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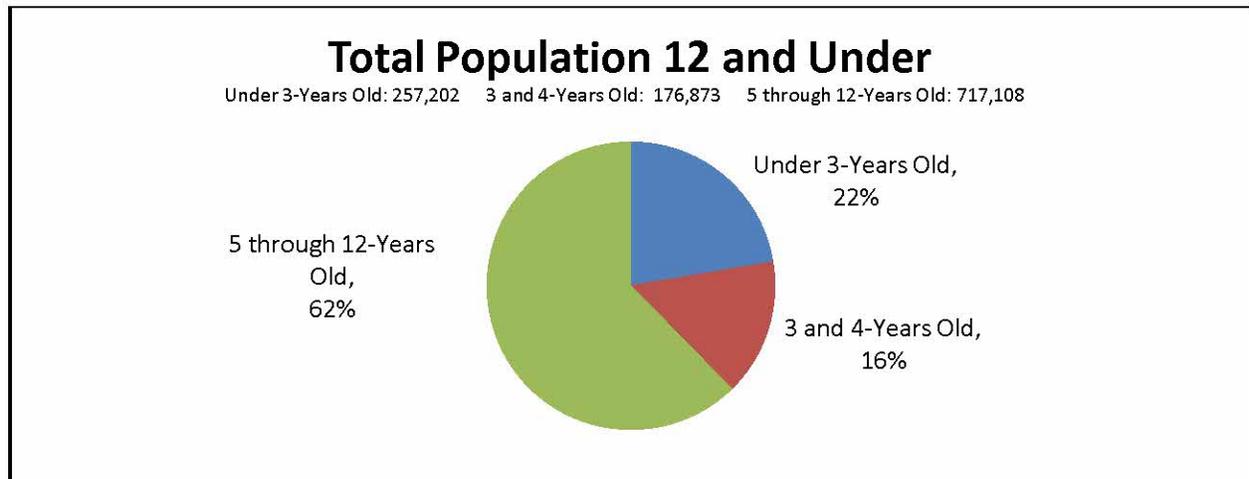
State and Territory Profile - Indiana

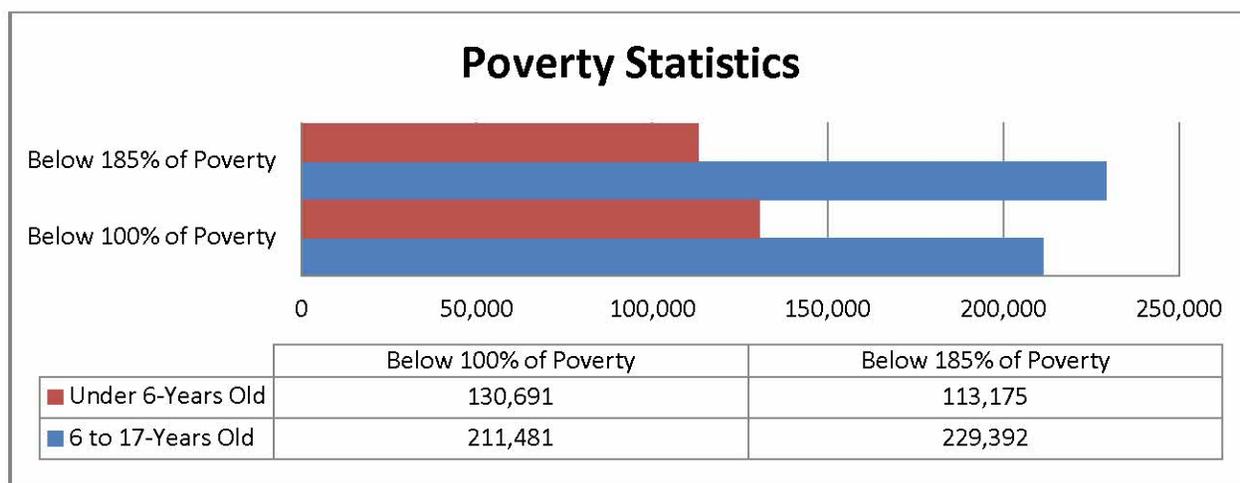
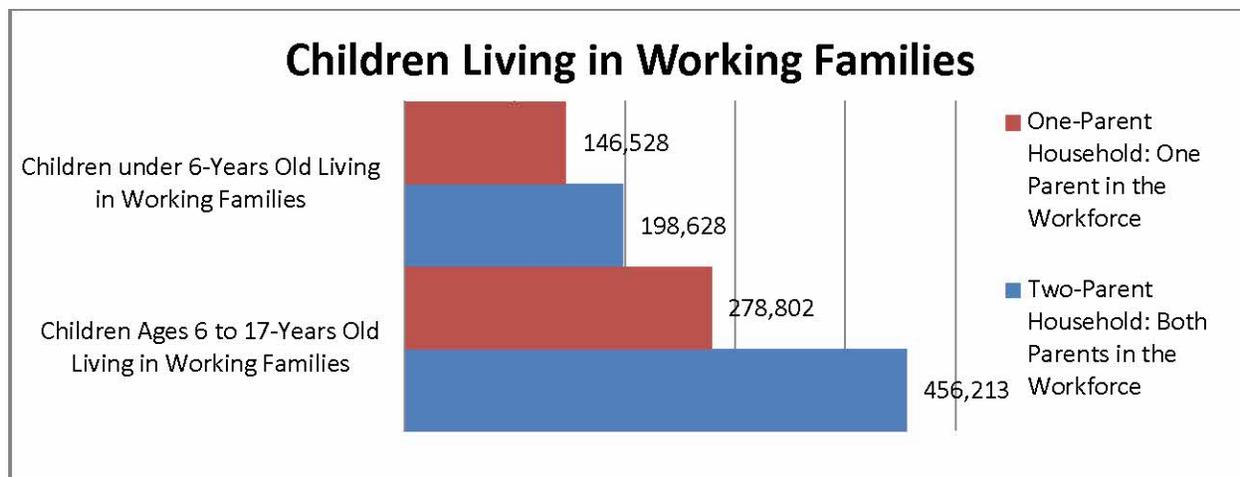
This profile highlights a current innovative effort to promote a subsidy system that is child-focused, family friendly, and fair to providers. It also provides demographic information, Early Care and Education (ECE) program participation and funding, subsidy innovation and program integrity information, program quality improvement activities, and professional development and workforce initiatives. Sources and links are provided at the end of the document.

Highlight of Innovative Effort

Indiana is collaborating with multiple partners to create and build a connected and coordinated statewide Professional Development Network for providers, administrators, and others who work with children —*infants, toddlers, preschoolers through schoolage*— and youth. The purpose of the network is to assist personnel working with children and youth outside of the formal K-12 system in providing professional development opportunities; help them to obtain credentials, degrees, and/or certification which aids in their skills and knowledge; and to coordinate/utilize and maximize a variety of funding streams, both public and private.

Demographics¹



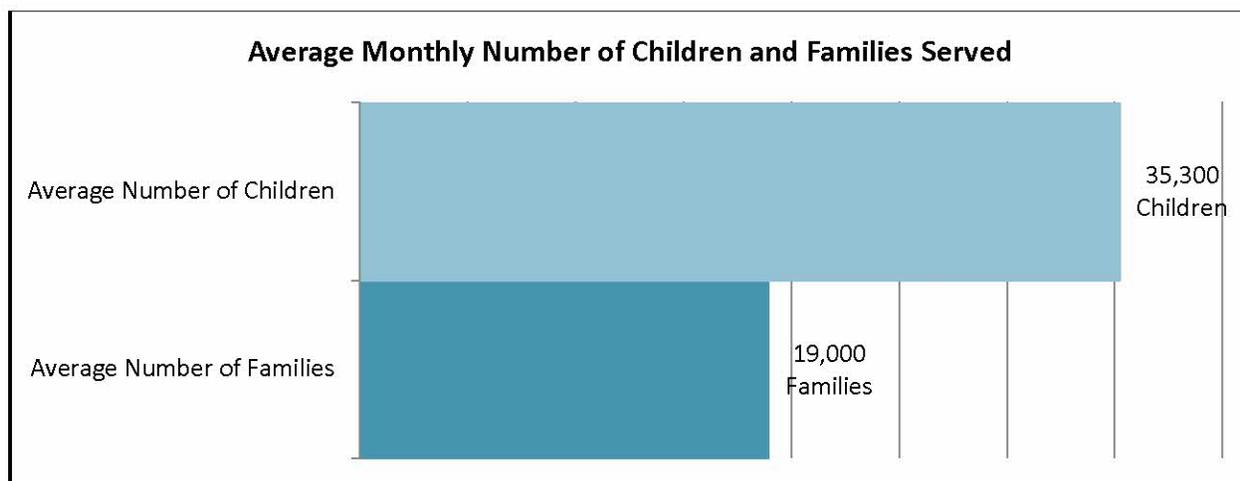
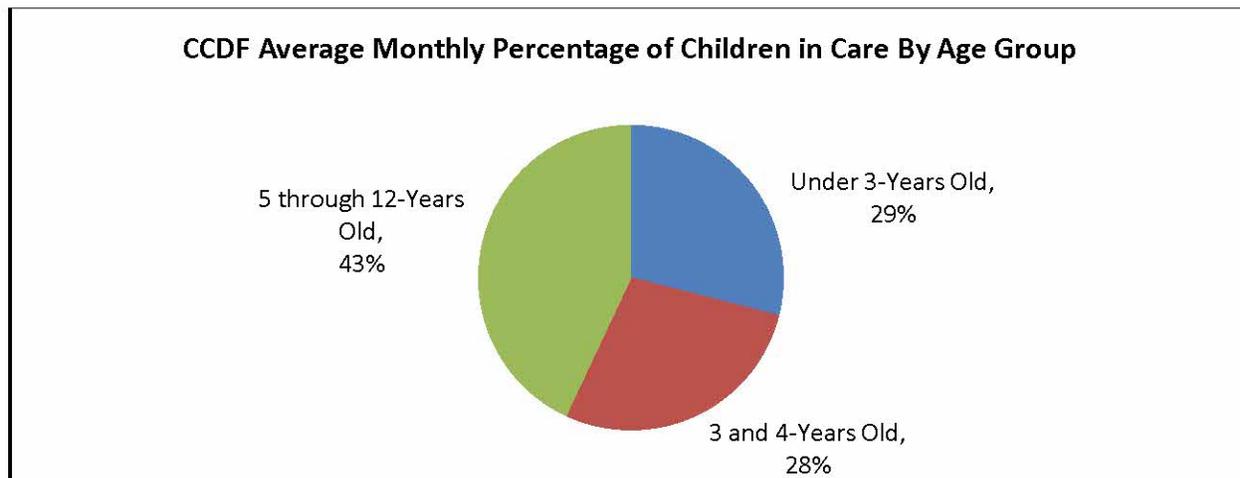


ECE Workforce

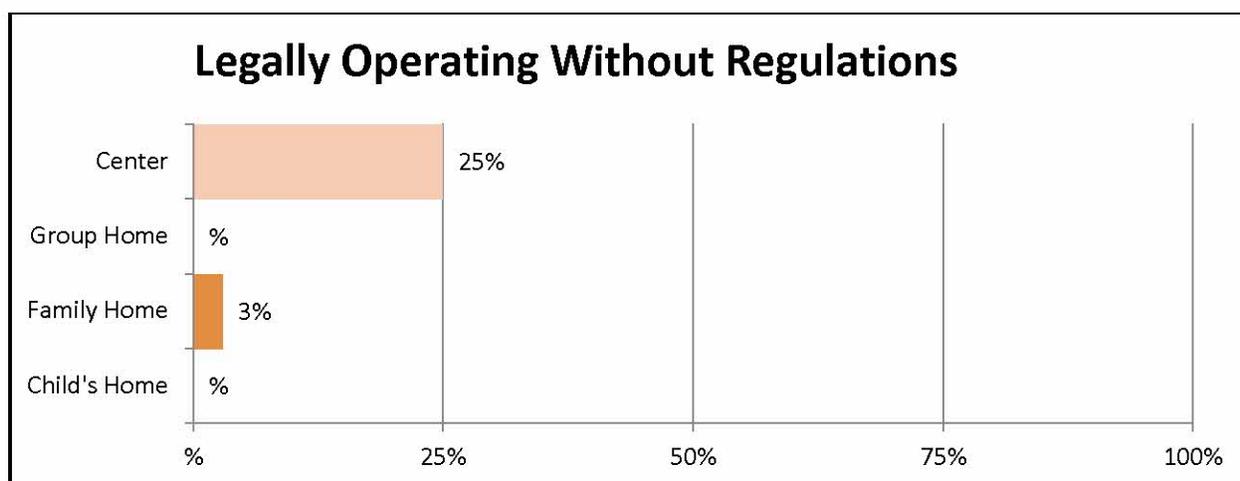
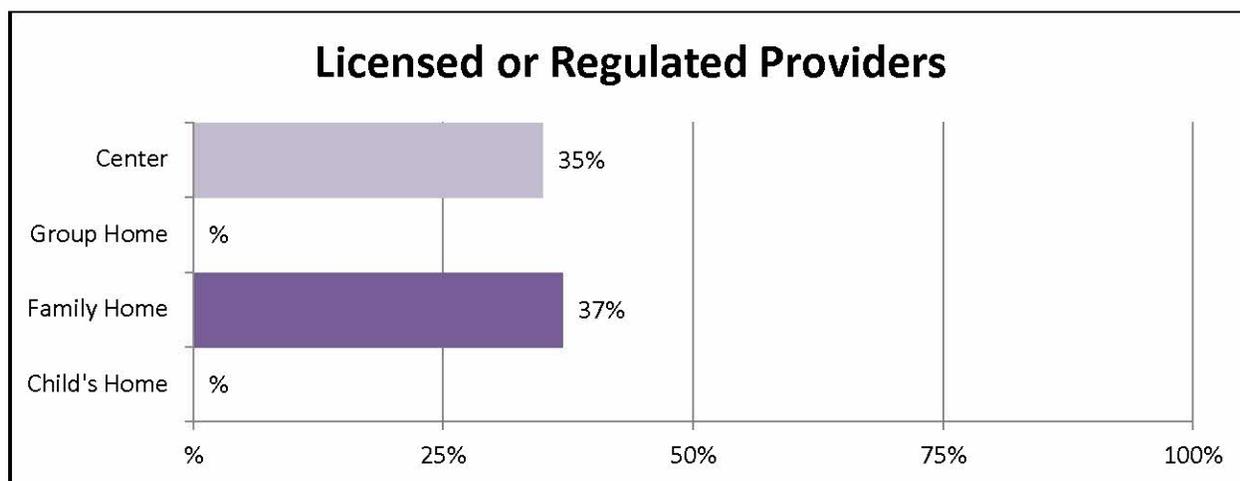
ECE Workforce ²	
Number of paid employees in child care establishments	13,472
Number of self-employed child care providers	13,294
Average annual wage for child care workers	\$19,240

ECE Program Participation and Funding³

Percentage and Number of Children/Families Served



Average Monthly Percentages of Children Served in All Types of Care⁴



Note: Unregulated provider data includes relative and non-relative care.

CCDF Funding and Quality Investments

Child Care and Development Fund (CCDF)	
Total CCDF Expenditure:	\$193,101,967
Federal Expenditure:	\$158,785,858
State/Territory Expenditure:	\$34,316,109

CCDF Quality Investments	
Infant and Toddler:	\$1,207,540
Quality Expansion Funds:	\$5,184,860
School-Age/Resource and Referral:	\$390,250

TANF Expenditure on Child Care

Temporary Assistance for Needy Families (TANF) ⁵	
TANF – Total Child Care Expenditure:	\$27,158,599
TANF – Direct Expenditure on Child Care:	\$0
TANF – Transfer to CCDF:	\$27,158,599

Funding and Participation for Other ECE Programs

Child and Adult Care Food Program (CACFP) ⁶	
CACFP Funding:	\$41,975,598
Participation:	
Number of Family Child Care Homes	2,131
Number of Child Care Centers (includes Head Start Programs)	858

Head Start ⁷	
Head Start Federal Allocation:	\$107,840,984
Head Start State/Territory Allocation:	\$0
Number of Children Participating:	12,957

IDEA Part B, Section 619 ⁸	
Funding:	\$8,727,260
Number of Children Served (Ages 3- through 5-Years-Old):	18,172

IDEA Part C ⁹	
Funding:	\$8,684,021
Number of Children Served (Ages Birth through 2-Years-Old):	8,976

Pre-K ¹⁰	
Total Expenditure:	N/A
Note: Total Expenditure includes all State/Territory, Local, and Federal dollars. In addition to 3- and 4-year-olds, some Pre-K programs enroll children of other ages.	
Enrollment (3- and 4-year-olds):	N/A

State/Territory and Federal Child Care Tax Credits

Child Care Tax Credits ¹¹	
Federal Total Amount Claimed:	\$55,793,000
Federal Number of Claims:	113,704
State/Territory Tax Credit Available:	No
State/Territory Credit Refundable:	No

CCDF Subsidy Innovation and Program Integrity¹²

Administration of Program

CCDF program rules and policies around eligibility, sliding fee scale, and payment rates are established at the State level.

Nearly all care is provided through certificates. Only 2.2 percent of care is provided through grants/contracts. Groups of accredited, level 4 Paths to QUALITY child care centers, from low income areas across the State, retain contracts to deliver CCDF services. These contracts ensure that accredited care will be available in communities where such care might not survive without contract support. These sites are required to maintain national accreditation and level 4 in Paths to QUALITY. Families have the option of a voucher or referral to a grantee funded through a contract.

The Lead Agency contracts with 10 community based nonprofit agencies (Intake Agents) to determine eligibility. It also contracts with a for-profit company to make provider payments. The Lead Agency contracts with Child Care Resource and Referral (CCR&R) agencies to help parents find care and with a combination of government agencies and professional associations to implement quality activities.

Income Eligibility Criteria

Income Eligibility Limit as a Percent of State Median Income (SMI)				
Family Size	100% of SMI (Monthly)	85% of SMI (Monthly)	Lower Than 85% of SMI, If Used to Limit Eligibility	
			Amount (Monthly)	Percent of SMI
Two	\$4,024.00	\$3,420.00	\$1,557.00	38.7%
Three	\$4,970.00	\$4,225.00	\$1,961.00	39.5%
Four	\$5,917.00	\$5,030.00	\$2,365.00	40%

SMI Year: 2011. Note: The State has a tiered eligibility system. Entry-level is set at 127 percent of the Federal Poverty Income Guideline (FPIG), and exit level is set at 170 percent of the FPIG. Entry-level income is presented.

Re-determination Period Upon Initial Authorization

The re-determination period is 6 months.

Waiting Lists

The Lead Agency has an active waiting list for only certain eligible families. All eligible families who apply are placed on the waiting list, with the exception of TANF or Indiana Manpower and Comprehensive Training (IMPACT) program families.

Prioritize Services for Eligible Children and Families

Children with special needs have priority over other CCDF eligible families.

Sliding Fee Scale and Family Contribution

Family Contribution for Family of Three					
Minimum Family Contribution	Maximum Family Contribution for First Child	Maximum Family Contribution for Multiple Children	Lead Agency Waives Family Contribution	Lead Agency Allows Additional Fees by Provider	Sliding Fee Scale Effective Date
No fee	7% of cost of care	7% of cost of care	NO families with income at or below the poverty level for a family of the same size ARE required to pay a fee. The poverty level used by the Lead Agency for a family of 3 is: \$1,544.	Yes	April 3, 2011
For illustrative purposes, the minimum and maximum fees for full-time care for a family of three upon entry into the program are presented. Note: Contribution is calculated as fee as percent of income and fee is per family. Family fee will increase by 1 percent per year of participation in program.					

Payment Rates for Child Care Services

Rates for Child Care Services – Marion County			
Age	Licensed		License Exempt
	Center	Family Child Care	
Infant	\$218.00/week	\$130.00/week	\$95.00/week
Toddler	\$188.00/week	\$125.00/week	\$89.00/week
Preschool	\$160.00/week	\$100.00/week	\$79.00/week
School Age	\$87.00/week	\$76.00/week	\$63.00/week

For illustrative purposes, reimbursement rate ceilings for full-time care in the largest urban area are presented. Effective date of payment rates: September 27, 2009. Note: The rate structure has three school-age rates (kindergarten, school-age before/after, and school-age all other). School-age before/after rates are presented. License exempt rates are for legally/license-exempt homes. The rate structure includes a separate rate for legally/license-exempt facilities. The Lead Agency uses hourly and daily, full-time payment units. Rates are based on the 2007 Market Rate Survey (MRS) and are set at the 54th percentile for licensed centers and 64th percentile for licensed homes of the current MRS. Differential rates are used for children with special needs and higher quality care. Geographic area: Rates vary by county. Rates for Marion County are presented.

Program Quality Improvement Activities¹³

Licensing

Licensed Facilities	Number	Capacity	Type of Center-Based Facilities/Programs Exempt from Licensing	
Child Care Centers	605	62,394	Parents are on the premises	No
Small Family Child Care Homes	NC	NC	Small number of children in care	No
Large/Group Family Child Care Homes	3,053	37,670	Part-day, small number of hours	Yes
Other Licensed Facilities	704	42,118	Preschools operated by public schools	No
Total:	4,362	142,182	Recreation programs, instructional classes for children, and/or club programs	No

Note: NC - Not category of facility

Child-Staff Ratios and Group Size by Age of Children for Centers		
Age of Children	Child-Staff Ratios	Group Size
9 months	4:1	8
27 months	5:1	10
3 years	10:1	20
5 years	15:1	30
10 years and older	15:1	30

Types of Routine Visits Conducted			
Type of Care	Announced	Unannounced	Frequency of Routine Visits
Child Care Centers	No	Yes	Unannounced visits once a year
Small Family Child Care Homes	Yes	No	Announced visits once a year
Large/Group Family Child Care Homes	No	No	N/A

Program Quality

Program Standards	
<ul style="list-style-type: none"> ■ State/Territory has quality improvement standards that are beyond what is required for licensing 	Yes
<ul style="list-style-type: none"> ■ Standards have provisions about the care of the following groups of children: <ul style="list-style-type: none"> ◆ Infants and toddlers ◆ School-age children ◆ Children with special needs ◆ Children who are dual language learners 	Yes
<ul style="list-style-type: none"> ■ Standards are part of an implemented quality rating and improvement system (QRIS) or similar quality improvement system 	Yes
<ul style="list-style-type: none"> ■ Standards are part of a pilot QRIS or similar quality improvement system, or are in development 	No
Program Supports To Improve Quality	
<ul style="list-style-type: none"> ■ State/Territory provides technical assistance (TA)/consultation to help programs improve quality 	Yes
<ul style="list-style-type: none"> ◆ TA/consultation is specific to infant/toddler care 	Yes

Program Supports To Improve Quality	
◆ TA/consultation is specific to school-age care	Yes
◆ TA is part of a QRIS	Yes
Quality Assurance And Monitoring	
■ State/Territory uses assessment tools (e.g., Environment Rating Scales, Classroom Assessment Scoring System, Program Administration Scale, and/or Business Administration Scale)	Yes
■ Program assessments are part of a QRIS	Yes
Financial Incentives and Supports	
■ State/Territory offers financial incentives tied to quality	Yes
■ Financial incentives are part of a QRIS	Yes
Outreach And Consumer Engagement	
■ State/Territory uses the media (e.g., print, radio, television, telephone, social marketing) to provide parents with information about quality	Yes
■ State/Territory communicates levels of quality for child care programs in a searchable database on the Web	Yes
■ State/Territory publishes information about licensing compliance on the Internet	Yes
■ State/Territory conducts consumer engagement campaign with a focus on quality	Yes
Quality Rating And Improvement System	
■ Paths to QUALITY, http://www.childcareindiana.org/childcareindiana/ptq.cfm	
State/Territory-wide Specialist Networks ¹⁴	
■ State/Territory has an Infant/Toddler Specialist Network	Yes
■ School-age Specialist Network	Yes
Early Learning Guidelines (ELGs) ¹⁵	
Age Group	
■ Birth to 3 years	Yes
■ 3 to 5 years	Yes
■ 5 years and older	Yes

Incorporation of Early Learning Guidelines into Child Care Systems

- | | |
|--|-----|
| ■ To define the content of training required to meet licensing requirements | No |
| ■ To define the content of training required for program quality improvement standards (e.g., QRIS standards) | No |
| ■ To define the content of training required for the career lattice or professional credential | No |
| ■ To require programs in licensing standards to develop curriculum/learning activities based on the voluntary ELGs | No |
| ■ To require programs in quality improvement standards to develop curriculum/learning activities based on the voluntary ELGs | Yes |
| ■ To develop State/Territory -approved curricula | No |
| ■ Other: ELG are incorporated into trainings offered by the CCR&Rs. | |

Alignment of Early Learning Guidelines with Child Care Systems

- | | |
|--|-----|
| ■ Cross-walked to align with Head Start Outcomes Framework | Yes |
| ■ Cross-walked to align with K-12 content standards | Yes |
| ■ Cross-walked to align with State/Territory pre-k standards | No |
| ■ Cross-walked with accreditation standards | Yes |
| ■ Other: Cross walked with State QRIS standards | |

Professional Development Systems and Workforce Initiatives¹⁶

Core Knowledge and Competencies

- | | |
|---|-----|
| ■ State/Territory has developed core knowledge and competencies | Yes |
| ■ Other: | |

Career Pathways

- | | |
|---|-----|
| ■ State/Territory has a career pathway or career lattice | Yes |
| ■ Career pathway includes specific topic credentials and/or specific role credentials | Yes |
| ◆ Infant/toddler credential | No |
| ◆ Preschool credential | No |
| ◆ School-age credential | No |
| ◆ Dual language learners credential | No |
| ◆ Children with special needs credential | No |
| ◆ Center staff credential | Yes |

Career Pathways	
◆ Family child care credential	Yes
◆ Director and/or administrator credential	Yes
◆ Education/Trainer credential	Yes
◆ Technical Assistance credential	Yes
• Consultant	No
• Mentor	Yes
• Coach	No
• Advisor	Yes
■ Other:	
Professional Development Capacity	
■ State/Territory has a training approval system	No
■ State/Territory has a trainer approval system	No
■ State/Territory has early childhood education degree programs ¹⁷	
◆ 1-year program	Yes
◆ 2-year program	Yes
◆ 4-year program	Yes
◆ Master's degree	Yes
◆ Ph.D. degree	Yes
■ State/Territory has articulation agreements	Yes
Access to Professional Development	
■ State/Territory has an online database or calendar of training opportunities	No
■ State/Territory has career advising	Yes
■ State/Territory provides supports to access professional development opportunities (e.g., scholarships, free training/education, reimbursement, grants/loans, release time, etc.)	Yes
■ State/Territory has technical assistance (such as mentoring and/or coaching) to help practitioners improve their skills	Yes

Compensation, Benefits, and Workforce Conditions

- State/Territory has a salary or wage scale for various professional roles No
- State/Territory provides financial rewards for participation in professional development (e.g., a one-time salary bonus for completing training) Yes
- State/Territory provides sustained financial support on a periodic, predictable basis (e.g., annual wage supplement, based on the highest level of training and education achieved, etc.) No
- State/Territory offers or facilitates benefits (e.g. health insurance coverage, retirement, etc.) to the workforce No

Workforce Data System

- State/Territory has a workforce data system (e.g., a workforce registry) No
 - ◆ Includes staff in centers No
 - ◆ Includes providers in family child care homes No
 - ◆ Includes administrators in centers No
 - ◆ Includes technical assistance providers (including mentors, coaches, consultants, home visitors, etc.) No
 - ◆ Includes education and training staff (such as trainers, CCR&R staff, faculty) No
- Other:

- ¹US Census Bureau. (n.d). In American FactFinder, 2010 Single Years of Age and Sex. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP2&prodType=table
- US Census Bureau. (n.d). In *American Community Survey, 2010*. C23008 Age of own Children under 18 Years in Families and Subfamilies by Living Arrangements by Employment Status of Parents: Universe: Own children under 18 years in families and subfamilies. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_C23008&prodType=table
- US Census Bureau. (n.d). In *American Community Survey, 2010*. B17024: Age By Ratio Of Income To Poverty Level In The Past 12 Months - Universe: Population for whom poverty status is determined. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B17024&prodType=table
- ²U.S. Census Bureau. (n.d.). 2009 County Business Patterns. <http://www.census.gov/econ/cbp/index.html>
- U.S. Census Bureau. (n.d.). 2009 Nonemployer Statistics. <http://www.census.gov/econ/nonemployer/index.html>
- Bureau of Labor Statistics, May 2010 State Occupational Employment and Wage Estimates. http://www.bls.gov/oes/current/oes_nat.htm
- ³U.S. Department of Health and Human Services, Office of Child Care. (September 2010). *FFY 2010 CCDF data tables [Preliminary estimates]*. Table 9 Average Monthly Percentages of Children In Care By Age Group and Table 1 Average Monthly Adjusted Number of Families and Children Served. http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/10acf800_preliminary/list.htm
- U.S. Department of Health and Human Services, Office of Child Care. (2010, September). *FFY 2010 Child Care and Development Fund (CCDF) state expenditures, Preliminary Estimates* <http://www.acf.hhs.gov/programs/ccb/data/expenditures/10acf696/overview.htm>
- ⁴U.S. Department of Health and Human Services, Office of Child Care. (September 2010). *FFY 2010 CCDF data tables [Preliminary estimates]*. Table 6 Average Monthly Percentages of Children Served in All Types of Care. http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/10acf800_preliminary/list.htm
- ⁵U.S. Department of Health and Human Services, Office of Family Assistance. (n.d.). Fiscal Year 2011 TANF financial data. http://www.acf.hhs.gov/programs/ofa/data/2011fin/tanf_2011_index.html
- ⁶Food Research and Action Center. (March 2012). Child and Adult Care Food Program: Participation Trends 2012. http://frac.org/newsite/wp-content/uploads/2009/05/cacfp_participation_trends_report_2012.pdf
- Food Research and Action Center. (March 2012). *State of the States: State Data Profile 201*. <http://frac.org/map/>
- ⁷U.S. Department of Health and Human Services, Office of Head Start. (2010, February). Head Start program fact sheet. www.acf.hhs.gov/programs/ohs/about/fy2010.html
- ⁸U.S. Department of Education, Office of Special Education Programs. (April 2012). Fiscal Year Allocations for Preschool Grants, Individuals with Disabilities Education Act - Part B, Section 619. <http://www2.ed.gov/fund/grant/apply/osep/2012apps.html>
- U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), (July 2012) OMB #1820-0043: Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act, 2011. <https://www.ideadata.org/PartBData.asp>
- ⁹U.S. Department of Education, Office of Special Education Programs. (May 2012). Fiscal Year 2012 Allocations for the Grants for Infants and Families Program, Individuals with Disabilities Education Act - Part C. <http://www2.ed.gov/fund/grant/apply/osep/2012apps.html>
- U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), (July 2012) OMB #1820-0557: Infants and Toddlers Receiving Early Intervention Services in Accordance with Part C, 2011. <https://www.ideadata.org/PartCData.asp>
- ¹⁰National Institute for Early Education Research. (2011). The 2011 state of preschool yearbook. <http://nieer.org/yearbook/>
- ¹¹Internal Revenue Service. (n.d.). SOI Tax Stats - Historic Table 2, Tax Year 2009. <http://www.irs.gov/taxstats/article/0,,id=171535,00.html>
- National Women's Law Center. (n.d.). 2011 Making Care Less Taxing: Improving State Child and Dependent Care Tax Provisions. <http://www.nwlc.org/resource/2011-making-care-less-taxing-improving-state-child-and-dependent-care-tax-provisions>
- National Women's Law Center. (n.d.). 2012 Supplement to Making Care Less Taxing: Improving State Child and Dependent Care Tax Provisions. <http://www.nwlc.org/resource/2012-supplement-making-care-less-taxing-improving-state-child-and-dependent-care-tax-provis>
- ¹²Information collected by the Child Care State Systems Specialist Network from State Web sites, documents, and FY2012-2013 State Plan.
- ¹³Information collected by the Child Care State Systems Specialist Network from State Web sites, documents, and FY2012-2013 State Plan. National Association for Regulatory Administration (NARA). Preliminary results from the NARA Child Care Licensing Programs and Policies Survey for 2011.
- National Center of Child Care Quality Improvement. (June 2012). Review of child care licensing regulations on the National Resource Center for Health and Safety in Child Care (NRC) Web site. <http://nrckids.org/>
- ¹⁴National Center on Child Care Professional Development and Workforce Initiatives (June 2012). Information collected from the former National Infant and Toddler Child Care Initiative website and from State Web sites.
- ¹⁵Information collected by the Child Care State Systems Specialist Network from State Web sites, documents, and FY2012-2013 State Plan.
- ¹⁶Information collected by the Child Care State Systems Specialist Network from state Web sites, documents, and FY2012-2013 State Plan.
- ¹⁷Information collected by the Child Care State Systems Specialist Network from State Web sites, documents, and FY2012-2013 State Plan. Council for Professional Recognition. (n.d.). National Directory of Early Childhood Educator Preparation Institutions. <http://www.cdacouncil.org/the-resource-center/directory-of-training-institutions>

Governor Events Calendar for IN.GOV

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Entry Details

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[GOV] Governor Pence Appoints Early Learning Advisory Committee

Start Date: 9/23/2013 Start Time: 12:00 AM
End Date: 9/23/2013 End Time: 11:59 PM

Entry Description

Indianapolis, IN – Governor Mike Pence today named appointees to the Early Learning Advisory Committee.

"I am pleased that these experts in early learning have agreed to serve on this committee and will be taking a comprehensive look at the quality and availability of early childhood programs in Indiana," said Governor Mike Pence. "I look forward to their assessment of the opportunities and challenges Indiana faces in early education, and to their recommendations."

Kevin Bain, of Evansville, will serve as Chairman of the Early Learning Advisory Committee. Currently, he serves as Executive Director and Chief Executive Officer of the Welborn Baptist Foundation, which provides grants to not-for-profit organizations that significantly contribute to community health in a fourteen-county area of Southeastern Illinois, Southwestern Indiana, and Western Kentucky. Prior to joining the Foundation in 2008, Bain spent 25 years with various divisions of Bristol-Myers Squibb. Bain is the Founder of the Southwestern Indiana Business Leaders Roundtable on Early Education and is Chairman of the Board for Early Childhood Development Coalition. He earned his undergraduate degree from Hanover College and his graduate degree from the University of Chicago.

Appointed to the Committee, Alonzo Weems currently holds the position of Vice President and Deputy General Counsel, Bio-Medicines Business Unit and General Counsel for Lilly USA, LLC. Prior to assuming this role in the beginning of 2013, Weems served as General Counsel and Corporate Secretary for Eli Lilly Canada. He is the past co-chair of the Success by Six Leadership Council, a n early childhood education partnership led by the United Way of Central Indiana. Weems earned his undergraduate degree from Wash College and his law degree from Indiana University School of Law.

Tammy Veselky, Early Childhood Principal of Tenders Point Christian Academy (TPCA), has been named to the Committee. Employed by TPCA for 25 years, Veselky began as a pre-kindergarten teacher and later took on an administrative role. Before joining TPCA, she worked at a daycare at Southport Heights Christian Church. Veselky earned her undergraduate degree from Lincoln Christian University.

Melanie Brizzi, Child Care Administrator for the Indiana Bureau of Child Care within the Family and Social Services Administration (FSSA), will also serve on the Committee. In her current role, Brizzi oversees the Indiana Child Care Development Fund, a child care subsidy program that serves approximately 40,000 children per year, and manages the licensing and inspection of approximately 5,000 child care programs. Prior to joining state government, Brizzi owned and operated a licensed child care facility from 1998 to 2004.

Charlie Geier has been named to the Early Learning Advisory Committee. Geier, who currently serves as Director of Early Learning and Intervention within the Indiana Department of Education, has experience as both an administrator and teacher in both Fort Wayne and Indianapolis. From 2004 to 2005, Geier taught English to high school students in Kenya and has spent time as an English as a New Language (ENL) teacher in the Hoosier state. Geier is a graduate of Indiana University and is currently enrolled in Butler University's Master's in Effective Teaching and Leadership Program, with an expected graduation this December.

Beckie Minglin, Director of the Head Start State Collaboration Office within FSSA, has been appointed to the Committee. Minglin, of Indianapolis, has worked with Head Start for seven years where, among her responsibilities, she serves on various committees to assist in building early childhood systems. She previously served on the South Indiana Conference United Methodist Church's Board of Youth Ministries from 1996 to 2005.

Connie Sherman, Executive Director of St. Mary's Child Center in Indianapolis, and John Burnett, President and Chief Executive Officer of the Community Education Coalition, will serve as Special Advisors to the Committee.



Entry Type:
Press Release

Entry Category:
Announcements

IN.gov Category:
About Indiana
Education & Training

Agency Name
Governor

###

Location Information:

Statewide
IN

Contact Information:

Name: Christy Denault
Phone: 317/233.9997
Email: cdenault@gov.in.gov

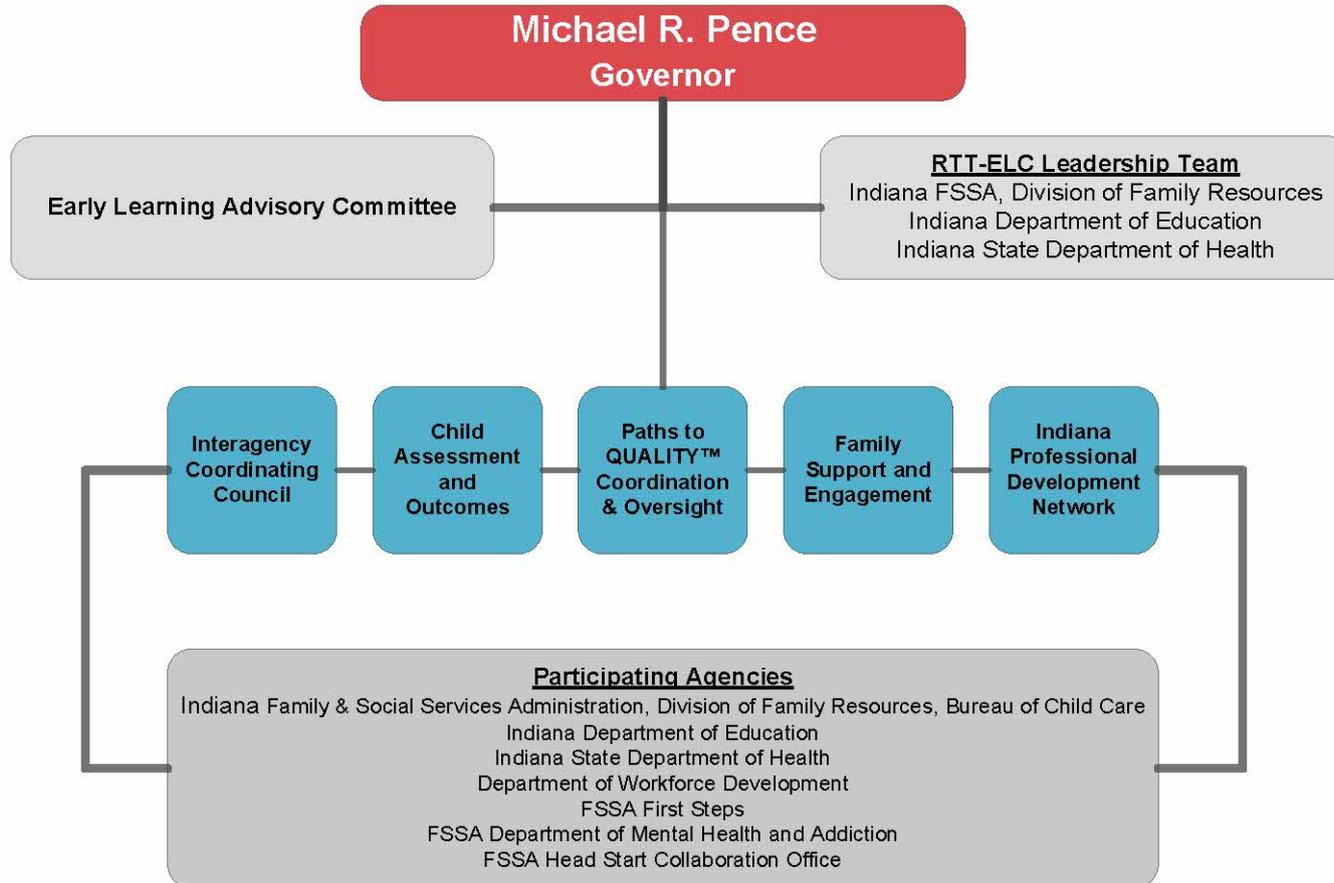
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INDIANA'S PROPOSED GOVERNANCE STRUCTURE
RACE TO THE TOP – EARLY LEARNING CHALLENGE



**MEMORANDUM OF UNDERSTANDING
BETWEEN:
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
AND INDIANA DEPARTMENT OF EDUCATION
EDS NUMBER: F1-4-99-14-1A-1181**

This Memorandum of Understanding ("MOU") is entered into by and between the **Family and Social Services Agency** ("Lead Agency") and **Indiana Department of Education** ("Participating State Agency"). The purpose of this agreement is to establish a framework of collaboration, as well as articulate specific roles and responsibilities in support of the State in its implementation of an approved Race to the Top-Early Learning Challenge grant project.

I. ASSURANCES

The Participating State Agency hereby certifies and represents that it:

- 1) Agrees to be a Participating State Agency and will implement those portions of the State Plan indicated in Exhibit I which is attached hereto and incorporated herein, if the State application is funded;
- 2) Agrees to use, to the extent applicable and consistent with the State Plan and Exhibit I:
 - (a) A set of statewide Early Learning and Development Standards;
 - (b) A set of statewide Program Standards;
 - (c) A statewide Tiered Quality Rating and Improvement System; and
 - (d) A statewide Workforce Knowledge and Competency Framework and progression of credentials.
- 3) Has all requisite power and authority to execute and fulfill the terms of this MOU;
- 4) Is familiar with the State's Race to the Top-Early Learning Challenge grant application and is supportive of and committed to working on all applicable portions of the State Plan;
- 5) Will provide a Final Scope of Work only if the State's application is funded and will do so in a timely fashion but no later than 90 days after a grant is awarded; and will describe the Participating State Agency's specific goals, activities, timelines, budgets, and key personnel ("Participating State Agency Plan") in a manner that is consistent with the Preliminary Scope of Work (Exhibit I), with the Budget included in section VIII of the State Plan (including existing funds, if any, that the Participating State Agency is using for activities and services that help achieve the outcomes of the State Plan; and
- 6) Will comply with all of the terms of the Race to the Top-Early Learning Challenge Grant, this agreement, and all applicable Federal and State laws and regulations, including laws and regulations applicable to the Race to the Top-Early Learning Challenge program, and the applicable provisions of EDGAR (34 CFR Parts 75, 77, 79, 80, 82, 84, 86, 97, 98 and 99), and the suspension and debarment regulations in 2 CFR Part 3485.

II. PROJECT ADMINISTRATION

A. PARTICIPATING STATE AGENCY RESPONSIBILITIES

In assisting the Lead Agency in implementing the tasks and activities described in the State's Race to the Top-Early Learning Challenge grant application, the Participating State Agency will:

- 1) Implement the Participating State Agency Scope of Work as identified in Exhibit I of this agreement;
- 2) Abide by the governance structure outlined in the State Plan;
- 3) Abide by the Participating State Agency's Budget included in section VIII of the State Plan (including the existing funds from Federal, State, private and local sources, if any, that the Participating State Agency is using to achieve the outcomes in the RTT-ELC State Plan);
- 4) Actively participate in all relevant meetings or other events that are organized or sponsored by the State, by the U.S. Department of Education ("ED"), or by the U.S. Department of Health and Human Services ("HHS");
- 5) Post to any Web site specified by the State, ED, or HHS, in a timely manner, all non-proprietary products and lessons learned developed using Federal funds awarded under the RTT-ELC grant;
- 6) Participate, as requested, in any evaluations of this grant conducted by the State, ED, or HHS;
- 7) Be responsive to State, ED, or HHS requests for project information including on the status of the project, project implementation, outcomes, and any problems anticipated or encountered, consistent with applicable local, State and Federal privacy laws.

B. LEAD AGENCY RESPONSIBILITIES

In assisting the Participating State Agencies in implementing their tasks and activities described in the State's Race to the Top-Early Learning Challenge application, the Lead Agency will:

- 1) Work collaboratively with the Participating State Agency and support the Participating State Agency in carrying out the Participating State Agency Scope of Work, as identified in Exhibit I of this agreement;
- 2) Timely award the portion of Race to the Top-Early Learning Challenge grant funds designated for the Participating State Agency in the State Plan during the course of the project period and in accordance with the Participating State Agency's Scope of Work, as identified in Exhibit I, and in accordance with the Participating State Agency's Budget, as identified in section VIII of the State's application;
- 3) Provide feedback on the Participating State Agency's status updates, any interim reports, and project plans and products;
- 4) Keep the Participating State Agency informed of the status of the State's Race to the Top-Early Learning Challenge grant project and seek input from the Participating State Agency, where applicable, through the governance structure outlined in the State Plan;
- 5) Facilitate coordination across Participating State Agencies necessary to implement the State Plan; and
- 6) Identify sources of technical assistance for the project.

C. JOINT RESPONSIBILITIES

- 1) The Lead Agency and the Participating State Agency will each appoint a key contact person for the Race to the Top-Early Learning Challenge grant.
- 2) These key contacts from the Lead Agency and the Participating State Agency will maintain frequent communication to facilitate cooperation under this MOU, consistent with the State Plan and governance structure.

- 3) Lead Agency and Participating State Agency personnel will work together to determine appropriate timelines for project updates and status reports throughout the grant period.
- 4) Lead Agency and Participating State Agency personnel will negotiate in good faith toward achieving the overall goals of the State's Race to the Top-Early Learning Challenge grant, including when the State Plan requires modifications that affect the Participating State Agency, or when the Participating State Agency's Scope of Work requires modifications.

D. STATE RECOURSE IN THE EVENT OF PARTICIPATING STATE AGENCY'S FAILURE TO PERFORM

If the Lead Agency determines that the Participating State Agency is not meeting its goals, timelines, budget, or annual targets, or is in some other way not fulfilling applicable requirements, the Lead Agency will take appropriate enforcement action, which could include initiating a collaborative process by which to attempt to resolve the disagreements between the Lead Agency and the Participating State Agency, or initiating such enforcement measures as are available to the Lead Agency, under applicable State or Federal law.

III. MODIFICATIONS

This Memorandum of Understanding may be amended only by written agreement signed by each of the parties involved, in consultation with ED.

IV. DURATION

This Memorandum of Understanding shall be effective, beginning with the date of the last signature hereon and, if a Race to the Top- Early Learning Challenge grant is received by the State, ending upon the expiration of the Race to the Top- Early Learning Challenge grant project period.

V. CONSIDERATION

The consideration for this MOU is the mutual assurances and covenants set forth herein. This is a zero dollar MOU which has no monetary consideration involved. The financial terms that are involved herein are set out on Attachment A which is attached hereto and incorporated herein.

VI. TERMINATION OF MOU

- 1) Either party may terminate this MOU at any time for any or no cause upon thirty (30) days prior written notice to the other party. Provided however, each party reserves the right to immediately terminate this MOU upon written notice to the other party should any material term of this MOU be breached by that party.
- 2) When the Director of the State Budget Agency makes a written determination that funds are not appropriated or otherwise available to support the continuation of performance of this memoranda, the memoranda shall be canceled. A determination by the Director of the State Budget Agency that funds are not available to support continuation of performance shall be final and conclusive.

THE REMAINDER OF THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK.

SIGNATURES

Authorized representatives of the Indiana State Department of Education and the Indiana Family and Social Services Administration have read and understand the foregoing terms of the Memorandum of Understanding and do by their respective signatures dated below agree to those terms.

In Witness Whereof, the parties hereto have by duly authorized representatives entered into this agreement. The parties having read and understood the foregoing terms of this agreement do by their respective signatures dated below hereby agree to the terms thereof.

**Authorized Representative of Lead Agency:
Family and Social Services Administration**

(b)(6)
By: _____
(b)(6)
Date: _____

**Authorized Representative of Participating State Agency:
Indiana Department of Education**

(b)(6)
By: _____
(b)(6)
Date: _____

**Authorized Representative of State Budget Agency:
State Budget Agency**

(b)(6)
By: _____
(b)(6)
Director
Date: 10-9-13



ATTACHMENT DOCUMENT SUMMARY
10/07/2013

ATTACHMENT:
AGREEMENT #:
AGREEMENT TERM:

(b)(6)

VENDOR INFORMATION:

LEGAL NAME:
AGENCY D/B/A:
MAILING ADDRESS:

CONTACT NAME:
EMAIL ADDRESS:

TELEPHONE NUMBER:

DIRECTOR'S NAME:

FSSA CONTRACT CONTACT:
EMAIL ADDRESS:

FID/SSN:
PS Vendor ID:

CHANGE NUMBER:

(b)(6)

FINANCIAL SUMMARY:

CLAIM PROG ID	SERVICE CODE	PROGRAM	EFFECTIVE DATES	AWARD AMOUNT
----------------------	---------------------	----------------	------------------------	---------------------

(b)(6)				
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TOTAL DOLLAR AMOUNT:

(b)(6)





ATTACHMENT DOCUMENT DETAIL
10/07/2013

ATTACHMENT: A
AGREEMENT #: 99-14-1A-1181
AGREEMENT TERM: 10/01/2013-09/30/2014

LEGAL NAME:	STATE OF INDIANA	PS VENDOR ID:	0000022460
CLAIM PROGRAM ID:	49-14-1A-1181-03	DUNS #:	n/a
PROGRAM TOTAL:	0.00	REGION:	STATEWIDE
FUND DESCRIPTION:	Race to Top-Early Learning 14	CFDA NUMBER:	93.596
FEDERAL YEAR:	2014	STATE YEAR:	2014
EFFECTIVE DATES:	10/01/2013-06/30/2014	CLOSE OUT DATE:	07/10/2014

SERVICE INFORMATION:	0224 RACE TO TOP-EARLY LEARNING		
SERVICE EFF DATES:	10/1/2013-6/30/2014		
COMPONENT DESCRIPTION	COMPONENT DATES	UNITS	RATE
.1 RTT-ELC PLANNING	10/01/13-6/30/14	ACTUAL COST	1.0000
SERVICE TOTAL:			0.00





ATTACHMENT DOCUMENT DETAIL
10/07/2013

ATTACHMENT: A
AGREEMENT #: 99-14-1A-1181
AGREEMENT TERM: 10/01/2013-09/30/2014

LEGAL NAME:	STATE OF INDIANA	PS VENDOR ID:	0000022460
CLAIM PROGRAM ID:	49-14-1A-1181-04	DUNS #:	n/a
PROGRAM TOTAL:	0.00	REGION:	STATEWIDE
FUND DESCRIPTION:	Race to Top-Early Learning 15	CFDA NUMBER:	93.596
FEDERAL YEAR:	2014	STATE YEAR:	2015
EFFECTIVE DATES:	07/01/2014-09/30/2014	CLOSE OUT DATE:	10/10/2014

SERVICE INFORMATION:	0224 RACE TO TOP-EARLY LEARNING		
SERVICE EFF DATES:	7/1/2014-9/30/2014		
COMPONENT DESCRIPTION	COMPONENT DATES	UNITS	RATE
.1 RTT-ELC PLANNING	7/01/14-9/30/14	ACTUAL COST	1.0000
SERVICE TOTAL:			0.00



Exhibit I

**Participating State Agency Scope of Work
Indiana Department of Education**

The Participating State Agency hereby agrees to participate in the State Plan as described in the State's application, and more specifically commits to undertake the tasks and activities described in detail below.

Selection Criteria	Participating Division	Type of Participation
(A) (3)	Office of Early Learning and Intervention	<ul style="list-style-type: none"> • Hire, organize, and implement 10 Regional Early Learning Specialists to provide outreach, technical assistance, professional development, and support to projects related to the grant
(B) (4)	Office of Early Learning and Intervention	<ul style="list-style-type: none"> • Facilitate an Early Learning Title 1 Preschool Programs Match Grant competition for schools serving High Needs children • Promote participation in Paths to Quality for Title 1 Preschool programs
(C) (1)	Office of Early Learning and Intervention	<ul style="list-style-type: none"> • Implement Foundations Framework Expansion • Align the Foundations framework with other key standards • Expand training on the Foundations framework for the early childhood professionals. • Create training and technical assistance framework that connects the use of the foundations to child assessments to individualized curricula and effective daily activities for PTQ programs levels 2-4 • Enhance the Foundations framework for multiple audiences and in different formats. • Increase number of ECE professions trained on the Foundations • Increase the number of ECE professionals trained in the Foundations-Assessment-Curricula methodology • Ensure Foundations are culturally and linguistically appropriate
(C) (2)	Office of Early Learning	<ul style="list-style-type: none"> • Provide increased training and TA on use of the ISTAR to PTQ programs

	and Intervention	<ul style="list-style-type: none"> • Establish an Early Learning Assessment and Data System Task Force; • Improve the capacity of early learning professionals; • Develop a School Readiness Report Card
(C) (2)	Office of Assessment	<ul style="list-style-type: none"> • Expand and align ISTAR-KR data system • Provide increased training and TA on use of the ISTAR to PTQ programs • Establish an Early Learning Assessment and Data System Task Force; • Improve the indicators of the ISTAR-KR; • Develop a School Readiness Report Card
(E) (1)	Office of Early Learning and Intervention	<ul style="list-style-type: none"> • Create Kindergarten Entry Assessment • Encourage usage of the Assessment within public funded PreK and PTQ programs • Offer training and TA to publicly funded PreK and PTQ programs to ensure reliable use of the tool • Pilot assessment tool • Utilize data to issue statewide kindergarten readiness report card
(E) (1)	Office of Assessment	<ul style="list-style-type: none"> • Create Kindergarten Entry Assessment • Encourage usage of the Assessment within public funded PreK and PTQ programs • Offer training and TA to publicly funded PreK and PTQ programs to ensure reliable use of the tool • Pilot assessment tool • Administer assessment tool statewide • Utilize data to issue statewide kindergarten readiness report card
(E) (1)	Office of Information Technology	<ul style="list-style-type: none"> • Modify Statewide Longitudinal Data System (SLDS) to accept data from the assessment • Enter data into SLDS
(E) (2)	Office of Early Learning	<ul style="list-style-type: none"> • Participate in the coordination of the Statewide Longitudinal Data System

	and Intervention	<p>(SLDS)</p> <ul style="list-style-type: none"> • Facilitate key partners to agree on common data practices including program, professional and child identifiers • Facilitate key partners to agree on data system governance and division of responsibility • Provide training and technical assistance to data system users
(E) (2)	Office of Information Technology	<ul style="list-style-type: none"> • Integrate SLDS • Ensure high quality, easy to access reporting is available from the integrated data system

**MEMORANDUM OF UNDERSTANDING
BETWEEN:
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
INDIANA STATE DEPARTMENT OF HEALTH
EDS NUMBER: F1-4-49-14-1A-1181**

This Memorandum of Understanding ("MOU") is entered into by and between the **Indiana Family and Social Services Agency** ("Lead Agency") and **Indiana State Department of Health** ("Participating State Agency"). The purpose of this agreement is to establish a framework of collaboration, as well as articulate specific roles and responsibilities in support of the State in its implementation of an approved Race to the Top-Early Learning Challenge grant project.

I. ASSURANCES

The Participating State Agency hereby certifies and represents that it:

- 1) Agrees to be a Participating State Agency and will implement those portions of the State Plan indicated in Exhibit I which is attached hereto and incorporated herein, if the State application is funded;
- 2) Agrees to use, to the extent applicable and consistent with the State Plan and Exhibit I:
 - (a) A set of statewide Early Learning and Development Standards;
 - (b) A set of statewide Program Standards;
 - (c) A statewide Tiered Quality Rating and Improvement System; and
 - (d) A statewide Workforce Knowledge and Competency Framework and progression of credentials.
- 3) Has all requisite power and authority to execute and fulfill the terms of this MOU;
- 4) Is familiar with the State's Race to the Top-Early Learning Challenge grant application and is supportive of and committed to working on all applicable portions of the State Plan;
- 5) Will provide a Final Scope of Work only if the State's application is funded and will do so in a timely fashion but no later than 90 days after a grant is awarded; and will describe the Participating State Agency's specific goals, activities, timelines, budgets, and key personnel ("Participating State Agency Plan") in a manner that is consistent with the Preliminary Scope of Work (Exhibit I), with the Budget included in section VIII of the State Plan (including existing funds, if any, that the Participating State Agency is using for activities and services that help achieve the outcomes of the State Plan; and
- 6) Will comply with all of the terms of the Race to the Top-Early Learning Challenge Grant, this agreement, and all applicable Federal and State laws and regulations, including laws and regulations applicable to the Race to the Top-Early Learning Challenge program, and the applicable provisions of EDGAR (34 CFR Parts 75, 77, 79, 80, 82, 84, 86, 97, 98 and 99), and the suspension and debarment regulations in 2 CFR Part 3485.

II. PROJECT ADMINISTRATION

A. PARTICIPATING STATE AGENCY RESPONSIBILITIES

In assisting the Lead Agency in implementing the tasks and activities described in the State's Race to the Top-Early Learning Challenge grant application, the Participating State Agency will:

- 1) Implement the Participating State Agency Scope of Work as identified in Exhibit I of this agreement;
- 2) Abide by the governance structure outlined in the State Plan;
- 3) Abide by the Participating State Agency's Budget included in section VIII of the State Plan (including the existing funds from Federal, State, private and local sources, if any, that the Participating State Agency is using to achieve the outcomes in the RTT-ELC State Plan);
- 4) Actively participate in all relevant meetings or other events that are organized or sponsored by the State, by the U.S. Department of Education ("ED"), or by the U.S. Department of Health and Human Services ("HHS");
- 5) Post to any Web site specified by the State, ED, or HHS, in a timely manner, all non-proprietary products and lessons learned developed using Federal funds awarded under the RTT-ELC grant;
- 6) Participate, as requested, in any evaluations of this grant conducted by the State, ED, or HHS;
- 7) Be responsive to State, ED, or HHS requests for project information including on the status of the project, project implementation, outcomes, and any problems anticipated or encountered, consistent with applicable local, State and Federal privacy laws.

B. LEAD AGENCY RESPONSIBILITIES

In assisting the Participating State Agencies in implementing their tasks and activities described in the State's Race to the Top-Early Learning Challenge application, the Lead Agency will:

- 1) Work collaboratively with the Participating State Agency and support the Participating State Agency in carrying out the Participating State Agency Scope of Work, as identified in Exhibit I of this agreement;
- 2) Timely award the portion of Race to the Top-Early Learning Challenge grant funds designated for the Participating State Agency in the State Plan during the course of the project period and in accordance with the Participating State Agency's Scope of Work, as identified in Exhibit I, and in accordance with the Participating State Agency's Budget, as identified in section VIII of the State's application;
- 3) Provide feedback on the Participating State Agency's status updates, any interim reports, and project plans and products;
- 4) Keep the Participating State Agency informed of the status of the State's Race to the Top-Early Learning Challenge grant project and seek input from the Participating State Agency, where applicable, through the governance structure outlined in the State Plan;
- 5) Facilitate coordination across Participating State Agencies necessary to implement the State Plan; and
- 6) Identify sources of technical assistance for the project.

C. JOINT RESPONSIBILITIES

- 1) The Lead Agency and the Participating State Agency will each appoint a key contact person for the Race to the Top-Early Learning Challenge grant.
- 2) These key contacts from the Lead Agency and the Participating State Agency will maintain frequent communication to facilitate cooperation under this MOU, consistent with the State Plan and governance structure.
- 3) Lead Agency and Participating State Agency personnel will work together to determine appropriate timelines for project updates and status reports throughout the grant period.
- 4) Lead Agency and Participating State Agency personnel will negotiate in good faith toward achieving the overall goals of the State's Race to the Top-Early Learning Challenge grant,

including when the State Plan requires modifications that affect the Participating State Agency, or when the Participating State Agency's Scope of Work requires modifications.

D. STATE RECOURSE IN THE EVENT OF PARTICIPATING STATE AGENCY'S FAILURE TO PERFORM

If the Lead Agency determines that the Participating State Agency is not meeting its goals, timelines, budget, or annual targets, or is in some other way not fulfilling applicable requirements, the Lead Agency will take appropriate enforcement action, which could include initiating a collaborative process by which to attempt to resolve the disagreements between the Lead Agency and the Participating State Agency, or initiating such enforcement measures as are available to the Lead Agency, under applicable State or Federal law.

III. MODIFICATIONS

This Memorandum of Understanding may be amended only by written agreement signed by each of the parties involved, in consultation with ED.

IV. DURATION

This Memorandum of Understanding shall be effective, beginning with the date of the last signature hereon and, if a Race to the Top- Early Learning Challenge grant is received by the State, ending upon the expiration of the Race to the Top- Early Learning Challenge grant project period.

V. CONSIDERATION

The consideration for this MOU is the mutual assurances and covenants set forth herein. This is a zero dollar MOU which has no monetary consideration involved. The financial terms that are involved herein are set out on Attachment A which is attached hereto and incorporated herein.

VI. TERMINATION OF MOU

- 1) Either party may terminate this MOU at any time for any or no cause upon thirty (30) days prior written notice to the other party. Provided however, each party reserves the right to immediately terminate this MOU upon written notice to the other party should any material term of this MOU be breached by that party.
- 2) When the Director of the State Budget Agency makes a written determination that funds are not appropriated or otherwise available to support the continuation of performance of this memoranda, the memoranda shall be canceled. A determination by the Director of the State Budget Agency that funds are not available to support continuation of performance shall be final and conclusive.

THE REMAINDER OF THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK.

SIGNATURES

Authorized representatives of the Indiana State Department of Health and the Indiana Family and Social Services Administration, Division of Family Resources, have read and understand the foregoing terms of the Memorandum of Understanding and do by their respective signatures dated below agree to those terms.

In Witness Whereof, the parties hereto have by duly authorized representatives entered into this agreement. The parties having read and understood the foregoing terms of this agreement do by their respective signatures dated below hereby agree to the terms thereof.

Authorized Representative of Lead Agency:

Family and Social Services Administration
Division of Family Resources

By: (b)(6)
(b)(6)
Chief of Staff, Family and Social Services
Date: 10-9-2013

Authorized Representative of Participating State Agency:

Indiana State Department of Health:

By: (b)(6)
(b)(6)
Chief of Staff
Date: 10-7-13

By: (b)(6)
(b)(6)
Chief Financial Officer
Date: 10/8/13

Authorized Representative of State Budget Agency:

State Budget Agency

By: (b)(6)
(b)(6)
Director
Date: 10-9-2013

EXHIBIT I

**Participating State Agency Scope of Work
Indiana State Department of Health**

The Participating State Agency hereby agrees to participate in the State Plan as described in the State's application, and more specifically commits to undertake the tasks and activities described in detail below.

Selection Criteria	Participating Division	Type of Participation
(A) (3)	Maternal and Child Health Division	<ul style="list-style-type: none"> • Participate in Project Teams; • Participate in data sharing.
(C) (3)	Women, Infants, and Children Division	<ul style="list-style-type: none"> • Create RFP for Breastfeeding a Social Networking Campaign Project. Select subcontractor and monitor progress. • Promote breastfeeding in child care
(C) (3)	Maternal and Child Health Division	<ul style="list-style-type: none"> • Expand evidenced based Home Visiting to families and Children with High Needs in additional rural Indiana counties • Provide appropriate home visiting services to women residing in Indiana (based on needs) who are low-income and high-risk, as well as their infants and families • Develop a system of coordinated services statewide of existing and newly developed home visiting programs in order to provide appropriate, targeted, and unduplicated services and locally coordinated referrals to all children, mothers, and families who are high-risk throughout Indiana • Coordinate necessary services outside of home visiting programs to address needs of participants, which may include: mental health, primary care, dental health, children with special needs, substance use, childhood injury prevention, child abuse / neglect / maltreatment, school readiness, employment training and adult education program
(C) (3)	Maternal and Child Health Division	<ul style="list-style-type: none"> • Administer grant award to identify children at risk due to developmental delays and autism spectrum disorder with desired vendor • Increase awareness, understanding, and use of ASQ and ASQ SE by early care and education staff and management • Increase awareness, understanding, and use of ASQ and ASQ SE by pediatricians and nurse practitioners

		<ul style="list-style-type: none"> • Increase referrals to specialized services • Within 8 regional centers, identify community partners who might contribute to identification, evaluation and intervention of children with or at risk of delays • Develop community specific process maps / algorithms to adopt standardized screening, referral, diagnosis and intervention and provide data feedback and communication among community partners
(C) (3)	Maternal and Child Health Division	<ul style="list-style-type: none"> • Collaborate with the Indiana University School of Medicine /Riley Child Development Center to expand Early Childhood Mental Health Consultation (ECMHC) • Link ECMHC training and curriculum materials to Indiana's FOUNDATIONS to the Indiana Academic Standards for Young Children Age Birth-5 and Indiana's Infant Mental Health Endorsement. • Expand number of providers with Infant Mental Health Endorsement across Levels 1, 2 and 3 • Recruit ECMHC in each of identified regions to create community based networks of infant/toddler mental health endorsed individuals to provide assessment and technical assistance activities in partnership with Inclusion Specialists • Increase utilization of ECMHC services to child care programs, particularly targeting rural and at risk communities. • Collaborate with an institution of higher learning to create and implement a program evaluation and outcome measurement system to ensure that the ECMHC system can document desired outcomes.
(C) (3)	Maternal and Child Health Division	<ul style="list-style-type: none"> • Collaborate with the Infant and Toddler Specialists of Indiana and the Indiana Association for Child Care Resource & Referral to provide training and technical assistance to parents, early care and education providers, and others that focus on nutrition, physical activity, and lactation support in child-care settings



ATTACHMENT DOCUMENT SUMMARY
10/07/2013

ATTACHMENT:
AGREEMENT #:
AGREEMENT TERM:

(b)(6)

VENDOR INFORMATION:

LEGAL NAME:	(b)(6)
AGENCY D/B/A:	
MAILING ADDRESS:	
CONTACT NAME:	
EMAIL ADDRESS:	
TELEPHONE NUMBER:	
DIRECTOR'S NAME:	
FSSA CONTRACT CONTACT:	
EMAIL ADDRESS:	
FID/SSN:	
PS Vendor ID:	
CHANGE NUMBER:	

FINANCIAL SUMMARY:

CLAIM PROG ID	SERVICE CODE	PROGRAM	EFFECTIVE DATES	AWARD AMOUNT
(b)(6)				
TOTAL DOLLAR AMOUNT:				(b)(6)





ATTACHMENT DOCUMENT DETAIL
10/07/2013

ATTACHMENT:
AGREEMENT #:
AGREEMENT TERM:

(b)(6)

LEGAL NAME:
CLAIM PROGRAM ID:
PROGRAM TOTAL:
FUND DESCRIPTION:
FEDERAL YEAR:
EFFECTIVE DATES:

(b)(6)

PS VENDOR ID:
DUNS #:
REGION:
CFDA NUMBER:
STATE YEAR:
CLOSE OUT DATE:

(b)(6)

SERVICE INFORMATION:
SERVICE EFF DATES:
COMPONENT DESCRIPTION

0224 RACE TO TOP-EARLY
LEARNING
10/1/2013-6/30/2014

COMPONENT DESCRIPTION	COMPONENT DATES	UNITS	RATE
(b)(6)			

SERVICE TOTAL:

(b)(6)





ATTACHMENT DOCUMENT DETAIL
10/07/2013

ATTACHMENT:
AGREEMENT #:
AGREEMENT TERM:

(b)(6)

LEGAL NAME:
CLAIM PROGRAM ID:
PROGRAM TOTAL:
FUND DESCRIPTION:

(b)(6)

PS VENDOR ID:
DUNS #:
REGION:

(b)(6)

FEDERAL YEAR:
EFFECTIVE DATES:

CFDA NUMBER:
STATE YEAR:
CLOSE OUT DATE:

SERVICE INFORMATION:

SERVICE EFF DATES:

COMPONENT DESCRIPTION

**0224 RACE TO TOP-EARLY
LEARNING
7/1/2014-9/30/2014**

COMPONENT DATES

UNITS

RATE

.1 (b)(6)

SERVICE TOTAL:

(b)(6)



Table (A)(3)-2: Early Learning Intermediary Organizations and local early learning councils (if applicable)	
List every Intermediary Organization and local early learning council (if applicable) in the State	Did this entity provide a letter of intent or support which is included in the Appendix (Y/N)?
4C of Southern Indiana	Y
About Special Kids	Y
Child Care Aware of America	Y
Children Health Improvement Partnership (CHIP)	Y
Early Learning Advisory Council (ELAC)	Y
First Steps	Y
Governor's Early Learning Advisory Committee	Y
Great Lakes Comprehensive Center	Y
Indiana Association for Child Care Resource & Referral	Y
Indiana Association for the Education of Young Children, Inc.	Y
Indiana Association of United Ways	Y
Indiana Council for Exceptional Children	Y
Indiana Early Childhood Education Forum	Y
Indiana Head Start State Collaborative	Y
Indiana Operation Military Kids	Y
Improving Kids' Environment	Y
Talent Alliance	Y
United Way of Central Indiana	Y
United Way of Greater Lafayette	Y
Welborn Baptist Foundation	Y



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

4C of Southern Indiana, Inc. (4C) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

4C is a Child Care Resource and Referral organization serving fourteen counties in Southwest Indiana. 4C also provides Child Care Development Fund Intake Agent, USDA Child and Adult Care Food Program, and Parents as Teachers™ home visiting services in the region. 4C's mission statement is: We believe every child deserves the opportunity to develop into a healthy, contributing citizen. We engage the community and provide a leading voice to improve the accessibility, affordability and quality of child care.

4C supports Indiana's application because key objectives in our theory of change frameworks are aligned:

- Improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- Strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- Tackling health issues such as infant mortality rates and childhood obesity
- Contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. 4C is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and enter school ready to succeed.

Sincerely,

(b)(6)

President, CEO

(b)(6)



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

About Special Kids (ASK) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Below is a list of the key objectives within the grant that closely align with ASK's goals and priorities.

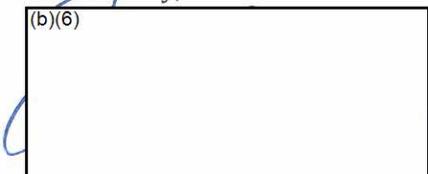
- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

About Special Kids (ASK) is a statewide nonprofit organization located in Indianapolis where parents, professionals, and volunteers support children with special needs, their families and the professionals who serve them. For more than 25 years, ASK has been helping families navigate the myriad of systems encountered when caring for a child who has a disability or chronic illness.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. ASK is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)



(b)(6)



October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Child Care Aware® of America is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Child Care Aware® of America is a national nonprofit organization that seeks to ensure that all children in the United States have access to quality child care and early learning services. To achieve its mission, Child Care Aware® of America works closely with Indiana and other partners to lead projects that increase the supply of quality child care, undertake research, and promote policies that advance quality child care and early learning. We are delighted to support Indiana's Race to the Top - Early Learning Challenge Grant application, which will benefit young children in the state by:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates;
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education; and
- tackling health issues such as infant mortality rates and childhood obesity.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Child Care Aware® of America is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early childhood development and ready to start school to succeed.

Sincerely,

(b)(6)



Executive Director



INDIANA UNIVERSITY
SCHOOL OF MEDICINE
Children's Health Services Research

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Child Health Improvement Partnership – Indiana (CHIP-IN) is pleased to support Indiana’s application for the Race to the Top - Early Learning Challenge Grant. CHIP-IN is a partnership among the Indiana University School of Medicine, Department of Pediatrics, Indiana State Department of Health, the Indiana Chapter of the American Academy of Pediatrics and Indiana’s Family Voices organization. We are part of the National Improvement Partnership Network (NPIN); a group of 18 states who share the common of using implementation science to improve the quality of care for children in our states. Our mission is:

To engage government agencies, professional medical organizations, insurers, family organizations, and community partners in collaborative, measurement based, quality improvement initiatives. We strive to provide optimal care for Indiana’s children and youth by working with the primary care medical home to:

- Translate evidence-based practices into practical / doable steps
- Understand and work through systems to create realistic, measurable improvements in quality
- Partner with families and the health care team to improve care

We commit to supporting the efforts of this application through our on-going efforts to implement statewide developmental screening in pediatric offices within the next 30 months. Our state does not have statewide screening and has never had grant funding support these efforts, hence, unlike states with ABCD or other programmatic funding, we are markedly delayed in early recognition of developmental delays and autism spectrum disorders. CHIP-IN has adopted the Healthy People 2020 goals as its mantra over the next 30 months – identification by 24 months, assessment by 36 months and intervention by 48 months. But, we believe we can do better with support from the Race to the Top - Early Learning Challenge Grant. This grant allows the overlay of community resources including early pre-school programs, family support and care coordination for families with children who have developmental disorders.

Choosing Indiana as a 2013 Race to the Top - Early Learning Challenge Grantee allows the greatest impact for the dollars invested in that we are at a “tipping point” where this investment will have a cascaded effect on ensuring that Hoosier children are healthy and ready to learn

Sincerely,

(b)(6)

(b)(6)





Welborn Baptist Foundation, Inc.

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

On behalf of both the Governor's Early Learning Advisory Committee as well as the Welborn Baptist Foundation, I am very pleased to voice our support for Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

As Chairman of Governor Pence's Early Learning Advisory Committee, our task is to frame ongoing statewide efforts to ensure Indiana maximizes access to high quality early childhood experiences – particularly for at-risk families. The Committee's efforts dovetail with a number of Grant priorities, including:

- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education. Parent engagement is a critical component of the pilot scholarship program now being finalized for high-risk families.
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment. The Committee views the availability

of top-quality early education as an essential enabler for today's and tomorrow's workforces.

The alignment of this Grant with Welborn Baptist Foundation's mission-driven objectives is outstanding, as well. From our beginnings as a health care conversion foundation, our initiatives have directly paralleled several Grant priorities, including:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- tackling health issues such as infant mortality rates and childhood obesity. In fact, the Foundation has pioneered a multi-year initiative called HEROES, based on the CDC's Coordinated School Health model – dedicated to reducing childhood overweight and obesity.

Since its inception in 2000, the Welborn Baptist Foundation has granted over \$6 million to advance early childhood development in the 14 county area we serve. High quality early childhood education is one of a handful of strategic priorities for the Foundation; we view interventions in the earliest years as key drivers of the educational success, health outcomes, and workforce development that exemplify our mission.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Both the Early Learning Advisory Committee and Welborn Baptist Foundation are committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Executive Director/CEO
Welborn Baptist Foundation

Chairman, Early Learning Advisory Committee



*"People
helping people
help
themselves"*

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

10/8/13

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Indiana's Part C Program (First Steps) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- tackling health issues such as infant mortality rates and childhood obesity

Indiana's First Steps System is a family-centered, locally-based, coordinated system that provides early intervention services to infants and young children with disabilities or who are developmentally vulnerable.

First Steps brings together families and professionals from education, health and social service agencies. By coordinating locally available services, First Steps strives to give Indiana's children and their families the widest possible array of early intervention resources.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. First Steps is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young



children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

A rectangular box with a black border, containing the text "(b)(6)" in the top-left corner. The rest of the box is empty, indicating that the signature has been redacted.

Bureau of Child Development Services Director

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Great Lakes Comprehensive Center (GLCC) at American Institutes for Research is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

GLCC is in the second year of a five year agreement with the United States Department of Education to serve the Indiana Department of Education. Our service to Indiana falls into three main projects; Academic Standards and Assessments Evaluation and Implementation, Outreach for School Improvement Model Development and Implementation, and Student-Centered Accountability Model Development and Implementation. The following key grant objectives most closely align with the GLCC technical assistance goals for Indiana:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Great Lakes Comprehensive Center at American Institutes for Research is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

Frank De Rosa
Senior Consultant, State Manager for Indiana



October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana Association for Child Care Resource & Referral (IACCRR) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

IACCRR and the system of community based CCR&Rs have a long history of partnering with the Bureau of Child Care in the implementation of Paths to QUALITY. The Race to the Top award will allow the state of Indiana to:

- assist all families in accessing highly rated Paths to QUALITY programs
- provide families with tools to ensure Hoosier children are in programs that are safe, healthy and improve school readiness and future academic success
- expand the participation of programs in Paths to QUALITY, thus raising the quality of care for thousands of Hoosier children

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indiana Association for Child Care Resource & Referral is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Interim Executive Director

(b)(6)



Indiana Association
for the Education of
Young Children, Inc.

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Indiana Association for the Education of Young Children (Indiana AEYC) and our 2,200 members are pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The mission of Indiana AEYC is to promote and support quality care and education for all young children birth through age eight in Indiana. Indiana AEYC supports the following grant objectives:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities that lead to increased knowledge, skills and abilities of those educating our youngest citizens
- aligning professional development opportunities with Indiana's early learning standards (Foundations), Indiana's Core Knowledge and Competencies leading to certification, credentialing and degree attainment.

Indiana Association for the Education of Young Children and our 2,200 early childhood professionals realize our mission by partnering with the Family Social Service Administration, Division of Family Resources, Bureau of Child Care in the implementation of the Paths To QUALITY™- Quality Rating and Improvement System, providing professional development opportunities for early childhood



Indiana Association
for the Education of
Young Children, Inc.

professionals through the T.E.A.C.H. Early Childhood@INDIANA project, Indiana Non Formal CDA (Child Development Associate) project and the Indiana Early Childhood Conference and program improvement through the Indiana Accreditation Project.

The 2013 Race to the Top - Early Learning Challenge Grant grant provides a unique opportunity for Hoosier children and families. The goals and outcomes of the grant closely align with Indiana's current focus on education, health, and economic development.

Indiana Association for the Education of Young Children and our 2,200 members across the state are committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children and their families have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Executive Director

(b)(6)

Indiana Association of United Ways



3901 North Meridian Street, #306, Indianapolis, IN 46208-4026, 317-923-2377, 800-457-1450, Fax 317-921-1397, www.iauw.org

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Indiana Association of United Ways (IaUW) is pleased to support the State of Indiana's application for the Race to the Top - Early Learning Challenge Grant (RTTP-ELCG). IaUW and our 61 United Ways work closely with local community- and faith-based organizations that help individuals and their families. Each year, Indiana's United Ways raise and invest nearly \$100 million in local communities, including in early care and education initiatives. We have worked with Indiana's Family and Social Services Administration (FSSA) to promote Paths To Quality, the voluntary quality rating system for early care and education.

IaUW supports efforts to create the structure for a strong early education system in Indiana. The RTTP-ELCG will provide the momentum for intentional dialogue and planning to increase and maximize public and private resources in early learning. High-quality early education is directly correlated with school readiness, reading on grade level and future success in school and life.

On behalf of Indiana Association of United Ways, please accept our strong support and encouragement for Indiana's application for the 2013 Race to the Top - Early Learning Challenge Grant. We are committed to working with federal and state agencies, private funders, community- and faith-based organizations to make this a success.

Please let us know how we can help to move the application and resulting plans forward.

Sincerely,

/s/ Roger L. Frick
President

/s/ Lucinda Nord
Vice President

Indiana Council for Exceptional Children



The voice and vision of special education

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

INCEC is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints. These measures and initiative include the following:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment.

In addition to the above measures, all of which represent the scope of the Indiana Council for Exceptional Children, and as a state unit membership, we endeavor to promote our joint mission with CEC. The Council for Exceptional Children is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities. CEC accomplishes its worldwide mission on behalf of educators and others working with individuals with exceptionalities by advocating for appropriate government policies; setting professional standards; providing continuing professional development; advocating for newly and historically under-served individuals with exceptionalities; and helping professionals obtain conditions and resources necessary for effective professional practice.

Indiana Council for Exceptional Children



INDIANA

The voice and vision of special education

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. INCEC is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

INCEC President

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana Early Childhood Higher Education Forum is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Early Childhood Higher Education Forum consists of early childhood education and child development faculty from two- and four-year colleges and universities throughout Indiana. We are committed to working together to prepare highly effective early childhood professionals. As a group, we work to increase the number of articulation agreements in the state, have a voice regarding early childhood policy, and ensure that policy makers are well informed on early childhood issues. We are committed to increasing opportunities for postsecondary credentialing and degree attainment for early childhood professionals, one of the goals of this grant application.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indiana Early Childhood Higher Education Forum fully supports the goals of this grant application and will work with the partners to ensure that high need young children have access to comprehensive, high quality early childhood education and start school ready to succeed.

Sincerely,

(b)(6)

Chair, Indiana Early Childhood Higher Education Forum



*Mike Pence, Governor
State of Indiana*

Indiana Family and Social Services Administration, Division of Family Resources
402 W. WASHINGTON STREET
INDIANAPOLIS, IN 46204

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana Head Start State Collaboration Office is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Indiana Head Start State Collaboration Office exists to facilitate collaboration among Head Start agencies and entities that carry out activities designed to benefit low income children from birth to school entry and their families. They provide a structure and a process for the Office of Head Start to work with State agencies and local entities to leverage their common interests around young children and their families.

The Scope of Work laid out in the Head Start Collaboration Offices Framework supports:

- Improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates;
- Parent, family and community engagement strengthening Indiana's families by providing the tools necessary to effectively support their children's education;
- Health priorities that include tackling childhood obesity through nutrition and exercise; and
- Professional Development that will bring about a stronger Hoosier workforce through increased early childhood educational opportunities.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indiana Head Start State Collaboration Office is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

(b)(6) Director

Indiana Head Start State Collaboration Office

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Indiana Operation: Military Kids (OMK) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

OMK is funded by the Army National Guard and Army Reserve and offers programming in collaboration with the Cooperative Extension Service. Our goal is to serve geographically dispersed military youth. These youth often face many additional challenges that their peers may not face. OMK aims to strengthen Hoosier military families by providing parents the tools necessary to effectively support their children's' education. We also provide opportunities for military youth to learn healthy living and fitness options, which the Army has identified as a key issue for their service members.

Our presence in the Cooperative Extension Service at Purdue University allows us to contribute to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment. Our ability to bring youth to a university and experience college life is one our unique abilities that we can provide to the success of this grant.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Indiana Operation: Military Kids is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

(b)(6) Indiana Operation: Military Kids



Improving Kids' Environment

(b)(6)

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Improving Kid's Environment is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The mission of Improving Kids' Environment (IKE) is to protect children from environmental health hazards through advocacy, education and initiatives that create environmentally healthy homes, schools and communities. Maternal Child Health at the Indiana State Health Department supports our mission and their ability to implement services promoting well-being for children is critical in sustaining and also addressing environmental health of infants and children.

There are 1.6 million children in Indiana. Many of them continue to be exposed to lead in their homes, pesticides and other chemicals in their schools, air pollution in their neighborhoods, and other environmental threats that can affect their ability to grow and thrive. Every child deserves a healthy home, daycare, school and playground. IKE pushes for reasonable solutions to these challenges and advocates policies that will improve children's environmental health in Indiana.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. IKE is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Executive Director



October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Talent Alliance, the collective impact network of organizations, community leaders, funders, advocates, and education institutions throughout Marion County, is pleased to support Indiana's application for the Race to the Top – Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Your support via this grant would assist Indiana to

- Improve school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- Strengthen Hoosier families by providing parents the tools necessary to effectively support their children's education
- Tackle health issues such as infant mortality rates and childhood obesity, and
- Contribute to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

Talent Alliance seeks to improve child care quality, strengthen transitions to kindergarten and early literacy by aligning initiatives throughout Marion County and develop quality measures that assess need for services, identify effective programs, and improve families to make informed decisions. The indicators we use are percentage of students attending high quality preschools and percentages assessed as ready for kindergarten.

The 2013 Race to the Top – Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Talent Alliance is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Talent Alliance

(b)(6)



United Way of Central Indiana

3901 N. Meridian Street
P.O. Box 88409
Indianapolis, IN 46208-0409
tel 317.923.1466
fax 317.921.1355

uwci.org

SPiRiT UNITED

2012 Award Winners

Allison Transmission, Inc.,
and UAW Local #933

BKD, LLP

CNO Financial Group, Inc.
Community Health Network

Top Contributors

Eli Lilly and Company

Lilly Endowment Inc.

Glick Fund - CICF

Indiana University Health

Allison Transmission, Inc.,
and UAW Local #933

Anthem Blue Cross and
Blue Shield of Indiana

OneAmerica

UPS

Indianapolis Power &
Light Company

The Indianapolis Foundation,
a CICF Affiliate

Dow AgroSciences LLC

AT&T Inc., CWA & IBEW

Roche Diagnostics Corporation

Citizens Energy Group

St.Vincent Health

Community Health Network

Herff Jones, Inc.

Chase

FedEx

CNO Financial Group, Inc.

IUPUI

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

United Way of Central Indiana (UWCI) is pleased to support Indiana's application for the *Race to the Top - Early Learning Challenge Grant*. The funding will enable the State to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods.

Through collaboration with community partners and volunteers, UWCI works to fulfill its mission to help people learn more, earn more and lead safe and healthy lives. We strategically focus our work in the broad areas of education, income, health and basic needs in our quest to improve the quality of life for Central Indiana residents.

In our education priority, we have positioned ourselves as a key leader in improving early childhood learning opportunities in our region and state. Much of this work is accomplished in partnership with the Bureau of Child Care, Indiana Family and Social Services Administration. Over the last five years, our collaborative efforts with the Bureau have included:

- Facilitating mentoring and other professional development for child care directors and teachers;
- Providing capital funds to improve the safety, accessibility and health environments of child care facilities;
- Conducting public awareness campaigns to increase demand for quality child care;
- Working to establish ISTAR-KR as a standard assessment tool for kindergarten readiness; and
- Advocating for public policy changes to better ensure the health and safety of children and ultimately to improve the quality of teaching and curricula in order for children to be ready for kindergarten.

Indiana's voluntary quality rating system, Paths to QUALITY, is the vehicle used to assess improvements in the child care centers with whom UWCI works.

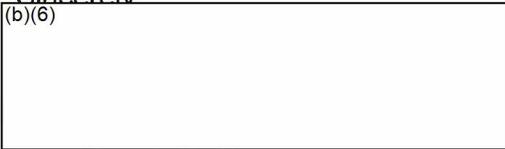
UWCI is very excited about the opportunities that *Race to the Top* grant funds will provide the state of Indiana to comprehensively address the early education needs of children, particularly those youngsters from low-income and disadvantaged families. We are also eager to expand the reach and scope of our work in partnership with the Bureau in ways that will assist them in achieving the following proposed objectives:

- Improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates;
- Strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education;
- Tackling critical health issues including childhood obesity; and
- Contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment.

The goals of the proposal closely align with Indiana's current goals and objectives for health, education, and economic development. UWCI is committed to working with the Family and Social Services Administration and its partners to ensure that high need young children have access to comprehensive, high quality early child development and are ready to succeed in school. I encourage the reviewers to thoughtfully consider how this proposal and recognize that an investment of this magnitude by the federal government will leverage additional public and philanthropic resources needed to significantly improve outcomes for Indiana's young children both now and for years to come.

Sincerely

(b)(6)

A rectangular box with a black border, used to redact the signature of the President & CEO. The text "(b)(6)" is written in the top-left corner of the box.

President & CEO



Mr. Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Ms. Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The United Way of Greater Lafayette is pleased to support Indiana’s application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Our United Way and the Community Commitment to Education, our community’s collective impact effort for which we serve as the “backbone” organization, are actively working to develop local supports for early child education with specific goals of having children entering kindergarten ready to succeed. Your support of a statewide effort through this grant would support an emerging groundswell of efforts in Indiana to:

- improve school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthen Hoosier families by providing parents the tools necessary to effectively support their children’s’ education
- tackle health issues such as infant mortality rates and childhood obesity
- contribute to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

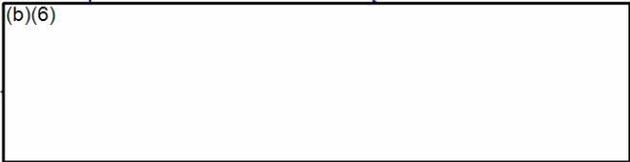
United Way provided Kindergarten Countdown Camp for 168 children this summer. These students had little or no preschool experience. Through this intervention, they were better prepared for school academically and non-cognitively. In fact, early literacy scores increased by an average of 15% and teachers reported much better behavior in the classroom at the start of the year.

Even as this effort is working, we know that empowering and supporting parents to be their child's first and best teacher make much more sense. To that end, our Community Commitment to Education is developing ways to help parents succeed in that important role. Building on our successful Read to Succeed program which focuses on third grade reading, we are developing Succeed With Me. This effort will be based on a definition of kindergarten readiness agreed upon by our three public school corporations. Our key partners include those schools as well as Greater Lafayette Commerce which is our community's economic development and chamber organization. We intend to leverage the support of more than 70 business partners to provide avenues to educate their workforce, the parents and grandparents of today's preschool children to build their capacity to better prepare their children for school. Already, this avenue has helped to change the culture of our community around the importance of third grade reading and we believe we can replicate that success around kindergarten readiness.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The United Way of Greater Lafayette is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

A rectangular box with a black border, used to redact a signature. The text "(b)(6)" is written in the top-left corner of the box.

Supporting Organization	Did this entity provide a letter of intent or support which is included in the Appendix (Y/N)?
1 st Kids, Inc.	Y
Anthem Indiana Medicaid	Y
Ball State University	Y
Child and Adult Care Food Program	Y
Day Nursery	Y
Division for Physical, Health and Multiple Disabilities	Y
Evansville Regional Business Committee, Inc.	Y
Evansville Vandeburgh School Corporation	Y
Family Voices Indiana	Y
Fort Wayne Community Schools	Y
Goodwill Industries of Central Indiana, Inc.	Y
Indiana Academy of American Pediatrics	Y
Indianapolis/Marion County Public Library	Y
Indianapolis Public Schools	Y
Indiana Center for Education and Career Innovation	Y
Indiana Commission on Hispanic/Latino Affairs	Y
Indiana Department of Child Services	Y
Indiana Department of Environmental Management	Y
Indiana State Department of Health Children's Special Health Care Services Division	Y
Indiana State Department of Health Division of Nutrition and Physical Activity	Y
Indiana State Representative Mahan	Y
Lakeshore Learning	Y
Mental Health America of Indianapolis	Y
PNC Bank	Y
Purdue University Extension Office	Y
Riley Child Development Center	Y
Teaching & Mentoring Communities (Migrant Head Start)	Y
University of Evansville	Y
University of Southern Indiana	Y
Wayne Township Preschool	Y



First Steps

1st Kids, Inc.

11045 Broadway, Suite F
Crown Point, IN 46307
219.662.7790/800.387.7837

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

1st Kids, Inc. is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

In our work with Northwest Indiana's Early Intervention system, we see the value in investing in our future through:

- improving school readiness and future academic success of our youngest children
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

1st Kids, Inc. is committed to assisting children and families in maximizing their potential. The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. 1st Kids, Inc. is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Executive Director



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Anthem Indiana Medicaid is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Race to the Top – Early Learning Challenge Grant will allow Indiana to tackle health issues such as infant mortality rates and childhood obesity while contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment.

As one of the Managed Care companies serving Hoosiers in the Hoosier HealthWise Program, Anthem Medicaid strongly endorses any and all opportunities to improve childhood health. We know that keeping kids healthy prepares them to be successful students and citizens.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Anthem Medicaid is committed to working with the Indiana Family Social Services Agency, the Indiana State Department of Health and their other partners to ensure that young children in need have access to comprehensive, high quality early child development and are positioned for success, educationally and in all aspects of their lives.

Sincerely,

(b)(6)

Chief Medical Officer



DEPARTMENT OF ELEMENTARY EDUCATION
OFFICE OF DEPARTMENT CHAIR

(b)(6)

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Department of Elementary Education at Ball State University is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Department of Elementary Education, which includes Early Childhood Education, is committed to preparing highly effective early childhood educators. Our department offers degrees in Early Childhood Education at the undergraduate, masters, and doctoral levels. We have a long-standing articulation agreement with Ivy Tech Community College, and we have recently implemented an online completion program for students with Associate's degrees. We participate in the T.E.A.C.H. Indiana scholarship program and our faculty is involved in numerous local and state professional development initiatives. We are committed to increasing opportunities for postsecondary credentialing and degree attainment for early childhood professionals, one of the goals of this grant application.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Ball State University is committed to working with the Lead Agency (FSSA) and its other partners to ensure that high need young children have access to comprehensive, high quality early childhood education and start school ready to succeed.

Sincerely,

(b)(6)

Interim Chair



October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

School and Community Nutrition is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Tackling health issues such as infant mortality rates and childhood obesity, as well as promoting nutrition education and improving the diets of young children in Indiana is a top priority for the Child and Adult Care Food Program. We touch the lives of young children daily in 979 child care centers and 2220 family day care homes.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. School and Community Nutrition is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

School and Community Nutrition

(b)(6)



CHILD CARE CENTERS
REFERRALS • TRAINING

(b)(6)

October 5, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Day Nursery Association is pleased to support Indiana’s application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The key objectives within this grant that align with Day Nursery’s goals and priorities include:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children’s education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

Day Nursery’s mission is to assure the highest level of early childhood education for children in central Indiana. Day Nursery currently operates seven centers in central Indiana and supports the highest standards of early care and education by adhering to NAEYC accreditation standards and the State of Indiana’s Path to Quality (PTQ) Level 4 standards.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana’s current goals and objectives for health, education, and economic development. Day Nursery is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

President and CEO



**A Division of the
Council for Exceptional Children**
1110 North Glebe Road, Suite 300
Arlington, VA 22201-5704
<http://web.utk.edu/~dphd>

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Division of Physical, Health and Multiple Disabilities (DPHMD) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow Indiana to move forward with many critical well-being measures by expanding currently existing initiatives and implementing promising partnerships and practices that have not been possible due to budgetary constraints.

This grant will provide opportunities to:

- improving school readiness and future academic success of our youngest children
- tackling health issues such as infant mortality rates and childhood obesity

Council for Exceptional Children (CEC) that advocates for quality education for all individuals with physical disabilities, multiple disabilities, and special health care needs served in schools, hospitals, or home settings. The goal of DPHMD is to promoting the continued development of adequate resources and programs that address the many areas of need associated with serving children and adults with physical and/or multiple disabilities, and special health care needs.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children as we seek to align with Indiana's goals and objectives for health, education, and economic development. DPHMD is committed to working with the Lead Agency (FSSA) and others to ensure that children have access to comprehensive, high quality education and health care.

Sincerely,

(b)(6)

Division for Physical, Health and Multiple Disabilities, President

Evansville Regional Business Committee, Inc.

One Vectren Square
Evansville, IN 47708

Voice 812-491-4936
Fax 812-491-4138
Email ehafer@vectren.com

October 7, 2013

(b)(6)

Arne Duncan, Secretary U.S. Department of Education 400 Maryland Ave., SW Washington, DC 20202	Kathleen Sebelius, Secretary U.S. Department of Health and Human Services 200 Independence Ave., SW Washington, DC 20202
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Dear Secretary Duncan and Secretary Sebelius,

The Evansville Regional Business Committee (ERBC), composed of the highest ranking executives of the twenty-two largest employer's in Southwest Indiana, is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The ERBC recognizes that improving early childhood experiences for High Need children is essential to developing better educated, trained citizens fully prepared to work in the global marketplace of the 21st century. ERBC leadership engages the Lead Agency (FSSA) and its partners with a common vision of economic and civic growth and supports the objectives described in their application:

- Improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- Strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- Addressing health issues such as infant mortality rates and childhood obesity
- Contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Evansville Regional Business Committee is committed to working with the Lead Agency (FSSA) and its partners to ensure that High Need young children have access to comprehensive, high quality early child development and enter school ready to succeed.

Sincerely,

(b)(6)

President



Center for Family, School, and Community Partnerships

123 Main Street, Evansville, Indiana 47708 Phone (812) 435-8866 Fax (812) 435-8604
www.evscschools.com

October 8, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Evansville Vanderburgh School Corporation (EVSC) is pleased to support Indiana's Race to the Top - Early Learning Challenge Grant application. The EVSC is the third largest urban school district in the state of Indiana, serving approximately 23,000 students. The Early Learning Grant would allow the State of Indiana to expand its successful early childhood initiatives while at the same time implementing an array of promising new methods based on research and best practice. The grant funding would provide the state with the resources it needs to build the infrastructure to support the creation and implementation of a high quality early childhood framework.

The EVSC would benefit from key components outlined in the state's application. They include:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Evansville Vanderburgh School Corporation is committed to working with the Lead Agency (FSSA) and its other partners to ensure that high-needs young children have access to comprehensive, high quality early childhood educational opportunities so that they are ready to enter school ready to learn.

Sincerely,

(b)(6)

Associate Superintendent
Evansville Vanderburgh School Corporation

(b)(6)

FAMILY VOICES[®]

INDIANA

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

Family Voices Indiana fully supports Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

FV Indiana is committed to supporting families in their quest to meet their children's needs and navigating complex systems. Our organization supports families in advocating for their children's educational and mental health needs. This grant opportunity will strengthen Hoosier families by providing parents the tools necessary to effectively support their children's' education. Family Voices Indiana is a family-led organization that provides information, education, training, outreach, and peer support to families of children and youth with special health care needs and the professionals who serve them. We have and will continue to partner with Indiana state agencies and other state and local parent/family organizations and social services providers in our collective efforts to meet the unique needs of Indiana children with the goal of helping the enter Kindergarten ready to learn.

The 2013 Race to the Top - Early Learning Challenge Grant provides a mechanism for our state to address our high needs children. FV Indiana stands ready to continue our partnership in Indiana's efforts ensure that young children have access to comprehensive, high quality early child development and arrive to Kindergarten ready to learn.

Sincerely,

(b)(6)

President

(b)(6)



WE ARE YOUR SCHOOLS

FORT WAYNE COMMUNITY SCHOOLS

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Fort Wayne Community Schools is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Below is a list of the key objectives within the grant.

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Fort Wayne Community Schools and Hoosier families by providing parents the tools necessary to effectively support their children's' education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The mission of Fort Wayne Community Schools is to educate all students to high standards enabling them to become productive, responsible citizens. Each year, our Title I Pre-K program enrolls just under 500 students with at least 100 students on the waiting list. Additionally, our district serves Pre-K students through Special Education services as well as focused programs utilizing the Montessori and Reggio Emilia methods.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Fort Wayne Community Schools is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Superintendent

(b)(6)



**Goodwill Industries
of Central Indiana, Inc.**

1635 W. Michigan St.
Indianapolis, IN 46222
317-524-4313
Fax: 317-524-4336
www.goodwillindy.org

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Goodwill Industries of Central Indiana, Inc. is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints. The following grant objectives align well with Goodwill Industries' strategic directions:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

Goodwill Industries of Central Indiana, Inc. provides an array of opportunities for families to improve their situations, focusing on employment, education, and public health efforts for populations in central Indiana that face considerable obstacles to success. Goodwill provides employment opportunities to over 3,000 people in over 50 sites in central Indiana. Most of these employees are involved in Goodwill's donated goods retail business in a variety of urban, suburban and small-town locations. Goodwill educates over 3,200 students in ten charter schools operated through Goodwill Education Initiatives. Its first charter school, the Indianapolis Metropolitan High School, opened in 2004. The Met serves traditional-age students, many of whom struggled to succeed in other schools. Goodwill's nine Excel Centers are charter schools for adults of all ages who have dropped out of school. The Excel Center's students earn a high school diploma (not a GED) while also gaining access to postsecondary credentials and certifications that improve their long-term employability. The Excel Centers in central Indiana provide supports for students to address out-of-school barriers they may face, including an on-site child drop-in center that allows students with children to bring their students to school while they attend class. Goodwill is the sole operator of The Nurse-Family Partnership (NFP) model in Indiana with a capacity to serving actively 600 families in central Indiana. NFP is an evidence-based nurse home visiting health program that helps transform the

lives of vulnerable, low-income mothers pregnant with their first children. Built upon the work of Professor David Olds, NFP's prenatal to age two model is proven to deliver better pregnancy outcomes, improved child health and development and increased economic self-sufficiency—making a measurable impact on the lives of children, families and their communities. Research shows that that when a parent improves his/her education, health and employment status, their children are more likely to be successful: they are more likely to graduate from high school, to be employed, and to make healthier choices. Consequently, the overall impact of Goodwill's mission activities may be greatest not with the generation of parents Goodwill currently serves, but instead with their children. Goodwill desires is to strengthen its child outcomes by empowering Goodwill parents with knowledge to access high quality care and to monitor their children's development to achieve better educational outcomes.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Goodwill Industries is committed to working with the Lead Agency (FSSA) and its other partners to ensure that high need young children have access to comprehensive, high quality early child development and are ready to start school to succeed.

Sincerely,

(b)(6)

[Redacted signature box]

Senior Vice President & Chief Operating Officer
Goodwill Industries of Central Indiana, Inc.

(b)(6)

[Redacted signature box]

Senior Vice President & Chief Operating Officer
Goodwill Education Initiatives, Inc.

cc:

(b)(6)

[Redacted cc list box]



**Indiana Chapter
American Academy
of Pediatrics**

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana Chapter of the American Academy of Pediatricians (INAAP) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

INAAP is committed to the attainment of optimal physical, mental and social health for all infants, children, adolescents and young adults. Our mission is to improve the health of children in the State of Indiana. To this end, collaboration with other groups to tackle issues such as infant mortality rates and childhood obesity are important to our group.

We find the goals of this grant very timely as our state is currently facing many barriers to providing healthy environments, family supports and early education to mitigate both infant mortality and childhood obesity in Indiana. INAAP, which represents 650 pediatricians in the state, has focused on the issues of infant mortality and childhood obesity as nationally reported rates show that these are two areas of grave concern for Hoosier families and children. According to the Indiana State Department of Health, Indiana has only had an infant mortality rate below 7% once in 113 years. And according to the CDC, as of 2007, 14.6 per cent of children and teens in Indiana, age 10 to 17, were considered obese. Therefore, INAAP is pleased to support this grant of the Indiana State Department of Health focuses on improving the health of children in Indiana.

The 2013 Race to the Top - Early Learning Challenge Grant grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. INAAP is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

President
Indiana Chapter – American Academy of Pediatrics
P.O. Box 99975

(b)(6)



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indianapolis Public Library is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Library supports these efforts because we serve our community as the preschooler's first door to learning, socialization, and play. Our branch libraries serve the entire county regardless of socioeconomic status – to be the center of innovation - the glue in the informal learning process regardless of age. Through our programs and services, we engage and partner with families, schools, and agencies to extend beyond the walls of our building to

- improve school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthen Hoosier families by providing parents the tools necessary to effectively support their children's' education

The Library is currently collaborating with United Way of Central Indiana to provide free books through the Early Readers Club to children in Marion County under the age 6. Outreach programs serve more than 2,500 children in licensed home and childcare centers. Storytimes at locations introduce and model reading aloud – one of the best ways for a child to learn to love reading. Extending efforts through digital products and software expose young learners to technology in very supportive setting. And programs and services continue to provide this access and experience to all ages – through job centers, tinker stations, to concerts and lectures.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indianapolis Public Library is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and start school ready to succeed.

Sincerely
(b)(6)



Director of Program and Project Development
The Indianapolis Public Library



Indianapolis Public Schools

(b)(6)

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indianapolis Public Schools' Francis Bellamy Preschool is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

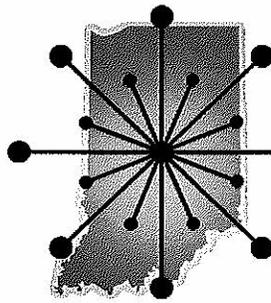
"All children should have access to high quality, developmentally appropriate preschool, enabling them to become life-long learners." is the Francis Bellamy Preschool Mission Statement. Approximately, 500 general education preschoolers are being served in our district with several thousand preschool age children not being served. This grant will help provide opportunities for needy and deserving children.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indianapolis Public School System is committed to working with the Lead Agency (FSSA) and its partners to ensure that underserved young children have access to comprehensive, high quality early childhood programming.

Sincerely,

(b)(6)

Principal
Francis Bellamy Preschool



CENTER FOR EDUCATION & CAREER INNOVATION

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Governor Mike Pence's Center for Education and Career Innovation is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Center for Education and Career Innovation is a newly created state agency whose mission is to enable the State to align K-12, higher education and workforce development resources and programs to deliver the most impactful results for Indiana families, employers and taxpayers. As such, this grant clearly aligns with the Center's priorities of:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Center for Education and Career Innovation is committed to working with the Family and Social Services Agency and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and are ready to start school to succeed.

Sincerely,

(b)(6)

Special Assistant to the Governor
for Education Innovation

(b)(6)

Special Assistant to the Governor
for Career Innovation

Center for Education & Career Innovation

(b)(6)



October 6, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

On behalf of the commissioners of the State of Indiana Commission on Hispanic/Latino Affairs, it is a pleasure to enthusiastically support Indiana's application for the Race to the Top – Early Learning Challenge grant.

As the State agency created to work with and advocate on behalf of our growing Latino community, our commissioners understand fully how critical efforts to strengthen Hoosier families and enhancing long-term academic success really are. While graduation rates amongst Latinos and other vulnerable communities are up, strategies aimed at increasing access to early learning opportunities may ultimately dictate the future economic and educational success of our state for decades to come.

To that end, we are fully committed to working with the State Family and Social Services Administration and other partner agencies and organizations to ensure that the objectives of the grant are brought to fruition. Many thanks for your consideration!

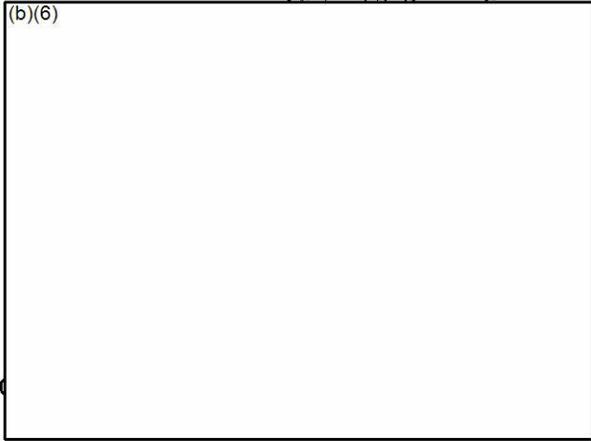
Sincerely,

(b)(6)

(b)(6)

Executive Director

(b)(6)



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Department of Child Services is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods. The grant will focus on:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The Department of Child Services is supportive of this grant application as it will assist in our efforts to ensure children involved in the child welfare system have the appropriate supporting programs to enhance their educational attainment.

The 2013 Race to the Top - Early Learning Challenge Grant grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Department of Child Services is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,



Deputy Director of Services and Outcomes





INDIANA DEPARTMENT OF ENVIRONMENTAL MANAGEMENT

We Protect Hoosiers and Our Environment.

100 N. Senate Avenue • Indianapolis, IN 46204

(800) 451-6027 • (317) 232-8603 • www.idem.IN.gov

Michael R. Pence
Governor

Thomas W. Easterly
Commissioner

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

The Indiana Department of Environmental Management (IDEM), Office of Compliance Support, is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible, due to budgetary constraints.

IDEM supports the key issues in the Race to the Top Challenge, with an emphasis on:

- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education, including environmental education; and,
- tackling health issues.

IDEM's mission is not only to protect the environment, but also the health of Hoosiers—through all stages of their lives. Schools not only play a key role in protecting children from environmental health threats in their buildings, but also through education to parents about the homes in which those children live. Children are more vulnerable to the negative effects of environmental hazards such as lead in paint and water, and pesticide exposure. Children are exposed to more pollutants in their food, water, and air because they eat, drink and breathe more per pound of body weight than adults. They are more vulnerable to the harmful effects of toxic chemicals because their bodily defense mechanisms are not fully formed. That is why it is essential to provide children with a safe, clean environment. IDEM supports any and all efforts to go above and beyond environmental health, and safety regulations to keep children healthy. Educating and empowering parents with information so they can make the best choices for their children and helps schools do their best for Hoosier children.

Page Two

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The Indiana Department of Environmental Management is committed to working with the Family and Social Services Agency and its other partners to ensure that high need young children have access to comprehensive, high quality early child development and are ready to start school to succeed.

Sincerely,

(b)(6)

Assistant Commissioner
Office of Compliance Support



**Indiana State
Department of Health**
An Equal Opportunity Employer

Michael R. Pence
Governor

William C. VanNess II, MD
State Health Commissioner

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

The Children's Special Health Care Services (CSHCS) Division at the Indiana State Department of Health (ISDH) is pleased to support Indiana's application for the Race to the Top-Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The CSHCS Division has a standing commitment to provide access to quality, comprehensive, coordinated community-based systems of services for children and youth with special health care needs (CYSHCN). Our mission to integrate and improve systems of care for CYSHCN is based on the six national priorities identified by the Maternal and Child Health Bureau, one of which strives for early and continuous screening for special health care needs. Our CSHCS Program helps eligible Indiana families of children ages birth-21 years old with severe chronic medical conditions, including Autism, pay for treatment related to their child's condition. CSHCS can serve as a referral source to those children who may qualify for our program and need financial assistance. Our Care Coordinators within the division are available to assist those participants/families in the program and all CYSHCN throughout the state with their efforts to understand the medical home concept as well as make medical and non-medical referrals, all of which are important to ensuring the families are well-informed and equipped to support their children's early learning and development.

The 2013 Race to the Top-Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. CSHCS is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

(b)(6) CSHCS Division
Indiana State Department of Health

(b)(6)



*To promote and provide
essential public health services.*



Indiana State
Department of Health
An Equal Opportunity Employer

Michael R. Pence
Governor

William C. VanNess II, MD
State Health Commissioner

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana State Department of Health (ISDH) Maternal and Child Health (MCH) Division is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

With our division's focus on the life course perspective, improving school readiness and future academic success of our youngest children is of particular importance in order to improve literacy at third grade and eventual high school graduation rates. Early childhood educational opportunities will also increase postsecondary credentialing and degree attainment, all of which contribute positively to individual life course trajectories and contribute to a stronger Hoosier workforce. Lastly, health issues such as infant mortality and childhood obesity are of great concern to our organization as they can affect the future health and success of our youngest Hoosiers.

The ISDH strives to promote and provide essential public health services for all Indiana residents. Specifically within the MCH Division, reducing infant mortality has become our number one priority as we work to improve the health of all mothers, children, and adolescents throughout Indiana.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The ISDH is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Director, Maternal and Child Health Division



(b)(6)

To promote and provide
essential public health services.



Michael R. Pence
Governor

William C. VanNess II, MD
State Health Commissioner

October 7, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana State Department of Health (ISDH) Division of Nutrition and Physical Activity (DNPA) is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The DNPA's work includes, but is not limited to, the implementation and evaluation of *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020* (the state obesity prevention plan) in collaboration with the Indiana Healthy Weight Initiative (IHWI) Task Force. Multiple early care and education providers, including the Family and Social Services Administration (FSSA), have been active members of the IHWI Task Force, providing information and technical assistance as it relates to addressing children's health (including childhood obesity) and development in the child care setting. The state obesity prevention plan focuses on primary prevention, more specifically nutrition, physical activity, and breastfeeding. There are six objectives in the state obesity prevention plan that focus on early childhood/child care including: training and technical assistance for parents and early care and education providers; increased participation in the child and adult care food program; improved nutrition, physical activity, and television viewing standards in the state's regulation for licensed and registered child care facilities and in the Paths to Quality rating system; and adding basic nutrition and physical activity requirements for unlicensed child-care providers in the Child Care and Development Fund (CCDF) voucher program provider eligibility standards.

The DNPA, along with the ISDH Chronic Disease Prevention and Control Division (CDPCD), is a recipient of the Centers for Disease Control and Prevention (CDC) State Public Health Actions to Prevent and Control Heart Disease, Obesity and Associated Risk Factors and Promote School Health program. The program funds two components with project periods of up to 5 years. All states and the District of Columbia are funded for a non-competitive, **basic component**. In addition to basic funding, 32 states (including Indiana) are funded for a competitive, **enhanced component**. The DNPA and CDPCD will work collaboratively on multiple cross cutting strategies to address chronic disease and risk behaviors including the implementation of physical education and physical activity in early care and education and the adoption of food service guidelines/nutrition standards, which include sodium, in early care and education.



2 North Meridian Street • Indianapolis, IN 46204
317.233.1325 tdd 317.233.5577
www.statehealth.in.gov

To promote and provide
essential public health services.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The ISDH DNPA is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Director
Division of Nutrition and Physical Activity



**STATE OF INDIANA
HOUSE OF REPRESENTATIVES**

THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

(b)(6)

Committees:
Government & Regulatory Reform, *Chair*
Family, Children and Human Affairs
Courts and Criminal Code
Insurance

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

I am pleased to submit this letter of support for Indiana’s application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The Race to the Top – Early Learning Challenge Grant will help Indiana educators:

- improve school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthen Hoosier families by providing parents the tools necessary to effectively support their children’s education
- tackle health issues such as infant mortality rates and childhood obesity
- contribute to a stronger Hoosier workforce through increased early childhood educational opportunities through increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana’s current goals and objectives for health, education, and economic development.

Sincerely,

(b)(6)

State Representative
House District 31



October 8, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The Indiana Youth Institute, whose mission is to promote the healthy development of Indiana children and youth by serving those who impact their well-being, is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant.

The grant priorities fit well with IYI's strategic vision, which is that all Indiana children and youth attain five critical elements of healthy youth development: physical health and safety, emotional fulfillment, academic achievement, civic engagement and economic self-sufficiency.

We look forward to the opportunity to participate in Indiana's efforts to increase the amount and quality of early learning opportunities, especially for children with high need, and to strengthen families in their ability to provide a solid foundation for our youngest citizens.

Sincerely,

(b)(6)

President & CEO

(b)(6)



Lakeshore®

October 4, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Duncan and Secretary Sebelius,

Lakeshore Learning Materials is pleased to support Indiana's application for the Race to the Top – Early Learning Challenge Grant. We believe that the state of Indiana has created a comprehensive plan to increase school-readiness skills and implement crucial well-being measures in young children. Funding from the RTT-ELC grant will allow the state to expand successful existing initiatives and implement promising new methods that budgetary constraints have prevented in the past.

Lakeshore firmly believes that quality early childhood programs and the development of literacy skills early in life are essential to ensuring children's future success—both in and out of the classroom. Research shows that early gains in school-readiness skills translate to increased academic achievement later in life, as well as economic improvement for children born into low-income families. We feel that Indiana's multi-faceted approach—targeting children's developmental and academic goals, involving families and providing professional development for teachers—can have a significant, positive effect on the future success of the state's high-needs children.

Lakeshore is a leading manufacturer of high-quality educational materials for early childhood organizations and elementary programs around the country. Through our partnerships with nonprofit organizations, as well as our own research and development, we've created products that boost early brain development, help children reach developmental milestones and build school-readiness skills.

The RTT-ELC grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for children's health, education and economic development. Lakeshore is committed to working with Indiana's Family and Social Services Administration and its partners to ensure that high-needs children have access to comprehensive, high-quality early childhood education and are able to enter school ready to succeed.

Sincerely,

(b)(6)

Regional Vice President

Lakeshore Learning Materials

(b)(6)



Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

Mental Health America of Indiana (MHAI) and its subsidiary Indiana Association for Infant Mental Health (IAITMH) completely supports Indiana's application for the Race to the Top - Early Learning Challenge Grant. Indiana's youngest citizens with high needs will benefit greatly from expansion or successful existing initiatives and implementation of promising new methods that have not been possible due to budgetary constraints.

The IAITMH implements Indiana's Infant Mental Health Endorsement system. The competency based system encourages providers including child care, home visitors, preschool, early intervention, social workers, psychologists, therapists and others to participate at one of four levels. The Endorsement process is increasing the mental health workforce capacity and creating an integrated infrastructure that will ensure that all Indiana families with very young children have access to well-trained providers in their home communities contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment.

The IAITMH vision is to advance the conditions which provide an early start toward optimal mental health. The association envisions that all infants and toddlers are entitled to an opportunity to grow, learn and develop in a way that enhances their social and emotional health so that they may reach their maximum potential. Optimal social emotional development is crucial for early learning and readiness for Kindergarten.

The IAITMH and MHAI have been longtime supporters of Indiana's efforts to provide optimal learning opportunities for Indiana's youngest citizens. The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. We look forward to our continued partnership with Indiana Family and Social Services Administration as well as our myriad partners who are all committed to ensuring that Hoosier young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

A rectangular box with a black border, containing the text "(b)(6)" in the top left corner. A horizontal line extends from the right side of the box.

President and CEO

(b)(6)

(b)(6)

(b)(6)



October 3, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

PNC Bank is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's education
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

PNC's primary philanthropic focus is on Early Childhood Education (with an emphasis on underserved children). This commitment is evidenced by our multi-year, \$350 million investment across our footprint, to this area of need.

The 2013 Race to the Top - Early Learning Challenge Grant grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. PNC Bank is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Regional President Central & Southern Indiana



COLLEGE OF HEALTH AND HUMAN SCIENCES
EXTENSION ADMINISTRATION

October 3, 2013

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Purdue Extension is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Purdue Extension is committed to improving the quality of life for Indiana residents and beyond. We have unique expertise in community engagement and early childhood development. One of our key initiatives is to prepare children for academic success. This priority aligns well with improving school readiness and future academic success of our youngest children through literacy programs.

Purdue Extension can provide educational content and website development expertise for this project. Dynamic tools that engage stakeholders are important elements to moving Indiana forward toward its goals.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Purdue Extension is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

Assistant Director
Purdue Extension

(b)(6)



Indiana University Health



SCHOOL OF MEDICINE

INDIANA UNIVERSITY

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

The Riley Child Development Center (RCDC) is delighted to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The RCDC is Indiana's Leadership Education in Neurodevelopmental Disorders (LEND) interdisciplinary training program funded by the HRSA/MCHB. The RCDC supports Indiana's many efforts to address the unique needs of at risk children. This proposal will allow Indiana a chance to expand several successful existing initiatives and implementing promising new methods.

Our center looks forward to supporting Indiana's efforts to build a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment, especially focusing on early childhood mental health consultation and early identification of learning challenges. The RCDC has been a primary supporter of training and technical assistance in implementing Indiana's Infant Mental Health Endorsement system. This statewide system seeks to enhance the mental health workforce capacity in all agencies, programs, and settings where young children are served in Indiana. Optimal social emotional development is critical for successful early learning and school readiness.

The 2013 Race to the Top - Early Learning Challenge Grant offers Indiana an opportunity to enhance and improve school readiness for Hoosier children with high needs to be ready for Kindergarten. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The RCDC stands ready to continue its partnership with the Indiana Family Social Services Administration, the Indiana State Department of Health, the Indiana Department of Education and the many other organizations that seek to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

Arne Duncan

(b)(6)

Director, Riley Child Development Center
Indiana University School of Medicine, Department of Pediatrics

(b)(6)

Indiana University School of Medicine
Riley Child Development Center
Indiana LEND Program,

(b)(6)

(b)(6)

“A Private Non-Profit Corporation”



October 4, 2013

Arne Duncan, Secretary
 U.S. Department of Education
 400 Maryland Ave., SW
 Washington, DC 20202

Kathleen Sebelius, Secretary
 U.S. Department of Health and Human Services
 200 Independence Ave., SW
 Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius:

TMC is pleased to support Indiana’s application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints, such as:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children’s education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased access to high quality early childhood educational opportunities

TMC provides Migrant Seasonal Head Start services to children and families in communities throughout Indiana. In our efforts, we have worked in partnership with Indiana Department of Education for many years helping to meet the needs of farm worker families in Indiana.

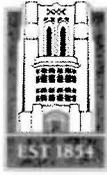
The 2013 Race to the Top - Early Learning Challenge grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana’s current goals and objectives for health, education, and economic development. TMC is committed to working with the Lead Agency (FSSA) and its other partners to ensure that high need young children have access to comprehensive, high quality early childhood education and start Kindergarten ready to succeed.

Sincerely,

(b)(6)

 A rectangular box with a black border, containing the text '(b)(6)', which redacts the signature of the President & CEO.

President & CEO



UNIVERSITY
OF
EVANSVILLE
Civic Mission... Sacred Trust

School of Education

(b)(6)

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The University of Evansville is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

The University of Evansville shares Indiana FSSA's commitment to:

- improving school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- strengthening Hoosier families by providing parents the tools necessary to effectively support their children's' education
- tackling health issues such as infant mortality rates and childhood obesity
- contributing to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. The University of Evansville is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and that they are ready to successfully start school.

