Helping Vulnerable Families:
Providing High-Quality Infant-Toddler Care for Mississippi’s Young Children

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High-quality infant and toddler care promotes all aspects of early childhood growth and development, including social, emotional, cognitive, and physical development. However, the United States struggles to provide an adequate amount of high-quality care at a reasonable price for vulnerable families that need it the most. When it comes to child well-being, Mississippi ranks lowest in the country because it is home to the highest percentage of single parent headed families, children in poverty, and low-birthweight babies, ultimately containing the highest vulnerable family population. Additionally, Mississippi reimburses infant and toddler care providers at a lower rate than federally recommended, making it difficult for providers to invest in quality service and perhaps accounting for the lack of high-quality early child care centers in the state. This article outlines four solutions for making infant and toddler center-based care more affordable and accessible: a) create partnerships between existing Early Head Start programs and community-based infant and toddler centers, b) ensure high-quality care in the home, c) mandate provider participation in the Mississippi Child Care Quality Step System, and d) provide tax incentives for families to use high-quality care and for providers to offer high-quality service. Ultimately, Mississippi must invest in an ordered sequence of action that first increases the availability of high-quality infant and toddler center-based care, then provides incentives for high-quality infant and toddler usage, and finally evaluates its impacts on the needs of vulnerable infants, toddlers, and their families.

High-quality infant and toddler care nurtures rapid brain development for children birth to age three (National Research Council, 2000). The creation of the National Association for the Education of Young Children (NAEYC) in 1929 began the movement towards high-quality early education. NAEYC accreditation ensures a variety of evidenced-based practices proven to facilitate social, emotional, cognitive, and physical development. These practices reinforce behaviors in later life, including higher
school achievement, controlled aggression, and greater cooperative interactions (National Scientific Council, 2004; Cohen & Ewen, 2008).

Recent research shifts the attention from high-quality benefits to low-quality damage. Of the 119,174 early child care centers in the United States, only 9.4% are accredited, meaning many more children use child care without approved standards (NACCRRA, 2009b). Scientists and researchers confirm the harmful effects of low-quality care on children’s growth and development, such as low trust towards adults and poor brain and emotional development (NCCP, 1999).

Vulnerable families are at or below 200% of the poverty line ($21,200 for a family of four), and most likely headed by a single parent dependent on non-parental child care to fulfill labor force commitments. In 2007, the percentage of infants and toddlers living in poverty rose to 5.4 million, or 43% of 0-3 year olds in the US (Douglas-Hall & Chau, 2008). Parents, especially in vulnerable families, depend on outside work to support their children financially. This dependency accounts for the 49% of low-income parents with infants working full-time and year-round (p. 2). The demand to work often results in a reliance on non-parental infant and toddler care. The high cost of high-quality child care, however, causes more low-income parents to enroll their young children in low-quality care (Capizzano & Adams, 2003).

The cost of infant and toddler care runs between $4,560 and $15,895 per child a year, depending on the state. Within each state, the cost of high-quality infant and toddler care lies in the upper range of state averages. For single parents, this expense consumes anywhere from 28% to 60% of their annual income, often leaving parents no choice but to find the best economical choice (NACCRRA, 2009b). Currently, child care subsidies allay some of the expense for parents. However, 40% of young children are in low-quality care mainly due to the limited number of high-quality options in low-income neighborhoods and the fact that some centers do not accept child care subsidies (Schumacher & Hoffmann, 2008; Cohen & Ewen, 2008).

Consequently, disparities between infants and toddlers using high-quality and low-quality care, or in another sense, between those who can access and afford it and those who cannot, grow. Young children in poverty face enormous barriers to success, such
as unstable housing, higher rates of maternal depression, poorer nutrition, and sporadic health care (Maternal & Children Health Bureau, 2007). These barriers give low-income infants and toddlers a delayed start in development, increasing the need for high-quality care. In fact, research shows that children in low-income families experience the effects of low-quality care more severely than their peers (Cohen & Ewen, 2008; Schumacher & Hoffmann, 2008).

Supporting children’s growth and development requires states to provide high-quality infant and toddler care and incentives for its usage. States can build upon an established infrastructure of proven high-quality infant and toddler care, such as Early Head Start and a Quality Rating and Improvement System. However, providing more slots for high-quality care needs to be coupled with incentives to encourage low-income families to use the service, such as consumer tax credits for high-quality infant and toddler care usage. Promoting healthy growth and development for young children depends on a state’s commitment to such initiatives and creative use of resources.

**Understanding High-Quality Infant and Toddler Care**

*What High-Quality Infant and Toddler Care Means*

*Current research and policy standards.* Four decades of research on neuroscience and developmental behavior conclude that early brain development depends on an infant’s genetic make-up, early experiences, and the environment. Although genetics set the stage for brain circuits, experiences and the environment determine the direction those circuits take. Infants develop best when in a loving and caring relationship with an adult – one that is responsive, interactive, and stimulating. Additionally, positive stress events, such as encountering new people while in the presence of a stable and supportive adult, help the brain develop positive coping and self-control skills. According to research led by the Center on the Developing Child at Harvard University, high-quality infant and toddler care promotes healthy brain development, which links to “emotional well-being, social competence, and emerging cognitive abilities,” in infancy and lasting well into adulthood (National Research Council, 2007).
The neuroscience and early education policy and research fields acknowledge that high-quality care provides the best avenue for positive child development. The effects of poverty greatly alter the development of the brain if not buffered by high-quality standards of operation and nurturing relationships found in high-quality centers. Studies from Early Head Start and other high-quality early education and care programs show that society gains between $2 and $17 for every $1 invested in high-quality early education—primarily from lower crime, fewer teen pregnancies, and higher education levels and individual earnings (RAND, 2008 & Schweinhart, 2004). The money lost from the damaging effects of low-quality infant and toddler care is also of significance for vulnerable young children, as this creates a cycle of poverty.

