providers. **State investment:** 11 c for every $100. **R&R:** Statewide network ([ND]).

HEART South Dakota still trails most other states in its commitment to child care.

Child care advocates hope that Loila Hunking, the state's new child care services coordinator, will take action to improve child care in South Dakota. To date, neither Governor William Janklow or state lawmakers have made it a priority. In an interview earlier this year, Hunking said she hopes to involve both business leaders and educators across the state in efforts to upgrade the quality of care. Many advocates hope her great enthusiasm to create new caregiver training programs will effect their implementation.

TENNESSEE

STAR STAR STAR

CROSS CROSS

FACE FACE

HEART HEART HEART

Number of children under 6: 449,000.
Number of accredited child care centers: 86.
Number of accredited family child care homes: 12.

STAR Number of children one adult can care for: 5 infants * 8 toddlers * 10 preschoolers * 25 school-agers.
Group size: Mediocre to poor standards.
Caregiver training: Center directors: None to start, 12 hours annually. Center staff: None to start, 6 hours annually. Family child care providers: None to start, 2 hours annually.
CROSS Adult supervision: Mediocre.
Size at which family child care is regulated: 5+ children.
Immunizations: ++.
Playground surfaces: +.
Hand-washing: Fair.
Healthy Child Care America: +.
Inspections: All licensed programs have inspections (1 unannounced) twice a year.
FACE The state boosted funding so that 4,000 more children will get child care

this year. **State investment:** 26 c for every $100. **R&R:** No statewide network. **HEART** Tennessee has increased funding for child care, but has yet to make some key quality improvements recommended by a committee of experts several years ago.

Like so many other states, Tennessee has boosted its funding for child care in the face of welfare reform. In his budget for the next fiscal year, Governor Don Sundquist has pledged $10 million in new funds. Much of that money will go to boost payments to caregivers--which may in turn lower parents' bills.

At the same time, state officials are still dragging their feet over new rules that were proposed three years ago to improve the quality of care for Tennessee's kids. The rules would upgrade caregiver training and lower adult-to-child ratios--important changes that studies show make programs better for kids. It looks like the rules will soon be approved, but they'll then be phased in over nearly

four years--an unfortunate delay. "A lot of us are really distressed that the state has not implemented these standards yet," says Phil Acord of the Children's Home and Shelter, a 24-hour child care center in Chattanooga.

TEXAS

STAR STAR

CROSS CROSS

FACE FACE FACE

HEART HEART

Number of children under 6: 1,899,000.
Number of accredited child care centers: 355.
Number of accredited family child care homes: 99.

STAR Number of children one adult can care for: 4 infants * 13 toddlers * 17 preschoolers * 26 school-agers.
Group size: Mediocre to poor standards.
Caregiver training: Center directors: 9 college credits in child development and 9 in business management, plus 3

years experience to start; 20 hours annually. Center staff: 8 hours to start, 15 hours annually. Family child care providers: None to start, 20 hours annually.

CROSS Adult supervision: Poor.

Size at which family child care is regulated: 4+ children.

Immunizations: [ND] (no HepB).

Playground surfaces: [ND].

Hand-washing: Good.

Healthy Child Care America: +.

Inspections: Centers have inspections 1 to 3 times a year, based on past performance; family child care homes have inspections every 1 to 3 years, based on past performance (most unannounced).

FACE The state continues to keep its strong commitment to pre-K programs, but still lacks a broad-based plan to serve children of other ages. **State investment:** 71 c for every $100. **R&R:** Statewide network ([ND]).

HEART Texas improved its infant standards this year by lowering the number of children one adult may care

for, but still has some distance to go on upgrading quality for older children. The state's extensive support of prekindergarten education remains the bright spot here.

This year, the Texas Licensed Child Care Association lobbied heavily against proposed standards which would have improved the adult-to-child ratios in many programs. Unfortunately, they prevailed. Lawmakers delayed adoption of the new rules.

Texas may finally get statewide resource and referral services, however, with new federal funds coming into the state. In addition to helping parents find care, R&Rs may handle both caregiver training and consumer education--a very positive development.

Child care providers across the state may also be able to get low-interest loans to buy new equipment, upgrade their facilities and do other things to improve the quality of care, under a bill pending in the state legislature which looked likely to pass as we went to press.

UTAH

STAR STAR

CROSS CROSS

FACE FACE

HEART

Number of children under 6: 232,000.

Number of accredited child care centers: 13.

Number of accredited family child care homes: 7.

STAR Number of children one adult can care for: 4 infants * 7 toddlers * 12 preschoolers * 20 school-agers.

Group size: Mediocre to poor standards.

Caregiver training: Center directors: Combination of child-related course work and experience to start, 20 hours annually. Center staff: 40 hours in first year, 20 hours annually. Family child care providers: 2 hours of state-approved training to start, 12 hours annually.

CROSS Adult supervision: Mediocre.

Size at which family child care is regulated: 4 children.

Immunizations: [ND] (no HepB).

Playground surfaces: [ND].

Hand-washing: Centers: Good. Family child care homes: Poor.

Healthy Child Care America: +.

Inspections: Centers have one announced and two unannounced inspections a year. Family child care homes have at least one announced inspection a year.

FACE The state still invests relatively little in expanding child care. **State investment:** 73 c for every $100. **R&R:** No statewide network.

HEART Utah lawmakers continue to be stingy in child care funding. The state is one of the few to actually lower its spending on child care, which could cause it to forfeit a chunk--$1.6 million--of federal money for child care.

Utah has delayed new child care standards, after a fractious battle over them. The state recently shifted child care oversight to a new government agency--the department of

health, and health officials must now start the rule-revision process from scratch.

In a more positive move, Utah officials have begun to explore ways to expand care for school-aged children. One interesting proposal: The state will offer $500,000 to local communities willing to put up matching funds to create new slots for school-age care. Half the money would be designated for programs run by private caregivers. This is an interesting approach, since it uses both public and private resources to help kids.

VERMONT

STAR STAR STAR STAR

CROSS CROSS CROSS

FACE FACE FACE

HEART HEART HEART HEART

Number of children under 6: 56,000.
Number of accredited child care centers: 29.
Number of accredited family child care homes: 3.

STAR Number of children one adult can care for: 4 infants * 5 toddlers * 10 preschoolers * 13 school-agers.

Group size: Good standards, except for school-age care.

Caregiver training: Center directors: 4 college courses to start, 9 hours annually. Master teachers: 4 college courses to start, 9 hours annually. Center staff: One college course to start, plus one year experience; 6 hours annually. Family child care providers: None to start, 6 hours annually.

CROSS Adult supervision: Good.

Size at which family child care is regulated: 3+ children.

Immunizations: [ND] (no HepB).

Playground surfaces: Centers: +. Family child care homes: [ND].

Hand-washing: Centers: Good. Family child care homes: Fair.

Healthy Child Care America: +.

Inspections: Centers have 2 unannounced inspections a year; family child care homes have inspections only upon complaint.

FACE Vermont offers modest assistance to start up new child care programs.

State investment: $1.09 for every $100.

R&R: Statewide network (+).

HEART This state continues to be a leader in quality child care.

Good rules and tenacious advocates mean child care here is high-quality--and still improving. When legislators wanted to cut funding for child care training last year, parents and caregivers mobilized. They spent a day at the capitol explaining why training is so important--and legislators agreed to restore 90 percent of the money they had proposed cutting.

The state recently began requiring that family child care homes be inspected before they're registered with the state. State officials spend two hours with new caregivers, offering training and guidance, explaining rules and making sure homes are safe. This is an excellent way to approach the job of state oversight.

Vermont has also published a set of "core standards" for all child care

programs. These standards are voluntary, but serve as a guideline for centers looking to improve quality.

VIRGINIA

STAR STAR

CROSS CROSS

FACE FACE FACE

HEART HEART

Number of children under 6: 526,000.

Number of accredited child care centers: 176.

Number of accredited family child care homes: 19.

STAR Number of children one adult can care for: 4 infants * 10 toddlers * 10 preschoolers * 20 school-agers.

Group size: No standards.

Caregiver training: Center directors: Some early-childhood education and experience to start, none annually. Master teachers: Combination of education and experience to start, 8 hours annually. Center staff: None to

start, 8 hours annually. Family child care providers: None to start, 6 hours annually.

CROSS Adult supervision: Mediocre.

Size at which family child care is regulated: 6+ children.

Immunizations: [ND] (Hib is required only for children under 30 months. HepB is required only for children born after January 1, 1994).

Playground surfaces: Centers: +. Family child care homes: [ND].

Hand-washing: Centers: Good. Family child care homes: Fair.

Healthy Child Care America: [ND].

Inspections: All licensed programs have inspections twice a year (at least 1 unannounced).

FACE This state launched no significant new initiatives to expand its supply of child care. **State investment:** 24 c for every $100. **R&R:** Statewide network ([ND]).

HEART Controversy continues to dominate the child care scene in Virginia, with very little accomplished in terms of improving or expanding options for families.

Child care advocates and Governor George Allen remained at odds all year, fighting over standards for child care. At one point, members of a child care council Allen appointed proposed lowering standards for caregiver training and reducing some adult-to-child ratios for preschool children. Fortunately, the proposals were beaten back in the state legislature.

On the positive side, the state did finally put up matching funds to secure its full share of federal child care funds (although there is concern among advocates over how these funds will be distributed). Virginia also set aside some modest funds for caregiver training.

WASHINGTON

STAR STAR STAR

CROSS CROSS CROSS CROSS

FACE FACE FACE FACE

HEART HEART HEART HEART

Number of children under 6: 460,000.

Number of accredited child care centers: 104.

Number of accredited family child care homes: 32.

STAR Number of children one adult can care for: 4 infants * 7 toddlers * 10 preschoolers * 15 school-agers.

Group size: Mediocre to poor standards.

Caregiver training: Center directors: 45 college quarter credits in earlt childhood aducation or equivalent to start, none annually. Center staff: None to start, some annually. Family child care providers: None.

CROSS Adult supervision: Good.

Size at which family child care is regulated: 2+ children.

Immunizations: ++.

Playground surfaces: Centers: +. Homes: [ND].

Hand-washing: Centers: Good. Homes: Poor.

Healthy Child Care America: +.

Inspections: All licensed programs have announced inspections every three years.

FACE Washington State made a significant new investment to expand child care, allocating $100 million in new funds. **State investment:** 65 c for every $100. **R&R:** Statewide network (+). **HEART** Washington State continues to be an innovator on child care, with the legislature and governor committed to improving and expanding care across the state.

Washington state officials are working hard to expand the supply of child care this year. Governor Gary Locke's proposed budget earmarked $350 million for child care, including $100 million in new dollars and $9 million for nontraditional care, such as off-hours programs for parents who work swing-shift or nights. This is an especially important innovation; child care advocates across the country report that parents with nontraditional hours find it nearly impossible to find care for their children. Last year, state lawmakers earmarked about $10 million in state funds to eliminate a waiting list for state-sponsored child care.

New funds have been made available for resource and referral, caregiver training and parent education efforts. Training requirements for all caregivers have been strengthened as part of the program. All providers in the state must now have 20 hours of training during their first year on the job, and ten hours annually after that. Previously, most caregivers needed no training at all before they started caring for kids.

WEST VIRGINIA

THIS STATE NOT FINAL

STAR STAR

CROSS CROSS

FACE FACE FACE

HEART HEART HEART

Number of children under 6: 112,000.

Number of accredited child care centers: 9.

Number of accredited family child care homes: 0.

STAR Number of children one adult can care for: 4 infants * 8 toddlers *10 preschoolers * 16 school-agers.

Group Size: No standards.

Caregiver training: Center directors: 9 hours to start, none annually. Center staff: None to start, unspecified number of hours required annually. Family child care providers: None.

CROSS Adult supervision: Mediocre.

Size at which family child care is regulated: 4 children.

Immunizations: Centers: ++. Homes: +.

Playground surfaces: [ND].

Hand-washing: Centers: Good. Family child care homes: Fair.

Healthy Child Care America: +.

Inspections: All licensed programs have announced inspections once a year.

FACE This state expanded its supply of family child care and continued to support its network of family resource centers. **State investment:** 21 c for every $100. **R&R:** No statewide network.

HEART West Virginia expanded the supply of family child care this year.

In the face of growing demand for child care, the state decided to create

a new class of family child care homes and many opened their doors in April. These new providers will be allowed to care for up to six children with just one adult on hand, regardless of the age of the children. This is certainly not an ideal situation, and one that state officials say is only being approved on an emergency basis to quickly expand options for working parents.

will be revised

The good news: Thanks to the previous governor, Gaston Caperton, West Virginia had an extra $2 million to spend on child care this year--a big chunk for a small state. West Virginia used the money to add licensing staff, support a school-age summer care program, and create two more resource and referral agencies this year. The added R&Rs mean all state residents now have access to help finding child care placements.

WISCONSIN

STAR STAR STAR

CROSS CROSS CROSS

FACE FACE FACE FACE

HEART HEART HEART

Number of children under 6: 485,000.

Number of accredited child care centers: 135.

Number of accredited family child care homes: 19.

STAR Number of children one adult can care for: 4 infants * 6 toddlers * 10 preschoolers * 18 school-agers.

Group size: Mediocre to poor standards.

Caregiver training: Center directors: None to start, 39 hours annually. Center staff: 80 hours to start, 39 hours annually. Family child care providers: 40 hours to start, 15 hours annually.

CROSS Adult supervision: Good.

Size at which family child care is regulated: 4+ children.

Immunizations: +.