Sincerely,

(b)(6)

Assistant Professor of Education
Member, 4C of Southern Indiana Board of Directors



University of Southern Indiana

Pott College of Science, Engineering, and Education

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

The University of Southern Indiana Pott College of Science, Engineering, and Education is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints. With this funding Indiana will be able to provide increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment which will contribute to a stronger Hoosier workforce. As a result of this increased professional development for the early childhood workforce, early childhood educators will provide enriched educational experiences for our youngest children that will lead to improved school readiness and future academic success

USI is an engaged learning community advancing education and knowledge, enhancing civic and cultural awareness, and fostering partnerships through comprehensive outreach programs. We prepare individuals to live wisely in a diverse and global community. The University of Southern Indiana is committed to preparing highly qualified early childhood educators who will enter the workforce committed to providing excellent programs for young children.

The 2013 Race to the Top - Early Learning Challenge Grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Your University of Southern Indiana Pott College of Science, Engineering, and Education is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and are ready to start school to succeed.

(b)(6)

Dean of the Pott College of Science, Engineering and Education



WAYNE TOWNSHIP PRESCHOOL

Developing Young Minds

Arne Duncan, Secretary
U.S. Department of Education
400 Maryland Ave., SW
Washington, DC 20202

Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20202

Dear Secretary Duncan and Secretary Sebelius,

Wayne Township Preschool is pleased to support Indiana's application for the Race to the Top - Early Learning Challenge Grant. The funding will allow the State the opportunity to move forward on many critical early childhood well-being measures by expanding successful existing initiatives and implementing promising new methods that have not been possible due to budgetary constraints.

Wayne Township preschool is a part of the MSD Wayne Township in Indianapolis, Indiana. Our school services families that are in a school community of 78% free and reduced. Our preschool program has 30% non-English speakers, and 56% minority.

As a public school preschool this grant would afford us the opportunity to:

- Help improve school readiness and future academic success of our youngest children including improving literacy at third grade and eventual graduation rates
- Help to strengthen Hoosier families by providing parents the tools necessary to effectively support their children's' education
- Contribute to a stronger Hoosier workforce through increased early childhood educational opportunities resulting in increased postsecondary credentialing and degree attainment

The 2013 Race to the Top - Early Learning Challenge Grant grant provides a unique opportunity for Hoosier children. The goals of the grant closely align with Indiana's current goals and objectives for health, education, and economic development. Wayne Township Preschool is committed to working with the Lead Agency (FSSA) and its other partners to ensure that High Need young children have access to comprehensive, high quality early child development and ready to start school to succeed.

Sincerely,

(b)(6)

A rectangular box with a black border, used to redact the signature of the principal. The text "(b)(6)" is written in the top left corner of the box.

Principal



UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF THE CHIEF FINANCIAL OFFICER

JUL 03 2013

Ms. Beverly Flanagan
Chief Financial Officer
Indiana Department of Education
115 W. Washington Street
South Tower, Suite 600
Indianapolis, IN 46204

Reference: Agreement No. 2010-113(A)

Dear Ms. Flanagan:

The original and one copy of the Indirect Cost Rate Agreement are enclosed. These documents reflect an understanding reached by your organization and the U.S. Department of Education. The rates agreed upon should be used for computing indirect cost grants, contracts and applications funded by this Department and other Federal Agencies. We are extending the effective period of the rate while we perform our review.

After reviewing the Rate Agreement, please confirm acceptance by having the original signed by a duly authorized representative of your organization and returned within thirty (30) calendar days from the date of this letter to:

U.S. Department of Education
OCFO / FIPAO / ICG
Attention: Nelda Barnes, Rm. 6044
550 12th Street, SW
Washington, DC 20202-4450

The enclosed copy of this agreement should be retained for your files. If there are any questions, please contact Nelda Barnes at (202) 377-3876 or Nelda.Barnes@ed.gov.

Sincerely,

(b)(6)

[Redacted signature box]

Director, Indirect Cost Group
Financial Improvement and Post Audit Operations

Enclosures

COPY

INDIRECT COST RATE AGREEMENT
STATE EDUCATION AGENCY

Organization

Indiana Department of Education
Room 229, State House
Indianapolis, IN 46204-2798

Date: JUL 03 2013**Agreement No:** 2010-113(A)

Filing Reference: Replaces previous
Agreement No. 2010-113
Dated: 5/7/2010

The approved indirect cost rates herein are for use on grants, contracts, and other agreements with the Federal Government. The rates are subject to the conditions included in Section II of this Agreement and issued by the U.S. Department of Education pursuant to the authority in Attachment A of Office of Management and Budget Circular A-87.

Section I - Rates and Bases

<u>Type</u>	<u>From</u>	<u>To</u>	<u>Rate</u>	<u>Base</u>	<u>Applicable To</u>
Predetermined	07/01/2010	06/30/2013	5.7%	MTDC	APwR
Provisional	07/01/2013	12/31/2013	5.7%	MTDC	APwR

Distribution Base:

MTDC Modified Total Direct Cost - Total direct costs excluding equipment, capital expenditures, participant support costs, pass-through funds and the portion of each subaward (subcontract or subgrant) above \$25,000 (each award; each year).

Applicable To:

APwR The rates herein are applicable to All Programs including those that require a restricted rate per 34 CFR 75.563 and 34 CFR 76.563.

Treatment of Fringe Benefits:

Fringe benefits applicable to direct salaries and wages are treated as direct costs, however, pursuant to OMB Circular A-87-Attachment B Paragraph 8.d.(3), terminal leave costs for all employees will be allocated as an indirect cost except for those employee salaries designated as a direct cost for the restricted rate calculation.

Capitalization Policy: Equipment items having an acquisition cost of \$500 or more, and an estimated useful life of at least one year, are capitalized and depreciated. Items under \$500 are charged as supplies.

Section III - Special Remarks

Alternative Reimbursement Methods: If any federal programs are reimbursing indirect costs by a methodology other than the approved rates in this agreement, such costs should be credited to the programs and the approved rates should be used to identify the maximum amount of indirect costs allocable.

Submission of Proposals: New indirect cost proposals are necessary to obtain approved indirect cost rates for future fiscal years. **The next indirect cost rate proposal is due six months prior to the expiration dates of the rates in this agreement.**

Section IV - Approvals

For the State Education Agency:

(b)(6)

(b)(6)

Signature

(b)(6)

Name

EXECUTIVE DIR OF FINANCE AND OPERATIONS

Title

07/16/2013

Date

For the Federal Government:

U.S. Department of Education
OCFO / FIPAO / ICG
550 12th Street, SW
Washington, DC 20202-4450

(b)(6)

Signature *J / O*

(b)(6)

Name

Director, Indirect Cost Group

Title

JUL 03 2013

Date

Negotiator: (b)(6)

Telephone Number: (b)(6)



Standards for Participation in Indiana

Licensed Child Care Center



Licensed Child Care Center Level 1

Level 1 Licensed Child Care Centers will be able to:

- ★ Meet minimum health and safety standards
- ★ Develop and implement basic health and safety policies and procedures

Licensed Child Care Centers meet the standards for a level 1 rating providing the following are met:

1. **The license issued by Family and Social Services Administration (FSSA), the Division of Family Resources (DFR) is current and in good standing.**

Licensed Child Care Center Level 2

Level 2 Licensed Child Care Centers will be able to:

- ★ Provide an environment that is welcoming, nurturing, and safe for the physical, emotional, and social well-being of all children
- ★ Provide a variety of learning materials that reflect the age, interests, and abilities of each child
- ★ Provide for children's language and literacy skill development
- ★ Provide pertinent program information to families
- ★ Promote staff development and training

Licensed Child Care Centers meet the standards for a level 2 rating providing the following are met:

1. All requirements of Level 1 are met.
2. Director receives orientation and trains staff on the *Foundations to the Indiana Academic Standards for Young Children Age Birth to Five*.
3. Director is a member of a nationally recognized early childhood organization.
4. Program has a written philosophy and goals for children.
5. 25% of teaching staff, including the Director, have either a Child Development Associate credential (CDA) or equivalent certificate, OR an early childhood degree or equivalent degree, OR have completed 45 clock hours of educational training leading to an Early Childhood/Child Development degree or CDA credential.
6. At least 50% of teaching staff participate annually in a minimum of 15 clock hours of educational or in-service training focused on topics relevant to early childhood.
7. A system is in place for communicating pertinent information to families, daily and in an annual family conference for each child.
8. An advisory board is in place to provide input and support to the director.

9a. Classroom environments are welcoming, nurturing and safe for children to have interactions and experiences that promote their physical, social and emotional well being. Indicators must include:

1. Each child and his/her family are warmly acknowledged upon arrival and departure
2. Each child feels safe, accepted, and protected and this is supported by daily practices that reinforce respect for people, feelings, ideas, and materials
3. Children are under adult supervision at all times
4. The environment includes representation of each child and family (including all age groups, abilities, and cultures), which might include books, pictures, photographs, music/songs, games, toys, dress-up clothes/materials, and foods
5. A place for storage of each child's personal belongings and possessions is labeled with the child's name
6. Teachers communicate with and listen to children (verbal and non-verbal messages) with lots of one-on-one attention throughout the day and usually at eye-level, including time when the teacher is down on the floor with the children
7. Children's ideas, requests, and questions are acknowledged with a verbal response or physical gesture
8. Children's feelings are acknowledged with an accepting, non-critical verbal response or physical gesture
9. Teachers refrain from negative verbal or physical responses to children at all times, which includes yelling, criticizing, scolding, threatening, using sarcasm, name calling, yanking, pinching, squeezing, or spanking
10. Destructive or disruptive behavior is addressed with children (face-to-face rather than from a distance) by the teacher, explaining the effect of the behavior, stating the desired behavior and redirecting, or helping the child make alternate choices
11. Conflicts are resolved by/with children through a problem-solving approaches (acknowledge feelings, listen to children share what happened, ask for ideas or solutions, and follow through)
12. The teacher sometimes joins in children's play, expanding upon their ideas and playing interactively
13. The classroom is generally characterized by varying sounds and/or comfortable conversations from engaged children and involved adults

9b. Specific Infant/Toddler indicators must include:

1. Infants are frequently held and comforted when crying
2. Infants are given one-to-one attention during feeding and diapering
3. Teachers engage in many one-to-one face-to-face interactions with infants/toddlers, including singing and playful interactions
4. Teachers acknowledge infant/toddler babblings with a verbal response, vocal imitation or physical gesture
5. Teachers engage in conversation with toddlers
6. Teachers give toddlers simple words to use to express feelings. Verbal toddlers are then encouraged to use words in conflict situations

10a. Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child. Indicators must include:

1. The daily schedule is consistent and predictable
2. The classroom is arranged with areas for individual, small group, and large group activities
3. Children are encouraged to choose the area in which they want to participate, and whether they want to play alone, with one friend, or with several
4. Routine tasks (which might include labeling, sorting, classifying, folding clothes, counting while cleaning up or setting the table) are used as learning opportunities
5. Transitions are generally relaxed, allowing time for play and completing activities. Children are transitioned from one activity to the next to avoid idle sitting and waiting time
6. Meal times are relaxed, with no scolding or nagging. Children are encouraged to sample new foods but allowed to eat the foods of their choice
7. Nap time is relaxed with alternative, supervised quiet activities available for the non-nappers
8. The teacher has a system for rotating toys and materials for variety so that unused toys are stored and later reintroduced
9. TV/VCR/DVD, if used, is primarily an educational experience. Caregiver discusses what is viewed with children, and provides an alternative activity; OR TV/VCR/DVD is not used at all

10b. Outdoor play time indicators must include:

1. Outdoor play is included daily when weather, air quality, or environmental safety conditions do not pose a health risk. Active indoor play may be a replacement when necessary
2. Outdoor/large motor activities and plentiful play materials for a variety of skills are offered (for example, climbing, running, jumping, balancing, riding and playing with balls)

10c. Specific Infant/Toddler indicators must include:

1. Individual napping schedules are respected for infants and toddlers
2. Play areas are protected and have open spaces for exploring
3. Children are offered a variety of outdoor play experiences

11a. The classroom is arranged and utilizes enough materials and activities to provide a variety of age and developmentally appropriate interest centers that invite children's exploration. Each interest center must contain at least three different items. Interest centers must include:

1. Reading:
Materials might include books, soft washable seating/pillows for use while reading
2. Writing:
Materials might include writing tools, paper, envelopes, typewriter, letters, and numbers
3. Art:
Materials might include drawing materials (crayons, markers, thick pencils, variety of paper, sizes and types, not coloring books or dittos/worksheets), painting materials, tools (scissors, hole punch, tape), staplers for school-age children, three-dimensional materials (play dough, clay with tools), collage materials (catalogs, magazines, paper scraps, fabric pieces, string, yarn, cotton balls, pipe cleaners, craft sticks)
4. Blocks:
Materials might include different size/types of blocks and accessories such as small people, animals, vehicles, road signs, and materials to enhance building, sticks, stones, tape, string, craft sticks, interlocking blocks
5. Dramatic Play:
Materials might include dress-up clothes, such as work boots, high heels, and a variety of hats, career gear/attire/uniforms, purses, billfolds and multicultural outfits. Other items would also include large pieces of fabric/scarves, child-size play furniture, dishes, pots, pans, dolls (multicultural dolls included), dollhouse or other play-sets, accessories for dolls, and "props" for different themes
6. Math/Numbers:
Materials might include small objects to count/sort/classify, measuring tools (scales, rulers), numbers/shapes, number games, puzzles and pattern blocks
7. Music and Movement:
Materials might include audio equipment, variety of tapes/CDs, and music boxes, musical toys, instruments, dance props such as scarves/streamers
8. Nature and Science:
Collections of natural items (shells, rocks, flowers, bugs), living plants, pets to care for, science games, toys, magnets, magnifying glasses, cooking opportunities
9. Sensory Play:
Materials might include water, play dough, sand, or similar materials, along with kitchen utensils, measuring containers, shovel, trough, buckets, small cars and trucks and water-play accessories for pouring, measuring, squeezing, and basting
10. Small Motor/Manipulative:
Materials might include blocks, puzzles, crayons, pencils, scissors, interlocking blocks and other small building toys, pegboard and pegs, games, counting materials, sorting or classifying materials and containers

11b. Specific Infant/Toddler indicators must include:

1. Materials are organized consistently on low, open shelves for independent use by children
2. Materials are sturdy and in good condition
3. Enough materials to avoid problems with children making the same toy choice and waiting
4. A variety of open-ended, washable toys, which might include rattles, teething/rings, balls, pop beads, nesting toys, containers, cuddle toys, push/pull toys are available
5. Furniture adapted for toddlers is available
6. Low, stable furniture is available for children to pull themselves up
7. Soft, washable elements, such as cuddle toys, soft furniture or cushions

12a. Children are read to daily and encouraged to explore books and other print materials. Indicators must include:

1. Teachers read and/or look at books with children daily, including during quiet, individual lap time
2. Books are available and accessible daily for children to look at and enjoy on their own
3. Children are invited to tell stories or “read” a picture book
4. Children are encouraged to explore print and writing. Examples might include scribbling, inventing spellings, writing their names or other words, and making books
5. Teachers write words dictated by children as they tell a story or describe their pictures
6. A variety of writing materials and toys to be used while writing is available
7. Materials might include: markers, child-sized pencils, chalk and chalk board, paper, envelopes, stamps, tape, paper punch, stickers, magazines, calendars, toy telephones, puppets, tape recorder, alphabet letters, or flannel boards
7. Preschoolers are provided language materials daily, in addition to books, which might include puppets, flannel boards, recorded stories, and picture card games
8. Books for preschoolers must include a variety of imaginative, rhyming, and informational books
9. Books for school-age children must include a variety of reading levels and topics, which might include adventures, mysteries, and informational books and magazines

12b. Specific Infant/Toddler indicators must include:

1. The availability of durable books with short stories about common daily activities
2. The availability of sturdy, simple books with pictures of real objects for toddlers to look at on their own
3. Daily language activities using books, pictures or puppets
4. Toddlers are encouraged to experiment with a variety of writing materials
5. Teachers respond to sounds/speech, including by imitating infants’ vocalization and engaging toddlers in conversation
6. Teachers talk about objects and events that infants and toddlers experience

Licensed Child Care Center Level 3

Level 3 Licensed Child Care Centers will be able to:

- ★ Implement a planned curriculum that addresses the stages of child development
- ★ Demonstrate professional growth of Director and staff in excess of licensing requirements
- ★ Facilitate family and staff input into the program
- ★ Establish a strategic plan
- ★ May be working towards accreditation

Child Care Centers meet the standards for a Level 3 rating provided that the following are met:

1. **All requirements for Level 1 and 2 are met.**
2. **Program has been in operation for a minimum of one year.**
3. **At a minimum, the Lead Teacher receives paid planning time.**
4. **50% of teaching staff have either a CDA or equivalent certificate, an early childhood degree or equivalent degree OR completed 60 clock hours of educational training leading to an early childhood/child development degree or CDA credential.**
5. **At least 50% of teaching staff, including the Director, participate annually in a minimum of 20 clock hours of educational or in-service training focused on topics relevant to early childhood.**
6. **Program evaluation is completed annually by families and staff.**
7. **A strategic plan is completed and includes annual evaluation/ goal setting and long range planning/goal setting.**

- 8. A written curriculum reflects the program philosophy and goals, is based on child development and appropriate practice and provides for the various ages, ability levels, and developmental stages of the children. This curriculum meets the following requirements:**
1. Provides for children's physical, cognitive, language, literacy, and social-emotional development. It includes goals for children that are consistent with the Indiana Foundations for Young Children
 2. Families are made aware of the curriculum of the program through one or more of the following ways: parent handbooks, newsletters, orientation, and/or family meetings
 3. Staff members are oriented to the curriculum. Lead teachers plan daily activities with assistants so that curriculum can be implemented effectively to provide support for children in their active learning experiences
 4. The curriculum and goals for children are reflected in everyday practice including through daily, weekly, or monthly written lesson plans
 5. Assessment is appropriate to the curriculum and focuses on children's strengths. It may include portfolios, conversations, anecdotal notes, and developmental notes
- 9a. Children's physical, cognitive, language, literacy, math, and creative development is supported. Indicators must include:**
1. Many opportunities throughout the day for communication (all ages), which might include sharing information, pointing out logical relationships, and encouraging children's ability to reason
 2. Many opportunities throughout the day for reading
 3. Every day children have many experiences and materials available to encourage imagination and creativity
 4. Children's thinking is stimulated through experimentation, exploration, and access to interesting materials and adult support
 5. Displays of children's art are available at children's eye level and show that most art work is exploratory and unique to each child
 6. Teachers encourage language and literacy development through interactions which might include books, songs, puppet play, and writing/drawing opportunities
 7. Math experiences are a part of everyday activities and routines
 8. Daily music experiences are available and may include singing, creative movement, a variety of types of music, and a variety of musical and rhythmic instruments
 9. Science exploration is part of daily activities (examples may include, collections of natural objects, living things to care for, cooking, and simple experiments)
 10. The daily schedule provides a balance of activities including: quiet and active, individual and small group and large group, child initiated and adult initiated
 11. Large group activities are not excessive for any part of the daily routine

9b. Specific Infant and Toddler indicators must include:

1. Infants and toddlers are not expected to function as a large group
2. Infants and toddlers are offered a variety of sensory experiences each day
3. Toddlers are offered opportunities for writing experiences each day

10. Children are actively engaged throughout the day in making choices about activities and materials. Indicators must include:

1. Children should be given several free choice periods daily. Children's choice (individual or small group play) occur at least one third of the time and includes indoor and outdoor play
2. The teacher supports children's development by gathering information through child observations that is used to guide lesson planning
3. The teacher supports children's play by providing additional materials and experiences that expand on children's interests and skills
4. The teacher extends learning for children by talking about what they are doing and asking open-ended questions that promote critical thinking skills
5. The teacher finds ways to help children learn skills when it is developmentally appropriate and when the child shows an interest
6. The teacher takes advantage of the many natural learning experiences associated with daily life and makes those "teachable moments" opportunities for learning

11. Plans and environmental accommodations for children with special needs are evident. Indicators must include:

1. A written plan is in place for effectively caring for children with special needs
2. Space is arranged to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitation or interference from one another
3. Adaptation of materials occurs to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitations or interference from one another
4. The teachers include children in age-appropriate self-help activities, such as dressing, picking up toys, washing hands, folding clothes, serving food, and setting or cleaning up meals
5. The teachers answer children's questions about differences in a respectful and factual way

Licensed Child Care Center Level 4

Level 4 Licensed Child Care Centers will be able to:

- ★ Meet the highest standards for high quality early care and education
- ★ Director agrees to assist other programs in quality improvement through volunteer mentoring

Licensed Child Care Centers meet the standards for Level 4 rating provided that the following are met:

1. **Program meets all the requirements for Levels 1, 2, and 3.**
2. **Accreditation by a Bureau of Child Care approved, nationally recognized accrediting body has been achieved and maintained.**
3. **Director volunteers to informally mentor a program at a Level 1, 2, or 3.**



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<http://www.in.gov/fssa/carefinder>
1-800-299-1627



Standards for Participation in Indiana

Licensed Child Care Home



Licensed Child Care Home Level 1

Level 1 Licensed Child Care Home Providers will be able to:

- ★ Meet minimum health and safety standards
- ★ Develop and implement basic health and safety policies and procedures

Licensed Child Care Home Providers meet the standards for a level 1 rating providing the following are met:

- 1. The license issued by Family and Social Services Administration (FSSA), the Division of Family Resources (DFR) is current and in good standing.**

Licensed Child Care Home Level 2

Level 2 Licensed Child Care Home providers will be able to:

- ★ Provide an environment that is welcoming, nurturing, and safe and promotes the physical, emotional, and social well-being of all children
- ★ Provide a variety of learning materials that reflect the age, interests, and abilities of each child
- ★ Provide for children's language and literacy skill development.
- ★ Provide pertinent program information to families
- ★ Promote assistant caregivers' development and training

Licensed Child Care Home providers meet the standards for a level 2 rating providing the following are met:

1. All requirements of Level 1 are met.
2. Lead Caregiver receives orientation and trains assistants on the *Foundations to the Indiana Academic Standards for Young Children, Birth to Age Five*.
3. Lead Caregiver is a member of a nationally recognized early childhood organization.
4. Child care home has a written philosophy and goals for children.
5. Lead Caregiver will have a current CDA or equivalent certificate, OR an early childhood degree or equivalent degree OR have completed 45 clock hours of educational training in early childhood education within the past three years leading to a CDA or an early childhood/ child development degree.
6. At least 50% of caregivers, including the lead caregiver, annually participate in a minimum of 15 clock hours of educational or in-service training focused on topics relevant to early childhood.
7. A system is in place for communicating pertinent information to families, daily and at an annual family conference for each child.

8. **A written emergency plan is established and implemented. The plan is shared with parents at the time of enrollment and any time the provider initiates a change in any aspect of the plan. The purpose of the written emergency plan is to make all emergency policies and procedures clear to parents. The plan is to be signed by the parent(s) to indicate their understanding and acceptance of the policies and procedures. The written plan will include:**
 1. The procedure for notifying parents in the event of the provider's illness, the illness of a member of the household who may be contagious to others, or any emergency that prevents children from being cared for in the provider's home
 2. Back-up plan for care that the provider will arrange in the event of an emergency
 3. Directions to parents for having a back-up plan for care in place, in the event of their child's illness or the provider's inability to care for children
 4. Alternative contacts and medical care authorization available in case parents can not be reached in the event of an emergency
 5. A list, provided by the parent(s), of people authorized to pick up a child.
 6. A plan for fire evacuation or any other type of evacuation
 7. A plan for safe shelter during a tornado warning or any other threatening weather emergency

9. **Written policies and a child care contract is established and implemented with families. The contract should be signed by the parent and must contain:**
 1. Persons authorized to pick up a child
 2. Illness policies, including reasons for exclusion
 3. Guidance and discipline policy
 4. Medication administration procedure
 5. Policy regarding parent conferences, visits and open door policy
 6. Information on transportation and field trips
 7. Hours care is provided
 8. Late pick up policy
 9. Payments and fee schedule
 10. Vacation policies for both provider and family vacations
 11. Sick leave policies for both provider and children's illness
 12. Alternate care/substitute policies
 13. Termination of care policy
 14. Child information including any special needs, fears or food preferences/allergies

10a. The home is welcoming, nurturing, and safe for children to have interactions and experiences that promote their physical, social, and emotional well-being. Indicators must include:

1. Each child and his/her family are warmly acknowledged upon arrival and departure
2. Each child feels safe, accepted, and protected. This is supported by daily practices that reinforce respect for people, feelings, ideas, and materials
3. The environment includes representation of each child and family (including all age groups, abilities, and cultures), which might include books, pictures, photographs, music/songs, games, toys, dress-up clothes/materials, and foods
4. A place for storage of each child's personal belongings and possessions is labeled with the child's name
5. Caregivers communicate with and listen to children (both verbal and non-verbal messages) with lots of one-on-one attention throughout the day and usually at eye-level, including time when the caregiver is down on the floor with the children
6. Children's ideas, requests, and questions are acknowledged with a verbal response or physical gesture
7. Children's feelings are acknowledged with an accepting, non-critical verbal response or physical gesture
8. Caregivers refrain from negative verbal or physical responses to children at all times, which includes yelling, criticizing, scolding, threatening, using sarcasm, name calling, yanking, pinching, squeezing, or spanking
9. Destructive or disruptive behavior is addressed with children (face-to-face rather than from a distance) by the caregiver, explaining the effect of the behavior, stating the desired behavior and redirecting or helping the child make alternate choices
10. Conflicts are resolved by/with children through a problem-solving approaches (acknowledge feelings, listen to children share what happened, ask for ideas or solutions, and follow through)
11. The caregiver sometimes joins in children's play, expanding upon their ideas and playing interactively
12. The home is generally characterized by varying sounds and/or comfortable conversation from engaged children and involved adults

10b. Specific Infant/Toddler indicators must include:

1. Infants are frequently held and comforted when crying
2. Infants are given one-to-one attention during feeding and diapering
3. Caregivers engage in many one-to-one face-to-face interactions with infants/toddlers, including singing and playful interactions
4. Caregivers acknowledge infant/toddler babblings with a verbal response, vocal imitation or physical gesture
5. Caregivers engage in conversation with toddlers
6. Caregivers give toddlers simple words to use to express feelings. Verbal toddlers are then encouraged to use words in conflict situations

11a. Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child. Indicators must include:

1. The daily schedule is consistent and predictable
2. Children direct their own free play (individual or group play) for at least one half hour at a time, totaling at least two hours in an eight hour day
3. Routine tasks (which might include, labeling, sorting, classifying, folding clothes, counting while cleaning up or setting the table) are used as learning opportunities
4. Transitions are generally relaxed, allowing time for play and completing activities. Children are transitioned from one activity to the next to avoid idle sitting and waiting time
5. Meal times are relaxed, with no scolding or nagging. Children are encouraged to sample new foods but allowed to eat the foods of their choice.
6. Nap time is relaxed with alternative, supervised activities\ available for the non-nappers
7. The caregiver has a system for rotating toys and materials for variety so that unused toys are stored and later reintroduced
8. TV/VCR/DVD, if used, is primarily an educational experience. Caregiver discusses what is viewed with children and provides an alternative activity; OR TV/VCR/DVD is not used at all

11b. Outdoor play time indicators must include:

1. Outdoor play is included daily when weather, air quality, or environmental safety conditions do not pose a health risk. Active indoor play may be a replacement when necessary
2. Outdoor/large motor activities and plentiful play materials for a variety of skills are offered (for example, climbing, running, jumping, balancing, riding, and playing with balls)

11c. Specific Infant/Toddler indicators must include:

1. Individual napping schedules are respected for infants and toddlers
2. Play areas are protected and have open spaces for exploring
3. Children are offered a variety of outdoor play experiences

12a. The home is arranged and utilizes enough materials and activities to provide a variety of age and developmentally appropriate interest centers that invite children's explorations. Caregiver offers at least three of the following centers daily, from which the children may choose. Caregiver regularly rotates the interest centers that are offered. Each interest center must contain at least three different items. Interest centers must include:

1. **Reading:**
Materials might include books, soft, washable seating/pillows for use while reading
2. **Writing:**
Materials might include writing tools, paper, envelopes, typewriter or keyboard, letters, numbers
3. **Art:**
Materials might include drawing materials (crayons, markers, thick pencils, variety of paper, sizes and types, not coloring books or dittos/worksheets), painting materials, tools (scissors, hole punch, tape), staplers for school-age children, three-dimensional materials (play dough, clay with tools), collage materials (catalogs, magazines, paper scraps, fabric pieces, string, yarn, cotton balls, pipe cleaners, craft sticks)
4. **Blocks:**
Materials might include different size/types of blocks and accessories such as small people, animals, vehicles, and road signs to enhance building, sticks, stones, tape, string, craft sticks, interlocking blocks
5. **Dramatic Play:**
Materials might include dress-up clothes (such as work boots, high heels, a variety of hats, career gear/attire/uniforms, purses, billfolds, and multicultural outfits.) Other items would also include large pieces of fabric/scarves, child-size play furniture, dishes, pots, pans, dolls (multicultural included), dollhouse or other play-sets, accessories for dolls, and "props" for different themes
6. **Math/Numbers:**
Materials might include small objects to count/sort/classify, measuring tools (scales, rulers), numbers/shapes, number games, puzzles and pattern blocks
7. **Music and Movement:**
Materials might include audio equipment, variety of tapes/CDs, music boxes, musical toys and instruments, dance props such as scarves/streamers
8. **Nature and Science:**
Materials might include collections of natural items (shells, rocks, flowers, bugs), living plants, pets to care for, science games, toys, magnets, magnifying glasses, cooking opportunities
9. **Sensory Play:**
Materials might include water, play dough, sand, or similar materials, along with kitchen utensils, measuring containers, shovel, trough, buckets, small cars and trucks, and water-play accessories for pouring, measuring, squeezing, and basting
10. **Small Motor/Manipulative:**
Materials might include blocks, puzzles, crayons, pencils, scissors, interlocking blocks and other small building toys, pegboard and pegs, games, counting materials, sorting or classifying materials and containers

12b. Specific Infant and Toddler indicators include:

1. Materials are organized consistently on low, open shelves for independent use by children
2. Materials are sturdy and in good condition
3. Enough materials to avoid problems with children making the same toy choice and waiting
4. A variety of open-ended, washable toys, which might include rattles, teething/rings, balls, pop beads, nesting toys, containers, cuddle toys, push/pull toys are available
5. Furniture adapted for toddlers is available
6. Low, stable furniture is available for children to pull themselves up
7. Soft, washable elements, such as cuddle toys, soft furniture or cushions

13a. Children are read to daily and encouraged to explore books and other print materials. Indicators must include:

1. Caregiver reads and/or looks at books with children daily, including during quiet, individual lap time
2. Books are available and accessible daily for children to look at and enjoy on their own
3. Children are invited to tell stories or “read” a picture book
4. Children are encouraged to explore print and writing. Examples might include scribbling, inventing spellings, writing their name or other words, or making books
5. Caregiver writes words dictated by children as they tell a story or describe their pictures
6. A variety of writing materials and toys to be used while writing is available. Materials might include: markers, child-sized pencils, chalk and chalk board, paper, envelopes, stamps, tape, paper punch, stickers, magazines, calendars, toy telephones, puppets, tape recorder, alphabet letters, or flannel boards
7. Preschoolers are provided language materials daily, in addition to books, which might include puppets, flannel boards, recorded stories and picture card games
8. Books for preschoolers must include a variety of imaginative, rhyming, and informational books
9. Books for school-age children must include a variety of reading levels and topics, which might include adventures, mysteries, and informational books and magazines

13b. Specific Infant/Toddler indicators must include:

1. The availability of durable books with short stories about common daily activities
2. The availability of sturdy, simple books with pictures of real objects for toddlers to look at on their own
3. Daily language activities using books, pictures or puppets
4. Toddlers are encouraged to experiment with a variety of writing materials
5. Caregiver responds to sounds/speech, including by imitating infants’ vocalization and engaging toddlers in conversation
6. Caregiver talks about objects and events that infants and toddlers experience

Licensed Child Care Home Level 3

Level 3 Licensed Child Care Home Providers will be able to:

- ★ Implement a planned curriculum that addresses the stages of child development
- ★ Demonstrate professional growth in excess of licensing requirements
- ★ Facilitate family and assistant input into the program.
- ★ Actively engage in program evaluation and have an action plan for improvement
- ★ May be working towards accreditation

Child Care Home providers meet the standards for a Level 3 rating provided that the following are met:

1. **All requirements for Level 1 and 2 are met.**
2. **Lead Caregiver has at least 12 months experience as a caregiver in a licensed child care setting or in a child care setting that is accredited by one of the Bureau of Child Care approved, nationally recognized organizations.**
3. **Lead Caregiver will have a current CDA or equivalent certificate, OR and early childhood degree or equivalent degree; OR have completed 60 clock hours of educational training leading to an early childhood/child development degree or CDA credential within the past three years.**
4. **At least 50% of caregivers, including the lead caregiver, annually participate in a minimum of 20 clock hours of educational or in-service training focused on topics relevant to early childhood.**
5. **Program evaluation is completed annually by families.**

6. A written curriculum reflects the program philosophy and goals, is based on child development and appropriate practice and provides for the various ages, ability levels, and developmental stages of the children. This curriculum meets the following requirements:

1. Provides for children's physical, cognitive, language, literacy, and social-emotional development. It includes goals for children that are consistent with the Indiana Foundations for Young Children
2. Families are made aware of the curriculum of the program through one or more of the following ways: parent handbooks, newsletters, orientation, and/or family meetings
3. Assistants are oriented to the curriculum. The lead caregiver plans daily activities with assistants so that the curriculum can be implemented effectively to provide support for children in their active learning experiences
4. The curriculum and goals for children are reflected in everyday practice, including through daily, weekly, or monthly written lesson plans

7a. Children's physical, cognitive, language, literacy, math, and creative development is supported. Indicators must include:

1. Many opportunities throughout the day for communication (all ages), which might include sharing information, pointing out logical relationships, and encouraging children's ability to reason
2. Many opportunities throughout the day for reading
3. Every day children have many experiences and materials available to encourage imagination and creativity
4. Children's thinking is stimulated through various means which might include experimentation, exploration, and access to interesting materials and adult support
5. Displays of children's art are available at children's eye level and show that most art work is exploratory and unique to each child
6. Caregiver encourages language and literacy daily through interactions which might include books, songs, puppet play, and writing/drawing opportunities
7. Math experiences are a part of everyday activities and routines
8. Daily music experiences are available and may include singing, creative movement, a variety of types of music, and a variety of musical and rhythmic instruments
9. Science exploration is part of daily activities (examples may include collections of natural objects, living things to care for, cooking, and simple experiments)
10. The daily schedule provides a balance of activities including: quiet and active, individual and small group and large group, child initiated and adult initiated

7b. Specific Infant and Toddler Indicators must include:

1. Infants and toddlers are not expected to function as a large group
2. Infants and toddlers are offered a variety of sensory experiences each day
3. Toddlers are offered opportunities for writing experiences each day

8. Children are actively engaged throughout the day in making choices about activities and materials. Indicators must include:

1. Children should be given several free choice periods daily. Children's choice (individual or small group play) occurs at least one third of the day and includes indoor and outdoor play
2. The caregiver supports children's development by gathering information through child observations that is used to guide lesson planning
3. The caregiver supports children's play by providing additional materials and experiences that expand on children's interests and skills
4. The caregiver extends learning for children by talking about what they are doing and asking open-ended questions that promote critical thinking skills
5. The caregiver finds ways to help children learn skills when it is developmentally appropriate and when the child shows an interest
6. The caregiver takes advantage of the many natural learning experiences associated with daily life and makes "teachable moments" opportunities for learning

9. Plans and environmental accommodations for children with special needs are evident. Indicators must include:

1. A written plan is in place for effectively caring for children with special needs
2. Space is arranged to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitation or interference from one another
3. Adaptation of materials occurs to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitations or interference from one another
4. The caregiver includes children in age-appropriate self-help activities, such as dressing, picking up toys, washing hands, folding clothes, serving food, and setting or cleaning up meals
5. The caregiver answers children's questions about differences in a respectful and factual way

Licensed Child Care Home Level 4

Level 4 Licensed Child Care Home Providers will be able to:

- ★ Meet the highest standards for high quality early care and education
- ★ Assist other programs in quality improvement through volunteer mentoring

Licensed Child Care Home providers meet the standards for Level 4 rating provided that the following are met:

1. **Program meets all the requirements for Levels 1, 2, and 3.**
2. **Lead Caregiver has a current CDA or equivalent or ECE degree or an equivalent degree.**
3. **Accreditation by a Bureau of Child Care approved, nationally recognized accrediting body has been achieved and maintained.**
4. **Lead caregiver volunteers to informally mentor a program at a Level 1, 2, or 3.**



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Standards for Participation in Indiana

Unlicensed Registered Child Care Ministry



Unlicensed Registered Child Care Ministry Level 1

Level 1 Unlicensed Registered Child Care Ministries will be able to:

- ★ Meet minimum health and safety standards
- ★ Develop and implement basic health and safety policies and procedures

Unlicensed Registered Child Care Ministries meet the standards for a level 1 rating providing the following are met:

1. **The registration issued by the Family and Social Services Administration (FSSA), the Division of Family Resources (DFR) is current and in good standing.**
2. **The ministry meets all CCDF provider eligibility standards.**
3. **The ministry meets Voluntary Certification Program guidelines in all four categories. If a facility does not serve infants and toddlers, the remaining three categories must be met.**
4. **The director has completed a Child Development Associate credential (CDA) or early childhood degree or equivalent degree OR the director of the ministry agrees to obtain a minimum of a CDA within three years of beginning Paths to Quality and shows progression towards completion each year.**
5. **The director of the ministry completes a Bureau of Child Care approved training on the practice of safe sleep and reducing the risk of SIDS in child care.**
6. **Staff members receive orientation within 30 days of being hired.**

Unlicensed Registered Child Care Ministry Level 2

Level 2 Unlicensed Registered Ministries will be able to:

- ★ Provide an environment that is welcoming, nurturing, and safe for the physical, emotional, and social well-being of all children
- ★ Provide a variety of learning materials that reflect the age, interests, and abilities of each child
- ★ Provide for children's language and literacy skill development
- ★ Provide pertinent program information to families
- ★ Promote staff development and training

Unlicensed Registered Ministries meet the standards for a Level 2 rating providing the following are met:

1. All requirements of Level 1 are met.
2. Director receives orientation and trains staff on the *Foundations to the Indiana Academic Standards for Young Children Age Birth to Five*.
3. Director is a member of a nationally recognized early childhood organization.
4. Program has a written philosophy and goals for children.
5. Director has a current CDA or equivalent certificate, OR an early childhood degree or equivalent degree.
6. 25% of teaching staff have either a CDA or equivalent certificate, OR an early childhood degree or equivalent degree, OR have completed 45 clock hours of educational training leading to an EC/CD degree or CDA credential.
7. At least 50% of teaching staff, including the Director, annually participate in a minimum of 15 clock hours of educational or in-service training focused on topics relevant to early childhood.

- 8. A system is in place for communicating pertinent information to families, daily and in an annual family conference for each child.**
- 9. An advisory board is in place to provide input and support to the director.**
- 10. Written policies and a child care contract is established and implemented with families. The contract should be signed by the parent and should contain:**
 1. Persons authorized to pick up a child
 2. Illness policies including reasons for exclusion
 3. Guidance and discipline policy
 4. Medication administration policy
 5. Written emergency plan
 6. Policy on parent conferences, visits and open door policy
 7. Information on transportation and field trips
 8. Hours of care provided
 9. Late pick up policy
 10. Payment and fee schedule
 11. Vacation policies regarding both facility and family vacations
 12. Sick leave policies for children's illnesses
 13. Alternative care/substitute policies
 14. Termination of care policy
 15. Children's information including any special needs, fears, or food preferences/allergies

11a. Classroom environments are welcoming, nurturing, and safe for children to have interactions and experiences that promote their physical, social and emotional well being. Indicators must include:

1. Children are under adult supervision at all times
2. Each child and his/her family are warmly acknowledged upon arrival and departure
3. Each child feels safe, accepted, and protected and this is supported by daily practices that reinforce respect for people, feelings, ideas, and materials
4. The environment includes representation of each child and family (including all age groups, abilities, and cultures), which might include books, pictures, photographs, music/songs, games, toys, dress-up clothes/materials, and foods
5. A place for storage of each child's personal belongings and possessions is labeled with the child's name
6. Teachers communicate with and listen to children (verbal and non-verbal messages) with lots of one-on-one attention throughout the day and usually at eye-level, including time when the teacher is down on the floor with the children
7. Children's ideas, requests, and questions are acknowledged with a verbal response or physical gesture
8. Children's feelings are acknowledged with an accepting, non-critical verbal response or physical gesture
9. Teachers refrain from negative verbal or physical responses to children at all times, which includes yelling, criticizing, scolding, threatening, using sarcasm, name calling, yanking, pinching, squeezing, or spanking
10. Destructive or disruptive behavior is addressed with children (face-to-face rather than from a distance) by the teacher, explaining the effect of the behavior, stating the desired behavior and redirecting, or helping the child make alternate choices
11. Conflicts are resolved by/with children through a problem-solving approaches (acknowledge feelings, listen to children share what happened, ask for ideas or solutions, and follow through)
12. The teacher sometimes joins in children's play, expanding upon their ideas and playing interactively
13. The classroom is generally characterized by varying sounds and/or comfortable conversations from engaged children and involved adults

11b. Specific Infant/Toddler indicators must include:

1. Infants are frequently held and comforted when crying
2. Infants are given one-to-one attention during feeding and diapering
3. Teachers engage in many one-to-one face-to-face interactions with infants/toddlers, including singing and playful interactions
4. Teachers acknowledge infant/toddler babblings with a verbal response, vocal imitation or physical gesture
5. Teachers engage in conversation with toddlers
6. Teachers give toddlers simple words to use to express feelings. Verbal toddlers are then encouraged to use words in conflict situations

12a. Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child. Indicators must include:

1. The daily schedule is consistent and predictable
2. The classroom is arranged with areas for individual, small group, and large group activities
3. Children are encouraged to choose the area in which they want to participate, and whether they want to play alone, with one friend, or with several
4. Routine tasks (which might include labeling, sorting, classifying, folding clothes, counting while cleaning up or setting the table) are used as learning opportunities
5. Transitions are generally relaxed, allowing time for play and completing activities. Children are transitioned from one activity to the next to avoid idle sitting and waiting time
6. Meal times are relaxed, with no scolding or nagging. Children are encouraged to sample new foods but allowed to eat the foods of their choice.
7. Nap time is relaxed with alternative, supervised quiet activities available for the non-nappers
8. The teacher has a system for rotating toys and materials for variety so that unused toys are stored and later reintroduced
9. TV/VCR/DVD, if used, is primarily an educational experience. Caregiver discusses what is viewed with children, and provides an alternative activity; OR TV/VCR/DVD is not used at all

12b. Outdoor play time indicators must include:

1. Outdoor play is included daily when weather, air quality, or environmental safety conditions do not pose a health risk. Active indoor play may be a replacement when necessary
2. Outdoor/large motor activities and plentiful play materials for a variety of skills are offered (for example, climbing, running, jumping, balancing, riding, and playing with balls)

12c. Specific Infant/Toddler indicators must include:

1. Individual napping schedules are respected for infants and toddlers
2. Play areas are protected and have open spaces for exploring
3. Children are offered a variety of outdoor play experiences

13a. The classroom is arranged and utilizes enough materials and activities to provide a variety of age and developmentally appropriate interest centers that invite children's exploration. Each interest center must contain at least three different items. Interest centers must include:

1. Reading:
Materials might include books, soft washable seating/pillows for use while reading
2. Writing:
Materials might include writing tools, paper, envelopes, typewriter, letters, and numbers
3. Art:
Materials might include drawing materials (crayons, markers, thick pencils, variety of paper, sizes and types, not coloring books or dittos/worksheets), painting materials, tools (scissors, hole punch, tape), staplers for school-age children, three-dimensional materials (play dough, clay with tools), collage materials (catalogs, magazines, paper scraps, fabric pieces, string, yarn, cotton balls, pipe cleaners, craft sticks)
4. Blocks:
Materials might include different size/types of blocks and accessories such as small people, animals, vehicles, road signs, and materials to enhance building, sticks, stones, tape, string, craft sticks, interlocking blocks
5. Dramatic Play:
Materials might include dress-up clothes, such as work boots, high heels, and a variety of hats, career gear/attire/uniforms, purses, billfolds and multi-cultural outfits. Other items would also include large pieces of fabric/scarves, child-size play furniture, dishes, pots, pans, dolls (multicultural dolls included), dollhouse or other play-sets, accessories for dolls, and "props" for different themes
6. Math/Numbers:
Materials might include small objects to count/sort/classify, measuring tools (scales, rulers), numbers/shapes, number games, puzzles and pattern blocks
7. Music and Movement:
Materials might include audio equipment, variety of tapes/CDs, and music boxes, musical toys, instruments, dance props such as scarves/streamers.
8. Nature and Science:
Collections of natural items (shells, rocks, flowers, bugs), living plants, pets to care for, science games, toys, magnets, magnifying glasses, cooking opportunities
9. Sensory Play:
Materials might include water, play dough, sand, or similar materials, along with kitchen utensils, measuring containers, shovel, trough, buckets, small cars and trucks and water-play accessories for pouring, measuring, squeezing, and basting
10. Small Motor/Manipulative:
Materials might include blocks, puzzles, crayons, pencils, scissors, interlocking blocks and other small building toys, pegboard and pegs, games, counting materials, sorting or classifying materials and containers

13b. Specific Infant/Toddler indicators must include:

1. Materials are organized consistently on low, open shelves for independent use by children
2. Materials are sturdy and in good condition
3. Enough materials to avoid problems with children making the same toy choice and waiting
4. A variety of open-ended, washable toys, which might include rattles, teething/rings, balls, pop beads, nesting toys, containers, cuddle toys, push/pull toys are available
5. Furniture adapted for toddlers is available
6. Low, stable furniture is available for children to pull themselves up
7. Soft, washable elements, such as cuddle toys, soft furniture or cushions

14a. Children are read to daily and encouraged to explore books and other print materials. Indicators must include:

1. Teachers read and/or look at books with children daily, including during quiet, individual lap time
2. Books are available and accessible daily for children to look at and enjoy on their own
3. Children are invited to tell stories or “read” a picture book
4. Children are encouraged to explore print and writing. Examples might include scribbling, inventing spellings, writing their names or other words, and making books
5. Teachers write words dictated by children as they tell a story or describe their pictures
6. A variety of writing materials and toys to be used while writing is available. Materials might include: markers, child-sized pencils, chalk and chalk board, paper, envelopes, stamps, tape, paper punch, stickers, magazines, calendars, toy telephones, puppets, tape recorder, alphabet letters, or flannel boards
7. Preschoolers are provided language materials daily, in addition to books, which might include puppets, flannel boards, recorded stories, and picture card games
8. Books for preschoolers must include a variety of imaginative, rhyming, and informational books
9. Books for school-age children must include a variety of reading levels and topics, which might include adventures, mysteries, and informational books and magazines

14b. Specific Infant/Toddler indicators must include:

1. The availability of durable books with short stories about common daily activities
2. The availability of sturdy, simple books with pictures of real objects for toddlers to look at on their own
3. Daily language activities using books, pictures or puppets
4. Toddlers are encouraged to experiment with a variety of writing materials
5. Teachers respond to sounds/speech, including by imitating infants’ vocalization and engaging toddlers in conversation
6. Teachers talk about objects and events that infants and toddlers experience

Unlicensed Registered Child Care Ministry Level 3

Level 3 Unlicensed Registered Ministry Providers will be able to:

- ★ Implement a planned curriculum that addresses the stages of child development
- ★ Demonstrate professional growth of Director and staff
- ★ Facilitate family and staff input into the program
- ★ Establish a strategic plan
- ★ May be working towards accreditation

Unlicensed Registered Ministries meet the standards for a Level 3 rating provided that the following are met:

1. **All requirements for Level 1 and 2 are met.**
2. **Program has been in operation for a minimum of one year.**
3. **At a minimum, the Lead Teacher receives paid planning time.**
4. **50% of teaching staff have either a CDA or equivalent certificate, OR an early childhood degree or equivalent degree, OR have completed 60 clock hours of educational training leading to an early childhood/child development degree or CDA credential.**
5. **At least 50% of teaching staff, including the Director, annually participate in a minimum of 20 clock hours of educational or in-service training focusing on topics relevant to early childhood.**
6. **Program evaluation is completed annually by families and staff.**
7. **A strategic plan is completed and includes annual evaluation/ goal setting and long range planning/goal setting.**

8. A written curriculum reflects the program philosophy and goals, is based on child development and appropriate practice and provides for the various ages, ability levels, and developmental stages of the children. This curriculum meets the following requirements:

1. Provides for children's physical, cognitive, language, literacy, and social-emotional development. It includes goals for children that are consistent with Indiana Foundations for Young Children
2. Families are made aware of the curriculum of the program through one or more of the following ways: parent handbooks, newsletters, orientation, and/or family meetings
3. Staff members are oriented to the curriculum. Lead teachers plan daily activities with assistants so that curriculum can be implemented effectively to provide support for children in their active learning experiences
4. The curriculum and goals for children are reflected in everyday practice including through daily, weekly, or monthly written lesson plans
5. Assessment is appropriate to the curriculum and focuses on children's strengths. It may include portfolios, conversations, anecdotal notes, and developmental notes

9a. Children's physical, cognitive, language, literacy, math, and creative development is supported. Indicators must include:

1. Many opportunities throughout the day for communication (all ages), which might include sharing information, pointing out logical relationships, and encouraging children's ability to reason
2. Many opportunities throughout the day for reading
3. Every day children have many experiences and materials available to encourage imagination and creativity
4. Children's thinking is stimulated through experimentation, exploration, and access to interesting materials and adult support
5. Displays of children's art are available at children's eye level and show that most art work is exploratory and unique to each child
6. Teachers encourage language and literacy development through interactions which might include books, songs, puppet play, and writing/drawing opportunities
7. Math experiences are a part of everyday activities and routines
8. Daily music experiences are available and may include singing, creative movement, a variety of types of music, and a variety of musical and rhythmic instruments
9. Science exploration is part of daily activities (examples may include, collections of natural objects, living things to care for, cooking, and simple experiments)
10. The daily schedule provides a balance of activities including: quiet and active, individual and small group and large group, child initiated and adult initiated
11. Large group activities are not excessive for any part of the daily routine

9b. Specific Infant and Toddler Indicators must include:

1. Infants and toddlers are not expected to function as a large group
2. Infants and toddlers are offered a variety of sensory experiences each day
3. Toddlers are offered opportunities for writing experiences each day

10. Children are actively engaged throughout the day in making choices about activities and materials. Indicators must include:

1. Children should be given several free choice periods daily. Children's choice (individual or small group play) occur at least one third of the time and includes indoor and outdoor play
2. The teacher supports children's development by gathering information through child observations that is used to guide lesson planning
3. The teacher supports children's play by providing additional materials and experiences that expand on children's interests and skills
4. The teacher extends learning for children by talking about what they are doing and asking open-ended questions that promote critical thinking skills
5. The teacher finds ways to help children learn skills when it is developmentally appropriate and when the child shows an interest
6. The teacher takes advantage of the many natural learning experiences associated with daily life and makes those "teachable moments" opportunities for learning

11. Plans and environmental accommodations for children with special needs are evident. Indicators must include:

1. A written plan is in place for effectively caring for children with special needs
2. Space is arranged to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitation or interference from one another
3. Adaptation of materials occurs to provide children of different ages and abilities daily access to materials and opportunities to engage in play and projects without limitations or interference from one another
4. The teachers include children in age-appropriate self-help activities, such as dressing, picking up toys, washing hands, folding clothes, serving food, and setting or cleaning up meals
5. The teachers answer children's questions about differences in a respectful and factual way

Unlicensed Registered Child Care Ministry Level 4

Level 4 Unlicensed Registered Ministry Providers will be able to:

- ★ Meet the highest standards for high quality early care and education
- ★ Director agrees to assist other programs in quality improvement through volunteer mentoring

Unlicensed Registered Ministry providers meet the standards for a Level 4 rating provided that the following are met:

1. **Program meets all the requirements for Levels 1, 2, and 3.**
2. **Accreditation by a nationally recognized accrediting body, approved by the State, has been achieved and maintained.**
3. **Director volunteers to informally mentor a program at a Level 1, 2, or 3.**

**Voluntary
Certification Program (VCP)
Standards**

For

**Unlicensed Registered
Child Care Ministry**

Attachment B: High-Quality Accountable Programs

CHECKLIST FOR FOOD / NUTRITION CERTIFICATION (All cites begin with 470 IAC unless otherwise noted)				
#	YES	N/A	NO	GUIDELINES (In order for a Ministry to qualify for Food/Nutrition Certification the facility must cook or vend meals.)
1				A copy of ISDH 410 IAC 7-24 rule book is in the kitchen and is followed. [410 IAC 7-24-107(d)]
2				Meets 410 IAC 7-24 requirements and standards. (410 IAC 7-24)
3				Posted instructions for proper manual dishwashing in the kitchen if dishes are washed and sanitized manually. [3-4.7-117(d)]
4				A cleaning schedule is posted in the kitchen and used. [(3-4.7-116(r))]
5				Illumination of 70 foot-candles in kitchen and food prep areas. (410 IAC 7-24)
6				Acceptable written and posted weekly menus in kitchen. [(3-4.7-76a(2))]
7				Milk is offered at all meals. Whole milk provided to all children under the age of two unless a physician orders a specific substitution. [3-4.778(d)]
8				Liquid refreshments shall meet the following guidelines: 1. All fruit juice shall be one hundred percent pure fruit juice with no sugar added. 2. All non-citrus juice shall be fortified with vitamin C. 3. The facility shall not serve or have accessible to children ades, soft drinks or powders. 4. A competing beverage is not being served with milk at lunch or dinner. [3-4.7-78 (e) (1), (2), (3), (4)]
9				For children one year old or older, meals and snacks are served every 2-3 hours. [3-4.7- 77(a)]
10				At least 1½ ounces of high protein food (such as meat, poultry, cheese, eggs or dried beans) are served at lunch and dinner. [3-4.7-78(f)(1)]
11				A good source of Vitamin A is served at least two (2) times a week. [3-4.7-78(a)]
12				Nutritious snacks (such as whole grain breads, muffins, cheese or peanut butter crackers or banana bread) are served daily. Include two (2) different food groups (i.e. fruit and dairy, bread and protein, etc). [3-4.7-77(a)]
13				Two (2) vegetables/salads, fruits are served with lunch/dinner meals. [3-4.7-77(a)]
14				Food is not used as a reward or punishment. [3-4.7-78(a)]
15				Seconds of at least two (2) items at each meal are provided and available. [3-4.7-79(b)]
16				If casseroles are served as the protein component, standardized recipes (including the pounds and ounces of protein, the number of servings, and the portion size) must be available and utilized. [(3-4.7-78(a))]
17				Staff assists, supervise, converse and sit with the children during all meals and snacks in age relative groups, small enough in number to assure assistance and safety. [3-4.7-79(i)]
18				Children are allowed to converse freely during meal times and snacks. [3-4.7-79(j)]
19				Food allergies and special diets are posted in the kitchen and/or in the area where the child's food is prepared. [3-4.7-82(a)]
20				BCC approved food service training for person responsible for food service operation. (410 IAC 7-24)
		Total YES		Certificate earned? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Total NO		

Date of survey (month, day, year)	Signature of Surveyor
Name of ministry	Acknowledged by (signature and title)
Identification number	County

Attachment B: High-Quality Accountable Programs

CHECKLIST FOR INFANT / TODDLER CERTIFICATION (All cites begin with 470 IAC unless otherwise noted)				
#	YES	N/A	NO	GUIDELINES
1				Infants and toddlers are kept under direct supervision at all times including while napping. [3-4.7-48(e)]
2				Infants and toddlers are kept in separate rooms unless room is approved for alternative mixed age groups, with age appropriate equipment, limited to infant-36 months (no throughways). [3-4.7-143(c) and 3-4.7-52]
3				Infants have at least one sink for hand-washing in the room. [3-4.7-143(e)]
4				Toddler rooms have toilet rooms opening directly in/attached to each room and include a lavatory in the room. [3-4.7-113(g)]
5				Each room has changing table or changed in own crib. [3-4.7-94(e1) and (e2)]
6				All surfaces except carpet in Infant / Toddler rooms are sanitizable. [3-4.7-131(d)]
7				Infants are out of cribs while awake. [3-4.7-126(4)]
8				Diaper bags are inaccessible to children. [3-4.7-94(a)]
9				Diapering and food area separate in each room. [3-4.7-94(k)]
10				At least one (1) rocking chair is available to each caregiver in infant rooms and at least one (1) rocking chair is available in toddler rooms. [3-4.7-129(22)]
11				Sheets changed daily / extra supply of bedding available. [3-4.7-129(o) and (r)]
12				Cribs / cots are spaced three (3) feet apart. [3-4.7-141(l) and (t)]
13				Cribs / mattress sizes correct / good shape of repair. [3-4.7-141(f)(g)(h)]
14				Daily needs records are kept and posted. [3-4.7-122(a)]
15				Parents provide a feeding plan for Infants and kept current. [3-4.7-134(b)]
16				Staff practices safe sleep procedures as approved by Bureau of Child Care.
17				A written safe sleep policy is signed by parents.
18				Infants' bottles are not "propped". [3-4.7-134(j)]
19				Infants are held when fed. [3-4.7-134(j)]
20				Toddler sized chairs and tables are used for eating. [3-4.7-140(e)]
21				Harnesses are used on highchairs. [3-4.7-140(f)]
22				Toddler foods are appropriate for age. (No choking hazards.) [3-4.7-139(e)]
23				Age appropriate dishes and utensils for infants and toddlers are used. [3-4.7-140(k)]
24				Infants and toddlers are fed in their own rooms. [3-4.7-132(h) and 140d]
25				Child staff ratios are 4:1 for infants and 5:1 for toddlers. [3-4.7-47]
26				No person under the age 21 shall at any time be alone with children under two years of age. [3-4.7-121(e)]
27				All infant/toddler staff have approved age appropriate first aid and CPR. [3-4.7-34(2) and 33(1)]
28				Use of a television is prohibited. [3-4.7-132d and 133c]
29				No microwaves are used to heat infant bottles. [3-4.7-134(h)]
		Total YES		Certificate earned? <input type="checkbox"/> YES <input type="checkbox"/> NO
		Total NO		

Date of survey (month, day, year)	Signature of Surveyor
Name of ministry	Acknowledged by (signature and title)
Identification number	County

CHECKLIST FOR SAFETY CERTIFICATION, UNLICENSED REGISTERED CHILDCARE MINISTRIES				
<i>(All cites begin with 470 IAC unless otherwise noted)</i>				
#	YES	N/A	NO	GUIDELINES
1				Child / staff ratios are maintained at all times as follows: [3-4.7-47] (a) 4:1 infants (e) 10:1 three years old (b) 5:1 toddlers (f) 12:1 four years old (c) 5:1 two-year-olds in diapers (g) 15:1 five years old and older (d) 7:1 toilet trained two's with three-year-olds
2				Children are under direct supervision at all times; during nap time child/staff ratios may be reduced to 50% of staff as long as child/staff ratio is maintained on the premises (does not apply to infants). [3-4.7-1(24)]
3				All child care providers are at least 18 years old and have a high school diploma or equivalent. [3-4.7-1(24)-(1)]
4				At least one staff member is trained in age appropriate CPR, is on the premises and available at all times. (IC 12-17.2-4-2)
5				All staff are currently trained in First Aid within six (6) months of employment. [3-4.7-33(2)]
6				The director and all staff receive at least twelve (12) clock hours of educational or in-service training in topics relevant to early childhood, annually. (3-4.7-35)
7				At least 35 square feet of usable indoor space is provided for each child. [3-4.7-110(a)]
8				Land-line telephone is available and working. [3-4.7-119(c)]
9				A written emergency plan is established and implemented. The plan is shared with parents at the time of enrollment and/or any time the provider initiates a change in any aspect of the plan. The purpose of the written emergency plan is to make all emergency policies and procedures clear to parents. The plan is to be signed by the parent(s) to indicate their understanding and acceptance of the policies and procedures. The written plan will include: (a) The procedure for notifying parents in the event of the illness of a staff member(s) that may be contagious to others, or any emergency that prevents children from being cared for in the facility; (b) Any back-up plan for care that the facility will arrange in the event of an emergency; (c) The need for the parent to have a back-up plan for care in place in the event of their child's illness or the facility's inability to care for children; (d) Exclusion policies pertaining to a child's health; (e) Alternative contacts and medical care authorization available in case parents cannot be reached in the event of an emergency; (f) A list, provided by the parent(s), of people authorized to pick up a child; (g) A plan for fire evacuation or any other type of evacuation; (h) A plan for safe shelter during a tornado warning or any other threatening weather emergency
10				Telephone numbers for fire, ambulance, hospital and poison control are available at each telephone. [3-4.7-119(c)(1-8)]
11				Emergency first aid procedures and disaster procedures are readily available and visible to all child care staff. [3-4.7-119(b)(9)]
12				Emergency phone numbers for all children are available. [3-4.7-42]
13				First aid supplies and manual are available. [3-4.7-91(c)(d)]
14				Medication not requiring refrigeration is stored in a locked cabinet or drawer outside of the kitchen. [3-4.7-88(i)]
15				Unused and / or outdated medications are discarded. [3-4.7-88(h)(k)(1)]
16				The janitor's closet containing chemicals, poisons, and items which state "HARMFUL" or "FATAL IF SWALLOWED" is kept LOCKED. [3-4.7-100(a)]
17				Hazardous items (such as bleach solution, other cleaning supplies, and teachers' purses) are inaccessible to children. [3-4.7-100(e)]
18				Floors are smooth, carpet firmly secured. [3-4.7-99]
19				Protective plugs are provided on all electrical outlets. Extension cords are not used. [3-4.7-101(a)(b)]
20				An approved hot water control valve is provided for all hand-washing lavatories. [3-4.7-114(d)]
21				A hand-washing lavatory is located within the same room or area as is the changing table or at least a minimum of 10 feet from the diapering table. [3-4.7-94(h)]
22				Hallways and corridors have 20 foot-candles of lights. [3-4.7-106(b)(5)]
23				Playground(s) is safely enclosed or protected. [3-4.7-68(b)]
24				Indiana state wide criminal history checks on all child care providers, with no felony convictions and/or misdemeanor convictions related to the health and safety of a child. [3-4.7-8(c)]
25				Drug screen (5 or 8 panel) on all child care providers with negative results; reviewed by a Medical Review Officer. [3-4.7-8(c)]
26				Indiana state sex/violent offender central registry check on all child care providers, with negative result. [3-4.7-8(a)]
27				Meets the requirements of FPBSC. ("Opt-out" letters not used.) [3-4.7-2(b)]
28				Occupancy capacities, as recommended by the Division are not exceeded. [3-4.7-2(h)]

CHECKLIST FOR SAFETY CERTIFICATION, UNLICENSED REGISTERED CHILDCARE MINISTRIES (continued)
 (All cites begin with 470 IAC unless otherwise noted)

#	YES	N/A	NO	GUIDELINES
29				Discipline: The director shall discuss and give the following information, in writing, to the parent at the time of the child's enrollment. (a) Any person, while on child care center premises, shall not engage in or direct any of the following actions toward children: (1) Inflict corporal punishment in any manner upon a child's body. (2) Hit, spank, beat, shake, pinch, or any other measure that produces physical discomfort. (3) Cruel, harsh, unusual, humiliating, or frightening methods of discipline, including threatening the use of physical punishment. (4) Placement in a locked or dark room. (5) Public or private humiliation, yelling, or abusive or profane language. (6) Caregiver shall not: (a) associate disciplinary action or rewards with rest. (b) associate disciplinary action with food or use food as a reward. (c) associate disciplinary action or humiliate a child in regard to toileting. (d) use time out for any child less than three (3) years of age. (e) use time out for any purpose other than to enable the child to regain control. (f) physically restrain children except: (1) when it is necessary to ensure their own safety or that of others; and (2) only for as long as is necessary for control of the situation. (g) use punishment to correct unacceptable behavior. (3-4.7-54), (3-4.7-55) & (3-4.7-56)
		Total YES		Certificate earned? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Total NO			

Date of survey (month, day, year)	Signature of Surveyor
Name of ministry	Acknowledged by (signature and title)
Identification number	County

CHECKLIST FOR HEALTH CERTIFICATION (All cites begin with 470 IAC unless otherwise noted)

#	YES	N/A	NO	GUIDELINES
1				All staff members have physical examination within one (1) month of employment or six (6) months prior to employment. [3-4.7-85(1)]
2				All staff are verified to be free of tuberculosis and other communicable disease within 30 days of employment and have biennial testing for tuberculosis. [3-4.7-85(1),(2),(3),(4)]
3				Each child has physical exam within 30 days of admission or six months prior to admission. [3-4.7-86(a)]
4				Cots are spaced two (2) feet or more apart. (3-4.7-53)
5				Hot water (100-120 degrees F) is provided to all hand washing sinks. (3-4.7-53)
6				Records are maintained on all children's injuries. [(3-4.7-114(c),(d)]
7				Written policy to notify parents in the event of a child's illness or an emergency [3-4.7-39(c)]
8				Emergency medical authorization in event parent can not be reached. [3-4.7-37(1)]
9				Medicine not requiring refrigeration is stored in a locked cabinet or locked drawer outside of the kitchen. [3-4.7-88(i)]
10				All medications have a physician's written order. [3-4.7-86(c)]
11				All medications are appropriately recorded immediately after being administered to child(ren). [3-4.7-40(a)]
12				One toilet and one lavatory is provided and maintained for each 15 children age 2-12 years old. [3-4.7-113(a)]
13				Diapering table is inaccessible to children and not used for any purpose except diapering. [3-4.7-94(f),(j)]
14				Diaper changing procedures posted by each diapering area. [3-4.7-94(r) and 3-4.7-19(b)(2)]
15				Cloth diapers and bedding used by facility is laundered in 160 degrees F or approved sanitizing solution. [3-4.7-141(p)]
16				A fresh, clean, waterproof paper is used on top of the diaper changing pad for each diaper changed. [3-4.7-94(n)]
17				Fifty (50) foot-candles of illumination are provided above classroom tables. [3-4.7-106(b)(3)]
18				Thirty (30) foot-candles of illumination are provided in bathrooms. [3-4.7-106(b)(4)]
19				Five (5) foot-candles in children rest and nap areas. [3-4.7-106(b)(6)]
20				Classroom temperature is maintained at sixty-eight (68) degrees F or more within two (2) feet of floor/ventilation adequate. [3-4.7-106(e)]
21				Swimming/wading pool meets and is maintained in accordance with ISDH rule under 410 IAC 6-2, and has current state/local health department permits. [3-4.7-70(d)(i)]
22				Children have age appropriate immunizations as recommended by ISDH immunization schedule. [3-4.7-38(2), 3-4.7-86(d)]
				Certificate earned?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
		Total YES		
		Total NO		

Date of survey (month, day, year)	Signature of Surveyor
Name of ministry	Acknowledged by (signature and title)
Identification number	County

Child Care Development Fund Provider Eligibility Standards Checklist



**CHILD CARE DEVELOPMENT FUND (CCDF)
PROVIDER ELIGIBILITY STANDARDS (PES) CHECKLIST**

State Form 51363 (R3 / 9-07) / BCC 0091

Provider	Inspector or Consultant
Identification number	Date (month, day, year)
Address (number and street)	Time From: To:
City	Telephone number ()
County	

During the inspection of this LLEP home, _____ children present & _____ were related to the provider.

REQUIREMENT:	YES	NO
IC 12-17.2-3.5-5 1. A Residential Building shall have working smoke detectors on each level, top of each stairway and adjacent to each sleeping area (as required by SFM) OR A Non-residential Building shall have fire alarm and suppression systems as required by applicable rule of the Fire Prevention and Building Safety Commission. Building Type: _____		
IC 12-17.2-3.5-10(b)(3) 2. Two and a half pound or greater ABC multiple purpose fire extinguisher on each floor and in the kitchen with valid expiration date.		
IC 12-17.2-3.5-10(a) (Applies to providers enrolled in CCDF program after June 30, 2002) 3. A facility where a provider operates a child care program must have two exits that: <ul style="list-style-type: none"> • Are on different sides of the building. • Do not go through a garage or storage area where hazardous materials are stored. • Are not blocked. • Are not windows. • Are operable from the inside in a one step process (no key or special knowledge required). 		
IC 12-17.2-3.5-10(b)(1) and (2) 4. Each child care provider shall have monthly documented fire drills including date/time/weather conditions/name of person conducting drill/full evacuation time and maintained for previous 12 months. <i>Date of last drill</i> _____		
IC 12-17.2-3.5-6 5. Each child care provider, household member, employee, volunteer caregiver shall have an intradermal tuberculosis test and result prior to giving care. <ul style="list-style-type: none"> • Each child care provider, household member, employee and caregiver who has a history of a positive TB test or disease shall have an annual health assessment by a physician to reflect symptom screening for TB. 		
IC 12-17.2-3.5-7 6. A child care provider shall have written plans for notifying parents of the following: <ul style="list-style-type: none"> • Illness, serious injury, or death of provider. • Care in an emergency. • Emergency evacuation (fire, tornado); this shall be posted in the facility where the provider operates the child care program. 		
IC 12-17.2-3.5-8 7. At least one adult shall have annual certification in CPR applicable to all age groups cared for and is present at all times when a child is in care. and Each child care provider, employee, or volunteer caregiver shall have current certification in First Aid.		
IC 12-17.2-3.5-5 8. The child care facility shall have hot and cold running water from an approved source in the area of the facility where the provider operates a child care program. Water source: _____ Public _____ Private _____ valid water test date _____ Meets IDEM standards as required. IDEM water system number _____		
IC 12-17.2-3.5-9 9. Each child care provider shall have a working telephone in each facility accessible to any staff member. <i>Record of phone service on site.</i>		
IC 12-17.2-3.5-11 10. Each child care provider shall have the following items inaccessible to children: <ul style="list-style-type: none"> • Firearms and ammunition <i>Location:</i> _____ • Poisons, chemicals, bleach and cleaning materials <i>Location:</i> _____ 		

Attachment B: High-Quality Accountable Programs

REQUIREMENT:	YES	NO
IC 12-17.2-3.5-4 11. Each child care provider, employee, household member, volunteer caregiver has provided evidence that they have not been named in the State Central Registry IC 17-6(7).		
IC 12-17.2-3.5-12 12. Each child care provider, household member, employee or volunteer caregiver has statewide limited criminal history check or Each child care provider has local criminal check with documentation that statewide check is applied for. (<i>Valid for 45 days</i>) <ul style="list-style-type: none"> • No child care provider has been convicted of a felony. • No child care provider has been convicted of a misdemeanor related to health and safety of a minor. • Each child care provider maintains written policy requiring that persons whose criminal check is maintained must report any criminal convictions to the provider. 		
IC 12-17.2-3.5-12.1 13. Each child care provider, household member, employee, volunteer caregiver shall have documentation of a drug test and result does not show presence of illegal controlled substance(s). (<i>Standard 5 or 8 panel urine test</i>) and a child care provider shall have: <ul style="list-style-type: none"> • Written policy requiring random drug testing of caregivers and • Required testing if individual is suspected of noncompliance and • Policy for suspension, rehabilitation and reinstatement of persons tested above. 		
IC 12-17.2-3.5-11.1 14. Each child has age appropriate immunizations including Varicella and Pneumococcal vaccines. Documentation includes: <ul style="list-style-type: none"> • Names of all children (<i>including provider's</i>) receiving care at the facility. • Immunization records for each child (<i>includes month, day and year given for each immunization and child's birth date</i>). • The child's physician documents child is in process of receiving immunizations or • A medical exempt statement from a physician or • A religious belief exemption statement from the parent. 		
IC 12-17.2-3.5-12.1 15. A child care provider shall have a written policy prohibiting: <ul style="list-style-type: none"> • use of tobacco, unintended use of toxic substances, use (<i>homes</i>) of alcohol; use or possession (<i>centers & ministries</i>) of alcohol; and use or possession of illegal substances in the facility where child care is operated when child care is being provided. 		
IC 12-17.2-3.5-5.5(a) 16. All children in care are continually (<i>sight or sound</i>) supervised by a caregiver.		
IC 12-17.2-3.5-5.5(b) 17. A provider who operates a child care program in the provider's home shall complete a training course in safe sleep practices, approved by the Division.		

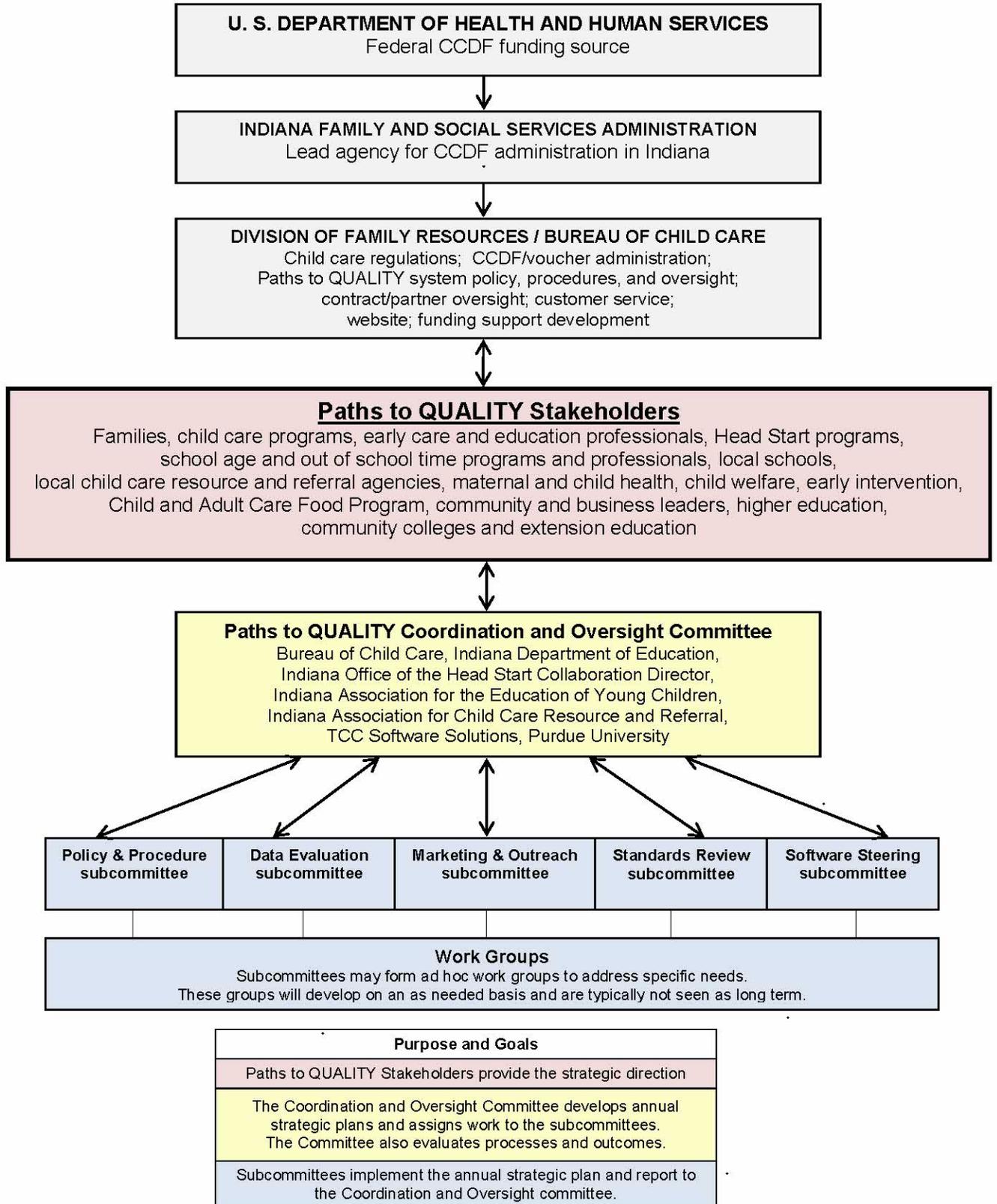
I understand that the information contained in this document is necessary for participation in the Child Care Development Fund (CCDF) program. I understand that the Indiana Family and Social Services Administration (IFSSA) and/or PES inspector may verify any information contained in this document and any misrepresentation may subject me to removal/exclusion from the program and/or prosecution under applicable laws. I have reviewed the information contained in this document and agree by my signature that the information is accurate and complete to the best of my knowledge and belief. I understand that any changes in the information contained in this document must be promptly reported to IFSSA or PES inspector. Failure to report any changes may result in my removal/exclusion from the CCDF program.

*I understand that I must correct the problems identified above, in order to begin or continue to receive funds from the Child Care Development Fund Program. I understand that I must contact the inspector/consultant listed below to submit required documentation and arrange for a subsequent visit, if necessary, to complete compliance with minimum standards. I understand that if I am currently receiving CCDF funds, I must demonstrate my compliance by the date indicated (**maximum of 21 days**) or I will be decertified as a CCDF provider.*

Signature of inspector/consultant	Date (month, day, year)	Signature of Provider	Date (month, day, year)
MEETS ALL STANDARDS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Approved by:	Date (month, day, year)



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1-800-299-1627



Child Care and Early Education: Everyone's Business

An Action Plan for
Fort Wayne and Allen County

September, 1996

Funded, managed and submitted to the community by:

Child Care of Allen County
Foellinger Foundation, Inc.
United Way of Allen County

Planning process directed by:

Fran Anderson Associates
Organizational Resources, Inc.

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Appendix: List of Planning Process Participants

Executive Summary

Background. The Fort Wayne/Allen County community is nationally renowned for uniting in times of crisis. But because the problem of inadequate child care doesn't pose an imminent threat, the community has produced more studies than solutions.

To help spark collective action *before* the local child care problem escalates to crisis proportions, Child Care of Allen County, Foellinger Foundation, Inc. and United Way of Allen County joined forces with leaders in child development, education, business, labor government, human services, and religion to convert reports into plans and analysis into action. During a six-month planning process, participants set out to:

- Develop a clear set of objectives for high-quality child care and early education.
- Identify the local assets for and barriers to achieving those objectives.
- Establish a working plan that would build on the assets, overcome the barriers and move the community toward its objectives.

Importance of Child Care and Early Education. Since the child care problem was first identified locally in 1984, the same local shortfalls crop up repeatedly, most recently in a 1995 study by Taxpayers Research Association, which found:

- Inconsistent quality and availability of child care in various parts of the community.
- Shortages of:
 - ⇒ Infant/toddler care
 - ⇒ Before- and after-school care
 - ⇒ Sick child care
 - ⇒ Care for children with special needs
 - ⇒ Child care during non-standard work hours.
- Insufficient child-care subsidies for low-income working families.

With fewer workers available to businesses in the post-baby boom era, nearly full employment in our community and state, more two-income families, the increase in single-parent households, and recently enacted welfare reform, child care is becoming increasingly important to all kinds of families. Only with affordable, high-quality child care can our community employ all those who want to work and have to work. Only with quality, affordable early learning can every child get an equal shot at educational success and future opportunities.

In short, child care and early education can help or hinder:

- Economic development
- Workforce quality and availability
- Children's success in school
- Prevention of youth violence
- Promotion of self-sufficiency and reduction of welfare assistance.
- Business success and productivity
- Quality of family life
- Family literacy

Community Objectives. Participants in this planning process showed remarkable consensus in their vision of high-quality, developmental experiences for children. They envision a child care and early education system that will:

1. Affirm and support the role of parents.
2. Provide opportunities for all children to develop optimally, whether their parents work or not.
3. Develop well-trained, qualified child care and early education staff in homes and centers.
4. Provide experiences which help children succeed in school.
5. Make affordable, high-quality child care available when and where families from throughout the community need it.
6. Encourage a more stable child care workforce through increased stature and improved salaries and benefits.
7. Help children make a smooth transition from preschool to kindergarten.

Assets and Barriers. In achieving these objectives, planners said Fort Wayne and Allen County have many assets to draw upon, including:

- Strong and varied base of existing child care centers.
- Genuine interest in the issue.
- Many community resources and a concern for its children.
- In-service training for child care and early education professionals.
- An active chapter of the Association for the Education of Young Children.

They also identified these barriers:

- Employers and other key opinion leaders have not embraced the issue.
- "Child care" is not seen as early education.
- Collaborative efforts have been difficult.
- Child care staff do not receive adequate compensation and stature.
- Limited pool of educated and trained staff.
- It is difficult for low-income families to find quality child care.
- Parents feel "on their own" to find child care.
- Many parents don't know the difference between child care and early education, so they choose what's less expensive.
- There is inadequate transportation.
- There are many informal child care providers, especially those caring for five or fewer children, who are not registered or licensed.
- There is tension among providers, especially between center providers and family child care.
- The community lacks a four-year degree program in early education.

Action Plan. To capitalize on the community's child care and early education assets, overcome its barriers and achieve the community's objectives, the planning group outlined the following broad action steps:

Step 1: Get organized.

- **Expand the current partnership to spearhead child care and early education improvements.** A single, broad-based community partnership will help centralize activities, ensure widespread participation, and help overcome the “turf” issues inherent in past efforts.
- **Find a corporate champion.** A respected leader from the business community should champion this cause to help make it a business and economic issue and build public and corporate support.
- **Engage diverse stakeholders to create a broad coalition.** To be successful, a reform effort of this magnitude must engage a wider circle of stakeholders who recognize the critical importance of child care and early education.
- **Establish spending priorities and an evaluation process.** The partnership will help identify needs and recommend spending priorities, match those needs to funders who can help, and establish standards for measuring the effectiveness of various initiatives.

Step 2: Redefine the issue and elevate it on the public agenda.

- **Public information campaign.** Once the partnership has been expanded, the corporate champion recruited and broad participation established, it will be important to proactively redefine the “child care” issue and to make that issue more important in the community as a whole. This will be done through a general public information campaign that repositions child care as early education; establishes it as an economic, rather than social service, concern; and highlights success stories. This campaign will also help parents become smarter consumers of child care and early education services.

Step 3: Plan, assemble resources and implement specific improvements. The partnership will identify necessary improvements and -- with the help of increased visibility and widespread community involvement -- encourage, as necessary, the development of new funding and other resources.

While specific actions will be determined by the partnership, community participants provided many ideas for improvements, especially in the areas of:

- Standards/rewards to encourage higher quality care.
- Improved communications and networking.
- New programs and services to fill gaps.
- Training and education programs.

Conclusion. Under the leadership of a community-based partnership and a respected corporate champion, Fort Wayne and Allen County can elevate the issue of child care and early education, bridge the long-standing gaps in services, and provide resources vital to our children, our families, our businesses, and the future of our community.

Introduction

For more than a decade, many organizations and individuals have discussed, debated, analyzed and researched the need for better child care in Fort Wayne and Allen County, Indiana.

- As early as 1984, the “Livable City Task Force” recommended public/private efforts to establish a child care center downtown.
- In 1989, the Women's Bureau identified shortages in infant/toddler care, before- and after-school care, sick child care, and care for children in low-income neighborhoods.
- In 1995, more than a decade after the issue was first raised, a study by Taxpayers Research Association said nearly all these child care problems still exist.

Fort Wayne is a community renowned for uniting in times of crisis. But unlike the imminent danger of a flood threatening lives and property or a big business bankruptcy idling thousands of workers, the dilemma of child care has not produced action -- it has generated more studies than solutions.

To help spark collective action *before* the local child care problem escalates to crisis standards, Child Care of Allen County, Foellinger Foundation, Inc. and United Way of Allen County joined forces with leaders in child development, education, government, human services, business, labor and religion to convert reports into plans and analysis into action.

With help from their consultants -- Fran Anderson Associates and Organizational Resources, Inc. -- participants set out to:

- Develop a clear set of objectives for high-quality child care and early education.
- Identify the local assets for and barriers to achieving those objectives.
- Establish a working plan that would build on the assets, overcome the barriers and move the community toward its objectives.

This document is *not* another study. It is an action plan, developed by and for the people of this community, to help address the child care and early education needs of Fort Wayne and Allen County. Your ideas and support can help make this plan a reality.

How the Plan Was Prepared and Who Helped

This plan results from a six-month community-wide planning process which included:

In-depth interviews with leaders representing:

- Business
- Organized labor
- Government
- Social services
- Foundations
- Education
- Child care and early education

Focus groups representing:

- Parents
- Family child care providers
- Child care and early education centers
- School personnel
- Social service providers
- Associations/alliances
- Neighborhood and religious organizations
- Employers

A community meeting attended by more than 80 local citizens.

Funding partners in the process were Child Care of Allen County, Foellinger Foundation, Inc. and United Way of Allen County.

The planning was overseen by an **advisory committee** representing employers, schools, funders, churches, government agencies, early education providers, and social service agencies.

The **consulting firms** leading the process were Fran Anderson Associates, an Ohio-based firm with extensive national experience in early childhood education, and Organizational Resources, Inc., a strategic planning and organizational development firm specializing in non-profit and governmental organizations.

A complete list of advisory committee members and interviewees is included in the Appendix.

Why You Should Care About This Issue And Why Our Community Cannot Afford to Settle for What It Has

If you're not a parent with young children, you probably don't wake up in the morning thinking about child care or early education. Yet nearly all of us are affected by this issue. At the national, state and local levels, child care and early education are getting increasing attention because they dramatically affect our businesses, families and society. Specifically, national experts have focused on:

- The importance of early learning in preparing children for success in school
- The need for accessible, affordable, high-quality child care so parents can work
- The stress parents experience in balancing work and family.

Past research in Allen County, verified by participants in this planning process, has found that early childhood education can help or hinder:

- Economic development
- Workforce quality and availability
- Children's success in school
- Prevention of youth violence
- Promotion of self-sufficiency and reduction of welfare assistance.
- Business success and productivity
- Quality of family life
- Family literacy

What's Wrong with the Existing System. Since this issue was first raised locally in 1984, the same shortfalls crop up in study after study. Most recently, Taxpayers Research Association, in its 1995 analysis of child care in Allen County, found that our community's major child-care concerns include:

- Inconsistent quality and availability of child care in various parts of the community.
- Shortages of
 - ⇒ Infant/toddler care
 - ⇒ Before- and after-school care
 - ⇒ Sick child care
 - ⇒ Care for children with special needs
 - ⇒ Child care during non-standard work hours.
- Insufficient child-care subsidies for low-income working families.

With fewer workers available to our businesses in the post-baby boom era, nearly full employment in our community and state, more two-income families, increase in single-parent households, and recently enacted welfare reform, child care is becoming increasingly important to all kinds of families. Only with affordable, high-quality child care can our community employ all those who want to work and have to work. Only with quality, affordable early learning can every child get an equal shot at educational success and future opportunities.

Common Objectives: Where Our Community Wants to Go

Participants in this planning process showed remarkable consensus in their vision of high-quality, developmental experiences for children. Even those who don't have a personal role as parents or service providers had clear views of what children should be able to experience in their early years. As a result of these collective opinions, this plan aims to create a child care and early education system in Allen County which helps achieve the following objectives:

1. **Affirm and support the role of parents.** Planning participants envision a system that helps parents learn more about parenting, provides access to a variety of services, encourages discussions about quality child care and early education, and delivers adequate information about transitions to kindergarten.
2. **Provide opportunities for all children to develop optimally, whether their parents work or not.** Planning participants want a system that meets the needs of all kinds of children from all kinds of family and work situations. This would include quality care for children of working parents, compensatory education for disadvantaged children, and enrichment and socialization for others.
3. **Develop well-trained, qualified child care and early education staff in homes and centers.** Local planning participants agree with national studies showing that children benefit from child care providers and educators with formal education and training. This training should not only include first-aid/emergency preparedness, but also course work in how to prepare children for school. Participants want to see measurable standards and incentives for early education training.
4. **Provide experiences which help children succeed in school.** Child care should offer more than watching television while parents are at work. Planning participants believe the community should invest early in the health and development of its children so they reach school ready to learn. Participants acknowledge that this investment will cost more up front, but they believe it will save the community money in the long run. Planning participants would like to see schools work directly with preschool programs -- especially those helping underserved populations.

5. **Make affordable, high-quality child care available when and where families from throughout the community need it.** The local child care resource and referral service should set benchmarks for filling the service gaps identified in local research so funders can target projects addressing those needs. The community also should encourage linkages between other community groups and the Educare Committee of the Step Ahead Council to address service gaps.
6. **Encourage a more stable child care workforce through increased stature and improved salaries and benefits.** To encourage a more stable, respected child care workforce, community members envision a system which provides better compensation and benefits, especially health insurance, in centers, schools, and family child care homes. One way to help would be an insurance pool for child care workers not covered under family policies.
7. **Help children make a smooth transition from preschool to kindergarten.** Parents want opportunities to learn more about what will be expected from their children in school. They also would like to see improved communication between schools and preschools. Teachers in both settings should know what each other's programs are like.

A Strong Foundation to Build Upon

Participants in the planning process say Fort Wayne and Allen County have many assets which make this plan's objectives realistic and realizable. The primary strengths cited by the group include:

- **Strong and varied base of existing child care centers.** Fort Wayne has the highest number of nationally accredited centers in Indiana. They exist in a variety of settings -- public school, non-profit agencies, and Head Start programs. The community can build upon the successes of these centers with opportunities for mentoring, incentives for becoming accredited, and financial resources to meet quality standards.
- **Genuine interest in the issue.** A core group of leaders, especially service providers, have taken an interest in this issue, participated in task forces and advisory committees, and advanced the community's resources to where they are today. Through the Step Ahead Council, its Educare Committee, the Community Alliance for Healthy Families, the Northeast Indiana Coalition for Children's Legislation and the local chapter of the Association for the Education of Young Children (see below), Fort Wayne and Allen County have strong advocates and an organizational framework on which to build.
- **Allen County has many resources and a concern for its children.** This community has always been known as a caring place and a good place to raise families. Among the assets that make that possible are several employers with exemplary child care programs, a productive workforce, active foundations, good public and private schools, quality post-secondary education programs, and strong religious organizations.
- **In-service training opportunities are available for child care and early education staff.** Step Ahead's Educare Committee, Child Care of Allen County, and community colleges have increased the availability of training for the people who care for and teach young children.
- **There is an active chapter of the Association for the Education of Young Children.** This local chapter of a national organization provides professional development and training, publications, conferences, and awareness programs for those serving children from birth to age 8. The national organization also accredits child care and early education centers, and the local group advocates such accreditation.

Obstacles to Overcome

This planning process revealed several obstacles that need to be addressed if our community is to successfully fill the gaps in local child care and early education and build a high-quality system available to all.

- **Employers and other key opinion leaders have not embraced the issue.** As long as the child care issue is championed by care providers, working parents, children's advocates and social service agencies, Fort Wayne and Allen County won't see the changes needed to fill the gaps and address the bigger issues. Business, media, and other opinion leader involvement is critical to long-term, effective solutions.
- **"Child care" is not seen as early education.** Many people see this as a "child care only" issue. It's not. Granted, child care has historically been viewed as separate from education. But for young children, child care *is* education. Early childhood experiences, whether in or out of the child's home, have a profound impact on the future for that child -- and, therefore, on our community, our workplaces and our nation. To get more people involved in solving this problem, it must be redefined as an education issue, not a "build more warehouses for the kids" issue.
- **Collaborative efforts have been difficult.** Some feel past collaboration has been forced from the top down. They also mention "turf" issues, long-standing rivalries, and concern over who gets "credit" for successes. Most communities which take a systemic approach to improving child care and early education rely on a broad-based partnership, diverse leadership, and widespread community involvement. The bigger the base of participants, the more likely the focus will be on the issue and not on the difficulty of collaboration.
- **Child care staff do not receive adequate compensation and respect.** Nationally and locally, there's a paradox in this field: How to balance quality services and the true cost of professional staffing with what parents can afford to pay. As a result, care providers don't earn much money compared to other professionals with similar impact on the community and don't enjoy the respect given to other professions.
- **There is inadequate training for early education staff.** Like many communities, Allen County suffers from a limited pool of qualified individuals willing to work in child care centers and homes. The community needs more comprehensive training programs, more follow-up to see that the training is implemented, and coordination of education and training opportunities.
- **It is difficult for low-income families to find quality child care.** Because there are not enough quality care providers in many low-income neighborhoods and because there are waiting lists and strict limits on subsidy programs, Allen County's biggest child care and early education problems are found among the people most in need.

- **Parents feel "on their own" to find child care.** Regardless of income, parents believe finding child care in Allen County is a difficult and stressful process. Although there is a local child care resource and referral service, it does not currently have the visibility or capacity to reach many parents and help them.
- **Many parents don't know how to compare child care and early education programs, so they choose what's less expensive.** After a quick facility or home tour, some families say they can't really see the difference between a \$75 per week program and a \$100 per week program, so they choose the lower-cost option. If parents don't understand the value and true cost of quality child care and early education, or the effects of low wages and high staff turnover on their children, they can find themselves being "penny wise and pound foolish".
- **There is inadequate transportation.** One parent in the planning process reported leaving at 6:00 a.m. to take a bus to the day care center and then another bus to be at work at 9:00 a.m. For a low-income family without reliable automobile transportation, getting a child to and from child care can be a nightmare.
- **There are many informal child care providers, especially those caring for five or fewer children, who are not registered or licensed.** Most informal caregivers and family child care providers are not licensed or registered -- they don't have educational and safety training, access to nutritious meal subsidies, or make themselves available via referral agencies to parents who might need their services. They also may be missing out on tax benefits they could receive as a home business.
- **There is tension among providers, especially between center providers and family child care.** Allen County needs to spend more time addressing common issues and less time debating which kind of care is best. Whether they work in centers, homes, or schools, a united front of early education professionals is critical to developing public awareness of and respect for child care and early education.
- **The community lacks a four-year degree program in early education.** Many early childhood professionals said their staff members would like to get a four-year degree, but there is none available. As a result, when new service providers open, they often deplete the supply of qualified staff, leaving existing centers with lower standards for child-care providers.

Action Plan: How to Get There from Here

Step 1: Get organized.

To redefine this issue in our community, elevate its importance on the public agenda, bring increased human and fiscal resources to the table, and improve the child care and early education system with maximum efficiency and minimum overlap, this planning group recommends the following action steps.

- 1.1 **Expand the current partnership to spearhead child care and early education improvements.** Establishing a single, community-based partnership will help centralize activities, ensure widespread participation, and help overcome the "turf" issues inherent in past efforts. The partners who funded this plan -- Child Care of Allen County, Foellinger Foundation and United Way of Allen County -- have agreed to continue and expand their partnership as a possible way to spearhead this issue.

- 1.2 **Find a corporate champion.** All the parties involved in creating this plan believe it is essential to find a respected leader from the business community to champion this cause for at least two to three years. Only if child care and early education become business and economic issues will there be support for significant change. Only peer leadership can make this a serious business/economic issue.

Key attributes of the champion should include:

- Respect of the business sector.
- Ability to relate to the many communities that make up Fort Wayne and Allen County.
- A mutually respectful relationship with community decision-makers.
- The ability to clearly articulate the issues.
- Strong leadership skills.

This individual should be asked to:

- Work behind the scenes to educate his or her colleagues about the business value of child care and early education and their long-term economic benefits.
- Convene an employer group to address work/family issues and educate the business leaders about family-friendly policies.
- Identify colleagues who can advise the Resource & Referral Service on marketing its employer-related services and designing projects to meet employer needs.
- Leverage resources for potential improvement projects and incentive programs.

1.3 **Engage diverse stakeholders to create a broad coalition.** To be successful, a reform effort of this magnitude must engage a wider circle of stakeholders who recognize the critical importance of child care and early education. Participants from various segments of the community should be asked to:

- Identify, reallocate, leverage and, if necessary, raise funds.
- Elevate the issue in their own sectors.
- Make decisions about projects.
- Interact with others.
- Continue the planning process so new ideas and programs are constantly being developed, tested and implemented.

1.4 **Establish spending priorities, ongoing evaluation and investment process.** To implement changes on the scale needed to ensure quality early education for children of all income levels, it will be important for the partnership to help identify the needs of the community and recommend spending priorities accordingly. This group also should help match the needs of child care and early education providers with community interests -- including United Way, schools, local foundations, employers, government, and parents -- who can help. Finally, the partnership should help establish standards for measuring the effectiveness of child care and early education.

Step 2: Redefine the issue and elevate it on the public agenda.

Once the partnership has been expanded, the corporate champion recruited and broad participation established, it will be important to proactively redefine the "child care" issue and to make that issue more important in the community as a whole. To accomplish this, the planning group recommends the following:

2.1 **Develop and launch a general public information campaign for child care and early education.** This campaign should include professional communications to:

- Reposition child care as early education.
- Reposition early education as an economic, rather than social service, issue.

Further, the campaign should elevate this issue on the public agenda by sending carefully targeted messages to identified audiences, as outlined below:

Audience

Businesses

Message

Workforce development and retention

Employee productivity

Future return on investment

<u>Audience</u>	<u>Message</u>
Local government	Economic development Increased education levels Dropout/youth violence prevention Self-sufficient families Quality of life
Parents	Most important time in your child's life How-to information

2.2 Develop specific communications to help raise awareness and (if necessary) funds, encourage and promote targeted improvements, and increase participation in the issue. Possible activities include:

- Publicize early education successes -- especially those that meet or exceed national standards -- as identified by the Association for the Education of Young Children and others working with children.
- Increase the visibility of existing groups and currently available resources, including Step Ahead, AEYC, and the resource/referral service, to encourage participation.
- Increase parent and consumer education about how to measure various early education programs to get the best option for children. Include information about the illegality of large, unlicensed home-based centers.
- Inform potential care providers about areas of child-care need and current funding for entrepreneurial solutions.
- Publicize activities of the partnership to encourage additional involvement and investment.

Step 3: Plan, assemble funding and implement specific improvements.

A key role of the partnership will be to identify improvements needed in the community's early education system and -- with the help of increased visibility and widespread community involvement -- to encourage, as necessary, the development of new funding and other resources.

While specific action steps will be determined by the partnership, participants in the planning process provided many ideas for improving child care and early education in Allen County. Their ideas are listed here, and will be carefully considered by the partnership as it develops a detailed course of action.

Standards/rewards to encourage higher quality care

- Develop a recognition program for exemplary centers and family child care.
- Create an incentive program for providers who meet or exceed accreditation standards.
- Establish a quality enhancement fund to be used for site improvements, tuition, and special projects, such as staff retention, CPR classes, etc.
- AEYC, the Educare Committee of the Step Ahead Council and/or the local resource/referral service should help centers and providers set benchmarks for training -- and publicize those standards.
- Public and private elementary schools should develop benchmarks related to the numbers of children who participate in child care and early education programs before entering school, then track the data and share results with the community to promote increased awareness of the value of early education and school success.
- AEYC and resource/referral service should survey providers to demonstrate the educational level of many home and center staff and to set local benchmarks for improved training and education.

Improved communications and networking

- Better coordinate and communicate training program information -- including course content, qualifications of the trainers, eligibility for post-secondary credit, and schedules.
- Encourage closer relationship between AEYC and association for family child care providers.
- Conduct joint forums between centers and home-based providers to improve communications and provide updates on current issues.
- Improve communications between school and pre-school educators and parents regarding transitions to kindergarten.
- Provide outreach to unregulated providers.
- Build the capacity of the community child care resource and referral service so it can:
 - ⇒ Deliver employer-related child care consultations and services.
 - ⇒ Provide ongoing community planning information.
 - ⇒ Build a more comprehensive, interactive database of providers and parents which can pinpoint local needs of employers, parents, neighborhoods, and special child populations.
 - ⇒ Create and distribute regular resource and referral reports.
- Expand parent education programs.
- Increase technical assistance programs available to providers.

New programs and services to fill gaps

- Develop more school-age child care.
- Recruit human resources directors who can join forces to help create non-standard-work-hour child care.
- Foster partnerships between the Educare Committee of the Step Ahead Council and other community groups to meet service gaps.
- Launch a provider recruitment campaign.
- Explore opportunities for public schools to incorporate school- or community-based programming for preschoolers at or near elementary schools, particularly for underserved populations.
- Develop and promote more parenting classes, morning-out programs and preschool programs with sliding fee scales.
- Encourage proposals from United Way agencies wanting to help fill gaps identified by United Way needs assessment.
- Establish seed dollars for start-up services or networks wanting to provide care in gap areas.
- Develop an insurance pool to help providers obtain coverage.

Training and education programs

- Enhance and promote training programs for all providers.
- Work with local colleges and universities to develop four-year program.
- Increase business management training to help centers and family child care homes maximize scarce resources.
- Develop mentoring programs which encourage successful programs to help newcomers.

Conclusion

Under the leadership of a community-based partnership and a respected corporate champion, Fort Wayne and Allen County can elevate the issue of child care and early education, bridge the long-standing gaps in services, and provide various resources vital to our children, our families, our businesses, and the future of our community. But no partnership can address this challenge without the ideas and involvement of the community. Only with your help can this common vision become a reality for our children.

For more information about this action plan, contact one of these individuals:

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Planning Process Participants

Funding Partners

- Child Care of Allen County
- Foellinger Foundation, Inc.
- United Way of Allen County

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- David Bennett, Ft. Wayne Community Foundation
- Thomas Callison, NIPSCO
- Kathleen Donnellan, Catholic Charities
- Pastor Vernon Graham, Associated Churches
- Lynnice Hamilton, Wayne Township Trustee Office
- Dr. Toni Kring, M.S.D. Southwest Allen County
- Marc Levy, United Way of Allen County
- Kathleen Likeness, Child Care of Allen County
- Betsy Prosser, Aldersgate Nursery School and Ft. Wayne Assoc. for the Education of Young Children
- Greg Purcell, Mayor's Office, City of Fort Wayne
- Jonathan Ray, Allen County Office of the Division of Family and Children
- Wendy Robinson, Fort Wayne Community Schools
- Dawn Runger, Foellinger Foundation
- Bea Williams-Tevis, Bea's Montessori Home Day Care and Family Day Care Home Association
- Julie Inskeep Walda, The Journal Gazette

Interviewees

- Betty Bates, Community Action of Northeast Indiana Head Start
- Jean Becker, Step Ahead Council
- John Becker, Indiana State Legislator
- David Bennett, Fort Wayne Community Foundation
- Barbara A. Burt, Foellinger Foundation
- Becky Carothers, East Wayne Street Head Start
- Joe Conrad, Community Action of Northeast Indiana
- Steve Corona, Job Works
- Nancy Flennery, Step Ahead
- Rosa Gerra, United Hispanic Americans
- Karen Goldner, City of Fort Wayne
- Steve Hinkle, ARC of Allen County
- Mary Honegger, Office of Congressman Mark Souder
- Anne Hoover, Community Partnerships with Youth
- Sandra Houlihan, Allen County Council
- Janet Imel, Ivy Tech State College
- Dee Klocke, North Side High School
- Phil Laux, Chamber of Commerce
- Tom Lewandowski, Northeast Indiana Central Labor Council
- Joyce Mallory, Fort Wayne Urban League
- Rosetta Moses-Hill, Allen County Local Education Fund
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- Carol Rolland, Lincoln National Corporation
- Ian Rolland, Lincoln National Corporation
- Sandra Shelly, Fort Wayne Women's Bureau
- Marilyn Moran Townsend, Custom Video Communications
- Donna Veiga, Bureau of Child Development, Family and Social Services Administration

Parent Focus Groups

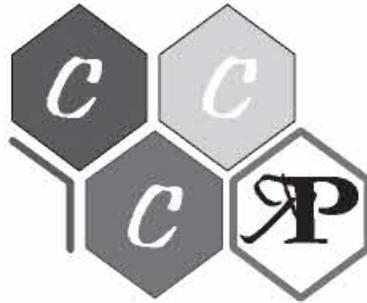
- Low income parents
- Middle income parents
- Single parents
- Rural parents
- Teen parents

Other Focus Groups

- Family child care providers
- School personnel
- Social service providers
- Child care and early education centers
- Associations/alliances
- Neighborhood and religious organizations
- Employers

Community Meeting

- 80+ participants



**COMMUNITY CHILD CARE RESEARCH PROJECT
FINAL REPORT**

**CHILD CARE FOR WORKING POOR FAMILIES:
CHILD DEVELOPMENT AND PARENT EMPLOYMENT OUTCOMES**

James Elicker, Carolyn Clawson, Soo-Young Hong
Tae-Eun Kim, Demetra Evangelou, & Susan J. Kontos

March, 2005
Purdue University

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- **Dianna Wallace**
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Indiana Association for the Education of Young Children

Executive Summary

COMMUNITY CHILD CARE RESEARCH PROJECT

CHILD CARE FOR WORKING POOR FAMILIES: QUALITY, CHILD DEVELOPMENT, AND PARENT EMPLOYMENT OUTCOMES

2001-2004

Purdue University

James Elicker, Carolyn Clawson, Soo-Young Hong,
Tae-Eun Kim, Demetra Evangelou, and Susan J. Kontos

March, 2005

While the effects of child care quality on low-income children and parents are well documented, little is known about how local communities are providing child care to low-income working families in the wake of welfare reform in the mid-1990s. The three-year Community Child Care Research Project examined child care for young children used by low-income working families in four Indiana communities (Marion, Lake, Allen, and St. Joseph counties). The project was funded by the U.S. Department of Health and Human Services/Child Care Bureau and conducted by researchers at Purdue University. Sources of the research data were parent focus groups, interviews with community child care leaders, structured observations and assessments of 307 children in their child care settings, and questionnaires completed by parents and caregivers.

Participants in the Community Child Care Research Project were volunteers in a non-random research sample. Therefore while the results accurately describe the experience of these low income working families and their child care providers, they cannot be confidently generalized to the broader population of low income working families in these Indiana cities or elsewhere.

Indiana offers a unique context for examining child care issues. Although many center-based and home-based child care providers are regulated by the state, a high proportion of child care providers are legally exempt from licensing. Indiana child care regulations exempt child care centers from licensing if they operate as “child care ministries,” programs operated by a church or religious organization that is tax-exempt. Another reason for abundant exempt child care in Indiana is that home-based child care providers are not required to be licensed unless they care for six or more unrelated children (with one provider). Family child care homes are licensed for six to sixteen children. In addition, many child care subsidy and quality improvement spending decisions are made at the county level. For these reasons, Indiana provides a unique opportunity to examine how differences in communities may play a role in the availability and quality of care.

THE OBJECTIVES OF THE RESEARCH WERE TO:

1. Describe child care for young children (6 months to 6 years) used by low-income working families in the four communities.
2. Assess the quality of child care used by low-income working families.
3. Determine if there are variations across four Indiana communities for low-income working families in the types and quality of child care used.
4. Determine if developmental outcomes for children and employment for parents in low-income working families are linked to the quality level of child care they use.

KEY FINDINGS

Low-income Working Families and Their Child Care Providers

1. The typical parent participating in this study was a woman, a single parent with two children, working full time, and earning less than \$18,000 per year, but not receiving Temporary Aid to Needy Families (TANF). Because it was not possible to randomly sample low-income working families, this study relied on a volunteer sample. Therefore the research results will not exactly represent the general population of low-income working parents and children in these communities. Compared to 2000 census population data for low-income families with at least one child under the age of 6 in the four communities, this sample reported a higher education level, a greater percentage of single parents (57% compared to 42%), and a greater proportion of African-Americans. However, this large sample of low-income working families provides valuable new information about members of a vulnerable population. With the welfare reforms of 1996, federal policy has encouraged personal responsibility and economic self-sufficiency. The families in this research were doing just that—working, going to school, and taking care of their children, with little or no government assistance.
2. The typical child care provider in this study was a 39-year-old woman with a high school diploma and some college credit, with about 10 years of child care experience, providing care without a specialized professional credential in early childhood education or child development. Caregivers of preschoolers were twice as likely (52%) to have specialized education in early education and care as caregivers of infants and toddlers (25%).

Child Care Issues in Four Communities

3. Availability of licensed child care and voucher subsidies to help low-income families pay for child care varied across these four communities, according to official state records. Licensed child care was least available in Allen County and most available in Marion County. Marion County had the largest waiting list for voucher subsidies to help low-income families pay for child care, while Lake County reported the shortest waiting list.
4. Selected child care leaders interviewed in the four communities identified several problems in providing child care

for children from low-income working families, including: insufficient funding for child care subsidies, low quality care (especially for infants and toddlers), concerns about the growth of legal yet unregulated child care, and a lack of available child care services during evening hours or for sick children. Community leaders also mentioned strengths and challenges specific to each community.

5. A large proportion of low-income working parents reported in focus groups and surveys that their primary reason for using child care was to work or attend school. Most parents surveyed expressed satisfaction with their current child care arrangements—85% thought the quality of their child care was “perfect” or “excellent.” However, parents also identified child care problems: concerns about the cost, quality, and safety of out-of-home child care; heavy reliance on friends and family members for primary or back-up child care; and lack of flexibility in child care and work schedules, especially for evening employment, sick children, or during holidays or school vacations.
6. More than one-third of the low-income working parents in this sample reported missing at least some work or school in the past month because of child care problems. A small proportion of mothers received assistance from their employers: finding child care (13%), financial assistance (8%), pre-tax accounts (17%), or allowing employees to take sick time to care for an ill child (53%). Fathers generally reported lower levels of child care assistance from their employers. Fathers in the sample in St. Joseph County reported the highest levels of employer flexibility, and fathers in Lake County reported the lowest levels.

Types of Child Care Used

7. The most common types used as primary child care by this sample of 307 low-income working families were licensed child care centers (38%) and licensed family child care homes (24%). Other types were child care ministries (16%), Head Start (9%), unlicensed family child care (8%), and relative care (5%). Twenty percent (20%) of the children started in child care soon after birth, and more than 75% of the children in this sample were enrolled in some type of child care by age 8 months. Infants and toddlers were slightly more likely to be in family child care homes, and preschoolers were more likely to be placed in child care centers.



8. Licensed family child care was used at a high rate by the sample families in Lake County (43%), while center-based care was more often used by the families in Marion and St. Joseph counties (57%). Families in the sample from Allen County used a more balanced distribution of types of child care.

Child Care Quality

9. Despite parents' high ratings of their child care quality, quality levels as assessed by our trained observers of all types of care used by our sample of low-income working families in these four communities were relatively low. Using widely accepted quality scales, the overall average level of child care quality was rated below "good," and just above "minimal." Almost half of the children in this sample attended child care that may not provide experiences and environment thought to be important for development. Approximately 25% of the classrooms or homes observed fell below "minimal" quality. The highest levels of overall or global quality were found in Head Start and licensed child care centers or preschools, while the lowest levels of quality were observed in child care ministries, licensed family child care, unlicensed family child care, and relative care.
10. In general, licensed child care in this sample was of significantly higher overall quality than unlicensed care. Child care for preschool age children was of higher quality than child care for infants and toddlers in both center-based and home-based settings. Child care quality for infants and toddlers was rated at the minimal level or below in all types of settings, in all four communities. The lowest mean quality levels of care for infants and toddlers were observed in unlicensed settings and in Lake County sample.
11. In general, child-adult ratios in the child care settings in this sample complied with National Association for the Education of Young Children (NAEYC) guidelines. Caregivers in center-based child care and all forms of licensed child care reported more general and specialized education than caregivers in home-based or unlicensed care.
12. The quality of relationships between parents and child care providers, as reported by both, was generally high, especially in home-based child care. However, in home-based child care settings, caregiver relationships with infants and tod-

dlers were significantly less positive than relationships with preschool age children. This age difference was not found in center-based settings. Head Start centers and licensed child care centers/preschools were observed to have higher caregiver sensitivity than other settings. The highest levels of caregiver responsive interaction with infants and toddlers were observed in Head Start, relative care, and licensed child care centers/preschools. The lowest levels were found in licensed family child care. In general, licensed family child care tended to be the lowest of all types of care in several process quality assessments (e.g., caregiver sensitivity; caregiver responsive interactions with children), especially for infant/toddler care.

Child Care Quality and Children's Development

13. Many children in this sample scored below established test norms in areas of cognitive and language competence. Among children under 3 years, more than 80% were below test norms in key aspects of cognitive competence. Among children 3 to 6 years, 80% scored below test norms in receptive language.
14. Using a number of different quality and child development measures, the quality of children's child care was found to be associated with their cognitive, language, and social-emotional development, even after controlling for mothers' education level and children's age. These associations between child care quality and children's development were found for both infants/toddlers and preschool children. In general, these findings did not vary by community, nor by type of child care setting.

Specific Results for Infants and Toddlers:

- When overall child care quality (measured with ECERS-R or FDCRS) was higher, infants and toddlers also scored higher on early learning skills (visual reception, fine motor, receptive vocabulary, and expressive vocabulary).
- When caregivers of infants and toddlers had specialized education in child development or early childhood education, infants and toddlers were rated higher in social-emotional competence by their parents.
- When caregivers were observed to be more sensitive in their interactions with children (positive, warm, and non-punitive), infants and toddlers also scored higher on early learning skills.

- When caregivers were observed using more complex language with infants and toddlers, the children were also rated higher on measures of social-emotional competence by their parents.

Specific Results for Preschool Age Children:

- When overall child care quality was higher, preschool age children also scored higher on early cognitive, language, and academic skills (i.e., *FACES* preacademic tasks and receptive vocabulary).
- When caregivers used more complex language with them, preschool age children also scored higher on early academic skills.
- When parents rated the quality of the parent-caregiver relationship more positively, children had more positive academic attitudes as assessed by parents and caregivers and were higher on measures of social-emotional competence as assessed by parents.
- With the exception of Head Start and relative care, when caregivers rated the parent-caregiver relationship more positively, children were rated higher on social-emotional competence by caregivers.
- When caregivers rated the caregiver-child relationship more positively, children also were rated higher on social-emotional competence by both parents and caregivers.

Child Care Quality and Parent Employment

15. In this research sample, many low-income working families experienced challenges balancing work, schooling, and child care. A majority of male and female heads of household in the sample were employed or attended school or training programs 35 or more hours per week. Most worked standard daytime shifts. Approximately 15% more males than females reported working full time. Males tended to report working at their current employer longer than females, and females were more likely to report work interruptions due to illness or child care problems.
16. In general, there were few significant links between child care quality and parent education and employment outcomes. The type of child care setting or the community of residence did not contribute to parent employment or education outcomes. However, there was scattered evidence that families whose children were enrolled in higher quality child care settings also had more stable employment patterns.

CONCLUSIONS & ISSUES FOR FUTURE RESEARCH

The results of the Community Child Care Research Project provide new data describing the child care experiences of low income working families in 4 communities in Indiana. Because the study participants were volunteers rather than randomly selected, and because the research design was correlational rather than experimental, conclusions drawn from these findings necessarily have limitations. The findings cannot be confidently generalized to other low income working families and child care providers, nor can the links between child care quality and children's development be assumed to be causal. For example, while it is quite possible that higher quality child care does support better child development outcomes, it is also plausible that families whose children have more advanced levels of development found and used higher quality child care. Despite these limitations, the research results do represent the recent experiences of more than 300 low income working families, their children, and their child care providers. The results suggest a number of key issues that need further investigation by policy makers and researchers.

1. **Are children from low-income working families at risk for less than optimal development?** Many children in this sample scored lower than established norms in areas of cognitive competence. This is not unusual for children from low income families. The existing research literature suggests that both family and child care experiences influence children's development and school readiness. However the significant correlations we found between child care quality and children's abilities, even after controlling for maternal education and children's age, suggest that efforts to improve child care quality could have an impact on children's development. These findings did not vary by community or type of child care.
2. **Is child care obtained by low income working families of low quality?** The observed quality levels of all types of child care used by this sample of low income working families in four communities were low. Almost half of the children in this study attended child care that may not provide experiences and environments thought to be important for development. Educating parents about how to select good quality child care is important. However, there also appeared to be limited child care options for families, due to issues of affordability and accessibility of good quality care. Effective child care policies for low income working

families should take quality, availability, and affordability into account, so that good quality care is a realistic option for all children.

3. **Is there is a critical need to improve the quality of infant and toddler care for low income working families?** Child care quality for infants and toddlers observed in this research was low, using several quality measures, in all types of settings, in all four communities. Finding and affording good quality infant-toddler care may be especially problematic for young parents with lower education levels and lower wages, because they are least able to afford infant-toddler child care, which is typically more expensive than care for older children.
4. **Are new efforts needed to improve the quality of licensed family child care?** Even though licensed child care was generally of higher quality than unlicensed care, licensed family child care in this sample was observed to be low in overall quality and low in several aspects of process quality (e.g., caregiver sensitivity; caregiver responsive interactions with children)-- especially for infant/toddler care. The need for improvement in caregiver-child relationships in licensed family child care should be further investigated.
5. **Indiana should investigate quality levels in the rapidly growing number of child care ministries, currently license exempt.** Registered child care ministries are serving increasing numbers of children in Indiana. While this research observed a small sample of children in child care ministries, in general quality in these programs was lower than in licensed child care centers or Head Start. These results suggest the need for a more comprehensive look at quality of care in child care ministries, to determine the need for increased regulation to improve quality.
6. **Greater flexibility in child care and employment is needed for low-income working families to accommodate changing work shifts, non-traditional hours, and care for sick children.** Parents as well as child care leaders in this study pointed to the need for affordable and

accessible quality child care that provides more flexibility for low income working families, to accommodate challenging work and school schedules, job training, and child illness. Employers should also look at the possibility of increasing support and work schedule flexibility for workers who are parents of young children.

7. **It is important that the strengths and limitations of individual urban communities are recognized and incorporated when planning for improvements in child care quality for low-income working families.** Indiana provides a unique context for child care because many child care decisions are made at the county level. Even though many experiences of this sample of low income families were similar across these four communities, there were significant differences in the demographics of families, availability of child care, types of care selected, quality levels of specific types of care, and in the focus of county-level quality improvement initiatives. This suggests there are important individual community strengths and limitations in child care for low income working families, and that future initiatives to improve quality should account for these variations.

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CHILD CARE FOR WORKING POOR FAMILIES: CHILD DEVELOPMENT AND PARENT EMPLOYMENT OUTCOMES

COMMUNITY CHILD CARE RESEARCH PROJECT DEPARTMENT OF CHILD DEVELOPMENT & FAMILY STUDIES PURDUE UNIVERSITY 2001-2004

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Introduction: Community Child Care Research Project

CHILD CARE FOR WORKING POOR FAMILIES: QUALITY, CHILD DEVELOPMENT, AND PARENT EMPLOYMENT OUTCOMES**INTRODUCTION**

While the effects of child care quality on low-income parents and their children are well documented, little is known about how local communities provided child care to low-income working families in the wake of the welfare reform of the mid-1990s. This research addressed this issue by studying the child care experiences of low-income working parents and their children (6 months to 6 years) in four communities in Indiana (Marion, Lake, Allen, and St. Joseph counties) during 2002 and 2003. The research employed an integrated design, including analysis of existing state- and county-level data, qualitative interview data, parent surveys, provider surveys, and researcher observations to describe and compare child care in these four diverse communities, identifying community-level variables that may affect the type and quality of care selected and used by low-income working families. We also describe the quality level of child care used by low-income working families in the four communities and relate these factors to parent employment patterns and children's developing competence (cognitive and social-emotional).

STATE CONTEXT

During the time data were collected for this study (2002-2003), Indiana provided a unique context for examining these issues. Although both center-based and home-based child care settings could be licensed, Indiana was and still is a state where a high proportion of child care settings are exempt from licensing. Indiana child care regulations exempt center-based child care settings from regulations if they operate as "child care ministries." Indiana law recognizes child care ministries as child care operated by a church or religious organization that is

exempt from federal taxation under Section 501c3 of the Internal Revenue Code. The religious organizations may choose not to become licensed by registering as a child care ministry. Another reason for abundant exempt care in Indiana is that home-based child care providers are not required to be licensed unless they care for six or more unrelated children (with one provider). Family child care homes are licensed for six to 12 children.

For family child care homes, caregivers were required to possess a high school diploma or a high school equivalency certificate (GED) to apply for a license. Since 2001, documentation was required that any new licensee had completed, enrolled in or agreed to complete within three years, a Child Development Associate (CDA) credential program or a similar program approved by the Division of Family and Children. For licensed child care centers, administrators were required to possess a college degree plus education and experiences in early childhood development including 15 college credit hours in early childhood education. Training requirements for licensed family child care providers included universal precautions, first aid, and one person on site to be pediatric CPR certified. Center teacher training requirements were the same but also included 12 hours of in-service training annually. Annual inspections for both family and center care included food, sanitation, health, program, and safety and fire. Child-adult ratios and group sizes for center- and home-based child care settings are displayed in Tables 1 and 2. For child care ministries, there was no educational requirement for administrators and no child-adult ratio requirement. Staff training requirements included only universal precautions and an annual inspection that included only fire.