**NAEYC accreditation.** Since 1985, the NAEYC’s voluntary accreditation system has represented the high-quality standard for both infant and toddler and preschool education. NAEYC accreditation meets many of the criteria professionals in the field deem necessary for high-quality infant and toddler care (see Table 1). The Association weaves accreditation criteria into program implementation through specific best practices. These include a low child-to-teacher ratio, small group size, highly skilled and educated teachers that are responsive and sensitive to both the child and parents, evidence-based curriculum in the classroom, and the use of frequent child assessments (National Scientific Council, 2007; Cohen & Ewen, 2008).

NAEYC’s standards prove developmentally effective in the way they address factors needed for ensuring school readiness and positive development. Its early learning standards—expectations for the learning and development of young children—meet the four essential criteria for a developmentally effective system. These factors include early learning standards that (a) emphasize significant, developmentally appropriate content and outcomes, (b) build on a valid source of multiple stakeholders’ expertise, (c) support all development in ethical and appropriate ways, and (d) require a foundation of support for early childhood professionals, programs, and families (NAEYC, 2002). NAEYC accreditation continually creates a stronger, more committed community of teachers, administrators, and families committed to high-quality early education. In support of NAEYC accreditation, the *Wall Street Journal* said “the primary gauge of quality has been
accreditation by the NAEYC...whose seal of approval is regarded as the gold standard by parents, educators and facilities" (Wall Street Journal, March 24, 2006).

NAEYC accreditation epitomizes a practical benchmark for infant and toddler centers and, therefore, represents the high-quality standard for this article. Legal operation does not require accreditation; however, early education leaders and early childhood experts recommend NAEYC accreditation criteria for high-quality care. Unfortunately, the cost of quality has discouraged many states, Mississippi included, from investing in high-quality standards. However, high-quality care enhances children’s growth

| 1. | Supportive relationships among all children and adults. |
| 2. | Curriculum that promotes social, emotional, physical, language and cognitive development. |
| 3. | Developmentally, culturally and linguistically appropriate and effective teaching. |
| 4. | Ongoing, systematic, formal and informal assessment approaches of child progress. |
| 5. | Promotes nutrition and health of children and protects children and staff from injury and illness. |
| 6. | Teaching staff with educational qualifications, knowledge, and professional commitment necessary to promote children’s learning and to support families’ diverse needs and interests. |
| 7. | Collaborative relationships with each child’s family. |
| 8. | Establishes relationships with and use the resources of the community to support program goals. |
| 9. | Safe and healthful indoor/outdoor spaces that are well maintained. |
| 10. | Strong leadership and management that effectively implements policies, procedures, and systems. |

*Note: Adapted from NAEYC (2005), NAEYC Early Childhood Program Standards and Accreditation Criteria: the Mark of Quality in Early Childhood Education.*
and development, which builds a strong foundation for learning, adapting, and contributing to society in later life.

**Federal funding.** Ongoing events in the House and Senate reveal that government officials understand the necessity of high-quality infant and toddler care. In February 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA) that agreed to fund an additional $2 billion for the Child Care and Development Block Grant (CCDBG) over a two-year period. The Act reserves $93.6 million of CCDBG funds for quality improvements in infant and toddler care. For CCDBG, Mississippi will gain $30,983,386. Another funding stream competitively provides Head Start $2.1 billion, split between Head Start and Early Head Start. This news comes at a pivotal point for the early education arena. States currently deny financial assistance to hundreds of children due to budget deficits caused by the current economic recession. The bill signifies a commitment to infant and toddler care and a promise towards accessible and affordable high-quality care for all families.

Secretary of Education Arne Duncan proclaimed on NPR Radio that stimulus package money will “not just increase seats and access [for early education], but make sure those [seats] are quality seats, not glorified babysitting” (Stephenson, 2009). Duncan also noted the many factors influencing future change in early education, such as bipartisan support from Congress, strong leadership from President Obama, a comprehensive agenda supported by proven strategies for success, and unprecedented resources from the ARRA.

**Affording and Accessing High-Quality Care in Mississippi**

Providing high-quality infant and toddler care is a nationwide concern. Mississippi, however, represents the state in most need of action for several reasons. First, as seen in Figure 1, Mississippi has the highest percentages in low-birthweight babies, children in poverty, and single parent families (Casey Foundation, 2008). These children need high-quality care the most. Low birthweight results in a higher risk of developmental delays and learning disabilities, and requires highly skilled teachers to identify problems and the use of child assessments to confirm such concerns.