Playground surfaces: Centers: +. Homes: -.

Hand-washing: ++.

Healthy Child Care America: +.

Inspections: All licensed programs have unannounced inspections once a year.

FACE This state boosted its child care supply significantly; it now serves 17,000 more children. **State investment:** 33 c for every $100. **R&R:** Statewide network (+).

HEART Wisconsin is making a big push to expand the supply of care, but some of the expansion may come at the expense of quality.

Governor Tommy Thompson made his name last year on a program called "Wisconsin Works," a welfare reform effort that included sweeping changes in the state's child care rules and funding. On the positive side, state funding is increasing by $36 million this year alone, which means all families on the waiting list for subsidies have now received them. In 1996-97, the state pumped $89 million in new state money into child care. By 1998, the number of children receiving aid will zoom from the current 17,000 to 60,000. That is a remarkable achievement.

The state also gave a big one-time boost to efforts to increase supply and quality, to the tune of $5 million. That money will translate into more staff for licensing, improved resource and referral services, and more grants for caregiver training.

At the same time, however, Wisconsin has created a new class of child care providers, known as "provisional" caregivers. These providers will not be required to have any training, and the state will reimburse them at half the rate it pays those who are certified and have credentials in early education. Many advocates are worried that these policies--paying caregivers less and lowering training standards--could hurt the quality of child care in Wisconsin.

WYOMING

STAR STAR

CROSS CROSS

FACE FACE

HEART HEART

Number of children under 6: 43,000.

Number of accredited child care centers: 22.

Number of accredited family child care homes: 11.

STAR Number of children one adult can care for: 5 infants * 8 toddlers * 10 preschoolers * 25 school-agers.

Group size: No standards.

Caregiver training: Center directors: None to start, 8 hours annually. Center staff: None to start, 8 hours annually. Family child care providers: None to start, 8 hours annually.

CROSS Adult Supervision: Mediocre.

Size at which family child care is regulated: 3+ children.

Immunizations: +.

Playground surfaces: [ND].

Hand-washing: +.

Healthy Child Care America: +.

Inspections: Centers and family child care homes have unannounced inspections once a year.

FACE This state has no broad initiatives to increase the supply of

child care. **State investment:** 18 c for every $100. **R&R:** No statewide network. **HEART** State lawmakers took a step backwards this year, delaying new rules that would have made significant improvements in the quality of child care across the state.

The state's Department of Family Services worked long and hard to improve child care licensing rules. The final proposals would have lowered adult-to-child ratios and required caregivers to have more training--two significant steps that are known to boost the quality of child care programs.

The new rules had received plenty of support when they were circulated to local child care associations. But lawmakers retreated from the rules in the face of vocal opposition from a few family child care providers who complained such improvements would ruin them financially. The legislature also proposed a moratorium on changes to licensing rules until 2001--fortunately, this failed to pass.

CCMC
Communications Consortium
MEDIA CENTER

MEMORANDUM

TO: Jennifer Klein
Senior Policy Analyst

FROM: Karen A. Cowles

DATE: July 28, 1997

RE: Senate Hearing

Per your request, attached are notes and written testimony from the July 17 Senate Hearing on "Improving Quality of Child Care." Please feel free to contact me at 202/326-8709 if I can be of further assistance.

1200 New York Avenue, NW, Suite 300 Washington, D.C. 20005-1754
Phone: 202/326-8700 Fax: 202/682-2154

SENATE HEARING
IMPROVING THE QUALITY OF CHILD CARE
JULY 17, 1997

Highlights of Hearing:

Attendees (Members of Congress): Sen. Jim Jeffords (R-VT), Sen. Christopher Dodd (D-CT), Sen. Bob Graham (D-FL), Sen. Edward Kennedy (D-MA), Sen. Connie Mack (R-FL), Sen. Patty Murray (D-WA), Sen. Paul Wellstone (D-MN), Sen. Jack Reed (D-RI), Rep. Peter Deutsch (D-FL), Rep. Benjamin Gilman (R-NY).

Senator Jim Jeffords began the hearing and provided some background statistics on child care.

- Twelve million children under the age of five are cared for by someone other than their parents.

- Child care is an essential element to the economic survival of many families.

- The average family spends $4,600 on child care and between $8,500 and $9,100 for high quality child care. Since 1990, the cost of child care has risen 6% annually, yet the quality of child care has declined.

Senator Jeffords continued by announcing he along with Sen. Christopher Dodd plan to introduce the CIDCARE Bill to improve the quality of child care "to give parents real choices." He quoted *Time Magazine* stating, "Good, quality child care costs money. Good, affordable day care is essential brain food for our children."

Senator Edward Kennedy remarked on the need for more protections and safeguards in the child care system. "The protections have to be out there for the children."

Senator Christopher Dodd remarked, "The basic right to quality child care should not just be a luxury for a select few." He referred to a Yale University study by Dr. Zigler that "only 33 percent of states have

regulations in place that meet minimum quality standards. Sixty-seven percent did not even meet minimum standards."

Senator Dodd continued by stressing the brain development during the first three years is critically important. The early years are critically important. He, along with Sen. Jeffords, plan to introduce the CIDCARE Bill today on the floor. "Child care should not be like Las Vegas where you take your chances and roll the dice."

Congressman Benjamin Gilman, Congressman Peter Deutsch, Senator Bob Graham, and Sen. Connie Mack gave brief remarks as panelists in support of Mark and Julie Fiedelholtz of Florida whose newborn son died while under the care of a licensed day care center. All called for national action on behalf of child care in the United States. Senator Mack and Senator Graham stated that affordability of child care is a primary concern of parents nationwide.

Mark and Julie Fiedelholtz testified before the Committee about the death of their son, Jeremy. Jeremy died at three months old at his first day in day care. Julie Fiedelholtz had left her son there for one hour and fifty minutes and went back to check on him and he was face down in his crib and had suffocated. Mark Fiedelholtz cried out to the Senators that "Our day care system is dead." He stated in outrage that "it is harder to cut a poodle than to get a day care license." The day care provider was later charged $200.00 for neglect.

Senator Dodd remarked on how the U.S. is going to have an explosion of a need for child care with the "so-called welfare reform."

Mark Fiedelholtz stated that a day care provider is not considered a profession in this country and parents need to be educated as to what they should look for in a day care. There needs to be a national parent awareness campaign on child care.

Senator Wellstone announced he along with Senator Mike DeWine (R-OH) will introduce a bill today that will allow loan forgiveness for men and women who earn college degrees in early childhood education and then work as day care providers.

James M. Poole, MD testified representing the American Academy of Pediatrics (AAP). "Early brain development and child care go hand in hand." Care cannot be separated from early development. Children need trust, not trauma, that they will be cared for. The child care center serves more as an "extended family"—children are spending many days and hours with child care providers. AAP has launched a "Back to Sleep Campaign" to inform parents and child care providers of the need to put infants on their backs while sleeping." They also have launched a "Healthy Child Care America Campaign" along with the Child Care Bureau and Maternal and Child Health Bureau.

Lynn Behrmann of Manchester, Connecticut provided testimony as a family child care provider. She urged the Committee to require states to consider a child care provider a profession and to make more training available. She also stated that no CCDBG money is coming down to child care providers for training.

Sen. Jeffords asked several questions that included, "How do we provide training for child care providers to identify children who may have special needs" and "Where are we in the ability to measure a child's ability to learn (referring to the recent brain research that has come out)?"

Sen. Dodd stated that the rhetoric that "parents have the right to choose" is ridiculous. We need to set standards. We would not tolerate this in any other profession. There is more rhetoric about kids and children than any other issue. Sen. Dodd also discussed welfare reform and stated, "you can't leave the children in the street if you make women move from welfare to work."

Several other panelists testified that included Ted Childs of IBM who discussed what IBM is doing to make child care available to its employees and its collaboration with 21 other companies called the American Business Collaboration for Quality Dependent Care (ABC), and Deborah Lowe Vandell who testified on behalf of the NICHD and its study on early child care and that the quality of care received by children is vitally important to their brain development and intellectual growth. Written testimony is attached.

JIM JEFFORDS

UNITED STATES SENATOR • VERMONT

COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

HEARING ON IMPROVING THE QUALITY OF CHILD CARE

JULY 17, 1997

1. Press release announcing the hearing with witness list
2. Statement of Chairman Jeffords
3. Testimony of all witnesses received by July 16, 1997

Press Contact: Joe Karpinski (202) 224-6770

Washington, D.C. (202) 224-5141 • Burlington (802) 658-6001 • Montpelier (802) 223-5273 • Rutland (802) 773-3875
Toll Free 1-800-835-5500

JIM JEFFORDS

UNITED STATES SENATOR • VERMONT

For Immediate Release
July 15, 1997

Contact: Joe Karpinski
(202) 224-6770

QUALITY OF DAY CARE TO BE SUBJECT OF LABOR COMMITTEE HEARING

WASHINGTON, D.C. --- The quality of day care will be the subject of a hearing by the Senate Labor and Human Resources Committee on Thursday, July 17, 1997. The hearing will begin at 2:00 p.m., will be held in SD-430, and will be broadcast on Senate channel 13.

The lead witnesses at the hearing will be Mark and Julie Fiedelholtz, whose three month old son died the first day he was left at a licensed Florida day care facility. The hearing will examine such quality issues as: the status of child care in the U.S., licensing and accreditation, and efforts to improve child care.

Witness

Panel One
Parents of a child who died during the initial visit to a home child care provider.

Mark and Julie Fiedelholtz, Pembroke Pines, Fl 33024
(Accompanied by:)
Senator Connie Mack (R-FL)
Senator Bob Graham (D-FL)
Congressman Benjamin A. Gilman (R-20-NY)
Congressman Peter Deutsch (D-20-FL)

Panel Two
Discussion of existing efforts to improve the quality of child care on the state level and in the private, business sectors.

J.T. (Ted) Childs, Vice President for Global Workforce Diversity, IBM Corp., North Tarrytown, N.Y.
William Waldman, Commissioner, New Jersey Department of Human Services, Trenton, N.J.

(More)

Panel Three

Discussion of current status of child care in terms of quality and availability of high quality child care.

Deborah Lowe Vandell, Ph. D., Principal Investigator, University of Wisconsin, representing the NICHD Early Child Care Research Network.
James M. Poole, MD, representing the American Academy of Pediatrics.
Lynn Behrmann, Family Child Care Provider, Manchester, CT.

###

JIM
JEFFORDS

UNITED STATES SENATOR • VERMONT

For Immediate Release
July 17, 1997

Contact: Joe Karpinski
(202) 224-6770

Opening Statement
Senator James M. Jeffords, Chairman
Hearing on Improving the Quality of Child Care

I want to welcome everyone to this important hearing on improving the quality of child care. I am pleased to have each of our witnesses here and look forward to hearing their testimony. I am especially honored to have Senator Mack, Senator Graham, Congressman Gilman, and Congressman Deutsch take time out of their busy schedules to join us today.

Today, there are more than 12 million children under the age of five----including half of all infants less than a year old---who spend at least part of their day being cared for by someone other than their parents. There are millions more school-aged children under the age of twelve who are in some form of child care at the beginning and end of the school day as well as during school holidays and vacations. And more six to twelve year olds who are latchkey kids---returning home from school to no supervision because parents are working and there are few, if any, alternatives.

Mothers working full-or part time, dual-income families, and single parents with children are now the norm in America. For most families, the need for child care is not choice, but an essential element of their economic survival. For parents who must work, good child care services---child care that is dependable, affordable, convenient, and of high quality---are critical for the family to reach and maintain economic self-sufficiency.

Steady increases in the number of employed women with young children, combined with last year's welfare reforms have placed tremendous pressures on communities to dramatically expand the amount of available child care. While the supply of child care has increased over the past 10 years, there are still significant shortages for parents in rural areas, those with school-aged children or infants, and for lower-income families.

(More)

I believe that few of us know how much child care costs. For a 3- to 4-year-old, which is the least expensive age group, the national average for center-based child care is $4,600 a year. The average cost for high quality care is between $8,500 and $9,100 a year. The cost for family-based child care is generally less expensive, but still a big chunk out of a family's budget.

A family normally spends about twenty-percent of its income on housing and ten-percent on food. The costs of child care for a low- or middle-income family can rival the cost of housing and be double the cost of food. Even though most of us recognize the critical part that child care plays in the economic survival of families, we often fail to recognize it as a basic cost which consumes a significant portion of a family's income.

While the cost of child care has risen about six-percent annually since 1990, there are strong indicators that the quality of child care has significantly decreased during that same period of time. Parents are paying more but getting less.

The quality of child care in America is very troubling. A recent nationwide study found that forty-percent of the child care provided to infants in child care centers was potentially injurious. Fifteen-percent of center-based child care for pre-schoolers is so bad that a child's health and safety are threatened. This study focused on center-based child care, the most heavily regulated and frequently monitored type of child care. Care for children in less regulated settings is predicted to be much worse.

Combining the research on the quality of child care with the recent breakthroughs on the development of the human brain produces a very disturbing picture. Many children enter child care by eleven weeks of age, are in care for close to 30 hours a week, and often stay in some form of child care until they enter school. During that same period of life, a child's brain is undergoing a series of extraordinary changes---building the foundation for future learning and development.

I know all parents want their children to be safe and nurtured---helped to grow and develop---while they are at work. But parents can only purchase the child care they can afford. Those who do find care that is affordable and convenient are often unsatisfied with the quality of care their child receives. In fact, one quarter of all parents would change their child care arrangement if they could find and afford something better.