TABLE 1. REQUIRED CHILD-ADULT RATIOS AND GROUP SIZES FOR INDIANA LICENSED CHILD CARE CENTERS

	Child-Adult Ratio	Maximum Group Size
Infants	4:1	8
Toddlers (18 to 27 Months)	5:1	10
3 years	10:1	20
4 years	12:1	24
5 years	15:1	30
School Age Children	20:1	30

COMMUNITY CONTEXT

In Indiana, child care spending decisions are often made at the county level. At the county level, Indiana's Step Ahead Initiative has also influenced child care. The purpose of Step Ahead was to develop a comprehensive, coordinated, seamless array of services for all young children, birth to 13, across the state. Each of Indiana's 92 counties was required to create a "Step Ahead Council" comprised of service providers, advocates, and families to make decisions about the provision and coordination of services. The assumption was that the needs and services in each county are different and, thus, solutions to improving the service delivery system are different. Step Ahead Councils were given the task of determining how Child Care Development Fund (CCDF) quality dollars were to be spent in each county. There were five priorities eligible for funding (increase awareness of child care issues, develop partnerships between business and the public sector around child care, increase child care capacity, increase the number of credentialed providers, and reduce child care staff turnover). Each county could decide which priorities would be their focus and what percentage of the CCDF quality improvement funds would be allocated to the priorities selected. Although all five of these priorities address important issues, several are more directly relevant to quality (e.g., increasing the number of credentialed providers) than others (e.g. increasing awareness of child care issues).

CRITICAL ISSUES FOR CHILD CARE USED BY LOW-INCOME WORKING FAMILIES

- **Quality Child Care is Important for Children's Development:** High quality child care can be an important contributor to children's development. Extensive research in child care and early childhood education conducted over the past 20 years has clearly demonstrated

strong, positive relationships between a variety of quality measures and various dimensions of children's development and well-being. (Lamb, 1998; Love, Schochet, & Meckstroth, 1996; NICHD, 2003; Scarr & Eisenberg, 1993; Vandell & Wolfe, 2000).

- **The Child Care Context is Different for Low-Income Working Families:** Low-income families are also more likely than middle class families to need "irregular" or flexible child care. In other words, they need child care that covers second and third shift work, changing shifts, etc. Formal child care settings are least likely to accommodate these needs (Phillips, 1995). Therefore, forms of informal, home-based care become more attractive to low-income families. Among families who have selected home-based care for their children, lower income and ethnic minority families are more likely than their white, middle-class counterparts to use relatives rather than regulated family child care providers, and were less likely to pay for care (Kontos, Howes, Shinn, & Galinsky, 1997). Therefore, low-income children are more likely to be cared for in legally exempt (not required to meet state licensing requirements) or illegal care (Helburn & Bergmann, 2002). The type of child care families select has implications for quality of the care they receive.
- **Children of low-income working families attend lower quality child care:** Although significant progress has been made in equalizing access to child care since the 1960s, including the expansion of Head Start and other state funded preschools for families living near or below poverty live, there are still disparities in the quality of care used by families at different income levels. Relative care, which is

TABLE 2. REQUIRED CHILD-ADULT RATIOS AND GROUP SIZES FOR INDIANA LICENSED FAMILY CHILD CARE HOMES

Age Range	Adult-Child Ratio for Licensed Family Child Care	Maximum Group Size for Licensed Family Child Care
Birth to 24 months	(6:1) [two of the 6 children must be at least 16 months and walking. Otherwise the ratio is 4:1]	Number of children allowed: 13-16;
Birth to 6 years	(10:1) [No more than 3 of the 10 children may be under sixteen months of age and must be walking]	Provider's own children are counted if under age 8
3-10 years	(12:1)	
All ages	(12:1) [the maximum capacity in a child care home is 1:12 plus 3 children during the school year who are enrolled at least in Grade 1]	

often utilized by low-income families, has been found to be significantly lower in quality than regulated family child care (69% of relatives were providing inadequate quality care). Kontos and colleagues (1997) found that a little less than half (43%) of low-income families using home-based care were receiving low quality care compared to 13% of their middle income counterparts.

- Low-Income Children Benefit from High Quality Early Care and Education but Frequently Lack the Opportunity to Participate in Such Settings:** Based in part on the early intervention literature, it has been assumed high-quality community-based child care can serve as a protective factor for children at risk for impaired development due to risk factors such as low parental education, minority ethnic background, single parent homes, and poverty (Lamb, 1998). Several studies have reported differential effects of child care on cognitive or language development related to socioeconomic status or family structure (Peisner-Feinberg & Burchinal, 1997) and ethnicity (Burchinal, Ramey, Reid, & Jaccard, 1995; Peisner-Feinberg & Burchinal, 1997). These researchers found the effects of child care are stronger for preschool children from less advantaged circumstances.
- Welfare Reform and Other Policies Have Brought Child Care to the Forefront of Concerns for Low-Income Working Families:** The implementation of welfare-to-work programs has placed new strains on the child care system. Income levels in Indiana, amount of child care subsidy funding, and rates of employment of low-income families post-welfare reform have resulted in a situation where the vast majority of families receiving subsidies are at 100% of poverty level or below (Janet Deahl, Educare consultant, Indiana Family Social Services Administration, personal communication, June, 2001). Few low-income families whose incomes are above 100% of poverty are receiving subsidies for their child care needs. This is a situation that has a major impact on low-income working poor families who must pay a large proportion of their income for child care in order to stay in the workforce. Focusing on child care for low-income families is particularly important as welfare reform continues and the demand for child care on the part of families transitioning from welfare to work increases (Collins, Layzer, Kreader, Werner, Glantz, 2000; Zaslow, Oldham, Moore, Magenheimer, 1998).

- Not Enough is Known About the Child Care Settings Utilized by Low-Income Working Families:** Little is known about how the child care market works for low-income working families. The differences in availability of non-parental care for different kinds of families has been well documented; however, less is known about the roles state policies and local contexts may play in affecting quality of available care. State policies that govern child care regulation as well as community-level contextual variables (such as use of federal child care dollars, availability of regulated versus exempt child care, employment rates, availability and saturation of child care subsidy funds, and diversity) are among the forces that may be affecting quality of child care.

RESEARCH DESIGN AND METHODOLOGY

The study was conducted in four urban communities in Indiana: Marion (Indianapolis), Allen (Fort Wayne), Lake (Gary, Hammond, East Chicago), and St. Joseph (South Bend) counties. These communities were chosen because they were abundantly populated with varying availability of licensed and unlicensed child care. During phase I of the research, 22 community key informants were interviewed, eight parent focus groups were conducted, 188 low-income working parents were surveyed, and existing community data were analyzed to describe child care utilization and to identify important community child care context variables for low-income families. Then, during phase II of the research, 307 low-income working families whose young children were in out-of-home child care (approximately 76 in each community; split between infants/toddlers and preschool-age children) and their child care providers in the communities were assessed, including rigorous measurements of child care structural and process quality, children's cognitive and social-emotional competence, and parents' employment patterns. (See Appendix A, Methodology, for detailed descriptions of procedures and measures.)

The families who participated in the study were recruited by research assistants in public places (public libraries, community centers, etc.), schools (vocational-technical, GED classes, state university, etc.), and government agency offices (workforce development services, WIC, Child Care and Development Fund (CCDF) voucher offices; etc.). Attention was given to recruiting an equal number of families in each community (approximately 76 in each community) and equal numbers of families with infants/toddlers and preschool-age children. A total of 307 low-

income working families whose young children were in out-of-home childcare were recruited to participate.

Several eligibility criteria were established to ensure the sample represented low-income working families with young children in out-of-home care. The criteria included:

- Annual family income was less than \$35,000.
- The head of the household was working (work, school, or job training totaling at least 20 hours per week).
- The family had a child between 6 months and 6 years old, and the child was in out-of-home care at least 15 hours per week for the past two months.
- The family was not on TANF (Temporary Assistance for Needy Families).
- The child care provider agreed to participate.

SURVEY MEASURES AND INSTRUMENTS

Phase I of the research had four main components: community child care leader semi-structured telephone interviews, parent focus groups with low-income working families, parent surveys of potential participants, and review of existing community data. The community child care leader interviews addressed issues from the perspectives of the family, the child care provider, and the community. Parent focus groups explored current child care arrangements and issues such as supplemental child care, flexibility of child care, and financial resources, as well as the parents' perceptions of ideal child care and what communities do to support families. Parents completed a brief, self-administered questionnaire about their employment status, income, number of children, and child care utilization, including difficulties with child care arrangements, employer assistance with child care, and how current arrangements could be ideal. Existing community data included community child care supply, employment level and wealth, availability of child care resources and referral, and availability and utilization of child care subsidy funds as well as the overall diversity of the community.

Phase II of the research included the child assessment, parent survey, caregiver survey, and classroom observations. The child assessments included the major components of cognitive and social-emotional development and were collected through direct child assessments and rating scales completed by parents and caregivers. The parent survey was designed to measure parent employment patterns, the parent's perceptions of child care and work, the parent's relationship with the caregiver, and their child's social and emotional development. The caregiver survey

was designed to gain information about their specialized training and experience in child care work, relationship with the child and their parents, and ratings of each child's social and emotional development. Classroom observations collected data on both structural and process quality of the care environment as well as children's play, social interaction and talk while in child care. (See Appendix A, Methodology, for detailed descriptions of procedures and measures.)

OVERVIEW OF PROJECT

The current document is a report of the Community Child Care Research Project (CCCRP) funded by the U.S. Department of Health and Human Services/Child Care Bureau. Subsequent chapters describe:

- Community contexts, including economic conditions and experiences of low-income working families in these four Indiana communities;
- The characteristics of the low-income working families, children and child care settings, and caregivers who participated;
- The child care experiences of low-income working families, including child care utilization, issues, problems, and solutions and variations in the child care context among communities;
- The quality of child care in the four communities and variations among communities;
- The children's social and cognitive competence, the relationship between child care quality variables and children's competence, and how the relationships vary across child care settings and communities; and
- The parents' employment and education patterns, the relationship between child care quality variables and parent employment and education patterns, and how the relationships vary in different child care settings and communities.

REFERENCES

- Burchinal, M. R, Ramey, S. L., Reid, M. K, Jaccard, J. (1995). Early child care experiences and their association with family and child characteristics during middle childhood. *Early Childhood Research Quarterly*, 10, 33-61.
- Collins, A. M., Layzer, J. I., Kreader, J. L., Werner, A. Glantz, E. B., (2000). *National Study of Child Care for Low-Income Families. State and Community Substudy Interim Report*. Bethesda, MD: Abt Associates, Inc.



- Helburn, S., & Bergmann, B. (2002). *America's child care problem: The way out*. New York: Palgrave.
- Kontos, S., Howes, C., Shinn, M., Galinsky, E. (1997). Children's experiences in family child care and relative care as a function of family income and ethnicity. *Merrill-Palmer Quarterly*, 43, 386-403.
- Lamb, M. (1998). Nonparental child care: Context, quality, correlates, and consequences. In I. Sigel & A. Renninger (Eds.), W. Damon (Series Ed.), *Handbook of child psychology: Vol. 4 Child psychology in practice* (5th ed., pp. 73-133). New York: Wiley.
- Love, J. M., Schochet, P. Z., Meckstroth, A. L. (1996). *Are They in Any Real Danger? What Research Does--and Doesn't--Tell Us about Child Care Quality and Children's Well-Being*. Child Care Research and Policy Papers. Princeton, NJ: Mathematica Policy Research, Inc.
- NICHD Early Child Care Research Network & Duncan, G. (2003). Modeling the impacts of child care quality on children's preschool cognitive development. *Child Development*, 74, 1454-1475.
- Peisner-Feinberg, E. S., & Burchinal, M. R. (1997). Relations between preschool children's child care experiences and concurrent development: The cost, quality, and outcomes study. *Merrill-Palmer Quarterly*, 43, 451-477.
- Phillips, D. A., (1995). *Child Care for Low-Income Families: Summary of Two Workshops*. Washington, DC: National Academy Press.
- Scarr, S., Eisenberg, M. (1993). Child care research: Issues, perspectives, and results. *Annual Review of Psychology*, 44, 613-644.
- Vandell, D. L., & Wolfe, B. (2000). *Child care quality: Does it matter and does it need to be improved?* Retrieved January 10, 2003 from the United States Department of Health and Human Services Web site: <http://www.aspe.hhs.gov/hsp/ccquality00/ccqual.htm>.
- Zaslow, M., Oldham, E., Moore, K. A., Magenheimer, E. (1998). Welfare families' use of early childhood care and education programs, and implications for their children's development. *Early Childhood Research Quarterly*, 13, 535-563.

Chapter 1

CHILD CARE FOR LOW-INCOME WORKING FAMILIES: FOUR COMMUNITY PROFILES

The first phase of the Community Child Care Research Project consisted of gathering information about the child care contexts of four Indiana communities: Marion, Lake, Allen, and St. Joseph counties. To provide an initial picture of these four communities in relation to child care, we examined existing community data and child care indicators available for the communities, conducted qualitative interviews with community child care leaders and low-income working parents, and did a brief non-random survey of potential parent research participants. Together, these sources provided a preliminary look at the child care perspectives of the families, the child care providers, and the larger community. We reviewed information about community child care supply, employment levels and income, availability of child care resources and child care subsidies, as well as current child care financial resources, utilization, and problems.

WHAT IS THE OVERALL DEMOGRAPHIC AND WELL-BEING PROFILE OF EACH COMMUNITY?

There were both commonalities and differences in the overall populations and in well-being indicators of the four communities during the 2002-2003 time frame of data collection. The **Marion County** site contained the largest population of Indiana's 92 counties at 862,499 people. It is home to Indiana's capital city, Indianapolis, which accounts for 91% of the county's population and is located in the geographic center of the state. According to 2000 U.S. Census data, nearly three-fourths of the population (71%) was European American, while African Americans (24%) and Latinos (4%) were the largest minority groups. Just over three-fourths of the adult residents were high school graduates (77%) and nearly one-fourth held college degrees (21%).

Lake County is Indiana's second most populous county with 485,851 people. The largest city in the county is Gary, home to nearly one-fourth of the county's populace. We also collected data in two other cities of significant size: Hammond and East Chicago. Lake County is located in the northwest portion of the state, sharing a border with Illinois and Chicago. Two-thirds of the population was European American, while African Americans (25%) and Latinos (12%) composed the largest minority groups. The majority of the adult population were high school

graduates (81%) and 16% held college degrees.

Allen County is located in the northeast portion of the state and is Indiana's third most populous county, occupied by 337,310 people. Fort Wayne is its largest city and is home to nearly two-thirds of the county's populace. Eighty-three percent of the population was European American, while African Americans (11%) and Latinos (4%) composed the largest minority groups. The majority of adults were high school graduates (86%) and nearly one-quarter held college degrees (23%).

Finally, **St. Joseph County**, located in the north central portion of the state, is Indiana's fourth most populous county with 266,378 people. South Bend is its largest city and is home to 40% of the county's populace. The majority was European American (82%), while African Americans and Latinos comprised the two largest minority groups (11% and 5%, respectively). Over three-fourths of the adults were high school graduates (79%) and 14% held college degrees.

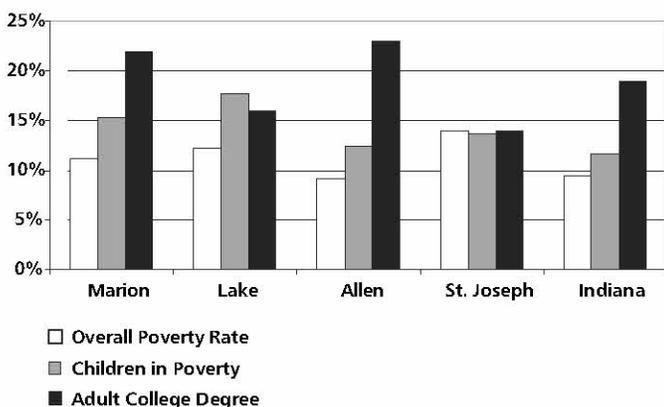
A noticeable difference among the communities was the percentage of minority population. All four communities had minority populations above the Indiana average (16%); however, greater proportions of minorities resided in Marion and Lake counties (30% and 33%, respectively) while Allen and St. Joseph counties were much closer to the state average (17%, 18%, respectively).

The proportion of families receiving Temporary Assistance for Needy Families (TANF) varied among the four counties. Three counties reported a greater percentage of families than the overall state average (6.2% of families with children under 18). The percentage of families with children receiving TANF ranged from 6% in Allen County to 16% in Lake County. St. Joseph and Marion counties fell between, reporting 8 and 11%, respectively. The four community sites were similar in unemployment rates (5%-7%), median household and per capita income (per capita income averaging around \$29,000 with median household income around \$41,000), and percentage of households headed by single parents (9-11%). Although a little less than 10% of all households in Indiana were headed by single parents at the time

of this study, 51% of low-income families (income at or below 200% of poverty level) in Indiana were headed by a single parent.

In general, poverty rates among the four communities were similar (9-12%); however, differences emerged when the percent of children living in poverty was considered. Figure 1.2 displays poverty rates for the four communities. Table 1.1 displays the rank order of the communities on key indicators. All communities were above the Indiana average percentage rate for children in poverty (12%); Lake County had the highest percentage (18%) while Marion, St. Joseph, and Allen counties followed with 15%, 14%, and 12%, respectively). While almost 12% of children under 18 lived in poverty in Indiana, 42% of Indiana children under age 6 lived in low-income families. Many low-income families (61%) included at least one parent who was employed full-time

FIGURE 1.1 POVERTY RATES, PERCENT OF CHILDREN IN POVERTY, AND PERCENT OF ADULT COLLEGE DEGREES^a



year round. Only 10% of low-income families included no employed parents (U.S. Census, 2003). Therefore, a large number of families must rely on non-parental care for their children while they work. See Well-being Indicators of Indiana and the Four CCCRP Communities (Table B1) in Appendix B.

WHAT ARE THE CHILD CARE EXPERIENCES OF LOW-INCOME WORKING FAMILIES IN THESE FOUR COMMUNITIES?

During Phase 1 of the Community Child Care Research Project, we reviewed existing community data, conducted interviews with community child care leaders (key informants) in each county, held focus group interviews with low-income working parents, and asked parents in public places to fill out a brief questionnaire. We used these data sources to construct descriptive profiles of the child care context for low-income working families in each of the four communities.

EXISTING COMMUNITY DATA

The availability of child care and utilization of child care vouchers in the four communities were examined using data compiled by the Indiana Youth Institute (2003). The number of licensed child care slots available per 100 children ages 0-4 ranged from 22 in Allen County to a little over 35 in Marion County. Lake and St. Joseph counties fell between these figures (24 and 30, respectively). These figures suggest families in Allen and Lake counties had less availability of licensed care for young children, while those in Marion and St. Joseph had a more adequate supply of licensed care. The percentage of children receiving child

TABLE 1.1 RANK ORDER OF COMMUNITIES' KEY INDICATORS, U.S. CENSUS DATA

Community	Marion	Lake	Allen	St. Joseph
Population, 2002 ^a	1	2	3	4
Percent of population in minority ethnic groups, 2002 ^a	2	1	4	3
Percent of households headed by single parents, 2000 ^a	1	2	4	3
Median household income, 2000 ^a	3	2	1	4
Overall poverty rate, 2000 ^a	2	1	4	3
Percent children in poverty, 2000 ^a	2	1	4	3
Unemployment rate, 2002 ^b	2	1	3	3
Number of licensed child care spaces per 100 children, age 0-4, 2002 ^b	1	3	4	2
Ratio of children receiving child care vouchers to waiting, 2002 ^b	4	1	2	3
Percent of children receiving child care vouchers with family income 100% poverty or below, 2002 ^b	4	2	3	1

^a U.S. Census Bureau, 2002. ^b Indiana Kids Count, 2003, Indiana Youth Institute. NA = data not available.



care vouchers who came from families with incomes at or below 100% poverty level ranged from 54% in Marion County to 78% in St. Joseph County. Allen and Lake counties were 63% and 77%, respectively. The ratio of the number children receiving child care vouchers to the number of children on waiting lists showed a similar pattern for the counties. Marion reported the smallest ratio (or relatively largest waiting list; 3:1) while Lake reported the greatest ratio (or relatively smallest waiting list; 38:1). St. Joseph and Allen counties reported ratios of 5:1 and 9:1, respectively. Therefore, of these four counties, it appeared child care subsidies were most available to low-income working families in Lake and St. Joseph counties, and least available to low-income working families in Marion and Allen counties. It is unclear whether this was a reflection of differences in the service delivery of vouchers, differences in funding levels, or differences in the demand for child care by families in the four communities.

There were differences in the types of child care parents purchased with vouchers in the communities. Allen County used child care vouchers relatively more often for home-based child care, which supported the community's apparent preference by low-income families for this type of child care. Allen County also used child care vouchers for exempt center care (i.e., child care ministries) considerably less than the other communities.

The use of child care vouchers varied by community and the child's age. St. Joseph County used the largest percentage of child care vouchers for toddlers and preschoolers (37%). Marion, Lake, and Allen counties used the largest percentage of child care vouchers for school-aged children (43%, 40, and 39%, respectively). Infants (12 months and under) comprised the smallest group using vouchers (ranging from 3% to 12%) in these communities. This could be due to the parents' preferences to stay home with their children at young ages, or to place them in more informal care arrangements, or perhaps a lack of knowledge about child care vouchers among parents of infants. Table B2, presenting an overview of child care data at state and community levels, is included in Appendix B.

COMMUNITY CHILD CARE LEADER INTERVIEWS

Semi-structured telephone interviews were completed with 22 community child care leaders—or key informants—from Marion, Lake, Allen, and St. Joseph counties, including five or six in each county. (See the list of key informants' positions, listed by county, in Appendix B.) Key informants were identified as

individuals who had knowledge and expertise in child care or the needs of low-income working families. They included representatives from Purdue Extension, a county official from the Division of Families and Children, members of the local Step Ahead coordinating council, business human resource specialists, representatives of WIC offices, representatives of the Child Care Resource and Referral Agencies, and a professor of psychology at a local university who works closely with early education and care programs.

The key informant interviews addressed child care issues from three perspectives: the family, the child care providers, and the larger community. Questions about the family perspective addressed the strengths and weaknesses of the community child care context, needed child care services, and child care subsidies. Questions about the child care provider perspective included training, resources, support, and quality. Questions about the larger community perspective addressed unique features of the community and ways that might best address the child care issues of the community. (Interview questions are listed in Appendix A.)

In all communities, key informants identified insufficient funding for child care subsidies; concerns about child care quality, especially infant-toddler care; and lack of extended hours and sick care as critical issues. While Marion key informants were mainly concerned about the quality of unlicensed ministries in their communities, St. Joseph informants expressed concerns about quality of both unregulated center care and unregulated relative care. Marion informants also identified the lack of funding for child care provider training resources as a critical issue. Lake informants expressed a need for more bilingual-bicultural care, reflecting the higher percentage of Latino residents in that county. Allen informants reported being concerned about the disparity of child care services between rural and urban areas, but praised the existing well-coordinated community services and strong partnerships among good providers. The following provides a summary of findings from the key informant interviews from each community:

Key informants identified insufficient funding for child care subsidies; concerns about child care quality, especially infant-toddler care; and lack of extended hours and sick care as critical issues.



MARION COUNTY

- **Strengths and Weaknesses of Community:** The strong collaboration of many diverse leaders and their willingness to join the effort for better child care were mentioned as strengths. One informant remarked, “In Marion County, people tend to be more politically savvy, and networking is part of the culture.” The large number of unregulated ministries, and a lack of adequate child care funding were identified as concerns.
- **Needed Child Care Services:** Weekend care, sick child care, second shift care, and child care for parents to attend school and job training were needed. Infant and toddler care appeared to be problematic, in particular, because young parents who are more likely to be poor, and thus least able to afford more expensive infant-toddler child care, were also most likely to have children in this age range.
- **Child Care Subsidies:** Even though every available resource was being fully utilized, subsidized care for low-income working families was considered to be insufficient.
- **Child Care Provider Needs:** Supports for training, incentives to education, mentoring programs, workshops and demand for higher standards were needed. One informant commented, “Even if efforts quadrupled in some instances, there would still be only minimal coverage of the need for training and education.”
- **Quality of Child Care:** The perception of key informants was that the general quality of care in Indianapolis is slightly above average. However, they expressed particular concerns about the quality of rapidly expanding unlicensed child care ministries.
- **Unique Features:** Because Marion County is the administrative seat of the state, unique features include the presence of a large bureaucracy, a distinctively different atmosphere between the center and the neighborhoods, as well as some of the problematic characteristics of large urban metropolitan areas, such as coordinating services for a large population.
- **Needs for the Future:** More business involvement, more training for quality, and increased enforcement of child care regulations were identified as needs.

LAKE COUNTY

- **Strengths and Weaknesses of Community:** Strengths included a strong caregiver network, a core group of people promoting quality for child care staff, and a large number of informal home-based child care providers. Concerns included low pay for child care providers, and the lack of regulated care.
- **Needed Child Care Services:** Care for infant/toddlers, non-traditional hours care (i.e., evening care, 24-hour care, drop-in care, etc.), child care for children with special needs, better quality school-age care, sick child care, and bilingual/multi-lingual care were identified as needs. Also identified were more licensed care, more accredited centers, and better outreach to low-income families, especially families in East Chicago, Hispanic families, and families on TANE. Licensed center child care was thought to be viewed by many parents as unapproachable, because of its high cost. Therefore, many parents preferred the use of license-exempt providers close to the family such as relatives, friends, and neighbors.
- **Child Care Subsidies:** Some believed subsidies were sufficient, while others cited large waiting lists as a barrier to families receiving the subsidies they need. Children requiring voucher-subsidized child care in Lake County represented 25% of all Lake County children. However, in densely populated, poverty dense areas of East Chicago, Gary, and Hammond, all of the children from families served by child care providers were voucher recipients. Consequently, child care providers in those areas relied solely on voucher dollars to provide care.
- **Child Care Provider Needs:** Better provider training (e.g., availability of a bachelor’s level program in early childhood education, Child Development Associate (CDA) certification, etc.) and better compensation and benefits were needed. There was also a need for facility improvements, new materials, and transportation resources for the children served.
- **Quality of Child Care:** No consensus. Most indicated there were good quality child care settings, but much room for improvement.



- **Unique Features:** No consensus. Some expressed Lake County was like any other metro area while others identified the following unique features: heavy reliance on in-home familial care as opposed to relative and non-relative home-based care, low educational level of child care providers, concerns about safety, the largest and most rapidly growing concentration of Hispanic families of any Indiana county, and a high unemployment rate due to steel mill closings.
- **Needs for the Future:** Licensed commercial child care programs had difficulties providing competitive wages and benefits to employees because of the instability of a client population that selects the lower cost options of license-exempt family or neighborhood-based care as an option. More licensed child care centers and more support for centers; better-coordinated/organized resources and education including better, locally-controlled child care resource and referral services; and better quality monitoring (regulations for child care homes and centers) were mentioned as needs for the future.

ALLEN COUNTY

- **Strengths and Weaknesses of Community:** Strengths were found in partnerships, a well-functioning child care resource and referral agency, coordinated services to children and families, and a strong partnership of providers and businesses interested in child care issues. Weaknesses included insufficient high-quality child care spaces for low-income working families.
- **Needed Child Care Services:** Care for school-age children during school vacations, sick child care, and second shift care were needed.
- **Child Care Subsidies:** Resources were being fully utilized, but there were not enough subsidies to go around, and there is a fear it will get worse.
- **Child Care Provider Needs:** Key informants were mostly satisfied with current efforts to train providers and attend to child care quality issues. There was a wide variety of choices, including programs like CDA credentials and other helpful processes such as mentoring for providers interested in becoming accredited, but there is a need for more providers to use the resource.

- **Quality of Child Care:** Child care quality in Allen County was perceived on a continuum ranging from fair to good, with a few excellent programs.
- **Unique Features:** Low-income families preferred child care arrangements within family settings, particularly for their younger children. As children get older, parents begin to look for a place that emphasizes education more. Center-based care was less preferable because it is perceived as bad, impersonal, and less safe, fueled by widely circulated news reports about children's maltreatment in one or two centers. Informants expressed the opinion that child care preferences of low-income families in Allen County were not likely to change, under the current funding system, because parents would still choose the same arrangements if it translated into income for a friend or a family member.
- **Needs for the Future:** Assisting families by offering living wages, tying child care funding to quality, and making it worthwhile for providers to get accredited by attaching higher value to their services were efforts needed, according to our key informants.

ST. JOSEPH COUNTY

- **Strengths and Weaknesses of Community:** Child care resources were present in the community, but they were not necessarily accessible to low-income working families. Barriers for these families included cost of care, finding quality licensed care in a convenient location, and locating Child Care Resource and Referral (CCR&R) services.
- **Needed Child Care Services:** Sick child care, school-age care during school vacations, second shift care, and care for special needs children were needed.
- **Child Care Subsidies:** There were not enough child care subsidies to meet the need. The need was perceived to be greater for low-income working families than for families on TANF. Because TANF families receive priority on child care vouchers, families who qualified for vouchers but were not on TANF may have to wait a year or more to receive it. Child care resource and referral services were understaffed as well, which exacerbated the subsidy gaps.

- **Child Care Provider Needs:** Affordable and accessible consultants and training, such as provided by Teacher Education and Compensation Helps (T.E.A.C.H.) Scholarships, as well as better information on what is available were needed.
- **Quality of Child Care:** Licensed child care sites were considered average or above average in quality. Concerns were expressed about the quality of unregulated center care and relative care.
- **Unique Features of Community:** Some could not identify unique features of this community; others mentioned a high availability of child care and good awareness of child care issues within the community.
- **Needs for the Future:** More funding to reduce the child care voucher waiting list, increased training for providers, and more employer involvement in child care issues were needed.

PARENT FOCUS GROUPS

Two parent focus groups were conducted in each community. A total of 46 parents participated in the focus group interviews in St. Joseph, Marion, Allen, and Lake counties (n = 9, 9, 8, 20, respectively). Focus groups took place in public libraries, job training centers, and child care centers. They were comprised primarily of clients of these agencies. The focus group interviews proved to be valuable sources of information, as parents were eager to share their ideas, concerns, and suggestions with the researchers. Questions used to guide focus group discussions are presented in Appendix A.

Focus group parents in all four communities expressed concerns about quality of child care. Most parents in the focus groups wanted a better quality child care arrangement for their children, but felt they had few options. Still, most parents commented they were satisfied with their current child care arrangement. These parents negotiated a number of significant issues while supporting the well-being of their children. One mother elected to keep her child in a less than ideal child care setting because her daughter had already endured a number of life changes including adoption, diagnosis of a chronic illness, and recently losing her father. To this mother, staying in the same setting regardless of quality provided long sought after stability for her child. A necessary **reliance on families, friends, and neighbors for**

supplemental care was expressed. One mother remarked, “It is kinda hard. I am relying on friends to pick him up and drop him off.” Still other parents reported not having back-up child care available to them on a predictable basis. **Lack of extended hours, flexibility, and sick care for their children** were also mentioned as

critical issues in their communities. A parent of the child diagnosed with a chronic illness expressed her frustration with changing jobs and settling for a lower paying job in order to have more flexibility and time with her child. “You can’t take a sick day for your child because they (the employers) say, ‘We didn’t hire your child.’” Another mother

expressed her frustration with the inflexibility of child care hours and the difficulty of getting basic family tasks done. “But in the evening, because I work far south and I get off at five, and it’s flooring it to get here (the child care center) at a decent time, where I know that I gotta get here on time. So it would be nice sometimes to know that, you know, it’s okay, it’s Tuesday, um, my kids can be there, um, I gonna do my grocery shopping.”

Some parents reported being satisfied with the **amount of financial support** they received for child care, while others were not. Parents reported they relied heavily on child care subsidies to make ends meet and keep food on the table for their children. One mother remarked, “You know, look at us, we are all single mothers. We all work 40 to 50 hours a week just to pay the rent and wonder if we are going to have enough groceries for the following week. Boy, boy, oh boy, I don’t know what I would do (without child care subsidies).” Many parents, however, expressed **frustration with the child care subsidy income requirements**. Parents felt there was a disincentive to get a promotion or get a better job. One mother summed it up, “So I can’t even afford to get any extra money, because I can’t afford to go without child care. If I make anything more than what I make (now), they’ll pull my child care. I know I could make more money if I wanted to, but it won’t balance out to where I could get child care. I mean even a nickel or 10 cents more an hour.”

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Although there were similarities among the four communities, unique issues were identified within these parent focus groups in each community. **Marion County** parents expressed a preference for center child care and reported being satisfied overall with their current arrangements, stating ideal arrangements are the ones currently keeping their children safe and allowing them to go to work. Ideal care would be open all the time and would have flexible drop-off and pick-up times. The “flexibility” parents needed in their current child care arrangements was primarily found in supplemental care provided by relatives. Some commented on changing their work schedule to make their child care arrangement work, and doing things for themselves such as studying for school after their children had gone to bed. Cost and location were important factors in selecting child care arrangements. Most had gone through a process of using different settings to arrive at an arrangement acceptable to them. Their expectations changed with the age of their child, but many reported the relationship with their child’s caregiver as central to their appraisal of the quality of their arrangement.

Stability in a caregiver was very important to Marion County parents, and they felt caregivers should be paid more so there would be less turnover and greater stability for their children. One parent commented, “I am very pleased with the way my kids are progressing here, but sometimes I wish I could be a fly on the wall and I could see everything that happens here. I don’t like that sometimes a lot of teachers are coming and going. I would like for them to get some good teachers and pay them a little more so that they can stay.” Marion parents also expressed a need for education about parenting as well as about services available to help low-income families. One mother observed, “You know, they need to show like a commercial, ‘If you qualify for this program and send your child to day care, so you can get to work,’ ‘cause I think that is why a lot of women sit at home. Because they’ve been thinking, ‘I have to pay all this money for it.’”

Lake County parents reported using a variety of child care arrangements, but most cited a close relative as their primary child care. Perhaps due to the reliance on relative care, parents in these groups did not indicate problems with flexibility in child care. They felt their mothers, sisters, and other relatives would take their child when needed. Trust in their child’s caregiver was also an important issue, which provided some explanation of their reliance on relative care. Parents had many concerns about their child’s health and safety in child care centers, especially for infants. Fears about maltreatment were also expressed. It seemed

their concerns were derived from their mistrust of caregivers whom they do not know. One mother stated, “You look at the baby and you’re, like, ‘What happened?’ And she’ll (the caregiver) be like, ‘Well, she fell is how this happened,’ but that’s not what happened.” However, relative care was not without its problems. For example, the issue of discipline was discussed. Parents felt their relative did not have the same disciplinary style and there would be inconsistency between what the child was allowed to do at home and allowed to do at child care. Negotiations about disagreements like these with relatives can be difficult, because the relative is often providing free care and has set ideas about child rearing.

Transportation was also heatedly discussed in the Lake County groups. Parents reported difficulties taking their child on the public transportation system because of its unreliability. The high cost for taxis or buses to and from child care and school or work was also problematic for parents. One mother said, “Anybody who stays here knows that if you don’t have your own transportation, you can’t depend on the public (transportation).” Another parent shared, “I take a cab to my mother’s house. And then I take a cab back home. Then I get on the bus to come to school. That’s what I go through everyday. Sometimes she (her mother) will keep my kids for three days in a row ... so I don’t have to keep coming back.” The lack of availability of child care settings

accommodating children with special needs (i.e., feeding tubes, etc. as well as enough staff in classrooms) was also mentioned. One mother recounted, “My son is on a machine. He had a hard time breathing when he was, like, 5 months old, and every day care I went to, we came in, he had that big old bag with him, and it was like, ‘We don’t do that, we don’t do that.’” According to these Lake County parents, ideal care would include non-traditional hours care on evenings and weekends, drop-in care to give them time to run errands, and reliable transportation to and from child care.

“I take a cab to my mother’s house. And then I take a cab back home. Then I get on the bus to come to school. That’s what I go through everyday. Sometimes she (her mother) will keep my kids for three days in a row ... so I don’t have to keep coming back.”

Allen County parents identified a preference for home-based care and a shortage of infant/toddler care. One mother related, “Most places (child care settings) I called, they wanted them 1 and walking or 3 and potty trained. I couldn’t find anywhere to take him.” In an ideal world, these parents said, they would stay home and be with their children. Even if families were receiving services, they still needed to supplement the child care cost. Parents also talked about “the vicious circle”—the impossible situation of needing a job to get money for child care and needing child care to get a job. It remains largely a puzzling problem for these parents. They seemed particularly disturbed with the idea of having to put their children in child care so they may keep their services, while not trusting the placements they could afford. They reported feeling as if they had to give their babies up, and had no control over who goes in and out of the places that they can afford. This seemed to be one of the major reasons they elected to keep children in the family or stay at home with them. They did not agree with the time limitations placed on public assistance, because they felt young mothers were very vulnerable for a long time, and the two-year benefits limit was not a fair option. The possibility of being laid off work or having their husband leave them are high, and this places young mothers in an extremely precarious situation. There were also concerns about quality of child care: “More money does not necessarily mean better child care; it just means better toys to play with, more field trips, more things.”

St. Joseph parents reported using a mixture of home-based and center-based care. Parents expressed some concerns about quality, but were for the most part satisfied with their current child care arrangements and believed that their community was doing enough about child care. However, they also said ideal child care would consist of longer hours, in-home care, and more assistance in paying for care. Consistently, parents of older children were concerned with the educational aspects of child care, just as the parents of younger children were concerned with the warmth and trust dimensions of their child care. Cleanliness and hygienic conditions were also an issue. Parents reported being distraught when they picked up their children at the end of the day, and they had not been kept clean. One parent reported, “And I don’t like the part that I come in there every day to get my daughter. My daughter’s face is filthy. And I’m, like, ‘Oh my god, what is all over you?’ And she (the caregiver) is like, ‘We gave her a wipe, but she preferred to clean the table with it instead.’ Okay, so why didn’t you grab another one and wipe her face?”

SUMMARY: COMMUNITY CHILD CARE LEADER AND PARENT FOCUS GROUP FINDINGS

Table 1.2 provides a side-by-side comparison of themes identified in the parent focus groups and key informant interviews for each community. There was some congruence between parents and key informants on critical issues. Key informants and parents in Marion both identified the importance of additional child care subsidies and the need for extended care hours. Lake informants and parents both expressed concerns about child care quality and the need for extended hours, flexibility, and sick child care. Informants and parents in Allen both identified concerns about the quality of care available to low-income families. St. Joseph informants and parents reported a frequent reliance on relative and informal care.

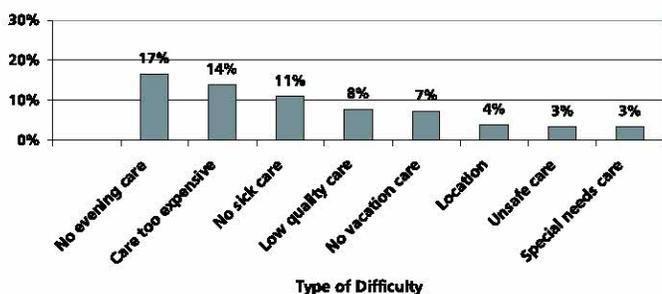
Parent surveys

A total of 151 low-income working parents completed a brief, self-administered, structured questionnaire about child care utilization. Low-income working parents were recruited in public places such as local agencies and organizations that served low-income working families, from employers who hire low-wage workers, and through local job training programs in each community.

Parents were given a list of difficulties with child care arrangements, a list of employer assistance with child care, and a list of how their current arrangements could be ideal. They were asked to indicate which items applied to them. Forty-eight of the responding parents were also focus group participants. Only one respondent was male. Participation level varied by community. The largest response was in St. Joseph County ($n = 72$). From Marion, Lake, and Allen counties, 32, 30, and 17 parents completed these surveys, respectively.

In general, parents reported using one caregiver in the past week ($M = 1.19$). However, a small number reported using up to six caregivers. One-third of the respondents (33%; $n = 50$) reported at least one difficulty with their child care arrangements. Figure 1.2 presents the difficulties parents identified. The most common difficulties were lack of evening or night care, too-expensive child care, and no sick child care available.

FIGURE 1.2 PARENTS' REPORT OF CHILD CARE DIFFICULTIES (N=151)



Problems with child care clearly affected a significant portion of low-income working parents' work performance. Thirty-five percent of the respondents (53 parents) reported their child care problems had directly affected their work. Of those whose work had been affected by child care problems, 70% reported they had to leave work early, while 62% reported missing days of work because of these problems. On average, parents reported approximately one day of work missed in the past year due to child care problems, but some parents reported missing as many as 14 days of work. Overall, parents reported leaving work early approximately two days in the past year, but some reported leaving

TABLE 1.2. SUMMARY OF CRITICAL CHILD CARE ISSUES FROM INTERVIEWS AND FOCUS GROUP

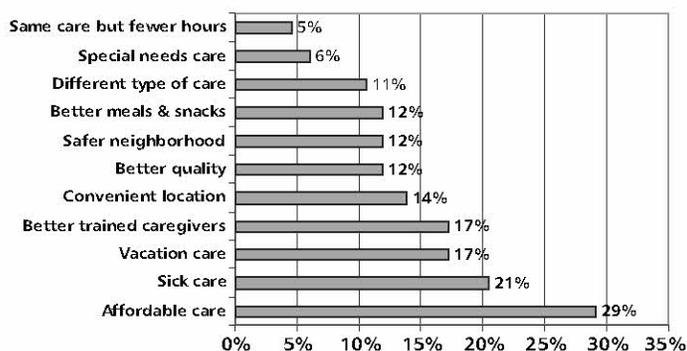
	Parent Focus Groups: Critical Issues	Key Informant Interviews: Critical Issues
Marion	<ul style="list-style-type: none"> Center care preferred. Multiple child care arrangements difficult to manage. Rely on relatives and friends for backup. Need for extended hours. Vouchers are critical. 	<ul style="list-style-type: none"> Insufficient funds for subsidies. Quality concerns about unlicensed ministries. Need for extended hours and sick care. Lack of funding for provider training.
Lake	<ul style="list-style-type: none"> Reliance on relative care. Lack of reliable public transportation. Extended hours and flexibility are important issues, often lacking in formal care. Concerns about quality, safety. Care for children with special needs. 	<ul style="list-style-type: none"> Great need for more quality care. No established resource & referral agency. Need for higher quality, extended hours, sick care. Need for bilingual-bicultural care.
Allen	<ul style="list-style-type: none"> Felt there was a disincentive to work Preferences for home-based care. Concerns about quality of care. Rely on family, friends, neighbors for supplemental care. Shortage of infant-toddler care. Need for sick child care or more flexible leave policies. High cost of child care 	<ul style="list-style-type: none"> Well-coordinated community services. Demand for child care increasing. Concerns about quality of child care for low-income families. Extended hours needed. Families prefer relative care for infants & toddlers. Insufficient subsidies. Disparity of services between rural and urban areas.
St. Joseph	<ul style="list-style-type: none"> Use mixture of home-based and center-based care. Rely on neighbors and relatives for backup. Most had no stable backup. Need more flexible hours, nights, weekends, and easy transportation for children to child care. Concerns about quality. Concerned about remaining eligible for child care subsidies 	<ul style="list-style-type: none"> High demand for child care. Relative/informal care used often. Insufficient subsidy funds. Need for extended hours, sick care, and care for special needs. Concerns about quality of unregulated center and relative care.

early up to 26 days. Forty-three percent of parents reported they couldn't concentrate on work because of child care problems.

When parents were asked how their employers helped them deal with their child care problems, almost 60% (n = 90) reported their employer did not help at all with child care. Few parents actually identified specific help they received from employers. These parents reported their employers helped with on-site child care (4%), a child care flexible spending account (3%), help with paying for child care (3%), and help with finding child care (3%).

Parents were also asked what their ideal child care circumstances would be. Figure 1.3 presents their responses. The most commonly selected features were more affordable child care, sick child care, care available when school is not in session, and better-trained teachers and caregivers.

FIGURE 1.3 PARENTS' IDEAL CHILD CARE CIRCUMSTANCES (N=151)



When communities were compared using the survey data, there were few differences in responses. A greater percentage of Lake County parents selected "care available when school is not in session (vacation care)" as an ideal child care feature than did

parents from other communities. Additionally, a greater percentage of Allen County parents reported that their employers helped respondents with child care problems by offering child care flexible spending accounts. However, only 5 parents in the Allen site actually reported receiving this kind of help from employers.

CONCLUSIONS

Availability of licensed child care and voucher subsidies to help families pay for child care varied across these four communities. Licensed child care was least available in Allen County and most available in Marion County. Marion County also had the largest waiting list for child care voucher subsidies, while Lake County reported the smallest waiting list.

Child care leaders interviewed in the four communities identified critical problems in providing care for children from low-income working families, including insufficient funding for child care subsidies; low quality care, especially for infants and toddlers; concerns about the growth of legal, unregulated child care; and a lack of child care services for evening hours or for sick children. The community leaders also mentioned several strengths and challenges specific to their communities.

The vast majority of low-income working parents in focus groups and brief surveys reported their primary reason for using child care was to work or attend school. Most expressed satisfaction with their current arrangements; however, they also identified a number of significant problems: concerns about the cost, quality, and safety of out-of-home child care; heavy reliance on friends and family members for primary or back-up child care; and a lack of flexibility in child care and their jobs for evening hours, sick children, or care during holidays or school vacations.

Chapter 2

WHO WERE THE FAMILIES, CHILDREN, AND CAREGIVERS?

The families who participated in the Community Child Care Research Project were recruited by research assistants in public places (e.g., public libraries, community centers, etc.), schools (vocational-technical, GED classes, state university, etc.), and government agency offices (e.g., workforce development services, WIC -Women, Infants, and Children, Child Care and Development Fund (CCDF) voucher offices; etc.). Care was taken to recruit an equal number of families in each community (approximately 76 in each community) and approximately equal numbers of families with infant/toddlers and preschool-age children. A total of 307 low-income working families whose young children were in out-of-home child care were recruited to participate.

Several eligibility criteria were established to ensure the sample represented low-income working families with young children in out-of-home care. These criteria included:

- annual family income less than \$35,000;
- head of the household is working (i.e., employed, going to school, or in job-training at least 20 hours per week);
- family has a child between 6 months and 5 years old, and the child is in out-of-home care at least 15 hours per week for the past 2 months;
- family is not enrolled in TANF (Temporary Assistance for Needy Families);
- child care provider agrees to participate.

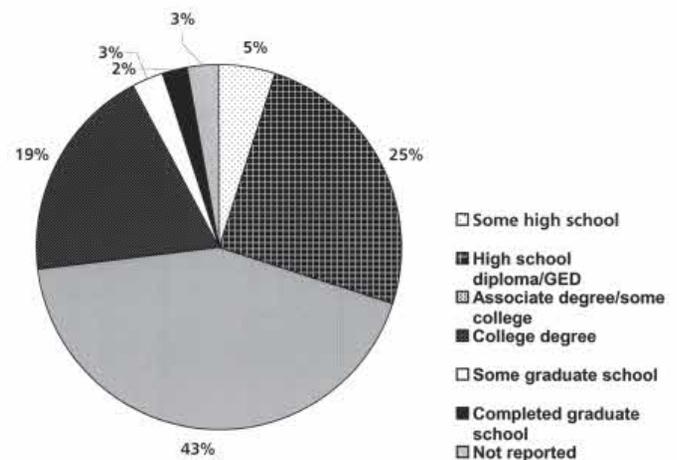
WHO WERE THE FAMILIES?

The 307 low-income working families were recruited from urban communities in St. Joseph, Marion, Allen, and Lake counties in Indiana ($n_s = 78, 76, 76, 77$, respectively). We recruited families from Indianapolis in Marion County; from Fort Wayne in Allen County; from Gary, Hammond, and East Chicago in Lake County; and from South Bend in St. Joseph County. Statistical tests revealed families did not differ in their demographic characteristics across communities. (See Table C1 in Appendix C for a detailed summary of characteristics of the 307 families.)

In general the participating low-income working families had the following characteristics:

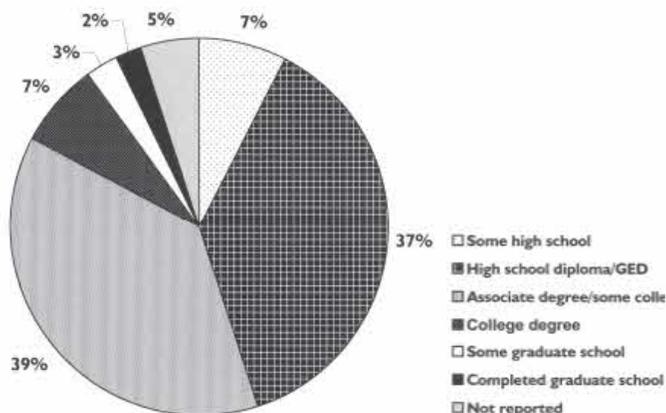
- Almost two-thirds of parents reported an annual income below the federal poverty level for a four-person family in 2002, \$18,100 per year, or less than \$1,500 per month. One-third of the participating families earned less than \$9,600 per year, or less than \$800 per month.
- Thirty percent of the parents were married, remarried, or living with a partner, while two-thirds of the parents (68%) were single and had no partner, or were divorced, or widowed.
- More than half (56%) of the parents were the only adult living in the household, while 34% identified one other adult living in the household. The remaining parents indicated an additional two to five adults resided in their household.
- The average number of children living in each household was two. A majority of the families reported one, two, or three children living in their household, but some reported up to eight children living in their household.
- Sixty percent of the families reported no male head of household. Among the 116 families identifying a male head of household, most (72%) identified the child's father as that person. The majority of male heads of household were employed (89%) and had a high school education or above (73%).

FIGURE 2.1. MALE HEAD OF HOUSEHOLD EDUCATION LEVEL



- Except for five families who did not report female heads of the household, all families identified one female head in the household. Most female heads of household were the child's mother (88%). The majority of these women were employed (83%) and had a high school education or above (88%).

FIGURE 2.2. FEMALE HEAD OF HOUSEHOLD EDUCATION LEVEL



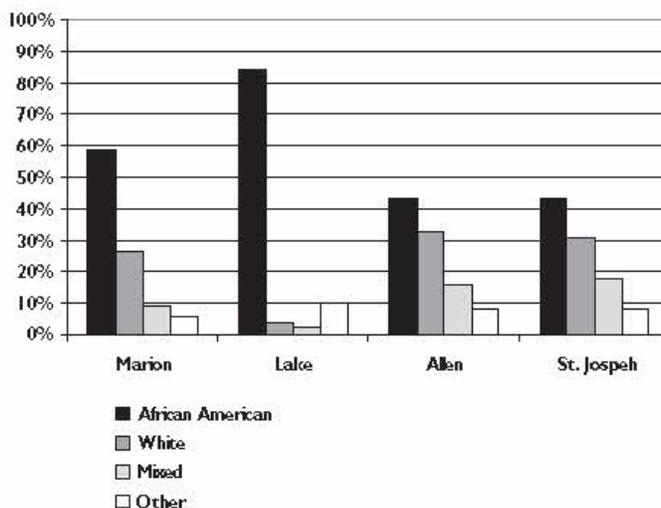
WHO WERE THE CHILDREN?

There were 307 participating children. (See Table C2 in Appendix C for a detailed summary of characteristics of the 307 children.) Here is a summary of their general characteristics:

- The children in the study ranged in age from 6 months to 6 years. Forty percent of children were under 36 months of age, while 60% were 36 to 72 months of age.
- There were approximately equal numbers of boys and girls.
- Fifty-nine percent (59%) of the children were African American, 23% were White, 3% were Latino, 1% were Asian/Pacific Islanders, and 14% were mixed race or ethnicity was not reported.
- Most children lived with their mothers (96%) but only 25% lived with their fathers. Twenty-four percent of children lived with both their mother and father. One child lived only with his/her father while 61% of children lived only with their mother. An additional 9% lived with their mother and another adult, other than the child's father or mother's partner. This could include a grandparent, relative, or friend. Two percent lived with their mother and mother's partner.

Statistical tests revealed the characteristics of families were not different across the four community sites, except for the distribution of children's race. Figure 2.3 displays child's race in the four communities. The sample in Lake County had 84% African American children and very few White children (4%).

FIGURE 2.3. CHILD'S RACE IN FOUR COMMUNITIES



WHO WERE THE CAREGIVERS IN THE CHILD CARE SETTINGS?

To be included in the study, both eligible families and their primary child care providers needed to volunteer to participate. A small number of providers declined to participate. Overall, the refusal rate for providers was 14%. Reasons for refusal included the closing of the child care setting, provider had too much going on, and the provider did not want to participate. However, refusal rates varied among the four communities. These differences in refusal rates may be attributed to the order of recruitment. Research assistants apparently became more skilled over time in recruitment of child care providers resulting in a decline in refusal rates over time. Lake County (the last county recruited) had the lowest refusal rate (5%) while Marion County had the highest (20%). Allen and St. Joseph counties had refusal rates of 16% and 19%, respectively. Table C3 in the Appendix C displays a summary of characteristics of the caregivers.

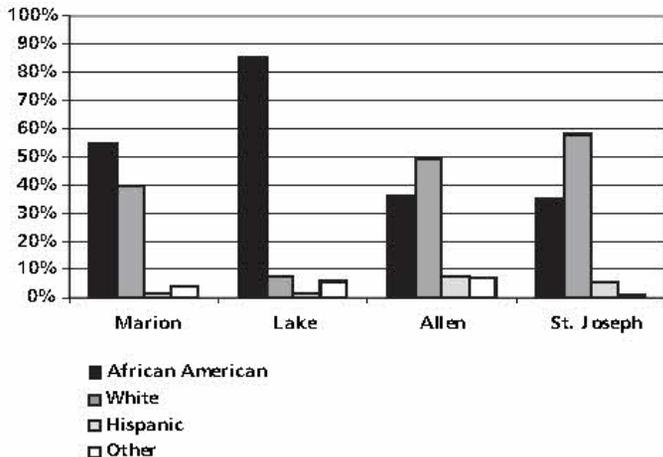
Unlike the family and child participants in the study, the characteristics of child care providers did vary considerably across communities, including age, family income, race, marital status, specialized training in early childhood education, and years of experience working with children.

- While the mean age of all caregivers was 39 years, caregivers in Lake County were about 10 years older than caregivers from the other three communities. The mean age of caregivers in Lake County was 46 years, compared to 35 to 37 years in other communities.
- About one-fourth of the caregivers reported a family income below the poverty level (\$18,100 per year, or less than

\$1,500 per month for a family of four). When communities were compared, caregivers in Marion County reported lower incomes than caregivers from other communities. Only 15% of caregivers in Marion County had a family income above \$3,000 per month, and a large majority (71%) had income between \$801 to \$3,000 per month. Although family income levels differed across communities, caregivers' personal income from child care work did not differ significantly from community to community. This suggests the caregivers in Marion County more often had to rely on their child care income, while caregivers in other communities often had other sources of family income.

- About half of the caregivers in the study sample were African American (49%). The second largest ethnic group was White (36%). Similar to children's race distribution, Lake County differed from other communities in that caregivers were predominantly African American (85%), with few White caregivers (7%). Figure 2.4 displays differences in caregivers' race in the four communities.

FIGURE 2.4. CAREGIVERS' RACE IN FOUR COMMUNITIES

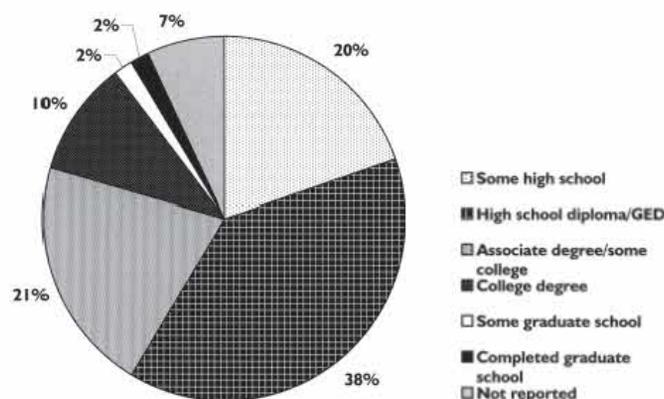


- More than half of the caregivers (57%) reported they were married, remarried, or living with a partner. Thirty-eight percent of the caregivers were single or had no partner, or were divorced or widowed. More caregivers in Lake County were divorced or widowed (21% compared to 8-12% in other communities) and fewer were single or reported no partner (15% compared to 27-38% in other communities). Also, a lower percentage of caregivers in Marion County (40%) were married than in other communities (50% or higher). The lower marriage rate in Marion County provides

explanation for why those caregivers reported lower family incomes; they are less likely to have two incomes contributing to the overall family income.

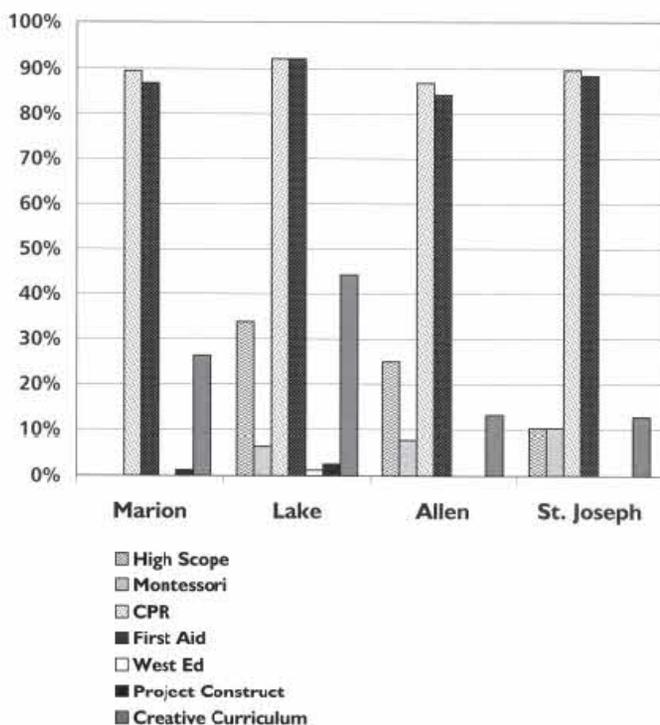
- There was no difference among the communities in caregiver education level. Figure 2.5 displays caregivers' general education. A majority of the caregivers had at least a high school diploma or GED (92%). Almost 70% (67%) had some college and 24% had at least a four year college degree.

FIGURE 2.5. CAREGIVER EDUCATION LEVEL IN THE FOUR COMMUNITIES



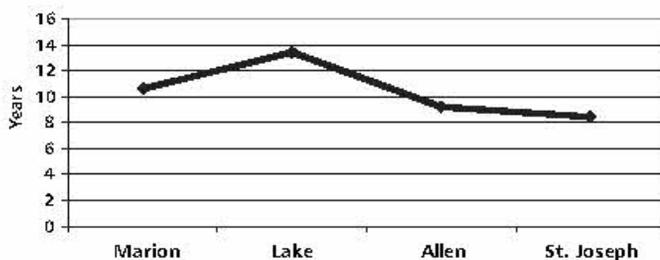
- Less than half of the caregivers (41%) indicated they had at least one specialized early childhood credential (e.g., early childhood teaching certificate, child development associate, Montessori certificate, early childhood special education endorsement, or kindergarten endorsement). However, this differed across communities. Approximately half of the caregivers in Marion and Lake Counties (48% & 52%, respectively) had at least one early childhood credential, compared to only 26% of the caregivers in St. Joseph County and 39% in Allen County.
- The majority of the caregiver sample (87%) had completed at least two specialized training programs. As expected, the two most frequently completed training programs were CPR and First Aid, as required by state regulation. Caregivers in Lake County reported more completed training programs than caregivers in the other three communities. Lake County caregivers averaged three completed training programs while the other three counties averaged two completed training programs. Figure 2.6 shows caregivers' training in the four communities.

FIGURE 2.6. CAREGIVER TRAINING IN THE FOUR COMMUNITIES.



- Caregivers in Lake County reported more years of experience in child care profession than caregivers in St. Joseph and Allen Counties (average 13 years versus eight and nine years). Figure 2.7 displays means for the four communities.

FIGURE 2.7. CAREGIVERS' MEAN YEARS OF EXPERIENCE IN CHILD CARE PROFESSION IN THE FOUR COMMUNITIES.



HOW DOES SAMPLE OF FAMILIES COMPARE WITH THE GENERAL POPULATION OF LOW-INCOME FAMILIES IN THESE FOUR COMMUNITIES?

Key demographic variables from our sample were compared to the 2000 census data of families with at least one child under the age of 6 and incomes below \$35,000 in the four urban communities of Indianapolis (Marion County), Gary (Lake County), Fort Wayne (Allen County), and South Bend (St. Joseph County).

Table C4 in Appendix C provides comparisons of our sample to these census data by community. There were some noticeable differences between the study samples and the census population. First, our sample reported a higher education level than the general low-income population. One of the sampling strategies relied on recruiting families from adult education centers, and this may have contributed to this difference. Also, those working or in school may have higher education levels than those who are not working or in school. Second, our sample consisted of greater percentage of single parents than the general population of low-income parents. While 57% of our sample reported being single, 42% of the low income census population reported being single. A greater discrepancy can be found in the percentage of those married. While 44% of the census population reported being married, only 17% of our sample reported being married. This could be due to a greater reliance on non-parental care by single parents who are balancing work and family responsibilities without the help of another adult in the household, thus more likely to be recruited into our sample. We were unable to determine what proportion of low-income families from the census population were using child care. The distribution of race also differed. In each community, there was a greater proportion of African-Americans represented in our sample than would be expected from the general population census data.

Although the study sample did not match the general population of low-income parents and children in these cities, this relatively large sample of low-income working or in-school parents provides valuable information about an important and vulnerable low-income population. Since the welfare reform of 1996, federal policy has encouraged personal responsibility and self-sufficiency. These low income working families are doing just that: working, going to school and taking care of their children with little or no government assistance. They are not receiving TANE, and their incomes from employment make them less likely to receive child care vouchers that may be necessary to afford quality child care. Therefore, these families have limited choices when it comes to obtaining quality child care; cost rather than quality may have to be their first consideration.

CONCLUSIONS

Phase 2 of this research is based on a volunteer sample of 307 children and parents from low-income working families in four communities in northern and central Indiana. Children ranged in age between 6 months and 6 years. The typical parent participating in the study was a young, African American, single female



with at least a high school diploma and two children earning less than \$1500 per month. Her child's care provider was typically a 39-year-old African American woman with some college and some specialized training in early childhood education and child care. While the study sample did not exactly match the general

population of low-income parents and children in these cities, results from this large sample of low-income working or in-school parents will at least suggest patterns that may apply to the larger population of low income working parents and their children and child care providers during 2002-2003.



Chapter 3

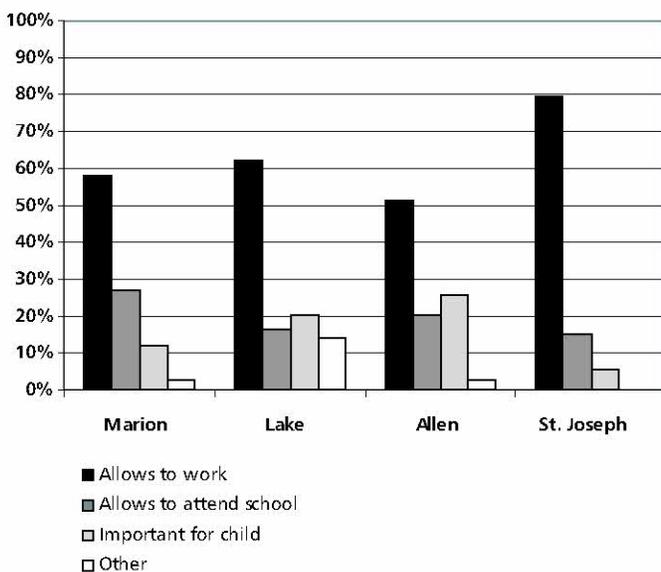
WHAT ARE THE CHILD CARE EXPERIENCES OF LOW-INCOME WORKING FAMILIES?

The Community Child Care Research Project provides information about the child care experiences of low-income working families. Specifically, we asked parents to identify their reasons for using care, identify the types of care they used, report on their work and child care flexibility, and rate the child care quality of their current arrangement. These factors were examined within each of the four communities. The following information is based on the sample of 307 families described in Chapter 2. Descriptive statistics are summarized in Appendix D.

WHY ARE FAMILIES USING CHILD CARE?

Parents were presented a list of reasons for using child care (allows parent to work, allows parent to attend school, allows parent to take part in sports, cultural, political or leisure activities, and important for child’s development) and were asked to select one main reason why their child was using child care. The dominant reasons selected were: allows parents to work (60%) and allows parent to attend school (19%). Figure 3.1 displays a comparison of the four community responses. In St. Joseph County, a greater percentage of families used child care to allow parents to work (74%) and lower percentage of families used child care because it was important for child’s development

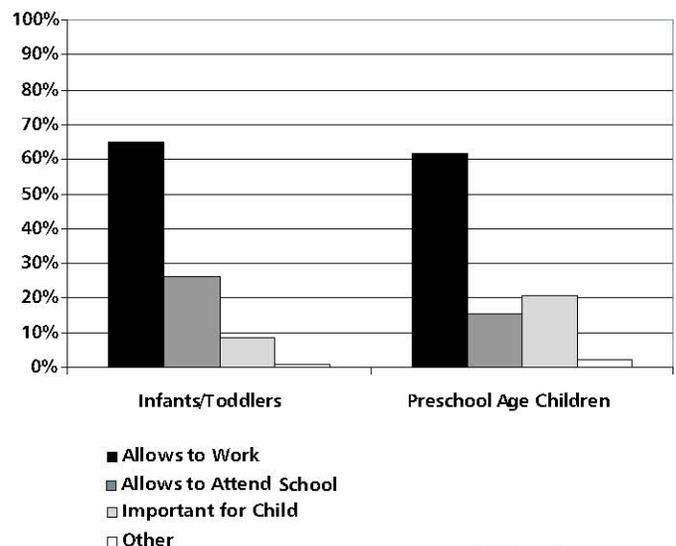
FIGURE 3.1 FAMILIES’ MAIN REASON FOR USING CHILD CARE (N=295)



(5%) than the other three communities. A greater percentage of families in Allen and Lake Counties (25% and 20 %, respectively) reported their main reason for using child care was because it was important for child’s development than other communities.

The pattern of responses changed slightly when age of child was considered. Allowing parents to work remained the main reason for child care (62% of parents of infants and toddlers compared to 59% of parents of preschool-age children). Differences existed in the percentage of parents who selected allowing parent to attend school and important for child’s development as the main reason for using child care. While 21% of parents of preschool-age children (children 3 to 6 years of age) selected important for child’s development as the main reason for using child care, only 8% of parents of infants and toddlers (children 6 to 35 months of age) did. This is not surprising as parents of preschool-age children are more likely to be thinking about their child entering school and may be concerned about how child care is promoting their child’s skills. Twenty-five percent (25%) of parents of infants and toddlers selected allow parents to go to school while 15% of parents of preschool-age children did. Figure 3.2 displays these differences.

FIGURE 3.2 FAMILIES’ MAIN REASON FOR USING CHILD CARE FOR INFANTS AND TODDLERS AND PRESCHOOL-AGE CHILDREN (N=295)



TYPES OF CHILD CARE

Licensed Child Care Center

Non-residential group child care by paid providers, governed by Indiana child care center licensing requirements that include requirements for staff training, health, safety, nutrition, appropriate discipline, and child development curriculum.

Registered Child Care Ministry

License exempt center-based program, an extension of a church or ministry that is a tax-exempt religious organization. No regulations for staff, group sizes, ratios, or program apply to registered ministries. They have only to meet general sanitation and fire safety rules.

Head Start

A national comprehensive preschool program for low income children prenatal to 6 years and their families. Programs must follow the Head Start Performance Standards which meet or exceed the standards for licensed child care centers in Indiana.

Licensed Family Child Care

Home-based child care provider caring for six or more non-relative children. Licensing sets minimum standards for health, safety, and caregiver training that must be maintained. Licensed family child care homes are inspected by the state once per year.

Unlicensed Family Child Care

Family care providers that are not licensed, legally caring for fewer than six children non-relative children in Indiana. Licensing is not required if the home-based provider is not paid; cares for only relative children; cares for less than 6 children, not including own children; or serves migrant children.

Relative Care

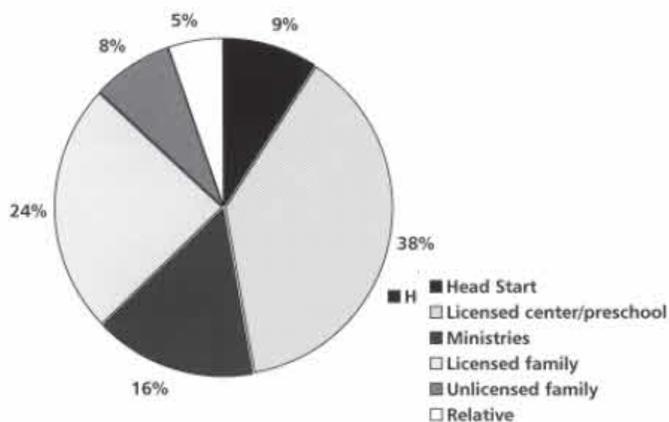
Relatives caring for children in the relative's home. Indiana does not regulate care provided by relatives.

(See Glossary page for additional definitions.)

WHAT TYPES OF CHILD CARE DO LOW-INCOME WORKING FAMILIES USE?

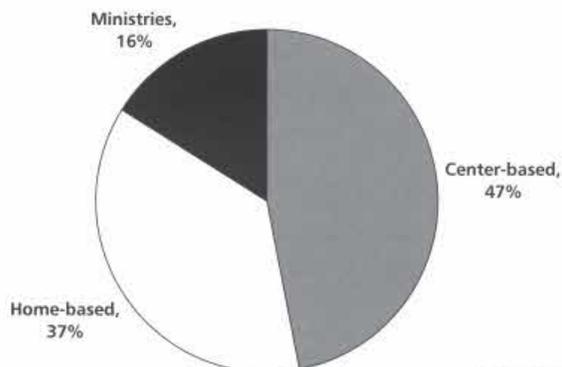
Families used a variety of child care: licensed center care/preschool, child care ministries (license-exempt centers operated by churches), relative care, Head Start, and licensed and unlicensed family child care. Figure 3.3 displays the proportion of families using each type of care. The most frequently used care for this sample of families was licensed center care/preschool (38%), followed by licensed family child care (24%) and child care ministry (16%).

FIGURE 3.3 TYPE OF CHILD CARE USED BY LOW-INCOME WORKING FAMILIES (N=307)



A majority of the children (71%) were cared for in licensed child care settings (i.e., licensed centers/preschools, Head Start, and licensed family child care) while the remaining 29% were cared for in unlicensed child care settings (i.e., child care ministries, unlicensed family child care, and relative care). About 47% of the children attended licensed center-based child care settings, including community child care programs and Head Start programs. More than one-third of the children (37%) attended home-based child care settings such as relative care and licensed/unlicensed family day care. Another 16% attended child care ministry programs, which are exempt from Indiana government regulation. Figure 3.4 displays this distribution.

FIGURE 3.4 USE OF CENTER-BASED, HOME-BASED, AND MINISTRY CARE (N=307)

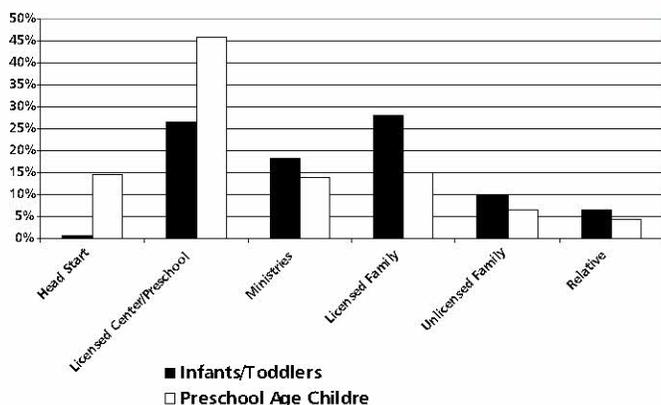


Twenty percent of these children started attending child care shortly after birth, and over half were in care by 3 months of age. Seventy-five percent were in care by 8 months of age and all children were in care by 48 months of age. On average children attended a different child care setting about every 15 months.

DO PARENTS OF INFANTS AND TODDLERS CHOOSE DIFFERENT TYPES OF CHILD CARE THAN PARENTS OF PRESCHOOL-AGE CHILDREN?

There was a greater percentage of preschool-age children receiving care in centers than infants and toddlers (74% compared to 46%) and a greater percentage of infants and toddlers were cared for in family child care than preschool-age children (55% compared to 26%). A greater percentage of preschool-age children were cared for in licensed settings (75% compared to 65%) than infants and toddlers. Figure 3.5 displays the type of child care used for infants and toddler and preschool-age children.

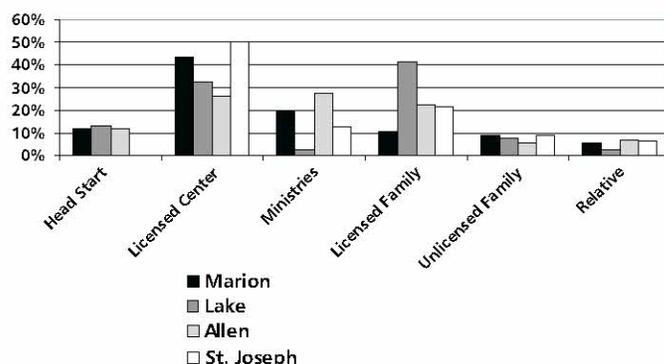
FIGURE 3.5 USE OF CARE FOR YOUNGER AND OLDER CHILDREN



DO TYPES OF CHILD CARE USED DIFFER FOR THE COMMUNITIES?

Statistical tests revealed there were differences in the distribution of child care types across the four community samples. Families in Allen County were evenly distributed in their use of licensed center care/preschool, licensed family child care, and child care ministry (22% to 27% each). Very few families in the Lake County sample (less than 3%) used child care ministries, while 42% used licensed family child care. Finally, over half of the families in St. Joseph and Marion counties (55%) selected licensed child care centers, including Head Start. Figure 3.6 shows the differences in child care placements among the four communities.

FIGURE 3.6 TYPE OF CHILD CARE USED IN THE FOUR COMMUNITIES



HOW DO LOW-INCOME WORKING FAMILIES BALANCE CHILD CARE AND WORK?

As presented in Chapter 1, data from preliminary focus group interviews and parent surveys indicated that parents encountered problems balancing work and child care. An expressed need for extended and sick care, as well as lack of financial resources were among the problems mentioned in the focus groups and preliminary surveys. Parents mentioned reliance on friends and families for supplemental care and reliance on child care vouchers for financial support as key factors allowing them to balance their work and child care. Flexibility in both work and child care appeared to be key components of a successful child care and work arrangement. The issues of child care and work flexibility were examined more closely with the large sample.

■ *Parents mentioned reliance on friends and families for supplemental care and reliance on child care vouchers for financial support as key factors allowing them to balance their work and child care.*

WHAT WERE THE EMPLOYMENT PATTERNS OF LOW-INCOME WORKING PARENTS?

Although the employment criteria for our sample was that the head of the household must be “working” at least 20 hours per week, most parents worked more than 20 hours. Of families who identified a male head of household (n = 116), 90 percent were employed and most (86%) worked full time (35 or more hours per week). Most men (72%) reported a daytime work shift. Five percent reported working a second shift during the evening.

Eighty-five percent of female heads of household were employed and a majority (72%) worked full time. Most women (79%) reported a daytime work shift. Five percent reported working a second shift during the day, evening or night. Seventy-two percent of two parent families reported both parents were working, with a majority of families having both parents working full time.

HOW FLEXIBLE DO PARENTS PERCEIVE THEIR WORK IN RELATION TO CHILD CARE ISSUES?

Both male ($n = 89$) and female ($n = 236$) heads of household were asked about the assistance and support they receive from their employer on child care, work stress, flexibility in dealing with child care problems, and child sickness.

The following percentages of male heads of household agreed with the following statements:

- 17% My shift and work schedule cause extra stress for me and my child.
- 38% Where I work, it is difficult to deal with child care problems during work.
- 6% My employer has a program or service to help employees find child care.
- 2% My employer provides direct financial assistance for child care.
- 16% I can pay for child care with pre-tax dollars.
- 36% My employer allows me to stay home when my child is ill and I have no child care.

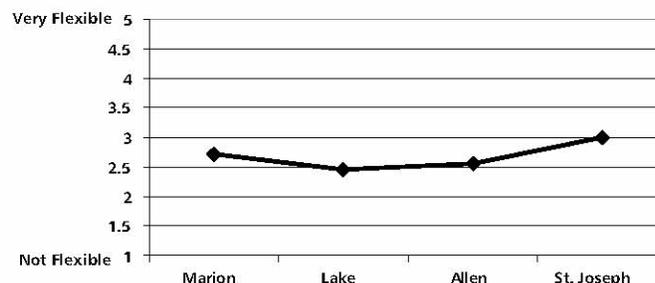
The following percentage of female heads of household agreed with the following statements:

- 19% My shift and work schedule cause extra stress for me and my child.
- 24% Where I work, it is difficult to deal with child care problems during work.
- 13% My employer has a program or service to help employees find child care.
- 8% My employer provides direct financial assistance for child care.
- 17% I can pay for child care with pre-tax dollars.
- 53% My employer allows me to stay home when my child is ill and I have no child care.

For both male and female heads of household, work offered moderate flexibility. While parents did not overwhelmingly report extra stress from their job or difficulty dealing with child care problems at work, few reported any direct child care assistance from their employer. The most striking gender difference in work flexibility was whether employers allowed parents to stay home when their child was ill and they had no child care. Females were significantly more likely to report their employer would allow them to stay home when their child was ill. It is unclear if this is due to differences in the types of jobs low-income men and women might hold, or if employers are more understanding when a mother rather than a father needs to miss work to care for a sick child. It should also be noted that there were fewer males than females included in these samples. There were data on 307 females, while there were data for only 124 males due to the high percentage of single-mother households in the sample.

Perceptions of work flexibility did not differ by age of child, but there were some differences across communities. In the area of male work flexibility, Lake County males reported the least amount of total flexibility, while St. Joseph County males reported the greatest. Figure 3.7 illustrates these differences. There were no differences among communities in female work flexibility.

FIGURE 3.7 MALE HEAD OF HOUSEHOLD WORK FLEXIBILITY IN THE FOUR COMMUNITIES



HOW DO PARENTS PERCEIVE THE FLEXIBILITY OF THEIR CHILD CARE ARRANGEMENT?

Low-income families are more likely to stay employed once they find a job, to work more hours, lose less time at work, and experience less job stress if the flexibility of their child care arrangement is congruent with their employment needs. As we have already noted, low-income workers are more likely to need flexible child care due to the nature of low wage work (e.g., shift work, changing shifts). Parents were asked about their child care as a source of needed flexibility in managing work and family.

A majority agreed with the following statements:

- 60% My caregiver understands my job and what goes on for me at work.
- 75% My caregiver is willing to work with me about my work schedule.
- 60% I rely on my caregiver to be flexible about hours and/or days.

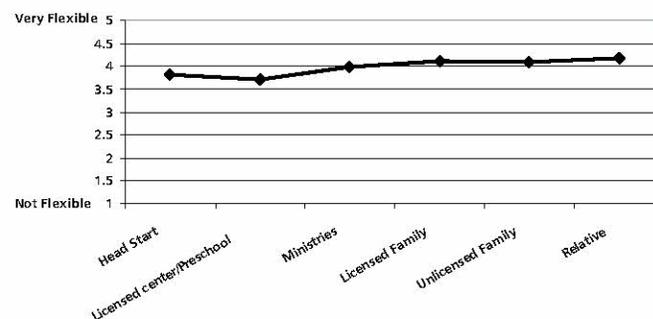
A majority disagreed with the following statements:

- 77% My child care setting makes it difficult for me to meet my work responsibilities because of rigid hours and/or no weekend care.
- 60% When my caregiver is ill, I have to make other arrangements for care.

For the most part, parents were positive about the flexibility they perceived in terms of their caregiver understanding their job, working with them and their employment schedule, offering flexible hours or days of care, and helping them meet work responsibilities. There was greater variability in how parents perceived the sick care flexibility their current caregiver provided. Forty-three percent reported that when their child is mildly ill, they are not allowed to bring him/her to child care. Also 28 percent did not have an arrangement at all if their child was mildly ill. This lack of flexibility in sick care results in a need for back-up care that parents must arrange with friends, family, or sick child care programs. Qualitative interviews with key informants and parent focus groups in each of the four communities supported a need for back-up care when a child is ill.

There were no differences in perceptions of child care flexibility based on the age of the child. However, there were some community differences on individual aspects of child care flexibility. Differences existed in parents' perceptions of caregiver understanding of their job and if they could rely on their caregiver to be flexible about hours and days. Although parents from all communities were generally positive about these aspects, Lake County parents agreed more strongly that their caregivers were understanding about their jobs, while St. Joseph parents agreed more strongly with caregiver's flexibility about hours and days. There were differences depending on the type of child care that families used. In general, licensed center care provided the least amount of flexibility, while relative care provided the most flexibility. Figure 3.8 presents these differences.

FIGURE 3.8. CHILD CARE FLEXIBILITY OF THE SIX CHILD CARE SETTINGS



HOW DOES THE CHILD CARE CONTEXT OF EACH COMMUNITY DIFFER FOR LOW-INCOME WORKING FAMILIES?

As reported in the Chapter 1 analysis of existing community child care data, parent focus groups, and key informant interviews, there are some unique aspects to each community. The variation counties have less availability of licensed care for their children (22 and 23 licensed slots per 100 children). Marion and St. Joseph counties had a more adequate supply (35 and 30 licensed among the number of licensed child care slots (center and family care) available per 100 children suggests differences in the availability and selection of licensed care for children. Allen and Lake slots per 100, respectively). These community differences were not however reflected in our samples' perceptions about the availability of child care.

The median number of days parents spent looking for their current child care arrangement was 14 days, but there was a great deal of variability, ranging from 0 to 210 days! Most parents (90%) spent 90 days or less looking for their current child care arrangement. When asked how difficult it was to find satisfactory child care arrangements in their area, 18 percent reported it was very easy, 19 percent reported it was easy, 34 percent reported it was neither easy nor difficult, 18 percent reported it was difficult, and 10 percent reported it was very difficult. Days spent looking for care did not differ by community, nor by age of child. While perceived difficulty in finding satisfactory child care arrangements did not differ by community, it did differ by age of child. Parents of infants and toddlers perceived it was easier to find satisfactory child care arrangements in their area than did parents of preschool age children. This may be because parents were more willing to consider more informal child care arrangements (e.g., relative care, unlicensed family child care) for infants and toddlers than for preschool-age children.

Parents were asked about availability of child care. Overall, parents had a neutral to positive view of the availability of child care arrangements in their area.

- Forty-five percent of parents felt there were good choices for child care where they live, while 28 percent did not and 27 percent were neutral.
- Fifty-eight percent of parents felt they had more than one choice when they made their current child care arrangement, while 33 percent did not and 9 percent were neutral.
- Fifty-eight percent of parents did not have difficulty finding the child care they wanted, while 29 percent did and 13 percent were neutral.
- Seventy-five percent of parents felt they did not have to take whatever child care they could get, while 14 percent did and 11 percent were neutral.
- When asked to reply yes or no to: "If I could, I would find a new child care arrangement for my child," only 7 percent of parents replied yes, while 83 percent replied no and 9 percent were neutral.
- Eighty-eight percent of parents felt their current child care arrangements met their child's need quite well, while only 6 percent did not, and 7 percent were neutral.

There were no differences in parent's responses based on the child's age. There was one community difference. Allen County parents did not feel they had as much difficulty finding the child care they wanted as parents from the other communities.

WHAT ARE THE PARENTS' PERCEPTIONS OF CHILD CARE QUALITY?

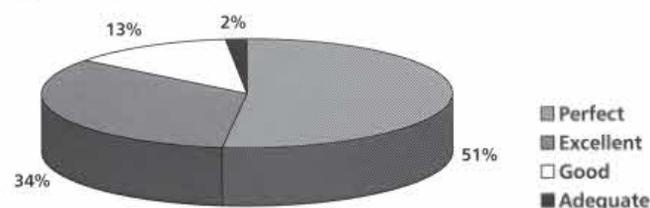
In general parents perceived their child care arrangements to be flexible and felt they had access to satisfactory child care arrangements that were good for their families. But how do parents view the quality of the child care arrangements they are using?

In general parents perceived their child care arrangements to be flexible and felt they had access to satisfactory child care arrangements that were good for their families.

Parents were asked to rate six aspects of child care quality. These included: caregiver warmth toward child, caregiver interest in child, child's safety, cleanliness of setting, number and variety of activities child engages in everyday, and the

amount and desirability of the equipment available to the children. A majority (70% to 80%) of parents rated these aspects as excellent or perfect. Very few parents rated any of these aspects as fair or poor (1% to 2%). A total score of perception of quality was created by combining the averages of each aspect of quality rated. Figure 3.9 displays parents' overall rating of child care quality. Responses to these six aspects were combined to form an overall score of quality, ranging from poor to perfect. These perceptions did not differ by community, age of child, or type of child care.

FIGURE 3.9 PARENTS' PERCEPTION OF CHILD CARE QUALITY (N=304).



CONCLUSIONS

The most common types of primary child care used by this sample of 307 low-income working families were licensed center care/preschool (38%) and licensed family child care (24%). Other types used were child care ministry (16%), Head Start (9%), unlicensed family child care (8%), and relative care (5%). Twenty percent of the children started in child care soon after birth, and more than 75% were enrolled in some type of child care by age 8 months. Infants and toddlers were slightly more likely to be in family child care, and preschool-age children were slightly more likely to be in center care. Licensed family child care was used at a high rate in Lake County (42%), while center-based care was often used in Marion and St. Joseph counties (55%). Families in Allen County used a more balanced distribution of types of child care.

More than one-third of these low-income parents reported missing at least some work or school because of child care problems. A small proportion of mothers reported receiving child care assistance from their employers: finding child care (13%), financial assistance (8%), pre-tax accounts (17%), or allowing employees to take sick time to care for an ill child (53%). Fathers reported lower levels of child care support from employers. Fathers in St. Joseph County reported the highest levels of employer flexibility, and fathers in Lake County reported the lowest levels.

Chapter 4

WHAT IS THE QUALITY OF CHILD CARE USED BY LOW INCOME WORKING FAMILIES IN THE FOUR COMMUNITIES?

In this chapter, we present results of the child care quality assessments conducted in the Community Child Care Research Project. The sample consisted of the 307 child care settings attended by the children in the study. Data collection took place during 2002 and 2003. Sixty-three percent (n=193) of children were placed in child care centers (licensed child care center, child care ministry, and Head Start program) while 27% (n=114) were in home-based settings (licensed and unlicensed family child care and relative care). This chapter describes the quality of child care utilized by these 307 children, and examines differences in quality among the communities and among types of care in the sample. Descriptive statistics are presented in Appendix E.

WHAT IS CHILD CARE QUALITY AND HOW DID WE ASSESS IT?

A number of measures of quality were used in this study because several elements of quality have been found to be important in previous research (Phillips, Mekos, Scarr, McCartney, & Abbott-Shim, 2000). The measures used in this study assessed the global, structural, and process quality of child care settings.

Global quality includes an overall view of quality that takes into account the space and furnishings of the program, safety and health precautions, program structure, as well as activities and learning opportunities presented to children.

Structural quality includes group size, staff-child ratio, and the training and experiences of caregivers. Past research has shown that child care settings staffed with a fewer numbers of children per teacher, a relatively small group sizes, and a teacher with a strong education background are more likely to have teachers who interact with children in sensitive, nurturing, and intellectually stimulating ways (Howes, Phillips, & Whitebook, 1992).

Process quality refers to the “process” aspects of the child care environment, including children’s daily classroom activities, caregiver-child interactions, child-child interactions, caregiver sensitivity and warmth, and relationships between caregivers and children, as well as between caregivers and parents. Table 4.1 presents a list of measures that we used to assess these three types of quality. More specific information about individual measures is presented in Appendix A.

TABLE 4.1 QUALITY MEASURES USED IN COMMUNITY CHILD CARE RESEARCH PROJECT

	Measure
1. Global Quality	1. Early Childhood Environment Rating Scale-Revised (for center-based care) or Family Day Care Rating Scale (for home-based care)
2. Structural Quality	1. Group Size 2. Child-Adult Ratio 3. Caregiver General Education Level 4. Caregiver Specialized Education in Child Development and/or Early Childhood Education 5. Caregiver Years in Experience in child care
3. Process Quality	1. Student Teacher Relationship Scale (STRS) 2. Parent Caregiver Relationship Scale (PCRS, parent and caregiver report) 3. Caregiver Interaction Scale (CIS) 4. Caregiver Responsive Interaction with Child 5. Caregiver Talk with Child 6. Child’s Activity Level

WHAT IS THE QUALITY OF CHILD CARE IN THE FOUR COMMUNITIES?

Global Child Care Quality: Environmental Ratings

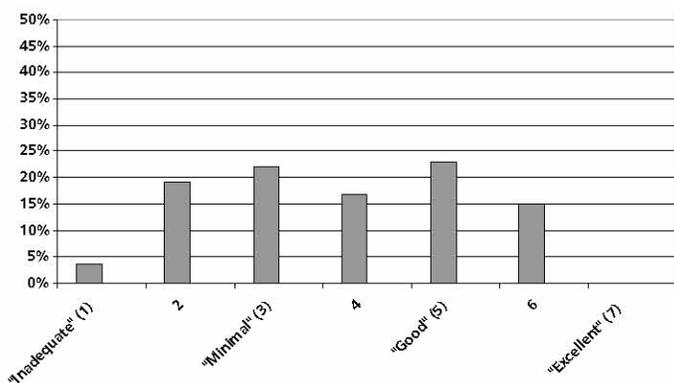
Researchers assessed the global quality of each child care setting via direct observation utilizing the Early Childhood Environment Rating Scale—Revised (ECERS-R, Harms, Clifford, & Cryer, 1998) in center-based child care settings and the Family Day Care Rating Scale (FDCRS, Harms & Clifford, 1989) in home-based child care settings, both widely used, well-validated measures. Scores on these quality scales range from 1 (inadequate) to 7 (excellent). The average quality levels of all types of care in the four communities were low. The median level of global child care quality in each community was near 4 on the ECERS-R and FDCRS scales, which is between “good,” and “minimal.” Ap-

nearly ½ of the children in this sample attended child care that may not provide the kinds of experiences and environment thought to be important for development.

proximately 25% of the observed classrooms and homes fell below “minimal” quality, while another 20% were rated at “minimal.” Thus, nearly ½ of the children in this sample attended child care that may not provide the kinds of experiences and

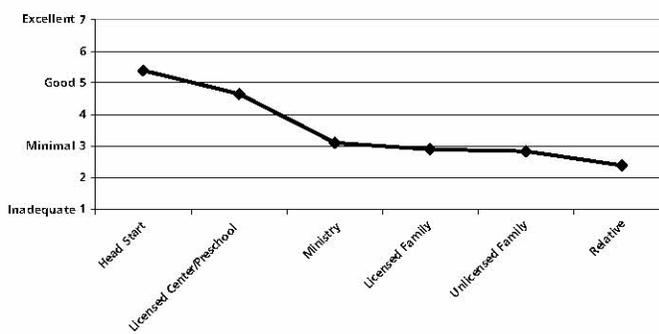
environment thought to be important for development. Figure 4.1 displays the quality rating scores. Overall child care quality level did not differ across community sites.

FIGURE 4.1 DISTRIBUTION OF GLOBAL QUALITY OF CHILD CARE CLASSROOMS AND HOMES



The highest quality care was found in Head Start settings and licensed child care/preschool centers. The lowest quality levels were observed in relative care and unlicensed family child care. On average, children in Head Start ($M = 5.39$) received higher global quality than children in all other care arrangements, while children in licensed child care/preschool centers received higher global quality care ($M = 4.66$) than children in child care ministries ($M = 3.10$), licensed family child care home ($M = 2.91$), unlicensed family child care home ($M = 2.85$), and relative care ($M = 2.40$). Global quality did not statistically differ for child care ministries, licensed family care, unlicensed family care, and relative care. Figure 4.2 provides a comparison of mean global quality ratings for the six types of child care arrangements.

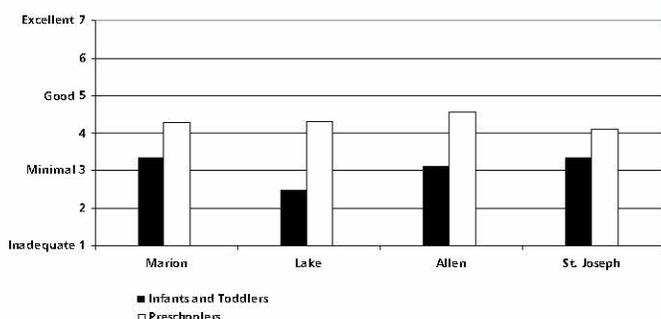
FIGURE 4.2. GLOBAL CHILD CARE QUALITY AND TYPE OF CHILD CARE



- Home-Based and Center-Based Care:** In general, children in center-based settings received higher quality care ($M = 4.38$) than children in home-based settings ($M = 2.84$). This difference was consistent across all communities.
- Licensed and Unlicensed Care:** Children in licensed child care settings received higher quality care ($M = 4.17$) than children in unlicensed settings ($M = 2.90$). This pattern of results was similar across communities.
- Child Care for Infants and Toddlers and Preschool-age Children:** Preschool-age children received higher quality care ($M = 4.30$) than infants and toddlers ($M = 3.06$). Global quality for infants and toddlers averaged at a minimal level or below in all types of settings in all four communities, regardless of whether the care was center- or home-based. Seventy percent of infants/toddlers in this sample were cared for in classrooms or homes that were of minimal or lower quality. There were differences in the global quality of infants and toddlers among communities.

Even though all quality levels were low, infants and toddlers observed in St. Joseph, Marion, and Allen counties ($M = 3.33$, $M = 3.33$, and $M = 3.09$, respectively) received significantly higher quality care than infants and toddlers in Lake County ($M = 2.46$). Figure 4.3 illustrates these differences.

FIGURE 4.3 GLOBAL QUALITY (ECERS-R AND FDCRS) FOR INFANTS/TODDLERS AND PRESCHOOL-AGE CHILDREN ACROSS THE FOUR COMMUNITIES



Structural Quality

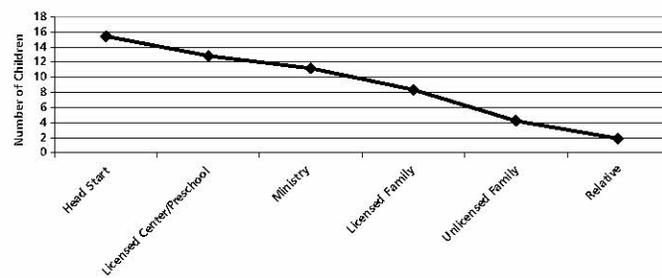
The structural quality variables assessed in this study included group size, child-caregiver ratio, caregiver general education level, caregiver specialized education, and caregiver years of experience in child care. Structural quality indicators are important because they have been shown to be related to developmentally appropriate practices (Howes, Phillips, & Whitebook, 1992). Lower group sizes and child-adult ratios provide children with more opportunities for interaction with caregivers and more access to space and materials, as well as promote the health and safety of children. There is a lower risk of infection, reduced disease transmission, and fewer situations involving potential danger (such as children climbing on furniture; Hayer, Palmer, & Zaslow, 1990) when the group sizes and child-adult ratios are smaller, because caregivers are able to better monitor and promote health practices and behaviors.

Structural Quality: Group Size

The number of children in each classroom or home setting was counted by a researcher during the ECERS-R or FDCRS observation. On average, there were 10 ($M = 10.42$) children in a classroom or child care home, but the range was 1 to 27 children. The largest group sizes were observed in Head Start settings and licensed child care/preschool centers ($M = 15.4$ and $M = 12.9$, respectively). The smallest group sizes were observed in unlicensed family child and relative care ($M = 4.3$ and $M = 1.9$, respectively). Child care ministries and licensed family child

care fell in the middle ($M = 11.2$ and $M = 8.4$, respectively). This pattern was similar for all communities. Figure 4.4 presents these group size patterns.

FIGURE 4.4. GROUP SIZE IN THE SIX TYPES OF CHILD CARE SETTINGS

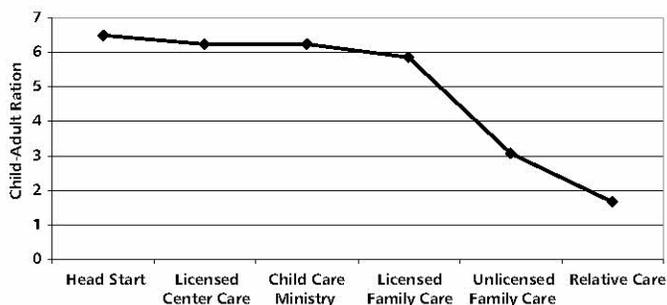


- Home-based and Center-based:** Overall, child care group sizes were larger in center-based ($M = 12.8$) than in home-based child care settings ($M = 6.6$). This pattern was similar across communities.
- Licensed and Unlicensed:** Child care group sizes were larger in licensed child care settings ($M = 11.6$) than unlicensed child care settings ($M = 7.4$). This pattern did not differ across communities.
- Child Care for Infants and Toddlers and Preschool-age Children:** Group sizes were larger for preschool-age children ($M = 12.5$) than for infants and toddlers ($M = 7.4$). These group sizes are consistent with the National Association for the Education of Young Children (NAEYC) recommendations of group sizes of six to eight children for infants, 10 to 14 children for toddlers, and 16 to 20 children for preschool-age children. There was no difference among the communities.

Structural Quality: Child-Adult Ratio

Child-adult ratio was calculated by a researcher during the ECERS-R or FDCRS observation. The average child-adult ratio was 5.6 children per adult, ranging from one to 16 children per adult. Overall, child-adult ratios were significantly different across types of child care settings (Figure 4.5). Specifically, child-adult ratios in unlicensed family care ($M = 3.1$ children per adult) and relative care ($M = 1.7$ children per adult) were lower than the other forms of care [Head Start, licensed center care/preschool, child care ministries, and licensed family care ($M = 6.5$, $M = 6.2$, $M = 6.2$, $M = 5.8$, respectively)]. This pattern was similar for all communities. Figure 4.5 illustrates these differences.

FIGURE 4.5. CHILD-ADULT RATIOS IN THE SIX TYPES OF CHILD CARE SETTINGS

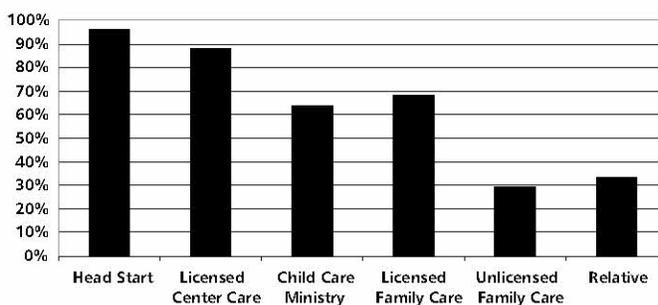


- **Home-based and Center-based Care:** Lower child-adult ratios were observed in home-based settings ($M = 4.6$ children per adult) compared to center-based child care settings ($M = 6.2$ children per adult). This pattern was similar for all communities.
- **Licensed and Unlicensed Care:** Child-adult ratios were significantly higher for licensed ($M = 6.1$ children per adult) than for unlicensed child care settings ($M = 4.4$ children per adult). There were no differences among the communities.
- **Child Care for Infants and Toddlers and Preschool-age Children:** Child-adult ratio was higher for preschool-age children than for infants and toddlers ($M = 6.3$ vs. 4.7). This difference was similar for all four communities.

Structural Quality: Caregiver General Education Level

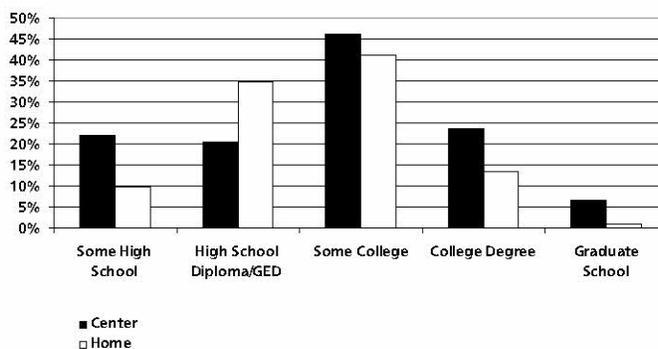
Caregivers were asked to report their highest level of general education. A majority of the caregivers had at least a high school diploma or GED (92%). Almost 70% (67%) had some college and 25% had at least a four year college degree. Caregiver education levels were highest for caregivers in Head Start settings and licensed child care/preschool centers; a majority of caregivers in these two settings had some college education (75% to 95%). The lowest levels of caregiver general education were found in relative and unlicensed family care; only a third of caregivers in these two settings reported more than a high school diploma or GED. Caregiver general education in child care ministries and licensed family child care fell in the middle. Caregiver general education did not differ by community. Figure 4.6 presents these patterns of general education.

FIGURE 4.6. CAREGIVER GENERAL EDUCATION LEVELS IN THE SIX CHILD CARE SETTING (% WITH SOME COLLEGE)



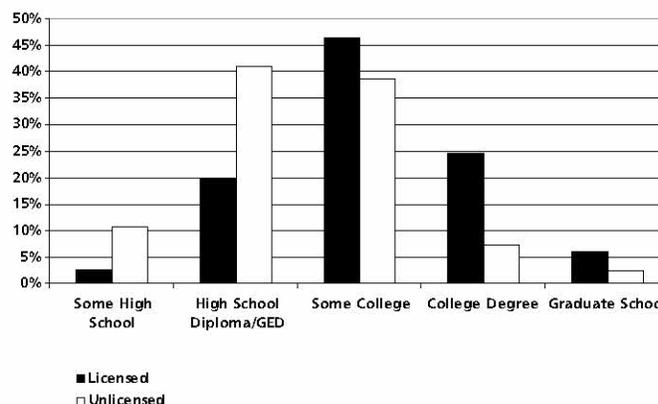
- **Home-based and Center-based Care:** Caregivers in center-based settings reported higher education levels than those in home-based settings. This pattern was similar for all communities (See Figure 4.7).

FIGURE 4.7. CAREGIVER GENERAL EDUCATION LEVELS IN HOME-BASED AND CENTER-BASED CARE



- **Licensed and Unlicensed Care:** Caregivers in licensed settings reported higher education levels than those in unlicensed settings. This did not differ for communities. (See Figure 4.8).

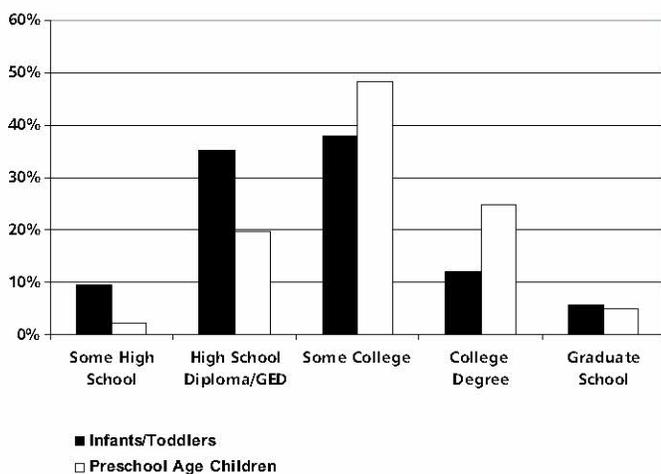
FIGURE 4.8. CAREGIVER GENERAL EDUCATION LEVELS IN LICENSED AND UNLICENSED CHILD CARE SETTINGS





- Child Care for Infants and Toddlers and Preschool-age Children:** Caregivers of preschool-age children reported higher levels of education than caregivers of infants and toddlers. This did not differ for communities. (See Figure 4.9)

FIGURE 4.9. CAREGIVER GENERAL EDUCATION LEVELS IN CHILD CARE FOR INFANT AND TODDLERS AND PRE-SCHOOL-AGE CHILDREN

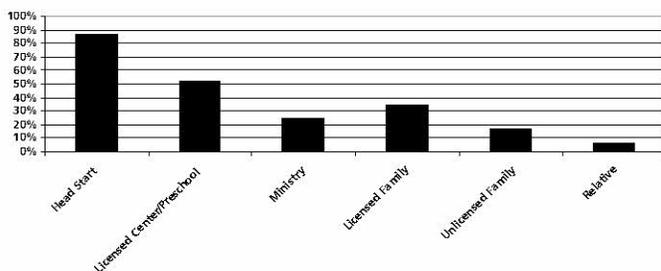


Structural Quality: Caregiver Specialized Education in Child Development

Caregivers were asked about the specialized education they had in child development and early childhood education. Specialized education was defined as possessing at least one specialized early childhood credential (e.g., early childhood teaching certificate, Child Development Associate credential, Montessori credential, early childhood special education endorsement, or kindergarten endorsement). Less than half of the caregivers (41%) indicated they possessed this level of specialized education.

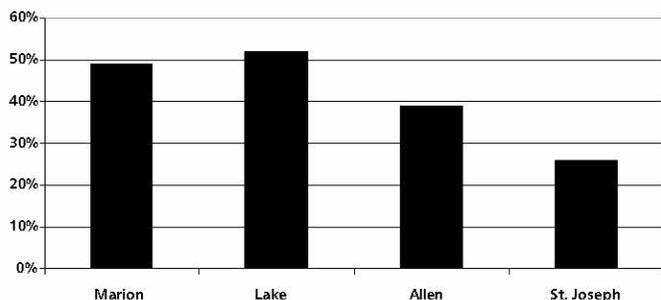
The rate of caregiver specialized education differed among the six child care settings. Almost 90% of Head Start caregivers and a little over half of licensed center care/preschool caregivers reported some specialized education, while only 6% of relative care and 17% of unlicensed family care caregivers reported specialized education. One-third of licensed family child care providers and one-fourth of child care ministry caregivers reported specialized education. Figure 4.10 displays these differences.

FIGURE 4.10. PERCENTAGE OF CAREGIVERS WITH SPECIALIZED EDUCATION IN CHILD CARE SETTINGS



Caregiver specialized education also differed by community. Lake, Marion, and Allen counties did not differ significantly in the percent of caregivers with specialized education (52%, 49%, and 39%, respectively). However only 26% of caregivers in St. Joseph County reported having specialized education, which differed significantly from Lake and Marion counties. Figure 4.11 illustrates these differences.

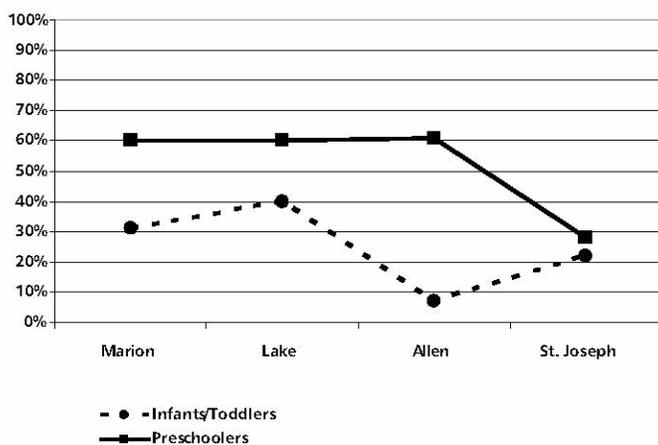
FIGURE 4.11. PERCENTAGE OF CAREGIVERS WITH SPECIALIZED EDUCATION IN THE FOUR COMMUNITIES



- Home-based and Center-based Care:** A greater percentage of caregivers in center-based settings (50%) reported specialized education than those in home-based settings (26%). This pattern was similar for all communities.
- Licensed and Unlicensed Care:** A greater percentage of caregivers in licensed settings (50%) reported specialized education than those in unlicensed settings (19%). This pattern was similar for all communities.
- Child Care for Infants and Toddlers and Preschool-age Children:** Caregivers of preschool-age children were twice as likely (52%) to have any specialized education in child development than were caregivers of infants and toddlers (25%). The greatest discrepancy in the proportion of caregivers with specialized education occurred in Allen

County. Sixty-one percent of caregivers of preschool-age children had specialized education while only 7% of caregivers of infants and toddlers did. In St. Joseph County, a small proportion of caregivers had specialized training, and the difference between caregivers of infants and toddlers and preschool-age children was minimal. (See Figure 4.12).

FIGURE 4.12. CAREGIVER SPECIALIZED EDUCATION IN CHILD CARE FOR INFANTS AND TODDLERS IN THE FOUR COMMUNITIES.

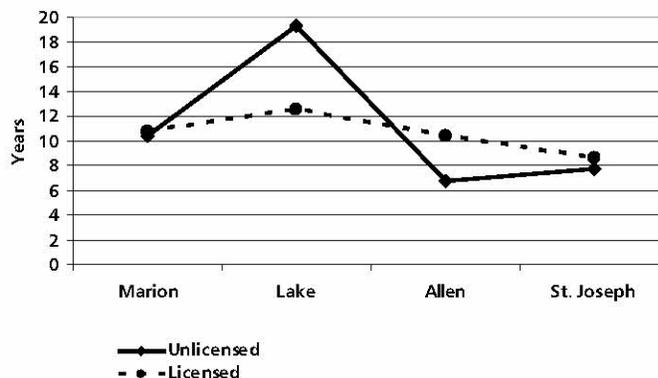


Structural Quality: Caregiver Years of Experience in Child Care

Caregivers were asked to answer a question, “Since you were 18, how long have you worked in child care?” On average, they had worked in child care for about 10 years, but there were significant differences in caregivers’ years of experience across communities. Caregivers in Lake County had worked longer in child care ($M = 13.38$) than those in St. Joseph County ($M = 8.43$). Although this difference coincides with the difference in caregiver specialized education in communities, the correlation between caregiver specialized education and years of experience was relatively small ($r = .16$). There was no difference in caregivers’ years of experience among the six child care settings, between home and center-based care, or between child care for infants and toddlers and child care for preschool-age children.

- **Licensed and Unlicensed Care:** Caregivers in licensed and unlicensed child care settings reported similar years of experience in child care. Lake County did not follow this pattern. Caregivers in unlicensed child care reported more years of experience ($M = 19$) than those in licensed child care ($M = 12.3$). (See Figure 4.13).

FIGURE 4.13. CAREGIVER YEARS OF EXPERIENCE IN LICENSED AND UNLICENSED CARE IN FOUR COMMUNITIES.



Process Quality

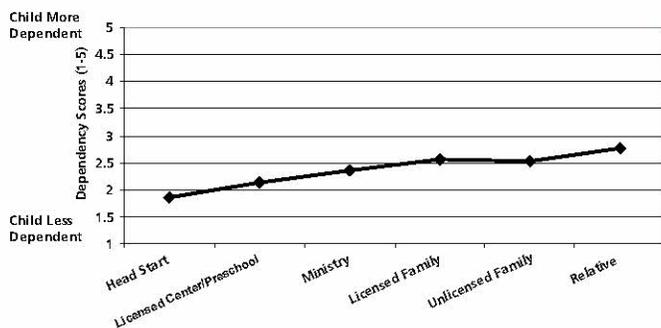
Process quality was assessed based on the caregiver-child relationship, caregiver-parent relationship, caregiver sensitivity, caregiver responsive interactions with the child, caregiver talk, and child’s activity level.

Process Quality: Caregiver-Child Relationship

Caregivers rated their perceptions of their relationship with the participating children using the Student Teacher Relationship Scale (STRS Pianta, 1992). The STRS asks the caregiver to rate the child’s interactive behavior, and how the caregiver thinks the child feels about him/her. Three subscales were used in this study to reflect different aspects of the caregiver-child relationship: Conflict/Anger, Closeness, and Dependency. Scores range from 1 to 5 with 5 indicating high conflict/anger, high closeness, and high dependency (or lack of independence). In general, caregivers rated their relationships with the child positively. Conflict and anger in their relationships was low ($M = 1.87$), while closeness was moderate to high ($M = 4.07$), and dependency was moderate to low ($M = 2.31$). There were no differences among the four communities.

There was a difference in the amount of dependency among the six child care settings. Head Start and licensed center care/preschool caregivers reported the least amount of dependency, while relative and unlicensed family care reported the most. Licensed family care and child care ministries fell in the middle. (See Figure 4.14).

FIGURE 4.14. CAREGIVER REPORT OF DEPENDENCY (STRS) IN THE SIX CHILD CARE SETTINGS



No differences in the other subscale scores (i.e., Conflict/Anger & Closeness) were found among the six types of child care settings, or between home and center-based care.

- Home-based and Center-based Care:** Caregivers in home-based settings ($M = 2.58$) reported greater dependency than in center-based settings ($M = 2.14$) in their relationships. This pattern was similar for all communities and was present even after controlling for age of the child.
- Licensed and Unlicensed Care:** Caregivers in unlicensed settings reported greater dependency ($M = 2.47$ compared to $M = 2.24$) and greater conflict ($M = 2.01$ compared to $M = 1.8$) in their relationships. This pattern was similar for all communities and was present even after controlling for age of the child.
- Child Care for Infants and Toddlers and Preschool-age Children:** Caregivers of preschool-age children reported greater closeness ($M = 4.17$ compared to $M = 3.92$) while caregivers of infants and toddlers reported greater dependency ($M = 2.53$ compared to $M = 2.17$) in their relationships. This difference was true for all communities.

Process Quality: Parent-Caregiver Relationship

Parents and caregivers used the Parent Caregiver Relationship Scale (PCRS; Elicker, Noppe, Noppe, & Fortner-Wood, 1997) to rate their perceptions of the quality of the dyadic parent-caregiver relationship. The scale assesses a parent's or a caregiver's perceptions, attitudes, and feelings about her/his relationship with the other partner in the caregiving dyad. Total and subscale scores were used for comparisons. For the parent version of

PCRS, the subscales are Trust/Confidence, Collaboration, and Affiliation. The caregiver PCRS has the same first two subscales and a Caring subscale instead of Affiliation. Scores range from 1 to 5 with 5 indicating a more positive perception of the relationship.

Parent Report

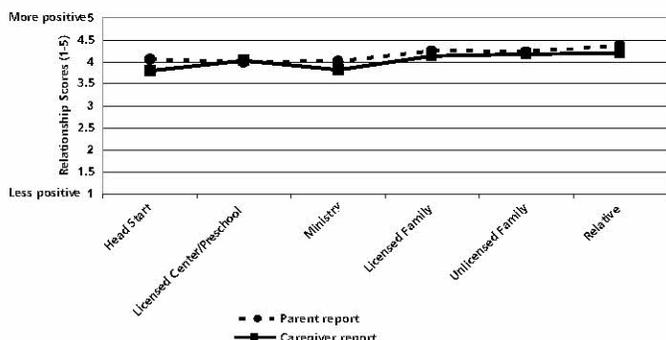
In general, relationships were rated positively ($M = 4.10$). The quality of relationships between parents and caregivers, as reported by parents, was highest in relative care ($M = 4.36$) and licensed and unlicensed family child care ($M = 4.22$); it was lowest in licensed center care/preschool ($M = 3.9$), child care ministries ($M = 4.02$) and Head Start settings ($M = 4.05$). This was true for the total and subscale scores (Trust/Confidence, Collaboration, and Affiliation). Figure 4.15 displays these differences for the total scores on the PCRS. There were no differences in the quality of parent-caregiver relationships between licensed and unlicensed care, or between child care for infants and toddlers and preschool-age children. There were community differences, however, on the total score and each subscale score. Lake County parents rated the relationship lower than Marion County parents. Parents in Allen and St. Joseph counties rated their relationships in-between parents in Lake and Marion counties.

- Home-based and Center-based Care:** The quality of relationships between parents and caregivers was higher in home-based care ($M = 4.25$ compared to $M = 4.0$). This was true for the total and subscale scores (Trust/Confidence, Collaboration, and Affiliation). This pattern was similar for all communities.

Caregiver Report

Overall, caregivers rated the parent-caregiver relationship quality similar to parent reports ($M = 4.03$ compared to $M = 4.10$). The quality of relationships between parents and caregivers, as reported by caregivers, was highest in relative care ($M = 4.26$) and licensed and unlicensed family child care ($M = 4.15$); it was lowest in licensed center care/preschool settings ($M = 4.03$), child care ministries ($M = 3.83$), and Head Start ($M = 3.79$). Figure 4.15 illustrates these differences. This pattern is similar to that reported by the parents on the PCRS. Ratings by caregivers did not differ for communities, between licensed and unlicensed care, or between child care for infants and toddlers and preschool-age children.

FIGURE 4.15. TOTAL SCORES OF PARENT-CAREGIVER RELATIONSHIP IN SIX CHILD CARE SETTINGS



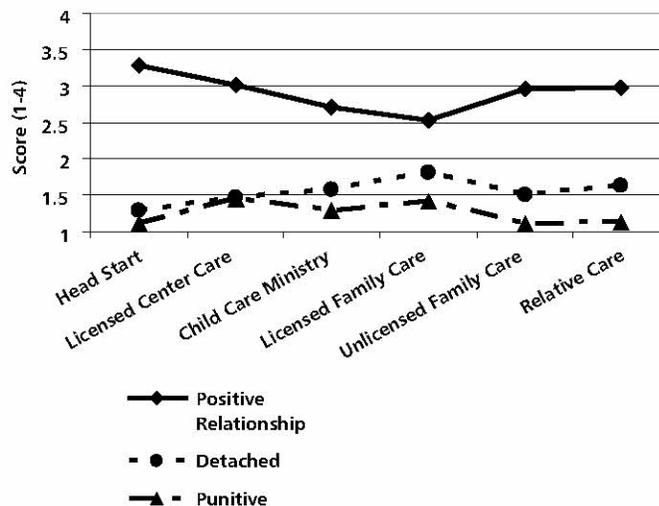
- Home-based and Center-based Care:** The quality of relationships between parents and caregivers was higher in home-based care ($M = 4.16$ compared to $M = 3.95$). This was true for the total and subscale scores (Trust/Confidence, Collaboration, and Affiliation). This pattern was similar for all communities.

Process Quality: Caregiver Sensitivity (CIS)

During the ECERS-R and FCDRS observations, researchers also rated caregiver sensitivity using the Caregiver Interaction Scale (CIS; Arnett, 1989). The subscales we used were Positive Relationship, Punitiveness, and Detachment. The Permissiveness subscale was omitted because the item scores in the subscale were not internally consistent. Scores range from 1 to 4, with 4 indicating more positive interactions, more punitiveness, and more detachment.

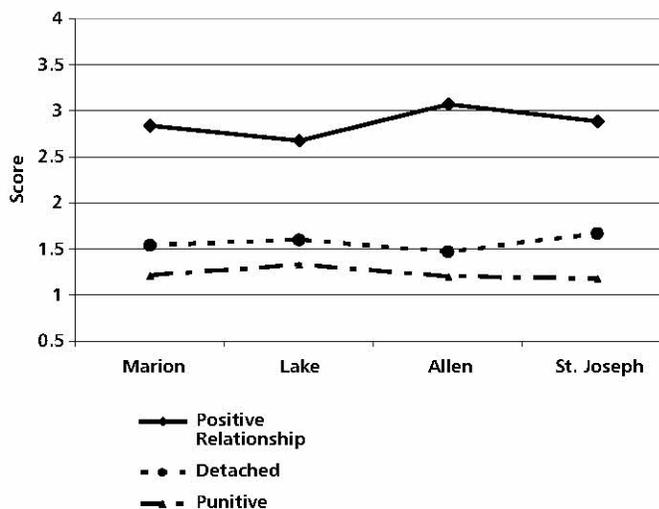
Overall, the mean scores for Positive Relationship, Punitiveness, and Detachment were 2.87, 1.23, and 1.56, respectively. There were differences in these scores among the six child care settings. Licensed family child care settings were rated higher on the Punitive subscale than all other settings ($M = 1.42$), and higher on the Detached subscale than Head Start and licensed center care/preschool settings. Licensed family child care along with child care ministries ($M = 2.5$, $M = 2.70$, respectively) were rated the lowest on the Positive Relationship subscale, while Head Start and licensed center care/preschool settings were rated the highest ($M = 3.75$, $M = 3.01$, respectively). Figure 4.16 presents the scores of each subscale for the six child care settings.

FIGURE 4.16. CAREGIVER SENSITIVITY SCORES FOR THE SIX CHILD CARE SETTINGS



The only community difference existed in the Positive Relationship subscale scores. Allen County caregivers were rated higher than Lake County caregivers on the Positive Relationship subscale ($M = 3.07$ compared to $M = 2.68$), while Marion and St. Joseph counties fell in the middle and did not differ significantly ($M = 2.84$ and $M = 2.88$, respectively). Figure 4.17 presents the scores of each subscale for the four communities.