High-quality care reduces the effects of poverty, such as poor nutrition. Further, as the poorest state in the nation, the current
economic recession has hit Mississippi particularly hard. In the last few years, Mississippi placed job creation and job opportunities as top priorities on the state’s agenda. The influx of more parents in the labor force, however, must be coupled with increased accessible child care (Sivak & Dixon, 2008). Single parents needing to work multiple jobs or extra shifts to make ends meet need out-of-home child care the most.

The cost of infant and toddler care in Mississippi burdens both families and providers. The average cost per child for infant and toddler care is $124 per week. The state reimburses centers $84 per week for each child. This translates into a 68% return of the market rate (Sivak & Dixon, 2008), 7% lower than the Federal recommendation (NCCIC, 2008-09). Federal reimbursement makes quality improvement costs more manageable for providers. Unfortunately, an already tight budget and a low reimbursement rate persuade many providers in Mississippi to avoid quality improvements.
Vulnerable families cannot manage the cost of infant and toddler center care without state assistance. Mississippi has one of the lowest full-time infant and toddler care costs in the country at $4,560 annually. For a single parent household, however, child care costs comprise 28% of the family’s income (NACCRRA, 2009b). With one-third of parents in low-wage jobs, the cost of infant and toddler care keeps vulnerable parents looking for the most economical solution. High-quality infant and toddler care comes at a cost, and when most parents are given the choice, they choose low-quality care as the only option that works within their budgets.

Mississippi’s child care system struggles with far more than costs. Throughout the state, only 13 of the 1,174 early education centers are NAEYC-accredited (NACCRRA, 2009b). The high cost of accreditation presumably causes high-quality centers to locate in wealthy areas, leaving one to suspect that the 13 accredited centers are inaccessible for vulnerable families in Mississippi. The move towards high-quality infant and toddler care must include increasing accessibility of high-quality facilities in vulnerable neighborhoods.

This article focuses on center-based infant and toddler programs over family-based programs as a vehicle for high-quality care in Mississippi for numerous reasons. In Mississippi, family-based child care lacks state regulations, meaning there are no standards or benchmarks required for operation (NITCCI, 2007). Startlingly, family-based providers in Mississippi face no limits for the amount of children served in each home. Moving from non-existent state regulations to high-quality standards would require many more resources and much more effort than working with center-based programs that follow state regulations. Furthermore, vulnerable families are much more likely to place their child in center-based rather than family-based programs, as seen through reported child care placement of CCDBG recipients in Mississippi (CLASP, 2008). The data demonstrate that improved practices in center-based infant and toddler programs would target vulnerable families.

Current Policies Promoting High-Quality Infant and Toddler Care

Early Head Start. In 1995, the Federal government addressed the need for high-quality care for vulnerable young children by
establishing Early Head Start (EHS). Funded through Head Start by the Administration for Children and Families (ACF), EHS focuses on healthy infant, toddler and family development (a list of their nine principles is found in Table 2). EHS targets vulnerable families by setting enrollment eligibility determinant on income and serving enrolled children at no cost to parents.

EHS represents a two-generational program – center-based care, home-based care or a combination of both forms of care offered for children and their parents. Services include prenatal health care and support, child health care and screenings, support systems for parents, and high-quality child care services. EHS center-based programs offer infant and toddler care that enhances children’s growth and development, provide parental education and health services, and facilitate two yearly home visits for each family. Mississippi currently has 38 EHS programs scattered throughout the state.

**Evaluation of Early Head Start.** Between 1996 and 2001, Mathematica Policy Research Inc., Columbia University’s Center for Children and Families, and the EHS Research Consortium (17 EHS programs, 15 university-based research teams, and ACF) evaluated 3-year old graduates from EHS in 17 programs throughout the country. The 3,000 children involved in the study also included a non-EHS comparison group of children with similar demographics. Between 2001 and 2004, the team evaluated the same children in a pre-kindergarten follow-up study. Evaluators measured children’s cognitive, language, and social-emotional outcomes through direct observations and parental reports. Parents were also assessed through interviews and self-reports. At age 3, center-based participants scored higher on cognitive and social-emotional measures and had larger vocabularies, lower levels of aggression, and higher levels of sustained attention compared to children in non-EHS centers. Parents involved in all forms of EHS had greater warmth towards their child, provided more stimulating environments at home, read to their child daily, and used physical punishment less frequently (DHHS, 2002). By 2010, the team plans to evaluate the same children in their sixth year of formal schooling.

The pre-kindergarten evaluation demonstrated that high-quality care could generate positive outcomes for vulnerable infants, toddlers and their families. Even though only 4 of the 17 sites
evaluated were center-based, it provides a framework for determining the success of high-quality infant and toddler center care. Positive results remained consistent across all children using EHS center care. However, a wider sample of EHS center-based programs would strengthen the evaluation.

Child Care and Dependent Block Grant. In addition to EHS funding for high-quality infant and toddler centers in states, the Child Care and Dependent Block Grant (CCDBG) Act gives money to vulnerable families with children under the age of 13 for child care cost assistance. In 2008, this Act funded $5 billion to states,
and the 2009 ARRA promised an additional $2 billion. One-fourth of CCDBG funds must always be used for quality initiatives, while the remaining amount helps families. CCDBG participants may or may not be recipients of Temporary Assistance for Needy Families (TANF); however, TANF agencies may transfer up to 30% of its dollars to CCDBG funds. For Mississippi, the 2009 ARRA plans to distribute $30,983,386 to CCDBG, with $1,483,365 specifically devoted to infant and toddler care (CLASP, 2009).