For most American working families good quality child care is not readily available or easily affordable--regardless of whether they want to have their child cared for in a family-based setting, in their own homes, or in a child care center. And if you cannot find quality care or afford to purchase that care—your choices for your child are severely limited.

That is why I introduced the CIDCARE (kid-care) Act today with Senator Dodd. The formal name of the legislation is "Creating Improved Delivery of Child Care: Affordable, Reliable, and Educational Act of 1997"—CIDCARE. There is no single factor which ensures the quality of child care, but rather a combination of factors. Child care that makes the healthy development and education of children its first objective. The CIDCARE Act incorporates what we know into a multi-level approach for improving the quality of child care—so that parents will have a <u>real</u> choice.

This legislation combines a number of elements into a comprehensive package to improve the quality of child care, including:

- modifications to the tax code,
- an incentive grant program for states, which includes a grant program to encourage small business partnerships to provide employee child care and wage subsidies for child care providers who get additional training and education,
- a technologically-based infra-structure for the professional development of child care providers,
- educational loan forgiveness for child care providers,
- requirements that states include the cost of child care in the calculation of child support orders,
- expansion of the federal government's technical assistance and information dissemination role, and
- requirements that child care centers located in federal facilities meet high quality standards of care,

Each of the provisions has been included to solve a specific problem that has been a barrier to improvements in the quality of child care. Taken as a whole, these provisions represent a cohesive, focused effort to increase the supply—while simultaneously creating a demand—for high-quality child care. And at the same time, CIDCARE makes high quality child care affordable for low-and middle-income families.

(More)

To offset the cost of these changes, the bill reduces, but does not eliminate, the dependent care tax credit for upper-income taxpayers. Over five years, it gradually decreases the amount that an employee can place in a dependent care assistance plan used to reimburse non-accredited or non-credential child care. In addition, the bill expands the coordinated enforcement efforts of the Internal Revenue Service and the HHS Office of Child Support Enforcement, which will significantly reduce the amount of fraud related to illegal tax deduction and credit claims by non-custodial, non-contributing parents.

The need for high-quality child care is compelling. Having affordable, convenient child care is tied directly to a family's ability to produce income. Good child care can be an effective way to support the healthy development of children, particularly in the acquisition of social and language skills. For the millions of children who spend much of their pre-school lives and non-school hours being cared for by someone other than their parents, child care provides the foundation upon which all future education will be built---and determines to a significant extent whether that foundation will be strong or weak.

As we all know, quality child care costs money. It costs money to parents who bear the biggest burden for the cost of child care. It costs businesses both through the direct assistance that they provide to employees to help with the costs of child care, and through their ability to hire and retain a skilled workforce. It costs government through existing tax provisions, direct spending, and discretionary spending targeted at child care.

But the costs of not making this investment are even higher. Those costs can be measured in the expense of remedial education, the expansion of an unskilled labor force, the increase in prison populations, and most importantly, the blunted potential of millions of children.

Through the testimony of our witnesses today, and the comments of those who have contributed written testimony we may discover even more ways that the federal government can effectively improve the quality of child care for our children. To quote *Time* magazine, "Good, affordable day care is...essential brain food for the next generation."

###

PETER DEUTSCH
20TH DISTRICT, FLORIDA

COMMITTEE ON COMMERCE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

SUBCOMMITTEE ON ENERGY AND POWER

SUBCOMMITTEE ON FINANCE AND HAZARDOUS MATERIALS

Congress of the United States
House of Representatives
Washington, DC 20515–0920

MAILING ADDRESS
204 CANNON HOUSE OFFICE BLDG.
WASHINGTON, DC 20515
(202) 225–7931
(202) 225–8456 (FAX)
E-MAIL: pdeutsch@hr.house.gov

MAIN DISTRICT OFFICE
10100 PINES BLVD.
PEMBROKE PINES, FL 33026
(954) 437–3936
(954) 437–4776 (FAX)

DADE (305) 371–8721
KEY LARGO (305) 852–0159
BIG PINE (305) 872–3916
KEY WEST (305) 294–5815

Testimony of Representative Peter Deutsch

Senate Committee on Labor and Human Resources

June 17, 1997

Mr. Chairman and Members of the Committee, I would like to thank you for having me here today, and I would like to thank Mark and Julie Fiedleholtz who have traveled from Plantation, Florida to offer their testimony regarding the tragic loss of their young son in a day care center.

The time has come for this Congress to reexamine the state of child care in America. Although the states retain jurisdiction over setting child care standards, Congress can and should take action to encourage the use and support of licensed, accredited child care; funding for accelerated training and information dissemination; and the general increase of quality, affordable care.

Child care standards in Florida are more stringent than those in many other states. Furthermore, Broward County, where the Fiedleholtz Family and I reside, is one of four Florida counties to enact even tougher local regulations pertaining to licensure for family child care centers. Yet even under these circumstances, tragedy occurred. The experience of the Fiedleholtz Family reminds us of the need for a national effort to ensure quality care, effective standards, and sufficient training.

For these reasons, I have joined my colleague, Representative Gilman, in sponsoring the CIDCARE Act to address the issue of quality in America's child care system. I reiterate my thanks to the Committee and my support and appreciation of the Fiedleholtz Family for their courage in testifying here and for their efforts to ensure the safety of day care for all children.

Testimony For The Senate Labor and Human Resources Committee

July 17, 1997

On

The Tragic Death Of Jeremy Fiedelholtz At Daycare

by

Julie and Mark Fiedelholtz
Plantation, Florida

Introduction

Mr. Chairman and members of the committee, the Fiedelholtz family would like to thank you for the opportunity to discuss our 3 month old son's tragic death after his first two hours of daycare and the national ramifications of this incident.

As American citizens we feel a moral obligation to shed light on a growing daycare safety problem in this country. We offer this testimony because of our deep faith in America and to insure that no other children die like Jeremy.

Historically, we are a country of constant change. Our system is designed to accommodate these changes and move forward. America is not afraid of change because we know without it, our society can't grow and prosper. Although we tend to initially resist change, America has a proud history of forging ahead. "There is nothing more permanent except change" (Heraclitus)

This hearing marks a new era in child care. As we move into the next millennium, our country faces many difficult challenges. One monumental challenge is the composition of America's workplace. Women now comprise a significant portion of the workforce and are important contributors in both the private and public sector.

Jeremy's story sheds light on fundamental perceptual problems regarding our view of daycare in America. This perception problem has cost the lives of many innocent children and must be changed quickly. Anyone who defers or decides to abandon this problem, is signing a death warrant for our children. Jeremy died from two episodes of neglect; he was neglected at a daycare center and neglected by an unregulated daycare system that is harming and killing our children.

Jeremy's Background

Jeremy Fiedelholtz was born on October 24, 1996 around 11:00p.m. at Plantation General Hospital in Plantation, Florida. Jeremy weighed 8 pounds and 2 ounces at birth and had no major medical problems during his short three month life span.

Prior to Jeremy's daycare center tragedy, he just starting smiling and was very playful. His favorite activity was looking in the mirror and playing with plastic figures that were attached to a vibrating chair. We adored this boy and showered him with great love and supervision. Jeremy was Mr. Fiedelholtz's first biological child and Mrs. Fiedelholtz's second child. Her first son Jonathan is 13 and loved Jeremy very much.

Mrs. Schwartzberg told us the following about her licensed daycare center:

1) Jeremy would be the 4th child with a few drop offs
2) Only the licensed room we saw would be used for daycare
3) Mrs. Schwartzberg has a permanent helper who is certified in CPR
4) Her permanent helper Cheryl Lavigne will run all the errands

After this meeting we did a civil and criminal background check, called references and was informed by Broward County licensing that no complaints were filed against the Schwartzberg daycare center. Based on our thorough background check, and the meeting with Mrs. Schwartzberg, we decided to try out her daycare for two hours.

A Fatal Decision

On January 29, 1997 at 9:00 a.m. Mr. Fiedelholtz called the Schwartzberg daycare center to see if there was enough room for Jeremy that day. The helper Cheryl Lavigne said, "yes, there is plenty of room". Based on that phone call, Mrs. Fiedelholtz took Jeremy to Mrs. Schwartzberg's daycare center around 10:00 a.m. Upon her arrival she saw only two children and figured everything was fine. Mrs. Fiedelholtz gave Mrs. Schwartzberg a few directions and then left the daycare center.

When Mr. Fiedelholtz arrived at the Schwartzberg home, Mrs. Schwartzberg was just pulling into the driveway. According to the police report she left for an errand to go to the supermarket for 45 minutes. Mrs. Schwartzberg went into the house and never spoke to the Fiedelholtz's again.

Lies, Ignorance, and Greed Suffocate Jeremy Fiedelholtz

It wasn't until the afternoon of January 29, 1997 that we found out the Schwartzberg daycare center was a death trap. Human Resource Service investigator Roy Chandler came to interview us at the hospital. We really didn't understand why he was there, but we assumed it was routine because the incident involved a child. The information that Mr. Chandler told us, would change our lives forever and shatter our faith in the American daycare system.

A Meat Market Mentality

When we decided to take Jeremy to Mrs. Schwartzberg's daycare center we based our decision on three criteria; our background check, tour of the facilities and meeting with Mrs. Schwartzberg. Everything Mrs. Schwartzberg told us about her daycare center was a lie and her motive was to procure our business at any cost. Mrs. Schwartzberg charged $125 per week. Mrs. Schwartzberg broke the law by having nine children over the legal limit of four infants. She more than tripled her income by violating the law:

Breaking The Law	vs.	Following The Law
13 x $125 = $1625		4 x $125 = $500

The next page shows the incredible lies Mrs. Schwartzberg told the Fiedelholtz's.

It was also discovered Mrs. Schwartzberg knew that Mrs. Lavigne couldn't run errands because she had a restricted drivers license. Additionally, Mrs. Schwartzberg knew that helper Lavigne was suffering from fainting spells. She had gone to the doctor for this problem.

Promise: Mrs. Schwartzberg said that helper Lavigne was certified in CPR and was fully qualified according to Broward County Licensing standards.

Truth: The licensing investigator found helper Lavigne was not certified in CPR and was not a qualified substitute. Mrs. Lavigne is also accused of giving a false social security number on her criminal background check.

Mrs. Schwartzberg's license was suspended. Inorder to avoid testifying at a revocation hearing she surrendered her license. Mrs. Schwartzberg and Mrs. Lavigne have refused to talk to police, the medical examiner or anyone else regarding Jeremy's death. Although the medical examiner's report hadn't been completed, Mrs. Schwartzberg told the parents we brought a very sick baby to her daycare. This statement contradicts what she told the licensing investigator. Mrs. Schwartzberg said, "Jeremy looked fine before she left for the supermarket." It was later determined by the medical examiner's office that Jeremy was a healthy boy but he suffocated.

A Cold Response

We knew neither Mrs. Schwartzberg nor Mrs. Lavigne would take responsibility for the lies to parents and dangerous conditions in their daycare center. But, we did expect some form of condolence for Jeremy's death, it never happened. Once Mrs. Schwartzberg came back from the supermarket, she immediately contacted her lawyer and we never heard from her or Mrs. Lavigne again. This woman and her helper gambled on the lives of 13 beautiful children and one died. However, she refused to show any humanity by at least sending formal condolences to the Fiedelholtz's.

More Neglect

At the time of writing this testimony, neither Mrs. Schwartzberg nor Mrs. Lavigne have been charged by the Broward County Attorney's Office. Although they have been actively investigating this case over three months, no charges have been filed. Since there are no criminal penalties for daycare violations, Mrs. Schwartzberg's only penalty has been a $100 fine. This illustrates how archaic the daycare laws are in this country.

The direct evidence is overwhelming that Mrs. Schwartzberg and Mrs. Lavigne conspired to defraud the Fiedelholtz's and other parents at their daycare center to procure their business. The violations Mrs. Schwartzberg was cited for by Broward County are extremely serious and strike at the heart of daycare. If you don't have supervision you don't have daycare. Mrs. Schwartzberg and Mrs. Lavigne's reckless behavior placed all 13 children in jeopardy that day.

Unfortunately, this type of mentality is prevalent throughout the country. When it comes to abuse or neglect cases at daycare centers, our children fall victim to the smothering political ambitions of prosecutors and their staff. Traditionally, prosecutors would shy away from these cases calling them an unfortunate accident. However, times are changing and District Attorney's are starting to recognize that juries will not tolerate the neglect or abuse of children from anyone. This is especially true of a daycare operator who has a higher duty of care to supervise and protect children.

Time For Change

Jeremy's story resonates loudly that something has to be done to stop the abuse and neglect of children at daycare. Thinking a woman or mother wouldn't hurt children and possesses an innate ability to care for kids is wrong. It's this mentality that has caused us to avoid regulating daycare which has resulted in scores of senseless deaths or abuse. Many daycare operators are using our children as pawns in a get rich scheme.

Parents are so worried about daycare, that it's a good day when their child hasn't been sexually molested or physically harmed at daycare. Even after Jeremy's death, many of the parents at the Schwartzberg daycare center said they would go back. This type of ignorance is what daycare operators feed on.

State daycare regulations are embarrassing. For instance in our state of Florida, you can take a three hour course, have a criminal and civil background check, pay a $25 application fee and your now a bona fide daycare operator. Fifty seven out of sixty seven counties could have licensing procedures but don't.

In Illinois, state officials want to give welfare moms a 4 month training course and presto, they are daycare operators. With all due respect to these people, many of the welfare moms are just starting to acquire the basic skills of reading and writing. This is a clear example of how the states are always looking for a quick fix.