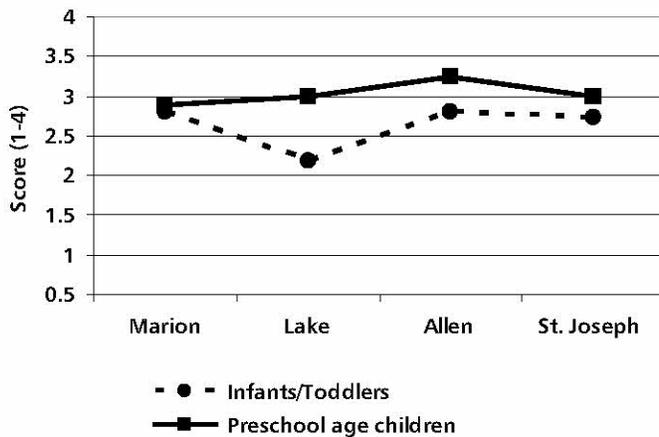
FIGURE 4.17 CAREGIVER SENSITIVITY SUBSCALE SCORES FOR THE FOUR COMMUNITIES



- Home-based and Center-based:** Home-based settings were rated lower on the Positive Relationship subscale ($M = 2.68$ compared to 2.97), higher on the Punitive subscale ($M = 1.32$ compared to 1.18), and higher on the Detached subscale ($M = 1.73$ compared to 1.47) than center-based settings. This was similar for all communities.

- Child Care for Infants and Toddlers and Preschool-age Children:** Caregiver interaction for infants and toddlers was rated as less positive ($M = 2.63$ compared to $M = 3.02$), less punitive ($M = 1.32$ compared to $M = 1.45$), and less detached ($M = 2.63$ compared to $M = 3.02$) than with preschool-age children. Within preschool-age children, there were no significant community differences. Within infants and toddlers, however, the Positive Relationship subscale score for Lake County ($M = 2.18$) was lower than the other three counties ($M = 2.74, 2.79, 2.8$, respectively). (See Figure 4.18)

FIGURE 4.18. POSITIVE RELATIONSHIP SUBSCALE SCORES FOR INFANTS AND TODDLERS AND PRESCHOOL-AGE CHILDREN IN THE FOUR COMMUNITIES

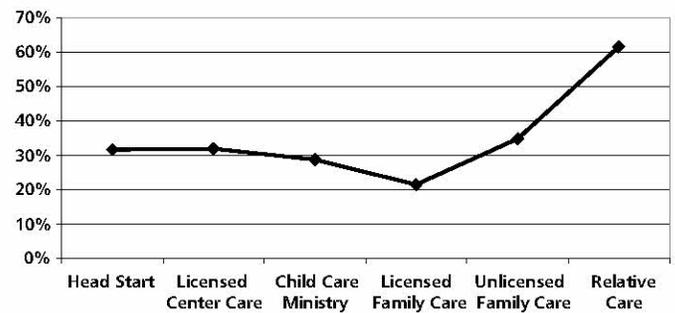


Process Quality: Caregiver Responsive Interaction with Child

Caregiver involvement with each participating child was also observed and categorized as ignore, routine/minimal, and simple/elaborated/intense using time-sampling techniques. Overall adult responsive interaction was calculated as the proportion of simple/elaborated/intense adult involvement out of the total time when an adult was within three feet of the child. In other words, the percent of time the adult was actively interacting with the child when the adult was within three feet of the child was calculated. On average, adults were observed to be interacting responsively with the child 30% of the observed times when they were within three feet of the focal child. Sixty-six sample children (21.5%) were either ignored by adult(s) or received routine or minimal involvement even when at least one adult was close to them.

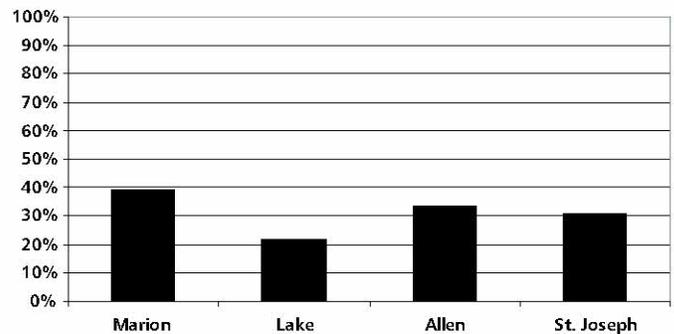
There was a significant difference in percentage of adult responsive interaction across types of child care settings. The mean percentages of adult responsive interaction in relative care (61.6%) were higher than all other forms of care. Licensed family care was observed to have the lowest percentage of adult responsive interaction (21.4%). Figure 4.19 illustrates these differences. There were no differences between home and center-based care or between licensed and unlicensed settings. (See Figure 4.19).

FIGURE 4.19. ADULT RESPONSIVE INTERACTION OF CAREGIVER WITH CHILD IN THE SIX CHILD CARE SETTINGS



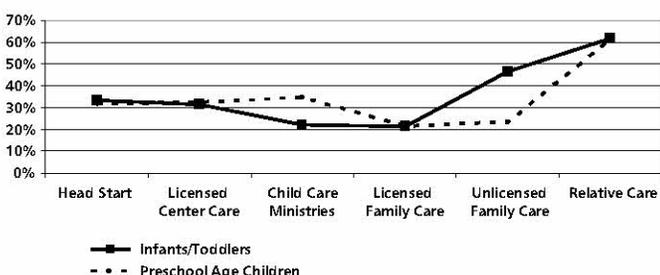
There were also differences in adult responsive interaction across communities. The mean percentages of adult responsive interaction in Marion and Allen counties were the highest (38.5% and 33.1%, respectively). Lake County was observed to have the lowest percentage of adult responsive interaction (21.4%), while St. Joseph County fell in the middle (30%). Figure 4.20 illustrates these differences.

FIGURE 4.20. ADULT RESPONSIVE INTERACTION OF CAREGIVER WITH CHILD IN THE FOUR COMMUNITIES



- Child Care for Infants and Toddlers and Preschool-age Children:** Overall, there was no difference in the level of adult responsive interaction between age groups. However, within the sample of infants and toddlers, the proportion of adult responsive interactions was significantly different across child care settings. More specifically, for infants and toddlers, caregivers were involved significantly more responsively in licensed center care/preschool centers ($M = 34.49\%$) and Head Start classrooms ($M = 50.24\%$) than they were in licensed family child care homes ($M = 20.87\%$). Adults were involved more responsively in Head Start classrooms than in child care ministries ($M = 27.37\%$). No significant difference was found for children older than 3 years. (See Figure 4.21).

FIGURE 4.21. ADULT RESPONSIVE INTERACTION IN THE SIX CHILD CARE SETTINGS



Process Quality: Caregiver Talk

Caregiver talk with child was observed by researchers using time-sampling techniques and categorized as Initiating or Responding to the child. Talk was then rated as Praise/acknowledgement, Social, Question, Expansion, Describes, Prompt/suggestion, or Directive. Proportions of time during which the caregivers were observed engaging in these types of talk were calculated. Caregivers initiated talk with the child 29% of the observed time; they responded 5% of the time. The greatest proportion was Description (14.6%), followed by Question (6.9%), Directive (5.8%), Praise (3.2%), and Prompt/suggestion (2.4%). Social talk and

Expansion were observed less than 1% of the time. There were no differences in caregiver talk among the six types of child care setting, between home and center-based care, or between licensed and unlicensed care. The only community difference was in the amount of directive talk. Allen County caregivers used directive talk significantly more than the other counties (3% compared to 6.5%).

- Child care for Infants and Toddler and Preschool-age Children:** Caregivers for preschool-age children were observed using descriptive talk more than caregivers of infants and toddlers ($M = 16\%$ compared to 12%). Although infant/toddler and preschool caregivers did not differ on other categories of talk, differences emerged in the percent of praise talk when the type of setting was considered. While relative and Head Start caregivers used more praise talk with infants and toddlers, unlicensed family child care caregivers used praise talk more with preschool-age children.

Process Quality: Child’s Cognitive Activity Level

Using time-sampling techniques (20-second intervals), research assistants coded the behaviors of each child to reflect the type of activity in which he/she was engaged. Then, based on the type of activity in which the child was engaged, the cognitive activity level was categorized as none, low-yield, medium-yield, and high-yield activities, and the proportions of each category to the total intervals observed were calculated. (See Table 4.2 for a description of the categories). The percent of each activity level was weighted by 0, 1, 2, and 3, and the sum of the four was used as

Children in Head Start displayed higher levels of cognitive activity ($M = 1.22$) than children in relative care and child care ministries ($m = .74$ and $M = .98$, respectively).

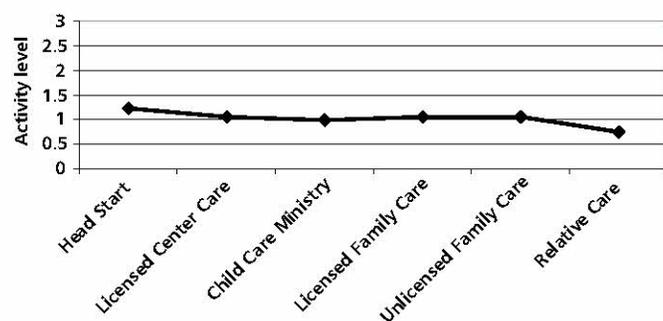
TABLE 4.2. DEFINITIONS OF CHILDREN’S COGNITIVE ACTIVITY LEVELS

Cognitive Activity Level	Activities Engaged	Weight Given
None	Routines, Other, and Unoccupied/wandering	0
Low-yield	Close-ended art, Didactic, TV (TV and TV-child), and Large motor.	1
Medium-yield activities	Manipulatives, Book/Writing, Sensory, Computer, and Music	2
High-yield activities	Open-ended art, Blocks, and Dramatic play	3

overall children's activity level. The possible range of the scores is 0 to 3. Overall, the average level of children's activity was 1.04 (min = .02 and max = 2.84). This means the overall children's activity level was a little higher than "low yield."

Differences were found in children's cognitive activity among the six types of child care settings. Children in relative care displayed lower levels of cognitive activity ($M = .74$) than other forms of care. Children in Head Start displayed higher levels of cognitive activity ($M = 1.22$) than children in relative care and child care ministries ($m = .74$ and $M = .98$, respectively). Figure 4.22 illustrates these differences. There were no differences between home and center-based settings or among the four communities.

FIGURE 4.22. CHILD COGNITIVE ACTIVITY LEVEL IN THE SIX CHILD CARE SETTINGS



- **Licensed and Unlicensed care:** The overall level of child's cognitive activity was higher in licensed settings ($M = 1.07$ vs. $.96$). This was similar for all communities.
- **Child Care for Infants and Toddlers and Pre-school-age Children:** The overall level of preschool-age children's cognitive activity was higher than that of infants and toddlers ($M = 1.13$ vs. $.91$). This was similar for all communities.

CONCLUSIONS

Despite the parents' high ratings of their child care quality, the global quality levels assessed by our trained observers of all types of care used by low-income working families in these four communities were relatively low. On a well-validated observation scale, the average level of child care quality observed was below "good," and just above "minimal." Almost $\frac{1}{2}$ of the children in this sample attended child care that may not have provided the kinds of experiences and environment thought to be important for development. The highest levels of global quality were found

in Head Start settings and licensed center care/preschool centers, while the lowest levels were observed in child care ministries, licensed family care, unlicensed family care, and relative care. Overall, licensed settings were of higher global quality than unlicensed settings.

In general, child-adult ratios in the settings complied with NAEYC guidelines. Caregivers in center-based care and licensed care reported more general and specialized education than caregivers in home-based or unlicensed care. On indicators of process quality, home-based settings had more positive parent-caregiver relationships, while center-based settings were higher on measures of caregiver sensitivity with children. Licensed family child care tended to be the lowest on process quality, especially for infant/toddler care. Overall, infants and toddlers received the lowest quality of care. Global quality for infants and toddlers was at a minimal level or below in all types of settings in all four communities, regardless of whether the care was center- or home-based. Caregivers of infants and toddlers also reported lower levels of general and specialized education than caregivers of preschool-age children.

REFERENCES

- Arnett, J. (1989). Caregivers in day-care centers: Does training matter? *Journal of Applied Developmental Psychology*, 10, 541-552.
- +Elicker, J., Noppe, I. C., Noppe, L. D., & Fortner-Wood, C. (1997). The Parent-Caregiver Relationship Scale: Rounding out the relationship system in infant child care. *Early Education & Development*, 8(1), 83-100.
- Harms, T., Clifford, R. M., & Cryer, D. (1998). *Early Childhood Environment Rating Scale, Revised Edition*. New York: Teachers College Press.
- Harms, T., & Clifford, R. M. (1989). *Family Day Care Rating Scale*. New York: Teachers College Press.
- Hayes, Palmer & Zaslow (1990). *Who cares for America's children? Childcare policy for the 1990's*. Washington, D.C.: National Academy Press.
- Howes, C., Phillips, D., & Whitebook, (1992). Thresholds of quality: Implications for the social development of children in center-based childcare. *Child Development*, 63, 449-460.

Pianta, R. (1992). The Student-teacher Relationship Scale. Unpublished manuscript. University of Virginia, Charlottesville.

Phillips, D., Mekos, D., Scarr, S., McCartney, K., Abbott-Shim, M. (2000). Within and Beyond the Classroom Door: Assessing Quality in Child Care Centers. *Early Childhood Research Quarterly*, 15, 475-496.

Chapter 5

LOW INCOME WORKING FAMILIES: CHILDREN'S DEVELOPMENT AND CHILD CARE QUALITY

This chapter explores variations in cognitive and social-emotional developmental outcomes among the 307 children who participated in the study. Cognitive development for infants and toddlers was assessed directly by researchers, and included early learning skills such as visual reception, fine motor, receptive vocabulary, and expressive vocabulary. For preschool-age children, cognitive development was also assessed directly by researchers, and included receptive vocabulary, social awareness (e.g., give name, date of birth), color naming, and counting. Preschool cognitive outcomes also included academic attitudes such as creativity, verbal intelligence, independence, task orientation, and distractibility, assessed by parent and caregiver ratings. Children's social-emotional development was assessed by caregiver and parent ratings of children's social competence and problem behaviors (e.g., anger/aggressiveness and anxiety-withdrawal). For a complete description of the child development measures see Appendix A.

Relationships between child care quality (discussed in Chapter 4) and children's cognitive and social-emotional outcomes were examined using correlation and regression analyses (see Appendix F for these statistics). The level of mothers' education, the child's age in months, the child care setting, and the community of residence were included as control variables in these analyses.

CHILDREN'S COGNITIVE OUTCOMES

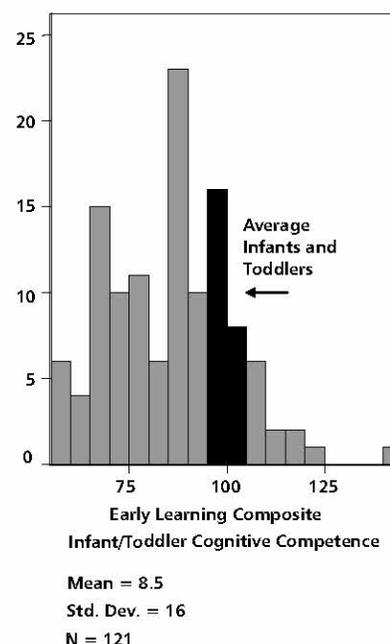
Infants/Toddlers

Each infant and toddler's visual reception (performance in processing visual patterns), fine motor skills (visual-motor ability), receptive vocabulary (understanding of words), and expressive vocabulary (ability to produce language—words and sounds) were assessed directly by researchers using the Mullen Scales of Early Learning. An overall Early Learning composite score was then created based on these subtests.

The majority of infants and toddlers in this low-income working family sample were less advanced in these areas of cognitive competence than average children of the same age. While the average score for the Mullen Early Learning Composite based on

a sample of children of any given age across all income levels is 100, infants and toddlers in this sample had a mean score of 85 (SD = 16, Mdn = 87). Scores of children in this research sample ranged from 56 to 143, with only 15% scoring above the test average (100) for infants and toddlers. No differences in infant and toddler early learning skills were found among the four communities. Figure 5.1 displays the distribution of scores.

FIGURE 5.1. DISTRIBUTION OF INFANT/TODDLER EARLY LEARNING COMPOSITE SCORES IN THIS RESEARCH SAMPLE



The typical infant or toddler in this sample was at the 15th percentile in early learning (cognitive) skills when compared to the test norms for children in the same age range. Even prior to age 3 years, children in this sample seem to be behind their age-mates in cognitive competence.

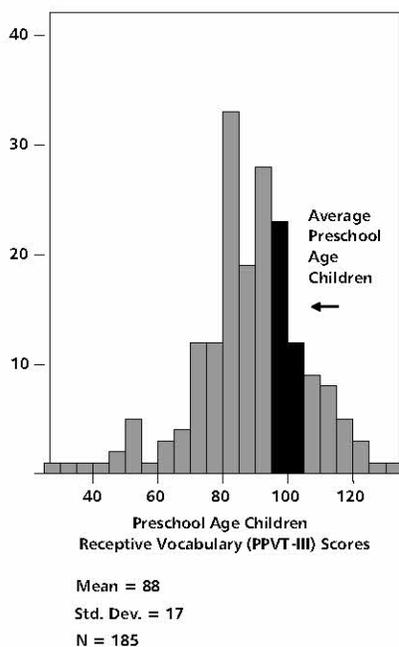
Preschool-Age Children

Preschool-age children's cognitive skills were assessed a number of ways. Early academic skills were assessed directly by research assistants. (See Appendix A for detailed descriptions of these assessments.) Children were asked to state their first and last name, age, and month and day of birth (FACES social awareness

task), name 10 colors (FACES color naming task), and count 10 bears while pointing to 10 objects (FACES bear counting task). The Peabody Picture Vocabulary Test-Third Edition (PPVT-III) was also administered to assess each child's receptive vocabulary. Academic attitude was assessed by parent and caregiver ratings of each child's creativity, verbal intelligence, independence, task orientation, and distractibility using portions of the Classroom Behavior Inventory (CBI). Scores on the CBI range from 1 (not at all like the child) to 5 (very much like the child).

One-third of the preschool-age children were able to state their first and last name, age, and month and day of birth; about half of the children were able to recall three out of five. On average, children could identify eight of 10 colors, and 55% of children could identify nine to 10 colors. Nearly two-thirds were able to complete the counting task (counting up to 10 bears). Similar to the Early Learning scale for the infant and toddler sample, the majority of preschool-age children in this research sample scored lower in receptive vocabulary than average of the same age, according to published norms. While the average test score based on a sample of children of a given age across all income levels is 100, children in this sample had a mean score of 88 (SD = 17 Mdn = 89). Scores ranged from 29 to 132, with only 20% of this sample scoring above the national average for preschool children. Figure 5.2 displays the distribution of scores.

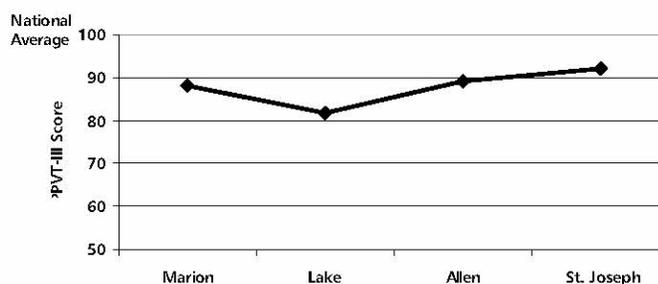
FIGURE 5.2. DISTRIBUTION OF PRESCHOOL-AGE CHILDREN'S RECEPTIVE VOCABULARY (PPVT-III) SCORES IN THIS RESEARCH SAMPLE



These results suggest that the typical preschool-age child from this sample of low income working families was at the 20th percentile in receptive vocabulary ability when compared to typical children in the same age range.

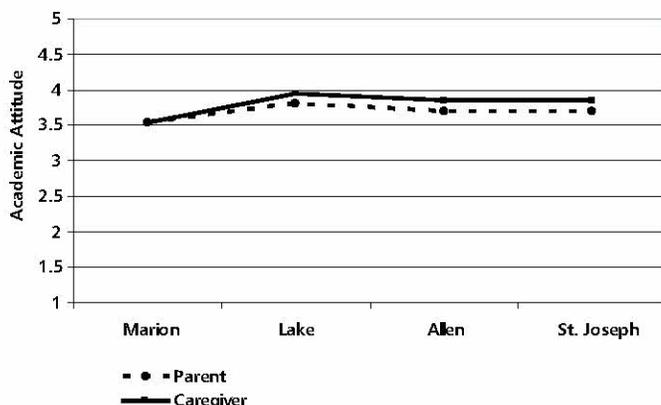
There were differences among the four communities in preschool children's receptive vocabulary (PPVT-III) abilities. Children in the Lake County sample (M=82) scored lower on receptive vocabulary ability than children in St. Joseph, Allen, and Marion counties (M=92, M=89, and M=88, respectively). These differences remained even after mother's education and child's age in months were taken into account. Figure 5.3 displays these differences.

FIGURE 5.3. RECEPTIVE VOCABULARY (PPVT-III) SCORES FOR PRESCHOOL-AGE CHILDREN IN THE FOUR COMMUNITIES



In general, children were rated positively in academic attitudes by both parents and caregivers. The mean scores were not significantly different for parent (M = 3.68) and caregiver reports (M = 3.53) (possible score range was 1 to 5). Therefore, on average, both caregivers and parents rated preschool-age children as relatively creative, verbally intelligent, independent, task-oriented, and not very distractible. In general, parents and caregivers viewed the children as having positive academic attitudes. Parent ratings of academic attitudes did vary by county. Lake County parents rated their children somewhat higher (M= 3.80) than did parents in Marion County (M=3.53). Children in St. Joseph and Allen counties fell between (M=3.70). Even after controlling for the effect of mother's education and child's age, these differences remained. Figure 5.4 displays academic attitude scores from parent and caregiver reports.

FIGURE 5.4. ACADEMIC ATTITUDE SCORES OF PRE-SCHOOL-AGE CHILDREN IN THE FOUR COMMUNITIES BY PARENTS AND CAREGIVERS



In general, preschool-age children in center-based care performed higher on all measures of cognitive competence than did children in home-based care. However, children in center-based care were older and also had mothers with slightly higher education levels. When the influence of mother's education and child's age were statistically controlled, these differences in cognitive competence disappeared. When we examined differences among the six specific child care settings, the difference found between home-based and center-based child care also faded. The only difference that remained was in the children's ability to state their first and last name, age, and month and day of their birth. Children in licensed center care/preschools could correctly complete about four out of five of these items, while children in licensed family child care and relative care could correctly complete two to three out of the five items. Child care ministries, unlicensed family child care, and Head Start fell in the middle. When licensed and unlicensed settings were compared, the only difference that emerged was in color naming. Preschool-age children in licensed child care were able to name almost eight colors, while children in unlicensed care named approximately six. However, this licensed-unlicensed difference may have been due to child age and mother education, because the differences disappeared when these characteristics were statistically controlled.

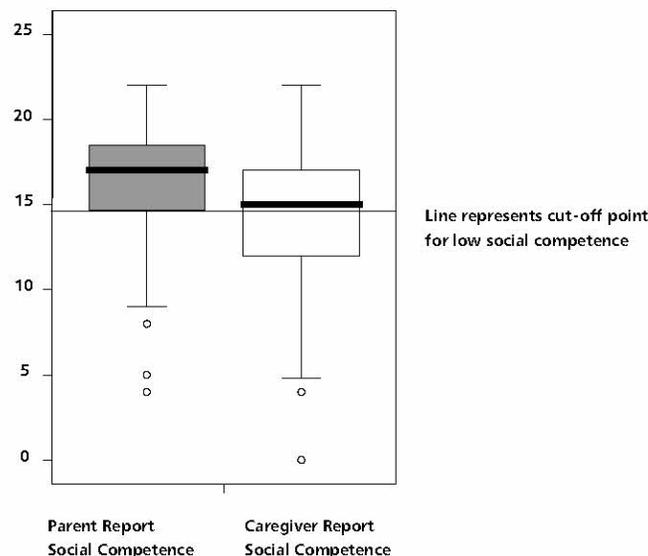
CHILDREN'S SOCIAL-EMOTIONAL OUTCOMES

Infants/Toddlers

Parents and caregivers reported children's social competence and behavior problems using the Brief Infant Toddler Social and Emotional Assessment (BITSEA). In general, both parents

and caregivers rated children low on behavior problems and high on social competence. Cut-off points to determine extreme scores for Problem Behavior and Social Competence scales were examined. Compared to a test sample researched by the BITSEA authors, children with scores above the 75th percentile on the Problem Behavior Scale and those with scores below the 25th percentile on the Social Competence Scale are of special interest. Children with scores in the highest quartile for behavior problems or the lowest quartile for competence on the BITSEA are not considered to have psychopathology or delayed competence, but they may be considered at-risk and warrant further assessment. Twenty-six percent (26%) of children in this research sample were identified by parents and 49% were identified by caregivers to have competence scores in the lowest 25th percentile. Figure 5.5 displays the distribution of scores from parent and caregiver social competence reports.

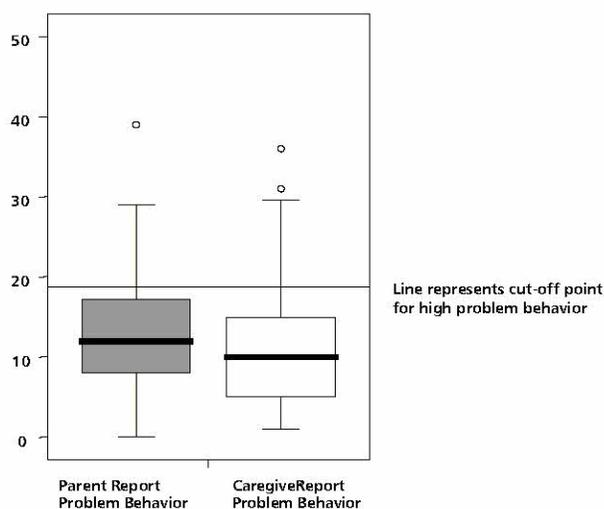
FIGURE 5.5. INFANTS/TODDLERS SCORES ON SOCIAL COMPETENCE SCALE OF BITSEA, REPORTED BY PARENTS AND CAREGIVERS



Note: Scores below the line indicate infants/toddlers who fell below social competence cut-off point, indicating risk.

Eighteen percent (18%) of children were identified by parents and 12% were identified by caregivers to have problem behavior scores above the 75th percentile. Figure 5.6 displays the scores on each problem behavior report. There were no differences in social outcomes as assessed with the BITSEA among the four communities, or among types of child care. Composite variables (combining parent and caregivers reports) were created for Social Competence and Problem Behavior.

FIGURE 5.6. INFANTS/TODDLERS SCORES ON PROBLEM BEHAVIOR SCALE OF BITSEA REPORTED BY PARENTS AND CAREGIVERS



Note: Scores above the line indicate infants/toddlers who were above the problem behavior cut-off point, indicating risk.

Preschool-age Children

Portions of the Classroom Behavior Inventory were completed by parents and caregivers to assess extroversion and considerateness. The Social Competence and Behavior Evaluation (SCBE) was completed by parents and caregivers to assess anger-aggression, social competence, and anxiety-withdrawal. Together, these measures were used to create two overall social-emotional competence composite scores for preschoolers, one reported by parents and one reported by caregivers. High scores indicate that the child's behavior was rated lower on anger-aggression and anxiety-withdrawal and higher on social competence; low scores imply that the child's behavior was rated higher on anger-aggression and anxiety-withdrawal and lower on social competence.

For our analyses, standardized scores were used ($M = 0$, $SD = 1$). If the score is a positive number, the child was more socially competent and less aggressive and anxious/withdrawn. If the score is a negative number, the child was more aggressive and anxious/withdrawn and less socially competent. If the score is close to 0, it means there is a balance between social competence and anger/aggression/anxiety/withdrawal. There were no differences in composite scores among counties or among types of child care. In general, most children were rated moderate to high on social competence and low on problem behaviors.

WHAT IS THE RELATIONSHIP BETWEEN CHILD CARE QUALITY AND CHILDREN'S COGNITIVE AND SOCIAL-EMOTIONAL DEVELOPMENT? DOES TYPE OF CHILD CARE OR COMMUNITY OF RESIDENCE MAKE A DIFFERENCE IN THESE RELATIONSHIPS?

The relationships between child care quality and children's cognitive and social-emotional competence were examined. Statistical analyses were conducted to determine if there were significant associations between child care quality measures and children's developmental competence measures, and also to determine if these associations still existed after the effects of mother's education level, child's age in months, and child care setting were considered. The effects of mother's education, child age, and type of child care were examined separately first, and then combined with child care quality indicators. Multi-level regression analyses were also used to determine if relationships between quality and children's competence varied by community. The relationships between mother's education, child's age, and child's competence were controlled in each analysis, so we could more clearly determine if there is a link between child care quality and child development.

Global Quality and Child Competence

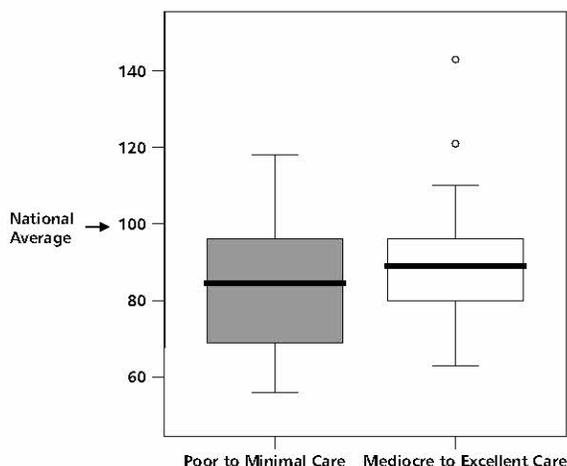
Global quality of child care settings (ECERS-R and FDCRS scores) was positively related to aspects of cognitive competence among both infants/toddlers and preschool-age children. We found no relationship, however, between global quality and social-emotional competence for either age group.

- **Infants/Toddlers**

Infants and toddlers in child care programs of higher global quality (ECERS-R or FDCRS) scored higher on early learning skills (visual reception, fine motor, receptive vocabulary, and expressive vocabulary) than infants and toddlers in child care programs of lower global quality. Higher levels of mother's education were also related to higher scores of early learning skills. There was no relationship between child's age, type of child care setting, and these early learning skills. When relationships with mother's education level, type of child care setting, and child's age were controlled, the relationship between global quality and early learning skills remained. Therefore, children who were cared for in the same type of child care setting and who had mothers with similar education levels were likely to exhibit higher

early learning skills if their child care setting was of higher global quality. Figure 5.7 provides a comparison of poor-to-minimal and mediocre-to-excellent quality programs. It should be recalled, however, that most infants and toddlers in our study received lower than average scores on the early learning measure, regardless of child care quality.

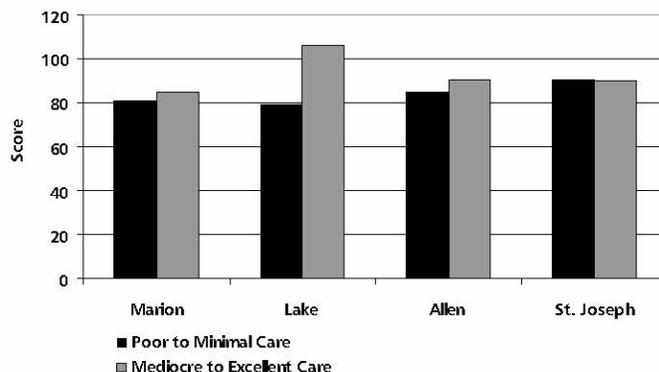
FIGURE 5.7. RELATIONSHIP BETWEEN GLOBAL QUALITY AND INFANT/TODDLER EARLY LEARNING COMPOSITE SCORES



Note: ECERS-R and FDCRS categories were coded as follows: 1-3.49 = poor to minimal care, 3.50-7 = mediocre to excellent care

When the effect of community was considered, the relationship between global quality and infant/toddler early learning skills varied. Figure 5.8 depicts early learning skills in the four communities. In Marion and Allen counties, the difference in early learning skills between infants/toddlers in low and high global quality settings was noticeable, but only statistically significant in Allen County. Lake County displayed the strongest relationship between global quality and early learning skills, but also averaged the lowest global quality and the least variation in global quality among communities. In St. Joseph County, no significant relationship between global quality and early learning skills was present; on average, infants and toddlers in low and high quality child care settings scored similarly on early learning skills. One explanation for this lack of difference in 3 counties is that the quality of child care for infants and toddlers does not vary too much and is relatively low in all counties.

FIGURE 5.8. EARLY LEARNING COMPOSITE SCORES IN HIGH AND LOW QUALITY CHILD CARE SETTINGS IN THE FOUR COMMUNITIES

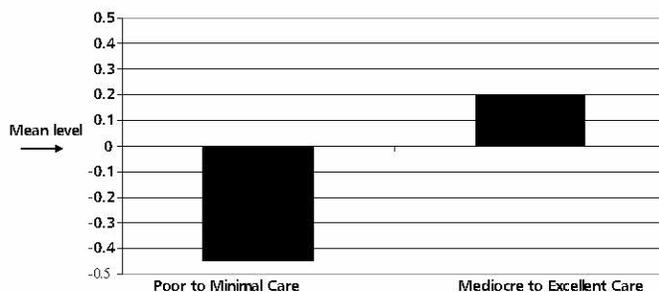


Note: ECERS -R and FDCRS categories were coded as follows 1-3.49=poor to minimal care; 3.51-7=mediocre to excellent care.

• **Preschool-age Children**

Preschool-age children in child care settings of higher global quality (ECERS-R or FDCRS) scored higher on early academic skills than children in child care settings of lower global quality. Mother's education and type of child care setting were not related to children's scores of early academic skills. Older children tended to score higher on early academic skills than younger children. When relationships with mother's education level, type of child care setting, and child's age were controlled, the relationship between global quality and early academic skills remained. Figure 5.9 illustrates this relationship. Variables that made up early academic skills (i.e., FACES tasks and receptive vocabulary) were submitted to factor analyses, and factor scores were used for regression analyses. These variables had a mean of 0 and standard deviation of 1. Positive scores indicate higher levels of early academic skills while negative scores indicate lower levels of early academic skills.

FIGURE 5.9 RELATIONSHIP BETWEEN GLOBAL CHILD CARE QUALITY AND PRESCHOOL-AGE CHILDREN'S EARLY ACADEMIC SKILLS SCORES



Note: 5.9 Relationship between global quality and early academic skills of preschool age children

The relationship between global quality and preschool children's early academic skills scores did not vary among the four communities. In conclusion: Regardless of community residence, children who were cared for in the same type of child care settings and had mothers with similar education were more likely to exhibit higher early academic skills if their child care setting was of higher overall quality.

Structural Quality and Child Competence

Some aspects of structural quality (adult-child ratio, caregiver education, and caregiver specialized training) were not associated with children's cognitive outcomes. There were associations, however, between indicators of structural quality and the social-emotional competence of both infants/toddlers and preschool-age children.

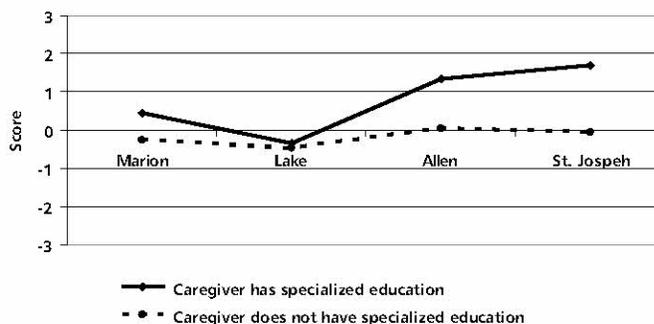
- **Infants/Toddlers**

Higher levels of caregiver general education were related to higher ratings of infant/toddler social-emotional competence, as rated by parents. Mother's education and type of child care setting were not related to social-emotional competence ratings by parents. Older children were rated higher on social-emotional competence than younger children. When mother's education, type of child care setting, and child's age were taken into account, the relationships between caregiver general education and social-emotional competence disappeared. Therefore, when mothers were more educated, when the child was older, and when they were in certain types of child care, children were more likely to be cared for by caregivers with higher levels of general education. While there was a link between these variables and social-emotional competence, it is impossible to disentangle their separate influences. This did not vary by community.

Caregiver specialized education in child development/early childhood education was also related to higher ratings of infant/toddler social-emotional competence, as rated by parents. When relationships with mother's education level, type of child care setting, and child's age were controlled, this relationship remained. Infants and toddlers with mothers of similar education and cared for in the same type of child care settings were more likely to be rated higher on social-emotional competence by parents if their caregiver had more specialized education in child development or early education. This relationship did, however, vary by community. In St. Joseph County this relationship remained, while in Marion and Allen counties the relationship was

weaker. In Lake County the relationship did not exist. Figure 5.10 presents these relationships.

FIGURE 5.10. SOCIAL-EMOTIONAL COMPETENCE SCORES OF INFANTS AND TODDLERS IN THE FOUR COMMUNITIES



Note. Positive score on social-emotional competence indicates more social competence and fewer problem behaviors; negative score on social-emotional competence indicates lower social competence and more problem behaviors.

- **Preschool-age Children**

Preschool-age children who were cared for by caregivers with higher levels of education were rated higher on social-emotional competence by their caregivers. Mother's education, type of child care setting, and child's age were not related to social-emotional competence rated by caregivers. However, when relationships with mother's education level, type of child care setting, and child's age were controlled, the relationship between caregiver education and social-emotional competence diminished. While there was a link between these variables and social-emotional competence, it is impossible to disentangle their separate influences. This did not differ for the four communities.

Process Quality and Child Outcomes

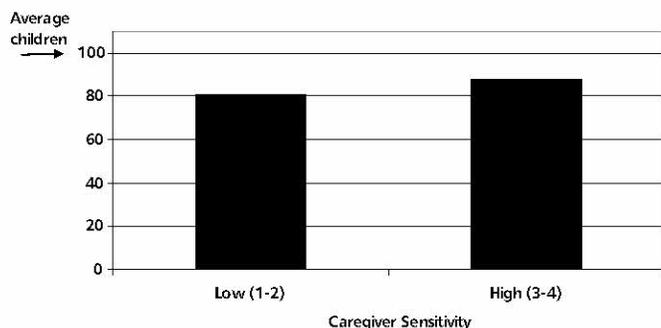
Indicators of process quality (including caregiver sensitivity, caregiver talk, and interpersonal relationships within the child care setting) were positively related to cognitive and social-emotional competence among both infants/toddlers and preschool-age children.

- **Infants/Toddlers**

Greater caregiver sensitivity (positive, warm, and non-punitive interactions with children) and a greater percentage of high-level caregiver talk (questioning, expanding, describing, and prompting/suggesting) were related to higher early learning composite scores for infants and toddlers. The relationship between caregiver sensitivity and early learning composite scores remained even after maternal educa-

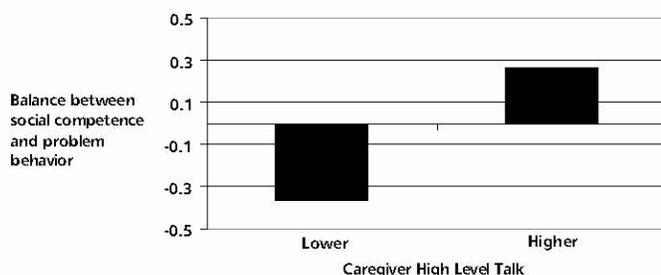
tion, type of child care setting, and child's age were taken into account. This relationship did not vary by community. Therefore, infants/toddlers with mothers of similar education and cared for in the same type of child care setting were more likely to exhibit higher early learning skills if the caregiver was involved in positive, warm, and non-punitive interactions with children, regardless of community residence. Figure 5.11 illustrates this relationship. The relationship between caregiver talk and early learning skills was not statistically significant when mother's education, type of child care and child's age were considered. This did not vary by community.

FIGURE 5.11. RELATIONSHIP BETWEEN CAREGIVER SENSITIVITY AND INFANT/TODDLER EARLY LEARNING SKILLS



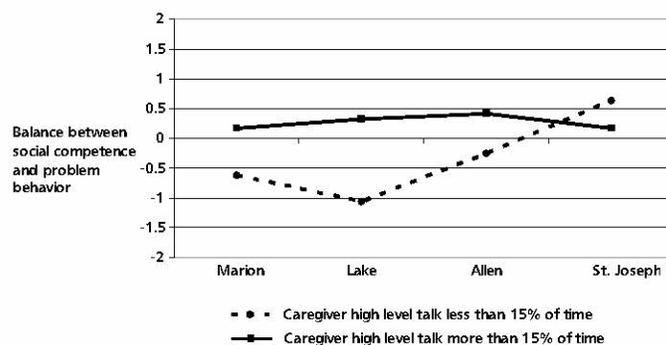
A greater percentage of high-level caregiver talk was related to higher ratings of social-emotional competence by the parent. When relationships with mother's education level, type of child care setting, and child's age were controlled, the relationship between caregiver talk and social-emotional competence remained. Therefore, infants and toddlers with mothers of similar education and cared for in the same type of child care settings were more likely to be rated higher on social-emotional competence by the parent if the caregiver used a greater percentage of high-level talk with the child. Figure 5.12 presents these differences.

FIGURE 5.12. RELATIONSHIP BETWEEN CAREGIVER HIGH-LEVEL TALK AND INFANT/TODDLERS SOCIAL-EMOTIONAL COMPETENCE REPORTED BY PARENT



The relationship between caregiver talk and social-emotional competence varied by community. In Marion, Allen, and Lake counties the relationship was present, with the strongest relationship in Marion County. Thus, infants and toddlers in Marion, Allen, and Lake counties were more likely to be rated higher on ratings of social-emotional competence if their caregivers used high caregiver talk more often. In St. Joseph County we found no statistically significant relationship between ratings of social-emotional competence and caregiver talk. Figure 5.13 illustrates these relationships.

FIGURE 5.13. RELATIONSHIP BETWEEN PARENT REPORT OF SOCIAL-EMOTIONAL COMPETENCE OF INFANTS AND TODDLERS AND CAREGIVER HIGH-LEVEL TALK IN THE FOUR COMMUNITIES



A greater percentage of adult responsive interaction with the child was related to lower ratings of social-emotional competence by the parent. When mother's education, type of child care setting, and child's age were taken into account, the relationship between the percentage of caregivers involved in complex interactions and lower ratings of social-emotional competence by the parent diminished. Therefore, when children's mothers were more educated, when the child was older, and when they were in certain types of child care, they also were cared for by caregivers who used a more adult responsive interaction. While there was a link between these variables and social-emotional competence, it is impossible to disentangle their separate influences. This was true for all communities.

- **Preschool-age children**

More positive ratings of the caregiver-child relationship by the caregiver and greater observed caregiver sensitivity were related to higher scores in children's early academic skills. However, when the relationship of mother's education, type of child care setting, and child's age were controlled, these relationships proved not statistically significant. Therefore, when children's mothers were more educated, when the child was older, and when they were in certain types of child care, the caregiver-child positive relationship and caregiver sensitivity was also higher. While there was a link between these variables and early academic skills, it is impossible to disentangle their separate influences. This relationship did not differ for the four communities.

A greater percentage of high-level caregiver talk (questioning, expanding, describing, prompting/suggesting) was linked to higher scores of early academic skills and higher ratings of social-emotional competence, rated by caregivers. The relationship between caregiver talk and early academic skills remained even after mother's education, type of child care setting, and child's age were considered. The relationship between caregiver talk and early academic skills did not vary by community. Therefore, preschoolers with mothers of similar education and cared for in the same type of child care setting were more likely to exhibit higher early academic skills if they experienced a higher-level caregiver talk, regardless of community residence. The relationship between caregiver talk and social-emotional competence proved not statistically significant when the effect of mother's education, type of child care setting, and child's age were taken into account. Therefore, when children's mothers were more educated, when the child was older, and when they were in certain types of child care, they also were cared for by caregivers who used higher level talk. While there was a link between these variables and social-emotional competence, it is impossible to disentangle their separate influences. This was true for each of the four communities.

Greater caregiver sensitivity was also correlated with higher early academic skills. However, when the relationship of

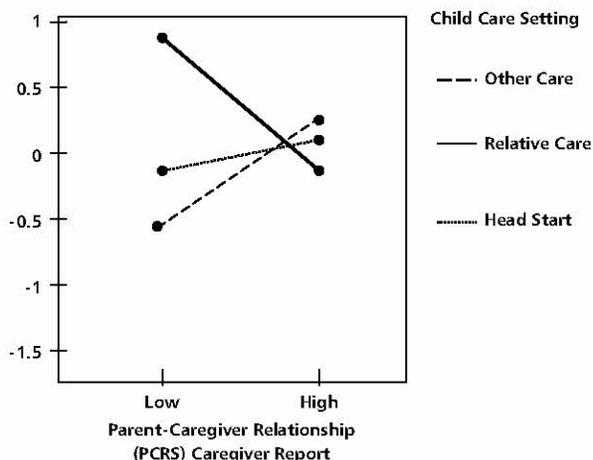
mother's education, child's age, and type of child care setting were controlled, these relationships proved not statistically significant. Therefore, when children's mothers were more educated, when the child was older, and when they were in certain types of child care, they also received more sensitive care. While there was a link between these variables and early academic skills, it is impossible to disentangle their separate influences. This finding was consistent among the four communities.

Positive ratings of the parent-caregiver relationship by the parent were also related to higher ratings of the child's academic attitude and higher ratings of social-emotional competence by the parent. Mothers' education, type of child care setting, and child's age were not related to either academic competence or social-emotional competence. When relationships with mother's education, type of child care setting, and child's age were controlled, the relationships remained. These relationships did not vary by community. Therefore, preschool-age children who were cared for in the same type of child care settings with mothers of similar education were more likely to be rated higher on social competence and academic attitudes if their parent rated the parent-caregiver relationship more positively, regardless of community residence.

Similarly, more positive ratings of the parent-caregiver relationship by the caregiver were related to higher ratings of children's social-emotional competence, rated by the caregiver. This relationship changed slightly after the type of child care setting was considered. The relationship was strong for licensed center care/preschools, child care ministries, licensed family care, and unlicensed family care. For Head Start settings, this relationship did not exist, while for relative care the relationship was opposite. Therefore, with the exception of Head Start and relative care, children cared for by caregivers who rated the parent-caregiver relationship more positively were more likely to be rated higher on social-emotional competence, regardless of mother's education, child's age in months, and community residence. Figure 5. 14 illustrates these differences.



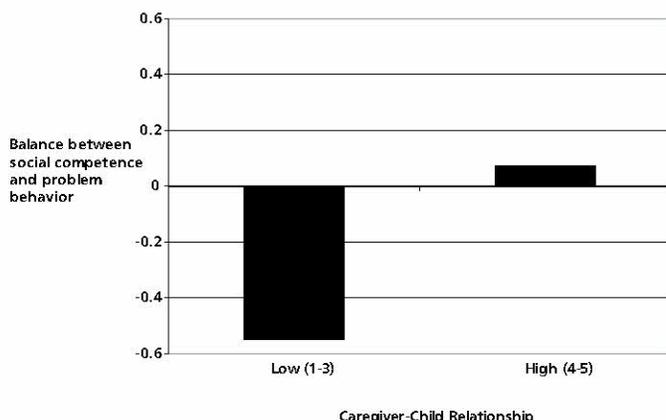
FIGURE 5.14. RELATIONSHIP BETWEEN PARENT-CAREGIVER RELATIONSHIP AND PRESCHOOL-AGE CHILDREN'S SOCIAL-EMOTIONAL COMPETENCE REPORTED BY CAREGIVERS IN DIFFERENT CHILD CARE SETTINGS



Note: Other care illustrates the similar relationships between parent-caregiver relationship and social-emotional competence that existed in licensed center/preschool care, child care ministry, licensed family care and unlicensed family care.

More positive ratings of the caregiver-child relationship by the caregiver were related to higher ratings of children's social-emotional competence by both parents and caregivers. These links between caregiver-child relationships and children's social-emotional competence remained even after maternal education, type of child care setting, and child's age were taken into account. Therefore, children who were cared for in the same type of child care settings with mothers of similar education were more likely to be rated higher on social-emotional competence if their caregiver-child relationship was more positive, regardless of community residence. Figure 5.15 illustrates this relationship.

FIGURE 5.15. RELATIONSHIP BETWEEN CAREGIVER-CHILD RELATIONSHIP AND PRESCHOOL-AGE CHILDREN'S SOCIAL-EMOTIONAL COMPETENCE REPORTED BY PARENTS



CONCLUSIONS

Children of low-income working parents in this sample scored lower than established average levels in some areas of cognitive competence. Even prior to the age of 3 years, children in this sample are behind their age mates in cognitive competence. This finding has important policy implications and suggests the need for enrichment in both family and child care settings to promote these children's early cognitive development. The availability of quality child care for infants and toddlers in this sample is of special concern based on the results of this research, since global quality ratings for the youngest children were at a minimal level or below, regardless of type of child care setting.

Global, structural, and process child care quality indicators were associated with children's cognitive and social-emotional competence, even after controlling for mothers' education and children's age. Therefore, efforts to improve child care quality are likely to have a positive impact on the development of children like those in this sample. In general, the relationships between child care quality and child competence did not vary by community, nor by child care setting. These links between quality and child development are robust. Improving child care quality for low-income working families is an issue that deserves attention in these Indiana communities, and probably in other communities.

CHILDREN AND CAREGIVERS: DOES ETHNICITY OR ETHNIC MATCH INFLUENCE RELATIONSHIPS IN CHILD CARE?

MICERE ODEN, UNDERGRADUATE RESEARCH ASSISTANT,
FEBRUARY 2, 2005

(Note: Micere Oden participated in the Community Child Care Research Project (CCCRP) as an undergraduate research assistant from 2002 to 2004. This is a summary of the independent study she conducted using the CCCRP data. Micere graduated from Purdue in December, 2004 with a B.S. in Youth, Adult, and Family Services.)

The objective of this study was to discover how ethnicity relates to interactions and relationships between caregivers and children. Using the data from the Community Child Care Research Project, I investigated whether or not child ethnicity, caregiver ethnicity, and caregiver-child ethnic match were associated with (1) caregivers' perceptions of their relationships with children and (2) the proportion of time caregivers talked to children.

Research Question 1: Are child ethnicity and caregiver ethnicity associated with caregiver-child relationships?

Research Question 2: Is caregiver-child ethnic match associated with caregiver-child relationships?

Research Question 3: Are child ethnicity and caregiver ethnicity associated with the amount of time caregivers talk to children?

Research Question 4: Is caregiver-child ethnic match associated with the amount of time caregivers talk to children?

Method

The study was conducted in four urban communities in Indiana: Marion, Lake, Allen, and St. Joseph Counties. The sample consisted of 307 low-income working families with young children who were being cared in out-of-home child care settings. Families who were eligible for this study had: annual family income less than \$35,000, head of the household was "working" at least 20 hours a week, family had a child between 6 months to 6 years old, and the child was in enrolled in out-of-home child care at least 15 hours per week for the past 2 months, family was not on

TANF (Temporary Assistance for Needy Families), and child care setting agreed to participate.

- **Caregiver-Child Relationship.** The Student Teacher Relationship Scale (STRS) assesses the child care provider's feelings and perceptions regarding their interpersonal relationship with the child. The total number of items on the STRS is 30. Average scores can range from 1 (low quality relationship) to 5 (high quality relationship). Four scores were calculated from the caregiver's completion of the STRS. The total score indicates the teacher's overall positive perceptions about their relationship with the child. The STRS also has subscales for closeness, conflict, and dependency.
- **Caregivers' Talk with Children.** Using observation by observers using time-sampling techniques (20-second intervals) we coded the caregiver's talk with the child to reflect the type of verbalizations they used. Whether the caregiver's talk was initiated or in response to the child was coded; then type of talk was coded. Types of talk coded included: "high level talk" (questions, expansions, prompts/suggestions, and describing) and "low level talk" (praise/acknowledgement and directives.)

Results and Implications

The results suggested that caregivers' perceptions of their relationships with the children were not related to the ethnic background of the child, and caregivers' ethnic match with the child was not related to the relationship they had with the focal child. Second, caregivers' ethnicity did not relate to the proportion of time they talked to children, and caregivers' ethnic match with the children did not relate to the proportion of time they talked to children.

The implications of this study, when considered with the other results of the CCCRP, are that the provision of high quality, nurturing, and age-appropriate care and education for children of low income working families in child care settings contributes to positive adult-child relationships and a richer learning environment, regardless of the ethnicity of the caregivers and the children. I found no evidence that children's ethnicity or ethnic match with their child care providers were associated with these important child care quality variables.



CHAPTER 6

LOW INCOME WORKING FAMILIES: PARENTS' EMPLOYMENT, EDUCATION, AND CHILD CARE QUALITY

This chapter explores parent employment and education outcomes in the 307 families who participated in the study. Each family was asked to report employment/education patterns for a female and male head of household; 116 male heads of households and 307 female heads of household were identified. Relationships between child quality variables (discussed in Chapter 4) and parent employment/education outcomes were examined. The combined relationships of a number of child care quality variables (discussed in Chapter 4) with parent employment/education were examined using correlation and regression analyses (see Appendix G for statistics). The effects of child's age in months, child care setting, and community residence were also included in these analyses. Parent outcomes included in this research were hours per week spent in paid employment or in a school or training program, work hours per day (full-time, part-time, temporary), work shift (day, evening, night, shift change), number of months working for employer, interruption in work due to illnesses or child care problems, and raises or promotions at work.

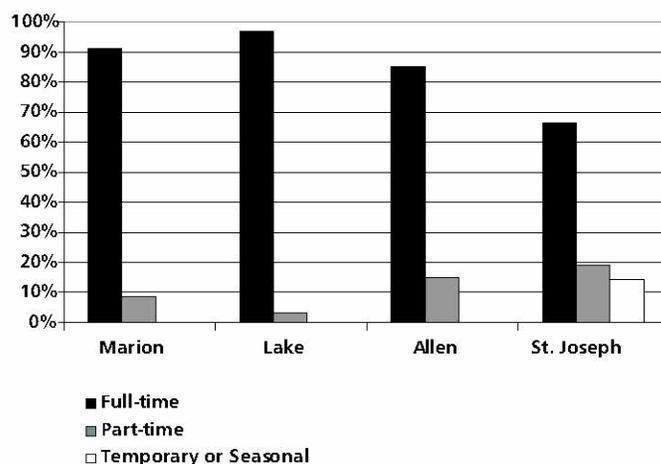
PARENT EMPLOYMENT AND EDUCATION OUTCOMES

Parent employment and education outcomes: Male heads of household

One hundred and sixteen (38%) families identified a male head in the household. Almost three-fourths (72%) of the identified male heads of households were the child's biological father. The remaining male heads of household were the child's grandfather (10%), the child's stepfather (8%), or other male living in the household (9%). Among the male heads' employment outcomes, only work hours (full-time vs. part-time and temporary) and length of current employment differed among communities. (See results reported below.) In general, male heads of household reported the following employment and education patterns:

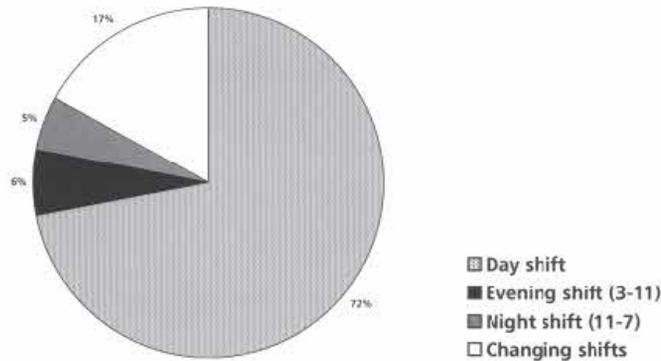
- A large majority of male heads of household (89%) were employed.
- On average male heads spent about 38 hours per week working or in school/training program.
- A majority (87%) of male heads worked full-time (35 or more hours per week not including time in school/training program). Only 14% reported working part-time (less than 30 hours per week) or at a temporary or seasonal position. Work patterns varied by community. A higher proportion of male heads worked full time in Lake, Allen, and Marion counties (96.8%, 85.2%, and 91.3%, respectively) than male heads in St. Joseph (67%). Although Lake County had the highest unemployment rate during the time of the study, male heads in the research sample in that county had the highest rates of both full- and part-time employment. St. Joseph County had one of the lowest employment rates, but male heads in the research sample in that county had the lowest rates of employment. Interestingly, the St. Joseph County sample was the group of males to report temporary or seasonal work. Figure 6.1 displays these differences. This community difference remained after child's age and type of child care setting were considered.

FIGURE 6.1. PERCENTAGE OF MALE HEADS IN FULL-TIME, PART-TIME AND TEMPORARY/SEASONAL EMPLOYMENT IN THE FOUR COMMUNITIES



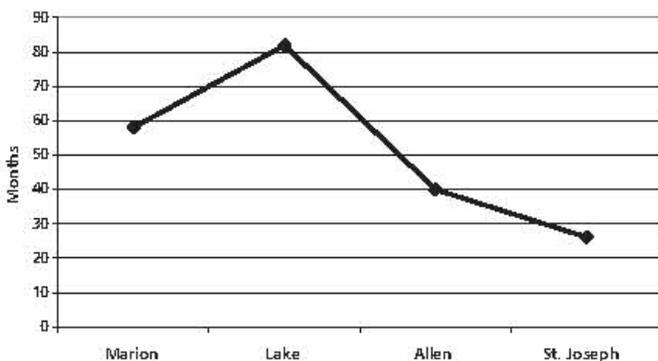
- Most male heads (72%) worked standard hours (daytime) as opposed to evening (3-11pm), at night (11pm-7am), or changing shifts. This ranged from 57% in Lake County to 81% in Allen County but did not differ statistically. Figure 6.2 displays the work shifts of all male heads of households.

FIGURE 6.2. MALE HEAD OF HOUSEHOLD WORKING SHIFTS (N=116)



- The average number of months male heads had been employed at their current employer was 53 months. The means in each community were 26 months in St. Joseph, 58 months in Marion, 40 months in Allen, and 82 months in Lake County. Statistical tests revealed male heads in Lake County had a significantly longer employment history with the current employer than male heads in St. Joseph County. This difference remained after child's age and type of child care setting were considered. Figure 6.3 displays means for each community

FIGURE 6.3. NUMBER OF MONTHS MALE HEADS WERE EMPLOYED WITH CURRENT EMPLOYER IN THE FOUR COMMUNITIES



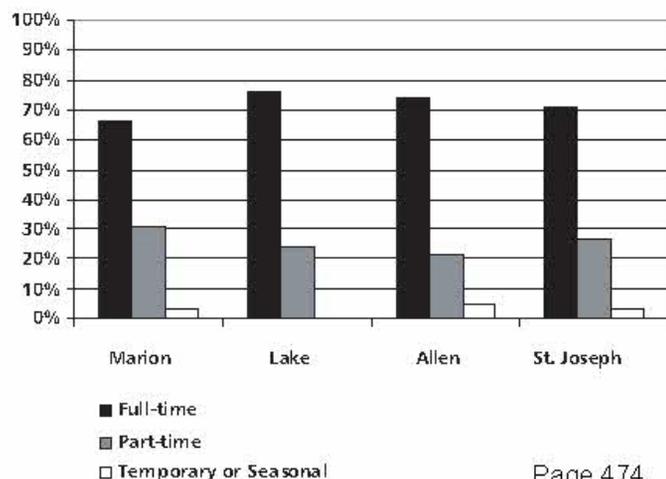
- Work had been interrupted at least once in the past month due to illness or child care problems for almost half of all male heads. The percentages of male heads whose work had been interrupted were 38% in St. Joseph, 61% in Marion, 43% in Allen, and 48% in Lake County. These community differences were not statistically significant.
- About one-quarter (27%) of the male heads of household in this study had received a recent raise or promotion. The percentage of male heads who received a raise ranged from 19% in St. Joseph County to 39% in Marion County, but community differences were not statically significant.

Parent employment and education outcomes: Female heads of household

Communities did not differ in the rate of female heads of household employment and education outcomes. In general, female heads of household had the following employment and education characteristics:

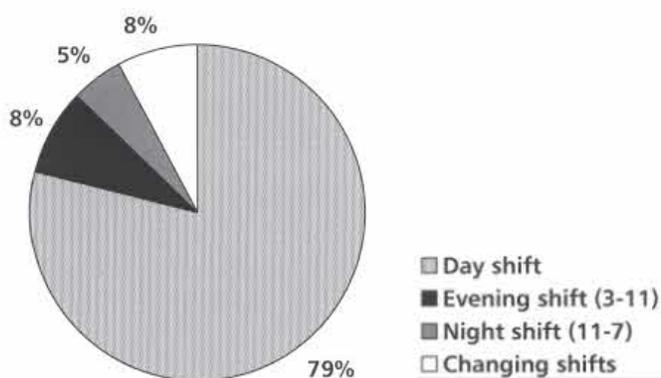
- A large majority of female heads (83%) were employed, ranging from 79% in Marion County to 89% in Lake County.
- On average, female heads spent about 33 hours per week working or in school/job training.
- On average, 72% of female heads worked full-time (35 or more hours per week, not including time in school/training program) as opposed to part-time (less than 30 hours per week) or temporary/seasonal position. The percentages of female heads working full-time were 71% in St. Joseph County, 66% in Marion County, 74% in Allen County, and 76% in Lake County. These differences were not statistically significant. Figure 6.4 displays these work patterns.

FIGURE 6.4. PERCENTAGE OF FEMALE HEADS IN FULL-TIME, PART-TIME AND TEMPORARY/SEASONAL EMPLOYMENT IN THE FOUR COMMUNITIES



- Almost 80% of female heads worked standard hours (daytime). The remainder either worked in the evening (3 pm-11pm), at night (11pm-7am), or changing shifts. The percentages of female heads working non-traditional hours were 17% in St. Joseph County, 16% in Marion County, 28% in Allen County, and 23% in Lake County. These differences were not statistically significant. Figure 6.5 displays the work shifts of all female heads of households.

FIGURE 6.5. FEMALE HEADS OF HOUSEHOLD WORKING SHIFTS (N=253)



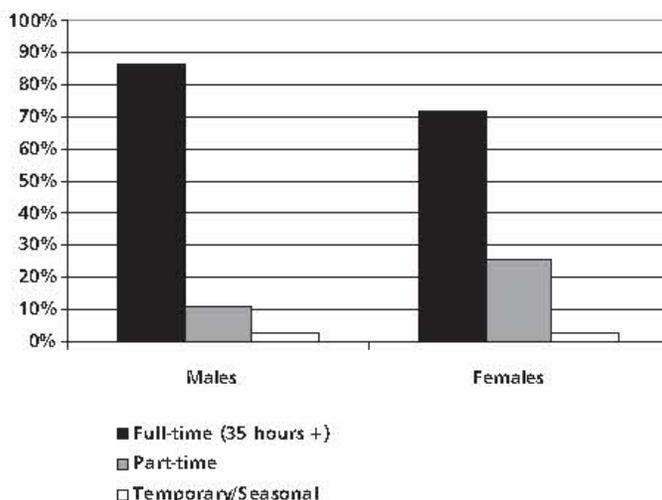
- The average number of months the female heads had been employed at their current employer was 36 months. The means for each community were 30 months in St. Joseph County, 34 months in Marion County, 31 months in Allen County, and 48 months in Lake County, but did not differ significantly.
- At least two out of three working female heads experienced missing work at least once in the past month due to illness or child care problems. The percentages of female heads who experienced missing work were 68% in St. Joseph County, 73% in Marion County, 63% in Allen County, and 70% in Lake County, but did not differ significantly.
- About one in five working female heads of household reported they had received a raise or promotion recently. The percentages of working female heads receiving a raise ranged from 13% in St. Joseph County to 32% in Allen County, but did not differ statistically.

Comparison of Male and Female Employment

In general, there are many similarities between the working patterns of male and female heads in this study. Most males and females in this sample of low income working parents were employed or in school or training programs 35 or more hours per week. However, almost 15% more males reported working

full time than did females. Therefore, it appears that while male heads of household are spending more time away from home at work, many female heads of household are balancing work, school, and family. Figure 6.6 compares these working patterns.

FIGURE 6.6. COMPARISON OF MALE AND FEMALE HEADS IN FULL-TIME, PART-TIME AND TEMPORARY/SEASONAL EMPLOYMENT



There were also differences in the stability of work reported by male and female heads. Male heads reported they had worked for their current employer longer than female heads (M = 53 months and Mdn=30 compared to M= 38 months and Mdn=19). This may have been due in part to women needing to take maternity leave. Also, not surprisingly, females were more likely to have their employment interrupted due to illness or child care problems. While a little over two-thirds of females reported this interruption, less than one-half of males reported it. This gender difference coincides with the gender differences we found in work flexibility (see Chapter 3). Females were more likely to report that their employer would allow them to stay home when their child was ill. Again,

Not surprisingly, females were more likely to have their employment interrupted due to illness or child care problems.

this could be a reflection of mothers' perceived or actual greater responsibility for child care. A greater role in child care may affect women's job stability as well. These apparent differences in child care responsibility and job stability may affect the types of jobs low-income men and women are able to obtain.

Comparison of Parent Employment Outcomes for Children in Home- and Center-based Care

The employment patterns for parents using home- and center-based care were compared. No differences were found between employment patterns of female heads using home-based care and those using center-based care. Only one difference between employment patterns of male heads was found. Males whose children were in center-based care were more likely to report their work had been interrupted during the past month due to illness or child care problems compared to those whose children were in home-based care (56% compared to 36%). There was a similar trend with female heads; however, the difference (72% compared to 63%) was not statistically significant. This difference between home- and center-based care may be explained by the relative lack of flexibility in hours for center-based child care

Males whose children were in center-based care were more likely to report their work had been interrupted during the past month due to illness or child care problems compared to those whose children were in home-based care (56% compared to 36%).

that parents reported in the focus group interviews. Licensed family child care or more informal home-based care are often more flexible in terms of allowing a parent to pick up their child later than scheduled, as well as in caring for sick children, services not often available with center-based care. Again, this gender difference

in work interruption reflects gender differences reported in work flexibility (i.e., employers would be more likely to allow mothers to stay home when their child was ill).

Comparison of Parent Employment Outcomes for Infants/Toddlers and Preschool-age Children

There were few differences in parent employment patterns between parents of infants/toddlers and preschool-age children. The only statistically significant difference was in the number of months male heads of household had been employed with their current employer. Male heads of household with preschool children reported being employed longer by their current employer than male heads of infants/toddlers (M=65 compared to M=38 months). There was a trend for male heads of household with preschool-age children to be more likely to report their work had been interrupted sometime in the past month due to

illness or child care problems (53% compared to 41%). This difference is likely due to differences in types of care chosen for preschool-age children versus infants/toddlers. As reported in Chapter 3, preschool-age children are more likely to be found in center-based programs, and infants/toddlers are slightly more likely to be found in home-based care. As reported above, males whose children were in center-based care were more likely to report their work had been interrupted due to illness or child care problems. For female heads of household, there were no statistically significant differences in employment patterns of parents with infants/toddlers and preschool-age children, but there were some trends. Female heads with preschool-age children were more likely to work full-time than those with infants/toddlers (70% compared to 63%). In addition, female heads with preschool-age children were more likely to work a daytime shift (82% compared to 75%). Again, there was no difference in hours working or in attending school. Taken together, these results suggest mothers of infants/toddlers may be working slightly less, but may be more often involved in education or training programs, which would necessitate part-time employment and evening or changing employment shifts. Therefore, although mothers of infants/toddlers may not work outside the home as many hours as fathers, they are spending similar amounts of time away from their children, necessitating similar demands for child care.

Comparison of Parent Employment Outcomes for Single vs. Two Parent Households

A little over two-thirds of our sample reported they were single with no partner, divorced, or widowed. Marital status and living arrangements for the child had implications for the parent outcomes examined. For female heads, the only difference existed in the length of time employed with current employer. Single, divorced, or widowed female heads with no partner reported shorter employment durations with their current employers (36 months compared to 46 months for married mothers). This may reflect more demands that single parents encounter when they are juggling employment, family, and child care.

We were also interested in comparing families who reported two heads of household with those who reported only one. Sixty percent of families reported only one head of household, which was female. Females in families with two heads of household reported a longer length of time employed with current employer (47 months compared to 29 months for women who were single heads of household). On the other hand, three-fourths of females in families with two heads of household reported their work had

been interrupted due to illness or child care problems in the past month, compared to two-thirds of females who were the sole head of household. Therefore, it appears that, regardless of marital status and living arrangements, low-income working

mothers are experiencing significant challenges with employment and child care.

Low-income working families of all types were experiencing similar struggles in balancing employment, schooling, and the child care needs of their family.

In general, families with children of different ages, in different child care settings, of different household composi-

tions, and in different communities reported similar employment outcomes. Therefore low-income working families of all types were experiencing similar struggles in balancing employment, schooling, and the child care needs of their family.

Relationship Among Child Care Quality and Parent Employment and Education Outcomes

One goal of this research was to determine if child care quality had any impact on parents' employment or education. In general, we found few relationships among indicators of child care quality and parent education and employment outcomes. Appendix G presents the significant correlation and regression statistics among child care quality and parent employment variables.

For male employment outcomes, greater child-adult ratio (more children per adult) was related to the number of hours in work, school, or training program and interruption to due to illness or child care problems. After the effect of child's age and type of child care setting were considered, these relationships remained. They did not vary by community. Although center-based settings were more likely to have higher child-adult ratios and, as reported above, males who reported work interruptions were more likely to have their child in center-based care, the type of child care setting did not contribute significantly to this relationship. Therefore, males with children of the same age were more likely to work or attend school for more hours and experience work interruptions if their child's care setting had a higher child-adult ratio, regardless of child care setting and community residence. It is possible that settings with more children per adult are less able to provide flexible care, and thus child care interruptions are more likely for fathers.

More positive ratings of the parent-caregiver relationship by the parent and higher levels of children cognitive activity were related to daytime working shifts of male heads of household. As reported in Chapter 4, more positive relationships between caregiver and parent were more likely in home-based care. Therefore, when relationships with type of child care setting and child's age were controlled, this connection between parent-caregiver relationship and working shift disappeared. This did not vary by community. The relationship between child's cognitive activity and working shift persisted after child's age and type of care was considered. The child's level of cognitive activity, as we observed it in child care, is a reflection of quality in the child care environment, but may also reflect more advanced development in the child. It is possible that stable daytime employment of fathers is supported by higher quality child care. It is also possible that fathers with more stable daytime employment are better able to support their children's cognitive development.

For female employment outcomes, higher levels of caregiver general education were related to interruption in females' work due to illness or child care problems. Caregiver general education was higher in center-based care, and center care tends to be less flexible in terms of allowing a parent to pick up their child later than scheduled, as well as caring for sick children. Thus, when relationships with type of child care setting and child's age were controlled, the relationship disappeared. This did not vary by community.

Caregiver specialized education was related to a recent raise for female heads. When relationships with type of child care setting and child's age were controlled, the relationship remained. Although communities differed in caregiver specialized education, the relationship between specialized education and recent raise did not vary by community. Advanced training is another child care structural quality indicator. It is possible that mothers who have their children in higher quality child care are also mothers who are more likely to advance in their employment. Higher levels of children's cognitive activity were related to the number of months female heads of household had been employed with their current employer. This is further evidence supporting the hypothesis that more stable employment of parents is related to more advanced cognitive activity in child care by children, either as a cause or effect. This relationship remained after child's age and type of care were considered, and did not vary by community.

CONCLUSIONS

In general, there are many similarities between the employment and education patterns of male and female heads of households in this study. A majority of both males and females were employed and worked or attended school or training programs 35 or more hours per week. Most worked standard daytime shifts.

There was some evidence that families whose children are enrolled in higher quality child care settings have more stable employment patterns.

However, 15% more males reported working full time than females. Males tended to report working at their current employer longer than females, and female heads were more likely to have experienced work interruptions due

to illness or child care problems. In general, families with children of different ages, those in different child care settings, those of different household compositions, and those in different communities reported similar employment patterns and outcomes. Therefore, in this research sample, many low-income working families were experiencing similar challenges in balancing work, schooling, and the child care needs of their families.

In general, there were few relationships among indicators of child care quality and parent education and employment outcomes. The type of child care setting or the community residence did not contribute to parent employment or education outcomes. However, there was some evidence that families whose children are enrolled in higher quality child care settings have more stable employment patterns.

Conclusions

The results of the Community Child Care Research Project provide new data describing the child care experiences of low income working families in 4 communities in Indiana. Because the study participants were volunteers rather than randomly selected, and because the research design was correlational rather than experimental, conclusions drawn from these findings necessarily have limitations. The findings cannot be confidently generalized to other low income working families and child care providers, nor can the links between child care quality and children's development be assumed to be causal. For example, while it is quite possible that higher quality child care does support better child development outcomes, it is also plausible that families whose children had more advanced levels of development located and used higher quality child care. Despite these limitations, the research results do represent the recent experiences of more than 300 low income working families, their children, and their child care providers. Therefore, the results suggest a number of key issues that need further investigation by policy makers and researchers.

1. **Are children from low-income working families at risk for less than optimal development?** Many children in this sample scored lower than established norms in areas of cognitive competence. This is not unusual for children from low income families. The existing research literature suggests that both family and child care experiences influence children's development and school readiness. The significant correlations we found between child care quality and children's abilities, even after controlling for maternal education and children's age, suggest that efforts to improve child care quality could have an impact on children's development. These findings did not vary by community or type of child care, suggesting that efforts to improve child care quality for low income working families be beneficial in all types of child care.
2. **Is child care obtained by low income working families low quality?** The observed quality levels of all types of child care used by this sample of low income working families in four communities were low. Almost half of the children in this study attended child care that may not provide experiences and environments thought to be important for development. Educating parents about how to select good quality child care is important. However, there also appeared to be limited child care options for families, due to issues of affordability and accessibility of good quality care. Effective child care policies directed at low income working families should take quality, availability, and affordability into account, so that good quality care is a realistic option for all children.
3. **Is there is a critical need to improve the quality of infant and toddler care for low income working families?** Overall child care quality for infants and toddlers observed in this research was at a minimal level or below in all types of settings in all four communities. Finding and affording good quality infant-toddler care may be especially problematic for young parents with lower education levels and lower wages, because they are least able to afford infant-toddler child care, which is typically more expensive than care for older children.
4. **Are new efforts are needed to improve the quality licensed family child care?** Even though licensed child care was generally of higher quality than unlicensed care, licensed family child care in this sample was observed to be low in overall quality and low in several aspects of process quality (e.g., caregiver sensitivity; caregiver responsive interactions with children)-- for infant/toddler care. The need for improvement in caregiver-child relationships in licensed family child care should be further investigated.
5. **Indiana should investigate quality levels in the rapidly growing child care ministries that are currently license exempt.** Registered child care ministries are serving increasing numbers of children in Indiana. While this research observed a small and select sample of children in child care ministries, in general observed quality in these programs was lower than in licensed child care centers or Head Start. These results suggest a more comprehensive look at quality of care in child care ministries is needed, to determine the need for increased regulation to improve quality.

6. **Greater flexibility in child care and employment is needed for low-income working families to accommodate changing work shifts, non-traditional hours, and care for sick children.** Parents as well as child care leaders in this study pointed to the need for affordable and accessible quality child care that provides more flexibility for low income working families, to accommodate challenging work and school schedules, job training, and child illness. Employers should also look at the possibility of increasing support and work schedule flexibility for workers who are parents of young children.
7. **It is important that the strengths and limitations of individual urban communities are recognized and**

incorporated when planning for improvements in child care quality for low-income working families.

Indiana provides a unique context for child care because many child care decisions are made at the county level. Even though many experiences of this sample of low income families were similar across these four communities, there were significant differences in the demographics of families, availability of child care, types of care selected, quality levels of specific types of care, and in the focus of county-level quality improvement initiatives. This suggests there are important individual community strengths and limitations in child care for low income working families, and that future initiatives to improve quality should account for these variations.

Glossary

Definitions and explanations for terms used in this report. Note that other organizations or researchers may define these terms differently.

- **Low-income Working Family**
Family with young child (6 months to 6 years) with annual household income below \$35,000 per year (approximately 200% of federal poverty level or below). At least one adult head of household is engaged in paid employment, school, or job training for a total of 20 hours or more per week.
- **Infant**
Children 6 months to 12 months of age.
- **Toddler**
Children 13 to 35 months of age.
- **Preschooler**
Children 36 to 60 months of age.

TYPES OF CHILD CARE

- **Licensed Child Care Center**
Non-residential building where at least one child receives care by paid non-relative provider. Indiana child care center licensing requirements include requirements for staff training, health, safety, nutrition, appropriate discipline, and child development curriculum. Director must have at least an associate degree with coursework in Early Childhood Education/Child Development (ECE/CD) and 3 years experience. Lead caregivers must be at least 18 yrs, high school graduates, and have a CDA credential OR take ongoing training in ECE/CD. Child care licensing consultants make a minimum of one visit to licensed facilities each year. There were only five preschools (part-day programs) included in the study, and they were included in this categorization.
- **Registered Child Care Ministry**
License exempt center-based program in Indiana, an extension of a church or ministry that is a tax-exempt religious organization. In 1991 an Indiana statute was passed recognizing ministries as license exempt, having only to meet general sanitation and fire safety rules. No regulations for staff, group sizes, ratios, or program apply to registered

ministries. There were less than 100 registered ministries at this time. The mid- to late-1990s saw a dramatic increase in ministries. Indiana had over 650 registered ministries in December, 2004. A child care ministry that is exempt from licensing must clearly state in all of its paid promotional advertising that the child care ministry is providing child care as an extension of the ministry's church or religious ministry.

- **Head Start**
A national comprehensive preschool program in the United States. Head Start serves children prenatal to 6 years and their families. The program provides comprehensive education, health, nutrition, and parent involvement services to low-income children, prenatal to 5 years, and their families. Sponsoring organizations in local communities apply for competitive grants to operate local Head Start programs under national guidelines, the Head Start Performance Standards. These standards meet or exceed the standards for licensed child care centers in Indiana.
- **Licensed Family Child Care**
Indiana requires home-based child care providers to be licensed if they care for more than six children. A provider's own children are only counted in group size limits if they are under the age of 8 years. A Class I child care home serves any combination of full time or part time children not to exceed at any one time 12 children, plus 3 school age children. A maximum of 15 children under 11 yrs. may be in a class I home at any one time. Class II child care homes have 2 or more providers, with more than 12 but not more than 16 children at any one time. Licensing does not guarantee high quality, but it does set minimum standards for health, safety, and caregiver training that must be maintained. Licensed family child care homes are inspected by the state once per year.
- **Unlicensed Family Child Care**
Family care providers that are not licensed, legally caring for fewer than six children non-relative children in Indiana. Licensing is not required for a child care home if the pro-

vider is not paid; cares for only relative children; cares for less than 6 children, not including own children; or serves migrant children.

- **Relative Care**

Relatives caring for children in the relative's home. Indiana does not regulate care provided by relatives.

CAREGIVER TRAINING AND EDUCATION

- **Child Development Associate Certification (CDA)**

A national competency-based credentialing program for early childhood education providers.

- **Montessori**

A comprehensive early education program based on the philosophy of Italian educator Maria Montessori, with a structured approach to environment and learning.

- **High/Scope**

A curriculum for early childhood education and child care that emphasizes child-initiated learning, based on the theory of Jean Piaget by the High/Scope Education and Research Foundation, Ypsilanti, Michigan.

- **West Ed**

The Program for Infant Toddler Caregivers (PITC), a training program for caregivers that targets high quality services for infants and toddlers. The program was developed by the West Ed, LaJolla, California.

- **Project Construct**

A program that provides training in pre-literacy and language following the philosophy of Jean Piaget.

- **Creative Curriculum**

A comprehensive developmental curriculum for young children developed by Teaching Strategies, Inc.

- **CPR and First Aid**

Cardio-pulmonary resuscitation and first aid, basic safety and emergency response training programs.

EARLY CHILDHOOD EDUCATION & CHILD CARE ORGANIZATIONS

- **National Association for the Education of Young Children (NAEYC)**

NAEYC is a national organization dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for children from birth through age 8. It is the world's largest organization working on behalf of young children with more than 100,000 members, and a national network of nearly 450 local, state, and regional Affiliates.

- **Indiana Association for the Education of Young Children (IAEYC)**

IAEYC is the state affiliate of the National Association for the Education of Young Children. IAEYC serves as a resource to early childhood professionals and parents as well as providing advocacy for issues regarding the quality care and education of young children.

- **National Academy of Early Childhood Programs (NAECP)**

NAECP administers a national, voluntary, professionally sponsored accreditation system for all types of preschools, kindergartens, child care centers, and school-age child care programs. It is generally acknowledged that the quality standards for programs accredited by NAECP are higher than for state licensing.

- **T.E.A.C.H. (Teacher Education and Compensation Helps) Scholarships**

The T.E.A.C.H. Early Childhood® INDIANA project serves as an umbrella for educational scholarship opportunities for people working in licensed, registered or legally exempt child care centers and homes in Indiana. T.E.A.C.H. Early Childhood® INDIANA covers partial costs to help with the costs of college tuition, books and travel. In return for receiving a scholarship, each recipient must complete a certain amount of education, in the form of college coursework, during a prescribed contract period. All scholarship recipients receive increased compensation in the form of a bonus or raise, after completing a certain amount of coursework following the contract period. Recipients make a commitment to remain in the sponsoring child care program or the field of early childhood for 6 months to one year beyond the contract period, depending on the scholarship model.



- **Paths to Quality**

Paths to QUALITY is a voluntary system for child care providers who are willing to go beyond the minimum state requirements of licensing to provide a higher level of care. It is offered by the Early Childhood Alliance Child Care Resource and Referral, a non-profit United Way Partner agency

that supports families and child care providers in Allen, DeKalb, LaGrange, Noble, Steuben, and Whitley Counties. Paths to QUALITY helps child care providers learn new ways to improve the quality of their care and give parents more choices when selecting quality child care.

Appendix A

METHODOLOGY

The study was conducted in four urban communities in Indiana, in Marion, Lake, Allen, and St. Joseph counties. These communities were chosen because they were abundantly populated and contained varying availability of licensed and unlicensed child care.

Research assistants visited public places, schools, and government agency offices to locate low-income parents of young children. Volunteer participants were recruited through the following sites:

- workforce development services;
- Women, Infants, and Children programs (WIC);
- Ivy Tech State Colleges, Indiana University-Purdue University Indianapolis (IUPUI), Indiana University-Purdue University Fort Wayne;
- breast feeding classes;
- GED classes;
- Baby Closet;
- housing authorities;
- Child Care and Development Fund (CCDF) voucher offices;
- community centers; and
- public libraries.

Several enrollment criteria were established to ensure that our sample represented low-income working families with young children in out-of-home care. The criteria included:

- annual family income was less than \$35,000;
- head of the household was “working” (work, school, or job training) at least 20 hours a week;
- family had a child between 6 months to 6 years old and the child was in out-of-home care at least 15 hours per week for more than two months;
- family was not receiving TANF (Temporary Assistance for Needy Families); and
- child care provider agreed to participate.

Eligible families were encouraged to complete a sign-up sheet and ask their children’s caregiver if he/she would participate in the study. A total of 475 families completed the sign-up sheet during initial enrollment. Next, research assistants made a follow-up

phone call to confirm whether both the family and their caregiver agreed to participate. If so, research assistants scheduled a visit with the caregiver to observe the child in the child care setting for about two and one-half hours. Among the 475 potential participating families, 307 families and their child care providers participated, a participation rate of 64.6%. Families dropped out from the study for a variety of reasons, including lost contact during the follow-up phone call, the caregiver did not consent to participate, or the family was no longer eligible when contacted.

During the child care visit, the caregiver was asked to read and sign a consent form before the research team conducted any observation or assessment. After receiving signed consent, the research team observed and assessed the global, process, and structural quality of the child care setting.

The global quality of each child care setting was assessed via direct observation by a research assistant utilizing the Early Childhood Environment Rating Scale—Revised (ECERS-R, Harms, Clifford, & Cryer, 1998) in center-based child care settings and the Family Day Care Rating Scale (FDCRS, Harms & Clifford, 1989) in home-based child care settings. Aspects of structural quality (child-adult ratio, group size, and caregiver education, training, and experience) were assessed via direct observation and caregiver survey. The Arnett Caregiver Interaction Scale (CIS, Arnett, 1989) and context coding of each child’s activity, caregiver-child involvement (modified from Howes & Stewart, 1987), child’s level of social interaction, and child’s cognitive level of object play was used to assess process indicators of quality. After establishing rapport with the child, the research team conducted standardized assessments: Mullen Scales of Early Learning (Mullen, 1995) was used if the child was under 36 months old; the Peabody Picture Vocabulary Test—Third Edition (PPVT-III, Dunn & Dunn, 1997) and FACES tasks were used if the child was over 36 months old.

After the observation was completed, the research assistant left a caregiver survey and a parent survey with the caregiver. Parents picked up and returned the survey to the caregiver. The parent survey was designed to measure parent employment patterns, parents’ perceptions of child care and work, parents’ relation-

ship with the caregiver, and their child's social and emotional development. The caregiver survey was designed to gain information about the caregivers' specialized training and experience in child care work, their relationship with the child and the parents, and each child's social and emotional development. Both packets were collected by a research assistant and a \$30 check was given to each parent and caregiver after the completed survey was received.

COMMUNITY CHILD CARE LEADER INTERVIEWS

Semi-structured telephone interviews were completed with a purposive sample of 22 community child care leaders—key

informants—from Marion, Lake, Allen, and St. Joseph counties, including five or six in each county. Key informants were identified as individuals who had knowledge and expertise in child care or the needs of low-income working families. Informants included representatives of Purdue Extension, a county official from the Division of Families and Children, members of the local Step Ahead coordinating council, business human resource specialists, representatives of WIC offices, representatives of the Child Care Resource and Referral Agencies, and a professor of psychology at a local university who works closely with early education and care programs. The key informant interviews addressed child care issues from three perspectives: the family, the child care providers, and the larger community.

TABLE 1.2. SUMMARY OF CRITICAL CHILD CARE ISSUES FROM INTERVIEWS AND FOCUS GROUP

Constructs	Instruments
Community context	Community child care leader (key informants) interviews Parent focus groups Existing state and county data
Parent and child characteristics	Parent survey
Caregiver characteristics	Caregiver survey
Global child care quality	Early Childhood Environmental Rating Scale—Revised (ECERS-R) or Family Day Care Rating Scale
Structural child care quality	Observation: group size & child-adult ratio Caregiver survey: Caregiver qualifications (education, training, years of experience)
Process child care quality	Caregiver Interaction Scale (CIS) Observation: caregiver involvement with child
Social-emotional competence and behavioral problems (Infants & Toddlers)	Brief Infant Toddler Social and Emotional Assessment (BITSEA) parent and caregiver report
Cognitive functioning (Infants & Toddlers)	Mullen Scales of Early Learning
Social and cognitive skills (Preschool Age Children)	Classroom Behavior Inventory (CBI) parent and caregiver report
Social competence, emotion regulation and expression, and adjustment difficulties (Preschool Age Children)	Social Competence and Behavior Evaluation (SCBE-30) parent and caregiver report
Receptive vocabulary (Preschool Age Children)	Peabody Picture Vocabulary Test (PPVT-III)
Knowledge of social environment (Preschool Age Children)	Family And Child Experiences Survey (FACES): Social Awareness Task
Knowledge of colors and counting ability (Preschool Age Children)	Family And Child Experiences Survey (FACES): Color Name & Counting



Interview Questions About Low Income Families:

1. What is the current and projected demand for child care services in this community for low-income families?
2. What are the strengths and weaknesses in child care resources in this county?
(How are families finding, paying and maintaining child care?)
3. What types of child care services are needed but are not available in your county?
(For example: sick child care, second shift, resource and referral.)
4. What types of child care do the low-income families use now? (Regulated or unregulated.)
5. What types of child care do most of these families prefer?
6. Are the available subsidies to low-income working families sufficient?
7. Are the available resources being fully utilized? (For example: funding, slots, R&R.)

Interview Questions About Child Care Providers:

1. What resources are available to county child care providers to help them offer good quality care for all families? (For example: money, training, mentors, accreditation, resource library.)
2. Are the available subsidies and other resources adequate, or are there unmet provider needs?
3. What is your sense of the quality of care available in this county?

Interview Questions About the Community:

1. Is this community unique in its child care services? How?
2. What are your recommendations for meeting this community's child care needs in the next five years?
3. What are the best ways for us to contact low-income working families in this community and enlist their participation in the study?
4. Are you aware of employers who might be or are interested in working with us?
5. What is the best way to contact the employers of these families in your community?

PARENT FOCUS GROUP INTERVIEWS

Two parent focus groups were conducted in each community. A total of 46 parents participated in the focus group interviews in

St. Joseph, Marion, Allen, and Lake counties (n = 9, 9, 8, 20, respectively). Focus groups took place in public libraries, job training centers, and child care centers, and were comprised primarily of clients of local child care centers, GED classes, family service agencies, or work training programs. The focus group interviews proved to be valuable sources of information, as these volunteer parents were eager to share their ideas, concerns, and suggestions with the researchers.

Focus Group Interview Questions:

1. What child care arrangements do you have for your children now while you are working, in school, or in job training?
2. When you need to find child care outside of your immediate family, who do you go to? Who do you ask first for help or information?
3. How much do you rely on relatives or friends for help with child care? What kinds of help?
4. How flexible are your current child care arrangements? In other words, what happens when you need to change your hours, take some time off, or when you need more hours of care?
5. Have you experienced problems finding or using child care of any type? What kinds of problems? How do these child care problems affect you and your family?
6. Do you have the financial resources you need to purchase the child care you want for your child? What kinds of resources are available to help you pay for care? Are you able to use these resources?
7. In a perfect world, what would your ideal child care solution be?
8. Do you have ideas about how your community could better support families with child care? What would help you, and who would do it?

PARENT SURVEY

Parents completed a paper and pencil survey that asked about child and family demographic characteristics, parent employment/education outcomes, and parent perceptions of work and child care. These data not only were used for sample descriptive purposes but also to examine the relations of demographics with child care quality, child development outcomes, and parent employment/education outcomes. Descriptions of parent employment/education patterns will be provided as a separate section later.

Child and Family Demographic Characteristics

Questions about number of children and adults in the household; child's age, sex, and race; reason for using out-of-home child care; child's child care history (age of entry and ending in each child care setting); and child's relations with adults living in the household were asked. Information regarding male and female heads and their employment status, occupation, highest level of formal education, marital status, family income, and type of housing were also collected.

Parent Perceptions of Work and Child Care

Work Flexibility Scale. This scale was adapted from Bond, Galinsky, and Swanberg (1998). Male and female heads of each household were asked to rate six items of work flexibility with respect to their child care issues (e.g., "My shift and work schedule cause extra stress for me and my child.") using a 5-point rating scale format (1 = strongly disagree, 3 = neutral, to 5 = strongly agree). A mean score for the scale was calculated to indicate the levels of work flexibility for male and female heads of household. The internal consistencies were minimally acceptable (Cronbach Alpha = .50 for male head and .64 for female head).

Child Care Flexibility Scale. This scale consists of seven items derived from Emlen (1998). Parents were asked to rate statements about their child's child care setting and caregivers (e.g., "My caregiver is willing to work with me about my work schedule.") using a 5-point rating scale format (1 = strongly disagree, 3 = neutral, to 5 = strongly agree). A mean score was calculated to indicate the level of flexibility the child care setting and caregiver provided parents. The internal consistency for this scale was minimally acceptable (Cronbach Alpha = .56).

Child Care Availability. Parents were asked about the number of days they spent looking for child care and to rate levels of difficulty in finding satisfactory child care on a 5-point Likert scale (1 = very easy to 5 = very difficult). In addition, parents also reported their perceptions of child care availability by rating six items adapted from Emlen (1998) (e.g., "There are good choices for child care where I live.") using a 5-point rating scale format (1 = strongly disagree, 3 = neutral, to 5 = strongly agree). A mean score was calculated for analysis. The internal consistency for this scale was acceptable (Cronbach Alpha = .75).

Child care quality scale. Parents rated the quality of their current child care setting on six items (e.g., "caregiver warmth toward

your child"), ranging from 1 (perfect) to 6 (poor). A mean score was calculated for analysis. The scale was found to have a high internal consistency (Cronbach Alpha = .92).

CAREGIVER SURVEY

Caregivers completed a paper and pencil survey that asked about their demographic characteristics and information regarding their child care work. These data were used not only for sample descriptive purposes but also to examine the relation of demographics with child care quality, child development outcomes, and parent employment outcomes.

Demographic Characteristics

This part of the caregiver survey consisted of questions regarding caregiver's age, marital status, race, and family income.

Information on Child Care Work

This portion of the caregiver survey included questions about their annual earnings from child care, fringe benefits from their child care work, the reasons that they work in child care, their plan for child care work (i.e., "How much longer do you plan to work in child care?"), the number of years during which they have been working in child care, possible reasons for leaving child care work, and whether or not they have a substitute caregiver.

CHILD CARE QUALITY

Global Quality

Center-based child care settings, including licensed child care centers/preschools, child care ministries, and Head Start settings were assessed using the Early Childhood Environment Rating Scale-Revised (ECERS-R). Quality of home-based child care settings such as family child care homes (licensed/unlicensed) and relative cares were assessed using the Family Day Care Rating Scale (FDCRS). The two measures, designed to carry similar conceptual structures, allow researchers to compare quality across types of child care settings.

In our study, observers spent at least two hours in the classroom or day care home rating the ECERS-R or FDCRS. Total and subscale scores for analysis were calculated by dividing total scores by the number of items. Four observers were trained to a minimum 80% reliability (calculated as agreements/agreements + disagreements) on the ECERS-R and FDCRS before beginning data collection. The average inter-rater percent agreement was



88% (range = 53 ~ 100%), and the average Cohen's Kappa was .82 (range = .41 ~ 1.00).

Early Childhood Environment Rating Scale—Revised edition (ECERS-R: Harms, Clifford, & Cryer, 1998). The ECERS-R was used to assess global quality in center-based child care settings. It consists of 43 items that address space and furnishings, personal care routines, language-reasoning, activities, interaction, program structure, and parents and staff. Each item was rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .921$; Harms, Clifford, & Cryer, 1998).

In the present study, the subscale internal consistencies ranged from .81 to .93. The total scale internal consistency was .97, calculated without item 37 (provisions for children with disabilities) because too few cases were scored. The total mean score of all items was used for analysis.

Family Day Care Rating Scale (FDCRS: Harms & Clifford, 1989). The FDCRS was used to assess global quality in home-based child care settings. It consists of 32 items organized under six subscales: space and furnishings, basic care, language and reasoning, learning activities, social development, and adult needs. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The authors reported adequate inter-rater reliability ($r = .86$) and significant positive relationships with independent home visitor quality ratings.

In the present study, the subscale internal consistencies range from .70 to .89, with a total scale internal consistency of .95. The total mean score was used for analysis.

Structural Quality

Group Size and Child-Adult Ratio. The number of adults and children in each child care setting was recorded six to eight times by a researcher during a two-hour visit to each child care setting. Group size was defined as the maximum number of children present in the child care setting, and child-adult ratio was calculated by dividing the maximum number of children by the maximum number of adults in the classroom or in the home.

Characteristics of Caregiver. Caregivers were asked to report their general education level, specialized training level (i.e., number of training programs they have completed), and their

child care experiences (i.e., number of years in child care work) in the caregiver survey.

PROCESS QUALITY

Student Teacher Relationship Scale (STRS: Pianta, 1992). The STRS is a paper and pencil measure caregivers completed. It was used to assess the caregiver's perceptions of his/her relationship with a particular child, the child's interactive behavior, and how the caregiver thinks the child feels about him/her. This measure blends theory on child-adult attachment with research on the importance of early school experiences in determining the trajectories of children's school progress. The STRS is a 5-point Likert-type scale (1 = Definitely does not apply, 5 = Definitely applies) consisting of 28 items that can be divided into three subscales: Conflict (12 items), Closeness (11 items), and Dependency (4 items). Previous studies conducted to test validity of this measure found a correlation between STRS scores and behavioral problems in elementary classrooms, peer relations, and the cost and quality of the child care environment. In addition, among children who were likely to be referred for special education, high scores on the STRS were predictive of success in the early school years, indicating the sensitivity of the instrument to resilience processes. The authors report internal consistencies (Cronbach's Alpha) of .91 for the total score, .93 for the Conflict subscale, .86 for the Closeness subscale, and .68 for the Dependency subscale (Pianta, 1992). For the present study, the internal consistencies (Cronbach's alpha) were .81 for Conflict, .71 for Closeness, .58 for Dependency, and .78 for the total scale. The total mean score was used for analysis.

Parent Caregiver Relationship Scale (PCRS: Elicker, Noppe, Noppe, & Fortner-Wood, 1997). The PCRS is a paper and pencil measure that parents and caregivers completed to assess the perceived quality of the dyadic parent-nonparental caregiver relationship. The 35 items on the scale assessed the parent or a caregiver's perceptions, attitudes, and feelings about her/his relationship with the other partner in the caregiving dyad. Each item consists of a statement about the relationship, scored by circling the appropriate number on a 5-point Likert-type scale (1 = Strongly disagree to 5 = Strongly agree). There are three factor-based subscales for each version of the PCRS. For the parent version of PCRS, the subscales are Trust/Confidence, Collaboration, and Affiliation. The caregiver PCRS has the same first two subscales and a Caring subscale instead of Affiliation. Validity correlations were computed between PCRS variables and theoretically-related variables in the child-care context, such as

group size and amount of time in care. Parent subscales correlations (Pearson's r) ranged from $-.22$ to $.37$; caregiver subscales ranged from $.25$ to $.48$. There were no significant correlations found between parent or caregiver PCRS scores ($r = .03$ to $.19$) and the child care variables examined. Our sample internal consistencies (Cronbach's alpha) for the parent version were $.95$ for the total score, $.93$ for the Trust/Confidence subscale, $.89$ for the Collaboration subscale, and $.66$ for Affiliation. For the caregiver PCRS, our sample internal consistencies were $.89$ for total score, $.91$ for Trust/Confidence, $.55$ for Collaboration, and $.61$ for the Caring subscale. A total mean score for parent report and a total mean score for caregiver report was used for the analysis.

Caregiver Interaction Scale (CIS: Arnett, 1989). The CIS was used to measure the quality of care and interactions provided by caregivers in child care settings. Research assistants rated dimensions of caregiver interactions using a 4-point scale [Not at all (1) to Very much (4)] during the child care setting observation. The CIS consists of 4 subscales: Positive interactions (10 items), Punitiveness (eight items), Detachment (four items), and Permissiveness (four items). The internal consistencies (Cronbach Alpha's) for this sample were: $.94$ for the Positive interactions scale, $.92$ for the Punitiveness scale, $.89$ for the Detachment scale, and $.06$ for the Permissiveness scale. We did not use the Permissiveness subscale due to the low internal consistency. The internal consistency for the total score without the Permissiveness scale was $.94$. A total mean score consisting of the Positive Interactions, and reversed scores for Punitive and Detachment subscales was used for analysis.

Adult Involvement Scale. Using time-sampling techniques (20-second intervals) research assistants coded the behaviors of caregivers to reflect the level of responsive interactions (modified from Howes & Stewart, 1987). The average inter-rater percent agreement was 89% (range = 55 to 100%), and the average Cohen's Kappa was $.83$ (range = $.38$ to 1.00). The following are code descriptions.

- **Ignore** – Adult within three feet of child but paying no attention to focal child.
- **Routine/minimal** – Caregiver touches the child for routine caregiving (e.g., blowing nose) but no verbal response to child; caregiver touches child only for necessary discipline, to move child away from another, to answer a direct request for help, or to give verbal directives with no reply encouraged.

- **Simple/elaborate/intense** – Caregiver uses warm or helpful contact beyond essential routine care or answers the child's verbal bids without elaboration; caregiver engages in some physical gestures, maintains close proximity to the child, acknowledges a child's statements and responds to but does not restate, or sits with the child during play, suggests materials, etc. Caregiver hugs or holds child, restates child's statement (thus acknowledges it) and provides answers to the child, engages the child in conversation, plays interactively with the child, or sits and eats with the child in a social atmosphere.

"Adult responsive interaction" was calculated as the proportion of simple/elaborated/intense adult involvement out of the total time when an adult was within three feet of the focal child. In other words, it is the percent of time during which an adult was interacting responsively to the focal child when the adult was within three feet from the child.

Children's activity. Using time-sampling techniques (20-second intervals) research assistants coded the behaviors of each child to reflect the type of activity in which he/she was engaged (modified from Howes & Stewart, 1987). The average inter-rater percent agreement was 96% (range = 85 to 100%), and the average Cohen's Kappa was $.95$ (range = $.78$ to 1.00). The following are code descriptions.

- **Art** – Children are painting at an easel or working on a project that involves some combination of paper, glue, paint, colored pencils, scissors, etc. Focus is on producing a product that is adult-determined (e.g., matching bunny rabbits) or child determined (open-ended). Putting on a smock to do an art activity is included. If the product is child-determined, put an 'O' in the box instead of a check.
- **Books/library/writing** – Child is "reading" books, even if it is not in the library area of the room (pretend reading is included), with peer/adult/self. Also code this if the child is in a designated writing center (in a classroom) or any other location where writing materials are provided for children to use in anyway they desire (don't count writing that is part of dramatic play).
- **Blocks** – Child is building with large blocks on the floor; using large constructive play materials (e.g., pipes).
- **Computer** – Child is playing computer games, using word processing to create documents, or surfing the Web. May be operating the mouse and keyboard or be a companion to child who is.

- **Dramatic play** – Child is in area of room/house designated for fantasy play (e.g., housekeeping or other theme area) or using dress-ups, housekeeping items, dolls, etc. Child does not have to be actually engaged in fantasy for this to be coded. They must be using materials designated for fantasy play, however.
- **Manipulatives/table toys** – Child is playing with tinker toys, bristle blocks, puzzles, peg boards, lotto, play dough, etc. (even if on the floor).
- **Music** – Child is using musical instruments, CD player/tape/record player for listening, singing, dancing, etc. (Do not code if music is in the background and child sings along while they are engaged in something else.)
- **Sand/water/sensory** – Child is using sand table, water table, or table with textured materials (such as beans, goop, rice, pudding, shaving cream).
- **Large motor** – Child is involved with a climber, running, balance beam, etc.
- **Television** – Child is watching the TV or a video/DVD and not engaged in any of the other activities listed. Not coded when the TV is in the background. If the show is child-oriented (e.g., children's cartoons, Sesame Street, Bear in the Big Blue House, etc.), put a 'C' in the box instead of a check.
- **Didactic** – Child is working with flash cards, worksheets (not coloring book; see art), reciting the alphabet or numbers. Could also include doing the calendar, weather, day of the week, or recognizing names with cards.
- **Routines** – Child is engaged in hand-washing, toileting, eating snack (code TV if eating snack in front of TV). If this is coded, then PLAY is not coded.
- **Other** – Child is in an undefined area (e.g., potted plant area) or in an activity not listed here.
- **Wandering/unoccupied** – Child is wandering among activities without being engaged in any of them, or is otherwise

unoccupied. Sitting on an adult's lap for comfort is considered unoccupied.

Children's activity categories were combined as: none, low-yield, medium-yield, and high-yield activities, based on concepts developed in previous studies (Howes & Smith, 1995; Kontos et al., 2002; Kontos & Wilcox-Herzog, 1997), and the proportions of each category to the total number of intervals observed were calculated. Table A.2. provides a description of each combined child's activity category.

We also created one index variable indicating the level of children's activity based on the four categories presented above. A weighted score for each category was calculated using the proportion values observed. Then the weighted scores for the four categories were summed, and we used the summed score as the level of each child's cognitive activity. Possible scores range from 0 (None) to 3 (high-yield activity).

Adult talk. Using time-sampling techniques (20-second intervals) research assistants coded the caregiver's talk to reflect the type of verbalizations that they used. Whether the caregiver's talk was initiated or in response to the child was coded; then type of talk was coded. The following are code descriptions.

Adult Initiates/Responds (check one):

- **Initiates** – Adult initiates verbal interaction with the child.
- **Responds** – Adult responds verbally to child's verbal or nonverbal initiation.

Type of Adult Talk (check one):

- **Praise/acknowledgement** – Teacher uses verbal praise with child (good job, excellent, that is a pretty picture, etc.) or acknowledges a child (okay, thank you, etc.).

TABLE A.2. DEFINITIONS OF CHILDREN'S COGNITIVE ACTIVITY CATEGORIES.

Cognitive Activity Level	Activities Engaged	Score Given
None	Routines, Other, and Unoccupied/wandering	0
Low-yield	Close-ended art, Didactic, TV (TV and TV-child), and Large motor.	1
Medium-yield activities	Manipulatives, Book/Writing, Sensory, Computer, and Music	2
High-yield activities	Open-ended art, Blocks, and Dramatic play	3

- **Social** – teacher talks to child about personal and home topics such as clothing being worn, what children or caregiver did outside of class, talking about siblings/parents, etc. (regardless of form the language takes).
- **Question** – The question is designated to elicit a verbal response from the child (yes/no or open-ended response). Code even if the intent is not realized. Verbal clue of correct response is not provided.
- **Expansion** – Teacher listens to what child says and restates with more complex language.
- **Describes** – Teacher describes what the child is doing or what child could be doing. Code if teacher is reading a book verbatim or describing pictures in a book.
- **Prompt/suggestion** – Child is given a verbal clue as to what he/she should do by giving only part of the information. Sort of a reminder. Not the same as a directive, because it does not tell the child exactly what to do. Examples include: How about trying this? Maybe this is a way to do it. It might help to _____. Why not put that block here? Is there another way? There might be another way to do it. A good choice would be to _____.
- **Directive** – Teacher makes a statement that tells child exactly what he/she should do with no reply encouraged. Examples: Tell Jim how you feel. Sit in that chair. Go to the front door. You need to stop.

Adult talk was further categorized as high level talk and low level talk. High level talk included question, expansion, prompt/suggestion, and describes; low level talk included praise/acknowledgement and directives. In our analyses, we only used adult high level talk as a process quality variable.

For the Adult Initiates/Responds section, the average inter-rater percent agreement was 96% (range = 90 to 100%), and the average Cohen's Kappa was .92 (range = .73 to 1.00). For the Types of Adult Talk section, the average percent agreement was 95% (range = 80 to 100%), and the average Cohen's Kappa was .90 (range = .67 to 1.00).

PARENT OUTCOMES

In the parent survey, families were asked to report on male and female heads of household employment patterns. The type of their work, whether or not a recent raise or promotion was received, work shift (daytime, evening, night, or shift change), length of time in current position, and if they work full-time (35

or more hours/week), part-time (less than 30 hours/week), or temporary position was determined for each male and female head household identified. Families were also asked to report the total number of hours per week each head of household was involved in work or school/training, and the amount of time lost from work in the last month due to illness, child illness, or child care problems.

CHILD OUTCOMES

Child Behaviors

For both infants/toddlers and preschool-age children, behaviors of children and caregivers were coded in 20-second intervals to reflect 'types of child's play,' 'people/objects with whom/which the child interacting/attending to,' and 'whom the child talks to.' The following are the code descriptions.

Play. Behaviors of each child were coded in 20-second intervals to reflect the type of play. The average inter-rater percent agreement was 91% (range = 60 to 100%), and the average Cohen's Kappa was .82 (range = .45 to 1.00). The following are code descriptions.

- **Unoccupied/wandering** – Check if checked in "activity" and/or "interacting/attending to" (15 seconds or more). Check if child is in Time-Out.
- **Onlooker** – Child is stopped and engaged in observing what other child/children is/are doing (15 second or more); watch adult prepare materials without talking to peers/adults.
- **Engaged with peers** – Child is focused on peer interaction (conversation, running/chasing) more than toys or fantasy.
- **Engaged with adults** – Child is focused on adult interaction more than toys or fantasy. Code if child is sitting on an adult's lap for comfort.
- **Engaged in manipulating/exploring** – mouths, takes apart, holds and caresses, otherwise focuses on toys without using them for play (the way they were intended or for fantasy); looking at pet.
- **Engaged in using toy in way intended** – Lotto is used as lotto rather than build little houses out of the lotto cards; holding pet.
- **Engaged in fantasy** – Any type of play that primarily involves fantasy (transforming objects or transforming people).



If an “engaged” category is tied with an “unoccupied/wandering” or “onlooker,” use the engaged category. Do not code if child is in Routine activity.

Child’s social interaction. Behaviors of each child were coded in 20-second intervals to reflect child’s social interactions. The average inter-rater percent agreement was 96% (range = 85 to 100%), and the average Cohen’s Kappa was .88 (range = .63 to 1.00). The following are code descriptions.

- **Peers** – Child’s primary focus is on interacting with peers – not involving fantasy – rather than primarily interacting with materials or engaging in fantasy play with peers. Must have eye contact or reciprocal behavior with peers.
- **Adults** – Child is focused on interactions with an adult who is reading, talking, playing with the child. Eye contact and/or reciprocal behavior is assumed. Only code if child is not engaged with play materials. Code if child is sitting on adult’s lap for comfort even if no verbal interaction is occurring.
- **Play materials** – Child is primarily focused on the play materials (blocks, table toys, art) rather than peers or adults. Child may be involved in fantasy play with or without props.
- **TV/video/computer** – Child is primarily engaged in interactions with these machines rather than peers, teacher, toys, or fantasy.
- **No one (wandering/unoccupied)** – Check this if wandering/unoccupied checked in area of room (unless child is sitting on adult’s lap for comfort). Put ‘A’ instead of check if child is alone in the room.

Child talk. Behaviors of each child were coded in 20-second intervals to reflect to whom the child talked. The average inter-rater percent agreement was 95.79% (range = 85 ~ 100%), and the average Cohen’s Kappa was .93 (range = .74 ~ 1.00). The following are code descriptions.

- **No one** – Coded if child speaks to no person during the entire observation interval.
- **If child speaks** (verbalizes – no sounds or gestures) even one time, then code into one of following:
- **Self, computer, unknown** – Child is talking to self rather than peers or teacher, talks to computer while working on it, talks to a stuffed animal, or talks but the observer cannot determine the exact audience.
- **Other children** – Child is talking to other children.
- **Adult** – Child is talking to an adult.

INFANTS AND TODDLERS (6 ~ 35 MOS.)

Brief Infant Toddler Social and Emotional Assessment (BITSEA: Briggs-Gowan & Carter, 2002)

The BITSEA was used to measure infants’ and toddlers’ social-emotional competence and behavioral problems. Both the parent and the caregiver responded to BITSEA items based on behaviors observed at home or in child care. This is a short version of ITSEA (Infant Toddler Social and Emotional Assessment). The BITSEA consists of 60 items selected from ITSEA, and each item is scaled 0: Not true/Rarely, 1: Somewhat true/Sometimes, and 2: Very true/Often. This measure contains two subscales, one of which measures problem behaviors (49 items) and the other measures competence (11 items). Internal consistency of the scales from the original data was .66 to .89 (Briggs-Gowan, Carter, Skuban, & Horwitz, 2001). Validity was measured by comparing parents’ report with evaluators’ ratings, and most correlations were significant ($r = .39$ to $.44$). As an additional measure of validity, they investigated whether or not “parental worry, parenting stress, and interference in family life (p. 26)” are significantly related to high scores on problem scale and low scores on competence scales to measure another kind of validity, and they found significant relationships among them ($r = .25$ to $.63$). The internal consistencies for our sample were .74 for competence scale and .84 for the problem scale. Internal consistency of parents’ report was .77, and that of caregivers’ report was .83. Two composite variables (one parent and one caregiver report) were created to combine Social Competence and Problem Behavior into a total measure of socio-emotional competence for analysis.

The Mullen Scales of Early Learning (Mullen, 1995)

The Mullen Scales of Early Learning was used to assess infants/toddlers cognitive ability. At the child care setting, research assistants administered the Mullen to participating infants and toddlers. It consists of four scales: Visual Reception Scale, Fine Motor Scale, Receptive Language Scale, and Expressive Language Scale. Using these four scales it is possible to compute an “Early Learning Composite” score, and this was the score used in this analysis. The Visual Reception Scale examines a child’s performance in processing visual patterns. The Fine Motor Scale examines a child’s visual-motor ability. The Receptive Language Scale examines a child’s ability to process linguistic input. The Expressive Language Scale examines a child’s ability to use language productively. Internal consistency was tested using modi-

fied split-half procedure for each scale and for the composite. The median values of the internal consistency for each scale were from .75 to .83 and that of the composite was .91. In addition, test-retest reliability was checked by administering the scales to two samples (50 1- to 24-month-old children and 47 25- to 56-month-old children). Test-retest reliabilities for the younger group were from .82 to .85; those for the older group were from .71 to .79.

To check construct validity, developmental progression of scores, intercorrelations of the scales, and principal-axis factor analysis were examined. Steady increases were found in mean scores through the age range confirming age differentiation in developmental progressions (younger children develop more rapidly). Mullen also examined the squared values of correlations and found that some variance in each scale was explained by other scales. This indicates "an underlying commonality of the separate scale scores to yield a meaningful composite (p. 60)." Principal-axis factor analysis was conducted as well, and it was found that all four scales provide estimate of general cognitive development with factor loading higher than .65, and that receptive language and expressive language measure gave the best estimate of general cognitive development.

In addition, the author examined correlations between Mullen Scales and other measures, such as Bayley Scales of Infant Development (Bayley, 1993) and found higher correlations between Mullen Scales and Bayley Mental Development Index (ranging from .53 to .59) than between Mullen Scales and Bayley Psychomotor Development Index (ranging from .21 to .52), suggesting that Mullen Scales is a valid measure of cognitive development. Mullen also included some literature supporting that Mullen Scale is a valid cognitive measures (e.g., Bangs, 1986; Brigrance, 1978;).

OLDER CHILDREN (3-5 YEARS)

Classroom Behavior Inventory (CBI: Schaefer, Edgerton, & Aaronson, 1977)

The Classroom Behavior Inventory (CBI) was used to measure preschool-age children's social and cognitive skills. The CBI is a paper and pencil adult report measure containing 30 items that are rated on a 5-point scale ranging from Not at all (1) to Very much (5). The original measure consists of 10 subscales: Considerateness (5 items), Creativity (5 items), Extroversion (5 items), Independent (5 items), Task-orientation (5 items),

Verbal intelligence (5 items), Dependence (3 items), Hostility (3 items), Introversion (3 items), and Distractibility (3 items). Internal consistencies were from .85 to .96 for individual scales. Osborne, Schulte, and McKinney (1991) conducted factor analysis in their study and created three composite subscales: Academic Competence factor (Creativity, Verbal intelligence, Independence, Task orientation, reversed Dependence, and reversed Distractibility), Extroversion factor (Extroversion and reversed Introversion), and Considerateness factor (reversed Hostility and Considerateness). This analysis creating three composite factors explained 82% of the total variance of the original framework for the CBI conducted by Schaefer et al. (1978). The internal consistencies for our sample were .90 for the Academic competence scale, .72 for Extroversion scale, and .79 for the Considerateness scale. Internal consistency of parents' report was .89, and that of caregivers' report was .94.

Social Competence and Behavior Evaluation (SCBE: LaFreniere & Dumas, 1996)

The short form of SCBE consists of three scales: Anger-Aggression (10 items), Social Competence (10 items), and Anxiety-Withdrawal (10 items). These scales were used to assess socio-emotional competence. Parents and caregivers rated items ranging from not at all like the child (1) to very much like the child (2). The original 80-item Social Competence and Behavior Evaluation (SCBE) was developed to measure 30- to 78-month-old children's "patterns of social competence, emotion regulation and expression, and adjustment difficulties (p.369)." Anger-Aggression scale contains items regarding angry, aggressive, egotistical, and oppositional behaviors; Social Competence scale consists of items related to joyful, secure, tolerant, socially integrated, calm, pro-social, cooperative, and autonomous behaviors; and Anxiety-Withdrawal scale includes items related to depressed, anxious, isolated, and dependent behaviors. Sixty-seven percent of the total variance was explained by these three factors. The authors collected data in three different sites: Quebec, Indiana, and Maine. Internal consistencies were from .72 to .89. Validity was tested by computing correlations of these three indexes with the corresponding 10-item scales, and the correlations were from .92 to .97. In addition, in the Indiana sample the authors asked teachers to rate children using another measure related to children's problem behaviors (the Revised Behavior Problem Checklist: RBPC) and computed correlations with Anger-Aggression and Anxiety-Withdrawal scales. The Pearson's correlations were .67 and .87. The internal consistencies for our sample were .84 for the Anger-Aggression scale, .83



for Social Competence scale, and .74 for the Anxiety-Withdrawal scale. Internal consistency of parents' report was .83, and that of caregivers' report was .88.

For data analysis, the CBI and SCBE were combined to create two socio-emotional competence composite scores, one reported by parents and one reported by caregivers. High scores imply that the child's behavior was rated low on anger-aggression and anxiety-withdrawal and high on social competence; and low scores imply that the child's behavior was rated high anger-aggression and anxiety-withdrawal and low on social competence. For our analyses, the standardized scores were used ($M = 0$, $SD = 1$). If the score is positive, the child is more socially competent than aggressive and anxious/withdrawn. If the score is negative, the child is more aggressive and anxious/withdrawn than socially competent. If the score is close to 0, it means there is a balance between social competence and anger/aggression/anxiety/withdrawal.

Peabody Picture Vocabulary Test – III (PPVT-III: Dunn & Dunn, 1997)

Peabody Picture Vocabulary Test – III (PPVT-III) was used to measure receptive vocabulary. Research assistants asked children to point to the picture that matches the words spoken by the examiners. The scores were converted to standard scores. Reliability was tested using modified split-half procedure, and the median reliability was .94 (ranging from .86 to .97). Alternate-forms reliability coefficients were also calculated by administering two different test forms to the same group of people. The coefficients computed from the standard scores were from .88 to .96 (median = .94). Validity was also investigated using other measures of vocabulary and verbal ability (WISC-III; KAIT; K-BIT; and OWLS). They found moderate to high correlations, with coefficients ranged from .62 to .91, supporting that PPVT-III is a valid instrument that measures some aspects of children's intelligence, verbal ability quite well.

Family And Child Experiences Survey (FACES)

Social Awareness Task. Social Awareness Task was used to test children's knowledge of their social environment. The examiners asked children to tell their full name (both first and last names), age, and date of birth (both month and day). Possible total score was 5 (first name, last name, age, month of their birth, and day of their birth; 1 point each), and reliabilities were from .61 to .63.

Color Name and Counting. Color naming and counting were used to test children's knowledge of colors and their counting ability. A picture containing randomly arranged bears in 10 colors (red, blue, white, pink, green, yellow, brown, purple, yellow, and black) was presented to children. Children were asked to point to each bear and name the color of the bears (2 points for each bear). Following the color-naming task, children were asked to count the bears. The examiners recorded the number at which children stopped counting or became incorrect (1 point if the number was correct). After that, the examiners asked children how many bears there were and recorded their answers (1 point if the answer was 10). Finally, the examiners rated children's one-to-one counting on a scale range from 1 (child could not count or did not try) to 5 (perfect, no mistakes). Color name and counting tasks have been found to be associated with different levels of school readiness skills of preschool children from low-income families (Zill, Resnick, Kim, McKey, Clark, Pai-Samant, Connell, Vaden-Kiernan, O'Brien, & D'Elia, 2001). The reported internal consistency of color names was .94. In addition, validity was examined by investigating correlations of color names and counting with reading scores at the end of kindergarten ($r = .39$ and $r = .40$, respectively) and with general knowledge scale at the end of kindergarten ($r = .38$ and $r = .36$, respectively). A multivariate regression analysis also provided similar results suggesting that counting task was a significant predictor of children's reading scores at the end of kindergarten year.

REFERENCES FOR APPENDIX A

- Arnett, J. (1989). Caregivers in day-care centers: Does training matter? *Journal of Applied Developmental Psychology*, 10, 541-552.
- Bangs, T. E. (1986). *Birth to Three Development Scale*. Allen, TX: DLM Teaching Resources.
- Bayley, N. (1993). *Bayley Scales of Infant Development, Second Edition*. San Antonio: Harcourt Brace & Co.
- Bond, J.T., Galinsky, E., & Swanberg, J. (1998). *The 1997 National Study of the Changing Workforce*. New York: Families and Work Institute.
- Brigance, A. H. (1978). *BRIGANCE Diagnostic Inventory of Early Development*. North Billerica, MA: Curriculum Associates.