Within Mississippi’s CCDBG program, children ages 0–3 comprised 43% of all recipients in 2007. The majority of parents reported supervision during employment as the main reason for participating in CCDBG (CLASP, 2008). Center-based programs remain the most commonly used facility for CCDBG recipients, in both Mississippi and the US as a whole. However, the uncertainty of available funds from one year to the next and the inaccessibility of this fund for many vulnerable families remains a major concern with CCDBG. Due to tight state budgets, the state dropped the number of children served each month from 39,100 children in 2006 to 30,600 children in 2007, meaning many vulnerable families who relied on CCDBG funds for infant and toddler care must now pay more of the bill. Although the funds support many children, without a funding increase or development of a more secure form of government assistance, the high price of high-quality infant and toddler care discourages vulnerable families from its usage.

Other policies. Smaller policies also contribute to increases in high-quality child care. In 2004, the Mississippi Department of Education applied for federal funding through Child Care Access Means Parents in Schools (CCAMPIS) – a program that supports campus-based child care for parents enrolled in higher education programs. The University of Southern Mississippi, Mississippi State University, and the Coahoma and Mississippi Gulf Coast Community Colleges encourage on-campus child care that meets Head Start standards and obtains NAEYC accreditation (Sivak & Dixon, 2008). The program provides not only flexible early child care, but high-quality flexible early child care. Although services are not limited to infant and toddler care, it exemplifies motivation towards high-quality care from early education activists in Mississippi.
New research from the Center on the Developing Child, influential findings published in *From Neurons to Neighborhoods: The Science of Early Childhood Development*, and continuing work from early education organizations such as the NAEYC all support stronger policies for the early education field. Federal policies and grants, such as EHS, CCDBG, and CCAMPIS help families access and afford child care. States such as Mississippi, however, need stronger and more creative policies that support high-quality care. The following section outlines four policy alternatives for ensuring that high-quality infant and toddler center-based care is affordable and accessible to vulnerable families.

**Ensuring High-Quality Infant and Toddler Center-Based Care in Mississippi**

Key agencies in Mississippi, including the state’s Department of Education, Department of Human Services, and Child Care Resource and Referral Agencies understand the importance of high-quality infant and toddler care. Without support from everyone in the community, however, committing to high-quality infant and toddler care remains a problem. A public education effort that describes the multiple benefits of high-quality care, with the message that benefits accrue overtime, will increase the probability of achieving any sort of long-term policy change. Additionally, positive outcomes gained in infant and toddler centers may decline if not followed by a strong preschool education (serving children 3-5). Helping vulnerable families cannot be limited to infancy and toddlerhood. Rather, early education lies on a continuum of care, starting at birth and continuing until age 5.

With this in mind, the following proposed solutions provide Mississippi with alternatives to increase high-quality infant and toddler centers throughout the state and create incentives for consumers and providers:

1. Create partnerships between Early Head Start and community-based infant and toddler centers.
2. Ensure a high-quality environment in the home.
3. Mandate participation in the Mississippi Child Care Quality Step System.
4. Provide tax incentives for families to use high-quality care and for providers to offer high-quality services.

These alternatives represent a framework for increasing the supply and usage of high-quality infant and toddler centers among vulnerable families.

Create partnerships between existing EHS and community-based infant and toddler centers

Early Head Start (EHS) – an infant and toddler program targeted at low-income families – offers services through center-based programs, family-based programs, or a combination of the two practices. States generally set eligibility criteria following the federal poverty guidelines. As discussed earlier, the ongoing EHS evaluation study confirms small, yet significant, benefits for young children enrolled (DHHS, 2002).

Many modifications incorporated into the 2007 Head Start make EHS initiatives more viable for states. Changes include allocating half of Head Start expansion funds to EHS, distributing 20% of Head Start training dollars to EHS, and allowing conversion of Head Start programs into EHS dependent on community needs (Zero to Three, 2008). Additionally, the 2009 ARRA competitively provided states a share of $1.1 billion for EHS. The government rewards states that comply with Head Start Program Performance Standards in existing EHS programs. These developments in EHS funding make expansion of the program an achievable goal.

Research shows that states have expanded upon EHS in four categories: lengthening the day/year of existing EHS services, expanding the capacity of EHS programs so a larger number of vulnerable families can use their services, providing resources and assistance to non-EHS providers to reach EHS standards, and supporting partnerships between EHS and non-EHS center-based providers for improving child care quality throughout the community (Schumacher & DiLauro, 2008). These initiatives serve as a launching pad for the Mississippi Department of Health and Human Services’ expansion of its 38 EHS programs.