In a 1996 study of Family Child Care in America by the Children's Foundation, it clearly shows the lack of uniformity in state daycare regulations:

Only 18 states require daycare licensing exclusively.

Only 23 states require regulated daycare providers to attend an orientation session.

Only 39 states require regulated daycare providers to have CPR/First Aid Training.

Only 42 states require more than basic CPR/First Aid training for regulated providers.

Only 32 states require unannounced inspection visits in response to a complaint.

Daycare Operator Educational Requirements

All daycare operators and staff must take a 40 hour substantive course with a heavy medical component. This is a uniform course that every accreditation center offers. The course can be offered through distant learning such as the internet, video training or traditional classroom style.

The substance of the course is divided into three parts:

First, medical training on infants, toddlers and older children. The curriculum supersedes the basic CPR/First Aid course. Verification of knowledge is measured by various written and role-playing tests.

Second, a thorough knowledge of state daycare laws. Daycare operators and staff will be trained on adult-child ratios, inspections, business practices and criminal penalties.

Third, all students have to show practical knowledge of their skills in a realistic crisis and non-crisis situation. Failure to pass this test means the daycare operator does not obtain a license. The days of ignorant daycare operators receiving licenses are over.

On the issue of retraining, daycare operators and staff must take a sixteen hour mandated retraining course every year with testing. Failure to meet this requirement means immediate suspension of an operator's daycare license.

Parent's Awareness

All the previous requirements are crucial, but parent awareness is essential to the success of this bill. Parents must be educated about daycare laws and procedures. All credentials need to be verified before the child comes to the center. Promises by the daycare operator must be authenticated. Quiz the daycare operator about fundamental daycare procedures. If they don't know or are unsure about these questions, don't take your child to that center. Additionally, visit the daycare center a few times before you bring your child there.

All daycare operators must hand out a brochure explaining the state's laws on ratios, inspections and other relevant issues. In addition to the brochure, the operator will give a parent the following:

* Educational Credentials (all formal education and child care classes)
* Copy of operators license, certifications and all staff certifications
* Disclosure of complaints or signed affidavit of no complaints
* Demonstrate skills to parents in CPR/First Aid on a toy doll
* The right to quiz the operator on fundamental daycare principles
* The right to inspect the entire facility during business hours.

These steps can't always overcome complex schemes like the Schwartzberg daycare center. But, it can reduce these type of daycare operators from flourishing.

Statement of

Mr. Ted Childs, Jr.

Vice President, Global Workforce Diversity, IBM Corporation

on the

American Business Collaboration for Quality Dependent Care
(ABC) Child Care Initiative

before the

United States Senate Committee
on Labor and Human Resources

July 17, 1997

IBM Written Statement

Mr. Chairman and Members of the Committee, my name is Ted Childs, Jr., and I am responsible for Global Workforce Diversity for the IBM Corporation. I want to thank you for the opportunity to appear before you today to describe what we at IBM have been doing to help make child care available where our employees live, and the collaborative effort we and 21 other companies have been involved in for the last five years. I will discuss this program, which is called the American Business Collaboration for Quality Dependent Care (ABC), in more detail later in my testimony. Let me begin, however, by sharing IBM's experience with you.

IBM Experience

IBM has long been recognized for addressing our employees' personal issues and needs and providing them with benefits that will enable them to come to work and be productive. IBM was one of the first companies in the 1930s to offer employees paid vacation plans and retirement benefits. We began offering employees medical benefits in the 1940s and have offered leaves of absence since the fifties. We have also been leaders in recruiting and maintaining a diverse workforce, from hiring our first disabled employee in 1914, hiring women in professional positions in 1935 (with a written commitment of equal pay for the same tasks), and hiring our first African-American salespersons in the 1940s. In addition to our Human Resources Programs, IBM has had a corporate commitment to education which we have supported for many years. In 1944, IBM was the first corporation to provide support to the United Negro College Fund. In 1994, we announced our "Reinventing Education" program which was started with a $25 million grant in ten cities.

IBM has been recognized for our innovative and effective worklife programs by Working Mother Magazine as part of its "Best Companies for Working Mothers" list. IBM is the only company that has appeared on Working Mother's "Best Companies" list the eleven years that they have compiled this and on the Top 10 list of companies all nine years that they have offered this designation. IBM Chairman and Chief Executive Officer Louis V. Gerstner, Jr., was recognized by Working Mother as the "Family Champion" in 1995. In February 1997, Working Mother listed the 25 Most Influential Working Mothers and IBM General Manager Linda

Over 500 projects were funded in the first five years of the FDCI program. Some examples of these include child care centers, family child care recruitment, summer camps, provider training, and adult day care.

In 1995, IBM replenished the FDCI at the rate of $50 million for the years 1995-2000. This was put in place to reach more communities and to address the needs in some of the original communities that had not been met. Between 1990-1994, IBM invested in 57 communities. The company provided funding for child care center development or expansion in 27 communities and funding for child care training and accreditation in 36 communities.

In the projects funded by IBM, we have a special requirement that any participating child care center is contractually obligated to meet, or begin work towards meeting, the accreditation requirements set forth by the National Association for the Education of Young Children (NAEYC). The NAEYC standards call for, among other things, compliance with specific staff/child ratios, training requirements and specific curriculum guidelines. The NAEYC conducts on-site inspections of centers prior to accreditation. These centers must then be re-accredited every three years. IBM has also funded accreditation projects in 21 communities that bring 20 child care centers together and provide them with guidance about how to go about the accreditation process. IBM provides funding for the training of child care providers, child care center directors and staff. This training is designed to move these centers to meet the accreditation requirements and includes training on curriculum, health and safety and business management.

In order to improve the services offered at centers, IBM provides computers to be used in the classroom of the child care centers. These are the latest technology loaded with age-appropriate software for use by the children enrolled. Any center receiving funding from IBM will have a contractual relationship with our dependent care vendor, Work/Family Directions, a nationally recognized dependent care consultant who monitors the centers and receives periodic reports from them. This organization has employees qualified to deal with any quality, business management and customer relations issues that the centers may have to handle. The centers also receive technical assistance from Work/Family Directions as part of this relationship.

Where there was insufficient child care in a community, efforts were made to increase the supply. Since this child care resource and referral program began in 1984, over 100,000 IBM employees have used these services. Over the years, this service has expanded to address additional employee needs such as adoption assistance, school achievement, and college selection. An Elder Care Consultation

Why Quality Child Care Is A Good Investment

IBM's referral service and the Funds for Dependent Care Initiatives (FDCI) are critical in addressing the needs of its employees. We continue to sponsor these programs because they help our employees meet their personal responsibilities while being productive and effective at work. Recruitment, retention and advancement of women have been greatly enhanced as a result of these programs. The percentage of women at IBM is at its highest level in the history of the company. IBM also has its highest level number of women senior managers and women executives.

However, these programs help not only our women employees but all employees who have dependent care issues or challenges in balancing work and personal responsibilities. These programs have been instrumental in helping the IBM Corporation execute the change in culture it needs in order for it to be profitable in the current economic environment.

As a company, IBM believes that funding development of child care resources is a good investment for a number of reasons. Our employees want good quality care for their children, and greater choice of care goes a long way toward easing their minds and enabling them to concentrate and be more productive at work. And as important, we believe that stimulating the supply of quality child care is an integral part of our company's commitment to education, and we believe it is essential to educating the workforce of tomorrow.

We are committed to the use of technology to provide quality child care. For example, IBM is involved in a partnership to market a product called "I SEE YOU." This product allows an employee to view their child at day care through the Internet. When this system is installed in a child care center, a parent can access a secure Internet location that allows them to see what their child is doing and be able to participate in the activities that their child is experiencing, even though the parent is at work. The parent will be able to look at still photos of their child's classroom that are updated every 30 seconds.

American Business Collaboration for Quality Dependent Care (ABC)

Through our experience in helping make child care more available in communities where our employees live and work in the late 1980s, we quickly

Today, the ABC project is on target to invest the $100 million, and it hopes to exceed that goal. The number of Champion companies has increased from 11 to 22, and the project is still talking with other companies who may be interested in joining at the Champion level. It has reached many new communities, many that do not have major ABC company installations or employees. The Championship models will be used to reach many more communities.

One example of the Championship model program is the Bridge Project, a voice messaging system for schools. Specifically, the Bridge Project allows teachers and school administrators to develop customized messages about home- work assignments and school activities which can be accessed by parents at any time of the day. This is a real plus for working parents. The Bridge Project has been installed in over 100 schools in 10 communities. They include Charlotte, North Carolina; Naperville, Illinois; Prince William County, Virginia; San Jose, California; Yonkers, New York; Poughkeepsie, New York; Bridgewater, New Jersey; Cobb County, Georgia; Roseville, California; and Stamford, Connecticut.

In the planning for the second phase of the ABC, for the years 1995-2000, our companies looked at what had been learned from their experience during the first two years and concluded the following:

- When better quality care is available, parents will pay for it;

- Child care centers require thoughtful planning and implementation;

- Local involvement helps ensure success; and

- Care for school-age children has been overlooked and needs attention.

One recent project which ABC partners are deeply involved in and is particularly close to our hearts is called the "I Am Your Child" national campaign. All of ABC's 22 champion companies have provided funding to ensure that materials from this campaign will be sent to the child care providers who have received funding in the past through ABC funded programs.

In addition, IBM and Price Waterhouse are funding the development and distribution of a CD-ROM for parents of children aged zero to three years. This program will provide information about the new brain research, information about

childhood education should be offered to help raise the professionalism of this field.

4. Congress should encourage the states to adopt high standards for child care (child care ratios for children/teachers, curriculum requirements, training for teachers, NAEYC accreditation standards, etc.).

Thank you for your time and consideration.

Department of Human Services
State of New Jersey
Testimony for
William Waldman, Commissioner,
before the
Senate Committee on Labor and Human Resources
Dirksen Senate Office Building, Room SD-430
Thursday, July 17, 1997
2:00 p.m.

Good afternoon. Thank you for this opportunity to share current information about child care in New Jersey with the Senate Committee on Labor and Human Resources. We are proud of our accomplishments in this area.

I realize there is concern that with the rush to reform welfare the states may reduce the quality for child care.

That is not true in New Jersey. In fact it is just the opposite. The flexibility granted in the welfare and child care block grants has helped us fashion a new child care system that both expands child care and improves quality. The urgent need to place welfare recipients in jobs before their five year time limit expires has highlighted the importance of child care for them as well as for low income families not on welfare to prevent their dependence.

The State of New Jersey carries out its child care policies based on the following principles:

State policies for child care must address the needs of all families in the state, with an emphasis on families who have the greatest need in terms of ability to pay, child care program availability and special needs of the children. All children and families deserve basic information about how to locate and select child care programs that meet their needs.

Families have the primary responsibility for caring for their children and have the right to choose the caregiver they want for their children. The State has the responsibility to protect the safety and health of all children in child care programs.

The State will offer child care subsidies to eligible families based on family size and income. Families are eligible for a subsidy if their gross income is below 200% of the Federal Poverty Index. Below the 200% eligibility level, families at or below 150% will have first priority, those between 151% and 175% will have second priority, and those between 176% and 200% lowest priority. Families above 250% are not eligible.

The State will support the current child care infrastructure by maintaining our child care contract system with 215 child care centers as well as a voucher system. The same eligibility requirements and reimbursement rates will apply to both contracts and to vouchers.

The State will work cooperatively with the community to establish child care policies. The State will promote the expansion of collaborative efforts among agencies responsible for delivering early childhood programs to children and families. This would include child care programs, Head Start, public school districts, employers and all levels of government.

The State will pay the same reimbursement rate to contracted child care centers as it does through the voucher system. The rate for centers will be composed of a state payment, a local match requirement and parent copayment fees. Parents receiving vouchers will pay the same copayment fee as parents in contracted programs.

Current Child Care Highlights

It has been an extraordinary year for child care in our state:

This year Governor Whitman announced "Bright Beginnings," a $8.5 million early childhood initiative in April, to expand and improve the quality of child care services and encourage collaboration among the groups and agencies involved with children.

"Bright Beginnings" will increase the number of registered family day care providers by reducing the waiting list for registration as a provider in each county. It will provide parent consumer education services on both a statewide and county-wide basis.

"Bright Beginnings" will expand child care facilities for young children through grants and low-interest revolving loans. All regulated child care programs are eligible to apply.

It will provide partnership grants to bring together various providers of early childhood programs: public schools, Head Start, child care programs, and our single county agency for child care service delivery.

"Bright Beginnings" will support the professional development of child care staff. It creates a statewide professional development center and provides scholarships and grants for educational activities that lead to credentials or accreditation.

"Bright Beginnings" is expected to create over 8,500 new child care spaces statewide. We anticipate that it will serve as a catalyst for further initiatives to serve young children and their families.

The Department of Human Services recently completed a year-long public process to redesign the subsidized child care system and provide more services to more families. The process involved 40 meetings and took testimony and comments from over 1,000 persons and organizations. Governor Whitman used many of the recommendations from these meetings to inform her "Bright Beginnings" initiative.

In December, 1996, the Department of Education announced the commitment of $288 million annually to 125 low-income school districts to establish full-day kindergartens and prekindergartens over a five-year period. My Department is working closely with the Department of Education and the federal government to encourage the most effective use of these and other early childhood funds.

DHS was pleased to learn that the most recent Head Start Expansion Grant will bring nearly $3.5 million into New Jersey in new money for early childhood programs. We were gratified that collaboration with members of the child care community was a priority in reviewing the proposals.