- Briggs-Gowan, M. J., & Carter, A. S. (2002). *Brief Infant-Toddler Social and Emotional Assessment (BITSEA) manual, version 2.0*. New Haven, CT: Yale University.
- Briggs-Gowan, M. J., Carter, A. S., Skuban, E., Horwitz, S. (2001). Prevalence of social-emotional and behavioral problems in a community sample of 1- and 2-year-old children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(7), 811-819.
- Dunn, L. M., & Dunn, L. M. (1997). *Peabody Picture Vocabulary Test, Third edition*. Circle Pines, MN: American Guidance Service.
- Elicker, J., Noppe, I. C., Noppe, L. D., & Fortner-Wood, C. (1997). The Parent-Caregiver Relationship Scale: Rounding out the relationship system in infant child care. *Early Education & Development*, 8(1), 83-100.
- Emlen, A. (1998). *AFS Consumer Survey: From parents receiving child-care assistance*. Report prepared for Adult and Family Services Division, Oregon Department of Human Resources.
- Harms, T. & Clifford, R. (1989). *Family Day Care Rating Scale*. New York: Teachers College Press.
- Harms, T., Cryer, D., & Clifford, R. (1998). *Early Childhood Environment Rating Scale – Revised*. New York: Teachers College Press.
- Howes, C., & Stewart, P. (1987). Child's play with adults, toys, and peers: An examination of family and child care influences. *Developmental Psychology*, 23(3), 423-430.
- Howes, C., & Smith, E. W. (1995). Relations among child care quality, teacher behavior, children's play activities, emotional security, and cognitive activity in child care. *Early Childhood Research Quarterly*, 10, 381-404.
- Kontos, S., & Wilcox-Herzog, A. (1997). Influences on children's competence in early childhood classrooms. *Early Childhood Research Quarterly*, 12(3), 247-262.
- Kontos, S., Burchinal, M., Howes, C., Wisseh, S., & Galinsky, E. (2002). An Eco-Behavioral Approach to Examining the Contextual Effects of Early Childhood Classrooms. *Early Childhood Research Quarterly*, 17, 239-258.
- LaFreniere, P.J. & Dumas, J.E. (1997). Social competence and behavior evaluation in children ages 3 to 6 years: The short form (SCBE-30). *Psychological Assessment*, 8(4), 369-377.
- Mullen, E. M. (1995). *Mullen Scales of Early Learning*. Circle Pines, MN: American Guidance Service, Inc.
- Osborne, S. S., Schulte, A. C., & McKinney, J. D. (1991). A longitudinal study of students with learning disabilities in mainstream and resource programs. *Exceptionality*, 2, 81-96.
- Pianta, R. (1992). *The Student-teacher Relationship Scale*. Unpublished manuscript. University of Virginia, Charlottesville.
- Schaefer, E. S., Edgerton, M., & Aaronson, M. (1977). *Classroom Behavior Inventory*. Chapel Hill, NC: The Frank Porter Graham Child Development Center.
- Zill, N., Resnick, G., Kim, K., McKey, R. H., Clark, C., Pai-Samant, S., Connell, D., Vaden-Kiernan, M., O'Brien, R., & D'Elia, M. A. (2001). *Head Start EACES: Longitudinal Findings on Program Performance*. Third Progress Report. Mclean, VA: Abt Associates, Inc.

Appendix B

CHILD CARE FOR LOW INCOME WORKING FAMILIES:
FOUR COMMUNITY PROFILES

TABLE A1. WELL-BEING INDICATORS OF INDIANA AND THE FOUR CCCRP COMMUNITIES

Community	Marion	Lake	Allen	St. Joseph	Indiana
Largest City	Indianapolis	Gary	Fort Wayne	South Bend	Indianapolis
Population, 2002 ^a	862,499	485,851	337,310	266,378	6,156,913
Population under 5 years, 2002 ^a	68,810	34,787	24,924	19,325	410,739
Number of families with children, 2000 ^a	106,350	59,587	43,884	32,260	767,836
Overall poverty rate, 2000 ^a	11.4%	12.2%	9.1%	10.4%	9.5%
Percent of children in poverty, 2000 ^a	15.3%	17.8%	2.4%	13.7%	11.7%
Unemployment rate, 2002 ^b	5.3%	6.9%	5.1%	5.1%	5.1%
Mean per capita income annual, 2001 ^b	\$31,292	\$27,521	\$29,265	\$28,098	\$27,522
Median household income, 2000 ^a	\$40,421	\$41,829	\$42,671	\$40,420	\$41,567
Percent of population in minority ethnic groups, 2002 ^a	29.5%	33.3%	16.9%	17.6%	16%
Percent of households headed by single parents, 2000 ^a	11.8%	11.3%	10.0%	9.9%	9.1%
Monthly average of families receiving TANF 2002 ^b	11,483 (10.8%)	9,635 (16.2%)	2,637 (6.0%)	2,671 (8.3%)	47,459 (6.2%)
Monthly average of persons issued food stamps 2002 ^b	77,058	55,996	21,548	19,793	395,440

^a U.S. Census Bureau, 2000.

^b Indiana Kids Count, 2003, Indiana Youth Institute.

TABLE A2. CHILD CARE DATA AT COMMUNITY LEVELS

Community	Marion	Lake	Allen	St. Joseph
Total licensed child care slots, 2002	22,740	8,209	5,626	5,607
Licensed capacity, 2003	21,061	7,746	5,673	5,003
Number licensed child care centers, 2002	135	52	37	40
Number licensed child care homes, 2002	519	302	182	227
Number of registered ministries, 2003 (no regulation of # of slots)	131	50	38	28
Number of registered ministries, 2002 (no regulation of # of slots)	125	49	36	32
Number of licensed child care spaces per 100 children, Ages 0-4, 2002	35.7	23.7	22.1	30
Annual number of children receiving child care vouchers, 2002	18,530	10,836	6,334	3,174
Monthly average of children on waiting list for child care vouchers, 2002 (ratio, receiving: waiting)	6,939 (3:1)	295 (38:1)	697 (9:1)	623 (5:1)
Percent of children receiving child care vouchers with family income 100% poverty or below, 2002	54%	77%	63%	78%
Percent of children receiving child care vouchers by child care setting, FFY2002				
Licensed center care	28.1%	19.1%	19%	28.1%
Licensed child care homes	14.7%	24.1%	23.7%	27.7%
Unlicensed child care homes (relative and non-relative)	31.5%	36.2%	42%	22.4%
Child care ministries	17.2%	17.4%	12.6%	16.9%
Other license exempt centers (YMCA, schools)	8.5%	.2%	2.7%	4.9%
Percent of children receiving child care vouchers by age, FFY2002				
Infants (0 to 1 yrs)	3%	6.6%	8.4%	11.7%
Toddlers (1 to 3 yrs)	17.9%	19.8%	20.5%	25.6%
Preschool age children (3 to 6 yrs)	35.6%	33.7%	32.6%	33.7%
School age children (6 yrs and up)	43.4%	39.8%	38.5%	29%

Source: Indiana Family and Social Services Administration, Bureau of Child Development



COMMUNITY CHILD CARE LEADER INTERVIEWS

Listed are the positions of the community child care leaders interviewed in each community.

Marion County

- A representative of the local Step Ahead council
- A representative of the Division of Families and Children
- A representative of the Resources and Referral Agency
- A business specialist
- An advocate for the homeless

Lake County

- Director of Child Enrichment Center
- An informant from IACCRR
- A director of Lake Area United Way
- A coordinator of Lake Area United Way and Gary WIC program
- An associate professor of psychology at a local university

Allen County

- A representative of the Division of Families and Children
- A representative of the WIC offices
- A member of the local Step Ahead Council
- A representative of a community action agency
- Two representatives from Early Childhood Alliance

St. Joseph County

- A representative of extension services
- A state official from the Division of Families and Children
- A member of the local Step Ahead Council
- A business specialist
- A representative of the WIC offices



Appendix C

CHARACTERISTICS OF FAMILIES, CHILDREN, AND CAREGIVERS

The following tables display the descriptive statistics for key characteristics of family, child, and child care participants. ANOVA and chi-square tests were completed to identify differences among communities on the variables. Statistical values (F and chi tests) are reported only for those characteristics that did differ by county.

TABLE C1. KEY CHARACTERISTICS OF FAMILY PARTICIPANTS IN CCCRP (N = 307)

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Number of adults in household	1.51(0.70)	299	1 - 6		
Number of children in household	2.37(1.24)	302	1 - 8		
Family income per month					
\$1 ~ 800		106(34.5)			
\$801 ~ 1500		95(30.9)			
\$1501 or more		95(30.9)			
Not reported		11(3.6)			
Marital status					
Single/no partner		174(56.7)			
Married		52(16.9)			
Divorced/widowed		34(11.1)			
Remarried		2(0.7)			
Living with a partner		42(13.7)			
Not reported		3(1.0)			
Male head in household					
Child's father		84(27.4)			
Child's stepfather		9(2.9)			
Child's grandfather		12(3.9)			
Other		11(3.6)			
None		183(59.6)			
Not reported		8(2.6)			
Male head employment					
Employed		103(88.8)			
Not employed		11(9.5)			
Not reported		2(1.7)			
Male head education level					
Some high school		23(19.8)			
High school diploma		45(38.8)			
Associates degree/some college		24(20.7)			
College degree		12(10.3)			
Some graduate school		2(1.7)			
Completed graduate school		2(1.7)			
Not reported		8(6.9)			

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Female head in household					
Child's mother		271(88.3)			
Child's stepmother		2(0.7)			
Child's grandmother		21(6.8)			
Other		8(2.6)			
Not reported		5(1.6)			
Female head employment					
Employed		256(83.4)			
Not employed		47(15.3)			
Not reported		4(1.3)			
Female head education level					
Some high school		23(7.5)			
High school diploma		115(37.5)			
Associates degree/some college		116(37.8)			
College degree		22(7.2)			
Some graduate school		9(2.9)			
Completed graduate school		7(2.3)			
Not reported		15(4.9)			

TABLE C2. KEY CHARACTERISTICS OF CHILDREN PARTICIPANTS IN CCCRP (N=307)

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Age in months	40.09 (16.75)	307			
Children under 36 months of age		121(39.4)			
Children over 36 months of age		186(60.6)			
Gender					
Boy		152(49.5)			
Girl		153(49.8)			
Race					41.96 (0.00)
African American		181(59.0)			
Asian/Pacific islander		2(0.7)			
Hispanic/Latino		8(2.6)			
White		72(23.5)			
Mixed		39(12.7)			
Not reported		5(1.6)			
Child's living arrangements					
Live only with mother		188(61.2)			
Live only with father		1(0.3)			
Live with mother and father		74(24.1)			
Live with mother, father, and another		2(0.7)			

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Live with mother and mother's partner			1 - 6		
Live with mother and another		6(2.0)	1 - 8		
Live with father and another		26(8.5)			
Live with other		2(0.7)			
Not reported		5(1.65)			
		3(1.0)			
Live with mother					
Yes		296(96.4)			
No		8(2.6)			
Not reported		3(1.0)			
Live with father					
Yes		79(25.7)			
No		225(73.3)			
Not reported		3(1.0)			
Live with someone else (e.g., relative, guardian)					
Yes		35(11.4)			
No		269(87.6)			
Not reported		3(1.0)			

TABLE C3. KEY CHARACTERISTICS OF CHILD CARE PROVIDER PARTICIPANTS IN CCCRP (N = 307)

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Age in years	38.95 (12.39)	286	16 - 62	12.46 (0.0)	
Education level					
Some high school		15(4.9)			
High school diploma/GED		77(25.1)			
Associate degree/some college		132(43.0)			
College degree		59(19.2)			
Some graduate school		8(2.6)			
Completed graduate degree		7(2.3)			
Not reported		9(2.9)			
Does caregiver have an early childhood education or child development credential?					13.30 (0.00)
Yes		127(41.4)			
No		180(58.6)			

TABLE C3. KEY CHARACTERISTICS OF CHILD CARE PROVIDER PARTICIPANTS IN CCCRP (N = 307)

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Number of specialized training program completed					57.11 (0.00)
0	2.34 (0.96)	14(4.6)			
1		15(4.9)			
2		165(53.7)			
3		66(21.5)			
4		34(11.1)			
5		2(.7)			
6		1(.3)			
Not reported		10(3.3)			
Marital status					23.19 (0.03)
Single/no partner		80(26.1)			
Married		148(48.2)			
Divorced/widowed		39(12.7)			
Remarried		6(2.0)			
Living with partner		22(7.2)			
Not reported		12(3.9)			
Race					60.23 (0.00)
African American/Black		149(48.5)			
Asian/Pacific Islander		3(1.0)			
Hispanic/Latino		11(3.6)			
White		111(36.2)			
Other		10(3.3)			
Not reported		23(7.5)			
Family income per month					22.50 (0.01)
\$1 ~ 800		32(10.4)			
\$801 ~ 1500		44(14.3)			
\$1501 ~ 3000		82(26.7)			
\$3001 or more		82(26.7)			
Not reported		67(21.8)			
Annual earnings from child care					
\$0 ~9,999		69(22.5)			
\$10,000 ~ 19,000		88(28.7)			
\$20,000 or more		66(21.5)			
Not reported		84(27.4)			
Years of experience	10.36 (6.69)		0 - 43	4.24 (0.01)	

TABLE C4. COMPARISON OF CCCRP SAMPLE AND CENSUS POPULATION ON KEY DEMOGRAPHIC VARIABLES

	Marion	Census ^a	Lake	Census ^a	Allen	Census ^a	St. Joseph	Census ^a
Number of children in household								
1	28.9%	39.1%	20.8%	34.5%	25.0%	34.2%	39.7%	33.1%
2	28.9%	34.0%	26.0%	34.4%	30.3%	34.1%	28.2%	33.6%
3	23.7%	19.2%	32.5%	18.7%	26.3%	18.7%	19.2%	24.9%
4	9.2%	5.3%	15.6%	9.2%	7.9%	9.1%	7.7%	4.9%
5	5.3%	1.7%	2.6%	1.8%	5.3%	1.8%	3.8%	2.4%
6	-----	0.3%	1.3%	0.9%	3.9%	0.9%	-----	1.0%
7	-----	0.2%	-----	0.4%	-----	0.4%	-----	-----
8	1.3%	0.2%	-----	-----	-----	0.6%	-----	-----
9	-----	-----	-----	-----	-----	-----	-----	-----
10	-----	-----	-----	-----	-----	0.3%	-----	-----
Not reported	2.6%	-----	1.3%	-----	1.3%	-----	1.3%	-----
Number of adults in household								
1	56.6%	42.4%	59.7%	40.5%	52.6%	37.3%	56.4%	44.1%
2	34.2%	54.6%	32.5%	54.4%	34.2%	58.6%	33.3%	55.2%
3	5.3%	2.5%	5.2%	3.1%	10.5%	3.8%	6.4%	0.8%
4	1.3%	0.5%	-----	1.0%	-----	0.3%	-----	-----
5	-----	-----	-----	1.0%	-----	-----	-----	-----
6	-----	-----	-----	-----	1.3%	-----	-----	-----
7	-----	0.1%	-----	-----	-----	-----	-----	-----
Not Reported	2.6%	-----	2.6%	-----	1.3%	-----	3.8%	-----
Education of head of household								
Some high school	9.2%	24.4%	5.2%	24.2%	3.9%	24.6%	11.5%	27.5%
High school diploma/GED	34.2%	37.5%	32.5%	37.3%	42.1%	38.3%	41.0%	36.4%
Associate degree/some college	42.1%	28.0%	42.9%	31.5%	36.8%	32.6%	29.5%	27.4%
College degree	6.5%	7.4%	9.1%	6.0%	13.1%	3.8%	11.6%	6.5%
Master's degree or higher	2.6%	2.7%	2.6%	1.1%	-----	0.7%	3.8%	2.3%
Not reported	5.3%	-----	7.8%	-----	3.9%	-----	2.6%	-----
Marital Status								
Single	-----	41.7%	-----	44.6%	-----	35.7%	-----	48.1%
No partner	64.5%	NA ^b	58.4%	NA ^b	46.1%	NA ^b	57.7%	NA ^b
Living with partner	14.5%	NA ^b	14.3%	NA ^b	13.2%	NA ^b	12.8%	NA ^b
Married	13.1%	42.4%	15.6%	43.5%	26.3%	50.3%	15.4%	38.7%
Divorced/widowed	7.9%	15.9%	10.4%	12.0%	14.5%	14%	11.5%	13.0%
Not reported	-----	-----	1.3%	-----	-----	-----	2.6%	-----

	Marion	Census ^a	Lake	Census ^a	Allen	Census ^a	St. Joseph	Census ^a
Race of child								
Black	64.5%	9.5%	84.4%	39.5%	43.4%	18.4%	43.6%	28.4%
Asian/Pacific islander	-----	1.1%	-----	0.5%	1.3%	1.5%	1.3%	1.2%
Hispanic/Latino	-----	NA ^c	2.6%	NA ^c 45.4%	3.9%	NA ^c 70.0%	3.8%	NA ^c 57.7%
White	26.3%	64.2%	3.9%	3.5%	32.9%	1.6%	30.8%	4.2%
Mixed	9.2%	2.2%	7.8%	11.1%	15.8%	6.0%	17.9%	8.6%
Other	-----	3.1%	-----	-----	-----	-----	-----	-----
Not reported	-----	-----	1.3%	-----	2.6%	-----	2.6%	-----
Ethnicity of child								
Hispanic	-----	5.4%	2.6%	21.4%	3.9%	9.6%	3.8%	11.4%
Non-Hispanic	100%	94.6%	97.4%	78.6%	96.1%	90.4%	96.2%	88.6%

^a U.S. Census Bureau, 2000.

^b NA indicates data Not Available from this data source.

^c NA indicates data Not Applicable. In census data Hispanic/Latino is categorized only as ethnicity; therefore, those individuals from the census data that are Hispanic/Latino are included in Black, White, Other, and Mixed race categories. Due to differences in data collection, a comparison of race and ethnicity should be interpreted with caution.

TABLE C5. DESCRIPTIVE STATISTICS OF PARENT AND CHILD DEMOGRAPHICS BY COUNTY

Variables	Marion	Lake	Allen	St. Joseph
Parents Demographics				
Number of children in household	2.38(1.33)	2.57(1.15)	2.49(1.32)	2.06(1.13)
Number of adults in household	1.50(.67)	1.44(.60)	1.63(.85)	1.47(.64)
Monthly Family income				
\$1-\$800	13.4%	13.5%	9.3%	16.4%
\$801-1500	28.4%	13.5%	11.1%	17.9%
\$1501 or \$3000	43.3%	30.8%	40.7%	22.4%
\$3001 or more	14.9%	42.3%	38.9%	43.3%
Marital Status				
Single/no partner	64.5%	58.4%	46.1%	57.7%
Married	11.8%	15.6%	25.0%	15.4%
Divorced/widowed	7.9%	10.4%	14.5%	11.5%
Remarried	1.3%	---	1.3%	---
Living with partner	14.5%	14.3%	13.2%	12.8%
Not reported	---	1.3%	---	2.6%
Percent of families with male head of household present	35.5%	42.9%	40.8%	32.5%

Variables	Marion	Lake	Allen	St. Joseph
Male head education				
Some high school	34.6%	12.9%	14.3	26.1%
High school diploma/GED	15.4%	48.4%	53.6	47.8%
Associates degree/some college	30.8%	29.0%	21.4	4.3%
College degree	19.2%	3.2%	10.7	13.0%
Some graduate school	---	3.2%	---	4.3%
Completed graduate school	---	3.2%	---	4.3%
Not reported	---	---	---	---
Female head education				
Some high school	9.2%	5.2%	3.9%	11.5%
High school diploma/GED	34.2%	32.5%	42.1%	41.0%
Associates degree/some college	42.1%	42.9%	36.8%	29.5%
College degree	2.6%	6.5%	9.2%	10.3%
Some graduate school	3.9%	2.6%	3.9%	1.3%
Completed graduate school	2.6%	2.6%	---	3.8%
Not reported	5.3%	7.8%	3.9%	2.6%
Days spent looking for current child care arrangement	50.22(87.70)	31.63(47.12)	26.36(39.93)	29.16(59.85)
Child care flexibility (1-5)	3.64(.66)	3.87(.55)	3.758(.65)	3.64(.70)
Child care availability (1-5)	3.61(.77)	3.87(.80)	3.77(.75)	3.81(.71)
Children Demographics				
Age in months	38.89 (15.53)	42.27 (16.99)	40.45 (18.37)	38.77 (16.06)
Percent of infants/toddlers	38.2%	39%	39.5%	41.0%
Percent of preschoolers	61.8%	61.0%	60.5%	59.0%
Gender				
Female	43.4%	53.2%	56.6%	47.7%
Male	56.6%	46.8%	43.4%	52.6%
Child's race				
African American	64.5%	84.4%	43.4%	43.6%
White	26.3%	3.9%	32.9%	30.8%
Hispanic/Latino	---	2.6%	3.9%	3.8%
Asian/Pacific Islander	---	---	1.3%	1.3%
Mixed	9.2%	7.8%	15.8%	17.9%
Not reported	---	1.3%	2.6%	2.6%
Child's living arrangements				
Live with mother and father	21.1%	23.7%	32.9%	22.4%
Live with mother only	61.8%	61.8%	57.9%	65.8%
Live with father only	---	1.3%	---	---
Live with mother and mother's partner	2.6%	1.3%	2.6%	1.3%
Live with mother and other adult	11.8%	9.2%	5.3%	7.9%
Live with father and other adult	1.3%	---	---	1.3%
Live with other adult only	1.3%	2.6%	1.3%	---
Age child entered child care in months	5.69(9.05)	6.57(10.09)	8.30(11.89)	7.60(9.75)

TABLE C6. DESCRIPTIVE STATISTICS OF CHILD CARE CHARACTERISTICS BY COUNTY

Variables	Marion	Lake	Allen	St. Joseph
Caregiver Demographics				
Age in years	35.84(11.01)	46.26(12.02)	36.93(11.61)	37.14(12.17)
Education level				
Some high school	4.0%	5.2%	4.3%	6.6%
High school diploma/GED	32.0%	16.9%	27.1%	27.6%
Associates degree/some college	34.7%	48.1%	50.0%	44.7%
College degree	20.0%	56.0%	15.7%	17.1%
Some graduate school	5.3%	0.0%	1.4%	3.9%
Completed graduate degree	4.0%	3.9%	1.4%	0.0%
Race				
African American	52.6%	75.3%	32.9%	33.3%
White	38.2%	6.5%	44.7%	55.1%
Hispanic/Latino	1.3%	1.3%	6.6%	5.1%
Asian/Pacific Islander	2.6%	---	1.3%	---
Other	1.3%	5.2%	5.3%	1.3%
Not reported	3.9%	11.7%	9.2%	5.1%
Marital Status				
Single/no partner	36.8%	14.3%	27.6%	25.6%
Married	39.5%	54.5%	51.3%	47.6%
Divorced/widowed	11.8%	20.8%	7.9%	10.3%
Remarried	---	2.6%	---	5.1%
Living with partner	9.2%	5.2%	6.6%	7.7%
Not reported	2.6%	2.6%	6.6%	3.8%
Monthly income from child care				
\$0-\$9,999	36.1%	34.0%	22.2%	31.0%
\$10,000-\$19,000	37.7%	30.0%	48.1%	41.4%
\$20,000 or more	26.2%	36.0%	29.6%	27.6%
Not reported				
Years of experience	10.61(9.34)	13.38(10.11)	9.1(6.82)	8.43(7.34)
Percent of caregivers with early childhood credential	48.7%	51.9%	39.5%	25.6%
Number of specialized training program competed	2.04(.82)	2.84(1.05)	2.32(.88)	2.17(.90)

Appendix D

CHILD CARE EXPERIENCES OF LOW-INCOME FAMILIES

The following tables display descriptive statistics of selected child care variables as well as a summary of the types of child care low-income working families used in our sample. ANOVA and chi-square tests were completed to identify differences among communities on the variables when applicable.

TABLE D1. TYPES OF CHILD CARE LOW-INCOME WORKING FAMILIES USED

Variable	M(SD)	N(%)	Range	F(p)	χ^2 (p)
Current child care setting					29.51 (0.00)
Center-based child care		145(47.2)			
Home-based child care		114(37.2)			
Child care ministry		48(15.6)			
Age entry child care in month	7.05(10.25)	276	0 - 48	0.87 (0.46)	
Number of child care placements by child age in year	0.8(0.62)	276	.18 – 5.14	0.19 (0.90)	
Reason for using child care					26.23 (0.01)
Allow parent to work		185(60.3)			
Allow parent to attend school		58(18.9)			
Allow parent time for leisure		1(0.3)			
Important for child development		47(15.3)			
Other		4(1.3)			
Not reported		12(3.9)			

TABLE D2. SUMMARY OF PARTICIPATING CHILDREN'S CHILD CARE SETTINGS.

CCCRP PARTICIPANTS SUMMARY TABLE

CC setting	ST. JOSEPH CO.							MARION CO.							ALLEN CO.						
	6~35 MOS.			3~6 YRS.			T	6~35 MOS.			3~6 YRS.			T	6~35 MOS.			3~6 YRS.			T
	M	F	T	M	F	T		M	F	T	M	F	T		M	F	T	M	F	T	
1. Lic.center/preschool	4	8	12	16	11	27	39	4	5	9	13	11	24	33	1	4	5	7	8	15	20
2. Child care ministry	1	2	3	6	1	7	10	6	3	9	3	3	6	15	4	5	9	5	7	12	21
3. Lic. FCCH	3	8	11	3	3	6	17	2	3	5	1	2	3	8	8	2	10	2	5	7	17
4. Unlic. FCCH	3	1	4	2	1	3	7	2	1	3	3	1	4	7	0	3	3	1	0	1	4
5. Relative care	1	1	2	2	1	3	5	2	0	2	0	2	2	4	2	1	3	0	2	2	5
6. Head Start	0	0	0	0	0	0	0	1	0	1	6	2	8	9	0	0	0	3	6	9	9
Center vs. Home																					
Center-based (1+2+6)	5	10	15	22	12	34	49	11	8	19	22	16	35	54	5	9	14	15	21	36	50
Home-based (3+4+5)	7	10	17	7	5	12	29	6	4	10	4	5	12	22	10	6	16	3	7	10	26
Lic. vs. Unlic.																					
Licensed (1+3+6)	7	16	23	19	14	33	56	7	8	15	20	15	35	50	9	6	15	12	19	31	46
Unlicensed (2+4+5)	5	4	9	10	3	13	22	10	4	14	6	6	12	26	6	9	15	6	9	15	30
Total	12	20	32	29	17	46	78	17	12	29	26	21	47	76	15	15	30	18	28	46	76
By child gender	MALE		41					MALE		43				MALE		33					
	FEMALE		37					FEMALE		33				FEMALE		43					

CC setting	ST. JOSEPH CO.							TOTAL						
	6~35 MOS.			3~6 YRS.			T	6~35 MOS.			3~6 YRS.			T
	M	F	T	M	F	T		M	F	T	M	F	T	
1. Lic.center/preschool	4	2	6	10	9	19	25	13	19	32	46	39	85	117
2. Child care ministry	1	0	1	1	0	1	2	12	10	22	15	11	26	15
3. Lic. FCCH	8	12	20	3	9	12	32	21	25	46	9	19	28	8
4. Unlic. FCCH	2	0	2	1	3	4	6	7	5	12	7	5	12	7
5. Relative care	0	1	1	1	0	1	2	5	3	8	3	5	8	4
6. Head Start	0	0	0	5	5	10	10	1	0	1	14	13	27	9
Center vs. Home														
Center-based (1+2+6)	5	2	7	16	14	30	37	26	29	55	75	63	138	193
Home-based (3+4+5)	10	13	23	5	12	17	40	33	33	66	19	29	48	114
Lic. vs. Unlic.														
Licensed (1+3+6)	12	14	26	18	23	41	67	34	44	79	69	71	140	219
Unlicensed (2+4+5)	3	1	4	3	3	6	10	24	18	42	25	21	46	88
Total	15	15	30	21	26	47	77	59	62	121	94	92	186	307
By child gender	MALE		36					MALE		153				
	FEMALE		41					FEMALE		154				

M: Male; F: Female
 T: Total (male + female)
 T: Total (younger children + older children)
 Lic.: Licensed
 Unlic.: Unlicensed
 FCCH: Family Child Care Home

Appendix E

QUALITY OF CHILD CARE

The following tables display descriptive statistics for selected child care variables. ANOVA and chi-square tests were completed to identify differences among communities on the variables when applicable.

Table E1.
Means (Standard Deviations) of Child Care Quality Variables ($N = 307$)

Child Care Quality Variables		M (SD)	N (%)	Range	F(p)	$\chi^2(p)$
Global Quality	Global Quality Score (ECERS-R & FDCRS)(1 ~ 7)	3.81 (1.44)		1.09- 6.48	1.15 (.33)	
	ECERS-R Score (1 ~ 7)	4.39 (1.28)		1.15- 6.48	.85 (.47)	
	FDCRS Score (1 ~ 7)	2.78 (1.10)		1.09- 5.32	.98 (.41)	
Structural Quality	Group Size	10.28 (5.54)		1-27	.97 (.41)	
	Child-Adult Ratio	5.64 (3.02)		1-16	1.98 (.12)	
	Caregiver General Education Level (1~6)	2.96 (.99)		1-6		17.50 (.29)
	Caregiver Specialized Education in Child Development		126 (44)			13.30* (.00)
	Number of Years in Experience (caregiver)	10.36 (8.69)		0-43	4.24* (.01)	
Process Quality	Caregiver-Child Relationship (STRS total: 1 ~ 5)	3.98 (.41)		2.63- 4.83	.56 (.64)	
	Conflict/Anger Subscale	1.87 (.63)		1-4.25	.27 (.85)	
	Closeness Subscale	4.07 (.51)		2.45-5	1.68 (.17)	
	Dependency Subscale	2.31 (.79)		1-4.75	1.14 (.33)	
	Parent-Caregiver Relationship (PCRS: 1 ~ 5)– parent report	4.10 (.54)		1.89-5	3.85* (.01)	
	Trust/Confidence Subscale (1 ~ 5)	4.36 (.55)		2.23-5	3.58* (.01)	
	Collaboration Subscale (1 ~ 5)	4.10 (.58)		1.64-5	3.14* (.03)	
	Affiliation Subscale (1 ~ 5)	3.65 (.58)		1.75-5	4.30* (.01)	
	Parent-Caregiver Relationship (PCRS: 1 ~ 5)– caregiver report	4.03 (.55)		2.46-5	.16 (.92)	
	Trust/Confidence Subscale (1 ~ 5)	4.03 (.62)		2.07-5	.15 (.93)	
	Collaboration Subscale (1 ~ 5)	3.23 (.37)		2.27- 4.13	.48 (.70)	
	Caring Subscale (1 ~ 5)	3.44 (.39)		2-5	.94 (.42)	

Child Care Quality Variables	M (SD)	N (%)	Range	F(p)	χ^2(p)
Caregiver Sensitivity (CIS: 1 ~ 4) ³	3.30 (.56)		1.05-4	2.53 (.06)	
Positive Relationship Subscale (1 ~ 4)	2.87 (.76)		1-4	3.53* (.02)	
Punitiveness Subscale (1 ~ 4)	1.23 (.47)		1-3.88	1.55 (.20)	
Detachment Subscale (1 ~ 4)	1.56 (.67)		1-4	1.16 (.33)	
Adult Responsive Interactions (0 ~ 1)	0.31 (.27)		0-1	5.40* (.00)	
Caregiver Talk					
Mean Percentage Praise/ acknowledgement (0 ~ 100%)	3.2% (3.5)		0-21	1.36 (.26)	
Mean Percentage Social (0 ~ 100%)	.5% (1.8)		0-16	1.96 (.12)	
Mean Percentage Question (0 ~ 100%)	6.9% (6.8)		0-56	1.07 (.36)	
Mean Percentage Expansion (0 ~ 100%)	.4% (1.3)		0-12	1.72 (.16)	
Mean Percentage Describes (0 ~ 100%)	14.6% (12.6)		0-57	1.76 (.16)	
Mean Percentage Prompt/suggestion (0 ~ 100%)	2.4% (3.8)		0-23	.756 (.52)	
Mean Percentage Directive (0 ~ 100%)	5.8% (6.8)		0-44	6.39* (.00)	
Children's Cognitive Activity Level (0 ~ 3)	1.04 (.45)		.02-2.84	2.49 (.06)	

Table E2.
Descriptive statistics of child care quality indicators by county

Variables	Marion	Lake	Allen	St. Joseph
Global Quality				
ECERS-R score (1-7)	4.31(1.37)	4.64(1.46)	4.47(1.20)	4.28(1.13)
Percent of infants/toddlers in center based care	65.5%	23.3%	46.7%	46.9%
Percent of preschoolers in center based care	80.1%	63.8%	78.3%	73.9%
FDCRS score (1-7)	2.68(1.17)	2.59(.81)	3.03(1.19)	2.88(1.25)
Percent of infants/toddlers in home based care	34.5%	76.7%	53.3%	53.1%
Percent of preschoolers in home based care	19.1%	36.2%	21.7%	26.1%
Structural Quality				
Child-adult ratio	5.42:1	6.31:1	5.68:1	5.13:1
Process Quality				
Parent report of Parent-caregiver relationship (1-5)	3.99(.50)	4.26(.49)	4.10(.48)	4.04(.54)
Caregiver report of parent-caregiver relationship (1-5)	4.03(.58)	4.05(.53)	3.99(.60)	4.04(.51)
Caregiver report of child-caregiver relationship (1-5)	3.97(.41)	4.02(.40)	3.94(.40)	3.98(.43)
Caregiver interaction (1-4)	3.30(.52)	3.17(.64)	3.42(.56)	3.31(.49)
Percent of caregiver intense interactions with child	38.50 (29.28)	21.44(24.42)	33.09(30.33)	29.95(22.92)
Percent of caregiver high level talk	27.19 (16.95)	23.99(17.54)	25.19(18.56)	20.86(13.98)
Level of child cognitive activity	.97(.35)	1.07(.53)	1.14(.50)	.98(.39)

Appendix F

The following tables display the descriptive statistics of child social-emotional and cognitive competence. ANOVA tests that indicated a difference among the four communities are reported. Significant zero-order correlations and multi-level regression analyses reporting the relationships between indicators of child care quality and children's competence are also presented.

Table F1
Means, Standard Deviations, and Ranges of Children's Cognitive Competence

Cognitive Competence		M (SD)	Range	F(p)
Infants/ Toddlers (n=121)	Mullen Early Learning Composite	85.24 (15.94)	56 – 143	
	Visual Reception	42.38 (11.00)	20 – 73	
	Fine Motor	41.99 (11.63)	20 – 80	
	Receptive Language	42.48 (11.69)	20 – 72	
	Expressive Language	41.29 (10.37)	20 – 73	
Preschool Age Children (n=186)	Receptive Vocabulary (PPVT-III)	87.49 (17.20)	29 – 132	3.06 (0.03)
	Social Awareness (FACES: 1~5)	3.46 (1.38)	0 – 5	
	Color Names (FACES: 0~20)	14.50 (6.88)	0 – 20	
	Counting (FACES: 0~5)	3.86 (1.55)	1 – 5	
	Academic Competence (CBI: 1~5) – parent report	3.68 (.45)	2.46 – 4.81	
	Academic Competence (CBI: 1~5) – caregiver report	3.53 (.63)	1.88 – 5.00	

Table F2

Means, Standard Deviations, and Ranges of Children's Social-emotional Competence

Social-emotional Competence		M (SD)	Range
Infants/ Toddlers	Social Competence (BITSEA: 0~2) – parent report	1.45 (.33)	.36 – 2.00
	Social Competence (BITSEA: 0~2) – caregiver report	1.32 (.35)	0 – 2.00
	Social Competence Sum Score (BITSEA: 0~22) – parent report	14.50 (3.84)	4.00 – 22.00
	Social Competence Sum Score (BITSEA: 0~22) – caregiver report	15.99 (3.58)	0 – 22.00
	Behavior Problems (BITSEA: 0~2) – parent report	0.27 (.16)	0 - .94
	Behavior Problems (BITSEA: 0~2) – caregiver report	0.23 (.16)	.02 – 1.00
	Behavior Problems Sum Score (BITSEA: 0~98) – parent report	15.39 (7.85)	0 – 45.90
	Behavior Problems Sum Score (BITSEA: 0~98) – caregiver report	11.42 (8.08)	1.00 – 49.00
Preschool Age Children	Extroversion (CBI: 1~5) – parent report	4.14 (.49)	2.48 – 5.00
	Extroversion (CBI: 1~5) – caregiver report	3.98 (.64)	1.88 – 5.00
	Considerateness (CBI: 1~5) – parent report	3.43 (.59)	1.88 – 5.00
	Considerateness (CBI: 1~5) – caregiver report	3.56 (.69)	1.38 – 5.00
	Anger-Aggression (SCBE: 1~6) – parent report	2.27 (.71)	1.00 – 4.90
	Anger-Aggression (SCBE: 1~6) – caregiver report	1.94 (.78)	1.00 – 5.10
	Social Competence (SCBE: 1~6) – parent report	4.14 (.77)	1.70 – 5.60
	Social Competence (SCBE: 1~6) – caregiver report	3.87 (.95)	1.40 – 5.80
	Anxiety-Withdrawal (SCBE: 1~6) – parent report	1.82 (.49)	1.00 – 3.70
	Anxiety-Withdrawal (SCBE: 1~6) – caregiver report	1.85 (.71)	.90 – 4.60



Data Reduction of Competence Variables

For infants and toddlers, the Mullen Early Learning composite score was used as the cognitive competence variable. Two composite variables (one parent and one caregiver report) were created to combine Social Competence and Problem Behavior into a total measure of social-emotional competence.

For older children, we identified six cognitive outcome variables (i.e., PPVT-III, FACES social awareness task, FACES color name, FACES counting, CBI academic competence – parent and provider reports) and four social outcome variables (i.e., parent and provider reports of CBI extroversion, CBI considerateness, and SCBE). Using Principal Components Analysis, four composite variables (two for cognitive competence and 2 for social competence) were created. Each composite variable has the mean of 0 and standard deviation of 1. Table F3 presents the final composites used for correlation and regression analyses.

Table F3

Preschool-Age Child Outcome Composite Variables

	Composite Variable	Components
Cognitive Competence	Early Academic Skills	PPVT-III, FACES social awareness task, FACES color name, and FACES counting
	Academic Attitude	CBI academic competence (parent & provider report)
Social- emotional Competence	Parent report	CBI extroversion, CBI considerateness, & SCBE
	Caregiver report	CBI extroversion, CBI considerateness, & SCBE

Table F4.
Means, Standard Deviations, and Ranges of Children's Competence by Community

Variables	Marion	Lake	Allen	St. Joseph
Infant/Toddler Cognitive Outcomes				
Mullen Scales of Early Learning	82.38 (15.34)	81.77(17.99)	86.23(14.73)	90.16(14.84)
Infant/Toddler Socio-emotional Outcomes				
BITSEA Problem Behavior (parent report)	.26 (.15)	.23 (.13)	.30 (.16)	.30 (.19)
BITSEA Problem Behavior (caregiver report)	.28 (.21)	.22 (.13)	.22 (.13)	.21 (.18)
BITSEA Social Competence (parent report)	1.46 (.28)	1.40 (.32)	1.44 (.37)	1.51 (.33)
BITSEA Social Competence (caregiver report)	1.43 (.23)	1.31 (.45)	1.23 (.33)	1.32 (.32)
Preschool Cognitive Outcomes				
FACES social awareness	3.30 (1.60)	3.74 (1.45)	3.09 (1.15)	3.71 (1.20)
FACES color naming	14.17 (6.99)	14.47 (7.25)	16.48 (5.30)	12.84 (7.48)
FACES Bear Counting	3.85 (1.66)	3.87 (1.51)	3.76 (1.55)	3.96 (1.54)
PPVT-III	88.04 (16.76)	81.68 (21.14)	89.04 (13.10)	92.09(15.94)
CBI Academic Attitude (parent report)	3.53 (.45)	3.80 (.47)	3.69 (.43)	3.70 (.40)
CBI Academic Attitude (caregiver report)	3.46 (.68)	3.63 (.66)	3.52 (.62)	3.53 (.56)
Preschool Socio-emotional Outcomes				
CBI extroversion (parent report)	4.11 (.48)	4.11 (.52)	4.17 (.46)	4.17 (.50)
CBI extroversion (caregiver report)	3.99 (.65)	3.99 (.62)	3.90 (.63)	4.03 (.66)
CBI considerateness (parent report)	3.32 (.59)	3.46 (.61)	3.44 (.56)	3.52 (.60)
CBI considerateness (caregiver report)	3.50 (.71)	3.62 (.72)	3.53 (.75)	3.58 (.59)
SCBE anger-aggression (parent	2.56 (.86)	2.03 (.54)	2.15 (.57)	2.32 (.71)

report)				
SCBE anger-aggression (caregiver report)	2.04 (.89)	1.81 (.72)	1.91 (.81)	2.00 (.70)
SCBE social competence (parent report)	3.95 (.78)	4.13 (.78)	4.23 (.80)	4.27 (.69)
SCBE social competence (caregiver report)	3.85 (.99)	3.96 (1.00)	3.75 (.82)	3.93 (1.00)
SCBE anxiety-withdrawal (parent report)	1.86 (.57)	1.80 (.49)	1.74 (.41)	1.90 (.49)
SCBE anxiety-withdrawal (caregiver report)	1.83 (.75)	1.82 (.47)	2.01 (.86)	1.72 (.71)

Table F5

Zero-order correlations of child competence and child care quality variables.

Child care Quality Variables	Child Cognitive and Social-emotional Skills						
	Infants/Toddlers			Preschool Age Children			
	Early Learning (Mullen)	Social Competence (parent)	Social Competence (caregiver)	Early Academic Skills	Academic Attitude	Social Competence (parent)	Social Competence (caregiver)
Global Quality (ECERS/FDCRS)	.33**			.37**			
Child-Adult Ratio							
Caregiver General Education		.26*					.16*
Caregiver Specialized Education		.18*					
Caregiver Interaction Scale	.28*			.18*			
Parent Caregiver Relationship Scale-Parent Report					.32**	.27**	
Parent Caregiver Relationship Scale-Caregiver Report							.50**
Student-Teacher Relationship Scale				.16*		.19*	.64**
Caregiver Responsiveness		-.19*					
Caregiver High Level Talk	.21*	.29*		.16*			.17*
Child Cognitive Activity							

+p<.10. *p≤ .05. **p≤ .01. ***p≤ .001.

Tables F6 – F11 present summaries of hierarchical regression analyses for variables predicting competence controlling for maternal education, child’s age in months and type of care.

Table F6
Summary of Hierarchical Regression Analyses for Variables Predicting Infant/Toddler Cognitive Competence.

Variable	Early Learning Skills			
	β	R^2	ΔR^2	F
Step 1		.08*		3.12
Maternal Education	.24**			
Child’s Age in Months	-.02			
Center vs. Home-based Care (CH)	.15			
Step 2a		.17***	.09***	5.64
Global quality (GQ)	.32***			
Step 3a		.17***	.00	4.48
CH X GQ	.02			
Step 2b		.14**	.06**	4.64
Caregiver Sensitivity (CS)	.26**			
Step 3b		.15**	.01	3.76
CH X CS	.06			
Step 2c		.10*	.02+	3.20
Caregiver Talk (CT)	.17+			
Step 3c		.11*	.01	2.63
CH X CT	.06			

Note. Global quality, caregiver sensitivity, and caregiver talk were centered at their means. + $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F7
Summary of Hierarchical Regression Analyses for Variables Predicting Infant/Toddler Social-emotional Competence (parent report).

Variable	Social-emotional Competence (parent report)			
	β	R^2	ΔR^2	F
Step 1		.06+		2.40
Maternal Education	-.07			
Child’s Age in Months	.24*			
Center vs. Home-based Care (CH)	-.01			
Step 2a		.05	.01	1.50

Variable	Social-emotional Competence (parent report)			
	β	R ²	ΔR^2	F
Caregiver Education (CE)	.12			
Step 3a				
CH X CE	.05	.06	.01	1.25
Step 2b		.09*	.03*	2.90
Caregiver Specialized Education (CSE)	.19*			
Step 3b		.10*	.01	2.36
CH X CSE	.05			
Step 2c		.08+	.02	2.40
Caregiver Responsiveness (CR)	-.14			
Step 3c		.08+	.00	2.00
CH X CR	-.07			
Step 2d		.12**	.06**	3.84
Caregiver Talk (CT)	.26**			
Step 3d		.13**	.01	3.26
CH X CT	-.09			

Note. Caregiver interaction and caregiver talk were centered at their means.
+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F8
Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children
Cognitive Competence (Early Academic Skills).

	Early Academic Skills			
	β	R ²	ΔR^2	F
Step 1		.32***		26.42
Maternal Education	.08			
Child's Age in Months	.55***			
Center vs. Home-based Care (CH)	.04			
Step 2a		.37***	.05***	24.11
Global Quality (GQ)	.25***			
Step 3a		.37***	.00	19.66
CH X GQ	-.09			
Step 2b		.33***	.02+	21.09
Caregiver Child Relationship (CCR)	.12+			
Step 3b		.34***	.01	17.07

		Early Academic Skills		
CH X CCR	.07			
Step 2c		.33***	.01+	20.89
Caregiver Sensitivity (CS)	.12+			
Step 3c		.33***	.00	16.62
CH X CS	-.01			
Step 2d		.34***	.02*	21.36
Caregiver Talk (CT)	.14*			
Step 3d		.34***	.00	17.26
CH X CT	-.07			

Note. Global quality, caregiver-child relationship, caregiver sensitivity, and caregiver high-level talk were centered at their means.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F9

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Cognitive Competence (Academic Attitude).

		Academic Attitude			
		β	R^2	ΔR^2	F
Step 1			.01		.824
Maternal Education	.07				
Child's Age in Months	.10				
Center vs. Home-based Care (CH)	.01				
Step 2			.12***	.10***	5.46
Caregiver Parent Relationship (CPP) parent report	.32***				
Step 3			.12***	.00	4.55
CH X CPP	.08				

Note. Caregiver parent relationship was centered at its mean.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F10

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Social-emotional Competence (parent report).

		Social-emotional Competence (parent report)			
		B	R^2	ΔR^2	F
Step 1			.01		.732
Maternal Education	-.05				
Child's Age in Months	.07				
Center vs. Home-based	.07				

	Social-emotional Competence (parent report)			
Care (CH)				
Step 2a		.05**	.04*	2.31
Caregiver Child Relationship (CCR)	.20**			
Step 3a		.05	.00	1.85
CH X CCR	-.02			
<hr/>				
Step 2b		.09	.08***	4.13
Caregiver Parent Relationship (CPP) Parent	.28			
Step 3b		.09	.00	3.29
CH X CPP	.01			

Note. Caregiver-child relationship and parent-caregiver relationship were centered at their means.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F11

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Social-emotional Competence (caregiver report).

	Social-emotional Competence (caregiver report)			
	B	R ²	ΔR^2	F
Step 1		.00		.169
Maternal education	.04			
Child's age in months	.04			
Center vs. Home (CH)	.00			
Step 2a		.00	.00	.27
Caregiver General Education (CE)	.01			
Step 3a		.03	.03+	1.00
CH X CE	-.16+			
<hr/>				
Step 2b		.54***	.54***	50.03
Caregiver Child Relationship (CR)	.74***			
Step 3b		.54***	.00	39.86
CH X CR	-.03			
<hr/>				
Step 2c		.30***	.30***	17.76
Caregiver Parent Relationship (CPC) Caregiver	.56***			
Step 3c		.30***	.00	14.66

	Social-emotional Competence (caregiver report)			
CH X CPC	.10			
Step 2d		.03	.03	1.07
Caregiver high level talk (CT)	.15+			
Step 3d		.05	.02	1.75
CH X CT	-.17*			

Note. Caregiver-child relationship, caregiver-parent relationship, and caregiver high-level talk were centered on their means.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Tables F12 – F17 present summaries of hierarchical regression analyses for variables predicting competence examining the interaction effect of community while controlling for maternal education and child's age in months.

Table F12

Summary of Hierarchical Regression Analyses for Variables Predicting Infant/Toddler Cognitive Competence.

Variable	Early Learning Skills			
	β	R^2	ΔR^2	F
Step 1		.05*		3.31
Maternal Education	.23*			
Child's Age in Months	-.01			
Step 2a		.17***	.11***	7.49
Global Quality (GQ)	.34***			
Step 3a		.20***	.04	4.72
Dummy 1 (M)	-.23*			
Dummy 2 (A)	-.14			
Dummy 3 (L)	-.14			
Step 4a		.24**	.04	3.84
GQ X M	.16			
GQ X A	.10			
GQ X L	.30*			
Step 2b		.13***	.07**	5.68
Caregiver Sensitivity (CS)	.28**			
Step 3b		.18***	.05	3.91
Dummy 1 (M)	-.24*			
Dummy 2 (A)	-.16			
Dummy 3 (L)	-.18			
Step 4b		.20**	.03	3.02
CS X M	.22+			

Variable	Early Learning Skills			
	β	R ²	ΔR^2	F
CS X A	.13			
CS X L	.14			
Step 2c		.09+	.04*	3.84
Caregiver Talk (CT)	.19*			
Step 3c		.15***	.06+	3.25
Dummy 1 (M)	-.26*			
Dummy 2 (A)	-.17			
Dummy 3 (L)	-.23*			
Step 4c		.18*	.03	2.54
CT X M	.18			
CT X A	.12			
CT X L	.26+			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.
 +p<.10. *p≤.05. **p≤.01. ***p≤.001.

Table F13
 Summary of Hierarchical Regression Analyses for Variables Predicting Infant/Toddler Competence.

Variable	Social-emotional Competence (parent report)			
	β	R ²	ΔR^2	F
Step 1		.06*		3.62
Maternal Education	-.07			
Child's Age in Months	.24*			
Step 2a		.11**	.07**	4.49
Caregiver General Education (CE)	.27**			
Step 3a		.19***	.08**	4.19
Dummy 1 (M)	-.134			
Dummy 2 (A)	.07			
Dummy 3 (L)	-.26*			
Step 4a		.22**	.03	3.16
CE X M	-.52+			
CE X A	-.20			
CE X L	-.19			
Step 2b		.09*	.03*	3.87
Caregiver Specialized Education (CSE)	.18*			

Variable	Social-emotional Competence (parent report)			
	β	R ²	ΔR^2	F
Step 3b		.16**	.07*	3.56
Dummy 1 (M)	-.11			
Dummy 2 (A)	.02			
Dummy 3 (L)	-.28*			
Step 4b		.19**	.03	2.88
CSE X M	-.20			
CSE X A	-.04			
CSE X L	-.32*			
Step 2c		.08*	.02	3.22
Caregiver Responsiveness (CR)	-.14			
Step 3c		.13*	.05	2.67
Dummy 1 (M)	-.09			
Dummy 2 (A)	-.04			
Dummy 3 (L)	-.25*			
Step 4c		.20**	.07*	2.90
CR X M	.11			
CR X A	-.22			
CR X L	.11			
Step 2		.12**	.06**	4.88
Caregiver Talk (CT)	.24**			
Step 3		.15**	.03	3.34
Dummy 1 (M)	-.13			
Dummy 2 (A)	-.03			
Dummy 3 (L)	-.22			
Step 4		.24***	.08*	3.70
CT X M	.45***			
CT X A	.34*			
CT X L	.35*			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F 14

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Cognitive Competence.

	Early Academic Skills			
	β	R ²	ΔR^2	F
Step 1		.32***		39.61

Early Academic Skills				
Maternal Education	.08			
Child's Age in Months	.56***			
Step 2a		.36***	.04***	31.62
Global Quality (GQ)	.21***			
Step 3a		.38***	.02	16.58
Dummy 1 (M)	-.03			
Dummy 2 (A)	-.13			
Dummy 3 (L)	-.11			
Step 4a		.38***	.00	11.09
GQ X M	-.10			
GQ X A	.01			
GQ X L	.00			
<hr/>				
Step 2b		.33***	.02*	28.17
Caregiver Child Relationship (CCR)	.12+			
Step 3b		.34***	.01	14.61
Dummy 1 (M)	-.02			
Dummy 2 (A)	-.09			
Dummy 3 (L)	-.12			
Step 4b		.35***	.01	9.93
CCR X M	-.09			
CCR X A	-.07			
CCR X L	.02			
<hr/>				
Step 2c		.33***	.01	27.94
Caregiver Sensitivity (CS)	.12+			
Step 3c		.35***	.02	14.74
Dummy 1 (M)	-.01			
Dummy 2 (A)	-.13			
Dummy 3 (L)	-.10			
Step 4c		.37***	.02	10.69
CS X M	-.22+			
CS X A	-.11			
CS X L	-.06			
<hr/>				
Step 2d		.34***	.02*	28.50
Caregiver Talk (CT)	.14*			
Step 3d		.35***	.01	14.94
Dummy 1 (M)	-.05			
Dummy 2 (A)	-.12			
Dummy 3 (L)	-.13			
Step 4d		.37***	.02	10.42
CT X M	-.12			

	Early Academic Skills			
CT X A	-.19+			
CT X L	-.10			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.
+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F15

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Cognitive Competence.

	Academic Attitude			
	β	R^2	ΔR^2	F
Step 1		.01		1.24
Maternal Education	.07			
Child's Age in Months	.10			
Step 2		.11***	.10***	6.99
Caregiver Parent Relationship (CPP) parent report	.31***			
Step 3		.14***	.03	4.35
Dummy 1 (M)	-.15+			
Dummy 2 (A)	-.02			
Dummy 3 (L)	.02			
Step 4		.15***	.01	3.24
CPP X M	-.01			
CPP X A	.03			
CPP X L	-.14			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.
+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F 16

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Social-emotional Competence.

	Social-emotional Competence (parent report)			
	β	R^2	ΔR^2	F
Step 1		.01		.74
Maternal Education	-.04			
Child's Age in Months	.09			
Step 2a		.05*	.04**	2.91
Caregiver Child Relationship (CCR)	.20**			

	Social-emotional Competence (parent report)			
Step 3a		.09*	.04+	2.66
Dummy 1 (M)	-.17+			
Dummy 2 (A)	.06			
Dummy 3 (L)	-.01			
Step 4a		.10+	.01	1.93
CCR X M	-.01			
CCR X A	.11			
CCR X L	.06			
Step 2b		.08**	.07***	4.65
Caregiver Parent Relationship (CPP) Parent	.26***			
Step 3b		.10**	.02	3.18
Dummy 1 (M)	-.16+			
Dummy 2 (A)	.03			
Dummy 3 (L)	-.05			
Step 4b		.13**	.03	2.83
CPP X M	.12			
CPP X A	.12			
CPP X L	-.11			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table F 17

Summary of Hierarchical Regression Analyses for Variables Predicting Preschool-Age Children Social-emotional Competence.

	Social-emotional Competence (caregiver report)			
	β	R^2	ΔR^2	F
Step 1		.00		.26
Maternal Education	.04			
Child's Age in Months	.04			
Step 2a		.03	.02+	1.65
Caregiver General Education (CE)	.15+			
Step 3a		.04	.01	1.03
Dummy 1 (M)	-.04			
Dummy 2 (A)	-.09			
Dummy 3 (L)	-.01			
Step 4a		.07	.03	1.24
CE X M	.33			

	Social-emotional Competence (caregiver report)			
CE X A	-.30			
CE X L	.41			
Step 2b				
		.54***	.54***	66.89
Caregiver Child Relationship (CCR)	.73***			
Step 3b				
		.54***	.00	32.92
Dummy 1 (M)	-.02			
Dummy 2 (A)	-.03			
Dummy 3 (L)	-.01			
Step 4b				
		.55***	.01	22.06
CCR X M	.06			
CCR X A	.07			
CCR X L	.10			
Step 2c				
		.29***	.29***	22.57
Caregiver Parent Relationship (CPC) Caregiver	.54***			
Step 3c				
		.29***	.00	11.32
Dummy 1 (M)	.04			
Dummy 2 (A)	-.04			
Dummy 3 (L)	.01			
Step 4c				
		.31***	.02	8.19
CPC X M	-.16			
CPC X A	-.17			
CPC X L	-.21			
Step 2d				
		.03	.03+	1.44
Caregiver Talk (CT)	.15+			
Step 3d				
		.04	.01	1.08
Dummy 1 (M)	-.05			
Dummy 2 (A)	-.12			
Dummy 3 (L)	.01			
Step 4d				
		.04	.00	.76
CT X M	.00			
CT X A	.02			
CT X L	.06			

Note: Community was represented by three dummy variables with St. Joseph County serving as the reference group. M = St. Joseph County vs. Marion County; A = St. Joseph County vs. Allen County; L = St. Joseph County vs. Lake County.

+ $p < .10$. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$

Appendix G

PARENT EMPLOYMENT AND EDUCATION OUTCOMES

The following tables display the descriptive statistics of parent employment and education outcome variables. ANOVA and chi-square tests were completed to identify differences among communities on the variables when applicable. Significant zero-order correlations and multi-level regression analyses reporting the relationships between indicators of child care quality and parent employment are also presented.

Table G1. Male head employment outcomes (N = 116).

	<i>M(SD)</i>	<i>N(%)</i>	<i>F(p)</i>	<i>χ² (p)</i>
Employment				2.06
<i>Yes</i>		103(88.8)		(.56)
<i>No</i>		11(9.5)		
<i>Not reported</i>		2(1.7)		
Hrs/wk working or in school/training (n = 92)	37.99 (12.74)		1.16 (.331)	
Work hours (n = 102)				10.22
<i>Full-time (>35 hrs/wk)</i>		88 (86.27)		(.02)
<i>Part-time (<30 hrs/wk) or Temporary</i>		14 (13.73)		
Work shift (n = 100)				5.38
<i>Daytime</i>		72 (72.00)		(.15)
<i>Evening/night/shift change</i>		28 (28.00)		
Months working for current employer (n = 95)	53.41 (67.12)		3.29 (.024)	
Work being interrupted due to illness or child care problems (n = 103)				2.65
<i>Yes</i>		49 (47.57)		(.45)
<i>No</i>		54 (52.43)		
Raise/Promotion (n = 103)				3.67
<i>Yes</i>		28 (27.18)		(.30)
<i>No</i>		75 (72.82)		

Table G2. Female head employment outcomes (n=302).

	<i>M(SD)</i>	<i>N(%)</i>	<i>F(p)</i>	χ^2 (<i>p</i>)
Employment				4.63
<i>Yes</i>		256(83.4)		(.20)
<i>No</i>		47(15.3)		
<i>Not reported</i>		4(1.3)		
Hrs/wk working or in school/training	32.62(12.59)		.42 (.74)	
Work hours (n = 253)				1.78
<i>Full-time (>35 hrs/wk)</i>		182(71.94)		(.62)
<i>Part-time (<30 hrs/wk) or Temporary</i>		71(28.06)		
Work shift (n = 248)				3.82
<i>Daytime</i>		196(79.03)		(.28)
<i>Evening/night/shift change</i>		52(20.97)		
Months working for current employer	38.03(46.78)		2.06 (.11)	
Work being interrupted due to illness or child care problems (n = 256)				1.53 (.68)
<i>Yes</i>		175(68.36)		
<i>No</i>		81(31.64)		
Raise/Promotion (n = 256)				6.77
<i>Yes</i>		60(23.44)		(.08)
<i>No</i>		196(76.56)		

Table G3. Male head employment outcomes of families using home and center care.

	<i>Home</i> (<i>n=47</i>)		<i>Center</i> (<i>n=69</i>)	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
<i>Yes</i>		42(89.4)		61(88.4)
<i>No</i>		5(10.6)		6(8.7)
<i>Not reported</i>				2(2.9)
Hrs/wk working or in school/training	35.53(14.67)		39.65(11.09)	
Work hours				
<i>Full-time (>35 hrs/wk)</i>		35(85.4)		53(86.9)
<i>Part-time (<30 hrs/wk) or Temporary</i>		6(14.6)		8(13.1)
Work shift				
<i>Daytime</i>		26(66.7)		46(75.4)
<i>Evening/night/shift change</i>		13(33.3)		15(24.6)
Months working for current employer	58.04(74.49)		50.46(62.47)	
Work being interrupted due to illness or child care problems				
<i>Yes</i>		15(35.7)		34(55.7)
<i>No</i>		27(64.3)		27(44.3)
Raise/Promotion				
<i>Yes</i>		11(26.2)		17(27.9)
<i>No</i>		31(73.8)		44(72.1)

Table G 4. Female head employment outcomes of families using home and center care

	<i>Home</i> (<i>n=114</i>)		<i>Center</i> (<i>n=193</i>)	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
<i>Yes</i>		94(82.46)		162(83.9)
<i>No</i>		18(15.79)		29(15.0)
<i>Not reported</i>		2(1.75)		2(1.0)
Hrs/wk working or in school/training	33.08(13.76)		32.37(11.92)	
Work hours				
<i>Full-time (>35 hrs/wk)</i>		72(63.2)		110(68.3)
<i>Part-time (<30 hrs/wk) or Temporary</i>		20(17.5)		51(31.7)
Work shift				
<i>Daytime</i>		71(78.9)		125(79.1)
<i>Evening/night/shift change</i>		19(21.1)		33(20.9)
Months working for current employer	36.78(42.3)		35.59(49.28)	
Work being interrupted due to illness or child care problems				
<i>Yes</i>		59(62.8)		116(71.6)
<i>No</i>		35(37.2)		46(28.4)
Raise/Promotion				
<i>Yes</i>		19(20.2)		41(25.3)
<i>No</i>		75(79.8)		121(74.7)

Table G5. Male head employment outcomes for families with infants/toddlers and preschool-age children.

	<i>Infants/Toddlers</i> (<i>n=50</i>)		<i>Preschool Age Children</i> (<i>n=60</i>)	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
<i>Yes</i>		44(88)		59(86.4)
<i>No</i>		6(12)		5(7.5)
<i>Not reported</i>				
Hrs/wk working or in school/training	39.22(13.03)		37(12.53)	
Work hours				
<i>Full-time (>35 hrs/wk)</i>		37(84.1)		51(87.9)
<i>Part-time (<30 hrs/wk) or Temporary</i>		7(15.9)		7(12)
Work shift				
<i>Daytime</i>		11(76.7)		
<i>Evening/night/shift change</i>		33(23.3)		
Months working for current employer	38.41(48.21)		64.79(77)	
Work being interrupted due to illness or child care problems				
<i>Yes</i>		18(40.9)		31(52.5)
<i>No</i>		26(59.1)		28(47.5)
Raise/Promotion				
<i>Yes</i>		12(27.3)		16(27.1)
<i>No</i>		32(72.7)		43(72.9)

Table G6. Female head employment outcomes for families with infants/toddlers and preschool-age children

	<i>Infants/Toddlers (n=121)</i>		<i>Preschool Age Children (n=186)</i>	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
Yes		102(84.3)		154(82.8)
No		19(15.7)		28(15.1)
Not reported				4(2.2)
Hrs/wk working or in school/training	31.51(13.59)		33.39(11.83)	
Work hours				
Full-time (>35 hrs/wk)		76(62.8)		106(69.7)
Part-time (<30 hrs/wk) or Temporary		25(20.6)		46(24.7)
Work shift				
Daytime		75(75)		121(81.8)
Evening/night/shift change		25(25)		27(18.2)
Months working for current employer	36.13(47.03)		35.96(46.77)	
Work being interrupted due to illness or child care problems				
Yes		70(68.6)		105(68.2)
No		32(31.4)		49(31.8)
Raise/Promotion				
Yes		27(26.5)		33(21.4)
No		75(73.5)		121(78.6)

Table G7. Male head employment outcomes by marital status.

	<i>Single/Divorced (n=27)</i>		<i>Married/Living with partner (n=89)</i>	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
Yes		22(81.5)		81(91.0)
No		4(14.8)		7(7.9)
Not reported		1(3.7)		1(1.1)
Hrs/wk working or in school/training	36.05(15.39)		38.53(11.96)	
Work hours				
Full-time (>35 hrs/wk)		20(90.9)		68(85)
Part-time (<30 hrs/wk) or Temporary		2(9.1)		12(15)
Work shift				
Daytime		15(68.2)		57(73.1)
Evening/night/shift change		7(31.8)		21(26.9)
Months working for current employer	78.02(103.2)		47.26(53.84)	
Work being interrupted due to illness or child care problems				
Yes		12(54.5)		37(45.7)
No		10(45.5)		44(54.3)
Raise/Promotion				
Yes		6(27.3)		22(27.2)
No		16(72.7)		59(72.8)

Table G 8. Female parent outcomes by marital status.

	<i>Single/Divorced (n=208)</i>		<i>Married/Living with partner (n=96)</i>	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
<i>Yes</i>		172(82.7)		83(86.5)
<i>No</i>		35(16.8)		12(12.5)
<i>Not reported</i>		1(.5)		1(1.0)
Hrs/wk working or in school/training	32.06(12.5)		33.79(12.83)	
Work hours				
<i>Full-time (>35 hrs/wk)</i>		121(71.2)		60(73.2)
<i>Part-time (<30 hrs/wk) or Temporary</i>		49(28.8)		22(26.8)
Work shift				
<i>Daytime</i>		131(78)		64(81)
<i>Evening/night/shift change</i>		37(22)		15(19)
Months working for current employer	36.13(47.03)		45.6(57.9)	
Work being interrupted due to illness or child care problems				
<i>Yes</i>		113(65.7)		62(74.7)
<i>No</i>		59(34.3)		21(25.3)
Raise/Promotion				
<i>Yes</i>		37(21.5)		23(27.7)
<i>No</i>		135(78.5)		30(72.3)

Table G 9. Female parent outcomes of families with no male present and male present in the household.

	<i>No male present (n=183)</i>		<i>Male present (n=116)</i>	
	<i>M(SD)</i>	<i>N(%)</i>	<i>M(SD)</i>	<i>N(%)</i>
Employment				
<i>Yes</i>		153(83.6)		97(83.6)
<i>No</i>		30(16.4)		17(14.7)
<i>Not reported</i>				2(1.7)
Hrs/wk working or in school/training	32.24(12.52)		33.42(12.55)	
Work hours				
<i>Full-time (>35 hrs/wk)</i>		106(70.2)		71(74.0)
<i>Part-time (<30 hrs/wk) or Temporary</i>		45(29.8)		25(26.0)
Work shift				
<i>Daytime</i>		116(77.9)		76(81.7)
<i>Evening/night/shift change</i>		33(22.1)		17(18.3)
Months working for current employer	28.89(38.18)		46.77(56.7)	
Work being interrupted due to illness or child care problems				
<i>Yes</i>		97(63.4)		73(75.3)
<i>No</i>		56(36.6)		24(24.7)
Raise/Promotion				
<i>Yes</i>		33(21.6)		27(27.8)
<i>No</i>		120(78.4)		70(72.2)

Table G 10. Zero order correlations among child care quality indicators and parent education and employment outcomes

Quality Variable	Parent Employment and Education Outcomes													
	Female Heads (N=307)							Male Heads (N=114)						
	Employed?	Hrs work/school	Full Time?	Months with Employer	Shift worked	Recent Raise?	Work interrupted?	Employed?	Hrs work/school	Full Time?	Months with Employer	Shift worked	Recent Raise?	Work interrupted?
Global Quality (ECERS/FDCRS)														
Child-Adult Ratio									.25*					.26**
Caregiver General Education							.13*							
Caregiver Specialized Education						.14*								
Caregiver Interaction Scale														
Parent Caregiver Relationship Scale-Parent Report														
Parent Caregiver Relationship Scale-Caregiver Report												.24*		
Student-Teacher Relationship Scale														
Caregiver Responsiveness														
Caregiver High Level Talk														
Child Cognitive Activity				.14*								.28**		

Table G11

Descriptive statistics of parent employment by community

Variables	Marion	Lake	Allen	St. Joseph
Percent of female heads of household employed	78.7%	89.3%	81.6%	88.3%
Percent of male heads of household employed	88.5%	93.9%	93.3%	84.0%
Number of hours female works or in school/training	33.66(12.00)	32.57(13.20)	31.29(14.65)	32.88(10.48)
Number of hours male works or in school/training	38.91(11.43)	35.37(16.02)	41.5(10.63)	36.21(11.02)
Percent of female heads who work full-time	66.1%	76.1%	74.2%	70.8%
Percent of male heads who work full-time	91.3%	96.8%	85.2%	66.7%
Number of months female has been employed with current employer	34.41(43.95)	48.00(60.04)	31.02(36.18)	29.88(40.80)
Number of months male has been employed with current employer	57.5(77.35)	82.07(85.10)	40.28(42.55)	26.43(31.36)
Female head work shift				
Daytime shift	84.5%	76.9%	71.7%	83.1%
Evening/night/shift change	15.5%	23.1%	28.3%	16.9%
Male head work shift				
Daytime shift	73.9%	56.7%	81.5%	80.0%
Evening/night/shift change	26.1%	43.3%	18.5%	20.0%
Female has had recent raise/promotion	25.4%	23.9%	32.2%	13.2%
Male has had recent raise/promotion	39.1%	19.4%	32.1%	19%
Female's work has been interrupted by child illness or child care problem	72.9%	70.1%	62.9%	38.1%
Male's work has been interrupted by child illness or child care problem	60.9%	48.4%	42.9%	38.1%

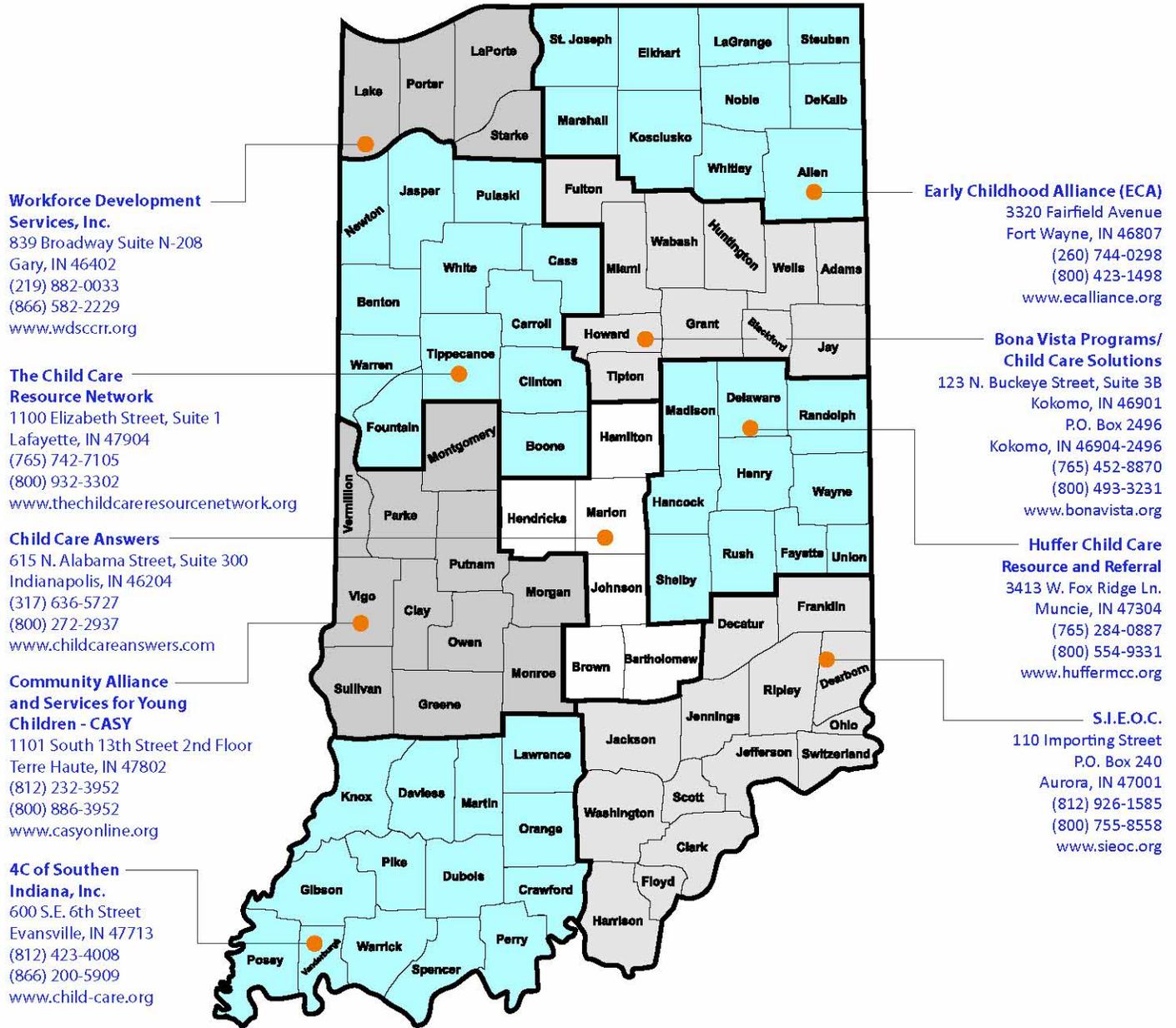
Table G 12
 Summary of Binary Logistic Regression Analyses for Variables Predicting Parent Employment
 Controlling for child's age and type of child care.

Variable	Male work interrupted			
	β	R ²	ΔR^2	Chi-square
Step 1		.06		4.49
Child's age in months	.00			
Center vs. home	.90*			
Step 2		.14	.08*	10.45
Child-Adult ratio (CA)	.20*			
Step 3		.16+	.02	12.23
Dummy 1 (M)	.83			
Dummy 2 (A)	.17			
Dummy (L)	.31			
Step 4		.16	.00	12.72
CA X M	.20			
CA X A	.07			
CA X L	.12			
	Male shift worked			
	B	R ²	ΔR^2	Chi-square
Step 1		.05		3.14
Child's age in months	-.02			
Center vs. home	.70			
Step 2		.06	.01	4.17
Parent-caregiver relationship (PCP) parent report	-.43			
Step 3		.11	.05	7.72
Dummy 1 (M)	-.41			
Dummy 2 (A)	.06			
Dummy (L)	-.97			
Step 4		.13	.02	8.99
PCP X M	-.57			
PCP X A	-.98			
PCP X L	-1.55			
	Male shift worked			
	B	R ²	ΔR^2	Chi-square
Step 1		.05		3.45
Child's age in months	-.03			

Center vs. home	.70			
Step 2		.12*	.07*	8.55
Child Cognitive activity (CCA)	-1.14*			
Step 3		.19*	.07	13.86
Dummy 1 (M)	-.52			
Dummy 2 (A)	.42			
Dummy (L)	-1.00			
Step 4		.25*	.06	19.10
CCA X M	2.90			
CCA X A	4.88			
CCA X L	5.24			
Female work interrupted				
	B	R ²	ΔR^2	Chi-square
Step 1		.01		2.56
Child's age in months	-.01			
Center vs. home	.46			
Step 2		.04	.03*	7.22
Caregiver general education (CE)	-.36			
Step 3		.05	.01	9.29
Dummy 1 (M)	.11			
Dummy 2 (A)	-.33			
Dummy (L)	.21			
Step 4		.06	.01	10.21
CE X M	-.09			
CE X A	.22			
CE X L	-.22			
Female Recent Raise				
	B	R ²	ΔR^2	Chi-square
Step 1		.01		1.36
Child's age in months	-.01			
Center vs. home	.36			
Step 2		.04	.03*	7.00
Caregiver specialized education (CSE)	.75*			
Step 3		.07*	.03	12.71
Dummy 1 (M)	.61			
Dummy 2 (A)	1.06*			
Dummy (L)	.614			
Step 4		.08	.01	13.45
CSE X M	-.31			
CSE X A	.16			
CSE X L	.40			

Indiana Association for Child Care Resource and Referral Local Agencies

Building networks to support families, providers and communities



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Evaluation Brief #1: Key Findings

What is Paths to QUALITY™?

Paths to QUALITY™ was created in Fort Wayne, Indiana in 2000 to help parents identify and select quality child care and to recognize providers who work to achieve higher-quality care, beyond minimum state licensing requirements. In 2008, Paths to QUALITY was introduced statewide as a voluntary system for licensed child care centers, licensed family child care homes, and unlicensed registered child care ministries.

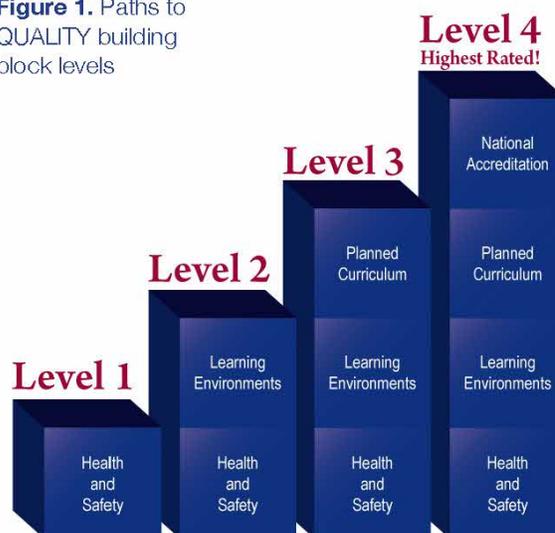
The goals of Paths to QUALITY are to:

- » improve child care quality
- » recognize providers for their quality achievements
- » provide a tool for parents to use to select high-quality child care
- » support better development for children birth to 5 years

The four-level Paths to QUALITY rating system has a “building block” structure¹. Each level has quality criteria that must be met. To advance, the provider must meet all standards for the new level and also maintain the required standards for lower levels. As providers take steps to improve quality, they progress toward Level 4 – *accreditation* – recognized nationally as the highest standard of child care quality.



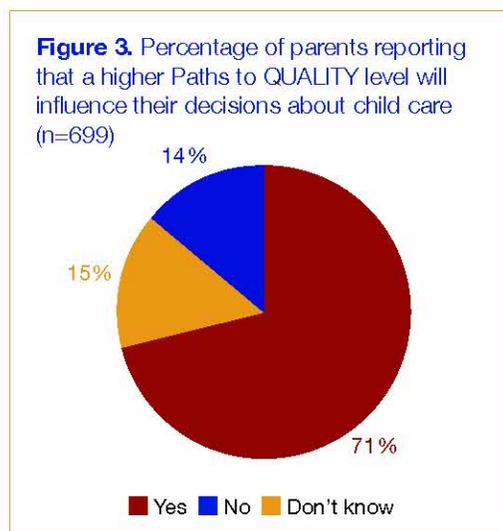
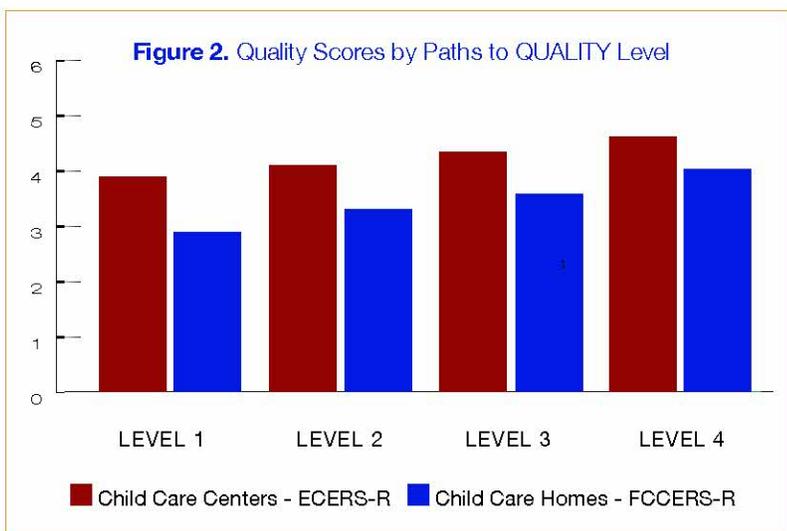
Figure 1. Paths to QUALITY building block levels



Purdue University Research on Paths to QUALITY

The state of Indiana contracted with Purdue University to evaluate the first three years of Paths to QUALITY, from 2008 to 2011. This research/policy brief highlights key findings from the Purdue research regarding the quality ratings, the child care providers, the parents, and the children. See other briefs in this series for more in-depth information about the Purdue evaluation research.





Do Paths to QUALITY ratings give parents valid information about child care quality?

» The Purdue researchers found that Paths to QUALITY ratings provide trustworthy information about child care quality, when compared to research-validated measures. Providers rated at Level 4 were observed to be providing significantly higher quality care and education when compared with providers at Level 1. (See Figure 2.)

Will parents use Paths to QUALITY ratings when they make child care decisions?

» Parents reported they planned to use the Paths to QUALITY ratings to select child care, and they may be willing to pay more for more highly rated care. In a random statewide survey, more than 70% of parents said they would use Paths to QUALITY ratings to guide their child care decisions. More than 55% said they might pay more for higher-rated care. (See Figure 3.)

Does Paths to QUALITY have benefits for child care providers?

» The first 2½ years of Paths to QUALITY saw a high rate of participation by Indiana’s child care providers. More than 85% of licensed child care centers, more than 55% of license family child care homes, and more than 10% of unlicensed registered child care ministries enrolled.

» Providers reported they benefited from the public recognition, and from the mentoring they receive from the state to improve quality.

Will Paths to QUALITY make a difference in children’s development?

» It is too early to tell if Paths to QUALITY will result in better development or better school readiness. That will require longitudinal research that takes into account what *amount* of child care, and *at what quality level*, is received over time.

» However, the Purdue researchers did find that in homes and centers where the caregivers were more positive and responsive to the children, and when they interacted with the children in more stimulating ways, the children were observed to have more social competence and better language and thinking skills.

Moving forward with Paths to QUALITY: Recommendations

While the Purdue evaluation research revealed many early successes of Paths to QUALITY, it also revealed areas for potential improvement:

- » Observations showed that Indiana child care providers were offering higher quality on some dimensions than others. The Purdue researchers recommended that Paths to QUALITY strengthen quality standards and rating methods related to:
 - ✓ health & safety practices;
 - ✓ caregivers’ support of language and cognitive development; and
 - ✓ learning activities, including early math, science, nature, literacy, and blocks.

The Purdue Research

Purdue University completed independent assessments of quality using research-validated measures in a statewide random sample of 312 licensed child care center classrooms, registered child care ministry classrooms, and licensed family child care homes. The Purdue team also interviewed more than 1800 parents and 270 child care providers, and completed developmental assessments with more than 550 infants, toddlers, and preschoolers in Paths to QUALITY centers and homes. The research took place between March, 2009 and June, 2011.

The Purdue evaluation research focused on the following questions:

1. Are child care providers of all types entering the voluntary Paths to QUALITY system? Do providers understand the system?
2. What are the incentives for providers to enroll? What are the barriers?
3. Do child care providers move to higher Paths to QUALITY levels after enrolling in the system?
4. Are providers aware of available training/technical assistance (T/TA) resources to help them increase Paths to QUALITY levels, and do they use them? Does T/TA help providers advance their Paths to QUALITY levels?
5. When providers attain higher Paths to QUALITY levels, does this result in higher quality care, as assessed using research-validated measures?
6. Are children who are placed with providers who have achieved higher Paths to QUALITY levels developing more optimally than children placed with providers having lower Paths to QUALITY levels?
7. Are parents of Indiana infants, toddlers, and preschool children aware of and do they understand the Paths to QUALITY system? Does the Paths to QUALITY system affect parents' child care decisions?

¹ QRIS National Learning Network, Glossary of Terms, <http://qrisnetwork.org/glossary>.

This research-policy brief was written by Treshawn Anderson and James Elicker at Purdue University. It is one in a series available on the Purdue Center for Families website (www.cfs.purdue.edu/cff) under "Publications."

1. Evaluation Brief #1: Key Findings
2. Evaluation Brief #2: Does Paths to QUALITY™ Produce Quality Care and Education for Indiana's Young Children?
3. Evaluation Brief #3: Does Paths to QUALITY™ Benefit Indiana's Child Care Providers?
4. Evaluation Brief #4: Does Paths to QUALITY™ Help Indiana Parents Find Quality Child Care?

For more detailed information about the methods, measures, and results, refer to the Paths to QUALITY Final Evaluation Report (2011) also on the Center for Families website.

For more information about Paths to QUALITY, visit the Paths to QUALITY website: www.in.gov/fssa/2554.htm.

Funding for this project was provided by contract with Purdue University from the Indiana Bureau of Child Care, Division of Family Resources, Indiana Family & Social Services Administration. The contents of the brief and reports are solely the responsibility of the authors and do not represent the official views of the funding agency, nor does this publication in any way constitute an endorsement by the funding agency.





Evaluation Brief #2: Does Paths to QUALITY™ Produce Quality Care and Education for Indiana’s Young Children?

What is Paths to QUALITY™?

Paths to QUALITY™ was created in Fort Wayne, Indiana in 2000 to help parents identify and select quality child care and to recognize providers who work to achieve higher-quality care, beyond minimum state licensing requirements. In 2008, Paths to QUALITY was introduced statewide as a voluntary system for licensed child care centers, licensed family child care homes, and unlicensed registered child care ministries.

The goals of Paths to QUALITY are to:

- » improve child care quality
- » recognize providers for their quality achievements
- » provide a tool for parents to use to select high-quality child care
- » support better development for children birth to 5 years

The four-level Paths to QUALITY rating system has a “building block” structure¹. Each level has quality criteria that must be met. To advance, the provider must meet all standards for the new level and also maintain the required standards for lower levels. As providers take steps to improve quality, they progress toward Level 4 – *accreditation* – recognized nationally as the highest standard of child care quality.

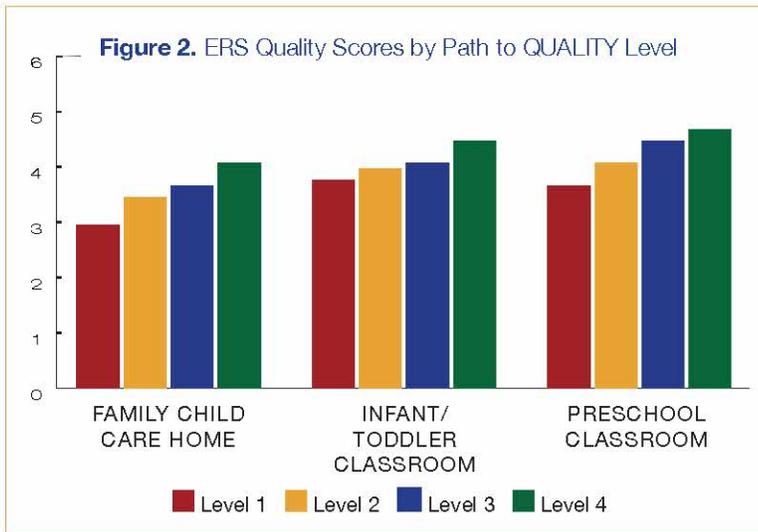
Figure 1. Paths to QUALITY building block levels



Purdue University Research on Paths to QUALITY

The state of Indiana contracted with Purdue University to evaluate the first three years of Paths to QUALITY, from 2008 to 2011. This research/policy brief highlights key findings from the Purdue research regarding the quality ratings and children’s development. See other briefs in this series for in-depth information about the Purdue evaluation research.





Do Path to QUALITY ratings give parents valid information about child care quality?

- » The Purdue researchers found that Paths to QUALITY ratings provided trustworthy information about child care quality, when compared with research-validated measures.
- » Providers at higher Paths to QUALITY levels displayed more positive interactions with children.
- » Level 3 and 4 providers were rated significantly higher than Level 1 providers in overall caregiver sensitivity and positive interactions.
- » As Paths to QUALITY levels increase, so does overall child care quality for infant-toddler and preschool classrooms, as well as in family child care homes.
- » Note that quality levels for all providers are consistently higher for providers progressing from Level 1 through Level 4. (See Figure 2.)

Does Paths to QUALITY make a difference in children’s development?

- » It is too early to tell if Paths to QUALITY will result in better development or more advanced school readiness for Indiana’s children. More time is needed for Paths to QUALITY to mature, and more extensive evaluation, including longitudinal research that follows children over several years, will answer questions about Paths to QUALITY’s impact on children’s development.

Does child care quality impact children’s development?

- » YES! In this research, higher quality child care, especially more supportive and stimulating adult-child interactions, was associated with advanced social, language, and cognitive development for both infants/toddlers and preschoolers.

FOR INFANTS/TODDLERS:

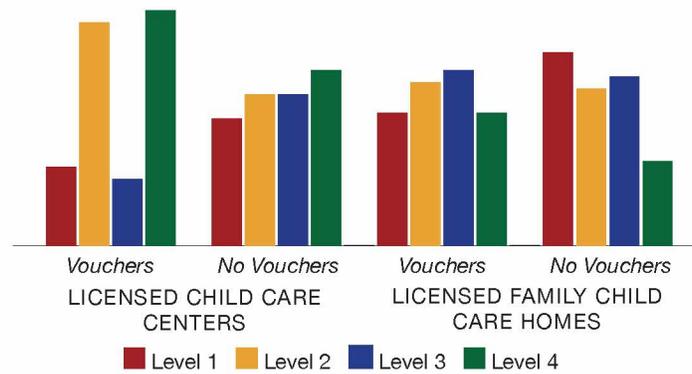
- » When child care quality was higher, infants/toddlers displayed higher levels of social competence.
- » When caregivers’ interactions with children were more positive and responsive, infants/toddlers’ cognitive and language scores were higher.

FOR PRESCHOOLERS:

- » When caregivers were rated higher on the Language/Reasoning portion of the global quality rating scale, preschoolers displayed greater language ability.
- » When caregivers were rated higher on the Parents/Staff portion of the global quality rating scale, preschoolers displayed less anxiety and aggression.
- » When caregivers interacted with children more positively, preschoolers displayed higher levels of social competence and greater language ability.



Figure 3. Percent of children receiving child care vouchers by Path to QUALITY level



Do children at all income and parent education levels have access to quality child care?

- » Yes! Parents’ income and education level did not affect children’s access to high quality care. Significant numbers of Indiana low-income children using federally-funded child care assistance vouchers were gaining access to child care at the highest quality levels. See Figure 3.
- » Within the evaluation sample, children using financial assistance vouchers were most likely to be found in child care at Level 4 or at Level 2.

Moving forward with Paths to QUALITY: Recommendations

The Purdue research revealed early Paths to QUALITY successes in improving child care quality:

- » Observations showed that child care providers participating in Paths to QUALITY were offering higher quality in the following areas:
 - ✓ *Parents and staff:* Provisions for parents and staff, staff cooperation, supervision, and evaluation of staff.
 - ✓ *Interactions:* Child supervision, discipline strategies, teacher-child and child-child interactions.
 - ✓ *Language and reasoning:* Amount and types of books accessible to the children, children’s communication in the classroom, how children use language to develop reasoning skills.
 - ✓ *Program structure:* Classroom schedule, free play and group time activities, and provisions for children with special needs.

» The evaluation also revealed areas for improvement:

- ✓ *Adult-child interactions:* that support children’s learning and well-being,
- ✓ *Space and furnishing:* Small and large motor play equipment, developmentally appropriate furnishings, room arrangement, and child-related displays in the classroom.
- ✓ *Health & safety practices:* Cleaning procedures for meals, snacks, and diapering, as well as safety practices and personal care routines.
- ✓ *Learning activities:* Use of early math, science, nature, literacy, and blocks activities.

Conclusions

Paths to QUALITY is an effective tool for parents to make child care decisions based on quality. The Paths to QUALITY levels give a valid picture of quality differences in child care centers, child care ministries, and family child care homes. Quality in some areas—adult-child interactions, learning activities, health practices, and space and furnishing—could be improved by strengthening Paths to QUALITY standards and assessments. Children from low-income homes have access to high quality care within the Paths to QUALITY system. Therefore, high quality care should result in better school readiness for those at-risk for early school failure. More research is needed to determine the impact of Paths to QUALITY on the development and school readiness of Indiana’s children.

The Purdue Research

Purdue University completed independent assessments of quality using research-validated measures in a statewide random sample of 312 licensed child care center classrooms, registered child care ministry classrooms, and licensed family child care homes. The Purdue team also interviewed more than 1800 parents and 270 child care providers, and completed developmental assessments with more than 550 infants, toddlers, and preschoolers in Paths to QUALITY centers and homes. The research took place between March, 2009 and June, 2011.

The Purdue evaluation research focused on the following questions:

1. Are child care providers of all types entering the voluntary Paths to QUALITY system? Do providers understand the system?
2. What are the incentives for providers to enroll? What are the barriers?
3. Do child care providers move to higher Paths to QUALITY levels after enrolling in the system?
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Evaluation Brief #3: Does Paths to QUALITY™ Benefit Indiana's Child Care Providers?

What is Paths to QUALITY™?

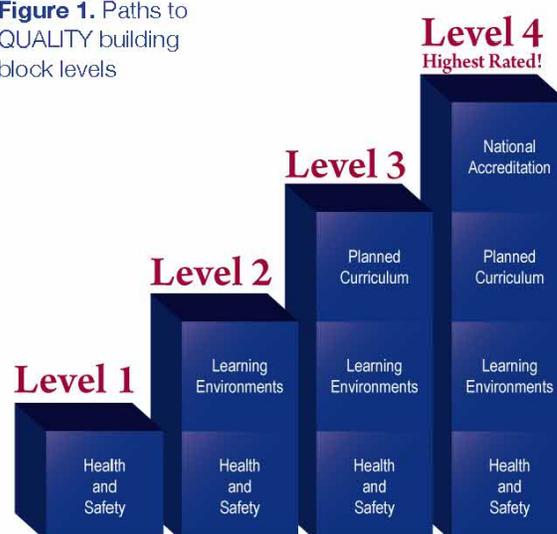
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The four-level Paths to QUALITY rating system has a “building block” structure¹. Each level has quality criteria that must be met. To advance, the provider must meet all standards for the new level and also maintain the required standards for lower levels. As providers take steps to improve quality, they progress toward Level 4 – *accreditation* – recognized nationally as the highest standard of child care quality.

Figure 1. Paths to QUALITY building block levels



Purdue University Research on Paths to QUALITY

The state of Indiana contracted with Purdue University to evaluate the first three years of Paths to QUALITY, from 2008 to 2011. This research/policy brief highlights key findings about child care providers' experiences with the new program. See other briefs in this series for in-depth information about the Purdue evaluation research.



How many caregivers chose to participate in Paths to QUALITY™?

- » As this research brief was written in July, 2012, there were 603 licensed child care centers, 2,280 licensed family child care homes, and 723 unlicensed registered child care ministries operating in Indiana. The strong and growing level of participation by these providers has been a striking success for Paths to QUALITY.
- » In June, 2011 at the completion of this evaluation research, 82% of all licensed child care centers, 52% of all licensed family child care homes, and 11% of all registered child care ministries had enrolled in Paths to QUALITY. These numbers have continued to increase over the past year. By September, 2012, 88% of licensed centers, 59% of licensed homes, and 10% of registered ministries were participating in Paths to QUALITY.

What were the child care providers' reasons for enrolling in Paths to QUALITY?

- » The Purdue evaluation team surveyed 270 randomly-selected child care providers who were participating in Paths to QUALITY.
- » Providers were asked, **“Why did you decide to join the Paths to QUALITY program?”**
Here are their most frequent responses:

Reasons for Enrolling	% of Providers
I wanted to improve the quality of my child care program.	82%
I wanted more professional recognition.	70%
I wanted to make my child care more attractive to parents.	66%
I wanted new ideas for my child care program.	63%
The gifts and cash incentives that were offered for Paths to QUALITY participation.	61%
I wanted the training or technical assistance that Paths to QUALITY offered.	61%
I wanted to increase my business.	49%

Note: Providers could give more than one reason.

What did child care providers say were the most important benefits of participating in Paths to QUALITY after one year?

Most Beneficial Aspect	% of Providers
The mentoring services I have received from the local child care resource and referral agency.	37%
The gifts and incentives I get from the program.	25%
The recognition I get from parents, other providers, or the public that I am providing high quality child care.	16%
The training provided through the program.	9%
Paths to QUALITY participation provides me with a marketing tool for my child care program.	9%

Note: Only the top 5 reasons given are shown.

Were child care providers who enrolled in Paths to QUALITY motivated to advance to higher quality levels?

- » Yes! 23% of providers interviewed had advanced to a higher level in the 6 months since the evaluation visit.
- » 54% of providers interviewed reported they were working hard to move up to higher Paths to QUALITY Levels.
- » Level 2 providers were most likely to advance within 6 months, followed by Level 1 providers:

Level of Provider at Time of Purdue Evaluation Visit	% of Providers Who Moved Up at Least 1 Level in 6 Months	% of Providers Who Stayed at the Same Level in 6 Months
Level 1 (n=65)	26%	69%
Level 2 (n=70)	41%	46%
Level 3 (n=53)	13%	81%
Level 4 (n=50)	NA*	96%

*Level 4 is the highest Paths to QUALITY level, so further advancement is not possible.

According to providers, what are the main challenges they face participating in Paths to QUALITY?

» There were challenges some providers faced in participating and advancing in Paths to QUALITY. Providers were asked, **“In your opinion, what have been the biggest obstacles you face in moving up to the next Paths to QUALITY level?”** 96% of the providers responded to this question. *Here are their most frequent responses:*

Challenges for Providers	% of Providers
Finding the time to complete tasks required by Paths to QUALITY	21%
Completion of required education and training	16%
Insufficient funding to meet standards	9%
Organization; getting paperwork and documentation in order	8%
Preparing for and meeting national accreditation standards	6%
Other obstacles.	6%
Difficulty making needed changes in environment.	4%
Having to wait 6 months to get the next Paths to QUALITY assessment.	4%
Need more feedback from my mentor.	2%
Challenges in developing curriculum.	2%
Reported no obstacles or no response	22%

Conclusions & recommendations for future work with child care providers in Paths to QUALITY.

According to providers, participating in Paths to QUALITY is most beneficial in terms of the mentoring they receive from quality advisors and the public recognition they receive for working to improve the quality of care and education they offer. But there are significant challenges for providers. They often lack the time and resources they need to make changes required to reach the next quality level.

Based on these findings, the Purdue Research Team recommends that:

- » Paths to QUALITY program staff consider providing training in leadership and time management, to support provider’s efforts to manage the new responsibilities that come with participation in Paths to QUALITY.
- » Continue to offer regional meetings and focus groups with providers around the state. Providers will offer valuable information about how Paths to QUALITY is working for them and potential improvements in marketing, incentives and training/technical assistance.
- » In the long term, child care providers need to feel confident that working to advance their Paths to QUALITY level will be beneficial, in terms of their pride in offering quality care to children and families, public recognition for their accomplishments, and financial rewards. Paths to QUALITY should make ongoing efforts to ensure that participating providers are actually receiving these benefits and recognition.



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2. What are the incentives for providers to enroll? What are the barriers?
3. Do child care providers move to higher Paths to QUALITY levels after enrolling in the system?
4. Are providers aware of available training/technical assistance (T/TA) resources to help them increase Paths to QUALITY levels, and do they use them? Does T/TA help providers advance their Paths to QUALITY levels?
5. When providers attain higher Paths to QUALITY levels, does this result in higher quality care, as assessed using research-validated measures?
6. Are children who are placed with providers who have achieved higher Paths to QUALITY levels developing more optimally than children placed with providers having lower Paths to QUALITY levels?
7. Are parents of Indiana infants, toddlers, and preschool children aware of and do they understand the Paths to QUALITY system? Does the Paths to QUALITY system affect parents' child care decisions?

¹ QRIS National Learning Network, Glossary of Terms, <http://qrisnetwork.org/glossary>.

This research-policy brief was written by Treshawn Anderson and James Elicker at Purdue University. It is one in a series available on the Purdue Center for Families website (www.cfs.purdue.edu/cff) under "Publications."

1. Evaluation Brief #1: Key Findings
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For more detailed information about the methods, measures, and results, refer to the Paths to QUALITY Final Evaluation Report (2011) also on the Center for Families website.

For more information about Paths to QUALITY, visit the Paths to QUALITY website: www.in.gov/fssa/2554.htm.

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Evaluation Brief #4: Does Paths to QUALITY™ Help Indiana Parents Find Quality Child Care?

What is Paths to QUALITY™?

Paths to QUALITY™ was created in Fort Wayne, Indiana in 2000 to help parents identify and select quality child care and to recognize providers who work to achieve higher-quality care, beyond minimum state licensing requirements. In 2008, Paths to QUALITY was introduced statewide as a voluntary system for licensed child care centers, licensed family child care homes, and unlicensed registered child care ministries.

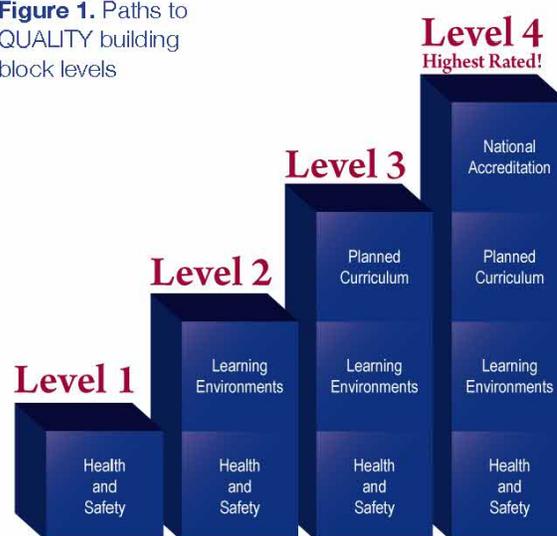
The goals of Paths to QUALITY are to:

- » improve child care quality
- » recognize providers for their quality achievements
- » provide a tool for parents to use to select high-quality child care
- » support better development for children birth to 5 years

The four-level Paths to QUALITY rating system has a “building block” structure¹. Each level has quality criteria that must be met. To advance, the provider must meet all standards for the new level and also maintain the required standards for lower levels. As providers take steps to improve quality, they progress toward Level 4 – *accreditation* – recognized nationally as the highest standard of child care quality.



Figure 1. Paths to QUALITY building block levels



Purdue University Research on Paths to QUALITY

The state of Indiana contracted with Purdue University to evaluate the first three years of Paths to QUALITY, from 2008 to 2011. This research/policy brief highlights key findings from the Purdue research regarding the awareness of the program among parents across Indiana as well as those with children in participating facilities, and the impact it might have on their future child care decisions. See other briefs in this series for more information about the Purdue evaluation research.



Indiana parents' awareness of Paths to Quality is growing slowly...

The Purdue research team conducted a random telephone survey of 765 Indiana parents with children ages 0 to 6 in 2009-2010, and again in 2011.

Are parents aware of Paths to QUALITY? How did they learn about the program? How will it affect their child care choices?

% of Parents That	2010 Survey	2011 Survey
...are aware of PTQ	12%	14%
...heard about PTQ from their child's caregiver	57%	67%
... would make a child care decision based upon a provider's PTQ quality level	61%	71%
...would consider paying more for child care rated at a higher level	47%	57%

Interviews revealed that parents who already have children enrolled with a Paths to QUALITY provider are becoming more aware of the program...

The researchers interviewed a random sample of 450 parents of children who were placed in Paths to QUALITY child care centers or family child care homes.

Do parents know that their child care provider is participating in Paths to QUALITY?

- » Yes! 78% of parents reported their provider was in PTQ.
- » 22% of parents reported their provider was not in PTQ or that they did not know.

How did parents learn about Paths to QUALITY?

- » Family's own child care provider – 62%
- » From a relative or friend – 7%
- » Employer – 7%
- » From a posted flyer – 6%
- » Child Care Voucher Program (CCDF) – 6%
- » Another child care provider – 5%
- » TV or radio – 5%
- » Website – 3%

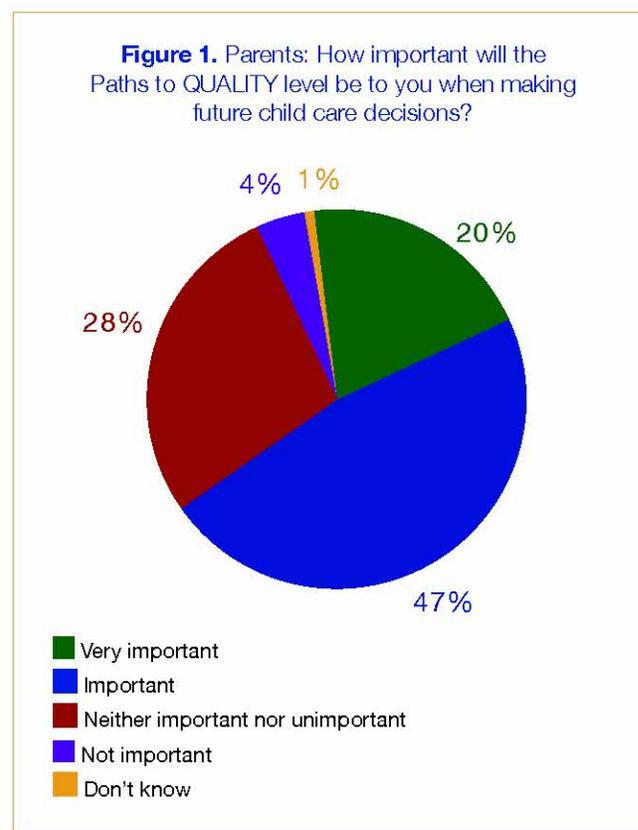
What are the most important reasons parents chose their current child care provider?

Reasons parents chose child care providers	% of parents
Level of trust with child care provider	92%
Level of comfort with child care provider	89%
Overall quality of child care provider	80%
Warmth of child care provider	75%
Experience of child care provider	55%
Educational activities provided by child care provider	51%
Provider is close to home	34%

Note: Parents could give more than one reason.

Are Paths to QUALITY levels likely to affect parents' future child care decision making?

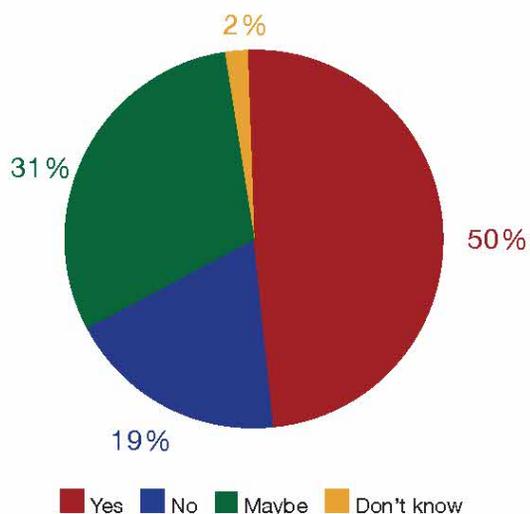
- » Yes! 67% said that a higher level would be either an "important" or "very important" factor in their decision when choosing child care. See Figure 1.



Are parents willing to pay more for child care that has a higher Paths to QUALITY level?

» Yes! About one-half of the 450 parents interviewed said that they would be willing to pay more to a provider on a higher level. See Figure 2.

Figure 2. Parents: Would you be willing to pay more for child care that is rated at a higher level in Paths to QUALITY?



Conclusions and Recommendations

According to Indiana parents, they want to know if providers have chosen to participate in Paths to QUALITY. This information helps parents with their child care decisions and the value they place on the care they choose. The Purdue researchers recommended:

- » Let Paths to QUALITY providers know that parents are willing to pay more for higher quality child care.
 - ✓ Between 13 and 27% of providers rated at the four PTQ levels have increased their fees to support higher quality care.
- » Encourage Paths to QUALITY providers to find new ways to reach current and future parents with PTQ information.
 - ✓ Providers can request marketing materials such as banners and flags that display their PTQ level, as well as information pamphlets and car decals for parents!
- » Develop media options to promote PTQ, such as TV/Radio public service announcements.
- » Include providers' Paths to QUALITY level on child care web sites, to increase public awareness.
 - ✓ Parents can now identify participating providers, their PTQ levels, locations, and other valuable information on www.childcareindiana.org.



The Purdue Research

Purdue University completed independent assessments of quality using research-validated measures in a statewide random sample of 312 licensed child care center classrooms, registered child care ministry classrooms, and licensed family child care homes. The Purdue team also interviewed more than 1800 parents and 270 child care providers, and completed developmental assessments with more than 550 infants, toddlers, and preschoolers in Paths to QUALITY centers and homes. The research took place between March, 2009 and June, 2011.

The Purdue evaluation research focused on the following questions:

1. Are child care providers of all types entering the voluntary Paths to QUALITY system? Do providers understand the system?
2. What are the incentives for providers to enroll? What are the barriers?
3. Do child care providers move to higher Paths to QUALITY levels after enrolling in the system?
4. Are providers aware of available training/technical assistance (T/TA) resources to help them increase Paths to QUALITY levels, and do they use them? Does T/TA help providers advance their Paths to QUALITY levels?
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Paths to  QUALITY

A Child Care Quality Rating & Improvement System for Indiana:

**Technical Report no. 2
Evaluation Methods and Measures**

**Carolyn Langill, Ph.D.
James Elicker, Ph.D.
Karen Ruprecht, M.P.A.
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Center for Families and Department of Child Development & Family Studies

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**Center for Families
Department of Child Development & Family Studies
Purdue University**

January, 2009

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We also thank selected child care providers, children, and parents who are participating in the PTQ Evaluation research. To the extent this evaluation benefits child care in Indiana, those in child care centers, homes, and ministries are the most important contributors and beneficiaries.

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Paths to QUALITY Evaluation Project Overview

The Child Care Bureau of the Indiana Family and Social Services Administration implemented a statewide voluntary child care quality rating and improvement system (QRIS) named “Paths to QUALITY” beginning in January, 2008. Paths to QUALITY (PTQ) is a quality rating and improvement system for state-regulated Indiana early care settings, including family child care homes, licensed child care centers, and unlicensed, registered child care ministries. Licensed or registered child care providers voluntarily participate. The goal of Paths to QUALITY is to improve child care quality and support better developmental outcomes for young children by giving parents information about what constitutes quality care. Paths to QUALITY also provides resources for child care providers to help them improve the quality of their service. (See Figure 1 for an overview “logic model” illustrating how PTQ is designed to work.)

The Purdue University evaluation research will determine whether the PTQ quality ratings are valid and also examine children’s learning and development within the PTQ system. PTQ establishes four levels of quality that apply to licensed centers, licensed family child care homes, and registered child care ministries. Each level includes specific criteria that must be met in order for that level to be awarded. The quality levels are labeled:

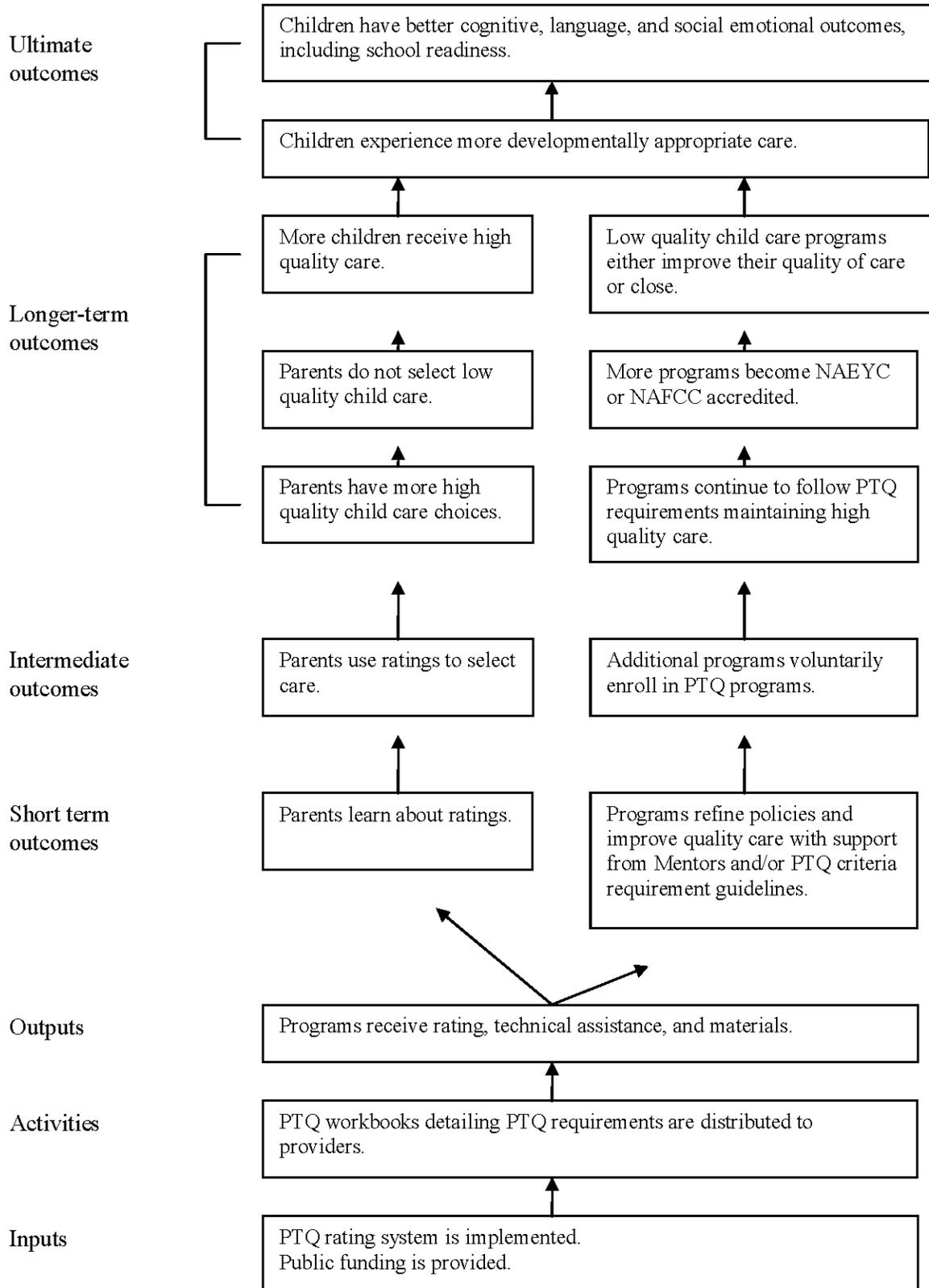
- Level 1 – Health and Safety
- Level 2 – Learning Environment
- Level 3 – Planned Curriculum
- Level 4 – National Accreditation

The Consulting Consortium, under a separate contract with the state, observes child care programs, interviews child care program owners and/or directors, and reviews administrative documents to determine the PTQ quality level of each facility. Licensed child care centers, family child care homes, and registered child care ministries have different but complementary standards to meet in order to advance from level to level. Providers who participate in this system are visited on a minimum of once per year to determine if their ratings have changed. (See overview of quality levels and the specific standards for each level on the Paths to QUALITY web site, www.in.gov/fssa/carefinder/2747.htm).

The overall goal of the Purdue University Paths to QUALITY Evaluation is to determine if the program is *effective* in its initial implementation phases, by focusing on the following questions:

- Does PTQ actually increase the quality of licensed child care centers, registered child care ministries, and licensed family child care homes that participate?
- Are children in higher level PTQ homes or centers learning more or developing more optimally?

Figure 1. A Logic Model for Indiana Paths to QUALITY



PTQ Evaluation Questions & Research Design

The Purdue Evaluation team has a four year contract with the Bureau of Child Care within the Families and Social Services Administration of the State of Indiana and is responsible for evaluating the PTQ program's effectiveness and impact on child care in the state. The overall goal of the Paths to QUALITY (PTQ) Evaluation is to determine if the child care quality rating and improvement system program is *effective*:

- Does PTQ actually increase the quality of licensed child care centers, registered child care ministries, and licensed family child care homes that participate?
- Are children in higher level PTQ homes or centers learning more or developing more optimally?

In the first phase of the project, completed in 2007, the Purdue evaluation team answered the following general question: "Is there scientific evidence that the Indiana PTQ standards are valid indicators of child care quality that support children's development?"

A validation study of the proposed system was completed, examining available research evidence that proposed Indiana PTQ levels criteria are clearly related to child care quality and positive child development outcomes. Published research articles, technical reports from QRS evaluations in other states, and results from two Indiana PTQ pilot programs were reviewed and analyzed. This preliminary PTQ validation study answered three specific questions:

1. Will the proposed Indiana PTQ levels and criteria result in increasing the quality of child care children receive? (What does existing research tell us?)
2. Will the Indiana PTQ system improve developmental outcomes for children? (What does existing research tell us?)
3. What are the known results and effects of the two Indiana PTQ pilot programs? (Fort Wayne and Evansville areas)

A technical report summarizing this review and providing answers to these questions was delivered to the Indiana Child Care Bureau in October, 2007. The title of the report is "Paths to QUALITY—A Child Care Quality Rating System for Indiana: What is its Scientific Basis?" This report is available on the Paths to QUALITY web site, www.in.gov/fssa/carefinder/2747.htm. To request a printed copy of the report, contact the Purdue Center for Families, (765) 494-9878 or (www.cfs.purdue.edu/CFF/).

Second, a number of evaluation measures were selected or developed. During the summer of 2007, lead staff members of the evaluation team received training on the revised University of North Carolina child care quality rating scales (ECERS-R, ITERS-R, and FCCERS-R) so they were prepared to train, supervise, and maintain reliability for the PTQ regional evaluation data collectors. Additional measures and survey instruments were selected or created by the evaluation team during 2007. All evaluation instruments were field tested, with preliminary data collected to assure that selected measures were appropriate and worked reliably, before data collection began.

Third, an evaluation advisory committee of key Indiana stakeholders was convened. The evaluation research plan has been reviewed and refined with input from this committee.

In the second phase of the evaluation the Purdue Evaluation team will begin to evaluate the PTQ program's effectiveness and impact on child care, nine months to one year following the initial PTQ roll out in each state region. Evaluation data collected in each region will be comprised of information

reported to the PTQ central data system as a part of the enrollment and assessment process, live observations by Purdue research assistants to assess quality in a randomly-selected sample of child care settings, assessments by Purdue research assistants of randomly-selected individual children's development in those settings, surveys with child care providers, and telephone surveys with parents served by PTQ providers. A second phase of data collection will begin in each region 17 months after the initial funding date (6 months after the first data collection phase ends.) This phase will include random telephone surveys with parents in the general public in each region, conducted by the Purdue Social Research Institute, and follow-up telephone surveys with the original sample of child care providers, conducted by Purdue Evaluation staff. The following specific questions will be addressed in this evaluation research:

1. Are child care providers of all types entering the voluntary PTQ system? Do providers understand the system? What are the incentives for providers to enroll? What are the barriers?
2. How many and what types of providers enroll in PTQ during the first year? How did providers find out about PTQ?
3. Is PTQ reaching providers of all types (licensed family child care homes, licensed child care centers, and non-licensed, registered child care ministries)? In all geographic areas? Urban vs. rural?
4. Are some types of providers slower or more reluctant to participate in PTQ? Why?
5. How long does it take for providers to enroll in the system and to receive their initial PTQ rating?
6. Do child care providers move to higher PTQ levels after enrolling in the system? How long does this take?
7. Over the first year of PTQ, how many providers increase, maintain, or decrease PTQ levels? What are the characteristics of providers who increase levels, compared to those who maintain or decrease levels?
8. Are providers aware of available training/technical assistance (T/TA) resources to help them increase PTQ levels, and do they use them? Does T/TA help providers advance to higher PTQ levels?
9. When providers attain higher PTQ levels, does this result in higher quality care and education for children?
10. Are children who are placed with providers with higher PTQ levels developing more optimally than children placed with providers having lower PTQ levels?
11. Are parents of Indiana infants, toddlers, and preschool children aware of and do they understand the PTQ system? How does the PTQ system affect parents' child care decisions?

Evaluation Data Collection Procedures

PTQ Recruitment

- Local child care resource and referral agencies in each state region recruit child care providers using existing communication and marketing channels, such as presentations at community meetings and brochures at community events.

PTQ Enrollment

- Providers attend a Paths to QUALITY Introduction session conducted by the Child Care Resource and Referral Agency for the county where the child care business is located. Providers receive information about participation in Paths to QUALITY at the session and the enrollment forms that provide basic information about who they are, how to contact them, and details about their child care operation.
- Providers are verified to be in good standing based on compliance with licensing regulations (licensed centers and family child care homes) or voluntary certification (registered ministries).
- Providers sign a “Memorandum of Agreement” with the State agreeing to comply with the voluntary requirements of the PTQ program and to participate in the Purdue University evaluation study if requested.
- All providers enter Paths to QUALITY with a Level 1 status. The provider is given a Level 1 certificate, a decal to place on their door, a workbook, toolkit, and a small non-cash participation incentive.
- Providers may request and then will be assigned a Mentor/Advisor to assist them through the PTQ process and to provide technical assistance for level advancement.
- After the provider meets all criteria for a level increase, they contact their mentor, Paths to QUALITY Specialist, or Quality advisor to request a level increase rating visit.
- A Readiness Checklist is completed by the mentor/specialist/advisor with the provider to verify readiness for the rater visit.
- The PTQ specialist/coordinator makes a request for a rating increase visit.
- A staff person from The Consultants Consortium (independent contractor with state government) visits the facility and rates them on a PTQ level between 1 and 4. The Level rating is shared with the child care facility and a rating recommendation is made to the Bureau of Child Care.
- Once approved by the Bureau of Child Care, the provider receives a new certificate, toolkit, and decal to place on their door indicating their current Paths to QUALITY level. In addition, the provider may receive a non-cash or cash award from the State.
- Whether a new level increase rating visit is requested or not, a follow-up annual maintenance visit will occur within 12 months of the initial rating visit to ascertain whether the PTQ level has changed or been maintained.
- For the annual maintenance rating visit, the provider has 90 days to make any adjustments they need to maintain their current rating.
- Providers can progress at their own pace, however they must wait six months after a level increase rating visit to request another level increase rating.
- Data from rating visits, incentives and awards are recorded in a central database operated by the State, and any follow-up activity is tracked.