Missouri’s EHS/Child Care Partnership Project is one example of an innovative EHS initiative that enhanced the quality of infant and toddler care throughout the community. In 1999, the state used a combination of money set aside from gaming revenues ($4.2
million) and CCDBG funds ($500,000) to create partnerships among EHS and community infant and toddler centers. The partnership helped expand services to full-day, full-year care and to attain Federal Head Start Program Performance Standards (Schumacher & DiLauro, 2008). EHS agencies recruited infant and toddler community-based centers that served children eligible for EHS, used state funds to help the centers reach EHS standards, and offered technical assistance, professional development, and additional health and family support services (Raikes & Love, 2002). The partnership symbolizes an agreement between EHS and community-based centers: EHS provides resources to the community-based infant and toddler center, and the center agrees to provide high-quality care to EHS eligible children (Schilder et al., 2005).

In the absence of an evaluation study of EHS partnerships, the evaluation of Ohio’s Head Start (HS) partnerships serves as an indicator of expected outcomes. The Center for Child and Families (CC&F) conducted a longitudinal, comparative study of Ohio’s partnerships between 2001 and 2005. The group analyzed 78 preschool centers in partnership with HS and 63 centers without Head Start programs. The research found that partnering centers received $3,600 for every eligible HS child served. The funds primarily increased teacher compensation packages, supplies and materials, and helped achieve HS Program Performance Standards (high-quality practices). Additionally, centers received teacher training, HS supplies, materials, and technical support. Partnerships increased curriculum usage in the classroom, child assessments, and additional services, including screenings and referrals for families. The evaluation identified best practices, including strong partnerships from the outset, consistent goals set for the community-based center, and good communication between all players (Schilder et al., 2005).

For Mississippi, funds to strengthen partnerships between their EHS centers and the hundreds of infant and toddler centers could increase high-quality services for vulnerable families. Families already using community-based centers will experience a transformation towards higher quality. Families in the process of finding an infant and toddler center will encounter greater options of high-quality care within their neighborhoods. Spreading the HS Program Performance Standards will increase high-quality infant
ensure high-quality care in the home

NAEYC accreditation targets center-based child care. Yet, the concept of high-quality infant and toddler care can be replicated in a family’s home. A few states have implemented an at-home infant child care program (AHIC) that provides cash directly to vulnerable parents with children under the age of two, allowing them to care for their child personally at home (Waldfogel, 2006). In 2004 and 2005, a federal stipulation funded five AHIC demonstration projects included in the reauthorization of TANF. Of the five demonstrations, Minnesota, Montana, and New Mexico continue to implement such programs for parents.

A combination of Minnesota’s and Montana’s AHIC programs serves as a workable model for Mississippi (National Partnership, 2005). In the early 2000’s, both states signed AHIC into law and started distributing benefits to eligible families. Benefits partially supplemented a loss in income in return for parental care in the home. The pilot Montana AHIC program used TANF Maintenance of Effort (MOE) funds – 80% of state funds spent under the former Aid to Families with Dependent Children (AFDC) program. However, Minnesota reserves 3% of the state’s Basic Sliding Fee (BSF) Child Care Assistance program funds for AHIC. In 2005, the 3% totaled $513,130, although the 32 families in the program only required $156,000 ($4,875 per family). Eligibility for AHIC in Minnesota follows the BSF criteria, equaling 174% of the federal poverty line ($27,423 for a family of three). The cash benefits covered a 12-month period and reflected 90–100% of the states’ child care cost at a full-time infant family-based provider. In Mississippi, that amount equals between $3,510 and $3,900 a year (NACCRRA, 2009b).

Both programs issued regulations and requirements for eligible families. While on the program, families in Montana cannot access TANF cash assistance. Minnesota families cannot use state assistance programs, such as the Diversionary Work Program or the Minnesota Family Investment Program. Before applying for services, the parent must show evidence of labor force participation, education/training, or job search activities. Once enrolled in AHIC, parents are required to discontinue any participation in such
activities. For a cash transaction, the parent must become the full-time caregiver for his/her child (below the age of 2) in his/her household.

Montana’s AHIC program also requires completion of a child development education plan specifying activities and experiences that will enhance the infant’s development. This portion of the program should be emphasized, for this requirement ensures AHIC programs will reflect high-quality practices. Mississippi should ensure that an AHIC program supplies participating parents with parent education and early child development classes, literature, and other resources. An additional benefit could grant parents useful, age-appropriate equipment, such as toys and books, as a way to ensure that families better utilize their newly learned knowledge and parenting techniques.

Mississippi, like Montana, can administer an AHIC program through the state’s 12 Child Care Resource and Referral Agencies (CCR&R). Mississippi’s CCR&R’s improve the quality of child care throughout the state by offering technical and training assistance/workshops to providers; resource centers for parents, providers, and community members filled with classroom toys, books, educational media, and curricula material for temporary use; and a database of licensed child care providers available to parents (NACCRRA, 2009a). Most of Mississippi’s CCR&R’s are located on community college campuses through the Mississippi State University Extension Service. This network provides an excellent vehicle for AHIC because the 12 CCR&R’s service all of Mississippi’s 82 counties.

Although this program could be feasible with proper implementation and the right amount of funding, it has a few drawbacks. First, the cash benefit per family poorly supports a family, an issue for single parent families in particular. Although the possibility of combining AHIC benefits with paid-leave benefits increases the amount slightly, vulnerable parents in Mississippi are more likely employed in low-wage jobs (Sivak & Dixon, 2008) and many working parents may not have the privilege of paid-leave benefits. Additionally, the threat of losing employment after parental leave frightens some working parents from taking a leave-of-absence.

