a state plan.

[3]See Sue Bredekamp's article "Composing a Profession" (*Young Children*, January 1992, pp. 52-55) for a full discussion of a lattice training. The concept of lattice simultaneously conveys upward motion and intersecting paths. For career development, the metaphor of a lattice seems much more appropriate than a ladder.

[4]Health, education, social services and fiscal committees in the state legislature may have to coordinate their work in order to participate effectively in the development of these mini-plans, and the strategic plan for family-centered early childhood services.

Figure 2

Comprehensive Child Development Programs—One Model

Low-income infants, toddlers and preschool children—and their parents—are currently served by demonstration projects called the Comprehensive Child Development Projects (CCDPs).

The CCDPs are authorized under The Comprehensive Child Development Act of 1988, which mandates that certain core services be provided.

For parents, starting in the prenatal period, these services include:

- prenatal care;
- education in infant and child development, health, nutrition and parenting;
- assistance in securing adequate income support, health care, nutritional assistance and housing;
- mental health care;
- vocational training and adult education; and
- substance abuse education and treatment.

For infants, toddlers and preschool children, these services include:

- health care, including screening, immunization and treatment;
- licensed child care;
- developmentally appropriate early childhood education;
- early intervention services for children at risk of developmental delay; and
- nutrition services.

For both parents and their infants, toddlers and preschool children, adequate transportation to access these services must also be provided.

The CCDPs are not required to provide all these services directly but are expected to coordinate with and use existing services in the community. The CCDPs typically develop interagency contracts or agreements with other community programs in order to provide these services. Some of these contracts and/or agreements include arrangements for financing (Hubbell, Cohen, Halpern, DeSantis, Chaboudy, Titus, DeWolfe, Kelly, Novotney, Newbern, Baker and Stec, 1991).

Figure 3

Types of Federal Funding Streams

Grant-in-aid

Funds appropriated by the Congress each year (within authorized levels) as direct grants to states or communities, to aid those entities in achieving certain purposes.

Examples: Head Start, the Child Care and Development Block Grant.

Open-ended entitlement

Funds which Congress has authorized as available to states, communities or (in some cases) individuals to help these entities achieve certain purposes. These funds must be made available to these entities for support and/or services to qualifying individuals.

In some cases matching funds must be provided by the entity receiving the federal funds. In addition, a federal and/or state cap may be set on the amount of funds paid to any one individual.

The total amount of federal funds made available, however, cannot be limited as long as the funds remain authorized as an open-ended entitlement

Examples: Social Security, the Child and Adult Care Food Program, the Family Support Act, Medicaid

Capped entitlement

Funds which the Congress has authorized as available typically to states or communities to help these entities achieve certain purposes.

In the case of a capped entitlement, Congress also authorizes a cap or lid on the total amount of federal funds which can be drawn down each year for those purposes. Thus these funds must be made available for support and/or services to qualifying individuals—until the annual cap is reached. The cap must be regularly reauthorized.

Example: Title IV-A At-Risk Child Care

Table 1. Nine Sources of Federal Funds/Family Centered Infant/Toddler Services

	Head Start		Fam.Sppt. Act (Title IV-A)	Title IV-A At-Risk Child Care	Child Care & Dev. Block Grant (CCDBG)	Social Ser. Block Grant (SSBG or Title XX)	Special Supplemental Food Program for Women, Infants & Children (WIC)	Child and Adult Care Food Program (CACFP)	Medicaid (Title XIX)	Part H of Individuals w/Disabilities Education Act (IDEA)
	Parent-Child Centers	Migrant Programs								
State or Local Match	20% local match (can be in-kind)		22% to 50% (effective state match)	22% to 50% (effective state match) for services; 0%-50% match for administration	No state match	No state match	No state match	No state match	22% to 50% (effective state match)	No state match[4]
Eligibility: Children 0-3	• infants and toddlers (0-3) up to 100% of poverty • 10% set-aside for children with disabilities		• infants and toddlers (0-3) of AFDC parents req. to complete high school • At state option, toddlers (1-3) of AFDC parents req. to participate in education, employment or training • infants and toddlers (0-3) of AFDC parents volunteering to participate in education, employment or training	• infants and toddlers (0-3) of parents "at-risk" of AFDC dependency who need child care in order to work	infants and toddlers (0-3) in families up to 75% of the state median income	at state discretion	infants and toddlers (0-3) in households up to 185% of poverty who are at nutritional risk	infants and toddlers (0-3) in: • nonprofit part-day or full-day centers • sponsored family child care homes • for profit part-day or full-day centers serving 25% of Title XX children[5]	• infants and toddlers (0-3) in families up to 133% of the poverty line • at state option, infants (0-1) up to 185% of poverty • at state option, infants and toddlers (0-3) qualifying for supplemental security income (SSI)	infants and toddlers (0-3) with • diagnosed developmental delay • physical or mental conditions with high probability of developmental delay • at state option, infants and toddlers (0-3) at risk of developmental delay