Evaluation Sample Selection

- A total of 520 child care environment quality assessments, 1,040 child assessments, and 1,040 parent interviews will be completed statewide over a 3 year period.
- A stratified random sample is selected for each region using the PTQ central database. In 10 of the 11 regions 9 licensed child care centers, 3 registered child care ministries, and 20 family child care providers are selected.
- In the remaining region (Marion County/Indianapolis), 20 licensed child care centers, 10 registered ministries, and 20 family child care home providers are selected. Additional providers are sampled in the Marion County Indianapolis region because 22% of Indiana's population and 25% of Indiana's young children (ages 0 – 4 years) reside there (Kids Count, 2007).
- Equal numbers of providers are selected at each PTQ Level if possible. (For example, at least 4 homes at each level; at least 2 centers at each level.)
- If there are insufficient numbers of any type of child care provider enrolled in the PTQ system in a particular region, additional providers of the other types will be sampled in that region.
- Selected child care facilities are mailed an invitation packet consisting of invitation letters and consent forms for directors/family child care home owners.
- Five days after packet is mailed to directors and family child care home owners, they are phoned to verify that they are willing to participate in the evaluation (see Appendix A, Consent Forms).
- If provider agrees to participate in the evaluation, the research assistant will ask the owner/director to complete and sign the consent form and hold it until the Purdue data collector arrives to conduct the quality and child assessments.
- The research assistant collects information about the classrooms (i.e., ages of children and number of classrooms) and randomly selects two classrooms in each center or ministry to be observed. An infant toddler classroom and a preschool age classroom will be selected in each center when possible.
- A second evaluation packet will be mailed to directors and family child care owners which will include: invitation to teachers to participate, teacher consent forms, invitation to parents to participate, parent/child consent forms, teacher survey, director survey, and an informational flyer for teachers and family child care home owners to post in their classrooms/homes for parents (see Appendix A, Consent Forms).
- The provider receives this second packet and distributes and collects parent consent forms.
- Data collector schedules a convenient time to conduct quality rating observations of the selected classrooms or family child care home environment and to assess 2 children in each classroom or family child care home.
- Upon arriving for the quality assessment visit, the data collector randomly selects two children (and their parents) from each classroom or family home to complete the child assessment and parent interview.

Data Collection

Training of Data Collectors

- In 2007, core key staff members of the evaluation team received intensive training on the revised University of North Carolina child care environmental quality rating scales (ECERS-R, ITERS-R, and FCCERS-R) at the Frank Porter Graham Child Development Center. This reliability training enabled them to train, supervise, and maintain reliability of the Indiana PTQ regional evaluation data collectors.
- In 2007-2008, measures and survey instruments were selected or created, and then field tested, with preliminary data collected to assure that the selected measures would work reliably when data collection began.
- Three months prior to data collection in each region, data collectors are hired in strategic locations throughout the state.
- Data collectors are trained on administration, reliability, and validity of the assessment measures, accurate scoring procedures, basic interpretations of terms used throughout the measures, and observation, assessment, and interview procedures required for each measure.

First Phase Data Collection

- Nine months to one year after each state region is funded for PTQ, the first phase of data collection begins, allowing time for each region to start up the program, enroll providers of all types, and assess each provider for initial placement in a PTQ quality level in sufficient numbers to make evaluation feasible.
- Four months are required to collect the phase 1 evaluation data in the regions in Wave 1 and 3, and 7 months in the regions in Waves 2 and 4. Table 1 provides an overview of the planned evaluation data collection schedule.
- Child care quality observations, provider surveys, child assessments, and parent interviews are completed for each classroom or family home.
- Preliminary results from each region will be issued to the Child Care Bureau two months following each data collection period.

Second Phase Data Collection

- Six months after the first phase of data collection for each region concludes, the Purdue Social Research Institute will randomly select and survey 60 parents of preschool children from the general public in each region to assess general awareness, understanding, and use of the PTQ system.
- Six months after the first phase of data collection for each region concludes, the Purdue Evaluation staff will conduct follow-up telephone surveys with the original sample of child care providers.

Table 1: Indiana Paths to QUALITY Child Care Regions—Evaluation Schedule

Region	QRS Funding Begins	Phase 1 Evaluation Begins	Phase 1 Evaluation Complete	Phase 1 Regional Report Due	Phase 2- Random Parent Survey & Provider Follow-up	Phase 2 Regional Report Due	Sample Sizes
Wave 1							64 providers (88 quality observations)
Early Childhood Alliance (Allen, De Kalb, La Grange, Noble, Steuben, Whitey) SDA 3	1/1/08	9/1/08	12/15/08	2/15/08	1/1/09-2/28/09	6/1/09	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
4C (Davies, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick) SDA 9	1/1/08	9/1/08	12/15/08	2/15/08	1/1/09-2/28/09	6/1/09	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Wave 2							128 providers (176 quality observations)
Bona Vista (Blackford, Grant, Howard, Huntington, Jay, Miami, Tipton, Wabash, Wells) SDA 5	5/1/08	2/1/09	8/31/09	10/31/09	12/1/09-2/28/10	5/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Childhood Connections (Bartholomew, Brown, Crawford, Harrison, Jackson, Jennings, Lawrence, Monroe, Orange, Washington) SDA 10	5/1/08	2/1/09	8/31/09	10/31/09	12/1/09-2/28/10	5/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Southeastern Indiana Economic Opportunities (Clark, Dearborn, Decatur, Floyd, Franklin, Jefferson, Ohio, Ripley, Scott, Switzerland) SDA 11	5/1/08	2/1/09	8/31/09	10/31/09	12/1/09-2/28/10	5/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public

PTQ Evaluation Methods

Community Alliances & Services for Children (Clay, Greene, Montgomery, Morgan, Owen, Parke, Putnam Sullivan, Vermillion, Vigo) SDA 6	5/1/08	2/1/09	8/31/09	10/31/09	12/1/09-2/28/10	5/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Wave 3							50 Providers (80 quality observations)
Wave 3 Childcare Answers (Marion, Hendricks, Hamilton, Johnson) SDA 7	10/1/08	5/1/09	10/31/09	1/15/10	2/1/10-4/30/10	7/1/10	20 centers 20 homes 10 ministries (80 observations) 160 children-parents 60 general public
Wave 4							128 providers (176 quality observations)
Hufer Memorial Children's Center (Delaware, Fayette, Hancock, Henry, Madison, Randolph, Rush, Shelby, Union, Wayne) SDA 8	1/1/09	10/1/09	4/30/10	6/30/10	8/1/10-9/30/10	12/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Connexions (Benton, Boone, Carroll, Cass, Clinton, Fountain, Jasper, Newton, Pulaski, Tippecanoe, Warren, White) SDA 4	1/1/09	10/1/09	4/30/10	6/30/10	8/1/10-9/30/10	12/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Workforce Development Services (Lake, La Porte, Porter) SDA 1	1/1/09	10/1/09	4/30/10	6/30/10	8/1/10-9/30/10	12/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public
Community Coordinated of St. Joseph (Elkhart, Fulton, Kosciusko, Marshall, Starke, St. Joseph) SDA 2	1/1/09	10/1/09	4/30/10	6/30/10	8/1/10-9/30/10	12/1/10	9 centers 20 homes 3 ministries (44 observations) 88 children-parents 60 general public

Implementation of the PTQ System

- The Indiana PTQ central database is utilized to gather basic information about the child care facilities that have volunteered to participate, such as:
 - the type of child care offered (center-based, home-based, registered ministry),
 - contact information for the director,
 - numbers and ages of children served, and
 - geographic area served
 - PTQ level history
 - how providers found out about PTQ,
 - rate of time between provider enrollment and PTQ quality rating, and
 - demographic characteristics of providers more successful and less successful in program.

Child Care Quality and Child Development Outcomes

- Data collectors observe each classroom or home for a period of 3 to 4 hours for the quality assessments using the appropriate measure (ECERS-R, ITERS-R or FCCERS-R).
- Child/teacher ratio and group size in each classroom or family child care home will be recorded.
- Data collectors rate provider sensitivity using the Caregiver Interaction Scale (CIS; Arnett, 1989).
- Children's developmental progress is assessed via direct observation and testing, plus child care provider surveys are completed.

Provider and Parent Perceptions of Paths to QUALITY

Initial Provider Survey and Classroom Teacher/Lead Caregiver Survey

- Child care directors/owners selected for the child care quality observations complete a self-administered survey to ascertain if providers understand the PTQ system, what prompted providers to enroll in the system, what obstacles, if any, they faced in participating in the system, what training/technical assistance resources they have used, and how their child care practices may have changed as a result of being on the PTQ system.
- Data collectors obtain the survey when they complete the quality rating observation and child assessments.
- Each classroom teacher and family child care home lead caregiver completes a short survey about their current level of education and training. Purdue research assistants collect this teacher/provider survey during the child care quality observation.

Follow up Provider Telephone Survey

- Child care directors/owners selected for the child care quality observations are interviewed by phone 6 months following the child care assessment visits to ascertain their understanding of the PTQ system, what obstacles they faced in participating in the system, what training/technical assistance resources were available to them and used, and how their child care practices may have changed as a result of being on the PTQ system.
- Telephone interviews last approximately 30 minutes and will be conducted by the research assistants based on the Purdue campus.

PTQ Parent Telephone Survey

- Parents of children selected for the child development assessments in each child care facility, are interviewed by phone to assess their understanding and use of the PTQ system within one week

of the completed child care quality assessment. Telephone interviews last approximately 15 minutes and are conducted by the Purdue research assistants.

General Public Parent Telephone Survey

- Using a purchased list of phone numbers for households in each region that include preschool age children, the Purdue Social Research Institute (SRI) will randomly select and survey 60 parents of preschool children from the general public in each of the 11 state regions (total = 660 interviews) to assess general public awareness, understanding, and use of the PTQ system.
- Informed consent is obtained on the phone.
- Telephone interviews last approximately 20 minutes and are conducted by SRI-trained research assistants.

PTQ Measures

Table 2 (pages 19-20) provides a summary of all research measures used in the Paths to QUALITY evaluation.

Characteristics of Child Care Providers, Children, and Parents

Education and training information of child care directors and family child care home owners is collected at time of program enrollment with the local child care resource and referral agency and entered in the statewide PTQ online database. Demographic information is collected in the director/family child care home owner survey. Classroom teachers and lead caregivers in family child care homes are also asked about their training and education. See Appendix C for the survey questions. When parents complete the consent form, they will also provide some initial information about their child. The parent contact information form is displayed in Appendix D.

Child Care Quality Measures

Classrooms caring for children ages 2 ½ and older in licensed child care centers and registered child care ministries are assessed using the Early Childhood Environment Rating Scale-Revised (ECERS-R), while classrooms caring for infants and toddlers (birth to 30 months) in licensed child care centers and registered child care ministries are assessed using the Infant Toddler Environment Rating Scale-Revised (ITERS-R). The Family Child Care Environment Rating Scale-Revised (FCCERS-R) will be used to assess quality in family child care homes. The three measures, designed to carry similar conceptual structures, allow researchers to compare quality across types of child care settings. Assessors will be trained on the three measures and then complete independent observations with reliable trainers to a 85% (within one point) reliability before beginning data collection. Inter-rater reliability will be monitored throughout the entire data collection period to maintain reliability among assessors. Reliability checks will be completed with each assessor throughout data collection.

Early Childhood Environment Rating Scale—Revised edition (ECERS-R: Harms, Clifford, & Cryer, 1998). The ECERS-R will be used to assess child care quality in center-based child care classrooms caring for children ages 2 ½ and up. It consists of 43 items organized under seven subscales: space and furnishings, personal care routines, language-reasoning, activities, interaction, program structure, and parents and staff. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .92$; Harms, Clifford, & Cryer, 1998).

Infant Toddler Environment Rating Scale—Revised edition (ITERS-R: Harms, Clifford, & Cryer, 2003). The ITERS-R will be used to assess child care quality in center-based child care classrooms caring for children ages 0 to 30 months. It consists of 39 items organized under seven subscales: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure,

and parents and staff. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .92$; Harms, Clifford, & Cryer, 2003).

Family Child Care Environment Rating Scale—Revised edition (FCCERS, Harms, Clifford, & Cryer, 2007). The FCCERS-R will be used to assess child care quality in family child care home settings. It consists of 38 items organized under seven subscales: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure and parents and provider. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .88$; Harms, Clifford, & Cryer, 2007).

Caregiver Interaction Scale (CIS; Arnett 1989). The Caregiver Interaction Scale assesses the quality and content of the teacher's interactions with children. The 26 items measure the emotional tone, discipline style, and responsiveness of the provider in the classroom or family home. Trained assessors will rate dimensions of provider interactions using a 4-point scale [Not at all (1) to Very much (4)] during the child care setting environmental rating scale observation. The CIS consists of 4 subscales: Positive interactions (10 items), Punitiveness (eight items), Detachment (four items), and Permissiveness (four items). Cronbach alphas ranging from .91 to .98 have been reported (Layzer, Goodson, & Moss, 1993; Resnick & Zill, 1999.)

Child Development Outcome Measures

Cognitive Development--Infants Toddlers (0-36 months)

Mullen Scales of Early Learning (Mullen, 1995). The Vision Reception Scale of the Mullen Scales of Early Learning will be used to assess infants/toddlers cognitive development. The Visual Reception Scale examines a child's performance in processing visual patterns. Internal consistency has been tested using modified split-half procedure for each scale and for the composite. The median values of the internal consistency for each scale have been reported ranging from .75 to .83 and that of the composite was .91. In addition, test-retest reliability has been checked by administering the scales to two samples (50 1- to 24-month-old children and 47 25- to 56-month-old children). Test-retest reliabilities for the younger group were from .82 to .85; those for the older group were from .71 to .79. In addition, the author of the measure has examined correlations between Mullen Scales and other measures, such as Bayley Scales of Infant Development (Bayley, 1993) which have been found to be predictive of school readiness measures (Berry, Bridges, & Zaslow, 2004). Higher correlations were found between Mullen Scales and Bayley Mental Development Index (ranging from .53 to .59) than between Mullen Scales and Bayley Psychomotor Development Index (ranging from .21 to .52), suggesting that Mullen Scales is a valid measure of cognitive development.

Cognitive Development-Preschool age children (3-5 years)

Woodcock Johnson III Applied Problems and Letter Word Identification Subtests. The two subtests will be used to assess cognitive development in preschool age children. The Letter-Word Identification subtests include items measuring symbolic learning, or the ability to match a pictographic representation of a word with an actual picture of the object, and items measuring children's reading identification skills in identifying letters and words. The Applied Problems subtest measures children's skill in analyzing and solving practical problems in mathematics. The Woodcock Johnson subtests measure aspects of cognitive functioning that have been associated with school readiness and has been widely used in evaluation research (Berry et al, 2004).

Language Development-Infants Toddlers (0-36 months)

Mullen Scales of Early Learning (Mullen, 1995). The Receptive Language and Expressive Language Scales of the Mullen Scales of Early Learning will be used to assess infants/toddlers language development. The Receptive Language Scale examines a child's ability to process linguistic input. The Expressive Language Scale examines a child's ability to use language productively. Internal consistency is reported above.

Language Development-Preschool age children (3-5 years)

Peabody Picture Vocabulary Test – 4 (PPVT-4: Dunn & Dunn, 1997). Peabody Picture Vocabulary Test – III (PPVT-III) will be used to measure receptive (hearing) vocabulary (designed to measure a children's vocabulary acquisition). Trained assessors will ask children to point to the picture that matches the words spoken by the assessor. The scores were converted to standard scores. Reliability has been tested using modified split-half procedure, and the median reliability was .94 (ranging from .86 to .97). Alternate forms reliability coefficients have also calculated by administering two different test forms to the same group of children. The coefficients computed from the standard scores ranged from .88 to .96 (median = .94). Validity was also investigated using other measures of vocabulary and verbal ability (WISC-III; KAIT; K-BIT; and OWLS). Moderate to high correlations were found, with coefficients ranging from .62 to .91, supporting that PPVT-III is a valid instrument that measures some aspects of children's intelligence, verbal ability quite well. The PPVT has been found to be related to other measures of cognitive development that predict school readiness (Berry et al, 2004).

Social Emotional Development-Infants Toddlers (0-36 months)

Brief Infant Toddler Social and Emotional Assessment (BITSEA: Briggs-Gowan & Carter, 2002). The BITSEA will be used to measure infants' and toddlers' social emotional competence and behavioral problems. Child care providers will respond to BITSEA items based on behaviors observed at home or in child care. This is a short version of ITSEA (Infant Toddler Social and Emotional Assessment). Three scales are derived from the BITSEA – Problem, Competence, and a combined Problem and/or Competence scale. The BITSEA consists of 60 items selected from ITSEA, and each item is scaled 0: Not true/Rarely, 1: Somewhat true/Sometimes, and 2: Very true/Often. This measure contains two subscales, one of which measures problem behaviors (49 items) and the other measures competence (11 items). Internal consistency of the scales from the original data was .66 to .89 (Briggs-Gowan, Carter, Skuban, & Horwitz, 2001). Validity has been measured by comparing parents' report with evaluators' ratings, and most correlations have been significant ($r = .39$ to $.44$). As an additional measure of validity, authors have investigated whether or not "parental worry, parenting stress, and interference in family life (p. 26)" are significantly related to high scores on problem scale and low scores on competence scales to measure another kind of validity, and they found significant relationships among them ($r = .25$ to $.63$). Scores on the BITSEA have also been found to be related to other measures of social emotional development (Berry et al, 2004). The internal consistencies have been reported as .74 for competence scale and .84 for the problem scale.

Social Emotional Development-Preschool age children (3-5 years)

Social Competence and Behavior Evaluation (SCBE: LaFreniere & Dumas, 1996). The short form of SCBE consists of three scales: Anger-Aggression (10 items), Social Competence (10 items), and Anxiety-Withdrawal (10 items). These scales will be used to assess socio-emotional competence. Providers rate items ranging from not at all like the child (1) to very much like the child (2). The original 80-item Social Competence and Behavior Evaluation (SCBE) was developed to measure 30- to 78-month-old children's "patterns of social competence, emotion regulation and expression, and adjustment difficulties (p.369)." Anger-Aggression scale contains items regarding angry, aggressive, egotistical, and oppositional behaviors; Social Competence scale consists of items related to joyful, secure, tolerant,

socially integrated, calm, pro-social, cooperative, and autonomous behaviors; and Anxiety-Withdrawal scale includes items related to depressed, anxious, isolated, and dependent behaviors. Sixty-seven percent of the total variance was explained by these three factors. The authors collected data in three different sites: Quebec, Indiana, and Maine. Internal consistencies ranged from .72 to .89. Validity was tested by computing correlations of these three indexes with the corresponding 10-item scales, and the correlations ranged from .92 to .97. In addition, in the Indiana sample the authors asked teachers to rate children using another measure related to children's problem behaviors (the Revised Behavior Problem Checklist: RBPC) and computed correlations with Anger-Aggression and Anxiety-Withdrawal scales. The Pearson's correlations were .67 and .87 indicating that scores on the SCBE are predictive of other measures of social emotional development.

Child Care Provider Surveys

Initial Provider Survey

Child care directors/owners selected for the child care quality observations complete a survey to determine if providers understand the PTQ system, what prompted providers to enroll in the system, what obstacles they face in participating in the system, what training/technical assistance resources they have used, and how their child care practices may have changed as a result of being on the PTQ system. See Appendix E for survey questions.

Follow up Provider Telephone Survey

The same sample of child care providers selected for the initial provider survey will be contacted 6 months following the child care assessment visits described above. They will be asked similar questions about their understanding of the PTQ system, what obstacles they believe they face in participating in the system, what training/technical assistance resources they have used, and how their child care practices may have changed as a result of being on the PTQ system. Telephone interviews will last approximately 30 minutes and will be conducted by the research assistants based on the Purdue campus. See Appendix F for survey questions.

Parent Surveys

PTQ Parent Telephone Survey

For the children selected for the child development assessments in each child care facility, the Purdue Evaluation Staff will also interview a parent from each child's household by phone to assess their understanding and use of the QRS system. Telephone interviews will last approximately 15 minutes and will be conducted by the research assistants. See Appendix G for survey questions.

General Public Parent Telephone Survey

The Purdue Social Research Institute (SRI) will use the following survey to ask 60 parents of preschool children from the general public in each of the 11 state regions (total = 660 interviews) about their general awareness, understanding, and use of the QRS system. See Appendix H for survey questions.

Table 2. Overview of Measures

Data collected from Child Care Provider		
Variable	Name of Measure	Measure Description
Child Care Quality-Global Assessment	Early Childhood Environmental Rating Scale—Revised (ECERS-R)	Assessors use scale to rate overall child care quality in center-based child care classrooms caring for children ages 2 ½ and up.
	Infant Toddler Environmental Rating Scale—Revised (ITERS-R)	Assessors use scale to rate overall child care quality in center-based child care classrooms caring for children ages 0 to 30 months.
	Family Child Care Environmental Rating Scale (FCCERS-R)	Assessors use scale to rate child care quality in family child care home settings.
Child Care Quality-Provider Sensitivity	Caregiver Interaction Scale (CIS)	Assessors rate the quality and content of the teacher’s interactions with children.
Providers’ perceptions of PTQ	Surveys of providers participating in PTQ	Includes questions about providers’ understanding of PTQ, perceptions of PTQ assessment, technical assistance received, and impact of PTQ on providers’ businesses
Providers’ perceptions of PTQ	Follow-up surveys with the original sample of providers	Survey follows up on perceptions of PTQ assessment, technical assistance received, and impact of PTQ on providers’ businesses
Data collected from the Parent		
Variable	Name of Measure	Measure Description
Parents’ perceptions of PTQ-- PTQ participants	Surveys with parents served by PTQ providers	Includes questions about parents’ understanding of PTQ and whether PTQ has affected their child care choices.
Parents’ perceptions of PTQ-- General public	Surveys with randomly-selected parents in the general public	Includes questions about parents’ understanding of PTQ and whether PTQ has affected their child care choices.

Data collected from/about the Child		
Variable	Name of Measure	Measure Description
Cognitive Development— infant and toddlers	Mullen Scales of Early Learning	Direct assessment of child's ability to process visual patterns.
Cognitive Development-- preschool age children	Woodcock Johnson Applied Problems subtest	Direct assessment of children's skill in solving practical problems in mathematics.
	Woodcock Johnson Letter Word Identification subtest	Direct assessment of early reading skill such as or the ability to match a pictographic representation of a word with an actual picture of the object and identifying letters and words.
Language Development— infant toddler	Mullen Scales of Early Learning	Direct assessment of receptive (vocabulary acquisition) and expressive (ability to use language productively) language.
Language Development— preschool age children	Peabody Picture Vocabulary Test	Direct assessment of receptive (vocabulary acquisition) language.
Social Emotional Development— infant toddler	Brief Infant Toddler Social and Emotional Assessment	Provider rates child's problem behavior and social competence.
Social Emotional Development— preschool age children	Social Competence and Behavior Evaluation	Provider rates child's aggression, anxiety, and social competence.

To learn more about the Indiana Paths to QUALITY program:

PTQ web site: www.in.gov/fssa/carefinder/2554.htm

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Bureau of Child Care

Family and Social Services Administration

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References

- Arnett, J. (1989). Caregivers in day-care centers: Does training matter? *Journal of Applied Developmental Psychology, 10*, 541-552.
- Bangs, T. E. (1986). *Birth to Three Development Scale*. Allen, TX: DLM Teaching Resources.
- Bayley, N. (1993). *Bayley Scales of Infant Development, Second Edition*. San Antonio: Harcourt Brace & Co.
- Berry, D. J., Bridges, L. J., & Zaslow, M. J. (2004). *Early Childhood Measures Profile*. <http://aspe.hhs.gov/hsp/ECMeasures04/report.pdf>.
- Brigance, A. H. (1978). *BRIGANCE Diagnostic Inventory of Early Development*. North Billerica, MA: Curriculum Associates.
- Briggs-Gowan, M. J., & Carter, A. S. (2002). *Brief Infant-Toddler Social and Emotional Assessment (BITSEA) manual, version 2.0*. New Haven, CT: Yale University.
- Briggs-Gowan, M. J., Carter, A. S., Skuban, E., Horwitz, S. (2001). Prevalence of social-emotional and behavioral problems in a community sample of 1- and 2-year-old children. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(7), 811-819.
- Dunn, L. M., & Dunn, L. M. (1997). *Peabody Picture Vocabulary Test, Third edition*. Circle Pines, MN: American Guidance Service.
- Harms, T., Cryer, D., & Clifford, R. (1998). *Early Childhood Environment Rating Scale – Revised Edition*. New York: Teachers College Press.
- Harms, T., Cryer, D., & Clifford, R. (2003). *Infant Toddler Environment Rating Scale – Revised Edition*. New York: Teachers College Press.
- Harms, T., Cryer, D., & Clifford, R. (2007). *Family Child Care Environment Rating Scale—Revised Edition*. New York: Teachers College Press.
- Howes, C., & Stewart, P. (1987). Child's play with adults, toys, and peers: An examination of family and child care influences. *Developmental Psychology, 23*(3), 423-430.
- LaFreniere, P.J. & Dumas, J.E. (1997). *Social competence and behavior evaluation in children ages 3 to 6 years: The short form (SCBE-30)*. *Psychological Assessment, 8*(4), 369-377.
- Layzer, J. I., Goodson, B. D., & Moss, M. (1993). *Observational Study of Early Childhood Programs, Final Report, Volume I: Life in Preschool*. Cambridge, MA: Abt Associates, Inc.
- Mullen, E. M. (1995). *Mullen Scales of Early Learning*. Circle Pines, MN: American Guidance Service, Inc.
- Osborne, S. S., Schulte, A. C., & McKinney, J. D. (1991). A longitudinal study of students with learning disabilities in mainstream and resource programs. *Exceptionality, 2*, 81-96.

Resnick, G., & Zill, N. (1999). *Is Head Start Providing High-Quality Education Services? "Unpacking" Classroom Processes*. Albuquerque, NM: Biennial Meeting of the Society for Research in Child Development, April 15-18.

Schaefer, E. S., Edgerton, M., & Aaronson, M. (1977). *Classroom Behavior Inventory*. Chapel Hill, NC: The Frank Porter Graham Child Development Center.

Zill, N., Resnick, G., Kim, K., McKey, R. H., Clark, C., Pai-Samant, S., Connell, D., Vaden-Kiernan, M., O'Brien, R., & D'Elio, M. A. (2001). *Head Start FACES: Longitudinal Findings on Program Performance. Third Progress Report*. Mclean, VA: Abt Associates, Inc.

APPENDIX A
Consent Forms

RESEARCH PARTICIPANT CONSENT FORM (Director or Family Child Care Home Owner)

Evaluation of Indiana Child Care Quality Rating System

Dr. Jim Elicker, Principal Investigator

Purdue University

Child Development and Family Studies

Purpose of Research

The purpose of this research is to evaluate the effectiveness of the statewide voluntary child care quality rating system, Paths to QUALITY (PTQ), implemented by the Child Care Bureau of the Indiana Family and Social Services Administration.

Specific Procedures to be Used

Researchers will randomly select a director or a family child care home owner from the list of providers enrolled in the PTQ system. We will contact you if you are selected. Once you agree to participate a member of the Purdue research team will schedule a visit(s) to your center or family child care home. Two center classrooms or your child care family will be selected and observed for about 4 hours by a Purdue research assistant for a confidential quality assessment.

During the child care quality observation, two children in each classroom or family child care home whose parents have returned consent forms will receive a child development assessment administered by the trained Purdue research assistant. These data will be released to and kept confidential by the Purdue University Evaluation Research Team. This child development assessment will be done in the classroom or family child care home or within sight and sound of the child care provider. It will involve the research assistant asking the child some simple questions such as counting two fingers or to pick up a toy or to do simple tasks such as identifying objects (e.g., bottle) or pictures of objects (e.g., dog).

Before or after the child care quality observation is completed, you will be contacted by a Purdue research assistant and asked to complete a survey questionnaire. This survey includes questions that ask about your experiences with the PTQ system. This survey should take you about 15 to 20 minutes to complete, and you may ask for assistance when the Purdue research assistant comes to your center or family child care home. You will be given an opportunity to ask questions regarding this evaluation research.

Finally, you will be contacted by phone by a Purdue research assistant again 6 months following first survey and visit. You will be asked similar questions about your understanding of the PTQ system. You will be given an opportunity to ask questions about the evaluation. All of the information gathered in these surveys and observations will be released to and kept confidential by Purdue University.

Duration of Participation

The duration of the participation of your center or family child care home will be approximately 4-5 hours, which includes having the Purdue research assistant observe your classroom or family child care home, administer two (in family child care homes) to four (in child care centers) child development assessments, and for you to complete the survey questionnaire. The observation of child care quality and the administration of child assessment will take approximately 4 hours.

Benefits to the Individual

There are no direct benefits to you or your center or family child care home. Your participation in this study may help Indiana understand the effectiveness of the PTQ system and may help find ways to improve the overall quality of child care in Indiana and in your community.

Compensation

Your center or family child care home will receive cash or a certificate worth \$25 for participating in this evaluation research. You will be asked to complete and sign the Participant Payment Disclosure Form upon the receipt of the payment. You will not be compensated for participating in the telephone interview six months after the visit.

Participant's initials_____
Date_____
Researcher's initials_____
Date**Risks to the Individual**

The risks to participating in this research study are minimal and are no more than you or the children would encounter in everyday life. There is small risk that you will be uncomfortable with the questionnaire or telephone interview questions. However, if at any time you are uncomfortable with any of the questions, you can either decline to answer a question or withdraw from the research without any coercion from the research assistant or Purdue staff. In addition, if the research

assistant believes that children are being abused or neglected while in the classroom, she is required to report such incidences to the proper authorities as mandated by Indiana law.

Confidentiality

All information collected in this research will be kept confidential. Only the Purdue research team will have access to the information gathered in your child care facility, and all identifying information will be removed so that participants cannot be identified. Interviews will not be tape-recorded. Detailed notes will be taken in the interviews and individual providers will be assigned number codes so that identifying information is removed from their interviews. The Principal Investigator will maintain all files identifying individual centers or family child care homes. These files will be stored in a locked filing cabinet in his office and will be maintained for a period of 3 years. The project's research records may be inspected by the Purdue University Institutional Review Board or its designees and by the funding source (e.g., the Child Care Bureau of the Indiana Family and Social Services Administration) to ensure that participants' rights are being protected.

Voluntary Nature of Participation

You do not have to participate in this research project. If you agree to participate you may withdraw your participation at any time without penalty.

Human Subject Statement:

If you have any questions about this research project, you can contact Dr. Jim Elicker, 765-494-2938. If you have concerns about the treatment of research participants, you can contact the Committee on the Use of Human Research Subjects at Purdue University, 610 Purdue Mall, Hovde Hall Room 307, West Lafayette, IN 47907-2040. The phone number for the Committee's secretary is (765) 494-5942. The email address is irb@purdue.edu.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Participant's Signature

Date

Participant's Name

Name of Child Care Program

Researcher's Signature

Date

RESEARCH PARTICIPANT CONSENT FORM (Parent/Child)

Evaluation of Indiana Child Care Quality Rating System

Dr. Jim Elicker, Principal Investigator

Purdue University

Child Development and Family Studies

Purpose of Research

The purpose of this research is to evaluate the effectiveness of the statewide voluntary child care quality rating system Paths to QUALITY (PTQ), implemented by the Child Care Bureau of the Indiana Family and Social Services Administration. Your child care provider has volunteered to participate in Paths to QUALITY and to be a part of this evaluation research by Purdue University.

Specific Procedures to be Used

As a participant in the research study, your child's classroom or child care will be observed for a period of about 4 hours by a Purdue research assistant for a confidential child care quality assessment.

If you agree to participate by returning the signed consent form to a Purdue research team, your child may be selected to receive a child development assessment.

During the child care quality observation, two children in each classroom or home whose parents have returned consent forms like this one will be selected, and they will receive a child development assessment administered by the trained Purdue research assistant. These data will be released to and kept confidential by the Purdue University Evaluation Research Team. This child development assessment will be done in your child's classroom or within sight and sound of your child's child care provider. The assessment will be done one-on-one with your child, when she/he feels comfortable with the research assistant. It will involve the research assistant asking your child some simple questions such as counting two fingers or to pick up a toy or to do simple tasks such as identifying objects (e.g., bottle) or pictures of objects (e.g., dog).

Shortly before or after the Purdue research assistant visits your child care program and works with your child, you will receive a call to do a phone survey with another Purdue research assistant. This phone interview will take about 15 minutes, and you will be asked about your experience and views of the Paths to QUALITY program. (You do not have to know anything about the PTQ program to participate!)

Duration of Participation

The duration of your child's participation in this research will be approximately 4 hours. Most of the time this will involve the research assistant observing normal activities going in your child's classroom or child care home. During much of this time your child will not be required to do anything except what he/she normally does in child care. This general observation of child care quality takes approximately 3 hours. The child development assessment, when the research assistant is working one-on-one with your child, will take less than 30 minutes.

Benefits to the Individual

There are no direct benefits to you or your child of participating in this research. Your participation and your child's participation in this study may help Indiana understand the effectiveness of the PTQ system and may help find ways to improve the overall quality of child care in Indiana and in your community.

Compensation

Your family will receive \$10 for participating in the study, upon completion of the child care visit and the parent interview.

Parent/Guardian's initials Date

Researcher's initials Date

Parent/Guardian's initials Date

Risks to the Individual

The risks to participating in this research study are minimal and are no more than your child would encounter in everyday life. There is a small risk that your child will be uncomfortable with the child development assessment. If at any time your child appears uncomfortable or expresses that he or she wants to stop, the research assistant will discontinue the assessment and return your child immediately to her/his child care provider. If observations or assessments are perceived to be disruptive to the child, the observation or assessment will be suspended. If the research assistant observes evidence that children have been or are being abused or neglected, she is required to report such evidence to the proper authorities as mandated by Indiana law.

Confidentiality

All information collected in this research will be kept confidential. Only the Purdue research team will have access to the information gathered, and all identifying information will be removed so that participants cannot be identified. The Principal Investigator will maintain all files identifying individual programs. These files will be stored in a locked filing cabinet in his office and will be maintained for a period of 3 years. The project's research records may be inspected by the Purdue University Institutional Review Board or its designees and by the funding source (e.g., the Child Care Bureau of the Indiana Family and Social Services Administration) to ensure that participants' rights are being protected.

Voluntary Nature of Participation

You and your child do not have to participate in this research project. Even when you give consent to participate and for your child to participate, you or your child may withdraw from participation at any time without penalty.

Human Subject Statement:

If you have any questions about this research project, you can contact Dr. Jim Elicker, 765-494-2938. If you have concerns about the treatment of research participants, you can contact the Committee on the Use of Human Research Subjects at Purdue University, 610 Purdue Mall, Hovde Hall Room 307, West Lafayette, IN 47907-2040. The phone number for the Committee's secretary is (765) 494-5942. The email address is irb@purdue.edu.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND I AGREE TO PARTICIPATE MYSELF, AND I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROJECT.

_____	_____
Parent/Guardian's Signature	Date
_____	_____
Parent/Guardian's Name (print)	Name of Child Care Program
_____	_____
Parent/Guardian's Signature	Date
_____	_____
Parent/Guardian's Name (print)	
_____	_____
My child's full name	My child's age (Years & Months)
_____	_____
Researcher's Signature	Date

PLEASE RETURN THIS CONSENT FORM TO THE MARKED ENVELOPE AT YOUR CHILD'S CHILD CARE CENTER OR HOME. THANK YOU!

RESEARCH PARTICIPANT CONSENT FORM (Teachers/Caregivers)

Evaluation of Indiana Child Care Quality Rating System

Dr. Jim Elicker, Principal Investigator

Purdue University

Child Development and Family Studies

Purpose of Research

The purpose of this research is to evaluate the effectiveness of a statewide voluntary child care quality rating system (PTQ), Paths to QUALITY (PTQ), implemented by the Child Care Bureau of the Indiana Family and Social Services Administration.

Specific Procedures to be Used

Researchers will randomly select a child care provider from providers enrolled in the PTQ system. Once you agree to participate, a Purdue research assistant will schedule a visit in two of the classrooms in your center or in your child care home and then come to observe for about 4 hours for a confidential quality assessment. This is to evaluate the Paths to QUALITY rating assessment. During the child care quality observation, two children in your classroom or home whose parents have returned consent forms will receive a child development assessment administered by the trained Purdue research assistant. These data will be released to and kept confidential by the Purdue University Evaluation Research Team. This child development assessment will be done in your classroom or within sight and sound of you or the director or family child care owner. It will involve the research assistant asking the child some simple questions or to do simple tasks.

Before or after the child care quality observation is completed, you will be contacted by a Purdue research assistant and asked to fill out a short survey form about your education and training, and answer some questions about the two selected children's development. All of the information collected will be kept in secure storage by the research team from Purdue University.

Duration of Participation

The duration of your participation will be approximately 4 hours, which includes having a research assistant from Purdue observe your classroom or child care home and completing the survey about the 2 children's development. The observation of child care quality will take approximately 4 hours. Completing the survey will take about 15 minutes per child (for a total of 30 minutes).

Benefits to the Individual

There are no direct benefits to you or your center or child care home. Your participation in this study may help Indiana understand the effectiveness of the PTQ system and may help find ways to improve the overall quality of child care in Indiana and in your community.

Compensation

Your center or child care home will receive cash or a certificate worth \$25 for participating in this evaluation research.

Risks to the Individual

The risks to participating in this research study are minimal and are no more than you would encounter in everyday life. If the research assistant believes that children are being abused or neglected while in the classroom or child care home, she is required to report such incidences to the proper authorities as mandated by Indiana law.

Participant's initials_____
Date_____
Researcher's initials_____
Date

Confidentiality

All information collected in this research will be kept completely confidential. Only the Purdue research team will have access to the data gathered, and all identifying information will be removed so that participants cannot be identified. The Principal Investigator will maintain all files identifying individual programs. These files will be stored in a locked filing cabinet in his office and will be maintained for a period of 3 years. The project's research records may be inspected by the Purdue University Institutional Review Board or its designees and by the funding source (e.g., the Child Care Bureau of the Indiana Family and Social Services Administration) to ensure that participants' rights are being protected.

Voluntary Nature of Participation

You do not have to participate in this research project. If you agree to participate you may withdraw your participation at any time without penalty.

Human Subject Statement:

If you have any questions about this research project, you can contact Dr. Jim Elicker, 765-494-2938. If you have concerns about the treatment of research participants, you can contact the Committee on the Use of Human Research Subjects at Purdue University, 610 Purdue Mall, Hovde Hall Room 307, West Lafayette, IN 47907-2040. The phone number for the Committee's secretary is (765) 494-5942. The email address is irb@purdue.edu.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

 Participant's Signature

 Date

 Participant's Name

 Name of Child Care Program

 Researcher's Signature

 Date

APPENDIX B
Letters to Participants



Invitation to Participate in Research (Director or Child Care Home Owner)

Dear Director (or Child Care Home Owner),

Your child care program has been selected to participate in the Purdue University evaluation of Paths to QUALITY, the state child care quality rating system. The purpose of this research is to evaluate the effectiveness of the Paths to QUALITY system, not to evaluate your program.

The evaluation process includes onsite visit(s) to your child care program (one visit if you are a family child care home owner or two visits if you are a child care center director). During the visit(s), we will ask you to answer some questions about your experience with the Paths to QUALITY program. We will also be observing and assessing some of the children in the program. During the visit(s), we will make every effort to limit interruption to your child care business. We expect each visit to last about 4 hours. This is an announced visit. This is *not* a rating visit. Your child care program will receive a \$25 gift certificate for your participation.

The enclosed consent forms provide additional information about your participation. One is for you to complete and return to us during our visit to your program and one is a copy for your reference. We will call you soon to make arrangements for you to take part in this evaluation. If you have questions, send email to Joellen Guenin at ptq@purdue.edu or phone her at [1-866-807-0810](tel:1-866-807-0810).

Thank you for participation in this important research!

Sincerely yours,

Jim Elicker, Ph.D., Associate Professor
Child Development & Family Studies
Purdue University





Invitation to Participate in Research (Parents)

Dear Parents,

We are inviting you and your child to participate in the Purdue University evaluation of Paths to QUALITY, the new Indiana child care quality rating system. The purpose of this research is to evaluate the effectiveness of the Paths to QUALITY program, not to provide an evaluation your child or your child care provider.

We hope you help us evaluate Paths to QUALITY by answering questions in a phone interview. We would also like to observe your child and check on some of her/his developmental skills at his/her child care. Two families in your child's class or family child care home will be randomly chosen to participate. If you and your child are chosen, you will receive a \$10 gift certificate for your participation.

The enclosed consent form provides additional information about your participation. If you are willing to participate, please fill out and sign the attached contact information and consent form and return them to the envelope at your child care provider's home or center. We have enclosed a copy of the consent for your reference. If you have any questions, email Joellen Guenin at ptq@purdue.edu or phone her at [1-866-807-0810](tel:1-866-807-0810).

Thank you for considering participation in this important research!

Sincerely,

Dr. Jim Elicker, Ph.D., Associate Professor
Child Development & Family Studies
Purdue University





Purdue University Paths To QUALITY Evaluation

Parent Contact Information

Please fill this out and return with the consent form in the envelope at your child care center or child care home.

Yes! My child and I will participate in this study.

Child Name: _____ Date of Birth: _____ Gender: Boy Girl
Month/year

Parent Name: _____ Email: _____

Phone Number 1 _____ Phone Number 2 _____

Preferred Time for us to call you: _____

Please Check Your Preferred Time for the 15 minute Parent Phone Interview (all that apply)

- Weekday → Morning Afternoon Evening
- Weekend → Morning Afternoon Evening

Comments: _____

Has your child been diagnosed as having a disability? Yes No

Do you speak English well enough to do a phone interview? Yes No

Does your child speak English? Yes No

Thank you very much for consideration.

(You and your child may or may not be randomly selected to participate!)



Invitation to Participate in Research (Teacher or Caregiver)

Dear Teacher or Caregiver,

We are inviting you to participate in the Purdue University evaluation of Paths to QUALITY, the state child care quality rating system. The purpose of this research is to evaluate the effectiveness of Paths to QUALITY, not to evaluate you, your child care program, or your children. Your center or family child care home has agreed to participate in this evaluation.

We will visit your classroom/family child care home and observe normal, everyday activities. We will also be selecting two children in your classroom whose parents have given permission to be assessed. During the visit, we will make every effort to limit interruption to the care of the children in your classroom or family child care home. We expect the visit to last about 4 hours. This is an announced visit that we will schedule with you and your director/family child care owner. We hope you will help us by completing a brief questionnaire about the two selected children's development and also answer some questions about your education and training.

If you are willing to participate, please fill out and return the enclosed consent form to the Purdue research assistant when she visits the center. There is also a copy of the consent form for you to keep. If you have questions, email to Joellen Guenin at ptq@purdue.edu or phone her at [1-866-807-0810](tel:1-866-807-0810).

Thank you for considering participation in this important research!

Sincerely,

Jim Elicker, Ph.D., Associate Professor
Child Development & Family Studies
Purdue University



APPENDIX C
Classroom Teacher/Lead Caregiver Survey

Classroom Teacher/Lead Caregiver Survey

1. What is the highest level of education you have completed so far? (Check only one:)

- Less than high school diploma
- High school diploma (or GED)
- Some college credits, but no degree
- Child Development Associate Credential
- Associate degree (2 yr.) (Major: _____)
- Bachelor degree (4 yr.) (Major: _____)
- Masters degree (Major: _____)
- Doctorate degree (Major: _____)

2. Do you belong to any early childhood professional organizations? (Check each organization, if you are a member:)

- IAEYC (Indiana Association for the Education of Young Children)
- NAEYC (National Association for the Education of Young Children)
- ACEI (Association for Childhood Education International)
- NAFCC (National Association for Family Child Care)
- CEC (Council for Exceptional Children)
- My local Community Child Care Provider Organization or Network
- Any other Professional Organization (Name of organization: _____)

3. How many early childhood conferences (one day or more) have you attended in the past two years? (Check only one:)

- None
- 1
- 2
- 3
- 4
- More than 4

4. Approximately how many total training hours have you completed during the past 12 months? (total contact hours in attendance at workshops, conferences, classes, etc.) (Check only one:)

- None
- Less than 12 hours
- 12 to 23 hours
- 24 to 50 hours
- 51 to 75 hours
- More than 75 hours

APPENDIX D
Parent Contact Information



Purdue University Paths To QUALITY Evaluation

Parent Contact Information

Please fill this out and return with the consent form in the envelope at your child care center or child care home.

Yes! My child and I will participate in this study.

Child Name: _____ Date of Birth: _____ Gender: Boy Girl
Month/year

Parent Name: _____ Email: _____

Phone Number 1 _____ Phone Number 2 _____

Preferred Time for us to call you: _____

Please Check Your Preferred Time for the 15 minute Parent Phone Interview (all that apply)

- Weekday → Morning Afternoon Evening
- Weekend → Morning Afternoon Evening

Comments: _____

Has your child been diagnosed as having a disability? Yes No

Do you speak English well enough to do a phone interview? Yes No

Does your child speak English? Yes No

Thank you very much for consideration.

(You and your child may or may not be randomly selected to participate!)

APPENDIX E
Initial Survey with Child Care Providers

ID #: _____**Initial survey with child care providers**

Dear Child Care Provider,

Thank you for helping Purdue University evaluate the Paths to QUALITY program. All of your answers to this questionnaire will be completely confidential—not shared with anyone except those on the Purdue research team. Please be as complete and as honest as you can with your answers to this survey. We appreciate your time and effort in sharing your experience with Paths to QUALITY!

1. What was the approximate date you first enrolled in Paths to QUALITY, the new state child care quality rating system? (For those in the Evansville or Fort Wayne areas, this is not the original local Paths to QUALITY, but the new program run out of Indianapolis.)

 Month Date Year

2. Since you first enrolled in Paths to QUALITY, has someone come out to visit and give you a Paths to QUALITY rating?

YES

NO

3. If YES, what was the approximate date you received this rating?

 Month Date Year

4. What is your current Paths to Quality level? (check only one)

1

2

3

4

5. If your PTQ level has changed since you were first rated, what was the approximate date of your most recent rating?

 Month Date Year

6. At what level do you expect to be when you have your next yearly Paths to QUALITY assessment visit? (check only one)

- 1
- 2
- 3
- 4

7. How did you learn about Paths to QUALITY? (check ALL that apply)

- From my local child care resource and referral (CCR&R) agency

Name of my CCR&R program: _____

- From my child care licensing consultant
- From my child care food program (CCFP) sponsor
- From another child care provider
- Radio advertisement
- TV advertisement
- From a parent of one of my child care children.
- Other. Please specify: _____

8. Why did you decide to join the Paths to QUALITY program? (check ALL that apply):

- The gifts and cash incentives that were offered for PTQ participation.
- I wanted to improve the quality of my child care program.
- I wanted new ideas for my child care program.
- I wanted the training or technical assistance that Paths to QUALITY offered.
- I wanted to make my child care more attractive to parents.
- I wanted to increase my business.
- I wanted more professional recognition.
- Other. Please specify: _____

9. Have you read the Paths to QUALITY levels and standards? (check only one!)

- No, I have not read Paths to QUALITY levels and standards for my type of care.
- Yes, I have read some but not all of the Paths to QUALITY levels and standards for my type of care.
- Yes, I have read ALL of the Paths to QUALITY levels and standards for my type of care.

Rate the following statements from 1-5 (**circle one number for each item**)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
10. I understand the Paths to QUALITY levels and standards.	1	2	3	4	5
11. I understand the goals of the Paths to QUALITY program.	1	2	3	4	5
12. I clearly see the benefits of participating in Paths to QUALITY.	1	2	3	4	5
13. I feel that the benefits of participating in Paths to QUALITY outweigh the costs.	1	2	3	4	5
14. I have used to Paths to QUALITY standards to improve my classroom/ family home.	1	2	3	4	5

15. Do you feel your center/home was fairly assessed when your current Paths to QUALITY level was assigned? (check only one!)

- YES
- NO

Why or Why not? _____

16. Do you feel that your current Paths to QUALITY level rating (1, 2, 3, or 4) reflects the *true* level of quality of the child care you provide?

- YES
- NO

Why or Why not? _____

Answer the following questions, thinking about the staff or assistant(s) that currently work with you in your child care facility.

Check only one:

- I have at least one co-worker or assistant. (Continue with questions below.)**
- I have no staff or assistants. I work alone in my child care home. (Skip to Question # 20)**

17. In what ways have you shared information about Paths to QUALITY with your staff/assistant(s)?

Check ALL that apply.

- I have NOT shared any information about Paths to QUALITY with my staff/assistant(s).
- I have shared the actual written Paths to QUALITY standards for each level with my staff/assistant(s).
- I have shared a *summary* (or brief overview) of the Paths to QUALITY standards with my staff/assistant(s).
- I have shared brochures about Paths to QUALITY with my staff/assistant(s).
- I have shared written information I received from the Bureau of Child Care or my local resource and referral agency about how Paths to QUALITY benefits the *program* with my staff/assistant(s).
- I have shared my personal opinions about how Paths to QUALITY benefits the *program* with my staff/assistant(s).
- I have shared written information I received from the Bureau of Child Care or my local resource and referral agency about how Paths to QUALITY benefits the *children* in our care with my staff/assistant(s).
- I have shared my personal opinion about how Paths to QUALITY benefits the *children* in our care with my staff/assistant(s).
- I have talked with my staff/assistant(s) during a staff meeting about the Paths to QUALITY standards.
- I have talked with my staff/assistant(s) individually (not in a formal meeting) about the Paths to QUALITY standards
- I have shared information about Paths to QUALITY with my staff/assistant(s) in *other ways*.
Please specify: _____
- _____

18. Are your staff or assistants aware of the different Paths to QUALITY levels?

- YES
 NO

19. Do your staff or assistants know what is required for your child care center or home to advance to the next Paths to QUALITY level?

- YES
 NO

Answer each of the following questions, thinking about the parent(s) of the children you currently care for in your child care facility.

20. In what ways have you shared information about Paths to QUALITY with parent(s)? Check ALL that apply.

- I have NOT shared any information about Paths to QUALITY with parent (s).
- I have shared the actual written Paths to QUALITY written standards for each level with parent (s).
- I have shared a summary (or a brief overview) of the Paths to QUALITY standards with parent (s).
- I have shared brochures about Paths to QUALITY with parent (s).
- I have shared written information that I received from the Bureau of Child Care or my local resource and referral agency about how Paths to QUALITY benefits the *program* with parent (s).
- I have shared my personal opinion on how Paths to QUALITY benefits the *program* with parent(s).
- I have shared written information I received from the Bureau of Child Care or my local resource and referral agency about how Paths to QUALITY benefits the *children* in our care with parent(s).
- I have shared with parent(s) my personal opinion about how Paths to QUALITY benefits the *children*.
- I have shared a summary of the Paths to QUALITY standards in a newsletter with parent(s).
- I have shared information about Paths to QUALITY with parent(s) in other ways.
Please specify:

21. Have you received any type of assistance (mentoring, phone or onsite consultation, training, etc.) from your local child care resource and referral agency while you have been enrolled in Paths to QUALITY?

- YES

NO

22. If yes, how many contacts (meetings, visits, or phone consultations) have you had with your local resource and referral agency?

___ (Number of contacts)

23. Check the resources listed below that you **have used** so far to help you improve or maintain your child care quality, so that you can either progress to the next Paths to QUALITY level, or maintain your current level. (Check all that apply)

- Mentoring
- Training provided in my child care center or home
- Training session(s) I attended at the local child care resource and referral agency or in my community
- Consulting in person or by phone from the local child care resource and referral agency's *Infant/Toddler Specialist*
- Consulting in person or by phone from the local child care resource and referral agency's *Inclusion Specialist*
- Attended a local child care conference
- Joined a local accreditation work group
- Used the Lending Library
- Received a Scholarship for conference
- Talked with an IAIEYC accreditation advisor
- I have used other kinds of resources or assistance (Please specify:)

24. Have you received assistance from the Indiana Association for the Education of Young Children (IAEYC) while you have been enrolled in Paths to QUALITY?

- YES
- NO

25. If yes, how many contacts (visits or phone consultations) have you had with IAIEYC?

___ (Number of contact)

26. Are there other organizations you have received assistance from to help you improve your child care quality, while you have been enrolled in Paths to QUALITY?

- YES

NO

If YES, please specify the organization:

27. If yes, how many contacts (visits or phone consultations) have you had with the organization?

___ (Number of contacts)

28. Do you feel that participating in PTQ has made a difference in your child care business?

YES

NO

If yes, describe how has it made a difference: _____

If no, why not?

29. When you examine your child care rates (parent fees) for the next year, do you think those rates will increase?

YES

NO

We do not have child care rates (child care is free).

30. If YES, why? (Check all that apply)

Rates increased to offset my costs of participating in Paths to QUALITY

Rates increased as part of a standard of living increase, to increase wages for myself, staff, or assistants.

Because I am a Paths to QUALITY participant, I feel I can now charge more for child care.

Other reason(s) you have increased your child care rates? Please specify:

31. Have parents asked about your Paths to QUALITY rating?

YES

NO

32. In your opinion, what has been the *biggest obstacle* you face in moving up to the next Paths to QUALITY level?

33. How do you expect you can overcome that obstacle?

34. What aspect of Paths to QUALITY has been most beneficial to you? (Check only one!)

- The gifts and cash incentives I get from the program
 - The mentoring services I have received from my local child care resource and referral agency
 - The training provided through the program
 - The recognition I get from parents, other providers, or the public that I am providing high quality child care
 - Paths to QUALITY participation provides me with a marketing tool for my child care program
 - Other most beneficial aspect. (Please specify:)
-

35. What percentage of the children in your care have their child care paid for by federal/state child care subsidies or vouchers (CCDF)?

___ (Approximate % of children who are paid for by vouchers)

For REGISTERED MINISTRIES ONLY. If you are not the director of a registered ministry skip to question # 40.

36. Are you *in the process* of seeking a child care center license at this time?

- YES
- NO

37. Are you *considering* seeking a child care center license at this time?

YES

NO

38. In your opinion, what has been the biggest obstacle you faced in getting your voluntary certifications for the PTQ program?

39. How did overcome that obstacle?

Please answer a few more questions about yourself and your experience as a child care provider. (Information you share will be kept *completely confidential!*)

40. What is the highest level of education you have completed so far? (Check only one:)

- Less than high school diploma
- High school diploma (or GED)
- Some college credits, but no degree
- Child Development Associate Credential
- Associate degree (2 yr.) (Major: _____)
- Bachelor degree (4 yr.) (Major: _____)
- Masters degree (Major: _____)
- Doctorate degree (Major: _____)

41. Do you belong to any early childhood professional organizations? (Check each organization, if you are a member:)

- IAEEYC (Indiana Association for the Education of Young Children)
- NAEYC (National Association for the Education of Young Children)
- ACEI (Association for Childhood Education International)
- NAFCC (National Association for Family Child Care)
- CEC (Council for Exceptional Children)
- My local Community Child Care Provider Organization or Provider Network
- Any other Professional Organization
(Name of organization: _____)

42. How many *early childhood conferences* (one day or more) have you attended in the past two years? (Check only one:)

- None
- 1
- 2
- 3
- 4
- More than 4

43. Approximately how many total training hours have you completed during the past 12 months?
(Total contact hours at workshops, conferences, classes, etc.) (Check only one:)

- None
- Less than 12 hours
- 12 to 23 hours
- 24 to 50 hours
- 51 to 75 hours
- More than 75 hours

THANK YOU! for taking the time to share this information with the Purdue University PTQ Evaluation Team. Your views and experiences will be included with many other providers to summarize providers experiences with PTQ. All information you provide to the Purdue Evaluation Team will be held strictly confidential.

Please return your completed questionnaire to the Purdue University Research Assistant who visits your child care center, ministry, or home.

OR return the questionnaire by mail to:

Dr. Jim Elicker
Child Development & Family Studies
Purdue University
1200 W. State St.
West Lafayette, Indiana 47907-2055
765-494-2966
ptq@purdue.edu

APPENDIX F
Follow-up Telephone Surveys with the Original Sample of PTQ Providers

Follow-up telephone surveys with the original sample of PTO providers

ID #: _____

PTQ Level at time of initial survey: _____

1. Is your child care program still participating on Paths to QUALITY?

1. YES
2. NO

If no, why?

2. What is your current Paths to Quality level?

1. 1
2. 2
3. 3
4. 4

3. If level has changed since you enrolled in PTQ, what was the date of the assessment?

Month	Date	Year
-------	------	------

If level status has changed since last interview asked the following questions:***If program advanced:***

4. In your opinion, what was the biggest challenge you faced in advancing to the next level?

5. How did you overcome that challenge?

If program has stayed the same

6. In your opinion, why has your level on Paths to QUALITY remained the same rather than increase or decreased?

7. In your opinion, what was the biggest challenge you face in advancing to the next level?

8. How do you plan to overcome that challenge?

If program has dropped a level:

9. In your opinion, why has your level on Paths to QUALITY changed?

10. What obstacles prevented your child care program from remaining on its previous Paths to QUALITY level?

For all providers:

11. What level do you expect to be at during your next yearly visit?

1. 1

- 2. 2
- 3. 3
- 4. 4

12. Have you received assistance from your local child care resource and referral agency **in the past 6 months**?

- 1. YES
- 2. NO

13. If yes, how many contacts (visits or phone consultations) have you had with your local resource and referral agency?

14. Thinking about the **past 6 months or since our last interview**, have you used the following resources to help you either progress to the next level or maintaining your current level in the

14a. Mentoring

- 1. YES
- 2. NO

14b. Training provided in my child care center or home

- 1. YES
- 2. NO

14c. Training session I attended at the local child care resource and referral agency or in my community

- 1. YES
- 2. NO

14d. Consulting in person or by phone from the local child care resource and referral agency's Infant/Toddler Specialist

- 1. YES
- 2. NO

14. Consulting in person or by phone from the local child care resource and referral agency's Inclusion Specialist

- 1. YES
- 2. NO

14f. Local child care conference

- 1. YES
- 2. NO

14g. Local Accreditation work group

- 1. YES
- 2. NO

14h. Lending Library

- 1. YES
- 2. NO

14i. Scholarships for conference

- 1. YES
- 2. NO

14j. IAIEYC accreditation advisor

- 1. YES
- 2. NO

14k. I have used other kinds of resources or assistance

- 1. YES

2. NO, please specify:

15. Have you received assistance from IAEYC **in the past 6 months**?

1. YES
2. NO

16. If yes, how many contacts (visits or phone consultations) have you had with IAEYC **in the past 6 months**?

17. Are there other organizations you have received assistance from **in the past 6 months**?

1. YES
2. NO

If yes, please specify the organization:

18. If yes, how many contacts (visits or phone consultations) have you had with the organization **in the past 6 months**?

19. Have parents asked about your PTQ rating **in the past 6 months**?

1. YES
2. NO

20. Have you increased your child care rates **in the past 6 months**?

1. YES---CONTINUE with QUESTION 21
2. NO—END INTERVIEW

21. Did you increase your child care rates in the past 6 months to offset your costs of participating in Paths to QUALITY?

1. YES
2. NO

22. Did you increase your child care rates in the past 6 months as part of a standard of living increase, to increase wages for yourself, staff, or assistants.

1. YES
2. NO

23. Did you increase your child care rates in the past 6 months because you are a Paths to QUALITY participant, feel you can now charge more for child care.

1. YES
2. NO

24. Are there other reasons you increased your child care rates in the past 6 months?

1. YES
2. NO

If yes, tell me why?

That's it. We are done! Thank you very much for talking with me and for giving your views on child care and Paths to QUALITY!

APPENDIX G
Telephone Survey with Parents who have Children in
PTQ Classrooms/Family Child Care Homes

**Telephone Survey with parents who have children in
PTQ classrooms/family child care homes**

This survey is to be completed by the parent or guardian of (Child's Name), who attends child care with (Provider's Name.)

Hi, my name is _____ and I am a research assistant from Purdue University. Your child's day care provider is participating in Paths to QUALITY, a new Indiana program designed to improve the quality of care and education for young children. To help Purdue evaluate Paths to QUALITY, will you please take about 20 minutes on the phone with me to answer some questions?

All of your answers to these questions will be completely confidential. Your name will not be shared with anyone. Your answers to these questions will not be shared with your child care provider or anyone else.

Please answer each question as honestly and completely as you can. Thank you for taking the time to answer these questions!

(Confirm the child's name, age, and child care provider.)

Just to confirm, your child's name is: _____

And she/he is (#) years old?

And the name of the center or home he/she attends is?

Additional Introductory Questions

Now we would like to ask you about the average number of hours per week NAME of CHILD is in child care outside of the home.

1. About how many hours each week (on average) does NAME OF CHILD OBSERVED attend NAME OF CHILD CARE FACILITY?
2. Do you use any other child care or babysitting outside of your home, other than NAME OF CHILD CARE FACILITY for NAME OF CHILD OBSERVED on a regular weekly basis?
 1. Yes
 2. No
88. Don't know
99. Refused

IF YES ASK FOLLOWING QUESTIONS:

- 2a. Is the OTHER out of home child care you use for (Child's Name) provided by . . .
 1. A Licensed Child Care Center
 2. A Licensed Family Day Care Home
 3. A church affiliated registered Ministry
 4. With a relative in her/his home

- 5. With a friend in his/her home
- 6. Early Head Start or Head Start Center
- 7. Other (please specify)
- 88. Don't know
- 99. Refused

2b. How many hours a week does NAME OF CHILD OBSERVED attend this NAME OF SECOND CHILD CARE FACILITY?

- 3. Do you receive any help paying for your child care from the government? For example, do you receive child care vouchers or subsidies from the government to help pay for child care?
 - 1. Yes
 - 2. No
 - 88. Don't know
 - 99. Refused

Now we would like to ask you some questions about your NAME of FIRST CHILD CARE PROVIDER.

- 4. Is your child care provider licensed by the State of Indiana?
 - 1. Yes
 - 2. No
 - 88. Don't know
 - 99. Refused

If a parent asks: What does “licensed” mean?

Respond: Centers and homes are required by the state to be licensed, to show they meet basic health and safety needs.

- 5. Is your child care provider accredited by a Professional Organization?
 - 1. Yes
 - 2. No
 - 88. Don't know
 - 99. Refused

If a parent asks: What does “accredited” mean?

Respond: Accreditation is a voluntary system that certifies child care quality at a higher level than licensing.

- 6. Were you aware that your child care provider is enrolled in the Indiana Paths to Quality program?
 - 1. Yes
 - 2. No—IF NO SKIP TO QUESTION 10
 - 88. Don't know
 - 99. Refused

7. Did your child care provider share verbal information about Paths to Quality with you, such as talking with you individually or with other parents about Paths to QUALITY?

1. Yes
2. No

-77. DID NOT ASK

88. Don't know

99. Refused

8. Did your child care provider share written information about Paths to Quality with you?

1. YES
2. NO

-77. DID NOT ASK

88. Don't know

99. Refused

10. What is the current Paths to QUALITY level that your provider has earned?

1. Level 1
2. Level 2
3. Level 3
4. Level 4

88. Don't know

99. Refused

11. What was your main reason for choosing this particular child care provider for your child? Listen carefully and then tell me which of the following things was the one most important factor in your choice of a child care provider for NAME OF CHILD OBSERVED.

1. Cost/affordability
2. Child care provider accepts vouchers
3. Child care is close to home
4. Child care is close to your or spouse's work
5. Flexible hours child care provider is open.
6. Your trust/comfort level with provider
7. Educational activities provided
8. Warmth of child care provider toward my child
9. Keeping your child with his/her brother or sister
10. Amount of experience caring for children of the child care provider
11. Amount of education of the child care provider
12. The overall quality of care the child care center or home provides
13. Paths to QUALITY rating
14. The provider was recommended by friend
15. Church affiliation
16. Other (please specify)

88. Don't know

99. Refused

12. What was the second most important reason for choosing your child care provider(s)?
(Take out the one already mentioned when you read the list.)

1. Cost/affordability
2. Child care provider accepts vouchers
3. Child care is close to home
4. Child care is close to your or spouse's work
5. Flexible hours child care provider is open.
6. Your trust/comfort level with provider
7. Educational activities provided
8. Warmth of child care provider toward my child
9. Keeping your child with his/her brother or sister
10. Amount of experience caring for children of the child care provider
11. Amount of education of the child care provider
12. The overall quality of care the child care center or home provides
13. Paths to QUALITY rating
14. The provider was recommended by friend
15. Church affiliation
16. Other (please specify)
88. Don't know
99. Refused

13. If cost was not an issue for you, if all child care was affordable for you, what would be the most important thing you would look for in child care?

3. Child care is close to home
4. Child care is close to your or spouse's work
5. Flexible hours child care provider is open.
6. Your trust/comfort level with provider
7. Educational activities provided
8. Warmth of child care provider toward my child
9. Keeping your child with his/her brother or sister
10. Amount of experience of the child care provider
11. Amount of education of the child care provider
12. The overall quality of care the child care center or home provides
13. Paths to QUALITY rating
14. Recommended by friend
15. Church affiliation
16. Other (please specify)

88. Don't know
99. Refused

Paths to Quality is a program that some child care providers in your county participate in. There are 4 levels in Paths to Quality (from 1 to 4). Providers with higher level have met requirements for what research tells us is high quality child care.

14. Would you be willing to pay more for child care, if the provider had a higher level of Path to Quality?

1. Yes
2. No
3. Maybe

88. Don't know
99. Refused

15. In the future, if you choose to put your child in a different child care, and the provider is in Paths to QUALITY, would a higher level (1 - 4) influence your decision about whether to put your child there?

1. Yes
2. No

88. Don't know
99. Refused

16. On a scale of 1 to 5 with 5 being very important and 1 being not at all important, how important would a higher level of Paths to Quality be in your decision in choosing a child care provider?

(READ EACH OPTION BELOW)

1. Not at all important
2. Not important
3. Neither important nor unimportant
4. Important
5. Very important

88. Don't know
99. Refused

Finally, I have a few more questions to ask you about yourself. These are completely confidential, and I am asking them just so we can give a general description of all the parents who completed this survey.

17. What is your current marital status?

1. Married
2. Not married and living with partner or significant other
3. Single-never married
4. Divorced
5. Separated
6. Widowed

88. Don't know
99. Refused

18. What is the highest level of schooling you have completed?

1. Less than 9th grade
2. 9th to 12th grade (but did not graduate)
3. High school diploma or GED
4. High school plus some college credits (but no degree)
5. Associate degree (2 years)
6. Four-year college graduate (bachelors degree)
7. Graduate or professional degree (beyond the bachelors degree)

88. Don't know
99. Refused

19. Which one of the following racial or ethnic groups do you most closely identify with?

1. Caucasian or white American
2. African/Black American
3. Native American
4. Hispanic American
5. Asian American/Pacific Islander
6. Bi-racial or multi-racial
7. Other Specify: _____

88. Don't know
99. Refused

20. How would you describe where you currently live?

Would you say it is . . .

1. In a large city
2. in a small city or town
3. In the suburbs or outskirts of a large city
4. In a country village
5. A farm or home in the country
6. Other (please specify)

88. Don't know
99. Refused

21. Please stop me when I reach the category that best describes your total household income in 2007 from all wages, salary, investments, and interest before taxes. Would you say that it is . . .

1. Less than \$15,000 per year
2. \$15,000 to under \$25,000
3. \$25,000 to under \$35,000
4. \$35,000 to under \$50,000
5. \$50,000 to under \$75,000
6. \$75,000 to under \$100,000
7. More than \$100,000

88. Don't know

99. Refused

That's it. We are done! Thank you very much for talking with me and for giving your views on child care and Paths to QUALITY! If you have not already received your \$10 thank you gift from the director of NAME OF CHILD CARE FACILITY, please request it from him/her.

APPENDIX H

Telephone Survey with Parents of Children in the General Public

Telephone survey with parents of children in the general public (random sample)**Q: intro1**

Hello, my name is _____. I am a research assistant for the Social Research Institute at Purdue University in West Lafayette, Indiana. We are conducting a survey as part of an ongoing study of Paths to Quality, a child care rating system recently launched by the state in your area. Your phone number was selected at random and I will not ask you for your name or any other information that can be used to identify you. You may also refuse to answer any question you wish by just saying so. The survey takes about 10 minutes to complete. Do you have time now to answer some questions?

1. Yes
2. No (ASK IF ANOTHER TIME WOULD BE MORE APPROPRIATE. KEY 2.)

Q:adult

Thank you.

Our survey requires that I speak to adults that are 18 years of age or older. Are you at least 18 years of age?

1. Yes
2. No

Q: Intro2

Is there someone 18 or older at home I can speak to?

1. Yes
2. No

Q: intro3

Hello, my name is _____. I am a research assistant for the Social Research Institute at Purdue University in West Lafayette, Indiana. We are conducting a survey as part of an ongoing study of Paths to Quality, a child care rating system recently launched by the state in your area. Your phone number was selected at random and I will not ask you for your name or any other information that can be used to identify you. You may also refuse to answer any question you wish by just saying so. The survey takes about 10 minutes to complete. Do you have time now to answer some questions?

1. Yes
2. No (ASK IF ANOTHER TIME WOULD BE MORE APPROPRIATE. KEY 2.)

Q: Six

Thank you for taking time to answer our questions! Here is the first one . . .

Currently, do you have children in your household under the age of six that have been taken care of by other people while their parents are at work?

1. Yes
2. No

8. Don't know
9. Refused

Q: county

In which counties do you reside?

- 1=Allen
- 2=De Kalb
- 3=La Grange
- 4=Noble
- 5=Steuben
- 6=Whitley
- 7=Daviess
- 8=Dubois
- 9=Gibson
- 10=Knox
- 11=Martin
- 12=Perry
- 13=Pike
- 14=Posey
- 15=Spencer
- 16=Vanderburg
- 17=Warrick

- 18=Don't know

Q:age1

How old is the first child under age six receiving this care?

Q: hours1

Now we would like to ask you about the average number of hours per week your children are in child care outside of the home, starting with your first child.

For this child under age six, how many hours?

Q:care1a

For this child, is the out of home child care provided by . . .
(READ ENTIRE LIST)

1. A Licensed Child Care Center
2. A Licensed Family Day Care Home
3. A church affiliated registered Ministry
4. With a relative in their home
5. With a friend in their home
6. Early Head Start or Head Start Center
7. Other (please specify)

8. Don't know
9. Refused

Q: child2

Do you have a second child under age six receiving child care outside of the home?

1. Yes
2. No

8. Don't know
9. Refused

Q:age2

How old is the second child?

Q: hours2

For your second child, how many hours?

Q:care1b

For this child, is the out of home child care provided by . . .
(READ ENTIRE LIST IF NECESSARY)

1. A Licensed Child Care Center
2. A Licensed Family Day Care Home
3. A church affiliated registered Ministry
4. With a relative in their home
5. With a friend in their home
6. Early Head Start or Head Start Center
7. Other (please specify)

8. Don't know
9. Refused

Q: child2a

Do you have a third child under age six receiving child care outside of the home?

1. Yes
2. No

8. Don't know
9. Refused

Q:age3

How old is the third child?

Q: hours3

For your third child, how many hours?

Q:care1c

For this child, is the out of home child care provided by . . .
(READ ENTIRE LIST IF NECESSARY)

1. A Licensed Child Care Center
2. A Licensed Family Day Care Home
3. A church affiliated registered Ministry
4. With a relative in their home
5. With a friend in their home
6. Early Head Start or Head Start Center

7. Other (please specify)

- 8. Don't know
- 9. Refused

Q: payhelp

Do you receive any help paying for your child care from the government? For example, do you received child care vouchers or subsidies from the government to help pay for child care?

- 1. Yes
- 2. No
- 8. Don't know
- 9. Refused

Q: reason1

Now we would like to get your thoughts on how you chose your child care provider(s). For each of the following items, please tell us how important each item was in choosing your childcare provider by indicating whether it is very important, important, neither important nor unimportant, unimportant, or not at all important.

Here's the first one . . .

Cost.

- 1. Very important
- 2. Important
- 3. Neither important nor unimportant
- 4. Unimportant
- 5. Not at all important
- 8. Don't know
- 9. Decline to answer

Q: reason2

Child care provider accepts vouchers.

- 1. Very important
- 2. Important
- 3. Neither important nor unimportant

4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason3

Child care provider is close to home.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason4

Child care provider is close to your work.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason5

Child care provider is close to my spouse's/partner's work.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important
6. Not married nor partnered

8. Don't know
9. Decline to answer

Q: reason6

Child care provider has flexible hours that they're open.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason7

My level of trust with the child care provider.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason8

My level of comfort with the child care provider.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason9

Educational activities provided by the child care provider.

1. Very important
2. Important
3. Neither important nor unimportant

4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason10

Warmth of the child care provider toward my child.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason11

Keeping my child with a sibling.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason12

The experience level of the child care provider in caring for children.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason13

The amount of education of the child care provider.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason14

The overall quality of care provided by the child care center or home.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason15

The child care providers Paths to Quality rating.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason16

The provider was recommended by a friend.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason17

The provider was recommended by a family member.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason18

The church affiliation of the child care provider.

1. Very important
2. Important
3. Neither important nor unimportant
4. Unimportant
5. Not at all important

8. Don't know
9. Decline to answer

Q: reason19

Were there other reasons involved in the decision?

1. Yes
2. No

8. Don't know
9. Decline to answer

Q: reason20

What were the other reasons?

Q:license

Is your child care provider licensed by the state of Indiana?

1. Yes
2. No

- 8. Don't know
- 9. Refused

Q:accred

Is your child care provider accredited by a Professional Organization?

- 1. Yes
- 2. No

- 8. Don't know
- 9. Refused

Q:paths

Is your child care provider enrolled in the Indiana Paths to Quality program?

- 1. Yes
- 2. No

- 8. Don't know
- 9. Refused

Q:paths1

Did your child care provider share information with you verbally about Paths to Quality, such as talking with you individually or with other parents about Paths to Quality?

- 1. Yes
- 2. No

- 8. Don't know
- 9. Refused

Q:paths2

Did your child care provider share written information about Paths to Quality with you?

- 1. Yes
- 2. No

- 8. Don't know
- 9. Refused

Q:paths3

There are four quality levels in Paths to Quality. Are you aware of the child care provider's current Paths to QUALITY level?

1. Yes
2. No

8. Don't know
9. Refused

Q:paths4

What is the current Paths to QUALITY level that Your provider has earned?

1. Level 1
2. Level 2
3. Level 3
4. Level 4

8. Don't know
9. Refused

Q:qual

Paths to Quality is a program that some child care providers in your county participate in. There are 4 levels in the Paths to Quality. Providers with higher level have met requirements consistent with what research tells is high quality child care. On a scale of 1 to 5, with 5 being very important and 1 being not at all important, how important would a higher level of Paths to Quality be in your decision in choosing a child care provider?

1. Not at all important
2. Not Important
3. Neither important nor unimportant
4. Important
5. Very Important

8. Don't know
9. Decline to answer

Q:qual1

Would you be willing to pay more for child care, if
The provider had a higher level of Path to Quality?

1. Yes
2. No

8. Don't know
9. Refused

Q: qual2

In the future, if you choose to put your child in a different
child care than the one you use now, and the provider is in
Paths to Quality, would a Paths to Quality higher level
(1 to 4) influence your decision about whether to put your
child there?

1. Yes
2. No

8. Don't know
9. Refused

Q:qual3

On a scale of 1 to 5 with 5 being very important and 1 being not
at all important, how important would a higher level of Paths
to Quality be in choosing a child care provider in the future?

1. Not at all important
2. Not Important
3. Neither important nor unimportant
4. Important
5. Very Important

8. Don't know
9. Decline to answer

Q: demog1

Finally, I have a few more questions to ask you about
yourself. These are completely confidential, and I am
asking them just so we can give a general description of
all the parents who completed this survey.

What is your current marital status?

1. Married
2. Not married and living with partner/significant other
3. Single-never married
4. Divorced
5. Separated
6. Widowed

8. Don't know
9. Refused

Q: educ

What is the highest level of schooling you have completed?

1. Less than 9th grade
2. 9th to 12th grade (did not graduate)
3. High school diploma or GED
4. High school plus some college (no degree)
5. Associate's degree (2 years)
6. Four-year college graduate (bachelor's degree)
7. Graduate or professional degree (beyond the bachelor's degree)

8. Don't know
9. Refused

Q: race

Which racial or ethnic group do you most closely identify with?

1. Caucasian or white American
2. African/Black American
3. Native American
4. Hispanic American
5. Asian American/Pacific Islander
6. Bi-racial or multi-racial
7. Other [BOX OPENS]

8. Don't know
9. Refused

Q: live

How would you describe where you currently live?
Would you say it is . . .

1. In a large city
2. In a small city or town
3. In a suburbs or outskirts of a large city
4. In a county village
5. A farm or home in the country

6. Other (please specify)

- 8. Don't know
- 9. Refused.

Q: income

Please stop me when I reach the category that best describes your total household income from wages, salary, and interests before taxes, in 2007. Would you say that it is . . .

- 1. Less than \$15,000 per year
- 2. \$15,000 to under \$25,000
- 3. \$25,000 to under \$35,000
- 4. \$35,000 to under \$50,000
- 5. \$50,000 to under \$75,000
- 6. \$75,000 to under \$100,000
- 7. More than \$100,000

- 8. Don't know
- 9. Refused

Q: end

That's it. We are done! Thank you very much for talking With me and for giving your views on child care and Paths To Quality.

(PRESS ANY KEY TO GET TO THE DISPOSITION BOX.)

Q: sex

What is the respondent's sex?

- 1. Female
- 2. Male
- 3. not sure

Q:end1

Thank them and hang up.
(hit any key)

**Evaluation of “Paths to QUALITY,” Indiana’s
Child Care Quality Rating and Improvement System:
Final Report
(Technical Report #3)**

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ENDNOTES

APPENDIX A: DESCRIPTION OF MEASURES

APPENDIX B: DESCRIPTION OF ENVIRONMENT RATING SCALES, CIS AND MEAN SCORES

APPENDIX C: DESCRIPTION OF MEASURES

Evaluation of Paths to QUALITY: Indiana's Child Care Quality Rating and Improvement System

What is Paths to QUALITY?

Paths to QUALITY (PTQ) is Indiana's new statewide child care quality rating and improvement system. Launched in January 2008 in a phased roll-out in four main state regions over the course of two years, PTQ aims to improve the quality of child care available to Indiana's young children and families, provide information to help parents select high quality care, and support child care providers in their efforts to provide the best possible care and education for children. According to the Indiana PTQ web site¹, the long-term goals are:

- Education of parents on the need for quality early education and child care and how to identify and select developmentally appropriate experiences that will help children as they enter school.
- Advocacy and public awareness within the community that promotes quality child care standards, child care worker education and its impact on business and economic development
- Development of well-trained qualified child care and early education staff through child care professional training and mentoring.
- Availability of high quality, affordable child care and appropriate early education experiences for families and children at all socio-economic levels.
- Collaboration with other community organizations as well as private businesses and foundations to develop solutions to ensure that all of our community's children will have opportunities to develop to their fullest potential.

As this report was written, 26 states in the United States had implemented some form of child care quality rating and improvement system (QRIS). Virtually all of the other states and territories had a QRIS in the planning or pilot phases. However, Indiana was among the first in the nation to launch a statewide QRIS program. Indiana's QRIS is unique because it began as a community-based quality improvement effort in one community—Fort Wayne, Indiana. PTQ was created in 1999 by a diverse community group concerned with the education and welfare of young children and families, the Early Childhood Alliance. In 2000, PTQ was successfully implemented in Allen County surrounding Fort Wayne. The following year, PTQ was launched in the five surrounding counties of DeKalb, Whitley, Steuben, Noble, and LaGrange. Between 2005 and 2007, PTQ was successfully replicated by another community group in the southwestern region of the state around Evansville.² In 2007, state leaders made the decision to develop PTQ as a statewide child care quality improvement program, and the statewide planning and implementation process began.

Indiana's Paths to QUALITY, like most other QRIS programs across the nation, includes five basic components to achieve its goals³:

1. **Quality standards:** PTQ has evidence-based child care quality standards at four levels, ranging from Level 1 (basic quality; licensing) to Level 4 (highest quality; national accreditation).
2. **A quality rating system:** PTQ has trained raters who assign the appropriate PTQ level, based on the standards each provider has attained.
3. **Incentives for advancement:** Child care providers receive rewards in cash or materials, as well as public recognition for achieving higher levels in the system.
4. **Information for parents:** PTQ provides accessible information about what child care quality is, which child care providers are participating in PTQ, and the providers' current PTQ quality level.
5. **Educational opportunities and other supports for child care providers:** PTQ offers educational opportunities and mentoring for providers who wish to enter the system and advance their PTQ level.

Evaluation of Paths to QUALITY by Purdue University

In 2007 Purdue University was contracted by the Indiana Family & Social Services Administration, Bureau of Child Care, to evaluate the implementation phase of Indiana's Paths to QUALITY child care initiative. This evaluation study, with data collection completed between July 2008 and September 2011 included all eleven Child Care Resource and Referral Service Delivery Areas (SDAs) in Indiana. The overall goals of the evaluation research were to validate the quality rating system and describe the experiences of child care providers, parents, and children with this new program as it was implemented. During the course of the research, Purdue provided program leaders with periodic reports that described aspects of PTQ implementation in each SDA region, so that they could better monitor the acceptance and impact of PTQ and make program adjustments as needed.

This final report reflects the early Paths to QUALITY experiences of a wide range of Indiana citizens working in or using regulated child care. The report summarizes the evaluation findings for Paths to QUALITY from all eleven SDA regions, which include all 92 counties in the state of Indiana. To accurately describe the workings of PTQ, the Purdue University research team randomly selected providers, parents, and children from all regions to participate in the evaluation study.

The final evaluation sample comprised a total of 276 child care providers: 95 licensed child care centers (including 135 classrooms assessed); 169 licensed family child care homes; and 12 unlicensed registered child care ministries (including 14 classrooms assessed). Within these selected child care providers, the research team interviewed or assessed 270 child care teachers/providers, and 557 children and their parents.

The evaluation questions addressed by the Purdue research team were:

For the PTQ Quality Rating and Improvement System--

- When providers attain higher PTQ levels, does this result in higher quality care for children?

For child care providers in PTQ--

- Are child care providers entering the PTQ system?
- What are the incentives and the challenges for providers?
- Are providers using available training/technical assistance (T/TA) resources?
- Are providers advancing to higher PTQ levels?

For parents using PTQ and parents in the general public--

- Are parents aware of PTQ?
- Will PTQ affect their parents' child care decisions?

For children in PTQ--

- Are children and families at all education and income levels gaining access to child care at the highest PTQ levels?
- Are children in higher PTQ levels developing more optimally than children in lower PTQ levels?

The Purdue team used a variety of research methods to address these questions, including face-to-face and telephone interviews with child care providers and parents, extensive assessments in each center or home by trained observers to assess quality; and observations, surveys, and standardized tests to assess children's development.⁴ The research team sent a trained observer to each of the selected centers, homes, and child care ministries, and the observer spent approximately 4 hours completing the assessments in each child care room or family child care home. (Table 1A. in the Appendix A provides an overview of measures used in the evaluation.)

The report is presented in five sections:

1. Do Paths to QUALITY Ratings Ensure Higher Quality? (p. 8)
2. What are the Experiences of Child Care Providers in Paths to QUALITY? (p. 15)
3. How do Parents View Paths to QUALITY? (p. 25)
4. How Are Children Doing in Paths to QUALITY? (p. 30)
5. Conclusions & Recommendations (p. 34)

Do Paths to QUALITY Ratings Ensure Higher Quality?

Assessment of Child Care Quality

An important question for the new PTQ system is whether the rated PTQ quality levels are a valid measure of child care quality for child care centers and family child care homes. The Purdue University research team conducted a rigorous validity check of PTQ-rated quality by doing independent quality assessments using research-tested measures. If the PTQ ratings and these quality measures are positively correlated, stakeholders can feel confident the PTQ ratings are meaningful and distinguish real differences in child care quality.

Two measures, the Caregiver Interaction Scale (CIS) and the University of North Carolina environment rating scales (ERS) were used to objectively rate quality levels of PTQ-rated providers.

The ERS group of child care quality scales was chosen to provide objective assessments of quality levels in the sampled PTQ providers. The ERS was chosen because at the time of the launch of the PTQ evaluation, it was the only measure that could objectively assess quality in infant/toddler classrooms, preschool classrooms, and family child care homes, using the same quality concepts. Completion of the ERS requires a 4-hour observation visit. Each scale has the following subscales: Space and Furnishings, Personal Care, Language and Reasoning, Activities, Interaction, Program Structure and Parents and Staff.

Here are brief descriptions of each of the three ERS scales:

- The Infant Toddler Environment Rating Scale—Revised edition (ITERS-R) was used to assess child care quality in licensed center and registered ministry classrooms caring for children ages 0 to 30 months. The ITERS-R has 7 subscales and 39 items.
- The Early Childhood Environmental Rating Scale- Revised edition (ECERS-R) was used to assess child care quality in licensed center and registered ministry classrooms caring for children ages 2 ½ and up. The ECERS-R has 7 subscales and 43 items.
- The Family Child Care Environment Rating Scale—Revised edition FCCERS-R was used to assess child care quality in licensed family child care home settings. The FCCERS-R has 7 subscales and 38 items.

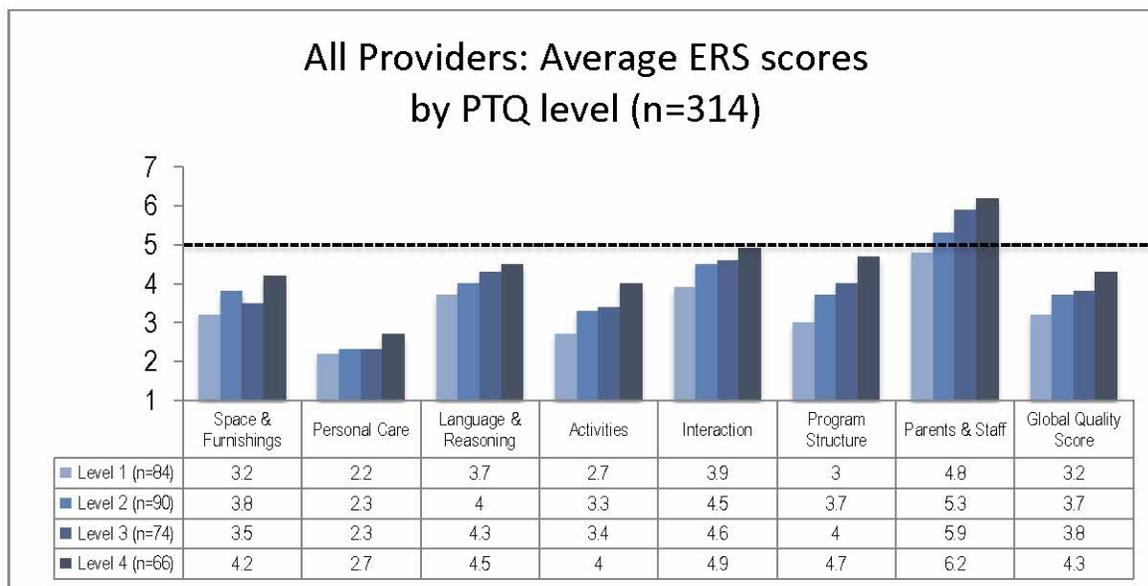
The ERS are 7-point scales, with higher scores indicating better child care quality (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). Each ERS consists of seven subscales: Space and Furnishings, Personal Care, Language and Reasoning, Activities, Interaction, Program Structure, and Parents and Staff. For more information on each of the ERS, see Appendix B.

The Caregiver Interaction Scale is a 26 item measure that uses the 4-hour observation time to assess the level of positive caregiver-child interactions, permissiveness, detachment, and punitiveness in the classroom. Each item is rated on a four point scale, from “not at all” to “very much.” The total score, considered a measure of overall positive, supportive interactions with children, indicates the caregiver is warmer, less permissive, less punitive, and less detached. (For more details about the CIS, see Table B1 in Appendix B.)

Relationships between PTQ levels and child care quality – all providers

As PTQ levels increase, so does overall child care quality. In the graph below, note that average quality levels for all providers are consistently higher for provider groups progressing from Level 1 through Level 4.

- The association between ERS quality and PTQ ratings was strongest for the Parents and Staff, Activities, and Program Structure subscales.
- Overall (global) ERS quality was moderately correlated with PTQ ratings.
- Smaller but statistically significant associations were also found between PTQ levels and the Space and Furnishings, Personal Care Routines, Language/Reasoning, and Interaction subscales.
- Level 4 providers were rated statistically higher in ERS quality than Level 1 providers in all of the quality subscales and the global quality score.
- Observed ERS quality, while related to the PTQ ratings, was *highly variable* within each PTQ level. For example, preschool classrooms at Level 1 had an *average* global quality score of 3.8, but a *range* of 1.7 to 5.5. Level 4 preschool classrooms had an *average* global quality score of 4.6, but *ranged* from 2.9 to 5.7. This amount of variability was found throughout the study, in all PTQ levels and in all types of care.



Associations between PTQ levels and caregiver sensitivity—all providers

Daily interactions between adults and children in child care are a key aspect of quality, closely connected to children’s learning. Small but statistically significant relationships were found between caregiver interactions and PTQ levels, meaning that caregivers were observed to interact more positively and supportively with children when providers at higher PTQ levels. (For more details, see Tables B2, B3, B4, and B5 in Appendix B.)

- Higher PTQ levels were positively associated with overall caregiver sensitivity and positive interactions. Providers at higher PTQ levels were more sensitive to children and displayed more positive interactions with children.
- Higher PTQ levels were negatively associated with caregiver permissiveness subscale and detachment. Providers at higher PTQ levels were less permissive and detached from children.
- Level 3 and 4 providers were rated *statistically higher* than Level 1 providers in overall caregiver sensitivity and positive interactions.
- Level 1 providers were rated *statistically higher* than Levels 2, 3 and 4 providers on detachment with children.

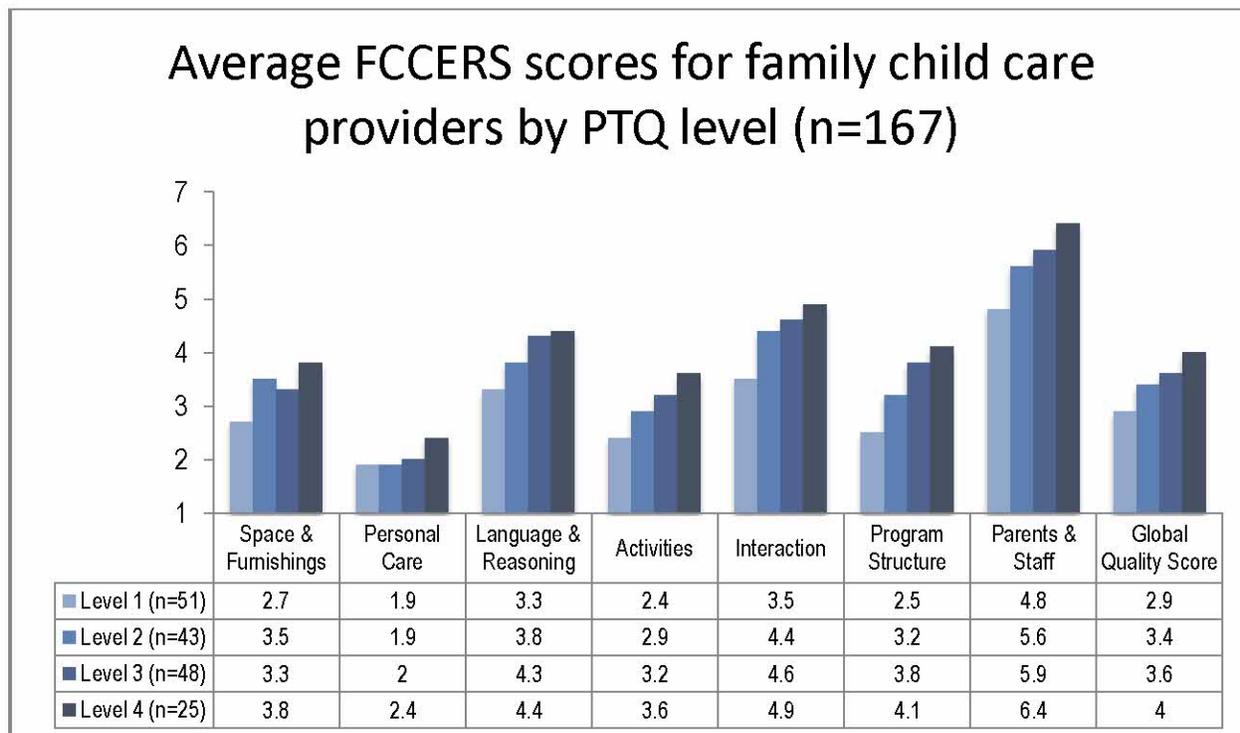
Relationships between PTQ levels and child care quality – Licensed family child care homes

Licensed family child care providers represented half (53%) of the evaluation sample. Overall, 167 family child care providers were observed using the FCCERS-R and the CIS. The ERS overall quality and subscale scores, by PTQ level, are presented in the graph below.

As a group, the licensed family child care homes showed the strongest association between Purdue-assessed quality and the rated PTQ levels:

- Level 2, 3 and 4 providers scored *significantly higher* on the Global Quality scale and the Interaction subscale than Level 1 providers. Level 4 providers had an average score of 4.0 in Global Quality, between “minimal” and “good.” (This compares very favorably with quality studies using the FCCERS scale completed recently in Georgia⁵ and Rhode Island.⁶)
- Level 3 and 4 providers scored *significantly higher* on the Space and Furnishings, Language/Reasoning, Activities, Program Structure subscales than Level 1 providers.
- Level 4 providers scored *significantly higher* than Levels 1, 2, and 3 on the Parents and Staff subscale.

- When family child care providers were rated higher by PTQ, they were more likely to interact sensitively and positively with the children, and less likely to be overly detached, punitive, or permissive.

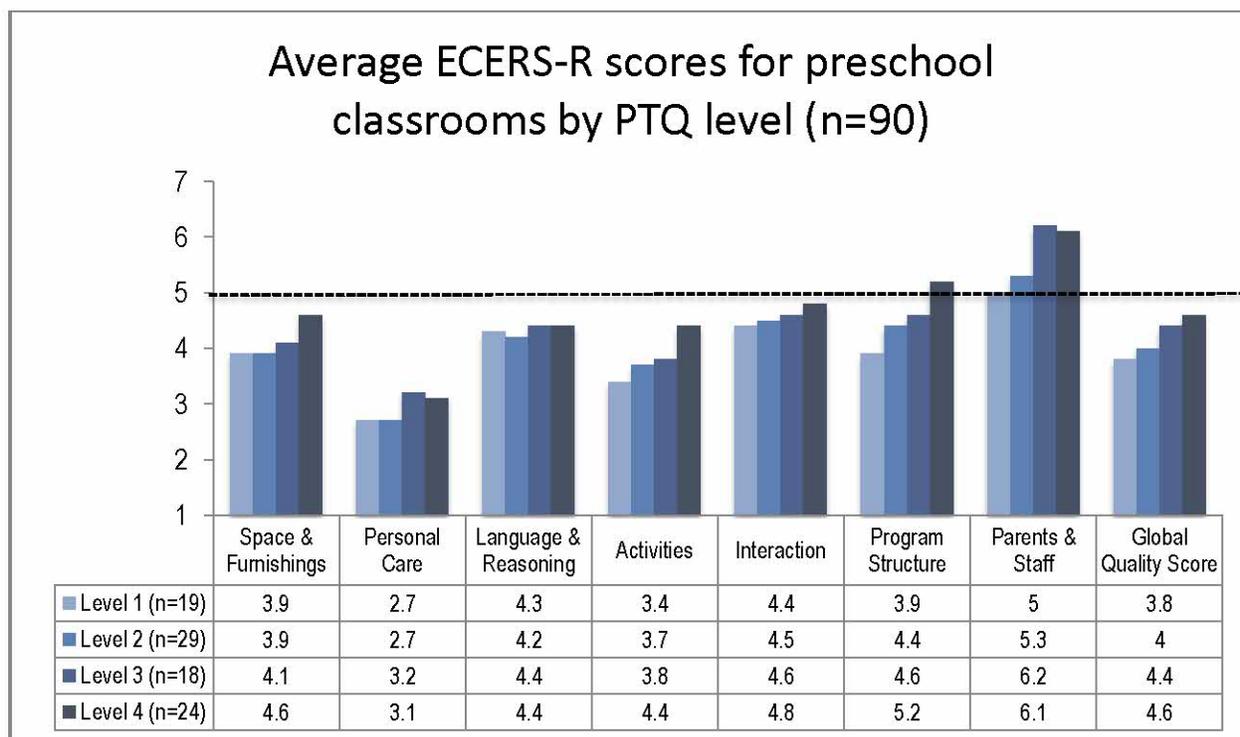


Relationships between PTQ levels and child care quality – preschool classrooms

Ninety (90) preschool classrooms were observed in both licensed child care centers and registered child care ministries using the ECERS-R. A summary of the quality ratings, by PTQ quality level, is presented in the graph below. In general, as PTQ levels increased, so did overall child care quality. Overall quality was somewhat low, with an average rating of 4.6 for PTQ Level 4 providers (5 = “good” on the ECERS-R). However this level of quality compares favorably with an average rating of 4.8 for Head Start classrooms in a recent national study.⁷ Also, quality was rated somewhat higher in preschool classrooms compared with licensed family child care homes (4.6 vs. 4.0 in ERS global quality at PTQ Level 4.)

However, the *association* between PTQ ratings and ERS quality was not as strong for preschool classrooms as it was for family child care homes. In other words, PTQ ratings are a stronger indicator of ERS quality in family child care homes than in centers. Here is a summary of the main results for preschool classrooms:

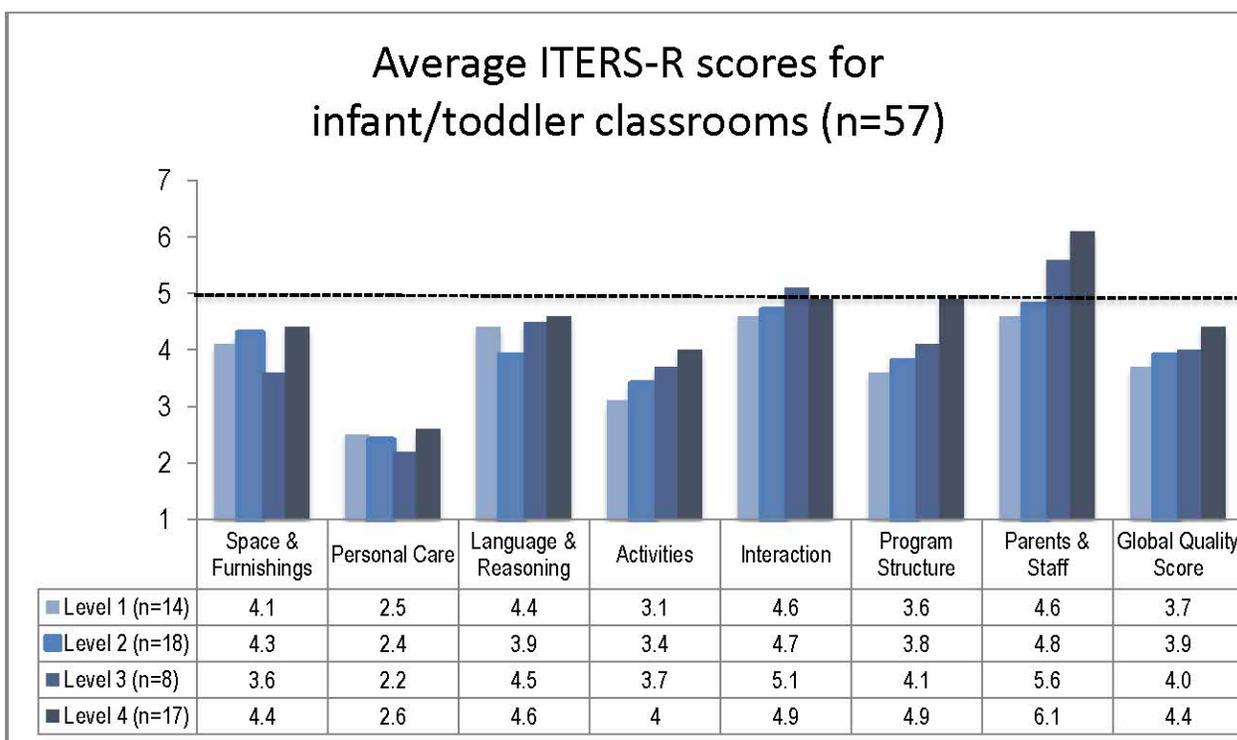
- When preschool classrooms were rated at higher PTQ levels, they had significantly higher ERS quality scores in Global Quality, Space and Furnishings, Activities, Program Structure, and Parents and Staff subscales.
- Level 4 providers scored *significantly higher* than Level 1 providers on the Global Quality score and the Space and Furnishings, Activities, Program Structure, and Parents and Staff subscales.
- Higher PTQ levels were not related to caregiver sensitivity as measured by the CIS.



Relationships between PTQ levels and child care quality--Infant/toddler classrooms

Fifty seven (57) infant-toddler classrooms were observed in both licensed child care centers and registered child care ministries using the ITERS-R. A summary of the quality ratings, by PTQ quality level, is presented in the graph below. In general, as PTQ levels increased, so did overall child care quality. Overall quality in infant-toddler groups was relatively low, similar to the preschool classrooms—4.4 global quality at PTQ Level 4. However, these quality levels compare favorably to those observed in a recent national study of quality in Early Head Start infant-toddler classrooms (average= 3.8).⁸ Here is a summary of results for infant-toddler classrooms:

- PTQ level was moderately associated with the Activities and Program Structure subscale and the Global Quality score. Providers at higher PTQ levels tended to be rated higher on Activities and Program Structure subscale and the Global Quality score.
- Level 4 providers scored *significantly higher* than Level 1 and 2 providers on Parents and Staff subscale.
- PTQ level was strongly associated with to the Parents and Staff subscale. Providers at higher PTQ levels were rated higher on the Parent and Staff subscale.
- No relationships were found between PTQ level and caregiver sensitivity with infants and toddlers.



Were there differences in child care quality in Waves 1, 2, 3, and 4?

Paths to QUALITY was implemented in a sequence of four regional waves over one year. Since Wave 1 providers (SDA 3, Fort Wayne area; and SDA 9, Evansville area) had been participating in Paths to QUALITY for years prior to the statewide expansion, additional analyses were done to determine if there were quality differences among the Wave regions. Here is a brief summary of the findings:

- In licensed child care centers, Wave 1 providers were rated statistically higher than other Waves in ERS Space and Furnishings, and CIS sensitivity and positive interaction. They were also rated statistically lower in caregiver permissiveness.
- In licensed family child care homes, Wave 1 providers were rated higher than other Waves in ERS Space and Furnishings and CIS overall positive caregiver-child interactions. The Wave 1 caregivers were rated lower in punitiveness and permissiveness with children.
- In the small sample of registered child care ministries, there were no differences in quality by the wave of data collection.

How can quality be improved for PTQ child care providers?

The evaluation research, as summarized above, found that PTQ levels do reliably distinguish between child care quality levels, as assessed using research-validated measures. However, the overall quality of even the PTQ Level 4 providers is on average lower than program leaders might expect or want, just below the 5 (“good”) level. What specific quality indicators could be targeted for improvement in order to improve the overall quality levels of PTQ providers?

To answer this question, the Purdue team examined each of the items on the ERS measures to determine which items had the lowest average scores. There were some common trends across this analysis of the ITERS-R, ECERS-R and the FCCERS-R scores. (See more detailed results of these analyses in Tables B6, B7, and B8 in the Appendix B.)

Here is a summary listing of the lowest rated items type of care:

Preschool classrooms (Level 4 average item score in parentheses)

- Meals/snacks (2.6)
- Diapering/toileting (2.4)
- Health practices (2.0)
- Safety practices (2.5)
- Using language to develop reasoning skills (3.4)
- Math/number (3.9)

Infant/toddler classrooms (Level 4 average item score in parentheses)

- Meals/Snacks (1.9)
- Diapering/Toileting (1.9)
- Health Practices (2.0)
- Safety practices (2.6)
- Blocks (2.2)
- Science/Nature (3.1)

Family child care homes (Level 4 average item score in parentheses)

- Meals/Snacks (1.9)
- Diapering/Toileting (1.7)
- Health Practices (2.1)
- Safety practices (1.9)
- Nap/Rest (2.5)
- Active Physical Play (2.1)

Note: The Personal Care subscale is the lowest rated subscale among all types of providers and at all PTQ levels. The seven items that comprise this subscale across all three ERS scales are Greetings/Departure, Meals/Snack, Nap/Rest, Toileting, Diapering, Health Practices and Safety Practices. All but the Greetings/Departure item are among the lowest rated items for PTQ

providers. If ERS-rated quality is to be improved across all PTQ levels, then providers, mentors, quality advisors, licensing consultants and the PTQ raters may want to focus attention on the items identified in this analysis.

What are the Experiences of Child Care Providers in Paths to QUALITY?

Are Indiana child care providers enrolling in PTQ?

In the first three years, the level of participation by licensed child care centers and licensed family child care homes has been a striking success for PTQ. In September 2011, at the conclusion of the Purdue evaluation study, there were 608 licensed child care centers, 2,972 licensed family child care homes, and 736 unlicensed registered child care ministries in operation in Indiana. Of these providers, 82% of all licensed child care centers, 52% of all licensed family child care homes, and 11% of all registered child care ministries had enrolled in PTQ. In this early phase of PTQ, as expected, most of the enrolled providers were rated at Level 1 or Level 2. (All providers who enroll in PTQ must come in at Level 1. In order to attain higher levels, they must meet the standards for the higher level, but also continue to meet the standards for all the levels below.) There were a total of 2,110 providers enrolled in PTQ, 53% rated at Level 1, 23% at Level 2, 14% at Level 3, and 10% at Level 4.

Table 1. Number of providers enrolled in PTQ by type of child care and PTQ level, September, 2011

PTQ Level	Licensed Child Care Centers	Licensed Family Child Care Homes	Registered Child Care Ministries	Total
Level 1	131	931	48	1110
Level 2	110	357	15	482
Level 3	128	165	7	300
Level 4	128	90	0	218
Total	497	1543	70	2110

What were the incentives for providers to enroll in PTQ?

Providers who participated in the evaluation completed a written survey, which was collected during the observation visit. These surveys were completed by 270 of 276 participating providers. Providers were asked, "Why did you decide to join the Paths to QUALITY program?" Seven choices were available, and providers could check more than one option. Nearly all (96%) of the providers responded to this question. Percentages are given for all providers and are broken down by type of care and PTQ level.

Table 2. Providers' reasons for enrolling in PTQ, by type of care

Incentive to enroll in PTQ	All Providers (n=270)	Licensed Child Care Center (n=94)	Family Child Care Homes (n=164)	Registered Ministry (n=12)
I wanted to improve the quality of my child care program.	82%	83%	81%	100%
I wanted more professional recognition.	70%	71%	72%	50%
I wanted to make my child care more attractive to parents.	66%	64%	66%	75%
I wanted new ideas for my child care program.	63%	58%	68%	50%
The gifts and cash incentives that were offered for PTQ participation.	61%	64%	61%	42%
I wanted the training or technical assistance that PTQ offered.	61%	61%	60%	67%
I wanted to increase my business.	49%	54%	47%	33%

Child care providers were also asked, "What aspect of the Paths to QUALITY has been most beneficial to you?" since enrollment in PTQ. Providers were given six choices and asked to pick only one answer. Overall, 76% of the providers responded.

Table 3. Child care providers: Most beneficial aspect of PTQ, by type of care

Most beneficial aspect of PTQ	All providers (n=210)	Licensed Child Care Center (n=74)	Family Child Care Homes (n=126)	Registered Ministry (n=10)
The mentoring services I have received from the local child care resource and referral agency.	37%	35%	38%	30%
The gifts and incentives I get from the program.	25%	30%	24%	0%
The recognition I get from parents, other providers, or the public that I am providing high quality child care.	16%	14%	17%	20%
The training provided through the program.	9%	4%	10%	30%
PTQ participation provides me with a marketing tool for my child care program.	9%	11%	7%	0%
Other (providers chose more than one answer)	6%	7%	5%	20%

What are the challenges for providers?

There were significant challenges for providers participating and advancing through the PTQ quality levels. Providers were asked, “In your opinion, what have been the biggest obstacles you face in moving up to the next Paths to QUALITY level?” 96% of the providers responded to this question.

Challenges for providers	All providers
Finding the time to complete tasks required by PTQ	21%
Completion of required education and training	16%
Insufficient funding to meet standards	9%
Organization; getting paperwork and documentation in order	8%
Preparing for and meeting national accreditation standards	6%
Other obstacles	6%
Having to wait 6 months in order to get the next assessment	4%
Difficulty making required environmental modifications	4%
Need more feedback from my mentor	2%
Challenges in developing a curriculum	2%
Reported they had no obstacles	14%

Are providers using available training/technical assistance (T/TA) resources?

The vast majority (94%) of providers reported that they had received some type of assistance from their local child care resource and referral agency. 76% of the providers reported the number of contacts (meetings, visits, or phone consultations) they had with their local resource and referral agency since they had enrolled in PTQ. Use of assistance from local child care resource and referral agency and the number of contacts did not differ by type of care. 92% of licensed child care centers, 100% of registered ministries, and 94% of family child care reported they had received assistance from their local child care resource and referral agency. Use of assistance did differ by PTQ level. 95% of Level 1 providers, 92% of Level 2 providers, 96% of Level 3 providers, and 90% of Level 4 providers reported receiving assistance from their local child care resource and referral agency.

All providers, number of CCR&R contacts since enrollment in PTQ:

- Average number of contacts reported = 7
- Middle number of contacts (median) = 6
- Minimum = 0
- Maximum = 32

During a follow-up telephone survey completed 4 to 9 months after the observation visit providers were again asked if they had received any assistance from their local child care

resource and referral agency. 68% providers reported receiving assistance for their local child care resource and referral agency in the past six months. Use of assistance from local child care resource and referral agency and the number of contacts did not differ *significantly* by type of care or PTQ level. 71% of licensed child care centers, 90% of registered ministries, and 64% of family child care reported they had received assistance from their local child care resource and referral agency. 70% of Level 1 providers, 79% of Level 2 providers, 53% of Level 3 providers, and 69% of Level 4 providers reported receiving assistance from their local child care resource and referral agency.

All providers, number CCR&R contacts within past 6 months:

- Average number of contacts reported = 8
- Middle number of contacts (median) = 5
- Minimum = 1
- Maximum = 48

Many providers (44%) reported receiving assistance from IAEYC in the initial provider survey. Most Level 3 (64%) and Level 4 (92%) providers reported having contact with IAEYC since they had enrolled in the system.

Level 3 providers reported:

- Average number of contacts = 3
- Middle number of contacts (median) = 3
- Minimum = 1
- Maximum = 10

Level 4 providers reported:

- Average number of contacts = 5
- Middle number of contacts (median) = 4
- Minimum = 2
- Maximum = 20

During the follow up provider survey, 58% of Level 3 providers and 77% of Level 4 providers reported receiving assistance from IAEYC in the last six months.

Level 3 providers reported:

- Average number of contacts = 1
- Most common number of contacts = 1
- Middle number of contacts (median) = 1
- Minimum = 1
- Maximum = 2

Level 4 providers reported:

- Average number of contacts = 1
- Most common number of contacts = 1
- Middle number of contacts (median) = 1
- Minimum = 1
- Maximum = 2

The child care providers reported using a variety of training/technical assistance resources to help them improve or maintain child care quality, so they could either progress to the next PTQ level or maintain their current level. Here are the training/technical assistance resources providers reported in the initial provider survey by type of care and PTQ level.

Table 4. Training/technical assistance used by type of care

Training/technical assistance resources used to improve or maintain child care quality	All Providers (n=270)	Licensed Child Care Center (n=94)	Family Child Care Home (n=164)	Registered Child Care Ministry (n=12)
Mentoring	83%	75%	87%	92%
Training session(s) I attended at the local child care resource and referral agency or in my community	68%	58%	72%	92%
Attended a local child care conference	57%	55%	57%	83%
Training provided in my child care center or home	42%	52%	32%	100%
Talked with an IAEYC accreditation advisor	40%	50%	36%	17%
Consulting in person or by phone from the local child care resource and referral agency's <i>Infant/Toddler Specialist</i>	39%	35%	39%	67%
Consulting in person or by phone from the local child care resource and referral agency's <i>Inclusion Specialist</i>	37%	43%	32%	50%
Used the Lending Library	32%	20%	39%	42%
Joined a local accreditation work group	27%	24%	27%	50%

Table 5. Training/technical assistance used by PTQ level

Training/technical assistance resources used to improve or maintain child care quality	Level 1 (n=78)	Level 2 (n=75)	Level 3 (n=67)	Level 4 (n=50)
Mentoring	84%	92%	83%	66%
Training session(s) I attended at the local child care resource and referral agency or in my community	67%	58%	74%	78%
Attended a local child care conference	49%	46%	65%	76%
Training provided in my child care center or home	47%	39%	32%	52%
Talked with an IAETC accreditation advisor	11%	15%	64%	90%
Consulting in person or by phone from the local child care resource and referral agency's <i>Infant/Toddler Specialist</i>	38%	39%	41%	38%
Consulting in person or by phone from the local child care resource and referral agency's <i>Inclusion Specialist</i>	29%	37%	39%	44%
Used the Lending Library	32%	36%	28%	34%
Joined a local accreditation work group	22%	23%	30%	38%

Are providers advancing to higher PTQ levels after entering the system?

During the follow up telephone surveys, providers were asked if their PTQ level had changed since the Purdue Evaluation Team visit, approximately six months earlier. Two hundred thirty eight providers responded to this question-- **23% of providers' level had changed since the evaluation visit (22% advanced one or more levels, 2% dropped a level) while 71% of providers remained on the same level.**

Table 6. Rates of PTQ level change in 6 month period between Purdue evaluation visit and follow-up telephone interview

Level of provider at time of Purdue evaluation visit	% of providers that moved up at least 1 level	% of providers that went down 1 level	% of providers that stayed at the same level	% of providers that closed facility	% of providers that moved and are not on PTQ yet
All Providers (n=238)	22%	2%	71%	4%	1%
Level 1 (n=65)	26%	NA	69%	5%	0%
Level 2 (n=70)	41%	4%	46%	7%	2%
Level 3 (n=53)	13%	2%	81%	2%	2%
Level 4 (n=50)	NA	2%	96%	2%	0%
Licensed Child Care Centers (n=90)	19%	1%	77%	2%	1%
Level 1 (n=19)	42%	NA	47%	11%	0%
Level 2 (n=27)	30%	0%	67%	0%	3%
Level 3 (n=18)	6%	0%	94%	0%	0%
Level 4 (n=26)	NA	4%	96%	0%	0%
Family Child Care Homes (n=164)	24%	3%	66%	6%	1%
Level 1 (n=40)	20%	NA	75%	2.5%	2.5%
Level 2 (n=41)	47%	7%	34%	12%	0%
Level 3 (n=33)	18%	3%	73%	3%	3%
Level 4 (n=25)	NA	92%	0%	4%	4%
Registered Ministries (n=11)	27%	73%	0%	0%	0%
Level 1 (n=7)	14%	NA	86%	0%	0%
Level 2 (n=2)	100%	0%	0%	0%	0%
Level 3 (n=2)	0%	0%	100%	0%	0%
Level 4 (n=0)	0%	0%	0%	0%	0%

Do child care providers in PTQ plan to advance?

When the research team asked providers about their plans for advancement during the follow-up survey, most responded that they were actively pursuing a higher PTQ level. (This question was added to the follow-up survey after Wave 1, so providers in those first regions are not included.)

Table 7. Providers' plans for advancement, by type of care

	All Providers (n=219)	Licensed Child Care Centers (n=83)	Family Child Care Homes (n=125)	Registered Child Care Ministries (n=11)
I am working hard to move up PTQ levels.	54%	52%	54%	55%
I have advanced to the PTQ level where I would like to be.	20% (3% of Level 1, 2, & 3)	29% (4% of Level 1, 2, & 3)	15% (2% of Level 1, 2, & 3)	9% (No level 4 ministries)
I have no plans to move up PTQ levels.	4%	1%	6%	0%
Other responses.*	22%	18%	24%	36%

*Other responses included Level 4 providers, providers waiting for accreditation, and responses like working but at a slow pace or not too hard.

What level do providers hope to attain by next year?

In the follow-up phone interviews, providers were asked about their specific plans for advancement. These hoped-for advancements in PTQ level, if actually attained, would result in significant increases in the number of Level 3 and Level 4 child care.

- Level 1 4%
- Level 2 18%
- Level 3 33%
- Level 4 46%
- Do not know 2%

If market forces are operating in a system like PTQ, one would expect that higher rated services could demand higher prices from consumers. (An example is the hotel star rating system, in which 4-star hotels typically have higher rates than 2-star hotels.) In the implementation phase of PTQ, some providers reported they had raised their fees to parents, but there was no significant correspondence between raising fees and the providers PTQ quality level, so other factors must be at work. Reasons that providers increased child care rates included: the cost of PTQ (14% of those who increased rates), to increase staff wages for a standard of living increase (89%), and because as a PTQ participant I feel I can charge more (19%).

Table 8. Have you increased your fees to parents in the past 6 months?

	Yes	No
Level 1	15%	85%
Level 2	27%	73%
Level 3	13%	87%
Level 4	18%	82%

How do Parents View Paths to QUALITY?

Are parents aware of PTQ?

Four hundred fifty (450) parents of children in the observed PTQ child care settings were interviewed by members of the PTQ evaluation team on the telephone. This survey will be referred to as the “PTQ parent survey.”

Do parents know that their child care provider is participating in PTQ?

- 78% of parents reported their provider was in PTQ
- 18% of parents reported their provider was not in PTQ
- 4% of parents reported they did not know whether their provider was in PTQ

After Wave 1 was completed, the question "*Had you heard about PTQ before we asked you to be in this study?*" was added to the PTQ parent survey. Two hundred thirty-three (233) parents responded to this added question.

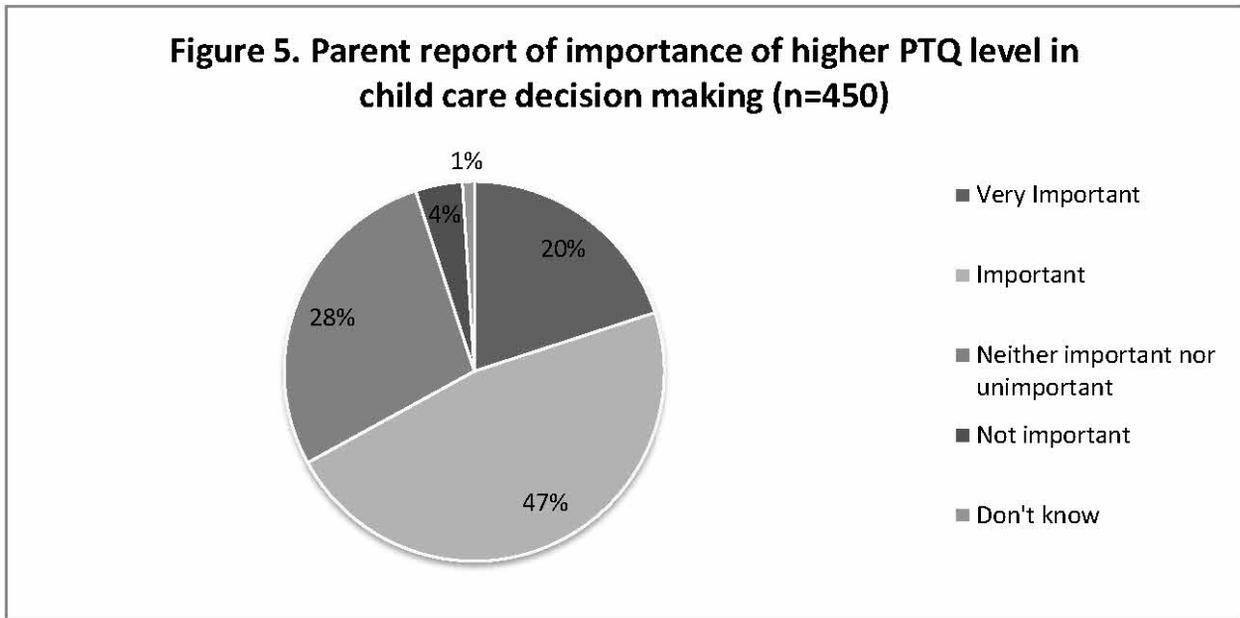
- 37% of parents reported they had heard about PTQ before being asked to participate in the Purdue evaluation study.
- 63% of parents reported they had **not** heard about PTQ before being asked to participate in the Purdue evaluation study.