The Advisory Council on Women of the General Assembly held two public hearings on child care issues in October 1996 and May 1997. Legislation introduced as a result of the hearings is presently under review by the Department and the Child Care Advisory Council.

The New Jersey Child Care Advisory Council took the lead in preparing the final report of Sows the Seeds for Growth: An Early Childhood Professional Development Plan in collaboration with five state departments and representatives of the business, higher education and early childhood communities,. A request for proposals will be issued later this year to establish a Center for Early Childhood Professional Development.

The Woodrow Wilson School of Public and International Affairs of Princeton University held an Early Childhood Symposium in April. The Symposium brought together researchers, employers, elected officials, state policy makers, representatives of Head Start, and the wider child care community.

Today, I would like to speak to three key topics regarding quality child care: Child Care Subsidies, Child Care Regulations, and Professional Development Issues. Each of these target areas is a focus for New Jersey because each impacts directly on the availability, affordability and quality of child care.

Child Care Subsidies

New Jersey currently projects its FY 1998 spending of State and Federal funds for child care at $121,101,000. These funds subsidize 49,510 children. This figure is subject to change based on client participation rates and type of child care arrangement needed. Our reimbursement rates are based on a sliding fee scale and are determined by age of child, the type of child care used and the amount of time child care is needed. In addition to State-administered funds, Federally-funded Head Start programs in New Jersey serve over 12,000 children at a cost of $76 million.

New Jersey is presently exploring the full range of possible sources for short-term and long-range funding for child care. As a result of our redesign of the subsidized child care system, we expanded our search for resources beyond the Department and beyond State and Federal government subsidies. In November 1996, the New Jersey Child Care Advisory Council sponsored a one-day roundtable at the Eagleton Institute at Rutgers University. This meeting led to the formation of the Resource Development Committee. The Committee is working with DHS and others to identify all possible sources of child care support and will meet with a national consultant on child care financing later this summer to develop a cohesive, long-range plan for financing child care.

DHS redesigned the subsidized child care system by means of a year-long public process. This process resulted in the following improvements.

There will be a two year, post-TANF, transitional child care (TCC) subsidy available to working parents who have left welfare. This is an important part of our Work First New Jersey welfare reform program and doubles the previous TCC of one year.

We redesigned our child care delivery system, including child care resource and referral services (CCR&R). We reduced from over 30 contracts to 16 and contracted with a single agency in each of our 21 counties to carry out a range of child care services. These services include voucher management for welfare and low-income families, CCR&R services, the family day care provider registration process, and the promotion of child care as an employment opportunity. This streamlining of the child care system resulted in a savings of $8 million which we reinvested in child care.

We set our eligibility entrance for child care subsidy at 200% of the federal poverty index and set priority tiers at 150% and 175%. Families exit the subsidy system at 250% of FPL

We committed to maintain a two-part subsidized system: contracts and vouchers. We contract with over 200 community-based centers and

provide vouchers to families based on a county-based formula. We have contracts with 215 non-profit, community-based child care centers serving approximately 12,000 eligible children in centers in their own neighborhoods.

The process also indicated some areas that will require further work and study.

Our research on subsidies has targeted two major subsidy areas: reimbursement rates and the subsidy waiting list. These reflect the concern raised earlier in our redesign process: whether or not programs are being paid enough to do a quality job with our children and the extent to which we can meet the needs of both welfare recipients and low-income working parents.

Over time, the administration of child care services has transferred from the Division of Youth and Family Services to the Division of Family Development. In the near future, we expect that the contracting management for the State-contracted centers will move to the Division of Family Development as well. The responsibility for child care regulations is assigned to the Division of Youth and Family Services by law and will remain there.

Child Care Regulations

New Jersey has been licensing child care centers since 1946 and has been registering family day care providers on a voluntary basis since 1987. The Bureau of Licensing in the Division of Youth and Family Services is responsible for child care regulation. We are particularly proud of the licensing regulations, and, in particular, of the process by which the regulations are periodically reviewed.

The purpose of child care regulations is to balance the safety, health and development of children with the programmatic design of the child care program. Regulations are an important safeguard for children in child care and we pay a lot of attention to the process of developing, implementing and improving them.

Regulations limit the number of children served in a program and the number of children for whom a staff member can be responsible. Some persons outside the child care community have suggested that the way to increase the availability of child care is to lower the regulatory requirements. New Jersey will not lower its current requirements. Licensing laws and regulations represent the a consensus among interested parties of what is required to safeguard the lives and contribute to the development of young children. There can be no compromise on this issue.

In our most recent periodic review of our child care regulations, several significant changes have been recommended for final public review, including an annual staff development requirement for all staff directly involved with children and an improved child-staff ratio for four-year-olds. This review was carried out by the Bureau of Licensing staff and involved over 25 members of the community representing all types of child care programs

In a move to increase the contact between licensing regulators and the centers they inspect, DYFS Bureau of Licensing staff will begin to visit centers every 18-months, rather than every three years. Presently, two inspections are made at the time of licensing renewal: a site inspection and a program review.

Beginning in September, the Bureau will send the site inspector out to determine compliance with building codes. Approximately 18 months later, the program inspector will visit the center. In either case, if any problems are noted, the relevant inspector will visit to the center immediately. The Department will continue to examine the current policy to see how well it is working. We have recently made arrangements to add more inspectors to the DYFS Bureau of Licensing staff.

Approved Homes

In 1987, New Jersey began its REACH welfare reform program and offered parents the option of selecting their own child caregiver. With the advent of the 1990 Child Care Development Block Grant (CCDBG), the federal government required an approval process for this form of child care.

New Jersey established requirements for approved homes at that time. After a parent identifies their provider, a site inspection is required. The number of children cared for is limited, no referrals are made to the provider, and the reimbursement rate is 60% of the family child care rate.

The results of a 1990 New Jersey research study showed that approved home providers are usually family members or friends who want to help out, that they usually maintain compliance with the enrollment requirements, and that they meet with the approval of parents.

A committee has been established to make recommendations on how best to provide support to approved homes. We are already attempting to replicate a 1990 study on approved homes usage by the Edward J. Bloustein School of Planning and Public Policy at Rutgers, The State University. Beginning in August, a specially designed newsletter prepared by a national organization will be distributed to approved providers on a quarterly basis.

Testimony on the

NICHD Study of Early Child Care

By

Dr. Deborah Lowe Vandell

Principal Investigator of the University of Wisconsin Site

Before the

Committee on Labor and Human Resources

United States Senate

Washington, D.C.

July 17, 1997

The newsletter will include helpful information to persons who care for other people's children.

Professional Development

One of the main components of a quality child care system is the level of professional development of program staff. New Jersey has many early childhood career opportunities available and has an array of educational and staff preparation programs, both for-credit and not-for-credit.

We are committed to setting up an information system on training resources. We will be able to tell those interested in careers in early childhood education how best to pursue them.

The Center for Early Childhood Professional Development proposed by the Sows the Seeds for Growth project will be available to all early childhood professionals at every level, novice to professor. The Center is expected to address professional standards, resource development, and the establishment of a directory of early childhood professional services and a registry of early childhood professionals.

Governor Whitman's "Bright Beginnings" proposal for professional development supports the Center, by offers scholarships for early childhood students and by gives support to programs in the process of becoming accredited.

We all care about the young children in our states. We want them to grow up to be healthy contributing citizens and parents. Their future is in our hands. We leave a legacy to the world--and we need now and then to reflect on just what that legacy is. I am pleased that Governor Whitman and the New Jersey Legislature are working toward a better world for children. I feel certain that we will continue to improve our child care system.

I am available for any questions you may have. Thank you again for this opportunity to talk with you about this important issue.

Good afternoon, Mr. Chairman and members of the Committee. I am Dr. Deborah Lowe Vandell, Professor of Educational Psychology at the University of Wisconsin at Madison. I am an investigator with the Study of Early Child Care funded by the National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health. It is a pleasure to be here.

Today I would like briefly to describe the NICHD Study and then present recent findings from the Study that are relevant to Committee's consideration of how to improve the quality of child care. The first set of findings pertains to structural and caregiver characteristics that are associated with the quality of care received by infants in different types of child care settings. The second set of findings relates to the effects of positive caregiving quality on children's cognitive development and attachment to mother.

Over the last two decades, researchers have sought to determine the effects of early child care on young children. Some researchers presented evidence that early and extensive nonmaternal child care pose risks for infants. Others showed that children thrive in child care so long as the quality of care is high. Still others argued that early experiences do not affect children's development, unless the experiences are characterized by extreme deprivation. There were data to support each position. The public was confused.

Why was there so much disagreement about the effects of child care? First, the research studies were not large enough to take into account all of the critical family, child and

child-care characteristics that influence the development of young children. Conclusions about the effects of early child care were based on small samples of primarily white children, most from middle class families. Second, many of these studies were limited in that they did not take into consideration differences in the types of care or the quality of the care that children received in their mothers' absence.

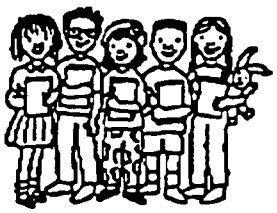
Recognizing these limitations, in 1988, there was a call for more comprehensive child care research. In response, Dr. Duane Alexander, the Director of NICHD, initiated a large scale study to examine the effects of child care, particularly infant care, on the development of children in the United States. Following stringent scientific review by independent experts, 10 teams of investigators were selected from universities and research institutes across the country. Together with the NICHD scientific program staff, these researchers became the NICHD Early Child Care Research Network. As a group, we have designed, implemented, and co-authored the NICHD Study of Early Child Care. See Figure 1 for locations of the 10 Study sites and the names and affiliations of the investigators.

The overall aim of the study has been to examine the effect of variations in early child care experiences on America's children. We recruited children and their families to participate in the study soon after birth. NICHD has made it possible for us to follow these children until the end of first grade. This study is an improvement upon all earlier studies in three ways. First, we included a diverse sample of families. Second, we measured pre-existing characteristics of the children, their mothers, and their fathers. And third, we made extensive

observations of these children's experiences at different ages and across a wide variety of child care settings.

Figure 1

NICHD Study of Early Child Care



University of Arkansas
University of California, Irvine
University of Kansas
University of Pittsburgh
Temple University

University of Virginia
University of Washington
Wellesley College
Western Carolina Center
University of Wisconsin

NICHD Early Child Care Research Network

Mark Appelbaum, University of California at San Diego
Jay Belsky, Pennsylvania State University
Cathryn Booth, University of Washington at Seattle
Celia Brownell, University of Pittsburgh
Bettye Caldwell, Arkansas Children's Hospital
Alison Clarke-Stewart, University of California at Irvine
Kaye Fendt, NICHD
Kathryn Hirsh-Pasek, Temple University
Elizabeth Jaeger, Temple University
Nancy Marshall, Wellesley College
Marion O'Brien, University of Kansas
Deborah Phillips, National Academy of Sciences
Henry N. Ricciuti, NICHD
Deborah Lowe Vandell, Univ. of Wisconsin at Madison
Marsha Weinraub, Temple University

Dee Ann Batten, Vanderbilt University
Kimberly Boller, NICHD
Robert Bradley, University of Arkansas at Little Rock
Margaret Burchinal, Frank Porter Graham Child Dev. Ctr.
Susan Campbell, University of Pittsburgh
Martha Cox, University of North Carolina at Chapel Hill
Sarah L. Friedman, NICHD
Aletha Huston, University of Texas at Austin
Bonnie Knoke, Research Triangle Institute
Kathleen McCartney, University of New Hampshire
Margaret Tresch Owen, University of Texas at Dallas
Robert Pianta, University of Virginia at Charlottesville
Susan Spieker, University Washington at Seattle
Kathleen Wallner-Allen, Research Triangle Institute

Let me begin with a brief description of the participating families and the data that are being collected. We screened nearly 9000 births at more than 24 hospitals across the 10 research sites located across the U.S. From this group, 1364 families were selected. The families were diverse. They lived in urban, suburban, and rural areas. They varied in income, ethnicity, family structure, and whether or not the mother was employed outside the home. The Study included families in which children were cared for by their mothers, as well as families of children cared for by others on a regular basis.

Children and their families were observed in their homes when the children were 1, 6, 15, 24, 36 and 54 months old. Starting at 15 months, families visited us at our laboratories. Starting at 6 months, we observed children in their child care settings. In these different settings, we have measured children's relationships with their mothers, fathers, peers, and teachers. We have measured the children's social skills and adaptive behaviors, their behavior problems, and their self concept. And, we assessed the children's general intellectual functioning, language skills and school readiness. This year, the children are turning 6 years of age, and we will be seeing them in first grade. In addition to continuing our study of the children's social, emotional, and cognitive development, we plan to examine their adjustment to school and success in first grade.

A major component of the study has been the intensive study of children's experiences in child care. At each assessment point, we recorded the number of hours of nonmaternal care children received, the stability of that care, and the type of care setting (grandparent, in-home

sitter, father, child-care home, and centers). If children were in a child-care arrangement for 10 or more hours per week, we visited them in their child care settings during two half-day visits. We recorded structural characteristics such as the number of children in the setting, the child:caregiver ratio, and the age configuration of children within the settings. We obtained information about the caregivers, such as their education and training, experience, and child-rearing beliefs. Features of the physical environment relating to health, safety, and cognitive enrichment were rated. Finally, we used highly trained observers to take extensive and detailed records of the quality and frequency of caregivers' behaviors with the study children. From these observations, we were able to rate caregivers' sensitivity to the children's needs, their warmth, and stimulation of child development. Developmental theory and previous research lead us to focus on these aspects of caregiver behavior as indications of the quality of the child care settings. We hypothesized that the quality of caregivers' interactions with the infants would contribute to the children's development.