[4]While there is no state match required for Part H, there is a "last dollar" provision which in effect causes a state match.

[5]A recent USDA memorandum liberalizes this provision somewhat. See Blank, H. and Adams G. "Memorandum to Child Care Advocates," November 25, 1991.

Table 1. Nine Sources of Federal Funds/Family Centered Infant/Toddler Services

	Head Start		Fam.Sppt. Act (Title IV-A)	Title IV-A At-Risk Child Care	Child Care & Dev. Block Grant (CCDBG)	Social Ser. Block Grant (SSBG or Title XX)	Special Supplemental Food Program for Women, Infants & Children (WIC)	Child and Adult Care Food Program (CACFP)	Medicaid (Title XIX)	Part H of Individuals w/Disabilities Education Act (IDEA)
	Parent-Child Centers	Migrant Programs								
Administration Federal:	Dept. of Health & Human Svcs./Admin. for Children & Families (DHHS/ACF)		DHHS/ACF	DHHS/ACF	DHHS/ACF	DHHS/ACF	United States Department of Agriculture (USDA)	USDA	DHHS/Health Care Financing Administration (HCFA)	Dept. of Education Office of Special Education Programs (DOED/OSEP)
State: administrating (or lead agency)	Not State-Administered		At Governor's Discretion[1]	At Governor's Discretion	At Governor's Discretion	At Governor's Discretion	Typically state health agency	At Governor's Discretion (Typically state education, human resources or health agency)	Single State Agency Typically state health agency)	At Governor's Discretion
Local:	Local governments and community-based organizations									
Type of Funding Mechanism:	Discretionary grant-in-aid		Open-ended entitlement	Capped entitlement	Discretionary grant-in-aid	Discretionary grant-in-aid	Discretionary grant-in-aid	Open-ended entitlement	Open-ended entitlement	Discretionary grant-in-aid[2]
Amount of Federal Funds Available in FY'92	• PCC's $30 million • Head Start in general: $2.2 billion	at the discretion of the Secretary, of DHHS, within the general Head Start appro-priation	Open-ended	$300 million	$825 million	$2.8 billion[3]	$2.6 billion	Open-ended	Open-ended	Part H: $175 million

[1]Eligibility must be determined by the state IVA agency; other administrative functions can be delegated to other agencies.

[2]Although Part H entitles (in participating states during the fifth official year of participation) eligible children 0-3 to the services listed in the child's Individualized Family Service Plan (IFSP) as entitled services, the federal funding mechanism authorized by Part H is discretionary grant-in-aid.

[3]A portion of this is used by states for child care.

Table 1. Nine Sources of Federal Funds/Family Centered Infant/Toddler Services

	Head Start		Fam.Sppt. Act (Title IV-A)	Title IV-A At-Risk Child Care	Child Care & Dev. Block Grant (CCDBG)	Social Ser. Block Grant (SSBG or Title XX)	Special Supplemental Food Program for Women, Infants & Children (WIC)	Child and Adult Care Food Program (CACFP)	Medicaid (Title XIX)	Part H of Individuals w/Disabilities Education Act (IDEA)
	Parent-Child Centers	Migrant Programs								
Eligibility: pregnant women and new mothers	• pregnant women • new mothers up to 100% of poverty					at state discretion	• pregnant women and new mothers up to 185% of poverty who are at nutritional risk		• pregnant women and very new mothers up to 133% of poverty • parents and or caretaker relatives receiving AFDC • at state option, pregnant women and very new mothers up to 185% of poverty	