If the parents indicated they had heard of PTQ before, a follow up question, "*How did you hear about Indiana's Paths to QUALITY?*" was asked. The most common source of information was from the family's own child care provider.

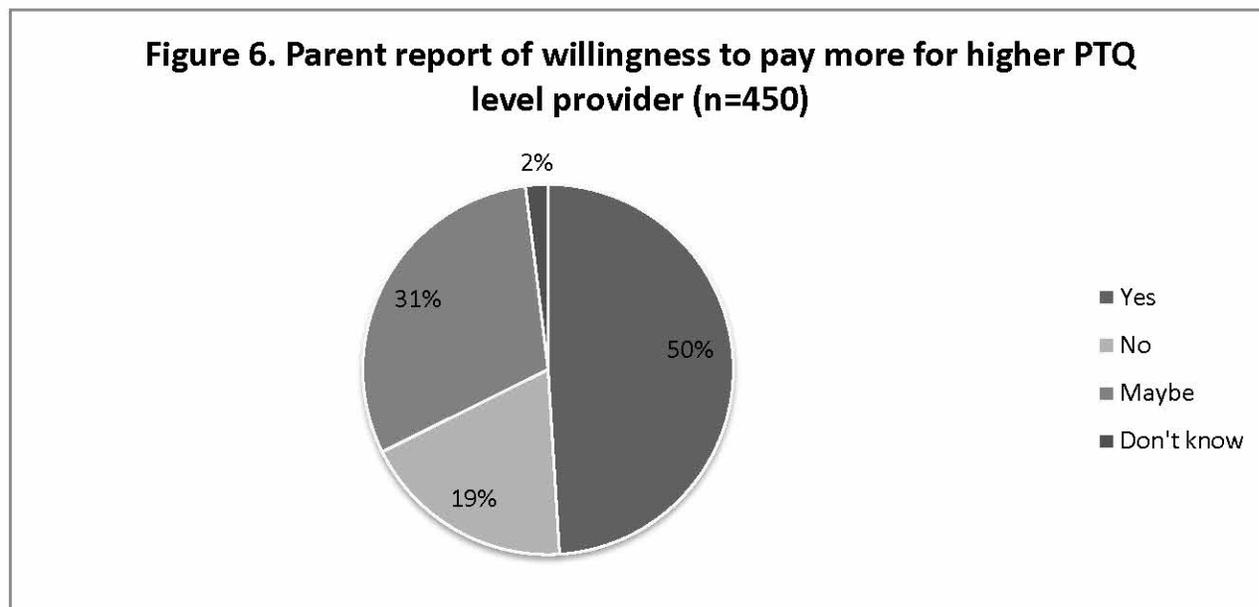
- | | |
|------------------------------------|-----|
| • Family's own child care provider | 62% |
| • From a relative or friend | 7% |
| • Employer | 7% |
| • From a posted flyer | 6% |
| • CCDF | 6% |
| • Another child care provider | 5% |
| • TV or radio | 5% |
| • Website | 3% |

Will PTQ affect parents' child care decisions?

Parents were asked during the PTQ parent interview about the importance the PTQ level of a provider may play in their future child care decision making. The majority of parents (67%) answered a higher PTQ level would be either an important or very important factor in their decision in choosing child care.



Parents were also asked during the observed parent survey about their willingness to pay more for child care if the provider was on a higher level in the PTQ program. Half of the 450 parents responded "Yes" they would be willing to pay more to a provider on a higher PTQ level, and 37% replied, "Maybe."



Parents in the General Public: Are they aware of Paths to QUALITY?

A telephone survey of parents with children ages 0 to 6 from the general public in Indiana was conducted from January 2009 to August 2010 (Time 1). The Kent State Survey Research Lab and Purdue Social Research Institute randomly selected and surveyed parents to assess general awareness, understanding, and use of the QRS system. Again, in April - June, 2011 (Time 2), the Kent State Survey Research Lab completed the survey with randomly selected parents of children ages 0 to 6 from the general public in Indiana. Questions were similar to those asked in the PTQ parent survey.⁹ Here is a summary of results from the General Public Surveys:

- Parents of the surveys at Time 1 and Time 2 were similar in reporting the average number of hours each week using child care. Both Time 1 and Time 2 parents reported using child care an average of 28 hours per week. They used all types of child care and were similar at Time 1 and Time 2.
- There was a slight increase from Time 1 to Time 2 in parents' awareness of PTQ. At Time 1 data collection 12% (75) of parents reported that had heard of PTQ, while at Time 2 data collection 19% (131) of parents reported that had heard of PTQ. In Time 1 parents from SDA 9 and SDA 3 were not included in the question "Have you ever heard of Indiana's Path to QUALITY child care quality improvement program before I called you

today?" When parent responses from SDA 9 and SDA 3 are removed from Time 2 only 14% of parents reported that they had heard of PTQ.

- Parents in SDAs 9 and 3 were most likely to report that they had heard about PTQ. 45% of parents in SDA 9 reported they had heard about PTQ while 35% of parents in SDA 3 reported they had heard about PTQ. SDA 3 and 9 are the SDAs in which the pilot PTQ programs were implemented, and parents in those communities have historically had more exposure to PTQ through their providers and previous marketing initiatives in each community.
- Child care providers were parents' most frequent source of information about PTQ. 57% of Time 1 parents who had heard of PTQ reported hearing about it from their provider while 67% of Time 2 parents reported hearing about it from their provider. However, the proportion of parents who reported receiving written or verbal information from their providers declined.
- Time 2 parents did identify more sources from which they heard about PTQ and reported hearing more about PTQ in the community from sources like church, work, library, stores, children's fairs, school (both children's school and college courses) and friends than Time 1.
- More parents in Time 2 than Time 1 reported hearing about PTQ from traditional marketing avenues such as signs, posters, bookmarks, or brochures in the community, newspaper, magazines, television, radio, yard signs, websites such as Carefinder, Facebook or YouTube, and community events.
- 13% of Time 1 parents reported their provider was in PTQ, while 14% of Time 2 parents reported that their provider was in PTQ. 58% of the self-identified PTQ Time 1 parents reported they knew their provider's PTQ level while 70% of the self-identified PTQ Time 2 parents reported they knew their provider's PTQ level. This suggests an increase in awareness of the PTQ levels among parents who know their provider is participating in PTQ.
- Parents from Time 1 were more likely to report that their provider had shared written information about PTQ with them. Among the 93 Time 1 parents who were aware their provider was enrolled in PTQ, 70% said they had received written information and 68% had received verbal information from their provider about PTQ. Among the 99 Time 2 parents who were aware their provider was enrolled in PTQ, 55% said they had received written information and 64% had received verbal information from their provider about PTQ.
- Parents in Time 2 were more likely to report that a higher PTQ level would influence their decision about where to enroll their child in child care. 61% of the Time 1 parents compared with 71% of the Time 2 parents said that PTQ level would have some influence on their child care decisions.

- Time 2 parents were more likely to report that PTQ would be very important or important in child care decisions. 55% of Time 1 parents reported that PTQ level would be very important or important in their child care decisions compared with 66% of Time 2 parents.
- Time 2 parents were more likely to report they were willing to pay more for child care if provider was on a higher PTQ level. 47% of Time 1 parents reported they would be willing to pay more for child care at a higher PTQ level, while 57% of Time 2 parents reported they would be willing to pay more for child care at a higher PTQ level.
- Overall, the main differences between Time 1 and Time 2 were in parents' reports of their awareness of PTQ, the sources from which they heard about PTQ, whether a higher PTQ level would influence their decision about enrolling child in child care, the importance of PTQ in future child care decisions, and willingness to pay more for child care if provider was on a higher PTQ level.

How Are Children Doing in Paths to QUALITY?

The Purdue evaluation team completed assessments with 557 children and their parents to learn about children's participation in PTQ. Evaluation questions addressed whether children from higher risk families (lower parent education and income levels) were getting access to the highest quality levels of care, and whether all children were developing optimally, especially within the highest PTQ levels.

Are children and families at all education and income levels gaining access to child care at the highest PTQ levels?

Data were analyzed in three ways: (1) comparing children whose parents received child care assistance payment vouchers, (2) comparing children at different household income levels, and (3) comparing children at different parental educational levels.

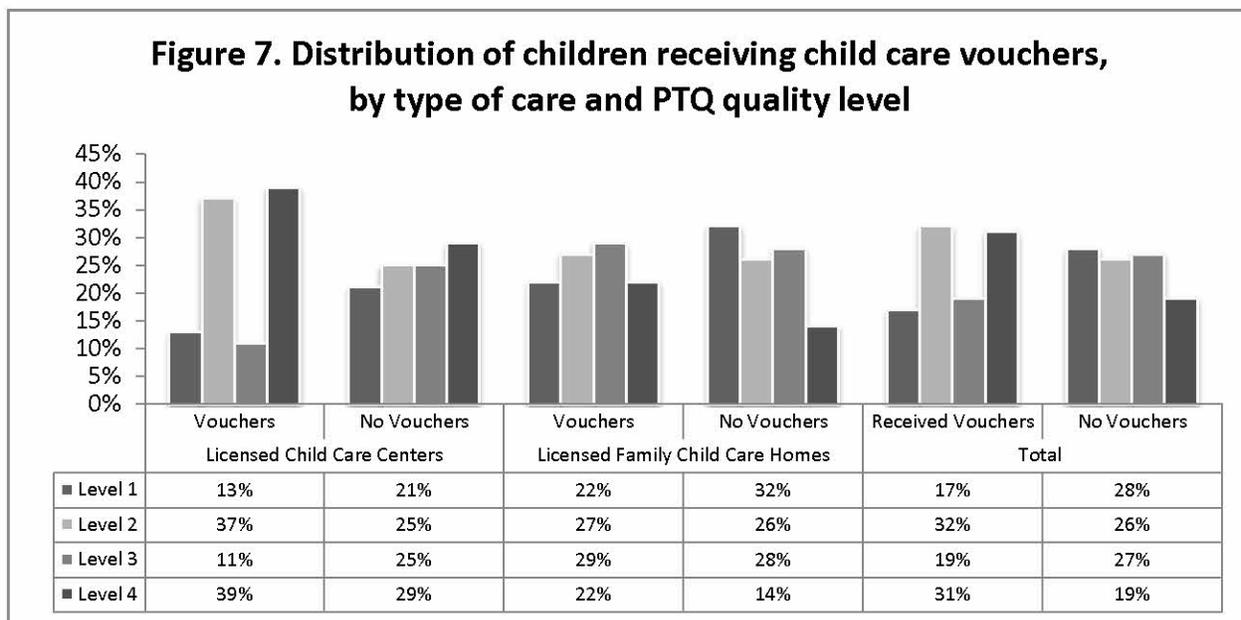
Parents who participated in the PTQ parent phone interviews were asked three demographic questions – whether they received child care vouchers or subsidies, what was their household income level, and what was the parent's education level.

Families Using Child Care Vouchers—Related to PTQ Level?

Of the 448 parents responding, 22% (n=99) received child care vouchers or subsidies, and 78% (n=349) did not. Below is a table summarizing the proportions of children receiving child care vouchers or subsidies by type of provider and PTQ level.

Children in licensed child care centers who were receiving vouchers were most likely to be found in child care rated at Level 2 and Level 4, and less likely to be found in child care rated at Level 1 and Level 3, when compared with children who were not receiving vouchers. This means that within our sample of voucher-using PTQ children, they were most likely to be found at Level 4 or at Level 2. This finding suggests that significant numbers of children using vouchers are gaining access to the highest quality level of child care. This is possibly because children from low income families are served by Head Start or by community child care centers that have been serving this population for many years.

For children in licensed family child care, there were no differences in child care voucher use by PTQ level. This means that non-voucher using children were evenly distributed among the four PTQ quality levels. Of the 18 children in registered child care ministries we assessed, none were using child care vouchers.



Parent Household Income and Education Levels—Related to PTQ Level?

In the PTQ parent interviews, parents were asked to report their annual household income level and highest level of education completed. Data were analyzed to test whether children from households with different income levels were gaining access to providers with higher PTQ levels. There were no differences found by income levels in children’s likelihood of being with providers with higher or lower PTQ levels. Finally, data were analyzed to test whether children from households with reported different educational levels were gaining equal access to providers with higher PTQ levels. There were no associations found between education level and children’s access to higher or lower PTQ levels. This supports the conclusion that families with lower socio-economic status (SES) are just as likely as families with higher SES to get quality child care in PTQ. (See Tables C1 and C2 in Appendix C for details.)

Infant-Toddler Development and PTQ Levels

Two children from each classroom or family child care home were randomly selected for a developmental assessment. The children were assessed by trained research assistants in a 20-45 minute time period during the Purdue quality assessment visit. 249 children ages 6 to 35 months were assessed statewide. The *Brief Infant Toddler Social and Emotional Assessment* was used to assess social competence and problem behavior. The *Mullen Scales of Early Learning* was used to assess cognitive development. (Descriptive data for these assessments are presented in Table C3 in the Appendix.)

Analyses were conducted to determine if children’s developmental levels on these measures were higher at PTQ Level 4 vs. Level 1. In other words, at this point in the implementation of

PTQ, was there evidence PTQ Level conferred any advantage to infants' and toddlers' development?

- Infant-toddler developmental outcomes did not differ by type of care or PTQ level, even when parental education and household income were taken into account.

Although these associations for infants/toddlers did not reach statistical significance, the average scores indicated a trend in the expected direction – infants and toddlers in Level 4 sites had higher average social competence, fewer reported behavioral problems, and scored higher on the cognitive assessments.

Preschool Age Children Development and PTQ Levels

308 children ages 36 to 60 months were assessed statewide. The *Social Competence and Behavior Evaluation* was used to assess social competence and problem behavior. The *Woodcock Johnson III Applied Problems and Letter Word Identification Subtests* were used to assess cognitive development. The Peabody Picture Vocabulary Test – 4 was used to measure receptive vocabulary (comprehension). (Descriptive data for these assessments are presented in Table C4 in the Appendix.)

Analyses were conducted to determine if children's developmental levels on these measures were higher at PTQ Level 4 vs. Level 1. In other words, at this point in the implementation of PTQ, was there evidence PTQ Level conferred any advantage to preschoolers' development? There was one statistically significant finding:

- PTQ level was negatively related to anxiety/withdrawal behaviors, $r = -.12$, $p = .03$. Children with providers at higher PTQ levels displayed fewer anxiety/withdrawal behaviors than children with providers at lower PTQ levels.

Further analyses were conducted to determine if these child outcomes differed by type of care or PTQ level.

- Child outcomes did not differ by type of care or PTQ level, even when parental education and household income were taken into account.

Child Development Outcomes for Children of Families Using Child Care Vouchers

Of the 99 children receiving child care subsidies or vouchers, 41 infants/toddlers and 56 preschoolers were assessed using the developmental measures. As with the whole sample of children, there were no statistically-significant relationships between PTQ level and the developmental levels of this subgroup of voucher-using children. (See Tables C5 and C6 in the Appendix for details.)

Is child care quality, as measured by the Purdue University quality assessments, related to child development and learning?

As a part of the validation of PTQ, Purdue researchers conducted independent assessments of the quality of licensed child care centers, licensed family child care homes, and unlicensed registered child care ministries in the evaluation sample. The quality measures used were:

- Early childhood Environment Rating Scale-Revised (ECERS-R; for preschool classrooms in licensed centers and registered ministries)
- Infant Toddler Environment Rating Scale-Revised (ITERS-R; for infant-toddler classrooms in licensed centers and registered ministries)
- Family Child Care Environment Rating Scale-Revised (FCCERS; for children of all ages in licensed family child care homes)
- Caregiver Interaction Scale (CIS; quality of caregiver-child interactions in all settings)

Analyses revealed that higher quality child care was associated with some aspects of child development for both infants/toddlers and preschoolers.

Infants/Toddlers:

- When environmental quality as measured by several ITERS-R scales was higher, infants/toddlers displayed higher levels of social competence.
- When caregivers' interactions with children were higher quality, infants/toddlers' cognitive and language scores were higher.
- Infant's and toddlers' cognitive and language development higher when caregivers' interactions with them were of higher quality. Children who scored higher on the Mullen Scales of Early Learning tended to have caregivers who were less permissive and less detached and displayed more sensitivity and positive interactions with children than the caregivers of children who scored lower on these cognitive measures.

Preschoolers:

- When providers were rated higher on the Language/Reasoning scale of the ECERS-R or FCCERS, children displayed greater language ability.
- When providers were rated higher on the Parents/Staff scale of the ECERS-R or FCCERS, children displayed less anxiety or aggression.
- When caregivers were observed to interact with children more positively and less punitively or permissively, children displayed higher levels of social competence and greater language ability.

Conclusions & Recommendations

Validity of the PTQ Quality Rating System

There is strong evidence from this evaluation research that the PTQ rating system, as implemented in the first two years of the program, measures meaningful differences in child care quality. PTQ ratings were compared to independent quality assessments using the University of North Carolina Environmental Rating Scales (ERS: ECERS-R, ITERS-R, FCCERS-R), assessing global environmental quality, and the Caregiver Interaction Scale, assessing the quality of caregiver-child interactions. Using these measures, PTQ Level 4 providers are providing significantly higher quality care than Level 1 providers. In most cases, incremental increases of quality are seen when assessing Level 1, 2, and 3 providers. The PTQ rating system distinguishes quality levels best for licensed family child care providers, who have a wider range of quality than center-based child care providers.

The average ERS global quality level for all Level 4 providers in PTQ was 4.3 on the 7-point scale, which is below the “good” quality level (5). The average global quality levels for Level 4 providers were 4.0 for licensed family child care providers, 4.6 for all preschool classrooms in licensed child care centers, and 4.4 for infant-toddler classrooms in licensed centers. While these quality levels are comparable to averages found in national studies of Head Start and Early Head Start, clearly there is room for quality improvement at the top PTQ levels.

ERS rated quality was highly variable within each PTQ level. This means that PTQ levels are assigned to centers, homes, and ministries that have widely varying ERS quality scores. While PTQ standards and ERS quality indicators are not strictly aligned, the amount of variability we observed is an issue worth attention in the future. One possible reason for the quality variations would be if the PTQ ratings are not done in a consistent, reliable manner across all providers within each PTQ level. Highly variable quality among providers at the same level, especially at the highest PTQ levels, may degrade trust in the PTQ quality rating system if this issue is not addressed and reduced.

Some quality indicators in the ERS assessments were especially low, and these indicators lowered the overall quality scores for PTQ providers. The lowest-scoring indicators were in the areas of Personal Care (meals/snacks; diapering/toileting; health practices; safety practices; nap/rest) and several curriculum areas (using language to develop reasoning skills; math/number; blocks; science/nature; active physical play.) Improvements in assessed quality in these indicators would raise overall quality scores.

Recommendations:

- *Continue to improve the PTQ quality rating system, to ensure that providers are assessed consistently and according to the PTQ standards for each level.*
- *Conduct a detailed review of the ERS quality assessments completed in this evaluation, to identify needed revisions in PTQ standards and/or areas of emphasis in future PTQ training/technical assistance for providers.*

- *In future revisions of PTQ standards and training/technical assistance goals, consider greater emphasis on personal care/health, early childhood curriculum, and teaching quality. PTQ raters, mentors, and advisors may need new tools to specifically address quality indicators in these areas.*

Child Care Providers' Experiences with PTQ

Indiana child care providers have chosen to participate in Paths to QUALITY in phenomenal numbers. In September, 2011, less than three years after PTQ was fully funded statewide, 2110 providers were enrolled, including 82% of all licensed child care centers, 52% of all licensed family child care homes, and 11% of all unlicensed registered child care ministries. These are among the highest participation rates for centers and homes in any voluntary statewide quality rating and improvement system.¹⁰

Providers report they enrolled in PTQ in order to improve their program quality, gain public recognition, get new ideas through training or technical assistance, make their programs more attractive to parents, and increase their business. The cash and materials incentives available in PTQ were also important for more than half of the providers.

Once enrolled in PTQ, providers found important benefits from participating. The mentoring they received from the child care resource and referral agency was a significant benefit for many providers. Also mentioned were gifts and cash incentives, and the public recognition they got from parents, other providers, and in their community. The value of mentoring stood out in providers' responses-- especially for family child care homes, registered child care ministries, and Level 1 and 2 providers. Workshops and conferences were valued by all providers, but especially by Level 3 and 4 providers.

Participation in PTQ is not without its challenges. Many challenges were experienced, including finding the time to complete the tasks required for PTQ advancement, finding and paying for required training for staff, insufficient funding to meet PTQ standards, getting documentation in order for PTQ rating or accreditation, and having to wait six months for the next PTQ rating.

In spite of these challenges, many providers are advancing their PTQ quality level. More than half of all providers reported they were "working hard to move up PTQ levels," and only 4% stated they had no plans to increase their level. In fact, we observed that many providers we interviewed had increased their PTQ level within a six month period: 25% of Level 1 providers, 48% of Level 2 providers, and 14% of Level 3 providers had advanced to the next level between the time we visited them and when we called back approximately six months later. 79% of the providers we interviewed stated they hoped to advance to either Level 3 or Level 4 within the next year! Statewide, according to the PTQ central data system, 52% of all providers who enrolled in PTQ have advanced at least one level since enrollment.

Recommendations:

- *Child care providers need to have confidence that working to advance their PTQ quality level will be beneficial, in terms of pride in offering quality care to children and families, public recognition for their accomplishments, and financial rewards. PTQ should take continuing steps to ensure that providers are actually receiving benefits and recognition for their participation and advancement in PTQ.*

- *In future evaluation research, study in more depth the impact of mentoring, which providers benefit most, and what specific mentoring activities are related to PTQ advancement.*
- *Continue targeted efforts to inform registered child care ministries about PTQ and to support their participation.*
- *Conducting regional meetings and focus groups with providers may provide valuable information about how PTQ is working for them and potential improvements in PTQ marketing and incentives.*
- *Find new ways to give providers community- and state-level public recognition, especially as they advance to Levels 3 and 4.*
- *Consider a tiered child care voucher reimbursement rate that will provide higher reimbursements for each PTQ level.*
- *Assess needs for training and technical assistance of all providers participating in PTQ, specifically for each state region and each type of provider. Target T/TA resources to these identified needs. Give particular attention to training that is proven effective and whether it is affordable and accessible to providers who need it.*
- *Consider providing training in leadership and time management, to support providers efforts to manage the new responsibilities that come with participation in the PTQ system.*
- *Continue to focus T/TA efforts with Level 3 and Level 4 providers on gaining and maintaining national accreditation, but also on assessing and maintaining caregiver-child interaction quality.*

Parents' Experiences with PTQ

In statewide random public surveys and interviews with PTQ parents, we found that awareness of PTQ and its potential benefits is still relatively low. In the summer of 2011, only 14% of parents of preschoolers in Indiana had heard of Paths to QUALITY. Rates of general public parent awareness were highest in the two regions of the state where PTQ began: Fort Wayne (35%) and Evansville (43%). Even among parents we interviewed whose children were actually enrolled with a PTQ provider, only 37% reported they had heard about PTQ.

Among the parents already using PTQ providers who were aware of PTQ, their own child care provider was the most common source of information. 62% reported they had found out about the program from their provider. Other reported sources of information were relatives, friends, employers, flyers posted, the child care voucher program, other child care providers, TV/radio, and a website. In the general public surveys, parents who knew about PTQ also identified their own child care provider as the most common source of information, 57% in 2010 and 67% in 2011. Beyond the providers, many sources of PTQ information were mentioned, especially in 2011 after the statewide PTQ awareness campaign was conducted-- church, work, library, stores, children's fairs, school (both children's school and college courses) friends, signs, posters, bookmarks, brochures, newspaper, magazines, television, radio, yard signs, websites such as Carefinder, Facebook or YouTube, and community events were all mentioned. However, child care providers remained by far the most common source for parents.

Whether parents were already aware of PTQ or not, they reported they value the information PTQ provides, and they intend to use it to guide their child care decisions. In the general public parent surveys, 61% in 2010 reported that PTQ quality level would have some influence in their future child care decisions, and this number increased to 71% in 2011. Among parents already using a PTQ provider, 67% said PTQ level would be important in their future decisions.

Parents reported they are willing to pay more for child care rated higher in PTQ. In the general statewide parent surveys, in 2010, 47% of those interviewed said they would consider paying more for child care rated at a higher PTQ level, and this number increased to 57% in the 2011 survey. Among parents already using a PTQ provider, 50% said they would pay more, and 31% said they might pay more, for care at a higher PTQ level.

Recommendations:

- *Inform PTQ child care providers about the results of this evaluation. Knowing that parents intend to use PTQ levels to choose care and that they may be willing to pay more for higher-rated care may motivate providers to continue their efforts in PTQ.*
- *Continue efforts to build public awareness of PTQ. The higher parent awareness levels in the first regions implementing PTQ (Fort Wayne, the founding region, and Evansville, the first replication region) suggest building public awareness takes time and sustained effort. Study and learn from the successes of these regions.*

- *Be aware that different parent education strategies may be needed to reach different parent groups in diverse regions of the state. Allow for local effort, tailored to parents' ways of getting information in their communities, coordinated with statewide efforts designed for all parents.*
- *Child care providers are an important source of information for parents about PTQ. Continue a strong marketing campaign through providers.*
- *Talk with providers around the state, through regional meetings and focus groups, to investigate potential new ways to reach current and prospective parent clients with PTQ information.*
- *Consider finding new funding and developing one or more new statewide TV public service announcements, to increase general public awareness of the PTQ brand and goals and how to access quality child care.*
- *Continue to explore ways to make information on the Child Care Indiana and Indiana Carefinder web sites more useful to parents and also to highlight PTQ. Consider the following enhancements to these web based information systems:*
 - *Integrate content and functions of these two information site, so the resources parents need to find quality child care are easy to access, with a few clicks.*
 - *Improve web site functionality so that parents can:*
 - *Specify their location*
 - *See providers located within a certain number of miles of the parents' work or home, including locations on a map;*
 - *See immediately if each provider has current openings or not;*
 - *Allow providers to update their space available information directly—it is in their own interest.*
 - *See information about each identified provider's PTQ level and what this means in terms of quality and benefits for children and families;*
 - *Allow parents to filter their searches by PTQ level.*
 - *Access information via mobile phones.*

Children in PTQ

Children from Indiana families at all income and education levels are gaining access to higher quality care within PTQ. Children using child care vouchers and those from families with lower parent income and education levels are found in PTQ Level 4 child care centers and homes at the same rate as families with higher income and education levels. This is an especially important finding, because research shows that children from low-resource families can benefit most from high quality early care and education.

At this early stage of PTQ implementation, we did not find consistent, strong associations between PTQ quality level and young children’s development and learning. Considering all of the cognitive, language, and social-emotional child assessments, we found only small trends suggesting children that placed in care at higher PTQ levels were doing better. These trends were not statistically significant, after parent education and income was controlled. This is not so surprising, due to several limitations:

1. The sample of children in this evaluation may not have been adequate to provide a valid assessment of the link between PTQ level and children’s development. Even though 557 children were assessed statewide, only two children from each classroom or family child care home could be included. We attempted to randomly sample classrooms and children-- but we were reliant on parents’ permission for their children to participate. Therefore, our sample is relatively small and not technically representative of all Indiana children participating in PTQ.
2. PTQ is still a new program. Normally a large-scale child care quality improvement program must operate for a while before it can produce its full effect on children’s development. Researchers on the national level recommend programs like PTQ be fully operational and running smoothly for at least 3 years before child development outcomes are used to evaluate program effectiveness.¹¹
3. As reported in an earlier section of this report, quality as assessed by Purdue was quite variable within each PTQ level. This variability within each level will have the effect of obscuring positive effects of higher PTQ levels on children’s development.
4. More rigorous (and more expensive) research designs, such as experimental and longitudinal research, are needed to determine if PTQ will improve children’s developmental outcomes and their readiness for school.¹² The one-time correlational design used this evaluation study was not intended to test PTQ effectiveness in improving children’s outcomes.
5. The current study did not include any measure of *dosage* (i.e., the amount of exposure, or time in care, each child had experienced.) Therefore, for example, we cannot distinguish children who have been in Level 4 care for shorter or longer periods of time.

These limitations should be considered in planning future evaluations of the impact of PTQ on children’s learning and developmental outcomes.

While PTQ levels did not predict children’s outcomes in this study, we did find that specific measures of child care quality did predict children’s development and learning. For infants and toddlers, higher levels of ERS quality predicted higher levels of social competence, and more positive, responsive interactions with caregivers predicted more advanced cognitive and language skills. For preschoolers, those who were in settings rated higher in ERS Language/Reasoning displayed higher language ability. Preschoolers in settings rated higher on the Parents/Staff ERS scale displayed fewer problem behaviors. When caregivers interacted more positively and responsively with preschoolers, the children tended to display more social competence and higher language abilities.

Recommendations:

- *In future PTQ evaluation planning, consider the costs/benefits of conducting a rigorous evaluation of children’s developmental and school readiness outcomes as a measure of PTQ effectiveness. This research will be expensive, so private funding or collaborations with other states or the federal government may be needed, if such a study is deemed necessary.*
- *In future revisions of the PTQ standards and rating procedures, consider strengthening standards focused on positive, responsive caregiver child interactions and caregivers’ support of children’s social skills, language, and cognition. While these recommended adult-child interactions are challenging to assess and improve, past research has shown that improvements in these aspects of teaching and caring lead to gains in children’s learning.*

Endnotes

¹ See the Indiana PTQ web site, www.in.gov/fssa/pathstoquality/3723.htm.

² For more information about the evaluation of the original two community-level implementations of Paths to QUALITY, see the Purdue University report, “*Paths to QUALITY- Child care quality rating system for Indiana: What is its scientific basis?*,” available at www.in.gov/fssa/files/ScientificBasisPTQ.pdf.

³ For more information about Paths to QUALITY and its standards, go to the Indiana PTQ web site, www.in.gov/fssa/2554.htm.

⁴ For detailed information about the evaluation methods used in this study, see the Purdue University report, “*A child care quality rating and improvement system for Indiana: Evaluation methods and measure*,” available at www.in.gov/fssa/files/PTQ_TechReport2_Measures.pdf.

⁵ Maxwell, K. L., Early, D. M., Bryant, D., Kraus, S., & Hume, K., (2010). Georgia study of early care and education: Family child care findings. Chapel Hill: The University of North Carolina at Chapel Hill, FPG Child Development Institute.

⁶ Maxwell, K. L., & Kraus, S. (2010). Rhode Island’s 2010 family child care quality study. Chapel Hill: The University of North Carolina, FPG Child Development Institute.

⁷ Head Start Family and Child Experiences Survey (FACES), 1997-2013. See www.acf.hhs.gov/programs/opre/hs/faces/index.html.

⁸ Vogel, Cheri A., Kimberly Boller, Yange Xue, Randall Blair, Nikki Aikens, Andrew Burwick, Yevgeny Shrago, Barbara Lepidus Carlton, Lara Kalb, Linda Mendenko, Judy Cannon, Sean Harrington, and Jillian Stein. Administration for Children and Families. *Learning As We Go: A First Snapshot of Early Head Start Programs, Staff, Families, and Children*. OPRE Report #2011-7, Washington, DC. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. 2011.

⁹ For more complete information and results of the randomized public surveys, see the Purdue University report, “*Paths to QUALITY Evaluation Research: General Parent Survey Statewide Comparison Report*.”

¹⁰ Tout, K., Starr, R., Soli, M., Moodie, S., Kirby, G., & Boller, K. (April, 2010). *Compendium of quality rating systems and evaluations*. OPRE Report, Washington, DC. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

¹¹ See for example Elicker, J. & Thornburg, K. R. (2011). *Evaluation of Quality Rating and Improvement Systems for Early Childhood Programs and School-Age Care: Measuring Children’s Development, Research-to-Policy, Research-to-Practice Brief*, OPRE 2011-11c. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Appendix A

Table A1. Overview of Measures

<i>Data collected from the Child Care Provider</i>		
Variable	Name of Measure	Measure Description
Child Care Quality- Global Assessment	Early Childhood Environmental Rating Scale—Revised (ECERS-R)	Assessors use scale to rate overall child care quality in center-based child care classrooms caring for children ages 2 ½ and up.
	Infant Toddler Environmental Rating Scale—Revised (ITERS-R)	Assessors use scale to rate overall child care quality in center-based child care classrooms caring for children ages 0 to 30 months.
	Family Child Care Environmental Rating Scale (FCCERS)	Assessors use scale to rate child care quality in family child care home settings.
Child Care Quality- Provider Sensitivity	Caregiver Interaction Scale	Assessors rate the quality and content of the teacher’s interactions with children.
Providers’ perceptions of PTQ	Surveys of providers participating in PTQ	Includes questions about providers’ understanding of PTQ, perceptions of PTQ assessment, technical assistance received, and impact of PTQ on providers’ businesses.
Providers’ perceptions of PTQ	Follow-up surveys with the original sample of providers	Survey follows up on perceptions of PTQ assessment, technical assistance received, and impact of PTQ on providers’ businesses.
<i>Data collected from the Parent</i>		
Variable	Name of Measure	Measure Description
Parents’ perceptions of PTQ-- PTQ participants	Surveys with parents served by PTQ providers	Includes questions about parents’ understanding of PTQ and whether PTQ has affected their child care choices.
Parents’ perceptions of PTQ-- General public	Surveys with randomly-selected parents in the general public	Includes questions about parents’ understanding of PTQ and whether PTQ has affected their child care choices.

<i>Data collected from/about the Child</i>		
Variable	Name of Measure	Measure Description
Cognitive Development—infant and toddlers	Mullen Scales of Early Learning	Direct assessment of child’s ability to process visual patterns.
Cognitive Development--preschool age children	Woodcock Johnson Applied Problems subtest	Direct assessment of children's skill in solving practical problems in mathematics.
	Woodcock Johnson Letter Word Identification subtest	Direct assessment of early reading skill such as or the ability to match a pictographic representation of a word with an actual picture of the object and identifying letters and words.
Language Development—infant toddler	Mullen Scales of Early Learning	Direct assessment of receptive (vocabulary acquisition) and expressive (ability to use language productively) language.
Language Development—preschool age children	Peabody Picture Vocabulary Test	Direct assessment of receptive (vocabulary acquisition) language.
Social Emotional Development—infant toddler	Brief Infant Toddler Social and Emotional Assessment	Provider rates child’s problem behavior and social competence.
Social Emotional Development—preschool age children	Social Competence and Behavior Evaluation	Provider rates child’s aggression, anxiety, and social competence.

Appendix B: Description of the Environment Rating Scales (ERS)

Center-based child care classrooms caring for children ages 2 ½ and up in licensed child care centers and registered ministries, were assessed using the Early Childhood Environment Rating Scale-Revised (ECERS-R) while classrooms caring for infants and toddlers (0 to 30 months) in licensed child care centers and registered ministries were assessed using the Infant Toddler Environment Rating Scale-Revised (ITERS-R). The Family Child Care Environment Rating Scale-Revised (FCCERS-R) was used to assess quality in family child care homes. The three measures, designed with similar conceptual structures, allow researchers to compare quality across types of child care settings. Assessors were trained on the three measures and then completed independent observations with reliable trainers to 85% (within one point) reliability before beginning data collection. Inter-rater reliability was monitored throughout the entire data collection period to maintain reliability among assessors. Reliability checks were completed with each assessor throughout data collection.

Early Childhood Environment Rating Scale—Revised edition (ECERS-R: Harms, Clifford, & Cryer, 1998). The ECERS-R was used to assess child care quality in center-based child care classrooms caring for children ages 2 ½ and up. It consists of 43 items organized under seven subscales: space and furnishings, personal care routines, language-reasoning, activities, interaction, program structure, and parents and staff. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .92$; Harms, Clifford, & Cryer, 1998).

Infant Toddler Environment Rating Scale—Revised edition (ITERS-R: Harms, Clifford, & Cryer, 2003). The ITERS-R was used to assess child care quality in center-based child care classrooms caring for children ages 0 to 30 months. It consists of 39 items organized under seven subscales: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure, and parents and staff. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .92$; Harms, Clifford, & Cryer, 2003).

Family Child Care Environment Rating Scale—Revised edition (FCCERS, Harms, Clifford, & Cryer, 2007). The FCCERS-R was used to assess child care quality in family child care home settings. It consists of 38 items organized under seven subscales: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure and parents and provider. Each item is rated on a 7-point scale (1 = inadequate; 3 = minimal; 5 = good; 7 = excellent). The total scale was shown to be reliable ($r = .88$; Harms, Clifford, & Cryer, 2007).

Table B1.

Sample Items from the Subscales of the Caregiver Interaction Scale (CIS).

Positive Relationships – this reflects appropriate interactions, enthusiasm and warmth. Example items include:

- Speaks warmly to children
- Seems to enjoy the children
- Encourages children to try new experiences
- Pays positive attention to the children as individuals

Caregiver Punitiveness – this reflects hostile and excessively critical behavior toward children. Example items include:

- Seems critical of the children
- Places high value on obedience
- Threatens children in trying to control them
- Finds fault easily with children

Caregiver Permissiveness - this reflects tolerance of misbehaviors. Examples items include:

- Exercises a great deal of control over the children
- Reprimands children when they misbehave
- Exercises firmness when necessary
- Expects the children to exercise self-control

Caregiver Detachment – this reflects the degree to which the teacher is uninvolved or uninterested in the children. Example items include:

- Seems distant or detached from the children
- Spends considerable time in activity not involving interaction with the children
- Fails to show interest in children’s activities
- Fails to supervise children very closely

Table B2. Mean Caregiver Sensitivity Ratings, by PTQ Level, All Providers Combined

	Positive Relationships	Punitive	Permissiveness	Detachment	Total Average Score
Level 1 (n=84)	2.4	1.4	2.1	1.8	3.0
Level 2 (n=87)	2.5	1.3	2.1	1.5	3.1
Level 3 (n=74)	2.8	1.2	1.9	1.4	3.2
Level 4 (n=65)	2.8	1.3	1.9	1.5	3.2

Table B3. Mean Caregiver Sensitivity Ratings, by PTQ Level, Preschool Classrooms Only

	Positive Relationships	Punitive	Permissiveness	Detachment	Total Average Score
Level 1 (n=19)	2.5	1.3	2.0	1.5	3.1
Level 2 (n=29)	2.6	1.3	2.0	1.4	3.1
Level 3 (n=18)	2.8	1.3	1.9	1.3	3.3
Level 4 (n=23)	2.8	1.5	2.0	1.5	3.2

Table B4. Mean Caregiver Sensitivity Ratings, by PTQ Level, Licensed Family Child Care Homes Only

	Positive Relationships	Punitive	Permissiveness	Detachment	Total Average Score
Level 1 (n=51)	2.2	1.4	2.2	2.0	2.9
Level 2 (n=40)	2.5	1.2	2.1	1.6	3.1
Level 3 (n=48)	2.8	1.2	1.9	1.5	3.2
Level 4 (n=25)	2.9	1.2	1.9	1.6	3.3

Table B5. Mean Caregiver Sensitivity Ratings, by PTQ Level, Infant-Toddler Classrooms Only.

	Positive Relationships	Punitive	Permissiveness	Detachment	Total Average Score
Level 1 (n=14)	2.6	1.4	2.1	1.6	3.1
Level 2 (n=18)	2.6	1.4	2.3	1.5	3.1
Level 3 (n=8)	2.8	1.3	2.2	1.4	3.2
Level 4 (n=17)	2.7	1.2	2.0	1.5	3.2

What subscales and items have the lowest scores on the ERS? Where can quality be improved for Level 3 and 4 providers?

Each of the items on the ERS was analyzed to determine which had the lowest average scores. There appears to be some trends across the ITERS-R, ECERS-R and the FCCERS-R. Following are the lowest rated items by PTQ level and type of care. Tables B6., B7., and B8. display means for the lowest ERS items.

Table B6. Means for the Lowest ERS Items in Preschool Classrooms

	Meals/Snack	Diapering/ Toileting	Health Practices	Safety practices	Using language to develop reasoning skills	Math/Number
Level 1	1.8	1.8	2.3	1.8	2.8	3.1
Level 2	1.5	1.6	2.3	2.1	2.8	2.9
Level 3	2.6	2.4	2.7	1.8	3.0	3.0
Level 4	2.6	2.4	2.0	2.5	3.4	3.9

Table B7. Means for the Lowest ERS Items in Infant/Toddler Classrooms

	Meals/Snack	Diapering/ Toileting	Health Practices	Safety practices	Blocks	Science/Nature
Level 1	1.5	1.8	1.9	2.3	2.4	2.8
Level 2	1.5	1.2	1.6	2.9	2.7	2.5
Level 3	1.0	1.6	1.6	2.0	1.6	2.0
Level 4	1.9	1.9	2.0	2.6	2.2	3.1

Table B8. Means for the Lowest ERS Items in Family Child Care Homes

	Meals/Snack	Diapering/ Toileting	Health Practices	Safety practices	Nap/Rest	Active Physical Play
Level 1	1.2	1.3	1.5	1.5	1.6	1.8
Level 2	1.4	1.3	1.6	1.6	1.9	1.6
Level 3	1.3	1.2	1.6	1.6	1.8	1.9
Level 4	1.9	1.7	2.1	1.9	2.5	2.1

APPENDIX C

Table C1. Distribution of Children by Household Income Levels, by Type of Care and PTQ Quality Level

	Licensed Child Care Centers			Licensed Family Child Care Homes		
	Low income ^a	Middle income ^b	High income ^c	Low income ^a	Middle income ^b	High income ^c
Level 1	12% (10)	25% (9)	23% (15)	27% (19)	33% (35)	27% (17)
Level 2	33% (28)	36% (13)	22% (14)	23% (16)	24% (26)	32% (20)
Level 3	28% (24)	17% (6)	15% (10)	34% (24)	27% (29)	26% (16)
Level 4	28% (24)	22% (8)	40% (26)	17% (12)	16% (17)	15% (9)
TOTAL	46% (86)	19% (36)	35% (65)	30% (71)	45% (107)	25% (62)

^aLow income = under \$35,000. ^bMiddle income = \$35,000-\$75,000. ^cHigh income = \$75,000 and higher.

Table C2. Distribution of Children by Parental Education Levels, by Type of Care and PTQ Quality Level

	Licensed Child Care Centers			Licensed Family Child Care Homes		
	Low education ^a	Middle education ^b	High education ^c	Low education ^a	Middle education ^b	High education ^c
Level 1	0	17% (14)	21% (15)	0	37% (28)	34% (36)
Level 2	17% (1)	29% (25)	32% (23)	25% (1)	25% (25)	28% (29)
Level 3	50% (3)	26% (22)	15% (11)	25% (1)	32% (33)	27% (28)
Level 4	33% (2)	28% (24)	32% (23)	50% (2)	16% (16)	11% (12)
TOTAL	4% (6)	52% (85)	44% (72)	2% (4)	48% (102)	50% (105)

^aLow education = high school diploma/GED or less. ^bMiddle education = some college or associate's degree. ^cHigh education = B.A. or higher.

Table C3. Mean (SD) Scores for Infant-toddler Developmental Measures, by PTQ Level

PTQ Rating	Children	Social Competence	Social Problem Behavior	Developmental Score-Cognitive M = 100, SD 15
Level 1	66	14.5 (4.42)	12.4 (8.5)	87.53 (17.26)
Level 2	76	15.3 (3.63)	13.1 (7.63)	90.81 (19.6)
Level 3	60	15.14 (3.79)	13.1 (8.1)	89.33 (17.45)
Level 4	47	15.23 (4.01)	13.01 (8.2)	92.57 (19.54)

Table C4. Mean (SD) Scores for Preschool Developmental Measures, by PTQ Level

PTQ Rating	Children	Social Competence and Behavior Evaluation			Woodcock Johnson		PPVT
		Social Competence	Anxiety Withdrawn	Anger Aggression	Letter Word identification	Math skills	Receptive language
Level 1	78	3.85 (.98)	1.94 (.62)	2.31 (.90)	99.21 (12.09)	103.58 (11.57)	100.18 (13.71)
Level 2	80	3.90 (.85)	1.87 (.59)	2.18 (.64)	98.2 (12.65)	102.57 (16.37)	99.56 (13.94)
Level 3	80	4.12 (.94)	1.72 (.56)	2.05 (.70)	96.37 (11.55)	102.30 (12.70)	97.67 (14.36)
Level 4	70	3.89 (.86)	1.76 (.62)	2.19 (.67)	101.16 (12.28)	103.58 (14.08)	102.45 (14.87)

Table C5. Mean (SD) Scores for Infant-toddler Developmental Measures of Children Receiving Child Care Subsidies or Vouchers, by PTQ Level

PTQ Rating	Children	Brief Infant Toddler Social Emotional Assessment		Mullen Scale of Early Learning
		Social Competence	Social Problem Behavior	Cognitive Score M = 100, SD 15
Level 1	3	19.67 (.58)	27.5 (4.9)	90 (19.31)
Level 2	17	14.43 (3.96)	15.62 (8.31)	80.18 (18.22)
Level 3	10	14 (2.8)	12.5 (6.24)	91.2 (14.8)
Level 4	11	13.27 (3.25)	12.4 (8.65)	88.3 (17.69)

Note. Because of the small numbers associated with children receiving vouchers, caution should be used in interpreting this data. (n=41).

Table C6. Mean (SD) Scores for Preschool Developmental Measures of Children Receiving Child Care Subsidies or Vouchers, by PTQ Level

PTQ Rating	Children	Social Competence and Behavior Evaluation			Woodcock Johnson		PPVT
		Social Competence	Anxiety Withdrawn	Anger Aggression	Letter Word identification	Math skills	Receptive language
Level 1	14	3.68 (1.25)	2.01 (.75)	2.34 (1.14)	95.57 (8.78)	98.79 (10.94)	95.71 (8.47)
Level 2	12	3.65 (.66)	1.71 (.75)	2.04 (.75)	93.4 (10.24)	101.23 (10.8)	94.15 (13.06)
Level 3	9	4.33 (.99)	1.74 (.50)	2.1 (.49)	91.89 (12.72)	94.78 (12.45)	94.89 (15.49)
Level 4	20	3.67 (.89)	1.99 (.67)	2.37 (.91)	98.90 (11.05)	100.25 (14.65)	98.05 (14.66)

Note. Because of the small numbers associated with children receiving vouchers, caution should be used in interpreting this data. (n=56).

Paths to  QUALITY

A Child Care Quality Rating System for Indiana
What is its Scientific Basis?

James Elicker
Carolyn Clawson Langill
Karen Ruprecht
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Center for Families and Department of Child Development & Family Studies

EXECUTIVE SUMMARY

Paths to QUALITY-- Child Care Quality Rating System for Indiana What is its Scientific Basis?

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October 23, 2007

Paths to QUALITY—A Child Care Quality Rating System for Indiana: What is its Scientific Basis?

Executive Summary

Paths to QUALITY is Indiana's new statewide child care quality rating system, scheduled to begin implementation in selected regions of the state in 2008 and then continue phased implementation through 2009. Child care quality rating systems are a relatively recent trend in the United States.

The main components of most state QRS programs are: 1) a set of quality standards that apply to home-based and center-based child care; 2) a process for objectively assessing child care quality and maintaining accountability; 3) a system of training and technical assistance to help child care providers improve quality; 4) incentives to encourage providers to reach higher levels of quality; and 5) public information to inform parents about what the QRS is and how to use it when they make child care decisions. As of January, 2007, 15 states had already implemented a QRS for child care, and several other states, including Indiana, were planning QRS programs.¹

In 2007 Indiana's Bureau of Child Care, a division of the Family and Social Services Administration, contracted Purdue University to complete a scientific review of the quality standards contained in Paths to QUALITY, the proposed quality rating system. The overall goal of this review was to conduct an external evaluation of the scientific validity of the Paths to QUALITY standards.

The review focused on the following three questions:

1. What are the known results and effects of the two existing Indiana QRS pilot programs to date? (Fort Wayne and Evansville areas)
2. Will the proposed Indiana QRS levels and criteria result in increasing the quality of child care children receive? (What does existing research tell us?)
3. Will the Indiana QRS system improve developmental outcomes for children? (What does existing research tell us?)

Paths to QUALITY Levels and Criteria

Indiana Paths to QUALITY (PTQ) establishes four levels of quality that apply to licensed child care centers, licensed family child care homes, and registered child care ministries. Each level includes specific criteria that must be met in order for that level to be awarded. The quality levels are labeled:

Level 1 – Health and Safety

Level 2 – Learning Environment

Level 3 – Planned Curriculum

Level 4 – National Accreditation

Paths to QUALITY History

Paths to QUALITY in Indiana

The Paths to QUALITY program was created by the Child Care and Early Education Partnership, a group of organizations working together in the Northeast Indiana “to develop awareness of and commitment to the importance of high quality early care and education for all children in the community.”² During 1996 to 1999, Paths to QUALITY, a child care quality indicator system, was created as a strategy to identify high quality early care and education.

Goals of Paths to QUALITY

Paths to QUALITY is a voluntary system created to assist parents in identifying and selecting quality child care and recognize providers for ongoing efforts to achieve higher standards of quality that the minimum state licensing requirements. Providers who choose to join PTQ receive a verification visit, are assessed, and are placed on one of four levels. Providers receive yearly re-verification visits to determine if they have maintained their current level or achieved a higher level.

The goals of the Paths to QUALITY as originally conceived were:

- 1. raise the quality of child care and early education experiences for children,**
- 2. give parents tools to help determine the best quality program for their children, and**
- 3. support and recognize providers for quality care.**

Implementation of Paths to QUALITY

In 2000, PTQ was implemented in Allen County in Northeast Indiana by the Early Childhood Alliance (ECA) Child Care Resource and Referral agency. In 2001, PTQ was implemented in the surrounding 5 counties of DeKalb, Whitley, Steuben, Noble, and LaGrange.

In 2005, 4C of Southern Indiana implemented the PTQ program in the 11 county service area of Vanderburgh, Posey, Pike, Dubois, Warrick, Knox, Martin, Daviess, Spencer, Gibson, and Perry Counties.

Conclusions from PTQ pilot programs in Northeast and Southwest Indiana:

- The dramatic growth in participation rates and increases in levels by providers in both regions illustrate the success of the program.
- In both regions relationships between providers and child care resource & referral staff, in particular mentoring services and training opportunities, were reported to be critical to the success of the programs and advancement in PTQ levels.
- Barriers for providers to advance levels in PTQ included: completing voluntary certification participation, meeting education and training requirements of staff, providing accessible, appropriate learning materials, understanding and implementing a developmentally appropriate curriculum, providing parent/teacher conferences, and implementing various administrative changes (developing parent contracts, writing strategic plans, instituting parent surveys and evaluations).
- Increased participation in training and professional development events made the greatest difference in helping providers advance to higher levels.
- The pilot programs demonstrate that the PTQ system is understandable to child care providers and provide preliminary evidence that when providers reach higher levels, they are increasing the quality of care and education they provide for children, as assessed by objective and valid quality measures.
- The successes of PTQ pilot programs provide encouragement for the development of a statewide quality rating system using the PTQ levels.

Key Quality Indicators Contained in the Paths to Quality Levels

After reviewing the Paths to QUALITY standards, the Purdue research team identified 10 “key quality indicators” within the standards: 1) Regulation, 2) Teacher education and specialized training, 3) Structural quality, 4) Process quality, 5) Assessment, 6) Provisions for children with special needs, 7) Program policies and procedures, 8) Director professional development, 9) Parent-teacher communication and involvement, and 10) Accreditation by NAEYC or other organizations.

We defined a “quality indicator” as something that:

1. is a concrete, observable, or otherwise documentable aspect of child care settings or practices;
2. has been identified as a “best practice” in national policies or professional position statements; and
3. has been evaluated specifically in the published scientific early education and child care literature.

Next, we identified the Paths to QUALITY levels and criteria that include each indicator and reviewed available evidence for the importance of each indicator and its relation to other measures of quality and its relationship to children’s development and well-being.

Conclusions: Validity of the PTQ Levels and Criteria

- A thorough review of 10 main quality indicators (including 12 additional sub-indicators) within the PTQ levels and standards revealed substantial scientific evidence for the validity of the PTQ quality criteria.
- 75% of the quality indicators we examined had “substantial evidence” for their validity.
- In addition, most of the PTQ quality indicators had significant evidence that they support children’s development, learning, or well-being in child care.
- Overall, we found significant support for the validity the PTQ quality indicators in the child development and early education scientific literature.
- In addition, most of the PTQ standards have the support of prominent early childhood education organizations, which have designated them as “best practices.”

General Conclusions

- Based on our analysis of the PTQ program as developed in regional pilots and upon review of the evidence for the validity of the proposed PTQ quality standards, we conclude that, if implemented with diligence, care, and accountability, the PTQ program has the potential to increase the quality in child care centers, child care ministries, and child care homes in Indiana.
- Further, if implemented with care, the PTQ system has the potential to help child care providers increase their support of Indiana young children's learning, development, and well-being.

¹ National Child Care Information Center. (2007, April). Quality rating systems: Definition and statewide systems. Retrieved September 21, 2007 from www.nccic.org/pubs/qrs-defsystems.html.

² Child Care and Early Care Partnership Mission, 1996.

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Paths to QUALITY—A Child Care Quality Rating System for Indiana: What is its Scientific Basis?

Introduction

Paths to QUALITY is Indiana's new child care quality rating system, scheduled to begin implementation in selected regions of the state in 2008 and then continue phased implementation statewide through 2009. Statewide child care quality rating systems are a relatively recent trend in the United States. According to the National Child Care Information Center:

A Quality Rating System (QRS) is a systemic approach to assess, improve, and communicate the level of quality in early care and education programs. Similar to rating systems for restaurants and hotels, QRS award quality ratings to early care and education programs that meet a set of defined program standards. These systems provide an opportunity for States to (1) increase the quality of care and education for children; (2) increase parents' understanding and demand for higher quality care; and (3) increase professional development of child care providers. QRS can also be an effective strategy for aligning components of the early care and education system for increased accountability in improving quality of care.¹

The main components of most QRS programs are: 1) a set of quality standards that apply to home-based and center-based child care; 2) a process for objectively assessing child care quality levels and maintaining accountability; 3) a system of training and technical assistance to help child care providers improve quality; 4) incentives to encourage providers to reach higher levels of quality; and 5) public information to inform parents about what the QRS is and how to use when they make child care decisions. As of January, 2007, 15 states had already implemented a QRS for child care, and several other states, including Indiana, were planning QRS programs.²

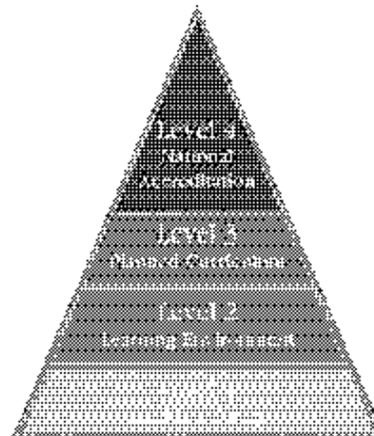
In 2007 Indiana's Bureau of Child Care, a division of the Family and Social Services Administration, contracted Purdue University to complete a scientific review of the quality standards contained in Paths to QUALITY, the planned quality rating system. The overall goal of this review was to conduct an external evaluation of the scientific validity of the Paths to QUALITY standards, as proposed. The review focused on the following three questions:

1. What are the known results and effects of the two Indiana QRS pilot programs to date? (Fort Wayne and Evansville areas)
2. Will the proposed Indiana QRS levels and criteria result in increasing the quality of child care children receive? (What does existing research tell us?)
3. Will the Indiana QRS system improve developmental outcomes for children? (What does existing research tell us?)

This report summarizes this review of scientific literature supporting the Paths to QUALITY standards. First, we present an overview of the four Paths to QUALITY levels, including the criteria child care providers must meet to attain each level. Second, we provide a summary of the original Paths to QUALITY program in the Fort Wayne area, and its subsequent replication in southwestern Indiana. We review the accomplishments and the documented impact of these

pilot programs on child care quality in these regions of the state. Third, we summarize our detailed analysis of 10 important “quality indicators” that are contained in the new Paths to QUALITY standards. This analysis includes a definition of each quality indicator, a description of where it appears in Paths to QUALITY levels, and a review of the scientific literature pertaining to each quality indicator. Fourth, we draw conclusions about the overall scientific validity of the Paths to QUALITY standards, projecting the program’s impact on Indiana’s child care quality and the development of its young children.

Overview: Paths to QUALITY Levels and Criteria



Indiana Paths to QUALITY establishes four levels of quality that apply to licensed child care centers, licensed family child care homes, and registered child care ministries. Each level includes specific criteria that must be met in order for that level to be awarded. The quality levels, with a brief description of the criteria for each level, are:

Level 1 – Health and Safety

- Basic requirements for health and safety are met.
- Develop and implement basic health and safety policies and procedures.
- Staff members receive orientation within 30 days of being hired.

Level 2 – Learning Environment

- Provide an environment that is welcoming, nurturing, and safe for the physical, emotional, and social well-being of all children.
- Activities and materials reflect the age, interests, and abilities of all children.
- Provide for children’s language and literacy skill development.
- Provide pertinent program information to families.
- Promote staff/assistant caregivers’ development and training.
- Program has a written philosophy and goals for children.

Level 3 – Planned Curriculum

- A written curriculum and planned program for children reflects developmentally appropriate practice.
- Program evaluation is completed annually by parents and staff.
- Actively engage in program evaluation and have an action plan for improvement
- Demonstrate professional growth of Director and staff or lead caregiver and assistants in excess of licensing requirements
- Facilitate family and staff input into the program.
- Program has been in operation for a minimum of one year or lead Caregiver has at least 12 months experience in a licensed or Bureau of Child Care nationally recognized accredited child care setting as a child care provider.

Level 4 – National Accreditation

- Accreditation is achieved through the National Association for the Education of Young Children (NAEYC) or the National Association of Family Child Care (NAFCC).
- Professional development and involvement continues including mentoring other directors/providers.

Paths to QUALITY: History**Goals of Paths to QUALITY**

Paths to QUALITY is a voluntary system created to assist parents in identifying and selecting quality child care and recognize providers for ongoing efforts to achieve higher standards of quality than the minimum state licensing requirements. Providers who choose to join PTQ receive a verification visit, are assessed, and are placed on one of four levels. Providers receive yearly re-verification visits to determine if they have maintained their current level or achieved a higher level.

The goals of the Paths to QUALITY as originally conceived were:

- 1. to raise the quality of child care and early education experiences for children,**
- 2. to give parents tools to help determine the best quality program for their children,**
and
- 3. to support and recognize providers for quality care.**

Through these goals it was proposed that PTQ would also provide the following benefits:

- Affirm and support the role of parents
- Provide opportunities for all children to develop optimally
- Develop well-trained, qualified child care and early education staff
- Provide experiences which help children succeed in school
- Make affordable, high quality child care available when and where families need it
- Encourage a more stable child care workforce through increased stature, professionalism, salaries and benefits
- Help children make a smooth transition to kindergarten

History of PTQ in Indiana

The Paths to QUALITY program was created by the Child Care and Early Education Partnership, a group of organizations working together in the Fort Wayne area “to develop awareness of and commitment to the importance of high quality early care and education for all children in the community.”³ In 1996, the Partnership funded a community action plan titled *Child Care & Early Education: Everyone’s Business* to address the child care and early education needs of Allen County. The partnership sought to develop a clear set of objectives for high quality child care and early education, identify the local assets for and barriers to achieving those objectives, and establish a plan to build on assets to overcome the barriers of and move the community toward high quality child care and early education. To develop awareness of and commitment to the importance of high quality early care and education, the standard for child care quality and support of quality early care and education were addressed in Northeast Indiana. During 1996 to 1999, Paths to QUALITY, a child care quality rating system, was created as a strategy to identify high quality early care and education.

Implementation of Paths to QUALITY

In 2000, PTQ was implemented in Allen County in Northeast Indiana by the Early Childhood Alliance’s (ECA) Child Care Resource and Referral agency. In 2001, PTQ was implemented in the surrounding 5 counties of DeKalb, Whitley, Steuben, Noble, and LaGrange.

In 2005, 4C of Southern Indiana, Inc. implemented the PTQ program in the 11 county service areas of Vanderburgh, Posey, Pike, Dubois, Warrick, Knox, Martin, Daviess, Spencer, Gibson, and Perry Counties.

Overview of Results: Early Childhood Alliance PTQ Program (Northeast Indiana)

The following summary of results is based on a review of annual reports provided by the Early Childhood Alliance. No external evaluation of the program has been conducted. Each of the 3 main goals of PTQ is addressed in this summary of PTQ outcomes. (For a more detailed summary report of the ECA Paths program and results, see Appendix 2, “Paths to QUALITY Pilot Program: Early Childhood Alliance.”)

Table 1 highlights participation levels of each provider type within the Early Childhood Alliance program from 2001-2007. Participation levels increased steadily each year for each type of provider. Registered ministries experienced a slight decrease from 2006 to 2007. Part time preschool programs experienced small variations in participation rate through the six years, but averaged around 40%.

Table 1. Participation rates for PTQ in Northeast Indiana (% of eligible providers)

	2001	2002	2003	2004	2005	2006	2007
All providers registered with PTQ	28%	42%	47%	47%	52%	53%	60%
Licensed Centers	75%	76%	82%	90%	88%	96%	96%
Family Homes	23%	41%	46%	50%	54%	54%	64%
Registered Ministries	9%	12%	23%	23%	25%	35%	32%
Part time programs	38%	40%	42%	34%	42%	38%	44%

Goal #1: Raise the quality of child care and early experiences for children.

Table 2 presents data about how providers increased in levels once they entered the system:

- Sixty-seven percent of providers increased a minimum of one or more levels of quality.
- By July 2007, 92% (217) of providers on PTQ increased at least one level since they began the program.

Table 2. Programs and providers initial and current PTQ rating in Northeast Indiana

	Initial Rating	Current Rating (July 2007)
Level 1	67%	24%
Level 2	9%	15%
Level 3	11%	25%
Level 4	13%	35%

Some of the providers who were receiving mentoring provided by ECA received quality assessments using one of three measures of classroom quality – the Early Childhood Environment Rating Scale (ECERS), the Infant Toddler Environment Rating Scale (ITERS), or the Family Day Care Environment Rating Scale (FDCRS).

- In this small sample of PTQ programs and providers (34 providers), those who had earned higher PTQ levels exhibited higher levels of assessed quality:

Table 3. Average global (overall) quality for providers at each PTQ level in Northeast Indiana

PTQ Level (# of providers)	Global (Overall) Quality Score (1-7)	Range of Quality Scores
Level 1 (15 providers)	3.8	2.4-4.9
Level 2 (12 providers)	4.7	3.3-5.5
Level 3 (7 providers)	5.1	3.4-6.8
Level 4 (2 providers)	5.7	5.6-5.7

Goal #2: Give parents tools to help determine the best quality program for their children.

- Parents were educated about the PTQ program in the following ways: PTQ brochures, mass media campaigns, PTQ website, visibility at health, job, or diversity fairs, and through the Early Childhood Alliance Child Care Resource and Referral.

Goal # 3: Support and recognize providers for quality care.

- Providers' professional organization membership and participation increased in Northeast Indiana, providing opportunities for providers to network and be recognized for their accomplishments in achieving higher levels of quality.
- Family child care home providers in Northeast Indiana created an organization called United Providers to continue networking and professional development opportunities and provide stability and professionalism for the participants.
- Incentives such as discounts at training programs and retreats, free resource library cards, delivery of materials from the Child Care Resource and Referral, discounts on books, and recognition in a list of Paths To QUALITY participants distributed to parents and businesses were utilized to encourage child care providers to participate and work toward higher levels of quality.

Challenges for the PTQ program in Northeast Indiana

- Participation among family child care providers has required the greatest effort to increase and maintain.
- Offering incentives to providers to participate in PTQ had the greatest impact on increasing participation.
- Barriers of providers to advancing levels in PTQ included: development of policies, completing voluntary participation, meeting education and training requirements of staff, providing accessible appropriate learning materials especially in the area of language and literacy, providing parent/teacher conferences, understanding and implementing a developmentally appropriate curriculum, getting parents and advisory board involved in the program, and the commitment to achieve and maintain accreditation.
- High levels of turnover, changing or increasing regulations, and the cost of providing staff training were reported obstacles by early education programs in maintaining level status.
- The most common reason for attrition from PTQ was due to programs closing. In particular, family child care providers stopped offering care.
- Mentoring of programs and providers and teacher education and training had the greatest impact on overcoming the barriers to level advancement.

Conclusions from PTQ pilot program in Northeast Indiana

The growth in participation rates and dramatic increases in levels by providers illustrate one measure of success of the PTQ program. According to Early Childhood Alliance staff, it is important that a rating system of this nature is a voluntary, strength-based system, and based on relationship building. Relationships between providers and the child care resource referral staff-- in particular mentoring services and training opportunities-- became critical to the success of the program. Increased participation in training and professional development events made the

greatest difference in helping providers advance to higher levels. ECA staff also suggested a strong sense of identity with the PTQ program is important for providers' sustained participation.

Overview of Results: 4C of Southern Indiana, Inc. Paths to QUALITY program

The following summary of results is based on a review of annual reports provided by 4C of Southern Indiana, Inc. and by an external evaluation study conducted by Purdue University the Purdue University Early Child Care Quality Initiative (ECCQI) evaluation study⁴ and funded by the Welborn Baptist Foundation, Inc. Each of the 3 main goals of PTQ is addressed in this summary of PTQ outcomes. (For a more detailed summary report of the 4C of Southern Indiana, Inc. Paths program and results, see Appendix 3, "Paths to QUALITY Pilot Program: 4C of Southern Indiana, Inc.")

Goal #1: Raise the quality of child care and early experiences for children.

- Using informal "word of mouth" advertising techniques, 4C was able to recruit 177 programs registering for PTQ during the first 9 months the program was operational.
- There has been a small increase in the number of family home providers and licensed centers achieving national accreditation.
- The Purdue University ECCQI evaluation study found that the two most common kinds of changes programs and providers implemented since joining Paths to QUALITY were: 1) classroom changes, such as adding materials, room arrangements and curriculum changes, (66%) and 2) program administrative changes, such as parent contracts, documentation and lesson planning, introducing primary caregiving and continuity of care, writing strategic plans, instituting parent surveys and evaluations, joining professional organizations (49%).

Similar to the Northeast Indiana programs, the providers in the 4C region experienced growth in the number of programs enrolled in PTQ over the 2 ½ years of implementation (Table 4).

Table 4. Participation rates of PTQ in Southwest Indiana (% of providers eligible)

	2005	2006	2007 (through June 2007)
% of providers registered with PTQ	30%	42%	46%
Licensed Centers	72%	89%	93%
Family Homes	20%	27%	31%
Registered Ministries	57%	71%	75%
Part time programs	36%	64%	67%

Providers often increased their levels in PTQ. During the first year of implementation (2005), most of the providers entered at Level 1. However, within two years, more than half of the providers were able to increase their levels.

- Overall in 2006, 36% of the registered programs (54 programs) increased at least one level and 22% (40 programs) increased more than one level.

Table 5. 4C providers initial and current PTQ rating

	Initial Rating	Current Rating (July 2007)
Level 0	20%	10%
Level 1	64%	39%
Level 2	9%	23%
Level 3	3%	16%
Level 4	5%	12%

Similar to the Northeast Indiana programs, a small sample of providers in the 4C region also participated in a mentoring program provided by 4C of Southern Indiana, Inc.. These programs were part of the Purdue University evaluation of the mentoring program.

- The Purdue University ECCQI study found that providers who had earned higher PTQ levels did exhibit higher levels of assessed quality:

Table 6. Average global (overall) quality for providers at each Paths to QUALITY level. (n=47)

Paths to QUALITY Level (# of classrooms observed)	Average Global Quality Score (1-7)	Range of Quality Scores
Level 0* (3 classrooms/homes)	3.19	2.78-3.49
Level 1 (28 classrooms/homes)	4.45	3.41-5.26
Level 2 (11 classrooms/homes)	4.64	3.69-5.48
Level 3* (5 classrooms/homes)	4.35	2.88-5.67

*Notes: Level 0 includes only 1 center-based provider, the rest were family child care homes.

Level 3 includes only 2 center-based providers.

Level 4 providers did not participate in the mentoring program, so quality data were not available.

Goal #2: Give parents tools to help determine the best quality program for their children

- Strategies similar to those used in Northeast Indiana (PTQ brochures, visibility at health, job, or diversity fairs, and through the 4C of Southern Indiana Child Care Resource and Referral) were utilized to inform parents about PTQ.

Goal #3: Support and recognize providers for quality care

- 4C of Southern Indiana, Inc. hosted annual Leadership Retreats for child care program directors and family child care providers, in response to providers' requests to meet and reflect upon different issues facing child care providers.
- Overall, evaluations of the first retreat were very positive, with 91% to 100% strongly agreeing or agreeing that by attending the sessions they had obtained the skills and knowledge necessary begin to bring about change.
- Ten months after the first retreat, while ratings were not as high as those collected immediately afterwards, many participants still thought the sessions had been useful.
- Incentives such as materials to improve quality, scholarships, special project grants, and recognition in a list of Paths To QUALITY participants distributed to parents and businesses were utilized to encourage child care providers to participate and work toward higher levels of quality.

Challenges for the PTQ program in Southwest Indiana

- The main challenge during the first year of implementation was adequately handling the high level of interest in the program among child care providers. Staff members were cross trained to register programs so the demand could be met.
- Some programs in this region were unable to meet Level 1 criteria. A majority of these programs were registered ministries or part-time preschool programs. 4C staff designated these programs as "Level 0," remained committed and assisted them when possible in achieving a Level 1 status.
- Barriers to providers to advance levels in PTQ included: implementing classroom changes such as adding materials and room arrangements, implementing or adopting a curriculum and lesson planning, and implementing administrative changes (developing parent contracts, writing strategic plans, instituting parent surveys and evaluations), joining professional organizations, and providing opportunities for more staff training hours.
- The most common reasons given for attrition from PTQ was programs closing, having license revoked, or lack of interest in continuing with the program.
- Mentoring, funding for developmentally-appropriate materials, and access to additional training for the staff had the greatest impact on overcoming the barriers to PTQ level advancement.

Conclusions from PTQ pilot program in Southwest Indiana

Information from the Purdue University ECCQI evaluation study and the annual reports of 4C of Southern Indiana, Inc. indicate that the PTQ system has been successful and accepted by many area child care providers. Because many providers enter Paths to QUALITY at Level 1 and then progress relatively quickly to Levels 2 and 3, it is important that child care provider training and support focus on nurturing environments for children, curriculum, staff and parents policies, planning, and program evaluation, which are Level 2 and Level 3 criteria. However, there was evidence that some providers may also need consistent support to maintain Level 1 health and safety standards, so it is important to continue to be vigilant about these issues, even when training with objectives focused on Level 2 or higher quality criteria.

General Conclusions: Indiana PTQ Pilot Programs

The growth in participation rates and increases in quality levels by providers illustrate the success of the PTQ program in both regions. Both pilot programs reported similar successes and challenges. Each found unique solutions to overcoming barriers of participation and advancement. However, in both regions relationships between providers and the child care resource & referral staff, in particular the mentoring services and training opportunities, were reported to be critical to the success of the programs. Increased participation in training and professional development events made the most difference in providers' advancement in quality levels. A strong sense of identity with the PTQ program for those providers participating was also deemed important. Participation rates are only one indicator of success. An even more important indicator of success was the quality level improvements that many participating providers and programs have made.

The successes of PTQ pilot programs in Northeast and Southwest Indiana provide encouragement for the development of a state wide quality rating system using the PTQ levels. Based on the experience of these two pilot regions, it is important that a rating system of this nature be a voluntary, strength-based system, and that it be based on relationship building. If Paths to QUALITY continues to be successful in attracting broad participation, it will be important for organizations that offer support and training to child care providers to coordinate efforts. Paths to QUALITY can become a primary vehicle for motivating child care providers to seek further education and to improve the quality of their services to children and families. If quality early care and education is a value held by the larger community, there is a need for all support organizations to coordinate efforts and invest resources in providers who are enrolled in Paths to QUALITY.

There were three limitations of the regional PTQ data and this report: 1) the report relied heavily on historical participation data collected by the PTQ sponsoring agencies; 2) there were relatively few quality assessments conducted by external observers, which limits conclusions we can draw about the relation between PTQ quality levels and other objective measures of quality; and 3) there were no data available to address the question of whether PTQ quality levels enhance children's development and learning. These limitations should be addressed in the evaluation of the statewide PTQ program.

What Are the Key Quality Indicators Contained in the Paths to QUALITY Levels?

In order to evaluate the scientific validity of the Paths to QUALITY standards, it was necessary to identify key quality indicators or variables that are contained in the proposed standards. We defined a “quality indicator” as something that:

1. is a concrete, observable, or otherwise documentable aspect of child care settings or practices;
2. has been identified as a “best practice” in national policies or professional position statements; and
3. has been evaluated specifically in the published scientific child care and early education literature.

This was a necessary step in searching the scientific literature for evidence that the PTQ standards are important aspects of care and education that contribute to children’s development and learning. We found 10 important main quality indicators in the PTQ standards. For a detailed summary of the 10 indicators and where they are found in the PTQ levels and criteria, see Appendix 1., “Quality Indicators Contained in Paths to QUALITY.”

1) Regulation

Minimum standards for centers and family child care homes to legally care for children. In Indiana this requires centers and homes to have a state child care license or registration. Indiana also offers the Voluntary Certification Program for registered ministries. The voluntary program consists of a list of guidelines in Health, Safety, Food/Nutrition, Infant/Toddler care for registered ministries.

2) Teacher education and specialized training

The level or amount of formal education as well as informal training and workshops through child care resource and referral offices, professional organizations, child care resource and referral agencies, related to child development issues, working with parents.

3) Structural quality

The features of the child care setting that are easily observable and regulatable, such as teacher-child ratio, group size, and physical features of the classroom or family child care home.

4) Process quality

The “process” aspects of the child care environment that reflect the child’s everyday experience, including teacher-child interactions, children’s engagement in activities, types of activities in the daily routine, the use of a developmentally appropriate curriculum, language and literacy opportunities, and respect for diversity and individual children and families.

5) Assessment

Authentic or naturalistic assessment methods are used for both child and program assessment. Child assessment is a way of keeping track of each child's progress and also a way of individualizing teaching to meet each child's needs. Program assessment is focused on measuring program trends, quality, or effectiveness.

6) Provisions for children with special needs

The American with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA) ensure the civil and educational rights of people with disabilities. IDEA states that children with disabilities should be provided with accommodations to participate equally in all educational activities with their typically developing peers. Accommodations or adaptations in child care include changes in the physical environment, activities, and time.

7) Program policies and procedures

Program management practices include adequate and timely staff orientation, written policies and procedures, accurate and updated records, an advisory board, annual program evaluation by families and staff, strategic planning for the program including short and long term goals, and teachers' paid planning time.

8) Director professional development

The director or family child care lead caregiver maintains general skills through continuing education and training opportunities to keep current with changing practices in the child care profession. It can also include memberships in professional organizations and participation in networking and mentoring activities with other child care professionals.

9) Parent-teacher communication and involvement

Parents and providers share information on a regular basis about the child and the program. All families are purposefully informed about and involved in program activities. Families have opportunities to participate in planning and evaluating curriculum and other activities for their child and the program.

10) Accreditation by NAEYC or other organizations

A voluntary process by which a representative body provides quality criteria substantially beyond the mandatory requirements of the government (licensing or registration). The most common accreditation body for child care centers is the National Association for the Education of Young Children (NAEYC) and for family child care homes the National Association of Family Child Care (NAFCC).

Paths to QUALITY Indicators: Evidence for Validity

Introduction

This section contains a summary of our analytic review of the 10 main “quality indicators” listed above that provide a framework of standards for the Paths to QUALITY levels, as they are addressed in the child care and early education scientific and professional literature. For each quality indicator, we:

- Define the quality indicator; (What is it?)
- Identify Paths to QUALITY levels and criteria that include this indicator; (What does Paths to QUALITY require?)
- Review available evidence for the importance of this indicator and its relation to other measures of quality; (Is it important for child care quality?) and
- Review available evidence for the relation of this quality indicator to children’s development and well-being. (Is it important for children’s developmental outcomes?)

When evaluating the amount and quality of scientific evidence for each quality indicator, we use the following phrases:

- “There is some or limited evidence...”
 - √ This means that there are at least one or two well-designed research studies that support this conclusion.
- “There is a moderate amount of evidence...”
 - √ This means that there are 3 to 5 well-designed research studies that support this conclusion.
- “There is substantial evidence...”
 - √ This means that this conclusion has been replicated more than 5 times in the research literature in well-designed studies.

1) Regulation

What is “regulation”?

Regulation refers to state child care license regulations for family child care home and child care centers as well as state registry regulations for child care ministries. In Indiana, the Family and Social Services Administration (FSSA), Division of Family Resources (DFR), Bureau of Child Care is the governing body that issues child care provider licenses. Child care ministries are exempt from licensing, but must meet registered ministries regulations also governed by the FSSA. Child care licensing and registration provide basic standards for centers and family child care homes to legally care for children. Additionally, Indiana offers a Voluntary Certification Program for registered ministries. The voluntary program includes a list of guidelines in Health, Safety, Food/Nutrition, Infant/Toddler care for registered ministries.

Regulation: What does Paths to QUALITY require?

Level 1:

- **The license issued by Family and Social Services Administration (FSSA), the Division of Family Resources (DFR) is current and in good standing.**
- **The registration issued by the Family and Social Services Administration (FSSA), the Division of Family Resources (DFR) is current and in good standing.**
- **The ministry meets all CCDF provider eligibility standards.**

Why is regulation important for child care quality?

Regulation, specifically licensing standards, is related to other measures of child care quality

There is a substantial amount of evidence supporting that child care regulation is related to other measures of child care quality.

- Centers in states with stricter child care licensing regulations provide better caregiver-child ratios, employ caregivers with more education specific to early childhood, employ more experienced directors, and have fewer poor quality centers.^{5 6 7}
- Family child care homes that are more regulated provide higher quality child care than less regulated providers.^{8 9}
- Family child care caregivers who are licensed provide higher quality care and are more sensitive to the children in their care than those caregivers who are not licensed.¹⁰
- In an Indiana sample of all types of child care, licensed child care was consistently rated higher in quality than unlicensed care.¹¹

Regulation, specifically stringency of licensing standards is related to child development outcomes

There is a substantial amount of evidence that child care regulation is related to child outcomes.

- Children cared for in centers in states with more stringent regulations score higher on tests of school readiness, language comprehension, and social behavior.^{12 13}
- As centers conform to stricter child care regulations, children's performance on developmental assessments increases.¹⁴

2) Teacher/Caregiver Education & Training

What is “teacher education and training”?

Teacher education and training refers to formal education as well as less formal non-credit training and workshops through child care resource and referral agencies, professional organizations, and child care resource and referral agencies. Education and training provide adults with knowledge and skills required to teach and care for children. The level of education and specialized training in early childhood education/child development and the hours of annual teacher training are related and are often included as one dimension of “structural” child care quality.¹⁵ (We discuss other aspects of structural quality below, but devote this section to teacher education and training, because it is an especially important quality indicator.)

Teacher education and training: What does Paths to QUALITY require?

Level 2:

- 25% of teaching staff have either a Child Development Associate credential (CDA) or equivalent certificate, OR an early childhood degree or equivalent degree, OR have completed 45 clock hours of educational training leading to an Early Childhood/Child Development degree or CDA credential.
- Lead Caregiver will have a current CDA or equivalent certificate, OR an early childhood degree or equivalent degree OR have completed 45 clock hours of educational training in early childhood education within the past three years leading to a CDA or an early childhood/ child development degree.
- Staff/assistants are trained on the *Foundations to the Indiana Academic Standards for Young Children Age Birth to Five*.
- At least 50% of teaching staff/caregivers participate annually in a minimum of 15 clock hours of educational or in-service training focused on topics relevant to early childhood.

Level 3:

- 50% of teaching staff have a CDA or equivalent certificate, an early childhood degree or equivalent degree, OR completed 60 clock hours of educational training leading to an early childhood/child development degree or CDA credential.
- Lead Caregiver will have a current CDA or equivalent certificate, OR an early childhood degree or equivalent degree; OR have completed 60 hours of educational training leading to an early childhood/child development degree or CDA credential within the past three years.
- At least 50% of teaching staff/caregivers participate annually in a minimum of 20 clock hours of educational or in-service training focused on topics relevant to early childhood.

Level 4:

- Lead Caregiver has a current CDA or equivalent or ECE degree or an equivalent degree.

Why is teacher education and training important for child care quality?

Higher levels of teacher education and training are important contributors to high quality early childhood education programs. There is a substantial amount of evidence supporting that teacher education and training are related to other measures of child care quality.

- Family child care providers who have more years of formal education¹⁶ and more training hours provide higher quality of care as measured by the Family Day Care Rating Scale—a widely used measure of global quality.^{17 18 19}
- Family child care providers who have more years of formal education and have recent and higher levels of training provide richer learning environments and warmer and more sensitive care to children.²⁰
- Formal education (college degree) is a better predictor of high quality than training alone. Family child care providers without a college degree who reported attending workshops provided less sensitive and lower quality care than the caregiver with a college degree who did not report attending workshops.²¹
- Child care center providers who attended workshops or professional meetings were rated higher on global quality and caregiver sensitivity than those that did not attend such workshops.²²
- A baccalaureate degree in early childhood education or related field has been found to be the best predictor of higher quality caregiver skills²³
- Children whose teachers have at least a baccalaureate degree in early BA in early childhood education or a Child Development Associate credential, have more creative activities, higher frequencies of language play and positive management than children whose teachers have a high school education only.²⁴

Higher levels of teacher education and training are related to better child development outcomes.

There is a substantial amount of evidence that teacher education and training are related to child outcomes.

- Children cared for by family child care providers who have more formal education and more training scored higher on tests of language and cognitive development.²⁵
- Higher levels of teacher education are linked to children's better academic skills.²⁶
- Children whose teachers had more years of education gained more in math skills over the pre-k year.²⁷
- Language scores among children in the preschool classes were significantly higher if their teacher had a college degree in early childhood and attended a training workshop in the community.²⁸
- Baccalaureate level teachers with specialized training in early childhood education leads to better outcomes for young children^{29 30 31}
- Infants and toddlers cared for by providers with specialized training in child development or early childhood education were rated higher in social-emotional competence by their parents.³²

3) Structural Quality

Structural quality refers to those aspects of the child care environment and practices that are easily observable or documented and thus are easy to check and regulate. We have already discussed one important aspect of structural quality: teacher education and training. This section covers other aspects of structural quality found in the PTQ quality levels: teacher/child ratio; group size; program duration; and classroom environment features.

3a) Structural Quality: Teacher/Child Ratios

What are teacher/child ratios? What are licensing requirements?

Current Indiana rules require the following teacher/child ratios to meet licensing requirements for licensed child care centers:

- 1 adult for every 4 infants (birth-12 months)
- 1 adult for every 5 toddlers (1-2 year olds)
- 1 adult for every 5 two year olds
- 1 adult for every 10 three year olds
- 1 adult for every 12 four year olds
- 1 adult for every 15 five year olds

Family child care providers who operate small homes may care for 6 to 11 children, plus 3 school-aged children. The maximum number of infants/toddlers to one provider is six children under the age of 2, with 2 or more 16 month olds and walking.

In large family child care homes, providers may care for 13-16 children. The maximum number of children per one provider in large family homes is 4:1 for infants; 6:1 for birth–2-years, with 2 or more 16-month old and walking; 10:1 for birth–6-year olds, with no more than 3 under 16-months; and 12:1 for 3 year olds and older.

What does Paths to QUALITY require?

- **Level 1:** Family child care homes and licensed child care centers have their license. Registered ministries must comply with the Voluntary Certification Program, which aligns their ratio requirements with licensed centers.

Why are teacher/child ratios important?

There is a substantial amount of evidence supporting that teacher/child ratios are related to other measures of child care quality.

- The NICHD Early Child Care Study, the most comprehensive national study of children in child care to date, plus other studies show that caregiver/child ratio is one of the most important structural characteristic of center-based care, particularly for younger children.^{33 34 35}
- One study of child care centers in three states found that, among several structural characteristics examined, teacher/child ratios were the only factor other than teacher wages that predicted the quality of preschool classrooms.³⁶
- Caregivers with fewer children in their care are more sensitive, responsive, warm, nurturing, and encouraging toward the children; exhibit more positive and less negative affect; exert less negative control; and provide more varied and developmentally appropriate activities for the children than caregivers with more children in their care.³⁷

- Lower teacher/child ratios allow caregivers to engage in more educational activities (e.g., teaching, promoting problem-solving) with children.³⁸

Lower teacher/child ratios are associated with improved child development outcomes.

There is a substantial amount of evidence that teacher/child ratios are related to child outcomes.

- Lower teacher/child ratios are associated with less distress in toddlers, less apathy and distress in infants and greater social competence.³⁹
- Lower teacher/child ratios are associated with more verbal communication between caregivers and children, which appears to foster language development in children.⁴⁰

3b) Structural Quality: Group Size

What is group size and what are the recommended group sizes?

NAEYC defines group size as “the number of children assigned to a staff member or team of staff members occupying an individual classroom or well-defined space, with clear physical barriers that prevent intermingling of children within a larger room.”⁴¹

Indiana licensing standards set forth recommendations for group sizes for children in center-based and family child care homes.

Table 7. Indiana Criteria for Ratios and Group Size⁴²

Age	Staff/Child Ratio	Maximum Group Size
0 - 1 ½ year old	1:4	8
1 ½ - 2 years old	1:4	10
2 years old (to 30 months)	1:5	10
2 ½ years old (30 -36 months)	1:5	10
3 years old	1:10	20
4 years old	1:12	24
5 years old	1:15	30
Kindergartners	1:15	30
6 - 8 years old	1:15	30
9-12 years old	1:15	30

Group Size: What does Paths to QUALITY require?

Level 1: Family child care homes and licensed child care centers have their license. Registered ministries must comply with the Voluntary Certification Program, which aligns them with licensing requirements summarized in Table 7 above.

Why is group size important for child care quality?

There is a substantial amount of evidence that group size is related to other measures of child care quality.

NAEYC confirms the importance of both group size and staff/child ratios, stating in its revised accreditation criteria that smaller group sizes and larger numbers of staff to children are related to positive outcomes for children.⁴³

- Research on child care classrooms indicates that when groups are smaller, teachers provide more stimulating, responsive, warm, and supportive interactions. They also provide more individualized attention, engage in more dialogues with children, spend less time managing children and more time in educational activities.^{44 45}

Smaller group sizes are related to improved child development outcomes.

There is a substantial amount of evidence that group size is related to child outcomes.

- The increased interaction and communication made possible in smaller classes have been shown to affect children's outcomes. Children in smaller groups were more likely to participate in child-initiated activities and experiences. In addition, when there are fewer children in the room, teachers can more closely mediate children's social interaction.⁴⁶
- In the National Day Care Staffing study, children in smaller classes had greater gains in receptive language, general knowledge, cooperative behavior, and verbal initiative, and showed less hostility and conflict in their interactions with others.⁴⁷

3c) Structural Quality: Program Duration

What is program duration?

Program duration refers to how long the site has been in operation. NAEYC guidelines require that licensed child care programs have been in operation for at least one year before a center can become eligible for the accreditation process.⁴⁸ NAFCC guidelines state that the provider must have at least 18 months experience as a family child care provider before the observation visit or 12 months experience if home visits are conducted monthly and intensive training is received.⁴⁹

Program Duration: What does Paths to QUALITY require?

Level 3:

- Program has been in operation for a minimum of one year.
- Lead Caregiver has at least 12 months experience in a licensed or Bureau of Child Care nationally recognized accredited child care setting as a child care provider.

Why is program duration important?

There is limited and conflicting evidence that program duration, at least as reflected by the child care provider's years of experience, is related to other measures of child care quality or child development outcomes.

- Some research has suggested that child care teachers with more experience are warmer and more responsive to young children.^{50 51}
- However, other research did not replicate these findings and years of caregiver experience was not associated with more responsive care for young children.^{52 53}

3d) Structural Quality: Classroom environment

What are classroom environment features?

Classroom environment features refer to the space and materials that children have available and accessible to them throughout their day in child care.

Classroom Environment Features: What does Paths to QUALITY require?

Level 2: The classroom is arranged and utilizes plentiful materials and activities in order to provide various age- and developmentally-appropriate interest centers that invite children's exploration. Indicators include:

Reading:

- Books, soft washable seating/pillows for use while reading

Writing:

- Writing tools, paper, envelopes, typewriter, letters, numbers

Art:

- Drawing materials (crayons, markers, thick pencils, variety of paper, sizes and types, not coloring books or dittos/worksheets)
- Painting materials
- Tools (scissors, hole punch, tape), staplers for school-age children
- Three-dimensional materials (play dough, clay with tools)
- Collage materials (catalogs, magazines, paper scraps, fabric pieces, string, yarn, cotton balls, pipe cleaners, craft sticks)

Blocks:

- Different size/types of blocks and accessories such as small people, animals, vehicles, road signs, and materials to enhance building, sticks, stones, tape, string, craft sticks, interlocking blocks.

Dramatic Play:

- Dress-up clothes, such as work boots, high heels, a variety of hats, career gear/attire/uniforms, purses, billfolds and multi-cultural outfits. Other items would also include large pieces of fabric/scarves, child-size play furniture, dishes, pots, pans, dolls (multicultural dolls included), dollhouse or other play-sets, accessories for dolls, and "props" for different themes.

Math/Numbers:

- Small objects to count/sort/classify, measuring tools (scales, rulers), numbers/shapes, number games, puzzles and pattern blocks

Music and Movement:

- Audio equipment, variety of tapes/CDs, music boxes, musical toys, and instruments, dance props such as scarves/streamers.

Nature and Science:

- Collections of natural items (shells, rocks, flowers, bugs), living plants, pets to care for, science games, toys, magnets, magnifying glasses, cooking opportunities.

Small Motor/Manipulative:

- Blocks, puzzles, crayons, pencils, scissors, interlocking blocks and other small building toys, pegboard and pegs, games, counting materials, sorting or classifying materials and containers.

Specific Infant/Toddler indicators include:

- Open spaces for exploring and protected play.
- Infants and toddlers are provided a variety of outdoor play experiences.
- Soft, washable elements, such as cuddle toys, soft furniture or cushions.
- Enough materials to avoid problems with children making the same toy choice and waiting.
- Materials are organized consistently on low, open shelves for independent use by children.
- Materials are sturdy and in good condition.
- A variety of open-ended, washable toys, such as rattles, teething/rings, balls, pop beads, nesting toys, containers, cuddle toys, push/pull toys are available.
- Low, stable furniture is available for children to pull themselves up.
- Furniture adapted for toddlers is available.

Toddler activities include building, pretending, experiencing art materials, enjoying stories and books, playing with toys, exploring sensory materials, having fun with music and movement.

Why are classroom environment features important?

Features such as books, art materials, music materials, dramatic play, blocks, fine motor materials, sensory play, math/number, and nature and science activities are all important features of a quality child care environment that enhance children's learning. Classroom environments are important to provide various age- and developmentally-appropriate materials that invite children's exploration of their environment.

Classroom environment features have been identified as important dimensions of quality.⁵⁴

There is substantial evidence that these classroom environment features are central to child care quality.

- Classroom environmental features weigh heavily in the ECERS-R, ITERS-R, and FCCERS, which are the child care environmental rating scales used in research to measure overall child care quality in preschool centers, infant centers, and homes.
- Spacious child care centers appear to be associated with focused solitary play, while the presence of a variety of age-appropriate materials and the arrangement of the space to accommodate group size, seems to influence social problem-solving skills.⁵⁵
- Some research has shown that more stimulating care is associated with centers and homes with better organized space and more varied materials.⁵⁶
- The quality of the physical space and materials provided is believed to affect both the level of children's involvement and the quality of interactions between children and adults.⁵⁷

There is limited evidence that varied and appropriate classroom materials support children's development.

- Better cognitive and social skills have been observed in children whose centers were more orderly, had more varied and stimulating materials, and were organized into activity areas.⁵⁸

4) Process Quality

“Process quality” refers to the child’s direct everyday experiences in the child care setting. Relationships and interactions between children and teachers or caregivers, active engagement in daily activities, a variety of developmentally-appropriate activities in an organized curriculum, and attitudes toward diversity are all part of process quality.

4a) Process Quality: Teacher-Child Interactions

What are teacher-child interactions?

Teacher-child interactions are at the heart of relationship-based care. Interactions occur during routine care, free play and group activities. The amount and type of interactions can impact young children's development, and teachers need to be actively involved and sensitive when interacting with young children.

Teacher-Child Interactions: What does Paths to QUALITY require?

Level 2: Classroom environments are welcoming, nurturing and safe for children to have interactions and experiences that promote the physical, social and emotional well being of children. Indicators include:

Why are teacher-child interactions important?

Relationships that young children develop with adults are crucial to early learning and development. Positive relationships formed through warm, sensitive, and responsive care help children feel valued and gain more from their learning experiences. Children need positive relationships so that they feel comfortable and learn how to cooperate with others.

The National Association for the Education of Young Children (NAEYC) suggests that teachers should "accept responsibility for actively supporting children's development" and that this active involvement should occur in the context of a solid understanding of children's individual needs and interests.⁵⁹

*There is substantial evidence that the quality of teacher- child interactions contributes to quality in early care and education settings.*⁶⁰

- Researchers have demonstrated that sensitive, involved care is related to positive outcomes for both children and classrooms. Studies have shown that the amount and type of adult involvement is related to overall classroom quality.⁶¹
- Some researchers have found that teacher education (one quality indicator) is related to more responsive care in both center-based care and family child care providers.⁶²

There is substantial evidence that children with involved and responsive caregivers fare better on a wide variety of child development measures.

- Children with more involved and responsive caregivers are rated as more sociable and considerate by parents and teachers⁶³, display more exploratory behaviors⁶⁴, are more positive⁶⁵, engage in more complex play⁶⁶, are better adjusted⁶⁷ and have better peer relations.⁶⁸

4b) Process Quality: Children's Active Engagement

What is active engagement?

Active engagement is providing opportunities for young children to freely choose their activities to explore their environments and interact with different peers. Children learn best when they are able to experience the world through a variety of learning materials and when the teacher expands their learning.

Children's Active Engagement: What does Paths to QUALITY require?

- **Level 3:** Children are actively engaged throughout the day in making choices of activities and materials.

Why is active engagement important for child care quality?

During the preschool years and early primary grades, children learn best through active, engaged, meaningful experiences. Through these experiences, young children construct their own knowledge by interacting with their environments and others.⁶⁹

The National Association for the Education of Young Children confirms the importance of direct, first-hand, interactive experience in their position statement on developmentally appropriate practice in early childhood programs.⁷⁰

- Children under age three learn about themselves and their world by experiencing the environment with all their senses — seeing, tasting, hearing, smelling, and feeling — and by moving around their environment as they develop the ability to crawl and walk.⁷¹
- Preschool children are active and social individuals who have lots of ideas they want to try out and share. Preschoolers benefit most when offered a variety of activity choices such as dramatic play, block building, art, table toys, sand and water, cooking, music and movement, and a rich selection of books.⁷²

There is a moderate amount of evidence that children who are encouraged to be active learners develop critical thinking skills and social competence.

- Findings from the Perry Preschool Study demonstrate that when an early childhood education program emphasizes choice and active learning rather than direct teaching and drills, children's acquisition of basic skills and their social competence are enhanced.⁷³
- Graduates of the high-quality, active-learning preschool program, who are now in their late twenties, are significantly more likely to have completed a higher level of schooling, to be employed, to own their own home, and to be in stable relationships, and significantly less likely to have needed social services or to have been arrested, than their peers who attended academically and highly structured preschools.⁷⁴

4c) Process Quality: Child-Initiated and Teacher-Directed Activities

What Are the Child-Initiated and Teacher-Directed Activities?

- Child-initiated activities are based on Piaget’s theory of development and a belief that a child should learn through an active process involving exploring the environment. Children learn concepts and skills through self-directed actions facilitated by a teacher. Teachers facilitate learning by providing children with a wide variety of experiences and by encouraging children to choose and plan their own activities. Child-initiated activities are interesting and engaging, and the difficulty level is suitable for the child.
- Teacher-directed activities are pre-planned and sometimes scripted to assure consistency in implementation across teachers. Teachers decide what concepts and skills children need to acquire and deliver what was planned. This approach focuses primarily on academic instruction, often to practice specific skills used in reading, language, and math.

Child-Initiated and Teacher-Directed Activities: What Does Path to QUALITY Require?

Level 2:

- Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child.

Level 3:

- Children are actively engaged throughout the day in making choices of activities and materials.

Why are Child-Initiated or Teacher-Directed Activities Important for Child Care Quality?

There is limited evidence supporting that child-initiated activity is related to global measures of child care quality.

- At care-oriented centers (low quality), children spend more time in adult-directed group and non-play activities than children at the educationally-oriented child care centers (higher quality)⁷⁵

There is a substantial amount of evidence that child engagement in the child-initiated activities is related to more favorable child outcomes.

- Preschool children in child-initiated classrooms demonstrate greater mastery of basic skills that include verbal, math, social skills than children in programs in which academics are emphasized and skills are directly taught by teachers⁷⁶. This trend is consistent across countries⁷⁷.
- Children are more motivated toward tasks⁷⁸ and more likely to engage in challenging tasks when the tasks are child-initiated⁷⁹.

- There is evidence that the teacher-directed instruction approach produces higher academic gains for children with disabilities⁸⁰. However, other researchers argue that this effect is temporary and should be weighed in light of evidence for possible negative consequences for social development.⁸¹

4d) Process Quality: Activities in the Daily Routine

What are the activities in the daily routine in child care?

The activities that may be found in the daily routine in child care include the followings⁸²;

- Games (informal games, games with rules)
- Pretend (transformation of objects, people, events so that their meaning takes precedence over reality)
- Movement/gross motor activity (large muscle movement, purposeful movement and cruising)
- Manipulation (mastering and refining of manual skills that require coordination of the hand/arm and the senses)
- Puzzle/construction (use of materials with design constraints, large- and small-scale construction)
- Non-involvement (child stands around gazing with no interest in any activity or waiting for an adult or another child or roaming)
- Domestic activity (lunch and snack time activities, use of the bathroom, changing shoes, etc.)
- Observation (task-related and non-task-related observation),
- Art and music (singing songs, painting, cutting and pasting, dancing and movement, drawing, playing instrument)
- Language (reading, writing, story-telling, conversation with peers or teachers, alphabet or phonological game)
- Math activities (activities involving calculations, number symbols and number concepts).

Activities in Daily Routine: What does Paths to QUALITY require?

Level 2:

- Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child.

Level 3:

- Children's physical, cognitive, language, literacy, math, and creative development are supported.

Why are activities in the daily routine important for child care quality?

There is limited evidence that more and higher level activities in the daily routine are linked to better quality of child care.

- When children are in classrooms with lower teacher-child ratios (one quality indicator) the classrooms are also likely to be rated as good or very good in caregiving and activities. Children in classrooms with smaller group sizes (another quality indicator) are also more likely to be rated higher in involvement with activities.⁸³

- In child care centers obtaining high scores on global quality measures, children have been observed participating in more activities associated with early reading, emergent writing, and active listening. Children in centers rated lower in overall quality participated in more activities associated with physical and creative development.⁸⁴

There is substantial evidence that more and higher level activities in the daily routine are linked to better child development outcomes.

- Children in classrooms rated as good or very good in caregiving are more likely to be securely attached to teachers. Securely attached children are more competent with peers⁸⁵
- Child language scores improve when the predominant type of activity in settings is free choice. Their cognitive performance improves as children spend less time in whole group activities led by the teacher, more time in small group activities, and the variety of equipment and materials available increases. These findings are consistent across 10 countries⁸⁶
- There were significant differences in characteristics of children's speech during free choice activities, routine activities, and teacher-guided activities. Children spoke significantly more, used more complex utterance and clauses, and used their language more frequently in symbolic and regulatory ways during free-choice activities, as compared to routine and guided activities⁸⁷.
- Complex interactions with objects occur more often in dramatic play activities and, when a teacher was present, in art activities. Complex interactions with peers was rare in general, but was most likely when children were engaged in activities with one child or with a group of children. Complex teacher behavior was most probable when children were alone with a teacher and in dramatic play activities.⁸⁸
- On the playground, children with or without disabilities are likely to engage in cooperative play only with other typically developing children during complex activities (e.g., playing with toys in the sand or talking). Children with or without special needs tend to engage in more cooperative play in inclusive groups during less complex or low-demand activities, involving mostly gross motor skills (e.g., running)⁸⁹.

4e) Process Quality: Developmentally- Appropriate Curriculum

What is curriculum?

Curriculum contains goals, content, and instructional practices. An effective and developmentally-appropriate curriculum:

- addresses multiple areas of learning and development
- ensures that children are active and engaged
- has goals that are clear and shared by all teachers
- is evidence-based
- enables children to learn through investigation, play and focused-intentional teaching
- builds on prior learning and experiences
- is comprehensive
- has demonstrated benefits for children.⁹⁰

Curriculum: What does Paths to QUALITY require?

- **Level 3:** A written curriculum reflects program philosophy and goals and is based on child development/appropriate practice. The program demonstrates a planned curriculum that provides for the various ages, ability levels, and developmental stages of the children.

Why is curriculum important?

“Well- planned, evidence-based curriculum, implemented by qualified teachers who promote learning in appropriate ways, can contribute significantly to positive outcomes for all children.”⁹¹

Developmentally-appropriate curriculum is a hallmark of high quality early childhood education. There is a substantial amount of evidence that developmentally appropriate curriculum is related to other measures of child care quality.

- A good, well-implemented early childhood curriculum provides developmentally appropriate support and cognitive challenges and, therefore is likely lead to positive outcomes.⁹²
- Quality early childhood curriculums have a statement regarding the guiding philosophy, goals and objectives, provide guidance about how to arrange the learning environment, and include provisions for engaging parents.⁹³

Developmentally-appropriate curriculum is associated with improved child development outcomes. There is a substantial amount of evidence that a developmentally appropriate curriculum is related to child outcomes.

- Researchers have found that young children with and without disabilities benefit more from the curriculum when they are engaged or involved. Particularly for younger children, firsthand learning—through physical, mental, and social activity—is key.⁹⁴

- At every age from birth through age eight play can stimulate children’s engagement, motivation, and lasting learning. Learning is facilitated when children can “choose from a variety of activities, decide what type of products they want to create, and engage in important conversations with friends”.^{95 96}

4f) Process Quality: Language and Literacy Opportunities

What are the language- and literacy-learning opportunities in child care?

To a great extent, the language used by teachers and children in classrooms determines what is learned and how learning takes place. The classroom is a unique context for learning and exerts a profound effect on children's development of language and literacy skills, particularly in the early years. Some have argued that children should have significant opportunities to integrate oral and written language in the classroom, because these experiences support and encourage the development of literacy.⁹⁷ Learning requires children's interaction and engagement in classroom activities -- engaged children are motivated to learn and have the best chance of achieving full competence across the broad spectrum of language and literacy skills.

Language- and Literacy-Learning Opportunities: What does Paths to QUALITY require?

Level 2:

- Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child.
- Children are read to daily and encouraged to explore books and other print materials.

Level 3:

- Children's physical, cognitive, language, literacy, math, and creative development are supported.

Why are language-and literacy learning opportunities an important aspect of child care quality?

There is a moderate amount of evidence that more and higher level language- and literacy-learning opportunities are more common in higher quality of child care.

- Higher rates of teachers' pretend talk and "de-contextualized talk" (e.g., relating the topic to the child's past experiences) and higher ratings of richness of teacher talk are associated with higher ratings of teachers' sensitivity-responsiveness⁹⁸.
- Links between some child care quality measures (teacher education level, pedagogical orientation, and activity settings) and the level of language stimulation teachers provide to children have been found. More educated teachers, teachers whose pedagogical orientations strongly support literacy or social development, and teachers who report spending more time in small group activities engage in more cognitively challenging conversations with children.⁹⁹

There is substantial evidence supporting that more and higher level language- and literacy-learning opportunities in child care are linked to better child development.

- Teacher's questions and responses encourage literary talk. Teacher talk serves to set the climate for children's engaged listening, encourages children to engage with the text, and builds an environment that supports literacy development¹⁰⁰.
- More time spent in emergent code-focused activities is associated with increased scores on alphabet and letter-word recognition by preschoolers. More time in meaning-focused activities (e.g., book reading) is related to increased scores on vocabulary¹⁰¹.
- Head Start teachers were trained to implement strategies about how to increase opportunities for language and vocabulary development in children during book reading and other classroom activities. Children in those teachers' classrooms performed significantly better than children in control classrooms on standardized vocabulary tests at the end of the year¹⁰².
- The amount of teachers' math-related talk is significantly related to increased mathematical knowledge in children over the preschool year.¹⁰³
- Although previous research suggests that high-level teacher talk is related to high-level play with objects, the results in one study indicated that high-level teacher talk was related to lower levels of play with objects and not at all related to play with peers¹⁰⁴.
- Many children from low-income families have limited access to opportunities to develop language and literacy skills. By the age of 3, children in poverty are already well behind their more affluent peers in their acquisition of vocabulary and oral language skills¹⁰⁵. Classrooms serving low-income children often do not provide optimal support for language and literacy learning¹⁰⁶. Limited access to reading materials and other literacy opportunities contributes to children from low-income families not being able to acquire the language and literacy skills needed for early school success¹⁰⁷.

4g) Process Quality: Diversity

What is diversity?

Diversity refers to basic differences among human individuals and more particularly among those in diverse social-cultural groups. These differences may range from those commonly labeled biological (e.g., skin color), to those recognized as social (e.g., language, religion, socio-economic status, etc.)¹⁰⁸.

Diversity has been measured in many different ways in the early childhood literature. Much child development and child care research on diversity has investigated whether standard measures of quality relate to child outcomes differently depending on the ethnicity of the child, the match between the child's and caregiver's ethnicity, and the match between parent's and caregiver's beliefs about child-rearing.¹⁰⁹

Diversity: What does Paths to QUALITY require?

Level 2:

- Classroom environments are welcoming, nurturing and safe for children to have interactions and experiences that promote the physical, social and emotional well being of children.

Level 3:

- The learning environment is developmentally and culturally appropriate and meets any special needs of the children.

Why respect for diversity is important?

There is substantial evidence that diversity is related to child development and child care quality.

- The quality of child care is more strongly associated with child outcomes for children of color¹¹⁰ or children experiencing risk factors (e. g., low parental education, single parent, and poverty) than for middle-class white children¹¹¹. One experimental early intervention study¹¹² found that high quality child care enhances cognitive development of children at-risk, and such effects continue to adulthood. This finding supports the general idea that quality child care quality is especially important when children experience discrepancies between care at home and at the child care setting.
- However, other studies failed to find evidence for these moderating effects when controlling for family or child characteristics such as family income and child gender¹¹³. Some others think that it will be even harmful to child development when children experience discontinuities between home and child care in child-rearing beliefs and practice¹¹⁴.

- Other researchers found that at-risk children from diverse cultural backgrounds benefited from sensitive and stimulating caregiving measured by standard assessment tools, especially when child care quality was reflected in practice that is similar to the children's ethnic communities¹¹⁵.

There is limited evidence that respect for diversity is related to child development.

- The findings of an evaluation of a pilot educational program using a variety of activities that intended to increasing children's awareness of and respect for diversity indicated that this program was found to increase the children's general awareness of and positive attitude toward diversity and their ability to recognize instances of exclusion¹¹⁶.

5) Assessment

What is “assessment?”

Assessment is used in two important ways by early childhood educators¹¹⁷:

- **Child assessment** is a way of keeping track of each child’s progress in an educational program and also a way of individualizing teaching to meet each child’s needs. There are two primary reasons to do child assessment: to improve children’s learning, or to identify children with special needs.¹¹⁸
- **Program assessment** is focused on measuring program trends, quality, or effectiveness. It used to determine whether a child care center or family child care home is providing the level of quality that is desired, or to determine whether the program is being effective at meeting it’s goals and objectives. There are three types of program assessment:¹¹⁹

Assessment: What does Paths to QUALITY require?

Level 3:

- **Assessment** is appropriate to the curriculum and focuses on children’s strengths. Assessment may include portfolios, conversations, anecdotal notes, and developmental notes.
- **Program evaluation** is completed annually by families and staff.

Level 4:

- Accreditation requires centers and homes to have a planned system of developmental screening, assessment of child development, and an annual plan for program evaluation.
- NAEYC center accreditation standards require that the “program is informed by ongoing systematic, formal, and informal assessment approaches to provide information on children’s learning and development. These assessments occur within the context of reciprocal communications with families and with sensitivity to the cultural contexts in which children develop. Assessment results are used to benefit children by informing sound decisions about children, teaching, and program improvement.”¹²⁰

Why is assessment important in child care?

Developmentally-appropriate assessment is a hallmark of high quality early childhood education.

- The National Association for the Education of Young Children recommends that “ethical, appropriate, reliable assessment be a part of all early childhood programs.”¹²¹

- High-quality programs are “informed by ongoing systematic, formal, and informal assessment approaches to provide information on children’s learning and development. These assessments occur within the context of reciprocal communications with families and with sensitivity to the cultural contexts in which children develop.”¹²²

There is moderate amount of evidence that developmentally-appropriate assessment is associated with improved child development outcomes.

- Authentic assessments involving observations of children’s naturally-occurring activities, such as the Work Sampling System¹²³, give teachers and parents an accurate picture of each child’s progress developmentally and in relation to the objectives of the early childhood curriculum.
- “Research demonstrates that early identification and intervention for children with or at risk for disabilities can significantly affect outcomes.”¹²⁴
- “Children with disabilities benefit from in-depth and ongoing assessment, including play-based assessment, to ensure that their individual needs are being met.”¹²⁵

6) Provisions for children with special needs

What Are Plans and Accommodations for Children with Disabilities?

The American with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA) ensure the civil and educational rights of people with disabilities. The ADA is a comprehensive civil law protecting individuals with disabilities from discrimination. It prohibits discrimination in public accommodations that include private programs, family child care homes, child care centers, and after-school programs for children.

IDEA states that children with disabilities should be provided with accommodations to participate equally in all educational activities with their typically developing peers. The accommodations or adaptations include changes in the physical environment, activities, and time.

Plans and Accommodations for Children with Disabilities: What Does Path to QUALITY Require?

Level 2:

- Classroom environments are welcoming, nurturing and safe for children to have interactions and experiences that promote the physical, social and emotional well being of children.

Level 3:

- The learning environment is developmentally and culturally appropriate and meets any special needs of the children.

Why Are Plans and Accommodations for Children with Disabilities Important?

There is a moderate amount of evidence that plans and accommodations for children with disabilities are linked to child care quality.

- Six months after a training program designed to help family child care home providers work with children with disabilities, caregivers' attitudes toward children with disabilities, knowledge about programming for children, and utilization of physical space for enhancing child development improved.¹²⁶
- Caregivers serving in inclusive child care rate themselves higher on most quality-related indicators than caregivers in non-inclusive settings. Observed quality was lower in inclusive family child care homes, but higher in inclusive center-based classrooms for preschoolers.¹²⁷

There is substantial evidence that plans and accommodations for children with disabilities are linked to child development.

- Children with disabilities benefit from participating in inclusive programs because they are provided with role models to facilitate learning of adaptive skills, such as feeding, dressing, and toileting, through observation and imitation¹²⁸.
- Children with disabilities in inclusive programs have more opportunities to practice social interaction and develop friendships with typically developing peers, which helps them prepare to live in the community¹²⁹.
- Both parents of children with disabilities and caregivers express concerns about children's behavioral differences in inclusive care. But they also envision the possibility of increased social opportunities in inclusive child care for children with disabilities.¹³⁰
- Decreases in challenging behavior in children with developmental delays were observed during free choice times. Free choice time was also related to an increase in independent initiation for children who otherwise seldom initiated activities.¹³¹

7) Program policies & procedures

What are “program policies and procedures”?

Child care program policies and procedures include a variety of program management practices that include adequate and timely staff orientation, written policies and procedures, accurate and updated records, an advisory board, annual program evaluation by families and staff, strategic planning including short and long term goals for the program and teachers paid planning time.

Program policies and procedures: What does Paths to QUALITY require?

Level 1:

- Staff members receive orientation within 30 days of being hired.

Level 2:

- Written policies and a child care contract is established and implemented with families.
- An advisory board is in place to provide input and support to the director

Level 3:

- Program evaluation is completed annually by families and staff.
- A strategic plan is completed and includes annual evaluation/ goal setting and long range planning/goal setting.

At a minimum, the Lead Teacher receives paid planning time.

Why are program policies and procedures important?

In general, program policies and procedures are critical to maintain high quality early childhood education.

No research has been conducted examining specific program policies and procedures and its relationship to other measures of child care quality. However, there some evidence that the implementation of program policies and procedures is related to other measures of quality. Researchers have concluded that:

- Quality policies and procedures must be in place at the program level to promote and maintain high quality interactions and learning environments at the classroom level.^{132 133}
- Written policies and procedures are necessary for a program to set and achieve goals for the program as well as the children and families they serve and in turn provide high quality care.¹³⁴
- NAEYC accredited centers tend to have better management and organizational policies and procedures in place.¹³⁵

- Improving director's administrative and organizational skills has a direct impact on policies and procedures and has a pronounced positive impact on teaching practices in the classroom (staff-child interactions, classroom curriculum, classroom arrangement, health and safety practices).¹³⁶

In general, program policies and procedures are necessary for high quality child development outcomes

No research has been conducted examining specific program policies and procedures and its relationship to child development outcomes. However, there some evidence that having program policies and procedures is related to child development outcomes. Researchers have concluded that:

- Program management practices in early childhood program are essential for high quality outcomes for children and families.^{137 138 139}

8) Director professional development

What is “director/family child care lead caregiver professional development”?

Professional development includes maintaining general skills through continuing education and training opportunities to keep current with changing practices in the child care profession. It can also include memberships in professional organizations and participation in networking and mentoring activities with other child care professionals.

Director/family child care lead caregiver professional development: What does Paths to QUALITY require?

Level 1:

- The director has completed a Child Development Associate credential (CDA) or early childhood degree or equivalent degree OR the director of the ministry agrees to obtain a minimum of a CDA within three years of beginning Paths to QUALITY and shows progression towards completion each year.
- The director of the ministry completes Safe Sleep Training.

Level 2:

- Director/Lead Caregiver receives orientation and trains staff on the *Foundations to the Indiana Academic Standards for Young Children Age Birth to Five*.
- Director/lead caregiver is a member of a nationally recognized early childhood organization.

Level 4:

- Director volunteers to informally mentor a program at a Level 1, 2, or 3.

Why is director/family child care lead caregiver professional development important?

In general, director/family child care lead caregiver professional development is a hallmark of high quality early childhood education. There is substantial evidence that director/family child care lead caregiver professional development is related to other measures of child care quality:

- Advantages of being a member of an early childhood professional group include the opportunity to network with other providers who are also caring for children, better access to resources (newsletters, websites, and conferences).¹⁴⁰
- Family child care providers who were affiliated with their local state family child care association or the National Association for the Education of Young Children (NAEYC) provided higher-quality care than nonaffiliated providers.¹⁴¹
- Family child care caregiver’s professionalism, level of planning, and commitment to the child care field predicts higher-quality care.¹⁴²

- The performance of the program director, particularly as it relates to providing leadership in program functioning at the administration level and providing high quality supervision and feedback, predicts program quality¹⁴³
- The director sets the tone and climate of concern that is the hallmark of a quality program.¹⁴⁴
- Research examining mentoring has focused on caregivers rather than directors. Mentoring programs that have paired caregivers with experienced child care educators have been very effective in improving the overall quality of the classrooms as well as making caregivers more sensitive to infants' needs.¹⁴⁵

There is limited evidence that director professional development is related to child development outcomes.

- Child care directors who have more experience and education are more likely to appropriately monitor staff, which promotes children's health.¹⁴⁶

9) Parent-teacher communication and involvement

Parents and providers share information daily and in scheduled conferences about the child and the program. All families are purposefully informed about and involved in program activities: Families have opportunities to participate in planning and evaluating curriculum and activities for their child and the program.

Parent-teacher communication/involvement: What does Paths to QUALITY require?

Level 2:

Provide pertinent program information to families

- A system is in place for communicating pertinent information to families, daily and at an annual family conference.
- Written policies and a child care contract is established and implemented with families.

Level 3:

Facilitate family and staff/assistant input into the program:

- Program evaluation is done annually by families and staff.
- Families are made aware of the curriculum of the program through parent handbooks, newsletters, orientation, and/or family meetings.
- All children and their families have equal opportunities to participate in classroom and program activities.

Why is parent involvement and provider-parent communication important?

There is substantial evidence that parent involvement and parent-provider communication important for high quality early childhood education.

- Parent involvement at all levels of education is now considered not only desirable but essential to effective schooling.^{147 148 149}
- The quality of parent-caregiver relationships in early care is associated with other quality indicators, including caregiver education level and sensitivity with the child.¹⁵⁰

There is substantial evidence that parent-involvement is related to child development outcomes.

- Parent involvement is linked to children's school readiness. Research shows that greater parent involvement in children's learning positively affects the child's school performance, including higher academic achievement.^{151 152 153}

10) Accreditation by NAEYC or other organizations

What is “accreditation”?

Accreditation is a voluntary process by which a professional body provides quality criteria that are above the mandatory requirements of government-supervised licensing or registration. To achieve accreditation, early childhood education programs volunteer to be measured against rigorous national standards for education, health, and safety. Programs that participate and pass the voluntary process are given a certification of accreditation. The most common accreditation body for child care centers is from the National Association for the Education of Young Children (NAEYC), and for family child care homes the most common accreditation is from the National Association of Family Child Care (NAFCC).

Accreditation: What does Paths to QUALITY require?

Level 4:

- **Accreditation** by a nationally recognized accrediting body, approved by the State, has been achieved and maintained.

Why is accreditation important?

Accredited child care centers and family child care homes provide higher quality care.

There is a substantial amount of evidence supporting that national accreditation is related to other measures of child care quality.

- Accredited centers provide better staff-child ratios, employ staff with more education specific to early childhood, employ more experienced directors, and provide more developmentally appropriate activities for children than non-accredited centers.^{154 155}
- Accredited centers provide better than average quality of care as measured by the Early Childhood Environmental Rating Scale—a widely used measure of quality.¹⁵⁶
- Accredited family child care caregivers provide higher quality care for children, have higher education, participate in hours of training, and are more involved in professional affiliations than non-accredited caregivers.^{157 158 159}

Research has indicated that accredited programs are benefit children’s development.^{160 161 162}

There is a moderate amount of evidence that national accreditation is related to child outcomes.

- National accreditation standards are based on developmentally appropriate practices promoting better child development outcomes such as academic skills, creativity, and social emotional outcomes.^{163 164}

Conclusions: Validity of the PTQ Levels and Criteria

The pilot programs in northeast and southwest Indiana demonstrate that the PTQ system is understandable to child care providers and provide preliminary evidence that when providers reach higher levels, they are increasing the quality of care and education they provide. The pilot programs do not provide data that answer the question, “Do children in child care with higher PTQ levels develop or learn better?”

A thorough review of 10 main quality indicators (including 12 additional sub-indicators) within the PTQ levels and standards revealed substantial scientific evidence for the validity of the PTQ quality criteria. In most cases, PTQ key quality indicators were found to be significantly associated with established measures of child care quality - 75% of the quality indicators we examined had “substantial evidence” for their validity. In addition, most of the PTQ quality indicators had significant evidence that they support children’s development. Overall, the PTQ quality indicators have significant support for validity in the child development and early education scientific literature. In addition, most of the PTQ standards have the support of prominent early childhood education organizations, which have designated them as “best practices.”

Based on this analysis of the results of the PTQ program as developed in its regional pilots and based on existing evidence for the validity of proposed PTQ quality standards, we conclude that, if implemented with diligence, care, and accountability in Indiana, the PTQ program has the potential to increase quality in child care centers, child care ministries, and child care homes. Further, as child care providers work and learn to increase their PTQ levels, we expect that Indiana’s young children will benefit through increased support for their learning, development, and everyday well-being.

Endnotes

¹ National Child Care Information Center. (2007, April). Quality rating systems: Definition and statewide systems. Retrieved September 21, 2007 from www.nccic.org/pubs/qrs-defsystems.html.

² Ibid.

³ Child Care and Early Care Partnership Mission, 1996.