What have we learned so far? First, the families began using nonmaternal care very early in infancy. Fully, 84% of the infants experienced nonmaternal care during the first year. On average, infants entered care at 3.1 months. At time of first entry, the average number of hours per week was 29 hours. At first entry, families used many different arrangements for infants including fathers/partners (25%), child care homes (24%), relatives including grandparents (23%), centers (12%), and in-home sitters (12%). In general, low-income children who were cared for in home settings by a family member or child-care home provider received lower quality care than other children. Poor children cared for in child-care centers

received care equivalent in quality to that received by children from more affluent families. Children just above the poverty level received lower quality care in child care centers than children in poverty, probably due to subsidies available to the low-income families that increased the quality of the care for children in poverty, bringing it up to the quality available to the more affluent.

Within infant care arrangements, we observed differences in structural features and caregiver characteristics. Infants were in groups that varied in sizes from a single child to 30 children. Child:caregiver ratios varied from one-to-one settings to one situation where 13 children were with one adult. Caregivers ranged in education from less than a high school degree to post baccalaureate work, with most caregivers having either a high school degree (34%) or some college (34%). Most of the caregivers did not have specialized training in child development (65%) or in the care of infants (71%). These differences in education and training were associated with caregivers' beliefs about child rearing. Caregivers with more training and with more education were more likely to have child-centered beliefs about child-rearing. Our two-day observations showed substantial variations in the quality of caregivers' behaviors with our study children. Whereas some caregivers were highly sensitive, positive, and emotionally engaged with the infants, others were insensitive, negative, and/or emotionally detached.

Next, we asked if the variations in structural or caregiver characteristics contributed to the quality of caregivers' behaviors with infants. We found evidence that this was the case.

Caregivers were more positive (i.e., sensitive, stimulating, warm) with infants (a) when there were smaller group sizes, (b) when child-adult ratios were smaller, and © when caregivers had child-centered beliefs about child rearing. Physical environments that were safe, clean, and contained age-appropriate toys also were associated with more positive behaviors from caregivers. These associations between structural and caregiver characteristics were found in all five types of child care settings (fathers, grandparents, in-home sitters, child-care homes, and centers), further supporting the importance of group size, ratios, and caregiver beliefs. In work to be completed this summer, we hope to extend this aspect of the study by examining the impact of structural and caregiver characteristics on the quality of observed caregiving for toddlers and preschoolers.

Let us now turn to our analyses that have examined the effects of caregiving quality on children's development. Because of time constraints, I will focus on two areas in which child care quality is associated with differences in child development during the first 3 years.

The first set of findings concerns children's cognitive and language development. Perhaps, not surprisingly, we found that family and maternal characteristics were significant predictors of children's cognitive and language outcomes at 15, 24, and 36 months. In addition, after taking these characteristics into account, we found that the child care quality defined in terms of positive caregiving quality and caregivers' language stimulation predicted children's performance on standardized cognitive and language tests at 15, 24, and 36 months. Higher quality child care predicted higher school readiness and higher language scores.

The second set of results pertains to children's attachment relationship with their mothers. Once again, we found that the mother's behavior with the child was the best predictor of infant's attachment security. Mothers of secure infants were more sensitive and better adjusted psychologically than mothers of insecure infants. We found no comparable overall effect of child care quality on children's attachment to their mothers. However, under some circumstances, child care quality was associated with attachment security. When mothers were insensitive to their children's needs AND the children were in low quality child care, the incidence of insecure attachment was elevated.

To summarize: We found substantial variations in child care quality, as reflected in the quality of caregivers' behaviors and interactions with the study children. Caregivers were more sensitive to infants' social, emotional and cognitive needs when child:caregiver ratios and group sizes were smaller, when the physical environments were safe, clean, and age-appropriate, and when caregivers had more child-supportive beliefs. The ratings of caregiving quality were related to children's language and cognitive development and, in some cases, to infants' attachment to their mothers.

This study is very much a work in progress. So far this year, our project has had 5 reports published or soon to be published in prestigious scientific journals. In addition to the findings summarized today, these reports have examined important topics such as the effects of child care hours, stability, and age of onset. Additional outcomes have included behavior problems, compliance, social competence, and mother-child interactions. We have examined

American Academy of Pediatrics

TESTIMONY

of the

AMERICAN ACADEMY OF PEDIATRICS

on

IMPROVING THE QUALITY OF CHILD CARE

before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Presented by

James M. Poole, MD, FAAP

July 17, 1997

Department of Government Liaison
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005

the effects of families' economic and psychological circumstances on child care usage. Work also has been completed regarding the child care arrangements of the poor and near poor. During the coming months, we will complete analyses examining structural and caregiver factors associated with child care quality for toddlers and preschoolers. Another paper is to examine the effects of regulable features such as child:caregiver ratio and caregiver education on children's social and cognitive outcomes. A paper examining fathers' role in early child development also is nearing completion. We would be delighted to keep the Committee informed about our results, and we welcome the opportunity to discuss these findings with you, as they become available.

On behalf of all the members of the Study Steering Committee and the many families who are participating in this research, I thank you for inviting us to report these initial findings. I would be pleased to answer any questions you may have.

Good afternoon Mr. Chairman. Members of the Committee. Thank you for the opportunity to testify today about the quality of child care in this country. My name is James M. Poole and I am testifying on behalf of the American Academy of Pediatrics (AAP), an organization of 53,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

I am a practicing pediatrician in Raleigh, NC, and also serve on the national AAP Committee on Early Childhood, Adoption and Dependent Care, which advises the AAP Board of Directors on medical and public policy matters related to child care. In addition, I direct five child care centers serving 1000 children in the Raleigh area.

The Academy and its members have been, and will continue to be, extensively involved in child care issues. Perhaps most significantly, the AAP literally helped to "write the book" on child care quality. The AAP and the American Public Health Association, with the support of the U.S. Maternal and Child Health Bureau, developed comprehensive health and safety standards for out-of-home child care, published in 1992. This 400-page publication, *Caring for Our Children -- National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care* ("National Health and Safety Performance Standards"), supplies detailed standards with respect to almost every aspect of child care quality. The Academy has also published a video tape series to help child care centers implement the standards, and has published a manual for pediatricians and a brochure for parents concerning the quality of child care.

In addition, the Academy recently assumed coordination of the "Healthy Child Care America Campaign" under a cooperative agreement with the Maternal and Child Health Bureau (in the Health Resources and Services Administration), and the Child Care Bureau (in the Administration for Children and Families) in the Department of Health and Human Services. The "Healthy Child Care America Campaign" is a nationwide effort to ensure safe and healthy child care by linking child care providers, health care providers and families. (See Appendix.)

Background

Six out of 10—nearly 13 million—infants, toddlers and preschool children are enrolled in child care, according to the National Center for Education Statistics (NCES). According to the NCES, nearly 88 percent of children whose mothers work full-time and 75 percent of children whose mothers work part-time are enrolled in child care. As children grow older, they are more likely to be enrolled in child care. About 45 percent of 1-year-olds are in a child care setting for at least part of the day or week, compared to 78 percent of 4-year-olds and 84 percent of 5-year-olds.

When they are not being cared for by their parents, young children may spend their time in one or several of the following types of child care: (1) in-home care -- where a child is cared for by a caretaker in the child's home; (2) family-based child care -- where one or more children are cared for in the caretaker's home (some family-based care is for small groups; some is for larger

groups, sometimes with more than one caretaker); or (3) center-based care -- where a number of children are cared for in a non-residential setting designed for that purpose. "Out-of-home" care as used in this testimony, refers to both family-based and center-based care.

Although some early childhood programs are intended to provide "education" (such as "nursery school" and "preschool") and others are intended simply to provide custodial care ("day care"), the Academy believes that "education" and "care" are inseparable in the case of infants and preschool children. Young children are constantly learning while they play and engage in every day activities; young children in "educational" programs still need "care" in terms of comfort and assistance in meeting their physical needs.

Thus, rather than distinguishing between "day care" and "early education programs," the Academy and others in the early childhood field prefer the term "*early childhood education/care programs*" for all out-of-home settings providing services to young children. The latest research on brain development attests to the fact that early childhood care and learning cannot be separated, and that a child's environment and experiences in the earliest years of life have profound, life-long consequences.

While this testimony emphasizes child care/education for young children, most of the recommendations concerning quality apply equally to programs for school-aged children outside of school hours and during the summer.

What kind of child care do children need?

In general

Pediatricians have always recognized the importance of the early years in the physical, social, intellectual and emotional development of children, and the long-term impact of a young child's experience and environment. Recent findings on early brain and child development indicate that the physical and chemical structure of the brain -- and thus, its future capacity for learning -- are influenced significantly by the environment and experiences of a child during the first few years after birth, particularly during the first three years.

Thus, the latest brain research confirms the importance to our society of quality child care -- within the family and outside it. To develop their potential, children must have trust and confidence in their caregivers, and caregivers must be able to provide adequate physical, emotional and mental stimulation in an appropriate environment.

Specific Elements of Quality Care

Research consistently has identified several factors most related to quality in early childhood education/care programs: small groups of children, with sufficient numbers of adults to provide warm, responsive caregiving; well-educated staff and administrators with specific training in early childhood care and education; adequate compensation for caregivers, and a low degree of staff turnover.

Simply put, the key elements of quality child care are: staff, environment, and activities. More specifically, but not exclusively, a high-quality program will include:

- appropriate child:staff ratios, with staff who are professionally qualified, mentally and physically healthy, well-compensated, committed, motivated, and evaluated
- activities to promote healthy child development, with appropriate supervision and discipline
- health protection and promotion (including health education, specific policies for managing child illness and injury, including child abuse and neglect)
- proper nutrition, safe food service practices
- safe and age-appropriate facilities, supplies, equipment, and transportation
- systematic record-keeping on children's health and development

Child care providers have, in many respects, taken on the role of the extended family for many children and their parents. As would an extended family, a good out-of-home child care provider should communicate closely with parents about their children's activities, health and development, and will also help parents with their own parenting questions or problems. It is important for the parent and child care provider to be consistent with one another in rules and discipline.

In addition, a high-quality out-of-home child care provider, particularly an organized center, will serve as an access point for other services a family might need, such as health or social services, and will help to ensure that children have a "medical home" in order to receive immunizations and other preventive health care. The Academy would like to see every child care provider have a health care consultant and encourages its members to provide consultative services to child care providers.

What kind of child care are children getting, and why?

The current state of out-of-home child care

Most people would agree that, at a bare minimum, our nation's children deserve to be **safe** in their out-of-home child care settings. Yet, in at least one study of licensed child care facilities, significant injury hazards were described by facility personnel in response to survey questions.[1]

With respect to child development, studies indicate that quality child care is the exception rather than the rule, especially for infants and toddlers. Studies have shown that about 35% of family-based, and 40% of center-based infant and toddler care is inadequate, or even potentially harmful to children's safety and development. One of these studies found that only one in 12 infant/toddler rooms provided developmentally beneficial care.

---

[1] MA O'Connor, WE Boyle, GT O'Connor, and R Letellier, "Self-reported Safety Practices In Child Care Facilities," *American Journal of Preventive Medicine*, 8(1):14-8, 1992 Jan-Feb. For example, 61.4% of facilities reported that they did not have an impact-absorbing surface under playground equipment; 30.3% of facilities with stairs accessible to children lacked safety gates; only 55.8% of facilities demonstrated access to the phone number for a poison control center; only 80% of providers could demonstrate access to the phone number of the local ambulance service.

The same studies found that only about 10-15% of the out-of-home child care settings offered care that promotes children's healthy development and learning. Another study found that only 12% of regulated family-based child care, 3% of non-regulated care, and one percent of out-of-home care by relatives was found to be *good* for children.

These are but a few of the disheartening data about the state of out-of-home early childhood education/care in this country. We know what high-quality care should look like. Why is it not universally accessible to children who need it?

The economics of child care

Quality child care cannot be attained by merely applying standards to facilities and caregivers; resources are necessary to meet the cost of quality care at a price that parents can afford.

Child care is a labor-intensive service. Staff wages make up the largest cost in providing care, and caregiver wages in the United States are generally too low to attract and retain qualified staff. In effect, the cost of child care in this country is subsidized by the low wages and benefits of caregivers, who leave their jobs at an astonishingly high rate.

High staff turnover adversely affects the health and safety of children. Frequently replaced, untrained, barely oriented, poorly compensated and over-worked staff cannot maintain sanitation routines, be prepared for emergencies, or meet the mental health need of children for constancy in relationships. Facilities cannot benefit from training provided to staff if the staff leave their jobs before the training is implemented.

In addition to better compensation, greater societal respect for caregivers of young children would also help to increase staff tenure and provide an element of professionalism that would attract competent and committed personnel.

Unfortunately, good, quality care costs more than the majority of low-income, and even middle-income families can afford, leaving no alternative for many parents but to purchase substandard, hazardous, and unhealthful arrangements for their children. This situation is likely to be exacerbated as changes in federal welfare law and state policies put more parents of young children into the work force.

Inadequate regulation

Regulation relating to the health and safety of children in out-of-home child care programs varies widely. Center-based child care programs are usually required to be licensed and are regulated to some extent. Some states have no or minimal regulation for before- and after- school child care, family-based child care, and preschool or nursery school programs, particularly if they operate on a part-time basis or if they are sponsored by a religious institution.