Second, vulnerable parents may not want to discontinue state assistance. The cash benefits from TANF and other Mississippi
assistance programs, along with a working salary, are substantially greater than the amount provided solely by AHIC. To meet other basic needs, parents might choose the option that provides the most financial resources for their family. Following Minnesota’s and Montana’s example, the Mississippi AHIC program would supplement parents between $3,510 and $3,900 a year – an amount far less than any family can possibly survive on.

Lastly, Mississippi would have to dedicate funding towards monitoring the program and its participants. The Minnesota and Montana programs do not do so; however, a fully-implemented AHIC program should incorporate a system of tracking compliance and success. For example, a case worker that regularly checks in with participating parents ensures that parents are indeed staying at-home with their child and providing them with a safe and stimulating environment.

Even in light of these drawbacks, however, the implementation of an AHIC program would make an impact on Mississippi’s infant and toddler child care system. Introducing an AHIC program may persuade some Mississippian parents to raise their young children at home full-time, especially in the presence of few high-quality providers in the community. If fewer infants and toddlers accessed low-quality child care, cognitive disturbance would decrease. Additionally, parents choosing to participate in the program would lower the total need for center-based child care slots and relieve some pressure for infant and toddler providers.

*Mandate participation in the Mississippi Child Care Quality Step System*

In 2006, Mississippi implemented a voluntary pilot Mississippi Child Care Quality Step System (CCQSS) in 9 counties through the Office of Children and Youth in the Department of Human Services. The pilot will last until 2011 (NCSL, 2007). Mississippi’s CCQSS is a Quality Rating and Improvement System (QRIS). Similar to restaurant and hotel star-ratings, a QRIS assesses, improves and communicates program quality. The system awards early education programs for achieving multiple stars that represent progressive program standards (see Table 3 for the five common elements of QRIS).
The goals of a QRIS include recognizing quality, improving customer awareness of quality, rewarding quality financially outside of subsidy systems, and establishing a consistent approach to quality across all early education programs in the state (Mitchell, 2005). When properly implemented, child care quality, professional development among early education providers, parents’ understanding of quality care, and program accountability all increase (NCCIC, 2007). As of 2007, 14 states officially incorporated a statewide QRIS and 9 states implemented a pilot.

The cost of a QRIS varies dramatically among participating states. Variability depends on administrative costs, assessment tools that establish compliance of standards and quality levels, and the frequency by which states require assessments. In Mississippi, child care facilities earning 2 to 5 stars and serving families using CCDBG assistance receive quality bonuses. The Office of Children and Youth (OCY) within the Mississippi Department of Human Services (MDHS) provided $2 million in fiscal year 2008 for the QRIS pilot initiative. The pilot expanded from 9 counties in 2006 to 60 in 2008.

Table 3

Common Elements in a Quality Rating and Improvement System

1. Standards: multiple steps between licensing and accreditation
2. Accountability: how well programs meet standards
3. Program and Practitioner Outreach & Support: training, mentoring, and technical assistance are included to help programs achieve higher levels of quality
4. Financing Incentives: tiered subsidy reimbursement awarded with each quality level achieved
5. Parent/Consumer Education Efforts: recognizable symbols, such as starts, to indicate the levels of quality

Table 4

**Mississippi Early Education 5-Star Rating**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Action/Requirement</th>
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<tbody>
<tr>
<td>Mississippi Department of Health license</td>
<td>Director training on MS Early Learning Guidelines</td>
</tr>
<tr>
<td>Director’s Self-Assessment</td>
<td>Director must have BA in Child Development or ECE</td>
</tr>
<tr>
<td>Director’s Professional Development Plan</td>
<td>Implement monthly on-site professional development</td>
</tr>
<tr>
<td>All teachers have GED/high school diploma</td>
<td>25% of teachers earn Child Development Associate</td>
</tr>
<tr>
<td>Employee evaluations</td>
<td>Plan and hold one parent workshop</td>
</tr>
<tr>
<td>Teacher trainings</td>
<td>Create lending library for parents</td>
</tr>
<tr>
<td>Obtain staff handbook</td>
<td>Teachers in 3-4 yr. old classroom complete training on MS Early Learning Guidelines</td>
</tr>
<tr>
<td>Create learning centers in all classrooms</td>
<td>Early Learning Guidelines</td>
</tr>
<tr>
<td>Review and file weekly lesson plans</td>
<td>File parent sign-in sheet for voluntary projects</td>
</tr>
<tr>
<td>5.1-7.0 on Early Childhood Environmental Rating Scale</td>
<td>Create a family resource center</td>
</tr>
<tr>
<td>Prepare monthly calendars of facility activities for parents</td>
<td>Conduct parent surveys</td>
</tr>
<tr>
<td>Prepare weekly notes and monthly newsletter for parents</td>
<td>File developmental checklist for all children</td>
</tr>
<tr>
<td>Install a bulletin board for parent information</td>
<td>Directors mentor another child care Director</td>
</tr>
<tr>
<td>Complete parent-teacher conferences twice a year</td>
<td>File kindergarten transition plan agreements with elementary schools</td>
</tr>
<tr>
<td>“Child Care as Business”</td>
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Early education programs participating in Mississippi’s CCQSS strive for a 5-star rating (see Table 4 for details). Each level meets specific requirements in administrative policy, professional development, learning environments, parent involvement, and evaluation. Centers prepare for participation by completing a
Director’s self-assessment, developing a professional development improvement plan for each employee, completing staff evaluations, and planning for the monitoring visit (Grace & Shores, 2008).