One review of state child care regulations in 47 states found that more than half of the states' safety-related regulations had inadequate or no standards for 24 out of the 36 safety topics examined. Most notable were the inattention to playground safety, choking hazards, and firearms.

Another review of state regulations found that the majority of states' child care regulations do not meet basic standards of acceptable/appropriate practice that assures the safe and health development of very young children. Edward Zigler, an expert in early childhood care and education, recently testified before this committee's Subcommittee on Children and Families that a recent analysis of center-based infant and toddler care found that *no* states have regulations that require good child care practice, and only 17 states' regulations can be characterized as minimally acceptable. The remainder of the states were rated "poor" or "very poor." This is especially disturbing in light of the recent findings about early brain and child development.

Moreover, monitoring and enforcement of child care standards varies widely from state to state and is inadequate in many areas. Research indicates that a significant percentage of settings that should be licensed are operating illegally. Even licensed facilities are not always held to applicable regulations.

With the increased demand for child care that should arise from changes in welfare law, states may be increasingly reluctant to implement stringent child care standards for facilities and personnel, and may encourage the provision of care by untrained personnel in order to meet the increased demand for child care and to provide jobs for welfare mothers.

AAP Recommendations: Long-Term Goals And Short-Term Action

The American Academy of Pediatrics would like to suggest the following long-term goals and short-term action steps:

Long-term Goals

In general, we believe that government policy at all levels should reflect a *systematic public commitment -- both moral and financial -- to make high-quality early childhood education/care available to all children who need it.* Accordingly, government policy, should:

Make early childhood education and care available and affordable for preschool children. While there is little disagreement that there should be public funding for the education of children age five and older, most parents have been left to their own devices to find and afford adequate out-of-home education/care for their preschool aged children. Now that most preschool aged children live in families where a single parent or both parents work, and we understand the importance of these early years on brain development, it is incumbent upon our society to ensure that safe, developmentally appropriate, and affordable early childhood education/care is available to all young children when they are not being cared for at home.

Financing of safe and healthful child care must come from a combination of public and private subsidies or tax credits for the cost of care that exceeds the reasonable ability of parents to pay for care themselves. Parents of young children generally have less disposable income that at any other phase of their lives. Just as society supports those elderly who can no longer fully support themselves, we must support young families raising our next generation.

Establish and enforce adequate health and safety standards. We believe that *all* out-of-home child care programs (including those for school-aged children) should be subject to the "National Health and Safety Performance Standards" regardless of what the programs are called or whether they provide care for all, or only part of the day or week. Ideally, these or equivalent requirements (or at least the minimum requirements set forth in "Stepping Stones" [see appendix]) would apply to all federally subsidized child care programs, and the federal government would provide strong incentives for states to adopt and enforce adequate health and safety standards for all child care programs.

Promote licensing and professionalism of early child care and education professionals. We recommend that all persons who provide child care or who may be responsible for children or alone with children in a facility should be individually licensed, certified, or credentialed by a state licensing agency or credentialing body recognized by the state regulatory agency.

Currently there is a rather haphazard manner for ensuring that the individuals who staff a child care facility are qualified. In most states, there is no licensing process for individual early childhood educators/caretakers. Rather, the qualifications of staff generally are evaluated as part of a facility licensing process, and must be re-examined each time an individual changes facilities. This is time-consuming, cumbersome, and leaves room for error.[2]

Suggestions for short-term action

Obviously, achieving the Academy's goals with respect to child care will require legislative changes and additional financial resources. Although we encourage you to work toward these changes, there are other, more modest steps that can you can take to improve the quality of child care in the near future. These include:

1. Support the federal government's ongoing efforts to improve the availability and quality of child care, including the Head Start and Early Start programs, and the activities of the Maternal and Child Health Bureau and the Child Care Bureau, including the "Healthy Child Care America Campaign" and the National Resource Center for Health and Safety in Child Care. (See appendix.)

2. Encourage the federal government to distribute "Stepping Stones" (see appendix) to all Governors, and challenge the Governors to implement these standards in their states.

[2] There are several private organizations that evaluate and accredit child care programs. Most prominent is the National Academy of Early Childhood Programs of the National Association for the Education of Young Children (NAEYC) which has an accreditation process for center-based child care providers through which the quality of programs is judged against a comprehensive set of consensus criteria developed by early childhood professionals. Parents and employers can be assisted in assessing the quality of a program by checking to see whether it has been accredited by NAEYC (or equivalent accreditation program). The availability of accreditation helps to improve quality by providing consumers a means of comparing child care programs.

3. Encourage the federal government to undertake a comparison of all state laws and regulations with "Stepping Stones" and the "National Health and Safety Performance Standards," and to publicize the adequacy of state health and safety regulations for child care. To facilitate this comparison, states should be encouraged to code their regulations in accordance with the "National...Standards."[3]

4. Ensure adequate monitoring of the effects of changes in welfare policy on the supply and quality of child care, and the resulting effects on children and families.

5. Encourage each state to establish, by law, a state-level commission on child care, charged with developing a child care plan and facilitating cooperation among government, human services agencies, schools, employers, pediatricians and other health care providers, and caregivers, to ensure that the health, safety, and child development needs of children are met by child care services provided in the state.

6. Encourage federal and state efforts to disseminate information to parents on child care standards and quality so that they can make wise choices about their child care options.

In addition, we urge you to talk to your constituents and your state and local government officials about the child care situation in your states. As you know, it is often these county or other local officials who are charged with enforcing regulations. To do so properly, they need the resources you can help to provide.

Again, thank you for this opportunity to testify on behalf of the American Academy of Pediatrics. The Academy would be happy to provide you with any additional information you might need.

[3] Currently, comparisons of state and local regulations with the "National...Standards" can be done only by tedious work taking many person-hours. Comparison of state and local standards with the ideal could be conducted much more efficiently if uniform codes (topic headings and numbering) were employed.

APPENDIX -- CURRENT EFFORTS TO IMPROVE CHILD CARE QUALITY

Described below are some of the activities of the federal government and the American Academy of Pediatrics related to improving the quality out-of-home child care. As evident from the other witnesses at this hearing, there are many state and local governments, businesses, and private nonprofit organizations (e.g., NAEYC, "Zero To Three") that are undertaking other individual and joint activities to improve the supply and quality of out-of-home child care. At the federal level, President Clinton recently directed the Department of Defense to share lessons learned from the military child development programs to improve civilian out-of-home child care.

"Stepping Stones"

As mentioned in my testimony, the American Academy of Pediatrics and the American Public Health Association developed comprehensive guidelines for child care health and safety that were published by the Maternal and Child Health Bureau ("National Health and Safety Performance Standards"). This publication supplies detailed standards with respect to almost every aspect of child care quality.

To make it easier for regulators and facilities to implement the standards or use them to analyze their current regulations, the Maternal and Child Health Bureau sponsored a project -- commenced in 1994 and completed earlier this year -- to identify the minimal standards directly related to protecting children from harm (injury, morbidity and mortality) in child care settings. The final product, called "Stepping Stones to Using Caring for Our Children -- Protecting Children from Harm" ("Stepping Stones") contains 182 of the 981 standards set forth in the more comprehensive guidelines. This user-friendly publication provides a starting point for regulators to establish *minimal* health and safety requirements, and for regulators, child care personnel, health care personnel and parents to evaluate child care settings.[4]

The "Healthy Child Care America Campaign"

As mentioned in my testimony, the "Healthy Child Care America Campaign," supported by the Maternal and Child Health Bureau and the Child Care Bureau, and administered by the American Academy of Pediatrics, is intended to facilitate cooperation among families, child care providers and health care professionals to promote the healthy development of children in child care, including increasing access to preventive health services and providing safe physical environments.

The goals of the Healthy Child Care America Campaign are to provide:

- a safe, healthy child care environment for all children, including those with special needs;
- up-to-date and accessible immunizations for children in child care;
- access to quality health, dental and developmental screening and comprehensive follow-up for children in child care;
- health and mental health consultation, support and education for all families, children and child care providers; and
- health, nutrition and safety education for children in child care, their families and child care providers.

---

[4] Both publications are readily available on the world wide web through the federally supported National Resource Center for Health and Safety in Child Care ("National Resource Center"), located at the University of Colorado Health Sciences Center and the University of Colorado in Denver. The Center's Internet address is: *http://nrc.uchsc.edu*.

More than 40 grants have been awarded by the MCHB to professionals and organizations representing health and child care communities, who will coordinate local activities to meet the goals of the campaign. In addition, communities can create or expand public and private resources that link families, health care professionals and child care providers by following 10 steps included in the *Blueprint for Action*, developed at the 1995 National Child Care Health Forum when the campaign initially began. Some of these steps include increasing immunization rates and preventive services for children in the child care setting, promoting and increasing comprehensive access to health screenings, and strengthening and improving nutrition services in child care.

Training and Recruiting Consultants to Child Care Programs

The Academy encourages pediatricians to be well-informed about child care issues so that they can adequately advise their patients' families about their child care arrangements. To this end, the American Academy of Pediatrics has published a manual for pediatricians, currently under revision, about health in child care, and has published a policy statement urging pediatricians to be prepared to counsel individual patients' families and to provide their health care expertise as consultants to organized child care programs. We hope to enhance these efforts in the future.

Other Testimony Submitted for the Record

Governor Jim Hunt
Statement on North Carolina's Smart Start Initiative
July 15, 1997

The most important thing we can do is prepare our children for the 21st century. To do that, we need to give children a good start in life so they can come to school healthy and ready to succeed.

New scientific studies show that 85% of brain development -- and much of a child's emotional and intellectual growth -- occurs in the first three years of life. In North Carolina -- a state with one of the nation's highest percentages of working mothers -- that means we must make sure every child has access to quality day care.

Smart Start helps children and families get access to higher quality child care, more child care spaces, better-trained child care teachers, preventive health screenings and family support services. Since we launched our early childhood initiative in 1993, Smart Start has grown into a national model for early childhood education. One reason is its innovative approach to helping children and families succeed. With seed money from the public and private sectors, local people -- families, churches, businesses, non-profits, parents and local government -- work together to determine how best to serve their children.

Because of Smart Start, thousands of North Carolina children are getting higher quality early education and greater access to preventive health care. In 43 of North Carolina's 100 counties where Smart Start is currently providing services:

- The percentage of high-quality, AA-licensed child care centers has increased by more than 60%.
- More than 37,000 children have received child care subsidies so their parents can work, and Smart Start has created more than 32,000 new child care slots.
- More than 87,000 children have received early intervention and preventive health screenings.
- More than 26,000 teachers have received additional training through Smart Start educational programs.

For example, in Burke County, a public dental health clinic was established, bringing together local dentists and the health department to provide dental treatment for children and dental education for parents. And in Nash and Edgecombe counties, 2,265 families with young children have been identified through the Smart Start outreach project and have received parent education and support.

Objective studies show Smart Start is working well. UNC-CH's Frank Porter Graham Child Development Center says Smart Start is significantly increasing the overall quality of child care. The NC General Assembly's Coopers & Lybrand audit called for the expansion of Smart Start and confirmed that it is "a credible program that delivers substantial good to children and families."

a)

In North Carolina we're on the right track, but we're still not reaching enough children. Over the next four years, we plan to expand Smart Start to all 100 counties in North Carolina so all of our children get the quality early childhood education they deserve.

WRITTEN TESTIMONY
TO THE LABOR AND HUMAN RESOURCES COMMITTEE,
UNITED STATES SENATE
Hon. Jim Jeffords, Chairman
July 17, 1997

Prepared by:
Yasmina S. Vinci
Executive Director
National Association of Child Care Resource and Referral Agencies

The recent release of research findings on the importance of early development of the human brain for later success has generated a wave of public interest in policies, practices and strategies that promote every child's ability to grow up and become a productive citizen. With nearly 10 million children spending some (often a large) portion of their days in the care of someone other than the parent, ensuring good, nurturing experiences for our youngest children becomes an issue for all: families, employers, communities, and government.

From federal, state, and local perspectives alike, the system of child care and early education is a complex one, an intricate array of providers of care, funders of care, consumers of care, and advocates for good care, for enough care, and for affordable care. While the public education system is one in which states and local governments are the primary planners and funders for the services, the child care and early education system has many stakeholders. They range from informal, unregulated caregivers to regulated family child care homes, non-profit and for-profit child care centers, Head Start, nursery schools, after-school and vacation care in centers, homes, schools, churches, parks and recreation departments. Unlike the elementary, secondary, and much of higher education, most of the early care and education is purchased by the parents themselves. This wide variety of providers, consumers and advocates speaks in various voices about how care should be regulated (or not regulated), and subsidized (or not subsidized), how training should be delivered, and how child care should be (or not) expanded and improved.

Research in both child care centers and family child care homes has shown that only a very small percentage of care (14% of center care and 12% of family child care) is of good quality and good for the children. The rest of available care – unsatisfactory or mediocre, even when it does not cause harm to the child's life, endangers healthy development.

The same research has also shown that the quality of care that a child receives is most critical for the most vulnerable children. This group includes young infants, children with special needs, and children from lowest income homes.

By now we know that good care is not only important in order for children to grow and develop (and ultimately to contribute to the future of the country and our competitiveness in the global economy), but also that it supports each family's ability to participate in the workforce.

We also know enough about what can and should be done in order to achieve good quality in most care settings.