Once the pilot is completed in 2011, and an evaluation confirms positive outcomes for children and centers, Mississippi must seriously consider expanding its QRIS to all counties and shifting from voluntary participation to mandatory compliance for infant and toddler centers. For example, North Carolina and Tennessee require all early education programs to participate in their states’ QRIS by attaching the rating system to the child care licensing process. Additionally, this system should incorporate NAEYC accreditation, with accreditation achieved in conjunction with the 5-star level of the QRIS.

To institutionalize a QRIS, Mississippi must establish stable financing. As seen in the pilot, the state reimburses centers at a higher rate depending on the level of quality achieved (quality bonuses), referred to as a tiered reimbursement system. Typically, this form of reimbursement is financed through the Child Care and Development Fund (CCDF), TANF, or general funds (Stone, 2004). If Mississippi does expand participation to every licensed infant and toddler center, however, the state must create a dependable funding source.

Lessons learned from the 14 states currently implementing QRIS offer examples of creative financing. Eight of the nine states established grants or merits for quality funded by CCDF quality dollars or state general funds. For example, Vermont established a special annual grant for infant and toddler programs that participate in their QRIS. Likewise, Pennsylvania created Star Support Grants for programs ranging from $1,250 to $12,000 per center per year dependent on the center’s size and star level (must achieve at least 3 stars to qualify). This form of financing is a creative opportunity for Mississippi. However, many states reported that this money was vulnerable to state budget cuts (Stone, 2004).

*Provide tax incentives for families to use high-quality infant and toddler care centers and for providers to offer high-quality service*

The creation of high-quality infant and toddler care solutions must include incentives for provider development and consumer
usage. Consumers in Mississippi – in this case vulnerable families – feel burdened by the high costs associated with quality care. Consequently, the demand for high-quality services declines. Early education providers also feel the burden from quality costs, leading many to increase their prices to supplement infrastructure improvements. Using incentives would give Mississippi two complimentary ways to combat this dilemma: providing consumer tax credits for families using high-quality care, and providing business investment tax credits to offset the costs of offering high-quality service.

**Consumer tax credits.** The availability of high-quality infant and toddler center care in no way ensures that vulnerable families will use these services. The cost of such care remains an issue. Early education represents a market-driven system, meaning consumers choose services and pay the price set by providers. However, economists at Cornell University claim that early education is an “underdeveloped market” because of the inadequate demand from consumers for high-quality services due to its costs (Stoney & Mitchell, 2007) and competing demands to pay for other basic necessities with limited resources.

The tax system helps working parents with children pay for expenses, including programs such as the Child and Dependent Care Tax Credit (CDCTC), the Earned Income Tax Credit (EITC), and the Child Tax Credit (CTC), which can be used to lessen the financial burden of child care. The Family Tax Relief Act of 2008 improved CDCTC – a credit for individuals who pay for child care – by making it fully refundable, raising the percentage of expenses that can be claimed, increasing the expense limit of child care costs, and adjusting the credit for inflation (NWLC, 2008). The EITC helps low-income working individuals and families rise above poverty levels by offering a tax credit of $2,917 for one child and $4,824 for two or more children. The CTC gives taxpaying families earning $11,300 – $110,000 annually $1,000 per child.

Although current tax credit programs provide extra money for families, they do not encourage use of high-quality child care. Once high-quality infant and toddler centers are available for families in Mississippi, the state might provide higher tax credits for families that use these services. Maine, Vermont and Louisiana have increased tax credits for families using high-quality child care centers that have a Quality Certificate from a Quality Rating and
Improvement System (QRIS) or NAEYC accreditation. Maine doubled the CDCTC for parents who enroll their children in Maine Quality Certificate programs. Vermont increased the CDCTC to 50% of child care costs if the center in use is NAEYC accredited. Louisiana enacted a “school readiness tax” that created a refundable, progressive tax credit for families with children under the age of 6 enrolled in a participating QRIS program (Stoney & Mitchell, 2007). Such tax credit strategies encourage families to choose high-quality care, when available, by providing financial relief.

Mississippi must bear in mind two paradoxical factors when structuring a consumer tax credit. Relying on lessons learned from the “green” energy tax credits, the tax must be large enough to create incentive to use higher priced services of higher quality. At the same time, the tax credit cannot be so large as to create fear of over-consumption, leading to an abrupt elimination of the credit. Additional tax credit considerations include advertising quality infant and toddler centers so parents can easily distinguish eligible providers, assuring public understanding of high-quality goals and tax credit options to help shift behaviors of consumers, offering applications at point of purchase, and ensuring benefits for low-income parents.