First, strong licensing standards and their enforcement are critical to the prevention of harm to children. While licensing standards are only a state's basic legal requirements, and not indicators of quality, research finds that outcomes for children are better in states with higher licensing standards.

Research and common sense tell us that children enter school ready to succeed when they have had continuous supportive relationship with a child caregiver. The key to a child care workforce with low-turnover, skill, and dedication to working with children, is in providing equitable pay and benefits. The issue of pay and benefits for people who are caring for children is one that will not go away and must be addressed.

From both research and experience, we know what good care looks like and how important it is for each child to have a stable, continuous relationship with a committed, skilled adult. Many people enter the caregiving field with strong motivation, but not necessarily with skills to manage a whole group of children, to provide activities that promote each child's readiness to learn, or to interact appropriately with different families. This is where training comes in. Again, a number of research efforts have shown that training results in better quality of care. The training needs of caregivers vary greatly, as do their learning modalities. In a profession which requires daylong presence, expanding access to training is something that must be addressed and can be addressed through creative uses of technology.

Accreditation of programs and credentialing of caregivers are further steps along the continuum to quality. These require resources and support as well.

Assuming that the supply of care is ample and that it is affordable, parents who are well-informed consumers of care further contribute to quality improvement, by choosing one program over another.

Work toward increasing the quality of care for all children will result in many desired outcomes - both as the investment in the nation's human assets, and as the best prevention strategy for many current concerns. **To be effective in this effort, the commitment to quality needs to be comprehensive, addressing all elements that support quality, and delivered through a coordinated, locally-driven system which links all the stakeholders and makes early care and education work for families and communities.**

This local infrastructure for quality already exists in most communities and under different names. It is child care resource and referral.

Summary of Proposed Legislation "Creating Improved Delivery of Child Care: Affordable, Reliable, and Educational"

CIDCARE

AN ACT CREATING IMPROVED DELIVERY OF CHILD CARE: AFFORDABLE, RELIABLE, AND EDUCATIONAL

SUMMARY OF THE CIDCARE ACT

July 15, 1997

A high-quality child care program is one that makes the healthy development and education of children its first objective and strives to stimulate the learning process of all children through developmentally appropriate activities that foster social, emotional, and intellectual growth.

Research has clearly demonstrated that no single factor ensures the quality of a child care program, but rather a combination of factors. This proposal incorporates current research into a multi-level approach for improving the quality of child care.

In the proposal, the terms **credential** and **accreditation** are used to refer to *formal credentialing and accreditation processes by a private non-profit or public entity that is state recognized (minimum requirements: age-appropriate health and safety standards, age-appropriate developmental and educational activities as an integral part of the program, outside monitoring of the program/individual, accreditation/ credentialing instruments based on peer-validated research, programs/facilities meet any applicable state and local licensing requirements, and on-going staff development/training which includes related skills testing).* There are several organizations that currently provide accreditation and/or credentialing for early childhood development programs and professionals.

In essence, this legislation is an effort to effectively stimulate the demand for higher quality child care for our nation's children while simultaneously removing barriers and providing resources to improve the quality of child care in the United States.

Title I --DEMAND FOR QUALITY CHILD CARE

1) Changes to the Dependent Care Tax Credit

A. Percent of the current $2,400 work related child care expenses ($3,600 for 2 or more dependents):

- The initial percentage is reduced by 1% for each $2,500 by which the taxpayers adjusted gross income exceeds $20,000 but does not exceed $70,000. The rate does not reduce below 12.5% for accredited/credentialed child care or 10% for non-accredited/non-credentialed child care.
- The 25% differential rate for accredited or credentialed child care (as defined in the bill) phased in over 5 years.

- For child care that is not accredited or provided by a credentialed child care provider, the initial percentage is 30% and the phase out percentage is 10%.

- The initial and phase out percentages for accredited/credentialed child care are:

Taxable year beginning in	Initial %	Phaseout %
1998	31.5	12.5
1999	33	12.5
2000	34.5	12.5
2001	36	12.5
2002	37,5	12.5

B. Credit made refundable for Low Income Tax Payers

- Taxpayers for whom credit under section 32 of the tax code (EITC) is allowable for the taxable year are eligible to receive a refund of their dependent care tax credit.
- The refundable dependent care tax credit is fully coordinated with the advance payments and minimum tax rules of the EITC, including eligibility certification and advance payment table.
- The refundability of the dependent care tax credit applies to taxable years beginning December 31, 2000.

2) Expansion of Dependent Care Assistance Program

A. Change in Dollar Limitation

- The changes in the dollar limit which an employee can contribute to a dependent care assistance plan applies to child care only---not elder or other dependent care.

- Changes in the amount which an employee can contribute to a dependent care assistance plan for child in accredited or credentialed child care are:

Taxable years beginning in:	for 1 qualifying child	for 2 or more qualifying children
1998	$5,200	$6,700
1999	$5,400	$6,900
2000	$5,600	$7,100
2001	$5,800	$7,300
2002 & thereafter	$6,000	$7,500

- The changes in the dollar limit for a child NOT in accredited or credentialed child care are:

Taxable years beginning in:	for 1 qualifying child	for 2 or more qualifying children
1998	$4,800	$6,300
1999	$4,600	$6,100
2000	$4,400	$5,900
2001	$4,200	$5,700
2002 & thereafter	$4,000	$5,500

B. Changes in eligibility for Dependent Care Assistance Program

- The legislation makes an exception in calendar year spending requirement and prohibition against using Dependent Care Assistance Program to pay a relative providing care in order to make it more financially possible for parents to stay home with their newborn child.
- A parent may elect to join their employers' Dependent Care Assistance Program at any time during pregnancy.
- If parent signs up during a pregnancy, each deposit into the individual's Dependent Care Assistance Account may be available for use for a 12 month period.

- If parent signs up during a pregnancy, the funds may be used to reimburse a parent or grandparent to remain at home with the newborn child as an alternative to placing the child in child care in order to return to work. The person who remains home with the child and for whom reimbursement is requested must meet the employment-related qualifications of the existing law.
- Federal employees are be provided with the opportunity to enroll in a Dependent Care Assistance Program

3) Inclusion of Child Care Costs in Child Support Orders

- When a custodial parent is employed or actively seeking employment, the state procedures for the determination of the amount of child support shall include an amount equal to or more than the child care rates used by the state to administer the Child Care and Development Block Grant Act.
- When child care is being provided by in an accredited child care center or by a credentialed child care that rate shall be increased by 50%.

Title II--SUPPLY OF QUALITY CHILD CARE

SUBTITLE A: Tax Benefits for Quality Child Care

1.) Changes to Business Deductions for Employee Child Care

- The legislation includes a tax credit for employers who contribute to child care arrangements for their employees including start-up costs, professional development, wage subsidies, and operating expenses. This tax credit includes:
  - 50% of eligible expenses incurred by the employer, up to a maximum of $150,000;
  - Allowable expenses include costs of accreditation and credentialing, increased compensation for providers with additional training, and resource and referral services for employees;
  - The tax credit sunsets after three years; and
  - A minimum of 30% of the available child care slots must be used or reserved for the use of employees of the business.

(NOTE: Passed Senate as Kohl Amendment on Budget Reconciliation)

2.) Charitable deduction for donating educational equipment & materials

- The bill extends eligibility for businesses to take a qualified charitable deduction for the donation of educational equipment and materials to public schools, accredited or credentialed non-profit child care providers, and public or non-profit child care support entities.

3.) *Tax deduction for specific accreditation and credentialing expenses for individual child care providers (including education and training)*

- To enable more child care providers to increase their skills and education, the legislation exempts expenses leading to child care credentialing (including the cost of education, training, and obtaining the credential) from the 2% floor applied to miscellaneous itemized deductions, if the taxpayer derives a portion or all of their income from the provision of child care services.

4.) *Expansion of the home office deduction to include use for dependent care*

- The bill includes a limited exception to the exclusive use rule permitting mixed use of space for business and personal purposes in the case of taxpayers who conduct home-based business while caring for dependents.

SUBTITLE B: Child Care Quality Improvement Incentive Program

- The CIDCARE bill establishes a $260 million competitive grant program to assist states in improving the quality of child care.
- To be eligible, a state must not have reduced the scope or otherwise decreased the state's licensing requirements since 1995, must be in compliance with the requirements of the Child Care and Development Block Grant, have drawn down at least 80% of the amount awarded to the state in federal entitlement child care funds requiring a state match, and conduct annual on-site monitoring of state licensed or otherwise regulated child care facilities, with at least one unannounced visit every 3 years.
- Priority will be given to states that raise at least a 10% match for the federal funds from business or other private sources.
- States must use at least 20% of the grant funds awarded to establish a subsidy program to provide salary increases child care providers who are credentialed in the state.
- States must use at least 20% of the funds awarded for a grant program to provide start-up funds for partnerships of small businesses to develop and operate child care cooperative services for their employees.
- States can use the remainder of grant funds awarded for any of the following activities: developing standards for of entities applying for state recognition for the accreditation and credentialing of child care providers; establishing a scholarship program to help child care providers meet the costs of education and training; expanding state-based child care training and technical assistance

activities; improve consumer education efforts including the expansion of resource and referral services and child care complaint systems; providing increased rates of reimbursement provided under federal or state child care assistance for children with special needs; purchasing special supplies, equipment, or meeting other extraordinary expenses necessary for the care of special needs children for distribution to child care providers serving special needs children, or providing increased rates of reimbursement provided under federal or state child care assistance for accredited and credentialed care.

- Administrative costs are limited to 10% of the aggregate funds awarded to the state.
- Funds are divided up between all eligible states which apply for funds and which propose activities which meet the guidelines of the legislation; no eligible applicant state which meets those guidelines shall receive a grant less than .75% of the total available grant funds, unless a lower amount is requested by that state. The amount of a grant awarded to a state is determined by a competitive grant process.

SUBTITLE C--Distribution of Information About Quality Child Care

1.) Expansion of Public Information and Technical Assistance Services

- The Department of Health and Human Services (HHS) will collect information about the importance of high quality child care (including what it is, how to identify it, why it is important for children), and in partnership with the ADCouncil or similar professional advertising entity, distribute that information through a national public awareness campaign and other mechanisms.
- HHS will award competitive grants to child care credentialing and accreditation entities (that have not been in existence more than 10 years) for the purpose of refining and evaluating their procedures for and methods of granting child care accreditation and/or credentialing
- $10 million is authorized to HHS to conduct these information and technology transfer activities.

2.) Child Care Training Infrastructure

- The bill provides $50 million to create and operate a technology-based training infrastructure to enable child care providers nationwide to receive the training, education, and support they need to improve the quality of child care

- The bill builds upon existing distance learning, Internet, and satellite resources, with sufficient funding to expand access to affordable child care training and information. The primary focus of the infrastructure will be to disseminate the training necessary to become an accredited child care center or a credentialed child care professional. Training and education, delivered at a minimal cost and accessible to individuals within 25 miles of their homes, will remove one of the most substantial barriers to child care credentialing and accreditation.
- Essentially, the legislation establishes a child care training and education interactive "network", to be utilized by child care credentialing and accreditation entities for training, skills testing, and other activities needed to achieve and maintain child care credentialing and accreditation.
- Entities recognized by 2 or more states as providing accepted child care credentialing or accreditation services will be active participants in decisions governing the use of the child care "training network".
- Time lines for the creation and implementation of the infrastructure and caps on administrative costs are included in the bill.

3.) Child Care Training Revolving Fund

- Through the child care training infrastructure, a no interest revolving loan fund is established to enable child care providers and child care support entities to purchase computers, satellite dishes, and other technological equipment which enable them to participate in the child care training provided on the national infrastructure.
- For the first 5 years of the legislation, at least 10% of the funds appropriated for the child care training infrastructure will be placed into the revolving loan fund.
- The legislation, like similar federal loan programs, establishes that the funds be kept in a separate interest bearing account, establishes application procedures, terms and conditions for the approval of such loans, and procedures for handling loan defaults.

SUBTITLE D--Quality Child Care Through Federal Facilities and Programs

- Federal child care centers (those in buildings leased or owned by the federal government--legislative, executive, judicial branches) will have to meet all state and local licensing and other regulatory requirements related to the provision of child care, within 6 months of the passage of this legislation---or make

substantial progress towards meeting those requirements

- The appropriate Administrator of each branch of government shall issue regulations specifying center-based child care accreditation standards and require all child care facilities in federal buildings under their control achieve accreditation within 3 years of the passage of this legislation.
- If the child care program located in a federal facility fails to be in compliance, or show substantial compliance with state and local licensing requirements within 6 months or with the identified accreditation standards within 3 years, the agency must cease providing child care in that child care center.
- On-site monitoring to ensure compliance with these regulations and standards must be performed by an outside entity.
- The legislation authorizes $900 thousand to the General Services Administration (GSA) to implement this Subtitle.
- Federal child care programs provided by the Corporation for National and Community Service, the Departments of Defense, Education, Housing and Urban Affairs, Justice, and Labor, shall ensure, to the maximum extent possible, that by October 1, 2001, any child care made available through programs funded or operated by those Departments and the Corporation, be provided by an accredited child care facility or a credentialed child care professional.
- The Community Development Block Grant is expanded to include the renovation or upgrading of child care facilities to meet accreditation standards as an allowable use of the grant funds.

SUBTITLE E--Miscellaneous Provisions

1.) Extending existing Perkins and Stafford Loan Forgiveness Programs

- The current law which provides loan forgiveness for Perkins and Stafford educational loans is expanded to include child care workers who are employed full time providing child care services and have a degree in early childhood education or development or receive professional child care credentials