**Business investment tax credits.** Quality improvements in early education costs money, and providers pay the bill. It remains unwise for providers to pass the costs to the consumer because increased costs deter parents from using high-quality care. Mississippi can increase its supply of high-quality centers by creating business investment tax credits for quality improvements.

Several states endorse tax credits that partially reimburse costs spent on improving quality. The Maine Quality Child Care Improvement Tax Credit, launched in 1999, compensates $1,000 for every $10,000 invested in quality improvements yearly for 10 years. Oklahoma reimburses 20% of high-quality improvements deemed eligible by the state. Florida established a sales tax exemption for educational material for early education programs that achieve one of several state accreditations. Although no evaluations of business investment tax credits exist, Maine noticed an increase in early education quality improvement initiatives (Stoney & Mitchell, 2007).
Consumer and provider tax policies introduce an important aspect in promoting high-quality infant and toddler center-based care. As seen in “green” energy tax credits, tax relief has been shown to greatly alter consumer and provider behavior. When pursuing tax incentive strategies, Mississippi could utilize tax experts and ensure that financial resources are dedicated to these credits. Tax policies remain an important feature for Mississippi to consider in its formulation of new infant and toddler policies.

**Recommendation for Action**

High-quality early education is the only way to combat the devastating challenges and effects of vulnerability – single parent households, children in poverty, and low-birthweight babies. High-quality care reverses many of the effects associated with vulnerability, such as lower levels of cognitive stimulation in a home with a time-constrained single parent, emotional detachment by parents experiencing depression from living in poverty, and undiagnosed developmental delays resulting from low-birthweight (National Research Council, 2000 & Federal Interagency Forum, 2007). Early services for infants and toddlers promote proper social, emotional, cognitive, and physical development – a formula for a strong and active community in the future. High-quality care reinforces not only the child’s growth and development, but also helps parents through referral services and opportunities for parental involvement in the classroom. As money trickles down from the Federal government, Mississippi must invest wisely in the care provided for its youngest citizens.

The policy alternatives pursued by Mississippi officials should ensure a gain in benefits superior to the costs. Ensuring high-quality care in the home through an at-home infant care program is not likely to produce these results. The concerns associated with the program – creating a monitoring system to decrease system abuse, insufficient cash benefits to support a family, public discontent about restricting state assistance, and a questionable funding source – outweigh the minimal benefits of the program. Furthermore, the only known implementation of AHIC consists of programs serving roughly 30 participants. Mississippi has far too many vulnerable families to rely on a program serving so few.
Therefore, this alternative will not produce the results Mississippi needs at this time.

Given the benefits of the other policy alternatives, and the fact that they can be used in combination with one another, Mississippi should consider a sequenced approach to high-quality infant and toddler care for vulnerable families (see Table 5). Before Mississippi advertises any tax incentives for consumers, they must ensure that high-quality options exist. Therefore, Mississippi should start by evaluating their current infant and toddler care system and determine why so few of them are high-quality. Then that the state can determine which option(s) – creating partnerships between EHS and community-based centers, enforcing Mississippi Child Care Quality Step System as mandatory, and/or providing business investment tax credits – best suits its vulnerable families. If money allows, a combination of all three options presents itself as an additional option for the state.

Creating EHS partnerships and enforcing a QRIS represent excellent choices because of the existing infrastructure, including 38 EHS programs throughout the state and a pilot QRIS. Strong evidence supports each option, predicting great outcomes for early education enrollees influenced by either initiative. Once high-quality infant and toddler care exists for all vulnerable families, Mississippi should then take a second step to ensure usage by creating consumer tax incentives. This sequence reduces the risk of solely benefiting those families that can access and afford high-quality care, by also ensuring that vulnerable families can access high-quality care.

Evaluation is an important step for any new policy. Funds should be reserved for evaluation, both during and after implementation. Documented gains – in this case, more vulnerable children in high-quality infant and toddler care – strengthens the argument for continued funding and replication in new communities. The goal for Mississippi is high-quality care throughout the state, and evaluation serves as the source of such accountability.

Lastly, Mississippi must extend state support to preschool education (services for children 3–5 years old). Investing time and money into infant and toddler care will only produce short-term benefits unless high-quality services support children throughout their entire childhood. Leaving a gap in services between infant
and toddler care and elementary school could easily erase the progress made in the earliest of years and continue the disparity for vulnerable children. These options for Mississippi’s infant and toddler care system could easily be replicated into preschool care.

### The Future of Infant and Toddler Care

The field of early education has made significant gains in the last few decades. The field has experienced the introduction of high standards formulated by the NAEYC, research-based findings clarifying the development of young children’s learning, and various policies fostering infant and toddler center-based care. One of the driving forces behind these advances has been widespread acknowledgement of the fact that low-quality child care can cause harm to young children’s growth and development. The nation learned that the early years matter, and, especially for vulnerable children, high-quality care generates great outcomes.

Many vulnerable families, however, continue to struggle with access to and affordability of high-quality child care. To ensure all children have the opportunity of utilizing high-quality care, states must implement creative policies that increase access and
affordability. The passing of the American Recovery and Reinvestment Act serves as a launching pad for the early education field to invest money in its services. The selected policy alternatives promise to bring the future of infant and toddler center-based care to new heights.

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References


Quality Care for Mississippi’s Young Children


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