⁴ Elicker, J. & Ruprecht, K. (2007). Early Child Care Quality Initiative Final Evaluation Report, January to December, 2006. Unpublished technical report, Purdue University, West Lafayette, IN.

⁵ Cost, Quality, and Child Outcome Study Team (1995). Cost, quality, and child outcomes in child care centers: Technical report. Denver, CO: University of Colorado at Denver.

⁶ Gormley, W., Jr. (1998). Regulatory enforcement: Accommodation and conflict in four states. *Public Administration Review*, 58, 285-293.

⁷ Phillipsen, L, Burchinal, M. R., Howes, C., & Cryer, D. (1997). The prediction of process quality from structural features of child care. *Early Childhood Research Quarterly*, 12, 281-303.

⁸ Galinsky E., Howes, C., Kontos, S., & Shinn, M. (1994). *The study of children in family child care and relative care*. New York: Families and Work Institute.

⁹ Raikes, H. A., Raikes, H. H., & Wilcox, B. (2005). Regulation, subsidy receipt and provider characteristics: What predicts quality in child care homes? *Early Childhood Research Quarterly*, 20, 164-184.

¹⁰ Burchinal M., Howes, C., & Kontos, S. (2002). Structural predictors of child care quality in child care homes. *Early Childhood Research Quarterly*, 17, 87-105.

¹¹ Elicker, J., Clawson, C., Hong, S. Kim, T., Evangelou, D., & Kontos, S. J. (2005). *Community Child Care Research Project Final Report. Child care for working poor families: Child development and parent employment outcomes*. West Lafayette, IN: Purdue University.

¹² Helburn, S., (Ed.) (1995, June). Cost, quality, and child outcomes in child care centers, technical report. Denver, CO: Department of Economics, University of Colorado at Denver.

¹³ Phillips, D. A., Howes, C., & Whitebook, M. (1992). The effects of regulation and auspice on child care quality. *American Journal of Community Psychology*, 20, 25-51.

¹⁴ Howes, C., Smith, E., & Galinsky, E. (1995). *The Florida child care quality improvement study: Interim Report*. New York, NY, Families and Work Institute.

¹⁵ Cost, Quality, and Child Outcome Study Team (1995). Cost, quality, and child outcomes in child care centers: Technical report. Denver, CO: University of Colorado at Denver.

¹⁶ Raikes, H. A., Raikes, H. H., & Wilcox, B. (2005). Regulation, subsidy receipt and provider characteristics: What predicts quality in child care homes? *Early Childhood Research Quarterly*, 20, 164-184.

¹⁷ Raikes, H. A., Raikes, H. H., & Wilcox, B. (2005). Regulation, subsidy receipt and provider characteristics: What predicts quality in child care homes? *Early Childhood Research Quarterly*, 20, 164-184.

¹⁸ Bordin, J., Machida, S., Varnell, H. (2000). The relation of quality indicators to provider knowledge of child development in family child care homes. *Child & Youth Care Forum*, 29(5), 323-341.

¹⁹ Burchinal, M., Howes, C., & Kontos, S. (2002). Structural predictors of child care quality in child care homes. *Early Childhood Research Quarterly*, 17, 87-105.

²⁰ Clarke-Stewart, K. A., Vanell, D. L., Burchinal, M., O'Brien, M., & McCartney, K. (2002). Do regulable features of child-care homes affect children's development? *Early Childhood Research Quarterly*, 17, 52-86.

²¹ Burchinal, M., Howes, C., & Kontos, S. (2002). Structural predictors of child care quality in child care homes. *Early Childhood Research Quarterly*, 17, 87-105.

²² Burchinal, M., Cryer, D., Clifford, R. M. (2002). Caregiver training and classroom quality in child care centers. *Applied Developmental Science*, 6(1), 2-11.

²³ Whitebook, M. (2003). *Bachelor's degrees are best: Higher qualifications for pre-kindergarten teachers lead to better learning environments for children*. Washington, DC: The Trust for Early Education.

²⁴ Howes, C. (1997). Children's experiences in center-based child care as a function of teacher background and adult-child ratio. *Merrill-Palmer Quarterly*, 43(3), 404-425.

²⁵ Clarke-Stewart, K. A., Vanell, D. L., Burchinal, M., O'Brien, M., & McCartney, K. (2002). Do regulable features of child-care homes affect children's development? *Early Childhood Research Quarterly*, 17, 52-86.

²⁶ National Institute of Child Health and Human Development, Early Child Care Research Network. (2002a). Child-care structure → Process → Outcome: Direct and indirect effects of child-care quality on young children's development. *Psychological Science*, 13(3), 199-206.

- ²⁷ Early, D. M., Bryant, D. M., Pianta, R. C., Clifford, R. M., Burchinal, M. R., Ritchie, S., Howes, C., & Barbarin, O. (2006). Are teachers' education, major, and credentials related to classroom quality and children's academic gains in pre-kindergarten. *Early Childhood Research Quarterly*, 21, 174-195.
- ²⁸ Burchinal, M., Cryer, D., Clifford, R. M. (2002). Caregiver training and classroom quality in child care centers. *Applied Developmental Science*, 6(1), 2-11.
- ²⁹ Barnett, W.S. (2003a). Better teachers, better preschools: Student achievement linked to teacher qualifications. *Preschool Policy Matters*, 2. New Brunswick, NJ: NIEER.
- ³⁰ Bowman, B., Donovan, M.S. & Burns, S. (Eds.) (2001). *Eager to learn: Educating our preschoolers*. National Research Council, Committee on Early Childhood Pedagogy. Washington, DC: National Academy Press.
- ³¹ Howes, C. & Brown, J. (2000). Improving child care quality: A guide for Proposition 10 commissions. In N. Halfon, E. Shulman, M. Shannon, & M. Hochstein (Eds.), *Building community systems for young children*. Los Angeles: UCLA Center for Healthier Children, Families, and Communities.
- ³² Elicker, J., Clawson, C., Hong, S. Kim, T., Evangelou, D., & Kontos, S. J. (2005). *Community Child Care Research Project Final Report. Child care for working poor families: Child development and parent employment outcomes*. West Lafayette, IN: Purdue University.
- ³³ National Institute of Child Health and Human Development Early Child Care Research Network (2000). Characteristics and quality of child care for toddlers and preschoolers. *Applied Developmental Science*, 4, 116-135.
- ³⁴ deSchipper, E., Rieksen-Walraven, M., & Guerts, S. (2006). Effects of child-caregiver ratio on the interactions between caregivers and children in child care centers: An experimental study. *Child Development*, 77, 861-864.
- ³⁵ Howes, C. (1997). Children's experiences in center-based child care as a function of teacher background and adult: child ratio. *Merrill-Palmer Quarterly*, 43, 404 – 425.
- ³⁶ Clarke-Stewart, K.A., Gruber, C.P. & Fitzgerald, L.M. (1994). *Children at home and in day care*. Hillsdale, NJ: Erlbaum.
- ³⁷ Ghazvini, A., & Mullis, R. L. (2002). Center-based care for young children: Examining predictors of quality. *The Journal of Genetic Psychology*, 163, 112 – 125.
- ³⁸ Palmerus, K., & Hagglund, S. (1991). The impact of children/caregiver ratio on activities and social interaction in six day care centre groups. *Early Child Development and Care*, 67, 29-38.
- ³⁹ Phillipsen, L.C., Burchinal, M.R., Howes, C. & Cryer, D. (1997). The prediction of process quality from structural features of child care. *Early Childhood Research Quarterly*, 12, 281–303.
- ⁴⁰ Palmerus, K. (1996). Child-caregiver ratios in day care center groups: Impact on verbal interactions. *Early Child Development and Care*, 118, 45 – 57.
- ⁴¹ NAEYC accreditation standards, pp. 45-66.
- ⁴² Retrieved online at <http://www.nccic.org/statedata/statepro/display.cfm?state=Indiana> on September 13, 2007
- ⁴³ NAEYC accreditation standards.
- ⁴⁴ Vandell, D.L. & Wolfe, B. (2002). *Child care quality: Does it matter and does it need to be improved?* Institute for Research on Poverty, University of Wisconsin-Madison
- ⁴⁵ Phillipsen, L.C., Burchinal, M.R., Howes, C. & Cryer, D. (1997). The prediction of process quality from structural features of child care. *Early Childhood Research Quarterly*, 12, 281–303.
- ⁴⁶ Bowman, B.T., Donovan, M.S., & Burns, M.S. (Eds.) (2000). *Eager to learn: Educating our preschoolers*. Washington, DC: National Academy Press.
- ⁴⁷ Ruopp, R., Travers, J., Glantz, F., & Coelen, C. (1979). *Children at the Center: Final Report of the National Day Care Study*. Cambridge, MA: Abt Associates.
- ⁴⁸ NAEYC Accreditation Standards. Online at: www.naeyc.org
- ⁴⁹ NAFCC Accreditation Standards. Online at: www.nafcc.org/accreditation/accredstandards
- ⁵⁰ Dunn, L. (1993). Proximal and distal features of day care quality and children's development. *Early Childhood Research Quarterly*, 8, 167-192.
- ⁵¹ Kontos, S., & Fiene, R. (1987). Child care quality, compliance with regulations, and children's development: The Pennsylvania Study. In D.A. Phillips (Ed.), *Quality in child care: What does research tell us?* (pp. 57-80). Washington, DC: National Association for the Education of Young Children.
- ⁵² Kontos, S. (1994). The ecology of family day care. *Early Childhood Research Quarterly*, 9, 87-110.
- ⁵³ NICHD Early Child Care Research Network (1996). Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly*, 11, 269-306.
- ⁵⁴ Hayes, C.D., Palmer, J. L. & Zaslow, M. J. (1990). *Who cares for America's children? Child care policy in the 1990s*. Washington, D.C.: National Academy Press.

- ⁵⁵ Colbert, J. (2002). *Regulating dimensions of quality in early care and education: A review of the research*. St. Paul, MN: National Association for Regulatory Administration.
- ⁵⁶ Moore, K., Manlove, J., Richter, K., Halle, T., Le Menestrel, S., Zaslow, M., Greene, A., Mariner, C., Romano, A., Bridges, L., & West, J. (1999). *A birth cohort study: Conceptual and design considerations and rationale*. (NCES Working Paper No. 999-01). Washington, D.C.: U.S. Department of Education. National Center for Education Statistics (NCES).
- ⁵⁷ Ibid.
- ⁵⁸ Clarke-Stewart, K.A., Vandall, D., Burchinal, M., O'Brien, M., & McCartney, K. (2002). Do regulatable features of child-care homes affect children's development? *Early Childhood Research Quarterly*, 17(1), 52-86.
- ⁵⁹ Bredekamp, S., & Copple, C. (Eds.). (1997). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8* (Rev. ed.). Washington, DC: National Association for the Education of Young Children.
- ⁶⁰ Bowman, B. T., Donovan, M. S., & Burns, M. S. (Eds.). (2001). *Eager To Learn: Educating Our Preschoolers*. Washington, DC: Committee on Early Childhood Pedagogy, National Research Council.
- ⁶¹ Howes, C., Phillips, D., & Whitebrook, M. (1992). Thresholds of quality: Implications for the social development of children in center-based child care. *Child Development*, 63, 449-460.
- ⁶² Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1995). *Quality in family child care and relative care*. New York: Teachers College Press.
- ⁶³ Phillips, D., McCartney, K., & Scarr, S. (1987). Child-care quality and children's social development. *Developmental Psychology*, 23, 537-543.
- ⁶⁴ Anderson, C. W., Nagel, R. J., Roberts, W. A., & Smith, J. W. (1981). Attachment to substitute caregivers as a function of centre quality and caregiver involvement. *Child Development*, 52, 53-61.
- ⁶⁵ Clarke-Stewart, K. A. (1987). In search of consistencies in child care research. In D. A. Phillips (Ed.), *Quality in child care: What does research tell us?* Washington, DC: National Association for the Education of Young Children.
- ⁶⁶ Howes, C., & Matheson, C. C. (1992). Sequences in the development of competent play with peers: Social and social pretend play. *Developmental Psychology*, 28, 961-974.
- ⁶⁷ Kontos, S.J. (1991). Child care quality, family background, and children's development. *Early Childhood Research Quarterly*, 6, 249-262.
- ⁶⁸ Howes, C., & Hamilton, C. E. (1992). Children's relationships with caregivers: Mothers and child care teachers. *Child Development*, 63, 859-866.
- ⁶⁹ J. Helm and G. Gronlund (2000). *Linking Standards and Engaged Learning in the Early Years*, *Early Childhood Research and Practice*, Volume 2, #1, Online: <http://ecrp.uiuc.edu/v2n1/helm.html>
- ⁷⁰ Bredekamp, Sue, & Copple, Carol (Eds.). (1997). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8*. (Rev. ed.). Washington, DC: National Association for the Education of Young Children.
- ⁷¹ Dodge, Diane Trister (1995). The importance of curriculum in achieving quality child day care programs. *Child Welfare*, 74, 1171-1188.
- ⁷² Ibid.
- ⁷³ Schweinhart, L. J., Barnes, H. V., & Weikart, D. P. (1993). *Significant benefits: The High/Scope Perry Preschool study through age 27*. Ypsilanti, MI: High/Scope Press.
- ⁷⁴ Ibid.
- ⁷⁵ Hadeed, J., & Sylva, K. (1999). Behavioral observations as predictors of children's social and cognitive progress in day care. *Early Child Development and Care*, 154, 13-30.
- ⁷⁶ Marcon, R. A. (1999). Differential impact of preschool models on development and early learning of inner-city children: A three cohort study. *Developmental Psychology*, 35, 358-375
- ⁷⁷ Montie, J. E., Xiang, Z., & Schweinhart, L. J. (2006). Preschool experience in 10 countries: cognitive and language performance at age 7. *Early Childhood Research Quarterly*, 21, 313-331.
- ⁷⁸ Stipek, D., Feiler, R., Daniels, D., & Milburn, S. (1995). Effects of different instructional approaches on young children's achievement and motivation. *Child Development*, 66, 209-223.
- ⁷⁹ Hadeed, J., & Sylva, K. (1999). Behavioral observations as predictors of children's social and cognitive progress in day care. *Early Child Development and Care*, 154, 13-30.
- ⁸⁰ Gersten, R. (1985). Direct instruction with special education students: A review of evaluation research. *Journal of Special Education*, 19, 41-58.

- ⁸¹ Devries, R., Reese-Learned, H., & Morgan, R. (1991). Sociomoral development in direct-instruction, eclectic, and constructivist kindergartens: A study of children's enacted interpersonal understanding. *Early Childhood Research Quarterly*, 6, 473-517.
- ⁸² Sylvia, K., Taggart, B., Siraj-Blatchford, I., Totsika, V., Ereky-Stevens, K., Gildea, R., & Bell, D. (2007). Curricular quality and day-to-day learning activities in pre-school. *International Journal of Early Years Education*, 15, 49-65.
- ⁸³ Howes, C., Phillips, D. A., Whitebrook, M. (1993). Thresholds of quality: Implications for the social development of children in center-based child care, *Child Development*, 63, 449-460.
- ⁸⁴ Montie, J. E., Xiang, Z., & Schweinhart, L. J. (2006). Preschool experience in 10 counties: Cognitive and language performance at age 7. *Early Childhood Research Quarterly*, 21, 313-331.
- ⁸⁵ Fekonija, U., Umek, L. M., & Kranjc, S. (2005). Free play and other daily preschool activities as a context for child's language development. *Studia Psychologica*, 47, 103-118.
- ⁸⁶ Kontos, S. & Keyes, L. (1999). An ecobehavioral analysis of early childhood classrooms, *Early Childhood Research Quarterly*, 14, 35-50.
- ⁸⁷ Nabors, L., Willoughby, J., & Badawi, M. A. (1999). Relations between activities and cooperative playground interactions for preschool-age children with special needs, *Journal of the Multihandicapped Person*, 11, 339-352.
- ⁸⁸ NAEYC position statement, Early Childhood Curriculum, Assessment, and Program Evaluation. Online: <http://www.naeyc.org/about/positions.asp#where>.
- ⁸⁹ Ibid.
- ⁹⁰ Frede, E.C. 1998. Preschool program quality in programs for children in poverty. In Early care and education for children in poverty: Promises, programs, and long-term outcomes, eds. W.S. Barnett & S.S. Boocock. Buffalo, NY: State University of New York Press.
- ⁹¹ Dodge, Diane Trister (1995). The importance of curriculum in achieving quality child day care programs. *Child Welfare*, 74, 1171-1188.
- ⁹² Raspa, M.J., R.A. McWilliam, & S.M. Ridley. 2001. Child care quality and children's engagement. *Early Education and Development*, 12, 209-24.
- ⁹³ Espinosa, L. 2002. High quality preschool: Why we need it and what it looks like. NIEER Policy Briefs 1. Online: <http://nieer.org/resources/policybriefs/1.pdf>.
- ⁹⁴ NAEYC Position Statement, Early Childhood Curriculum, Assessment, and Program Evaluation. Online: <http://www.naeyc.org/about/positions.asp#where>
- ⁹⁵ Dickinson, D.K., McCabe, A., Anastasopoulos, L., Peisner-Feinberg, E., S., & Poe, M. D. (2003). The comprehensive language approach to early literacy: the interrelationships among vocabulary, phonological sensitivity, and print knowledge among preschool-aged children. *Journal of Educational Psychology*, 95, 465-481.
- ⁹⁶ Gest, S. D., Holland-Coviello, R., Welsh, J. A., Eicher-Catt, D. L., & Gill, S. (2006). Language development sub-contexts in Head Start Classrooms: Distinctive patterns of teacher talk during free play, mealtime, and book reading. *Early Education and Development*, 17, 293-315.
- ⁹⁷ Smith, M. W., & Dickinson, D. K. (1994). Describing oral language opportunities and environments in Head Start and other preschool classrooms. *Early Childhood Research Quarterly*, 9, 345-366.
- ⁹⁸ Hansen, C. C. (2004). Teacher talk: Promoting literacy development through response to story. *Journal of Research in Childhood Education*, 19, 115-129.
- ⁹⁹ Connor, C. M., Morrison, F. J., & Slominski, L. Preschool Instruction and Children's Emergent Literacy Growth. *Journal of Educational Psychology*, 98, 665-689.
- ¹⁰⁰ Wasik, B., Bond, E. & Hindman, A. (2006). The effects of a language and literacy intervention on Head Start children and teachers. *Journal of Educational Psychology*, 98, 63-74.
- ¹⁰¹ Klibanoff, R. S., Levine, S. C., Huttenlocher, J., Vasilyeva, M., & Hedges, L.V., Preschool children's mathematical knowledge: The effect of teacher "math talk." *Developmental Psychology*, 42, 59-69.
- ¹⁰² Wilcox-Herzog, A. & Kontos, S. (1998). The nature of teacher talk in early childhood classrooms and its relationship to children's play with objects and peers. *Journal of Genetic Psychology*, 159, 30-44.
- ¹⁰³ Hart, B., & Risley, T. R. (1995). Meaningful differences in the everyday experience of young American children. Baltimore: Brookes.
- ¹⁰⁴ NICHD Early Child Care Research Network (2000). The relation of child care to cognitive and language development. *Child Development*, 71, 960-980.
- ¹⁰⁵ Neuman, S. B., & Celano, D. (2001). Access to print in low-income and middle-income communities: An ecological study of four neighborhoods. *Reading Research Quarterly*, 36, 8-26.

-
- ¹⁰⁶ Bernhard, J. K. (1995). Child Development, cultural diversity, and the professional training of early childhood educators. *Canadian Journal of Education*, 20, 415-426.
- ¹⁰⁷ Burchinal, M. R. & Cryer, D. (2003). Diversity, child care quality, and developmental outcomes. *Early Childhood Research Quarterly*, 18, 401-426.
- ¹⁰⁸ Burchinal, M. R., Peisner-Feinberg, E., Bryant, D. M., & Clifford, R. (2000). Children's social and cognitive development and child care quality: Testing for differential associations related to poverty, gender, or ethnicity. *Journal of Applied Developmental Sciences*, 4, 149-165.
- ¹⁰⁹ Peisner-Feinberg, E. S., & Burchinal, M. R. (1997). Relations between preschool children, child care experiences, and concurrent development: The Cost, Quality, and Outcomes Study, *Merrill-Palmer Quarterly*, 43, 451-477.
- ¹¹⁰ Campbell, F., & Ramey, C. T. (1994). Effects of early intervention on intellectual and academic achievement: A follow-up study of children from low-income families. *Child Development*, 65, 684-698.
- ¹¹¹ NICHD Early Child Care Research Network. (2000). The relation of child care to cognitive and language development. *Child Development*, 71, 958-978.
- ¹¹² Garcia-Coll, C., Crnic, K., Lamberty, G., Wasik, B. H., Jenkins, R., Garcia, H. V., & McAdoo, H. P. (1996). An integrative model for the study of developmental competencies in minority children. *Child Development*, 67, 1891-1914.
- ¹¹³ Wishard, A. G., Shivers, E. M., Howes, C., & Ritchie, S. (2003). Child care program and teacher practices: associations with quality and children's experiences. *Early Childhood Research Quarterly*, 18, 65-103.
- ¹¹⁴ Connolly, P., & Hosken, K. (2006). The general and specific effects of educational programs aimed at promoting awareness of and respect for diversity among young children. *International Journal of Early Years Education*, 14, 107-126.
- ¹¹⁵ NEGP (National Education Goals Panel). 1993. The national education goals report. Volume one: The national report. Washington, DC: U.S. Government Printing Office.
- ¹¹⁶ Shepard, L., S.L. Kagan, & E. Wurtz. 1998. Principles and recommendations for early childhood assessments. Washington, DC: National Education Goals Panel. Online: www.negp.gov/reports/prinrec.pdf.
- ¹¹⁷ Ibid.
- ¹¹⁸ NAEYC. (2007). Standard 4: NAEYC Accreditation Criteria for Assessment of Child Progress. Retrieved from www.naeyc.org/academy/standards/standard4/ on September 27, 2007.
- ¹¹⁹ NAEYC. (2003). Early childhood curriculum, assessment, and program evaluation: Building an effective, accountable system in programs for children birth through age 8. Washington, DC: National Association for the Education of Young Children. (www.naeyc.org)
- ¹²⁰ Commission on NAEYC Early Childhood Program Standards and Accreditation Criteria, 2003, np
- ¹²¹ Meisels, S.J., Liaw, F., Dorfman, A. & Nelson, R.F. (1995). The Work Sampling System: Reliability and validity of a performance assessment system for young children. *Early Childhood Research Quarterly*, 10, 277-296.
- ¹²² Shonkoff, J.P., & Meisels, S.J. (2000). *Handbook of early childhood intervention*, 2nd ed. New York: Cambridge University Press.
- ¹²³ Ibid.
- ¹²⁴ Jones, S. N., & Meisels, S. J. Training family day care providers to work with special needs children. *Topics in Early Childhood Special Education*, 7, 1-12.
- ¹²⁵ Knoche, L., Peterson, C. A., Edwards, C. P., & Jeon, H. (2006). Child care for children with and without disabilities: The provider, observer, and parent perspectives. *Early Childhood Research Quarterly*, 21, 93-109.
- ¹²⁶ Wolery, M., & Wibers, J. (1994). *Including Children with Special Needs in Early Childhood Programs*. National Association for the Education of Young Children. Washington DC.
- ¹²⁷ Guralnick M. J. (2001). *Early Childhood Inclusion: Focus on Change*. Baltimore, MD: Paul H. Brooks Publishing.
- ¹²⁸ Recchia, S. L., & Lee, Y. (2004). At the Crossroads: Overcoming Concerns To Envision Possibilities for Toddlers in Inclusive Child Care. *Journal of Research in Childhood Education*, 19, 175-188.
- ¹²⁹ Cole, C. L., & Levinson, T. R. (2002). Effects of within-activity choices on the challenging behavior of children with severe developmental disabilities. *Journal of Positive Behavior Interventions*, 4, 29-37.
- ¹³⁰ Bloom, P., J. & Sheerer, M. (1992). The effect of leadership training on child care program quality. *Early Childhood Research Quarterly*, 7, 579-594.
- ¹³¹ McCormick Tribune Center for Early Childhood Leadership, National-Louis University. Widening the lens: Looking at quality from a program administration perspective.

- ¹³² Bella, J., & Bloom, P. J. (2003). Zoom: The impact of early childhood leadership training on role perceptions, job performance, and career decisions. IL: National-Louis University, Center for Early Childhood Leadership.
- ¹³³ McCormick Tribune Center for Early Childhood Leadership, National-Louis University. Widening the lens: Looking at quality from a program administration perspective.
- ¹³⁴ Bloom, P., J. & Sheerer, M. (1992). The effect of leadership training on child care program quality. *Early Childhood Research Quarterly*, 7, 579-594.
- ¹³⁵ Bloom, P., J. & Sheerer, M. (1992). The effect of leadership training on child care program quality. *Early Childhood Research Quarterly*, 7, 579-594.
- ¹³⁶ Cost, Quality, and Child Outcome Study Team (1995). Cost, quality, and child outcomes in child care centers: Technical report. Denver, CO: University of Colorado at Denver.
- ¹³⁷ Whitebook, M., & Sakai, L. (2004). When directors leave: The causes and consequences of center administrative changes. *Exchange: The early Childhood Leader's Magazine*, 160, 8-11.
- ¹³⁸ NAEYC membership benefits. <http://www.naeyc.org/membership/benefits.asp>.
- ¹³⁹ DeBord, K. & Sawyer, J. (1996). The effects of training on the quality of family child care for those associated with and not associated with professional child care organizations. *Child & Youth Care Forum*, 25 (1), 7-15.
- ¹⁴⁰ Weaver, R. E. H. (2002)a. The roots of quality care: Strengths of master providers. *Young Children* 57, (1) 16-22.
- ¹⁴¹ Cost, Quality, and Child Outcome Study Team (1995). Cost, quality, and child outcomes in child care centers: Technical report. Denver, CO: University of Colorado at Denver.
- ¹⁴² Bloom, P., J. & Sheerer, M. (1992). The effect of leadership training on child care program quality. *Early Childhood Research Quarterly*, 7, 579-594.
- ¹⁴³ Fiene, R. (2002). Improving child care quality through an infant caregiver mentoring project. *Child & Youth Care Forum*, 31(2), 79-87.
- ¹⁴⁴ Fiene, R. (2002). 13 Indicators of Quality Child Care: Research Update. National Resource Center for Health and Safety in Child Care, University of Colorado.
- ¹⁴⁵ Comer, J. P., & Haynes, N. M. (1991). Parent involvement in schools: An ecological approach. *The Elementary School Journal*, 91(3), 271-277.
- ¹⁴⁶ Burchinal, M., Campbell, F., Bryant, D., Wasik, B. & Ramey, C. (1997). Early intervention and mediating processes in cognitive performance of children of low-income African American families. *Child Development*, 68, 935-954.
- ¹⁴⁷ Bredekamp, S., & Copple, C. (1997). Developmentally appropriate practice in early childhood programs. Washington, DC: National Association for the Education of Young Children.
- ¹⁴⁸ Elicker, James; Noppe, Illene C; Noppe, Lloyd D; Fomter-Wood, Cheryl. (1997). The parent-caregiver relationship scale: Rounding out the relationship system in infant child care. *Early Education and Development*, 8(1), 83-100.
- ¹⁴⁹ Burchinal, M., Campbell, F., Bryant, D., Wasik, B. & Ramey, C. (1997). Early intervention and mediating processes in cognitive performance of children of low-income African American families. *Child Development*, 68, 935-954.
- ¹⁵⁰ Daniels, S. (1995). Can pre-school education affect children's achievement in primary school? *Oxford Review of Education*, 21,163-177.
- ¹⁵¹ Zellman, G. & Waterman, J. (1998). Understanding the impact of parent-school involvement on children's educational outcomes. *The Journal of Educational Research*, 91, 370-380.
- ¹⁵² Griffith, J. (1996). Relation of parent involvement, empowerment, and school traits to student academic performance. *Journal of Educational Research*, 90, 33-41.
- ¹⁵³ Lin, Q. (2003). Research Digest: Parent involvement and early literacy. Harvard Family Research Project. Retrieved from www.gse.harvard.edu/hfrp/projects/fine/resources/digest/literacy.html, September 28, 2007.
- ¹⁵⁴ Apple, P. L. (2006). A developmental approach to early childhood program quality improvement: The relation between state regulation and NAEYC accreditation. *Early Education and Development*, 17(4), 535-552.
- ¹⁵⁵ Cost, Quality, and Child Outcome Study Team (1995). Cost, quality, and child outcomes in child care centers: Technical report. Denver, CO: University of Colorado at Denver.
- ¹⁵⁶ Zan, B.(2005). NAEYC accreditation and high quality preschool curriculum. *Early Education & Development*, 16(1), 85-102
- ¹⁵⁷ Campbell, N. D., Appelbaum, J. C. Martinson, K., & Martin, E. (2000). Be all the we can be: Lessons from the military for improving our nation's child care system. ERIC database ED441 582.

¹⁵⁸ National Association for Education of Young Children. (2002). Tiered reimbursement systems: States with systems to pay higher reimbursement rates to programs that are accredited and/or meet other quality standards. www.naeyc.org/childrens_champions/criticalissues/accred-reimburse/chart1.htm

¹⁵⁹ Smith, A.P. & Endsley, R. C. (1996). Comparison of accredited and non-accredited family child care programs on program quality, provider professionalism, and family support. *Child & Youth Care Forum*, 25, 353-378.

¹⁶⁰ Bowman, B., Donovan, M. & Burns, M. (Eds.). (2001). *Eager to learn: Educating our preschoolers*. Washington, DC: National Academy Press.

¹⁶¹ Cryer, D. & Clifford, R. (Eds.). (2003). *Early childhood and care in the USA*. Baltimore: Brookes.;

¹⁶² Lombardi, J. (2003). *Time to care: Redesigning child care to promote education. Support families, and build communities*. Philadelphia: Temple University Press.

¹⁶³ Charlesworth, R., Hart, C., Burts, D., and DeWolf, M. (1993). The LSU studies: Building a research base for developmentally appropriate practice. *Advances in Early Education and Day Care* 5:3–28.

¹⁶⁴ National Association for Education of Young Children. (2006). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8. A position statement of the National Association for the Education of Young Children*. <http://www.naeyc.org/about/positions/dap1.asp>.

Appendix

- 1. Quality Indicators Contained in Paths to QUALITY**
- 2. Paths to QUALITY Pilot Program: Early Childhood Alliance**
- 3. Paths to QUALITY Pilot Program: 4C of Southern Indiana, Inc.**

Appendix 1: Quality Indicators Contained in Paths to QUALITY Levels and Criteria

Quality Indicators	General PTQ Criteria	Specific PTQ Criteria	PTQ Level & Criteria Number
1) Regulation	<p>State child care license</p> <p>State child care registration</p>	<p>The license issued by Family and Social Services Administration (FSSA), the Division of Family Resources (DFR), Bureau of Child Care is current and in good standing.</p> <p>The registration issued by the Family and Social Services Administration (FSSA), the Division of Family Resources (DFR), Bureau of Child Care is current and in good standing.</p> <p>The ministry meets all CCDF provider eligibility standards.</p> <p>The ministry meets Voluntary Certification Program guidelines in all four categories. If a facility does not serve infants and toddlers, the remaining three categories must be met.</p>	<p>Level 1.1 (centers & homes)</p> <p>Level 1.1 (ministries)</p> <p>Level 1.2 (ministries)</p> <p>Level 1.3 (ministries)</p>
2) Teacher education/ Training	<p>Level of education/ Specialized training in ECE/CD</p>	<p>25% of teaching staff have either a Child Development Associate credential (CDA) or equivalent certificate, OR an early childhood degree or equivalent degree, OR have completed 45 clock hours of educational training leading to an Early Childhood/Child Development degree or CDA credential.</p> <p>50% of teaching staff have either a CDA or equivalent certificate, an early childhood degree or equivalent degree OR completed 60 clock hours of educational training leading to an early childhood/child development degree or CDA credential.</p> <p>Lead Caregiver will have a current CDA or equivalent certificate, OR an early childhood degree or equivalent degree OR have completed 45 clock hours of educational training in early childhood education within the past three years leading to a CDA or an early childhood/ child development degree.</p> <p>Lead Caregiver will have a current CDA or equivalent certificate, OR and early childhood degree or equivalent degree; OR have completed 60 hours of educational training leading to an early childhood/child development degree or CDA credential within the past three years.</p> <p>Lead Caregiver has a current CDA or equivalent or ECE degree or an equivalent degree.</p>	<p>Level 2.5 (centers)</p> <p>Level 2.6 (ministries)</p> <p>Level 3.4 (centers & ministries)</p> <p>Level 2.5 (homes)</p> <p>Level 3.3 (homes)</p> <p>Level 4.2 (homes)</p>

<p>3) Structural quality</p>	<p>Hours of teacher training per year</p>	<p>Staff/assistants are trained on the <i>Foundations to the Indiana Academic Standards for Young Children Age Birth to Five</i>. At least 50% of teaching staff/caregivers participate annually in a minimum of 15 clock hours of educational or in-service training focused on topics relevant to early childhood. At least 50% of teaching staff/caregivers participate annually in a minimum of 20 clock hours of educational or in-service training focused on topics relevant to early childhood.</p>	<p>Level 2.2 (all) Level 2.6 (centers & homes) Level 2.7 (ministries) Level 3.5 (centers & ministries) Level 3.4 (homes)</p>
<p>a. Teacher/child ratio</p>		<p>State license and Voluntary Certification Program</p>	<p>Level 1.1 (centers & homes)</p>
<p>b. Group size</p>		<p>State license and Voluntary Certification Program</p>	<p>Level 1.1 (centers & homes)</p>
<p>c. Program duration (at least one year)</p>		<p>Program has been in operation for a minimum of one year. Lead Caregiver has at least 12 months experience in a licensed or Bureau of Child Care nationally recognized accredited child care setting as a child care provider.</p>	<p>Level 3.2 (centers) Level 3.2 (homes)</p>
<p>d. Classroom environment features (specified quality features)</p>		<p>The classroom is arranged and utilizes plentiful materials and activities in order to provide various age and developmentally appropriate interest centers that invite children's exploration. Indicators include: <i>Reading:</i> Books, soft washable seating/pillows for use while reading <i>Writing:</i> Writing tools, paper, envelopes, typewriter, letters, numbers <i>Art:</i> Drawing materials (crayons, markers, thick pencils, variety of paper, sizes and types, not coloring books or dittos/worksheets) Painting materials Tools (scissors, hole punch, tape), staplers for school-age children Three-dimensional materials (play dough, clay with tools) Collage materials (catalogs, magazines, paper scraps, fabric pieces, string, yarn, cotton balls, pipe cleaners, craft sticks)</p>	<p>Level 2.10b & 2.10c (centers) Level 2.12b & 2.12c (ministries) Level 2.11b & 2.11c (homes)</p>

<p>d. Classroom environment features (specified quality features)-continued</p>	<p><i>Blocks:</i> Different size/types of blocks and accessories such as small people, animals, vehicles, road signs, and materials to enhance building, sticks, stones, tape, string, craft sticks, interlocking blocks.</p> <p><i>Dramatic Play:</i> Dress-up clothes, such as work boots, high heels, a variety of hats, career gear/attire/uniforms, purses, billfolds and multi-cultural outfits. Other items would also include large pieces of fabric/scarves, child-size play furniture, dishes, pots, pans, dolls (multicultural dolls included), dollhouse or other play-sets, accessories for dolls, and “props” for different themes.</p> <p><i>Math/Numbers:</i> Small objects to count/sort/classify, measuring tools (scales, rulers), numbers/shapes, number games, puzzles and pattern blocks</p> <p><i>Music and Movement:</i> Audio equipment, variety of tapes/CDs, music boxes, musical toys, and instruments, dance props such as scarves/streamers.</p> <p><i>Nature and Science:</i> Collections of natural items (shells, rocks, flowers, bugs), living plants, pets to care for, science games, toys, magnets, magnifying glasses, cooking opportunities.</p> <p><i>Sensory Play:</i> Water, play dough, sand, or similar material (such as corn meal, rice, beans, oatmeal), along with kitchen utensils measuring containers, shovel, trough, buckets, small cars and trucks and, water-play accessories for pouring, measuring, squeezing, and basting</p> <p><i>Small Motor/Manipulative:</i> Blocks, puzzles, crayons, pencils, scissors, interlocking blocks and other small building toys, pegboard and pegs, games, counting materials, sorting or classifying materials and containers.</p> <p>Specific Infant/Toddler indicators include:</p> <ul style="list-style-type: none"> ▪ Open spaces for exploring and protected play. ▪ Infants and toddlers are provided a variety of outdoor play experiences. ▪ Soft, washable elements, such as cuddle toys, soft furniture or cushions. ▪ Enough materials to avoid problems with children making the same toy choice and waiting. ▪ Materials are organized consistently on low, open shelves for independent use by children. 	<p>Level 2.10b & 2.10c (centers) Level 2.12b & 2.12c (ministries) Level 2.11b & 2.11c (homes)</p>
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<p>4) Process Quality</p>	<p>d. Classroom environment features (specified quality features)-continued</p>	<ul style="list-style-type: none"> • Materials are sturdy and in good condition. • A variety of open-ended, washable toys, such as rattles, teething/rings, balls, pop beads, nesting toys, containers, cuddle toys, push/pull toys are available • Low, stable furniture is available for children to pull themselves up. • Furniture adapted for toddlers is available. • Toddler activities include building, pretending, experiencing art materials, enjoying stories and books, playing with toys, exploring sensory materials, having fun with music and movement 	<p>Level 2.10b & 2.10c (centers) Level 2.12b & 2.12c (ministries) Level 2.11b & 2.11c (homes)</p>
	<p>a. Teacher-child interactions (specified types of interaction)</p>	<p>Classroom environments are welcoming, nurturing and safe for children to have interactions and experiences that promote the physical, social and emotional well being of children. Indicators include:</p> <ul style="list-style-type: none"> ▪ Each child and his/her family are warmly acknowledged upon arrival and departure. ▪ Each child feels safe, accepted, and protected and this is supported by guidelines that reinforce respect for people, feelings, ideas, and materials. ▪ Children are under adult supervision at all times. ▪ The environment includes representation of each child and family (including all age groups, abilities, and cultures), such as books, pictures, photographs, music/songs, games, toys, dress-up clothes/materials, and foods. ▪ Each child's individuality and cultural background is valued and respected by the provider. ▪ A place for storage of personal belongings and possessions is labeled with child's name. ▪ Teachers communicate with and listen to children (verbal and non-verbal messages) with lots of one-on-one attention throughout the day and usually at eye-level, including time when the teacher is down on the floor with the children. ▪ Children's ideas, requests, and questions are acknowledged with a verbal response or physical gesture. ▪ Children's feelings are acknowledged with an accepting, non-critical verbal response or physical gesture. ▪ Teachers refrain from negative verbal or physical responses to children at all times, such as yelling, criticizing, scolding, threatening, sarcasm, name calling, yanking, pinching, squeezing, or spanking. ▪ Destructive or disruptive behavior is addressed with children (face-to-face rather than from a distance) by the teacher, explaining the effect of the behavior, stating the desired behavior and redirecting, or helping the child make alternate choices. ▪ Although limits/consequences exist, the caregiver refrains from too many restrictions in the environment and rarely uses "no", except in dangerous situations. ▪ Conflicts are resolved by/with children through a problem-solving approach (acknowledge feelings, listen to children share what happened, ask for ideas or solutions, and follow through). 	<p>Level 2.9 & 2.9a (centers) Level 2.11 & 2.11a (ministries) Level 2.10 & 2.10a (homes)</p>

<p>4) Process Quality -continued</p>	<p>a. Teacher-child interactions (specified types of interaction)-continued</p>	<ul style="list-style-type: none"> ▪ The teacher plays interactive games, and joins in children’s play, expanding upon their ideas. ▪ The classroom is generally characterized by varying sounds or comfortable conversation and spontaneous laughter from happy, involved children and adults. when crying, and given one-to-one attention during feeding and diapering. <p><i>Specific Infant/Toddler indicators include:</i></p> <ul style="list-style-type: none"> ▪ Teachers engage in many one-to-one face-to-face interactions with infants/toddlers, including singing and playful interactions. ▪ Teachers acknowledge infant/toddler babblings with a verbal response, vocal imitation or physical gesture. ▪ Teachers engage in meaningful conversations with toddlers. ▪ Teachers give toddlers simple words to use to express feelings. Verbal toddlers are then encouraged to use words in conflict situations. 	<p>Level 2.9 & 2.9a (centers) Level 2.11 & 2.11a (ministries) Level 2.10 & 2.10a (homes)</p>
	<p>b. Children’s active engagement in activities</p>	<p>Children are actively engaged throughout the day in making choices of activities and materials. Indicators include:</p> <ul style="list-style-type: none"> ▪ Children should be given several free choice periods daily. Children’s choice (individual or small group play) occurs at least one third of the time and includes indoor and outdoor play. ▪ The teacher supports children’s development through observation and gathering information that is used to guide lesson planning. ▪ The teacher supports children’s play by providing additional materials and experiences that expand on children’s interests and skills. ▪ The teacher extends learning for children by talking about what they are doing and asking questions that require more than a “yes” or “no” response, such as “What would happen if...?”, “Can you tell me about...?”, “How could we get that to work?”. ▪ The teacher finds ways to help children learn skills when they show an interest (zipping, tying, writing name). ▪ The teacher takes advantage of the many natural learning experiences associated with daily life and makes those “teachable moments” opportunities for learning. 	<p>Level 3.11 (centers, ministries) Level 3.9 (homes)</p>
	<p>c. Child-initiated activity/teacher-directed activity</p>	<p>Children’s physical, cognitive, language, literacy, math, and creative development is supported. Indicators include:</p> <ul style="list-style-type: none"> ▪ Many opportunities for communication (all ages), including sharing information, pointing out logical relationships, and encouraging children’s ability to reason, reading, and writing (for toddler age and up) are provided throughout the day. ▪ Every day children have many experiences and materials to encourage imagination and creativity. 	<p>Level 3.10 (centers, ministries) Level 3.8 (homes)</p>

<p>4) Process Quality -continued</p>	<p>c. Child-initiated /teacher-directed activity-continued</p>	<p>Level 3.10 (centers, ministries) Level 3.8 (homes)</p>
	<ul style="list-style-type: none"> ▪ Children’s thinking is stimulated through experimentation, exploration, and access to interesting materials and adult support. ▪ Displays of children’s art are available at children’s eye level and show that most art work is exploratory and unique to each child. ▪ Teachers encourage language and literacy development through interactions, books, songs, finger plays, puppet play, and writing/drawing opportunities. ▪ Math experiences are a part of everyday activities and routines (use of numbers during meals, setting a table, during transition times, using a timer to take turns, counting who is absent). ▪ Music experiences include singing, creative movement, a variety of types of music, and a variety of musical and rhythmic instruments. ▪ Science exploration is part of daily activities (examples include, collections of natural objects, living things to care for, cooking, and simple experiments). ▪ The daily schedule provides a balance of activities including: quiet/active, individual/small group/large group, child initiated/adult initiated. Infants and toddlers are not expected to function as a large group. ▪ Large group activities are not excessive for any part of the daily routine. ▪ Children, especially infants/toddlers, have a variety of sensory-awakening experiences. 	
	<p>d. Activities in daily routine (specified types and amounts of activities)</p>	<p>Level 2.10 & 2.10a (centers) Level 2.12 & 2.12a (ministries) Level 2.11 & 2.11a (homes)</p>
	<p>Daily schedule provides ample time for child-directed choices with activities and materials that are geared to the age, interests, and abilities of each child. Indicators include:</p> <ul style="list-style-type: none"> ▪ The daily schedule is consistent and predictable but relaxed and can be adapted for individual children as needed. ▪ The classroom is arranged with areas for individual, small group, and large group activities. ▪ Children are encouraged to choose the area in which they want to participate, and whether they want to play alone, with one friend, or with several. ▪ Routine tasks (such as labeling, sorting, classifying, folding clothes, counting while cleaning up or setting the table) are viewed as learning opportunities. ▪ Transitions are generally relaxed and allow time for play and completing activities. Idle sitting and waiting time are avoided. ▪ Meal time is relaxed, with no scolding or nagging. Children are encouraged to sample new foods but allowed to eat the foods of their choice. ▪ Nap time is relaxed with alternative quiet activities available for the non-nappers. Individual napping schedules are respected for infants/toddlers. ▪ The teacher has a system for rotating toys and materials for variety so that unused toys are stored and later reintroduced. ▪ TV/VCR/DVD, if used, is primarily an educational experience. Caregiver discusses what is viewed with children, and provides an alternative activity; OR TV/VCR/DVD is not used at all. 	

<p>4) Process Quality -continued</p>	<p>f. Language and literacy opportunities</p>	<ul style="list-style-type: none"> ▪ Preschoolers are provided language materials daily, in addition to books, such as puppets, flannel boards, recorded stories, and picture card games. ▪ Books for preschoolers include a variety of imaginative, rhyming, and informational books. ▪ Books for school-age children include a variety of reading levels and topics, such as adventures, mysteries, and informational books and magazines. <p><i>Specific Infant/Toddler Indicators include:</i></p> <ul style="list-style-type: none"> ▪ Books are durable, with simple pictures and short stories about everyday activities. ▪ Sturdy, simple books and pictures of real objects are accessible to toddlers each day to look at on their own. ▪ Each infant/toddler is given opportunity daily for at least one language activity using books, pictures, or puppets. ▪ Toddlers are encouraged to scribble with crayons. ▪ Teachers respond to sounds/speech, including by imitating infants' vocalizations and engaging toddlers in conversation. ▪ Teachers talk about objects and events that infants and toddlers experience. ▪ Teachers use books or read with children during quiet, individual lap time. 	<p>Level 2.11 & 2.11a (centers) Level 2.13 & 2.13a (ministries) Level 2.12 & 2.12a (homes)</p>
<p>g. Emphasis on diversity and respect for individual children and families</p>	<p>g. Emphasis on diversity and respect for individual children and families</p>	<p>The environment includes representation of each child and family (including all age groups, abilities, and cultures), such as books, pictures, photographs, music/songs, games, toys, dress-up clothes/materials, and foods. Each child's individuality and cultural background is valued and respected by the provider.</p> <p>The learning environment is developmentally and culturally appropriate and meets any special needs of the children. Indicators include:</p> <ul style="list-style-type: none"> ▪ Children feel a sense of belonging in the classroom, by having a labeled space for their personal items, and a personal sleeping area. ▪ Children are taught to be considerate of each other's work and possessions. ▪ Children are taught to understand and respect others. The teacher answers children's questions about differences in a respectful and factual way. ▪ All children and their families have equal opportunities to participate in classroom and program activities. ▪ Space is arranged to provide children of different ages and abilities access to materials and an opportunity to engage in play and projects without limitation or interference from one another. ▪ A plan is in place for effectively working with children with special needs, including behavioral needs and adaptation of materials and space. <p>The teacher includes children in age-appropriate self-help activities, such as dressing, picking up toys, washing hands, folding clothes, serving food, and setting or cleaning up meals.</p>	<p>Level 2.9 (centers) Level 2.11 (ministries) Level 2.10 (homes) Level 3.12 (centers, ministries) Level 3.10 (homes)</p>

5) Assessment	Use of authentic or naturalistic assessment methods	Assessment is appropriate to the curriculum and focuses on children’s strengths. It may include portfolios, conversations, anecdotal notes, and developmental notes.	Level 3.9 (centers, ministries)
6) Children with special needs	Plans and environmental accommodations for children with special needs	A plan is in place for effectively working with children with special needs, including behavioral needs and adaptation of materials and space.	Level 3.12 (centers, ministries) Level 3.10 (homes)
7) Program policies & procedures	Orientation	<p>Staff members receive orientation within 30 days of being hired.</p> <p>Written policies and a child care contract is established and implemented with families. The contract should be signed by the parent and should contain:</p> <ul style="list-style-type: none"> ▪ Persons authorized to pick up a child ▪ Illness policies including reasons for exclusion ▪ Guidance and Discipline policy ▪ Medication administration policy ▪ Written emergency plan ▪ Policy on parent conferences, visits and open door policy ▪ Information on transportation and field trips ▪ Hours of care provided ▪ Late pick up policy ▪ Payment and fee schedule ▪ Vacation policies regarding both facility and family vacations ▪ Sick leave policies for children’s illnesses ▪ Alternative care/substitute policies ▪ Termination policy ▪ Child information including any special needs, fears or food preferences/allergies <p>A written emergency plan is established and implemented. The plan is shared with parents at the time of enrollment and/or any time the provider initiates a change in any aspect of the plan. The purpose of the written emergency plan is to make all emergency policies and procedures clear to parents. The plan is to be signed by the parent(s) to indicate their understanding and acceptance or the policies and procedures. The written plan will include: (child care homes)</p>	Level 1.6 (ministries)
	Written policies and procedures Records kept and updated		Level 2.10 (ministries) Level 2.9 (homes)
			Level 2.8 (homes)

<p>7) Program policies & procedures-continued</p>	<p>Written policies and procedures Records kept and updated-continued</p>	<ul style="list-style-type: none"> ▪ The procedure for notifying parents in the event of the provider’s illness, the illness of a member of the household who may be contagious to others, or any emergency that prevents children from being cared for in the provider’s home. ▪ Any back-up plan for care that the provider will arrange in the event of an emergency. ▪ The need for the parent to have a back-up plan for care in place, in the event of their child’s illness or the provider’s inability to care for children. ▪ Exclusion policies pertaining to a child’s health. ▪ Alternative contacts and medical care authorization available in case parents can not be reached in the event of an emergency. ▪ A list, provided by the parent(s), of people authorized to pick up a child. ▪ A plan for fire evacuation or any other type of evacuation. ▪ A plan for safe shelter during a tornado warning or any other threatening weather emergency. <p>A plan for safe shelter during a tornado warning or any other threatening weather emergency. An advisory board is in place to provide input and support to the director.</p>	<p>Level 2.8 (homes)</p>
	<p>Center advisory board</p>		<p>Level 2.8 (centers) Level 2.9 (ministries)</p>
	<p>Annual program evaluation</p>	<p>Program evaluation is completed annually by families and staff.</p>	<p>Level 3.6 (centers & ministries) Level 3.5 (homes)</p>
	<p>Strategic planning</p>	<p>A strategic plan is completed and includes annual evaluation/ goal setting and long range planning/goal setting.</p>	<p>Level 3.7 (centers & ministries)</p>
	<p>Teachers paid planning time</p>	<p>At a minimum, the Lead Teacher receives paid planning time.</p>	<p>Level 3.3 (centers & ministries)</p>
<p>8) Director/Lead Caregiver professional development</p>	<p>Director/lead caregiver membership in professional organization</p>	<p>Director/lead caregiver is a member of a nationally recognized early childhood organization.</p>	<p>Level 2.3 (all)</p>
	<p>Director’s/lead caregiver’s mentorship of other programs</p>	<p>Director/lead caregiver volunteers to informally mentor a program at a Level 1, 2, or 3.</p>	<p>Level 4.3 (centers & ministries) Level 4.4 (homes)</p>
	<p>Director/lead caregiver education/training</p>	<p>The director has completed a Child Development Associate credential (CDA) or early childhood degree or equivalent degree OR the director of the ministry agrees to obtain a minimum of a CDA within three years of beginning Paths to QUALITY and shows progression towards completion each year. The director of the ministry completes Safe Sleep Training. Director/Lead Caregiver receives orientation and trains staff on the <i>Foundations to the Indiana Academic Standards for Young Children Age Birth to Five</i>.</p>	<p>Level 1.4 (ministries) Level 1.5 (ministries) Level 2.2 (all)</p>

<p>9) Parent-teacher communication</p>	<p>System for sharing information with parents</p>	<p>A system is in place for communicating pertinent information to families, daily and in an annual family conference.</p>	<p>Level 2.7 (centers, homes) Level 2.8 (ministries)</p>
	<p>Parent/teacher conferences</p>	<p>A system is in place for communicating pertinent information to families, daily and in an annual family conference.</p>	<p>Level 2.7 (centers, homes) Level 2.8 (ministries)</p>
<p>10) Accreditation by NAEYC or other organizations</p>	<p>Accreditation by NAEYC or other organizations</p>	<p>Accreditation by a nationally recognized accrediting body, approved by the State, has been achieved and maintained.</p>	<p>Level 4.2 (centers) Level 4.3 (homes)</p>

Appendix 2. Paths to QUALITY Pilot Program: Early Childhood Alliance

Goals of Paths to QUALITY

Paths to QUALITY is a voluntary system created to assist parents in identifying and selecting quality child care and recognize providers for ongoing efforts to achieve higher standards of quality that the minimum state licensing requirements. Providers who choose to join PTQ receive a verification visit, are assessed, and are placed on one of four levels. Providers receive yearly re-verification visits to determine if they have maintained their current level or achieved a higher level.

The goals of the Paths to QUALITY as originally conceived were:

- 1. to raise the quality of child care and early education experiences for children,**
- 2. to give parents tools to help determine the best quality program for their children,**
and
- 3. to support and recognize providers for quality care.**

Through these goals it was proposed that PTQ would also provide the following benefits:

- Affirm and support the role of parents
- Provide opportunities for all children to develop optimally
- Develop well-trained, qualified child care and early education staff
- Provide experiences which help children succeed in school
- Make affordable, high quality child care available when and where families need it
- Encourage a more stable child care workforce through increased stature, professionalism, salaries and benefits
- Help children make a smooth transition to kindergarten
-

History of PTQ in Indiana

The Paths to QUALITY program was created by the Child Care and Early Education Partnership, a group of organizations working together in the Fort Wayne area “to develop awareness of and commitment to the importance of high quality early care and education for all children in the community.”¹ In 1996, the Partnership funded a community action plan titled *Child Care & Early Education: Everyone’s Business* to address the child care and early education needs of Allen County. The partnership sought to develop a clear set of objectives for high quality child care and early education, identify the local assets for and barriers to achieving those objectives, and establish a plan to build on assets to overcome the barriers of and move the community toward high quality child care and early education. To develop awareness of and commitment to the importance of high quality early care and education, the standard for child care quality and support of quality early care and education were addressed in Northeast Indiana. During 1996 to 1999, Paths to QUALITY, a child care quality indicator system, was created as a strategy to identify high quality early care and education.

Paths to QUALITY established four levels of quality, individually tailored for licensed child care centers, licensed and exempt family child care homes, registered child care ministries, and part-time early childhood (preschool) programs. Each level includes specific criteria that need to be met in order for that level to be awarded. The levels, with a brief description of criteria for each, are:

Level 1 – Health and Safety

- Basic requirements for health and safety are met.
- Orientation addresses interactions with children, child development and learning.

Level 2 – Learning Environment

- State requirements for child: staff ratios are maintained.
- Environments are safe and nurturing for children.
- Activities and materials reflect the age, interests, and abilities of all children.
- Written policies and procedures exist for parents and staff.

Level 3 – Planned Curriculum

- A written curriculum and planned program for children reflects developmentally appropriate practice.
- Program evaluation is done annually by parents and staff.
- A strategic plan for program improvement/ accreditation readiness is completed.

Level 4 – National Accreditation

- Accreditation is achieved through the National Association for the Education of Young Children (NAEYC) or the National Association of Family Child Care (NAFCC).
- Professional development and involvement continues.

Implementation of the Paths to QUALITY program

In 2000, PTQ was implemented in Allen County in Northeast Indiana by the Early Childhood Alliance's (ECA) Child Care Resource and Referral agency. In 2001, PTQ was implemented in the surrounding 5 counties of DeKalb, Whitley, Steuben, Noble, and LaGrange.

In 2005, 4C of Southern Indiana, Inc. implemented the PTQ program in the 11 county service area of Vanderburgh, Posey, Pike, Dubois, Warrick, Knox, Martin, Daviess, Spencer, Gibson, and Perry Counties.

PTQ pilot programs

Overview of Results: Early Childhood Alliance PTQ Program (Northeast Indiana)

The following summary of results is based on a review of annual reports provided by the Early Childhood Alliance. No external evaluation of the program has been conducted. Each of the 3 main goals of PTQ are addressed in this summary of PTQ outcomes.

Goal #1 Successes: Raise the quality of child care and early experiences for children

Participation rates, level advancements, and the relationship between PTQ levels and overall quality will be discussed.

Participation rates

The PTQ program in Northeast Indiana has grown tremendously over the first seven years of implementation. At the end of 2001, after the first full year of implementation, 28% (150) providers were registered with PTQ. This varied by type of care with the largest participation rates among licensed child care centers (75%) and the lowest among registered ministries (9%). During the following year of implementation (2002), participation rates jumped to 42% (174) of all providers with the greatest growth in participation rates among family child care homes (41%). From January 2002, to July 2007, participation rates have grown steadily. In July 2007, 60% (237) of providers were participating in PTQ. See Table 1 for participation rates over the last 7 years of implementation.

Table 1. Participation rates of PTQ in Northeast Indiana (percentage of all providers eligible to enroll in PTQ)

	2001	2002	2003	2004	2005	2006	2007
All providers registered with PTQ	28%	42%	47%	47%	52%	53%	60%
Licensed Centers	75%	76%	82%	90%	88%	96%	96%
Family Homes	23%	41%	46%	50%	54%	54%	64%
Registered Ministries	9%	12%	23%	23%	25%	35%	32%
Part time programs	38%	40%	42%	34%	42%	38%	44%

Paths to QUALITY level advancements

Most providers entered the program at Level 1 (67%). The remaining entered at Level 2 (9%), Level 3 (11%), and Level 4 (13%). When those rates are compared to the current percentages on PTQ, there are striking differences. As of July 2007, 24% of providers are registered as a Level 1, 15% as Level 2, 25% as Level 3, and 35% as Level 4. After the first year of full implementation (2001), 43% (64) providers had increased a level. However, by the second year (2002), 73% had increased a level since they began the program. This rate has steadily increased. By July 2007, 92% (217) of providers on PTQ have increased at least one level since they began the program. Table 2 compares initial and current ratings of programs and provider participating on PTQ.

Table 2. Programs and providers initial and current PTQ rating in Northeast Indiana.

	Initial Rating	Current Rating (July 2007)
Level 1	67%	24%
Level 2	9%	15%
Level 3	11%	25%
Level 4	13%	35%

Decreases in levels

High levels of turnover, changing or increasing regulations, and the cost of providing staff training were obstacles for early education programs in maintaining level status. Data on the total number of programs that have decreased in levels over the course of the 7 years of implementation is not available; however, from January 2006 to July 2007, 21 programs and providers have moved down a level of PTQ, primarily due to lack of maintaining annual training hours. Of those 21 programs 2 refrained from going through the re-accreditation process. ECA continues to work with these programs to ensure they have the mentoring and training opportunities available that will help these programs return to and maintain previous levels of quality.

Relationship between PTQ levels and child care quality

- During 2004-2006 some of the providers have also participated in a mentoring program provided by ECA. As part of this program, scores are available from one of three measures of classroom quality – the Early Childhood Environment Rating Scale (ECERS), the Infant Toddler Environment Rating Scale (ITERS), or the Family Day Care Environment Rating Scale (FDCRS). In a small sample of PTQ programs and providers (n=34), those who had earned higher PTQ levels exhibited higher levels of assessed quality. (See Table 3.)

. Providers who had earned higher PTQ levels did exhibit higher levels of assessed quality. Table 3 presents these data.

Table 3. Average global (overall) quality for providers at each Paths to QUALITY level in Northeast Indiana.

PTQ Level (# of providers)	Global (Overall) Quality Score (1-7)	Range of Quality Scores
Level 1 (15 providers)	3.8	2.4-4.9
Level 2 (12 providers)	4.7	3.3-5.5
Level 3 (7 providers)	5.13	3.4-6.8
Level 4 (2 providers)	5.7	5.6-5.7

Goal #2 Successes: Give parents tools to help determine the best quality program for their children

Parent education was conducted through PTQ brochures, mass media campaigns, visibility at health, job, or diversity fairs, and through the ECA Child Care Resource and Referral. The brochures were displayed at doctors' offices, libraries, churches, Lamaze classes, healthy family visits, and other places that parents may frequent. Additionally, radio commercials were used to inform parents about PTQ and a PTQ website was established to offer parents information on

how to select quality child care and provide information on the PTQ criteria. Parents who called the ECA Child Care Resource and Referral for assistance in finding child care were introduced to PTQ and given a *Paths to QUALITY Information Tool for Parents* brochure. This tool gave parents specific standards to look for when selecting child care. By educating parents, the expected outcomes are that parents will increase their expectations and require a higher level of quality from their child care providers, and parents will be empowered to make good decisions that will benefit their children. Data have not been collected to determine if parents have increased their expectations for child care.

Goal # 3 Successes: Support and recognize providers for quality care

To support and recognize providers for quality care and in turn, promote a stable child care workforce with increase stature, PTQ levels required providers to participate in a professional group or organization. Events such as “Provider’s Night Out” for family child care home providers offered opportunities to network with other providers and be recognized for their accomplishments in achieving higher levels of quality. Consequently, family child care home providers in Northeast Indiana created an organization called United Providers to continue networking and professional development opportunities and provide stability and professionalism for the participants.

A variety of incentives were utilized to encourage child care providers to participate and work toward higher levels of quality. They included: discounts at training programs and retreats, free resource library cards and delivery of materials from the Child Care Resource and Referral, discounts on books, assistance in achieving national accreditation, and recognition in a list of Paths to QUALITY participants distributed to parents and businesses. In addition, providers received \$250 incentive for renewing National Accreditation.

Challenges of the PTQ program in Northeast Indiana

Recruitment challenges

Participation among family child care providers has required the greatest effort to increase and maintain. Efforts were made to follow up with those individuals who attended Orientation trainings, state required trainings for family child care providers interested in licensing. Initially, ECA sent out packets to all potential providers who attended the trainings immediately following the training. It was discovered that many providers lost or forgot about the program during the licensing process and consequently, did not register with PTQ. In 2006, ECA changed its process and waited at least 3 months before sending materials to providers attending this training coinciding with the time it would take a provider to complete the licensing process. This change in procedure did not increase family child care providers participation so in October 2006, ECA began a new process. Mentors visited licensed family child care providers, registered them with PTQ during the visit, and offered new providers a small incentive (developmentally appropriate materials valued at \$50) for registering at Level 1 of PTQ. When the providers discovered they were receiving the incentive, they were much more receptive to participating in PTQ. This resulted in an increase in Level 1 providers during the first 6 months of 2007 and an overall increase in participation (from 57% in October 2006 to 71% in July 2007). Consequently, percentages of those providers participating at Levels 2, 3, & 4 have dropped since October due to this increase in participation.

Barriers of providers to enroll in program

Since Level 1 requirements for licensed family child care homes and license centers includes maintaining a valid license, once licensed programs were recruited in PTQ they were successful in registering in the program at least at Level 1 status. There were significant barriers, however, for license exempt programs to achieve Level 1 status. For registered ministries and part-time programs, those barriers included obtaining a physician's note of health for each staff, having a fenced-in play yard, implementing an orientation plan, and using positive discipline. To overcome these obstacles, ECA found that fundraising, the Child Development Associate credential (CDA) education for director and staff, and monthly mentoring visits were most helpful.

Barriers of providers to advance levels

Barriers for advancement on PTQ levels varied by level and type of care. Barriers for advancement to Level 2 (learning environment) included: maintaining adult/child ratios, development of policies, completing voluntary participation, meeting education and training requirements of staff, providing accessible appropriate learning materials especially in the area of language and literacy, and providing parent/teacher conferences. To overcome these barriers, mentoring of programs and providers, staff completion of CDAs as well as being able to implement what they learned in their CDA courses in their child care classroom made the biggest impact.

Barriers for advancement to Level 3 (planned curriculum) included: getting teaching staff involved in the PTQ process, meeting training requirements, joining a professional group, understanding and implementing a developmentally appropriate curriculum, and getting parents and advisory board involved in the program. Monthly on-site mentoring and continuing education had the biggest impact on advancing programs and providers to Level 3.

Barrier for advancement to Level 4 (national accreditation) included: training requirements and the commitment to achieve and maintain accreditation. Center based programs that were successful in reaching and maintaining national accreditation standards had enthusiastic directors who developed plans and worked with ECA to go through accreditation process in a thoughtful way. Support from the Indiana Accreditation Project of the Indiana Association for the Education of Young Children (IAEYC) was also very beneficial to these programs. Family child care providers who were successful in achieving and maintaining national accreditation benefited from training and mentoring from ECA and become informal mentors of other providers. Recognition from PTQ and incentives provided additional motivation to family home providers to achieve and maintain national accreditation standards.

Attrition Challenges

Even though participation rates have increased each year, there were still programs and providers who did not continue with the PTQ program. The most common reason for attrition was due to programs closing. In particular, family child care providers stopped offering care. During 2005, an implemented change in state regulations requiring licensed family child care home providers

to receive their CDA within three years of providing care resulted in a decrease in licensed homes in Northeast Indiana as well as a loss of those participating in PTQ. There were also a number of programs and providers that were not committed to adhering to the standards necessary to ensure the integrity of the PTQ program and others which ECA were unable to schedule re-verification visits. When a provider or program still in operation did not meet the standards of PTQ, ECA continued to communicate and work with them and leave an open door for their later participation. Attrition rates varied from 4 to 9%.

What are the lessons learned?

During the implementation of the PTQ program in Northeast Indiana, some important lessons were learned. ECA concluded that it is important that a rating system of this nature is a voluntary, strength-based system, and based on relationship building. Relationships between providers and the child care resource referral staff became critical to the success of the program. Mentoring services and training opportunities became crucial to the success of PTQ.

Increased participation in training and professional development events made the most difference in providers advancement in levels as well as a strong sense of identity with the PTQ program for those providers participating. It became important to encourage existing providers and programs on PTQ to continue with training required at the higher levels of the system and provide training that was motivating to participants on every level.

Conclusions from PTQ pilot program in Northeast Indiana

The growth in participation rates and dramatic increases in levels by providers illustrates the success of the program. It is important that a rating system of this nature is a voluntary, strength-based system, and based on relationship building. Relationships between providers and the child care resource referral staff in particular mentoring services and training opportunities became critical to the success of the program. Increased participation in training and professional development events made the most difference in providers advancement in levels as well as a strong sense of identity with the PTQ program for those providers participating.

ECA has proposed that providers, parents, businesses, the community as a whole as benefited from PTQ in the following ways:

Providers and programs in Northeast Indiana experienced the following benefits:

- Manageable, attainable steps outlined to assist with quality improvements
- The power to decide what level they want to participate at
- It was a voluntary, not regulatory program
- Assistance to achieve higher levels of quality, whether the program was regulated or not
- Incentives for quality improvements
- Recognition for offering quality child care (decals, annual dinner, certificates, name in newspaper or on list of providers given to businesses)
- Opportunities to network with other providers
- Enhanced professionalism and increased respect in the community
- Marketing tool
- Mentoring support

Parents in Northeast Indiana experienced the following benefits:

- Questions to ask so they can select quality child care
- Understanding of the child care options available
- Provider professionalism and contracts which lend to increased reliability, dependability and clear expectations regarding policy and procedures

Businesses in Northeast Indiana experienced the following benefits:

- Enhanced recruitment – a quality early education system can help attract and retain young working families
- Decreased provider turnover and reliable child care leading to decreases in absenteeism and productivity issues
- A tangible tool to help employees find quality child care

The community and state of Indiana experienced the following benefits:

- Accountability to funders, providing measurable outcomes of increased quality
- Awareness and commitment to quality early care and education
- A tool used to market the community as an attractive place to live and work

Limitations of data of PTQ in Northeast Indiana

The success of PTQ pilot program in Northeast Indiana gives much encouragement in the development of a state wide quality rating system using PTQ levels. Data from the pilot program suggest that participation and quality of child care have increased over the seven years of the program's implementation. There were three basic limitations of the data and this report: a) the report relied heavily on historical data that were collected a variety of ways, b) there were very few quality scores for those providers in PTQ which limits the conclusions we can make about the relationship between quality and PTQ levels, and c) there is no data available on PTQ levels and its relationship to children's development and learning.

Appendix 3. Paths to QUALITY Pilot Program: 4C of Southern Indiana, Inc.

Overview of Results: 4C of Southern Indiana, Inc. Paths to QUALITY program

The following summary of results is based on a review of annual reports provided by 4C of Southern Indiana, Inc. and by an external evaluation study conducted by Purdue University and funded by the Welborn Baptist Foundation [Purdue University Early Child Care Quality Initiative (ECCQI)]². Each of the 3 main goals of PTQ are addressed in this summary of PTQ outcomes.

Goal #1: Raise the quality of child care and early experiences for children

Participation rates, level advancements, and the relationship between PTQ levels and overall quality will be discussed.

Participation rates

Similar to the Northeast Indiana programs, the providers in the 4C region also experienced growth in the number of programs enrolled in PTQ in the two and half years of implementation (Table 4). One of the successes of the 4C of Southern Indiana, Inc. PTQ program was the successful recruitment of programs and providers. Instead of launching an expensive public awareness campaign, 4C staff distributed the information to the provider community in the following ways:

- Presentations at the 4C Early Childhood Conference,
- Two informational sessions hosted by 4C, with 55 providers in attendance,
- Monthly newsletter that reached 250 providers, and
- Various community presentations, including at the local Step Ahead councils and public and private school committees,

These presentations and “word of mouth” advertising resulted in (30% of 177) programs registering for PTQ in the first 9 months the program was operational. The 4C PTQ program has continued to grow in 2006 and 2007, but at a slower pace. The following table highlights the number of programs that are enrolled in PTQ through July 2007:

Table 4. Provider participation in PTQ in Southwest Indiana (percentage of all providers eligible to enroll in PTQ)

	2005	2006	2007 (through June 2007)
% of providers registered with PTQ	30%	42%	46%
Licensed Centers	72%	89%	93%
Family Child Care Homes	20%	27%	31%
Registered Ministries	57%	71%	75%
Part time programs	36%	64%	67%

NOTE: Figures include programs that registered, but did not meet Level 1 criteria

During 2006, Purdue University conducted an external review of the 4C pilot program entitled Early Child Care Quality Initiative (ECCQI) evaluation. One aspect of the evaluation focused on examining why providers enrolled in PTQ. Telephone interviews were conducted with 41 providers who had been registered with Paths to QUALITY for at least six months. Of the 41 providers who participated in the survey—

- 33% were licensed child care center directors
- 52% were family child care providers
- 12% were registered child care ministry directors
- 2% were part-time preschool program directors

A majority of providers (56%) indicated that they joined PTQ because they wanted to improve the quality of their child care business. The reasons given were fairly evenly split – 15% indicated they joined because of the financial incentives that PTQ offered, 12% joined because they wanted the recognition that they were a quality child care provider, and 12% joined because they believed that parents would feel it was important once they learned more about PTQ. A small group of providers, 5%, stated they joined in order to receive assistance with attaining national accreditation.

All of the providers indicated that they learned about Paths to QUALITY from 4C, either through a letter of invitation to join PTQ, a meeting or training session, or through their 4C mentor. No providers reported that they learned about PTQ from other providers. However as the program continues to grow, communication will likely come also from providers who have joined and successfully moved up levels.

Paths to QUALITY level participation and advancements

During the first year of implementation (2005), most of the providers entered at Level 1. There were a small percentage of providers that were interested in PTQ, but upon the initial visit, it was found that they were not eligible for Level 1. Overall in 2006, 36% of the registered programs

(54 programs) increased at least one level and 22% (40 programs) increased more than one level. Following is the breakdown by provider on their initial levels and then their subsequent levels (See Table 5)

Table 5. 4C Providers initial and current PTQ rating

	Initial Rating	Current Rating (July 2007)
Level 0	20%	10%
Level 1	64%	39%
Level 2	9%	23%
Level 3	3%	16%
Level 4	5%	12%

During 2006, there was an increase of family child care providers and licensed child care centers moving from Level 1 to Level 2 or 3. Both types of providers saw a small increase in the number of providers achieving national accreditation. Registered ministries and part-time programs had the largest proportion of providers that initially could not meet Level 1 requirements. In 2006, the proportion of providers that could not meet Level 1 did decrease, but there were still a higher number of providers in these two categories that were still unable to meet Level 1 criteria. The increases for registered ministries and part-time programs were found in moving programs from Level 0 to Level 1 and from Level 1 to Level 2. During 2006, one registered ministry achieved Level 3 rating, and no part time programs had achieved a Level 3 rating, but one part-time program had achieved a Level 4 rating. However, by July 2007, eight part-time programs had achieved a Level 3 rating, and two registered ministries had achieved a Level 3 rating.

In response to the number of programs that had met Level 1 criteria and were now looking to move to Level 2, 4C increased its efforts to offer training around increasing the quality of the learning environment by adding materials and activities.

The Purdue University ECCQI evaluation asked providers about their initial, current, and expected ratings in the PTQ program. At least once per year, or at the request of the child care provider, 4C verifies that the provider has either maintained or changed their Paths level. Table 6 details the findings.

Table 6. Interviewed Providers' PTQ ratings.

	Initial Rating	Current Rating During Interview (Summer, 2006)	Expected Rating at next visit
Level 1	67%	26%	5%
Level 2	19%	33%	26%
Level 3	5%	29%	33%
Level 4	7%	12%	36%

The findings indicate that in the previous six months, 25 of the providers interviewed had moved up levels. Of the 25 providers who have moved up levels, 15 moved up one level, and 10 moved

up two levels. The remaining 16 providers maintained current levels from their initial to current rating. A majority of the providers had advanced above Level 1 within the past 6 months. At the time when providers enrolled in PTQ, 67% were at a Level 1, compared to 26% at the time the interviews were conducted. At the initial rating period, only 12% of providers were at Level 3 or 4, but at the time of the interviews, 41% had attained a Level 3 or higher.

Part of the Purdue University ECCQI evaluation focused on 25 providers who had advanced in PTQ levels. Providers were asked to describe the kinds of changes they had implemented since initially joining Paths to QUALITY. The two most common changes reported were classroom changes such as adding materials, room arrangements and curriculum changes, (66%) and program administrative changes such as parent contracts, documentation and lesson planning, introducing primary caregiving and continuity of care, writing strategic plans, instituting parent surveys and evaluations, joining professional organizations (49%), followed by staff development changes such as providing opportunities for more staff training hours (19%). The most frequently cited classroom changes made were implementing a curriculum and changing the room arrangements. The most common program administrative changes mentioned were instituting parent surveys.

Decreases in levels

Since the 4C of Southern Indiana, Inc. PTQ program is still in the early stages of implementation, data about decreases in levels is not available at the time of this report.

Relationship between PTQ levels and child care quality

The Purdue University ECCQI evaluation also examined the relationship between PTQ levels and child care quality. Using valid and objective measures of quality [the Early Childhood Environment Rating Scale (ECERS-R), the Infant Toddler Environment Rating Scale (ITERS-R) and the Family Day Care Environmental Rating Scale (FDCRS)], it was found that providers who had earned higher PTQ levels did in fact exhibit higher levels of assessed quality. This was especially true in the transitions from Level 0 to Level 1, and Level 1 to Level 2. While some providers at Level 3 had the highest quality levels, the average quality levels at Level 3 were comparable to for the Level 2 providers we observed. (See Table 7.)

Table 7. Average global (overall) quality for MAP providers at each Paths to QUALITY level.
(n=47)

Paths to QUALITY Level (# of classrooms observed)	Global (Overall) Quality Score (1-7)	Range of Quality Scores
Level 0 (3 classrooms)	3.19	2.78-3.49
Level 1 (28 classrooms)	4.45	3.41-5.26
Level 2 (11 classrooms)	4.64	3.69-5.48
Level 3 (5 classrooms)	4.35	2.88-5.67

*Note: Level 0 represents only 1 center-based provider; the rest were family child care homes.
Level 3 represents only 2 center-based providers
Level 4 providers do not participate in MAP, so quality data were not available.

Goal #2: Give parents tools to help determine the best quality program for their children

Strategies similar to those used in Northeast Indiana (PTQ brochures, visibility at health, job, or diversity fairs, and information distributed through the 4C of Southern Indiana, Inc. Child Care Resource and Referral) were utilized to inform parents about PTQ. Data have not been collected to determine if parents have increased their expectations for child care.

Goal #3: Support and recognize providers for quality care

In August 2005, 4C of Southern Indiana, Inc. hosted its first Leadership Retreat for child care providers who were registered in Paths to QUALITY at the French Lick resort in French Lick, Indiana. The Leadership Retreat was in response to providers' request an opportunity to meet and reflect upon different issues facing child care providers. Providers had the opportunity to attend workshop sessions focused on 1) managing change; 2) your retirement goals (family child care home providers); 3) marketing you child care center (centers); and 4) leadership. At the conclusion of the retreat, 4C staff conducted a survey of participants that asked whether "this training provided me with the knowledge and skills necessary to begin the process of implementing change related to this topic." 57 participants completed this 4C survey. Overall, evaluations were very positive, with 91% to 100% strongly agreeing or agreeing that by attending the sessions they had obtained the skills and knowledge necessary begin to bring about change. 4C of Southern Indiana, Inc. has continued to offer the Leadership retreat annually.

A variety of other incentives were utilized to encourage child care providers to participate and work toward higher levels of quality. They included: free resource library cards and delivery of materials from the Child Care Resource and Referral, materials awarded to providers for each level advancements, scholarships for education and training opportunities, assistance becoming accredited, and recognition in a list of Paths To QUALITY participants in local newspapers.

Challenges of the PTQ program in Southwest Indiana***Recruitment challenges***

One of the main challenges during the first year of implementation was adequately handling the large interest in the program. During the first year, there was a backlog of programs waiting for their initial site visit, and the initial visits were more time intensive than originally planned. One way in which staff at 4C handled this backlog was to cross-train staff members to register programs so that one person was not responsible for registering all programs.

Another challenge was related to the number of programs that were willing to join PTQ but were unable to meet Level 1 criteria. 4C staff remained committed to these programs and assisted them when possible in achieving a Level 1 status.

The number of providers enrolling in 2006 and 2007 has tapered off significantly. Part of the reason why numbers have decreased (although overall participation rates continue to increase) is due to the struggle of enrolling family child care home providers. Anecdotally, some family child care providers have used the PTQ system as a friendly competition between providers. However, these numbers reflect a more significant challenge in enrolling family child care providers. Because family child care providers are more likely to be transient than other types of providers, some of the difficulty in enrolling them may have to do with the nature of their business.

Barriers of providers to enroll in program

Similar barriers existed for providers and programs in Northeast and Southwest Indiana to achieve Level 1 status. Barriers included: obtaining a physician's note of health for each staff, having a fenced-in play yard, implementing an orientation plan, and using positive discipline.

Barriers of providers to advance levels

The Purdue University ECCQI evaluation also examined barriers to advancing to the next level. Providers indicated in the qualitative interviews that there were few barriers in advancing from Level 1 to Level 2. However, there were barriers when advancing to Level 2 to Level 3, and then from Level 3 to Level 4. Barriers for advancement to Level 2 (learning environment) included: implementing classroom changes such as adding materials and room arrangements. Barriers for advancement to Level 3 (planned curriculum) included: implementing or adopting a curriculum and lesson planning and implementing administrative changes, such as developing parent contracts, writing strategic plans, instituting parent surveys and evaluations, and joining professional organizations. One barrier that transcended all levels was the need to provide opportunities for more staff training hours.

For those providers who had already achieved a Level 4, an additional question was asked to ascertain any challenges in maintaining that level. Of the providers that had already achieved Level 4, all mentioned that maintaining the annual 20 hours needed for staff training hours was the biggest challenge.

The most frequent obstacle in participating in PTQ providers mentioned was instituting program administrative changes (37%), such as making time for documentation and instituting parent surveys, followed by classroom changes (26%). Money was listed as an obstacle for 16% of the providers. However, 16% felt that there were not any obstacles to moving up to the next level.

In order to move up levels, child care providers need assistance, whether it is technical assistance, funding for developmentally appropriate materials, or access to additional training for the staff. A majority of providers – 93% -- indicated that they had received some sort of support from 4C to either progress within the PTQ system or to maintain their current level. Assistance came in the form of informal support through periodic phone calls, and more formal support and training through the mentoring program. Providers also mentioned they received financial incentives from 4C for moving up to the next level, materials from the Resource Library, or they had participated in 4C training. Only a small percentage – 7% -- reported they had not received any assistance from 4C in either maintaining or progressing to the next level.

Over one-quarter (27%) indicated they had received support from other organizations, such as the Indiana Child Care Fund, private foundations, Indiana Association for the Education of Young Children (IAEYC), or the Indiana Child Care Health Consultation Program. Nearly three-quarters (73%) indicated that they had not received any additional outside support.

Attrition Challenges

Since 2005, 31 programs that were originally registered on PTQ have decided to no longer participate. The main reason for dropping out of the program was due to the facility closing, having licensure revoked, or lack of interesting in continuing with the program. Of the 31 programs that dropped out, 25 were family child care home providers, four were part-time programs, 1 each were a licensed center and registered ministry.

What are the lessons learned?

Because many providers enter Paths to QUALITY at Level 1 and then progress relatively quickly to Levels 2 and 3, it is important that 4C training and support focus on nurturing environments for children, curriculum, staff and parents policies, planning, and program evaluation, which are Level 2 and Level 3 criteria. However, there was evidence that some providers may also need consistent support to maintain the Level 1 health and safety standards, so 4C should continue to be vigilant about these issues, even when training with Level 2 or higher providers. Also, 4C should continue to develop ways to support providers to achieve and maintain Level 4- national accreditation.

Conclusions about the effectiveness of PTQ in Southwest Indiana

Information from the Purdue University ECCQI study and from 4C of Southern Indiana, Inc. indicates that the PTQ system has been successful and accepted by area programs and providers. The levels seem attainable, and most providers had already progressed to a higher level in the short time the program has been implemented. While all the interviewed providers indicated they needed to make changes to move up to the next level, they seemed to be changes that were manageable with support from 4C and other training/technical assistance organizations. Because many providers enter Paths to QUALITY at Level 1 and then progress relatively quickly to Levels 2 and 3, it is important that training and support focus on nurturing environments for children, curriculum, staff and parents policies, planning, and program evaluation, which are Level 2 and Level 3 criteria. However, there was evidence that some providers may also need consistent support to maintain the Level 1 health and safety standards, so it is important to continue to be vigilant about these issues, even when training with Level 2 or higher providers.

Overall child care quality increased as providers attain higher levels in Paths to QUALITY, especially Level 1 and Level 2. It is not clear from these data that overall quality increases between Levels 2 and 3, so more study is needed. Also no quality data were available for Level 4 programs, so they should be included in future studies. It may be that the largest increases in overall quality will be found first in step from Level 1 to Level 2, and then later, when the provider reaches the highest, national accreditation level (4).

In terms of where interviewed providers turned for support to enhance quality, 4C was the most frequent source of support. However 25% of those interviewed received training or support from other organizations. If Paths to QUALITY continues to be successful in attracting broad participation, it will be important for organizations that offer support and training to child care providers to coordinate their efforts. Paths to QUALITY can become a primary vehicle for motivating child care providers to seek further education and to improve the quality of their services to children and families. If quality early care and education is a value held by the larger

community, there is a need for all of these support organizations to coordinate efforts and invest resources in providers who are enrolled in Paths to QUALITY.

The Paths to QUALITY program has been successful in attracting volunteer participants representing all types of care. Most providers reported they enrolled in PTQ because they want to improve the quality of care they offer. Financial incentives, public recognition, marketing advantages with parents, and assistance becoming accredited are other important reasons reported by participating providers.

General Conclusions from Pilot Programs

The growth in participation rates and dramatic increases in levels by providers illustrates the success of the PTQ program in both regions. Both pilot programs reported similar successes and challenges with the PTQ program. Each found unique solutions to overcoming the barriers of participation and advancement. However, in both regions relationships between providers and the child care resource referral staff, in particular mentoring services and training opportunities, became critical to the success of the program. Increased participation in training and professional development events made the most difference in providers' advancement in levels as well as a strong sense of identity with the PTQ program for those providers participating. Participation rates is only one indicator of success, however, a better indicator of success is the quality improvements that providers and programs have made.

The successes of PTQ pilot programs in Northeast and Southwest Indiana give much encouragement in the development of a state wide quality rating system using PTQ levels. It is important that a rating system of this nature is a voluntary, strength-based system, and based on relationship building. If Paths to QUALITY continues to be successful in attracting broad participation, it will be important for organizations that offer support and training to child care providers to coordinate their efforts. Paths to QUALITY can become a primary vehicle for motivating child care providers to seek further education and to improve the quality of their services to children and families. If quality early care and education is a value held by the larger community, there is a need for all of these support organizations to coordinate efforts and invest resources in providers who are enrolled in Paths to QUALITY.

There were three basic limitations of the data and this report: a) the report relied heavily on historical data that were collected in a variety of ways, b) there were few quality scores for those providers in PTQ which limits the conclusions we can make about the relationship between quality and PTQ levels, and c) there is no data available on PTQ levels and its relationship to children's development and learning.

Endnotes

¹ Child Care and Early Care Partnership Mission, 1996.

² Elicker, J. & Ruprecht, K. (2007). Early Child Care Quality Initiative Final Evaluation Report January to December 2006.

Grid 5: Crosswalk Indiana’s Core Knowledge and Competencies to Indiana Common Core Academic Standards and Indiana Foundations to the Indiana Academic Standards for Young Children from Birth to Age 5

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<u>Competency A:</u> Demonstrate ability to create learning environments using materials and activities	None	Not Specific
<u>Competency B:</u> Demonstrate the ability to use materials and activities to promote personal care and routines	None	Foundations for Personal Care
<u>Competency C:</u> Demonstrate ability of using materials and activities to promote physical development; Physical Education	Physical Education: <ul style="list-style-type: none"> • Movement forms and proficiency in a few movements • Learning and development of motor (movement) Skills • Physically active lifestyle • Health-enhancing level of physical fitness • Personal and social behavior in physical activity settings • Respect for differences among people in physical activity settings • Opportunity for enjoyment, challenge, self-expression, and social interaction 	Foundations for Physical Development/Physical Skills

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<p><u>Competency D</u>: Demonstrate ability of using materials and activities to promote language development and literacy</p>	<p><u>English Language Arts</u>:</p> <ul style="list-style-type: none"> • Reading Standards: Foundational Skills- Phonological Awareness • Reading Standards: Foundational Skills- Print Concepts; Phonics and Word recognition • Reading Standards: Foundational Skills- Information Texts • Reading Standards: Foundational Skills- Literature: stories, Novels, Drama, and Poetry • Writing Standards: Language Conventions- printing, punctuation, capitalization; Speaking and Listening- Comprehend and Collaborate 	<p>Foundations for English/Language Arts</p>

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<p><u>Competency G</u>: Demonstrate ability of using materials and activities to promote creativity and arts</p>	<p><u>Visual Arts</u>:</p> <ul style="list-style-type: none"> • Responding to Arts • Visual Literacy • Creating Arts • Integrated Studies 	<p>Foundations for Fine Art</p>
<p><u>Competency H</u>: Demonstrate ability of using materials and activities to promote positive interactions and guidance</p>	<p>None</p>	<p>Foundations for Social Emotional</p>

Aligning an Early Childhood Assessment to State Kindergarten Content Standards: Application of a Nationally Recognized Alignment Framework

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This article describes an alignment study conducted to evaluate the alignment between Indiana's Kindergarten content standards and items on the Indiana Standards Tool for Alternate Reporting. Alignment is the extent to which standards and assessments are in agreement, working together to guide educators' efforts to support children's learning and development. The alignment process in this study represented a modification of Webb's nationally recognized method of alignment analysis to early childhood assessments and standards. The alignment panel (N = 13) in this study consisted of early childhood educators and educational leaders from all geographic regions of the state. Panel members were asked to rate the depth of knowledge (DOK) stage of each objective in Kindergarten standards; rate the DOK stage for each item on the ISTAR rating scale; and identify the one or two objectives from the standards to which each ISTAR item corresponded. Analysis of the panel's responses suggested the ISTAR inconsistently conformed to Webb's DOK consistency and ROK correspondence criteria for alignment. A promising finding was the strong alignment of the ISTAR Level F1 and F2 scales to the Kindergarten standards. This result provided evidence of the developmental continuum of skills and knowledge that are assessed by the ISTAR items.

Keywords: alignment, accountability, early childhood

Over the past three decades, accountability initiatives have been developed and implemented in the nation's elementary and secondary classrooms and schools, leading to an increased emphasis on standards-based curricula and assessments in the United States. To date, early childhood education generally has not been included in the standards-based accountability movement. Two significant large-scale early childhood initiatives, however, have taken place in recent years, advancing the reach of standards-based accountability to early childhood classrooms: (a) the development of the Head Start Child National Reporting System, which requires every 4-year-old child attending a Head Start program to be assessed on literacy, math, and language skills at the beginning and end of each program year; and (b) the Bush Administration's Good Start, Grow Smart initiative, which requested that states develop quality indicators for early childhood education, including curricular objectives and activities for prereading and language skills that align with state K-12

standards. This press for early childhood standards and accountability reflects substantial research showing that children have a tremendous ability to learn academic concepts and skills before kindergarten (Barnett, 1995; Guralnick, 1998; National Research Council, 2000). Governmental and community agencies also have an understandable interest in evaluating the effectiveness of their investments in education and services for young children. In addition, the accountability pressures of the K-12 educational system have led to the increased anticipation that improved early education programs will improve academic performance in later grades.

Alignment Methods and Early Childhood Education

The development and implementation of three educational policy components—curriculum, instruction, and assessment—must be coordinated to facilitate the effectiveness of standards-based reform and accountability systems (Elliott, Braden, & White, 2001; Webb, 1997). The degree to which these components work together to facilitate child development and learning is often referred to as alignment. The concept of alignment is central to federal policies and guidelines regarding educational reform and accountability systems (Roach, Niebling, & Kurz, 2008).

The Council of Chief School Officers (CCSSO) has identified three preferred models for use in designing and implementing alignment studies of K-12 accountability systems: (a) the "Webb" model, (b) the Surveys of Enacted

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Curriculum (SEC), and (c) the Achieve model (CCSSO, 2002). These models generally focus on two dimensions of alignment: (a) breadth, or the number and diversity of goals and indicators included in each policy element; and (b) depth, or the relative emphasis given to different goals and indicators in standards, assessments, or instruction. In each of these models, the resulting descriptions of an accountability system's alignment are not dichotomous (i.e., in alignment vs. out of alignment). Rather, each model consists of a series of indices that provide a summary of the general match or coherence between standards, assessments, and (in some cases) classroom instruction (Resnick, Rothman, Slattery, & Vranek, 2003; Roach et al., 2008). Although each of these models has been applied to a variety of states' K-12 general education standards and the large-scale assessments, none of these "preferred" alignment methods has been applied to the early childhood standards and assessments being developed and implemented at either the national or state level.

Kagan and Scott-Little (2004) have developed an alignment procedure that has been used to examine the breadth and depth of states' early childhood learning standards and assessments. They combined breadth and depth in their coding system by using a set of 36 indicators that are organized into five domains (physical and motor, social and emotional, approaches toward learning, language and communication, and cognition and general knowledge) in terms of complexity or developmental challenge. The coding in these studies, however, was done by the researchers themselves rather than the panel of educators that is typical of the preferred models for alignment analyses (Scott-Little, 2005).

The purpose of this study was to evaluate the alignment of one state's early childhood accountability measure—the Indiana Standards Tool for Alternate Reporting (ISTAR)—by examining the content linkages between ISTAR assessment items at different developmental levels and indicators from Indiana's Kindergarten content standards. This study follows similar logic to the methods outlined by Wise and Alt (2006) in their discussion of vertical alignment. By using a nationally recognized alignment method (i.e., Webb's model) to compare curricular indicators from a higher grade (i.e., Kindergarten) to rating scale items for the "lower" ISTAR Basic and Foundation levels, we sought to understand the relationship between expectations at different developmental stages.

According to Wise and Alt (2006), several types of relationships between grades or developmental levels are possible. For example, higher grade-level test items or curricular indicators may reflect deeper mastery of target skills or knowledge (e.g., application rather than recognition) than related indicators and items at lower levels. Conversely, higher grade-level indicators or test items may be broader, reflecting a wider range of skills and concepts in specific content domain (e.g., reading comprehension). Wise and Alt identify two additional relationships that can be subsumed under the idea of broader content coverage: (a) prerequisite, which indicates that lower grade-level indicators or test items reflect different, but prerequisite skills and concepts needed for mastery of higher grade-level content; and (b) new, which indicates higher grade-level indicators or test items address new skills and knowledge unrelated to skills concepts covered at prior levels.

These relationships (i.e., broader and deeper) were expected to be reflected in the study results. In short, the expected outcome was that items on the ISTAR scale for infants

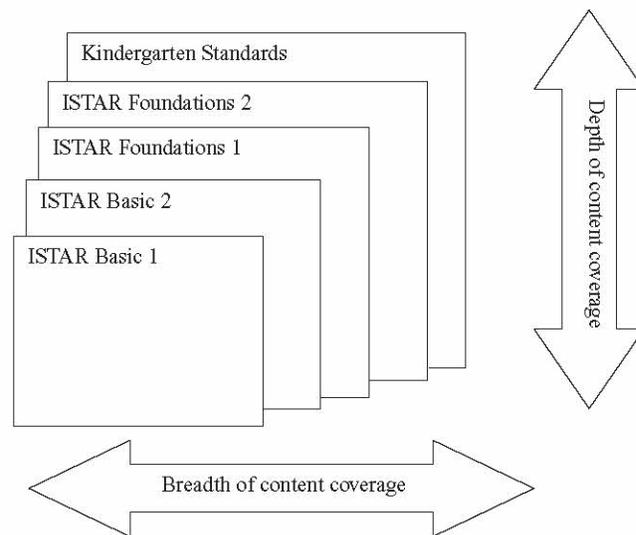


FIGURE 1. Graphical representation of anticipated relationship between Kindergarten standards and ISTAR items.

and toddlers would demonstrate the weakest alignment (in terms of breadth and depth) to the indicators on Indiana's Kindergarten standards with each subsequent developmental level showing improved alignment to the Kindergarten standards. Figure 1 presents a graphic representation of the expected relationship.

The content covered by the Indiana Kindergarten content standards was expected to be broader (to use Wise & Alt's [2006] categorization) than the skills and concepts measured by the ISTAR items at each level. The differences in breadth of coverage were expected to be most pronounced on the ISTAR rating scale for infants and toddlers, whereas the ISTAR preschool scales were expected to demonstrate closer correspondence to the Kindergarten standards in regards to the breadth of content coverage.

In addition, the indicators from the Kindergarten standards were expected to represent deeper content coverage than the items on the ISTAR rating scales. The expectation that the ISTAR items would represent less depth (i.e., less complex skills and concepts) than the Kindergarten standards represents a departure from the results typically expected in K-12 alignment studies (Webb, 2002; Webb, Horton, & O'Neal, 2002). Although it is desirable to observe a similar complexity of skills and concepts for curriculum indicators and assessment items from the same grade or developmental level, items on early childhood (i.e., infant/toddler and preschool) assessments might be expected to generally demand less "depth" than indicators from the Kindergarten content standards. Thus, although ISTAR items were expected to represent some of the range of concepts and skills outlined in the Kindergarten content standards, these items were anticipated to represent a lower level of complexity or "prerequisite" skill level that facilitated access for infants, toddlers, and preschoolers.

The Indiana Standards Tool for Alternate Reporting

The ISTAR initially was created for a small number of students who are unable to participate meaningfully in the state's general large-scale test due to their disabilities. The Indiana Department of Education (DOE) engaged a wide range of stakeholders and invested significant resources to

Indiana Department of Education



Foundations 1

Mathematics

0 Not Evident There is no evidence of progress.
 1 Developing There is evidence of progress.
 2 Demonstrated There is evidence of proficiency.

Performance:

Number Sense

Sings and dances to a number song

0 1 2

○○○

Counts a number of objects up to 3.

○○○

Counts on fingers.

○○○

Counts each object only once.

○○○

Uses whole numbers up to 5 to describe objects and experiences.

○○○

Rote counts to 5.

○○○

FIGURE 2. Examples of items from ISTAR Foundations 1 Mathematics scale.

develop and validate rating scale items to measure student achievement on indicators from the K-12 content standards (Jacobs, 2006). Unlike many assessments used for accountability purposes, the ISTAR is a teacher-completed rating instrument based on classroom- and community-based evidence of student progress.

ISTAR items (see Figure 2 for sample items) are scored using a three-point rubric (i.e., 0 = *not evident*; 1 = *developing*; and 2 = *demonstrated*). Educators base their ratings on classroom observations, work samples, portfolios, and other indicators of performance. For each of the seven standards in Math and Language Arts, the scores represent the percent proficient on indicators at a particular grade level. ISTAR results are reported with the grade level to the left of the decimal and a percentage to right of the decimal. Therefore, a score of 4.75 would indicate that the student demonstrated proficiency on 75% of the indicators from the 4th Grade Content Standards.

In developing the ISTAR ratings scales and reporting system, the Indiana DOE also developed items that measure skills and concepts at four developmental levels prior to kindergarten entry. Early childhood items on the ISTAR were developed based on the indicators from Indiana's K-12 content standards, which were extended downward developmentally to create Basic and Functional level curricular indicators in Language Arts and Mathematics. A wide range of stakeholder groups (e.g., special education and early childhood teachers, administrators, university faculty, Head Start teachers, speech-language pathologists, child care providers, families, and representatives from professional organizations and community groups) participated in developing and revising the curricular indicators for children from birth through age five.

These early childhood indicators then were adapted to create rating scale items. These were organized into four separate rating scales that comprise the ISTAR for early childhood:

- Basic 1 (B1) Language Arts/Mathematics (Developmentally 0–2 years)
- Basic 2 (B2) Language Arts/Mathematics (Developmentally 2–3 years)
- Foundations 1 (F1) Language Arts/Mathematics (Developmentally 3–4 years)

- Foundations 2 (F2) Language Arts/Mathematics (Developmentally 4–5 years).

Similar to scoring at the K-12 level, the scores represent the percent proficient for developmental-level indicators in Math and Language Arts. ISTAR results are reported with the developmental level to left of the decimal and the percent proficient to the right of the decimal. Thus, a score of F1.75 would indicate that the student achieved proficiency on 75% of the Foundations 1 curricular indicators.

Indiana GSEG to Develop and Validate an Early Childhood Accountability Measure

In April 2006, Indiana received a General Supervision Enhancement Grant (GSEG) from the United States Department of Education (USDOE) to refine and validate the ISTAR for use as its early childhood accountability measure. The proposal was written to support development of a universal state outcome measure and to enhance methods of collecting and analyzing achievement data for children birth to five years of age. The ISTAR was chosen as a potential universal early childhood accountability measure because it consisted of rating scale items that were based on concepts and skills in Language Arts and Mathematics that were identified previously as appropriate for young children by a wide range of stakeholders. In addition, because these items were based on downward extensions of the state's K-12 standards, use of the ISTAR in early childhood contexts was expected to support creation of a seamless accountability system for students from birth to high school graduation.

Evaluating the ISTAR for use as an early childhood accountability measure demanded a rigorous analysis of its alignment to the state's content standards. To meet this objective, the current study included (a) modifying an existing heuristic (i.e., the "Webb" model) used in K-12 alignment studies for use with a pre-K assessment; and (b) applying these modified alignment criteria procedures to examine the ISTAR's content and curricular validity.

Alignment studies typically compare test items for a specific grade level to the content standards and indicators (i.e., objectives) for the same grade level. However, because ISTAR

items represent modifications of actual indicators from the Indiana content standards at the corresponding developmental or grade level, this “traditional” alignment strategy would only confirm the recognized one-to-one correspondence between items and indicators. Therefore, the current study modified Webb’s alignment method by examining the alignment of ISTAR rating scale items at the Basic and Foundation levels to indicators on the state’s Kindergarten content standards. This approach also reflects the recommendations of the National Early Childhood Accountability Task Force (2007) that states should align standards, curriculum and assessments from preschool and prekindergarten programs through third grade.

Method

The alignment process used in this study was based on the methods of alignment analyses developed by Norman L. Webb (1997, 2002). Webb’s approach to alignment is featured in the U.S. Department of Education’s *Peer Reviewer Guidance for Evaluating Evidence of Final Assessments under Title I of the Elementary and Secondary Education Act* (U.S. Department of Education, 1999). In addition, the design and implementation of this study was informed by (a) previous analyses of the alignment between the alternate assessments for students with disabilities and state standards (e.g., Roach, Elliott, & Webb, 2005); and (b) the work of Cook (2006) to extend the Webb Alignment Model for assessments of English language learners.

To complete this evaluation of the ISTAR, the first author modified Cook’s six-stage model for depth of knowledge (DOK) ratings for use with early childhood standards and assessments. Cook’s first three DOK stages (i.e., “Respond,” “Reproduce,” and “Recall”) correspond to Webb’s DOK level 1 (“Recall”). These DOK stages allowed for a more fine-grained description of the differences between less-complex items and curricular indicators than is possible when using Webb’s original DOK levels. The first author’s proposed modifications to Cook’s DOK stages were reviewed by the second author, as well as two researchers in early childhood education and one nationally recognized expert in inclusive accountability. Each of these reviewers suggested a number of revisions to the DOK stages that were integrated into the version of the early childhood DOK stages used in the study. The Early Childhood DOK stage descriptors for Language Arts and Mathematics are provided in Figures 3 and 4.

Cook’s DOK Stage 6, which corresponds to Webb’s Level 4 (Extended Reasoning), was not used in this study. Items and tasks at DOK Stage 6 typically require complex reasoning, planning, developing, and thinking over an extended period of time. Items and indicators at this level require students to make several connections (e.g., relating ideas within the content area or among content areas) or to select one approach among many alternatives on how to complete a task or solve a problem (Webb, 2002). The authors felt it was unlikely that ISTAR items and indicators from the Kindergarten content standards would require young children to achieve this level of complexity in cognition and/or behavior.

Alignment panel. The alignment panel ($N = 13$) consisted of early childhood educators and researchers from all geographic regions of the state and personnel from the Indiana

Department of Education who participated in a 2-day ISTAR-Early Childhood Alignment Institute conducted in December 2006.

Alignment coding process. The alignment coding process included panel members’ ratings of the correspondence between ISTAR items and indicators on Indiana’s Kindergarten standards. The primary role of the panel members was to complete the following three tasks:

1. Rate the DOK stage of each indicator (i.e., knowledge and skills statement) in Indiana’s Kindergarten standards.
2. Rate the DOK stage of each item on the ISTAR rating scale at the Basic and Foundations levels.
3. Identify up to three indicators from the Kindergarten standards to which each ISTAR item corresponds.

Before completing their ratings, panel members received training on the alignment process. This training included a review of the general DOK levels and Early Childhood DOK stages created for this study as well as opportunities for panel members to assign DOK stages to sample items and curriculum indicators. These practice opportunities were followed by group discussion and feedback from the first author.

In addition, panel members were trained on how to use the Web Alignment Tool (WAT; <http://wat.wceruw.org/index.aspx>). The WAT is a computer-based data entry system that allows (a) panel members to complete and enter their ratings directly into the computer; and (b) alignment panel leaders to monitor the progress of panel members in completing the process. The WAT can also be used to analyze data and produce multiple reports regarding the alignment between content standards and assessments.

Following training, panel members worked together to reach consensus on the DOK stages for indicators from the Kindergarten Language Arts and Mathematics standards. This process involved panel members individually completing DOK ratings for each indicator on the Kindergarten standards. Upon completing their independent ratings, the panel members met as a group (facilitated by the first author) to discuss and debate the appropriate DOK stage for each indicator. Group members were encouraged to express their rationales for their DOK ratings and to question other group members’ ratings before arriving at a consensus DOK stage for each indicator. Working to reach consensus provided an opportunity for group discussion of the DOK stage criteria and “calibration” of panel members understanding of the DOK rating process (Webb, 2002).

Following this “calibration” process, panel members worked independently to assign a DOK stage and up to three corresponding indicators from Kindergarten standards to each ISTAR item at the Basic and Foundations levels. For example, a math item from the ISTAR Foundations 1 scale—“Counts a number of objects up to 3”—might be rated by a panel member as representing DOK Stage 2 (Reproduce). In addition, the panel member could identify the item as corresponding with two indicators from the Kindergarten Number Sense standard:

- K.1.1: Match sets of objects one-to-one.
- K.1.6: Count, recognize, represent, name, and order a number of objects (up to 10).

Because each panel member independently completed these ratings, different DOK stages and corresponding indicators for each item were sometimes identified by the different

Webb DOK Levels Early Childhood DOK Stages	Level 1—Recall of Information			Level 2—Basic Reasoning	Level 3—Complex Reasoning
	Stage 1-Respond	Stage 2-Reproduce	Stage 3-Recall	Stage 4—Procedures/Applications	Stage 5—Problem Solving
Early Childhood DOK Stages	<p>Stage 1 items or tasks require the ability to indicate, acknowledge, or respond to text, media, or orally presented materials. Examples:</p> <ul style="list-style-type: none"> ◆ Points to the letters, words, and/or pictures on a page ◆ Points to shapes, letters, and/or words ◆ Responds to a verbal prompt ◆ Acknowledges someone gesturing or signing ◆ Attends to text or media presentation 	<p>Stage 2 items or tasks require the ability to copy, replicate, repeat, re-enact, mirror, or match text, media, or orally presented materials. Examples:</p> <ul style="list-style-type: none"> ◆ Copies shapes, symbols, or letters ◆ Matches sound/sound ◆ Matches letter/letter ◆ Matches picture/picture ◆ Matches symbol/symbol ◆ Retells parts of a story or interaction either verbally or through symbolic representations (e.g., drawing) 	<p>Stage 3 items or tasks require the ability to recite or recall facts or information. Stage 3 involves the ability to distinguish among features in text, media, or orally presented materials. Examples:</p> <ul style="list-style-type: none"> ◆ Identifies pictures of objects (animate or inanimate) through verbal cues or text-based cues. ◆ Identifies details in text, media, or orally presented story. ◆ Identifies correct meaning of familiar words ◆ Identifies letters, sounds, symbols, or shapes ◆ Uses/recognizes environmental text 	<p>Stage 4 items and tasks require processing beyond recall and observation. Stage 4 requires both comprehension and subsequent processing of text, media, or orally presented materials. These items and/or tasks may involve ordering, classifying, and identifying patterns, relationships and main points. Stage 4 may involve two-step procedures. Examples:</p> <ul style="list-style-type: none"> ◆ Identifies and describes main ideas or events in a story ◆ Associates/identifies letters with sounds ◆ Indicates what comes next in a story ◆ Uses context to understand unfamiliar words 	<p>Stage 5 items and tasks require children to go beyond the information in text, media, and orally presented materials. Children may be required to explain, generalize and connect ideas. Some items or tasks may require students to use prior knowledge and to connect themes across passages. Examples:</p> <ul style="list-style-type: none"> ◆ Connects story or text to personal experiences ◆ Expresses an opinion citing evidence from a text or personal experience to support reasoning ◆ Describes whether a character in a story should be considered friendly or mean ◆ Uses words, symbols, and pictures to express a written message
	<p>Early Literacy / Language Arts</p>				

FIGURE 3. Expanded language arts depth-of-knowledge descriptors for early childhood accountability systems.

Webb DOK Levels	Level 1—Recall of Information			Level 2—Basic Reasoning	Level 3—Complex Reasoning
	Stage 1-Respond	Stage 2-Reproduce	Stage 3-Recall		
Early Childhood DOK Stages	<p>Stage 1-Respond</p> <p>Stage 1 items and tasks require the ability to respond to or indicate or acknowledge numeric or mathematical features. Example:</p> <ul style="list-style-type: none"> ◆ Points to a number ◆ Attends to someone counting ◆ Indicates size (e.g., big or little) ◆ Points to common shapes 	<p>Stage 2-Reproduce</p> <p>Stage 2 items and tasks require the ability to copy, replicate, repeat, re-enact, mirror, or match numeric or mathematical features. Example:</p> <ul style="list-style-type: none"> ◆ Copies numbers from 1 to 10 ◆ Counts from 1 to 10 with prompting ◆ Reproduces a shape or figure (e.g., circle, square, triangle, rectangle, smiley face) ◆ Demonstrates 1-to-1 correspondence ◆ Matches similar shapes together 	<p>Stage 3-Recall</p> <p>Stage 3 items and tasks require children to recall or observe facts, definitions, or terms. Stage 3 involves simple one-step procedures and simple computation. Examples:</p> <ul style="list-style-type: none"> ◆ Conducts simple addition using manipulatives or counting on ◆ Points to a number and the physical representation of that number (e.g., 2, two balls) ◆ Identifies common shapes and figures ◆ Identifies measuring devices (e.g., calendar, clock, ruler, measuring cup, scale) 	<p>Stage 4—Procedures/Applications</p> <p>Stage 4 requires children to make some basic decisions of how to approach an activity. Items and tasks may require children to compare, classify, organize, estimate or order numeric or mathematical information. Stage 4 typically involves two-step procedures. Examples:</p> <ul style="list-style-type: none"> ◆ Recognizes the pattern in a series of objects or numbers ◆ Organizes items from big to small ◆ Adds or subtracts quantities up to 10 ◆ Identifies and explains relationships between numbers, groups of objects, or shapes 	<p>Stage 5—Problem Solving</p> <p>Stage 5 requires reasoning, planning or use of evidence to solve problems, and may involve activities with more than one possible answer. These tasks and items may involve drawing conclusions from observations and using concepts to solve non-routine problems. Examples:</p> <ul style="list-style-type: none"> ◆ Identify and describe the similarities and differences between shapes and figures ◆ Develops question and/or problem from given situation or materials ◆ Applies numeric or mathematical concepts to solve real-life problems
Early Numeracy / Mathematics					

FIGURE 4. Expanded mathematics depth-of-knowledge descriptors for early childhood accountability systems.

Criteria	Description
Range-of-Knowledge Correspondence	At least 50% of the indicators for a standard corresponded with at least one related ISTAR item based on the ratings of Alignment Institute panel members. This criterion is based on the assumption that an assessment should test students' understanding or mastery of the majority of the knowledge (i.e., more than half the indicators) represented by any given standard (Webb, 2002). ROK was considered "weak" for standards where between 40% and 50% of indicators corresponded with an item.
Depth-of-Knowledge Consistency	"For consistency between the assessment and standard...at least 50% of the items corresponding to an indicator had to be at or above the level (stage) of knowledge of the indicator" (Webb, 2002, p.4). Meeting this criterion suggests an assessment demands the adequate depth of understanding and sufficient mastery of the knowledge and skills covered in the corresponding standards. DOK was considered "weak" for standards if between 40% and 50% of items were at or above the DOK stage for the corresponding indicator.

(Adapted from Webb, 2002.)

FIGURE 5. Webb's criteria for Depth of Knowledge Consistency and Range-of-Knowledge Correspondence.

panel members. According to Webb (2002), the alignment coding process is not designed to produce exact agreement between members of the alignment panel. In fact, variance in ratings "are considered valid differences in opinion that are a result of a lack of clarity in how the indicators (i.e., knowledge and skills statements) were written and/or the robustness of an item that may legitimately correspond to more than one (indicator)" (p. 3).

Analysis of the panel members' ratings resulted in descriptive statistics for the various criteria that comprise Webb's Alignment Model. Of these, the results on the range-of-knowledge (ROK) correspondence and depth-of-knowledge (DOK) consistency criteria were of particular interest in this study. Webb's ROK and DOK criteria are outlined in Figure 5.

Results

Reliability of ratings. Alignment Institute panel members reached consensus on the early childhood DOK stage ratings for the indicators from the Kindergarten standards in Language Arts and Mathematics. Following this consensus process, panel members independently rated the DOK stages of individual ISTAR items, achieving moderate to high consistency. Intraclass correlations (Shrout & Fleiss, 1979) were

Table 1. Reliability of ISTAR Alignment Panel Ratings

Subject—Level	Number of Reviewers	Intraclass Correlation
ISTAR Language Arts Level B1	10	.91
ISTAR Language Arts Level B2	11	.92
ISTAR Language Arts Level F1	13	.95
ISTAR Language Arts Level F2	13	.95
ISTAR Mathematics Level B1	11	.84
ISTAR Mathematics Level B2	8	.87
ISTAR Mathematics Level F1	8	.88
ISTAR Mathematics Level F2	9	.93

above .84 for each ISTAR level in both subject domains (Table 1). This statistic provides a measure of the percent of variance in the data due to the differences between the items rather than the differences between the reviewers. For example, an intraclass correlation value of .7 means that 70% of the variance in the data can be explained by differences between the items while the other 30% is due to differences between the reviewers. According to Webb's model, intraclass correlations are considered adequate for values greater than .7 and good for values greater than .8.

Table 2. Range-of-Knowledge Correspondence for ISTAR Language Arts Scales

Standard	Level B1			Level B2			Level F1			Level F2		
	Indicators Rated	Indicators Hit (Mean)/%	Range of Knowledge	Indicators Rated	Indicators Hit (Mean)/%	Range of Knowledge	Indicators Rated	Indicators Hit (Mean)/%	Range of Knowledge	Indicators Rated	Indicators Hit (Mean)/%	Range of Knowledge
1—Word Recognition, Fluency, and Vocabulary Development	22.4	6.8/31%	NO	22.27	8.18/37%	NO	22.15	13.54/61%	YES	22.08	13.46/61%	YES
2—Comprehension	5.4	1.7/32%	NO	5.18	2.64/50%	YES	5	2.46/49%	WEAK	5	4.08/82%	YES
3—Literary Response and Analysis	5.1	2.4/47%	WEAK	5	2.91/58%	YES	5	3.69/74%	YES	5	4.46/89%	YES
4—Writing: Process and Applications	8.1	2.1/26%	NO	8.36	3.91/47%	WEAK	8.08	3.23/40%	NO	8	7.15/89%	YES
5—Writing: English Language Conventions	2.1	1/48%	WEAK	2.09	1.45/70%	YES	2.08	2/96%	YES	2.15	2/92%	YES
6—Listening and Speaking	2.1	0.7/33%	NO	2.18	1/47%	WEAK	2.23	1.23/53%	YES	2.08	1.69/82%	YES
7—Listening and Speaking	5.6	3.2/57%	YES	5.55	4.36/78%	YES	5.23	4.77/91%	YES	5.23	5/96%	YES

Notes:

- *Indicators Rated* refers to the average number of indicators (knowledge and skills statements) for reviewers. If the number is greater than the actual number of indicators for a content standard, then at least one reviewer coded an item as corresponding to the standard, but was unable to find a specific indicator that corresponded with the item.
- *Indicators Hit* refers to the number of indicators for which raters indicate at least one corresponding ISTAR item.
- *% of Indicator Hit* refers the percentage of the total number of indicators which had at least one corresponding ISTAR item.
- *Range of Knowledge*
 - "Yes" indicates that 50% or more of the indicators had at least one corresponding item identified.
 - "Weak" indicates that 40–50% of the indicator had at least one corresponding item identified.
 - "No" indicates that less than 40% of the indicators had at least one corresponding item identified.

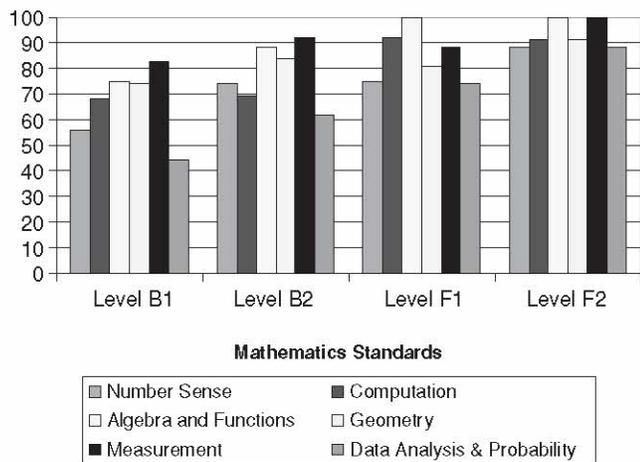


FIGURE 7. Percentage of Mathematics indicators for each standard identified as corresponding with at least one ISTAR item.

tation of how the range of Mathematics indicators “hit” (i.e., rated as corresponding to an ISTAR item) improves at each subsequent developmental level.

Depth-of-knowledge consistency. In addition to evaluating the correspondence between the skills and concepts addressed in the standards and the items on the ISTAR rating scales, the results of this study also provide a measure of the complexity of knowledge required by both components of the accountability system. DOK consistency indicates whether what is elicited from children by ISTAR items was as demanding cognitively as what children are expected to know and do as stated in the Kindergarten standards and indicators. “For consistency to exist between an assessment and the standards, as judged in this analysis, at least 50% of the items corresponding to an indicator had to be at or above the level of knowledge of the (indicator)” (Webb, 2002, p. 4). If between 40% and 50% of the items were at or above the level of knowledge required by the indicators for a standard, the DOK criterion was considered “weakly” attained.

Although it is generally desirable that the DOK levels for curriculum indicators and assessment items are similar, many early childhood assessment items may demand less depth of knowledge than (or be a prerequisite to) indicators on the state’s Kindergarten standards. ISTAR items represent the range of concepts and skills outlined in Indiana’s content standards, but these items are presented at a lower level of complexity that allows access for infants and young children. Therefore, the ISTAR was not expected to demonstrate acceptable DOK consistency to the Kindergarten standards.

The results of this study, however, indicate that for some Language Arts standards (e.g., Listening and Speaking) and at some developmental levels (e.g., Level F2) an acceptable level of DOK consistency was observed between the ISTAR items and the Kindergarten standards (Table 4). This result may be attributable to (a) the inclusion of a variety of performance options for each ISTAR item, allowing for more sophisticated performance on the part of students; and (b) the wording and content of the indicators for the Listening and Speaking standard, which may have been perceived by raters as generally focusing on discrete skills and application (i.e., lower DOK stages) rather than more extended problem

Table 4. Depth-of-Knowledge Consistency for the ISTAR Language Arts Scales

Standard	Level B1				Level B2				Level F1				Level F2			
	% of Items				% of Items				% of Items				% of Items			
	Below	At	Above	DOK?												
1—Word Recognition, Fluency, and Vocabulary Development	83	6	10	NO	76	18	6	NO	60	30	10	NO	55	33	12	WEAK
2—Comprehension	86	8	6	NO	76	21	3	NO	67	20	12	NO	47	31	22	YES
3—Literary Response and Analysis	67	27	6	NO	66	26	8	NO	46	41	13	YES	39	45	16	YES
4—Writing: Process	90	5	5	NO	61	37	2	NO	69	22	9	NO	45	33	22	YES
5—Writing: Applications	95	5	0	NO	91	9	0	NO	70	30	0	NO	65	35	0	NO
6—English Language Conventions	71	29	0	NO	27	71	1	YES	51	39	10	WEAK	23	40	37	YES
7—Listening and Speaking	53	35	12	WEAK	48	38	14	YES	48	29	22	YES	35	37	28	YES

Note: % of items refers to the mean percentage of items coded as “under” the Depth-of-Knowledge (DOK) level of the corresponding indicator, as “at” (the same) DOK level of the corresponding indicator, and as “above” the DOK level of the corresponding indicator.

solving (i.e., higher DOK stages). In addition, ISTAR items and indicators at adjacent developmental levels (i.e., Level F2 and Kindergarten) appear more likely to be rated by panel members as being at similar levels of complexity.

The results indicate that the ISTAR Mathematics scales generally did not meet the criteria for DOK consistency. In particular, ISTAR Level B1 did not achieve the DOK criteria for any standard (Table 5). The items at the more “advanced” ISTAR levels (F1 and F2), however, were more likely to demonstrate DOK consistency to indicators from the Kindergarten standards. DOK consistency for indicators from two standards (Measurement, and Algebra and Functions) was either acceptable or “weak” for the Level F1 scale; and DOK consistency with indicators from four standards (Measurement, Number Sense, Data Analysis and Probability, and Geometry) was acceptable or “weak” at Level F2.

Discussion

The alignment panel’s responses indicated that the ISTAR scales inconsistently met Webb’s (1997) ROK and DOK criterion for the alignment of assessments and content standards. This result was not unexpected because the ISTAR was designed to assess knowledge and skills that are “linked” to Indiana’s K-12 Academic Standards, but are extended or modified in ways that make them more accessible to and appropriate for young children (birth to age 5).

A promising finding from this alignment study is the strong alignment between ISTAR Levels F1 and F2 and the state’s Kindergarten Standards. Figures 6–9 illustrate this relationship. This result provides evidence of the developmental continuum of skills and knowledge that are assessed by the ISTAR items. In other words, the stronger alignment of Level F2 items (in comparison to items at the Basic levels) to indicators from the Kindergarten standards was expected because Level F2 is intended to assess items at the late preschool level. Because of this, demonstrating proficiency at Level F2 on the ISTAR might be considered evidence of a student’s “readiness” for kindergarten.

Figure 6 shows the ROK correspondence between the ISTAR items at each developmental level and the Kindergarten Language Arts standards. The graph shows the percentage of indicators for each standard that have a “hit” (i.e., corresponding item). At Level B1, none of the standards have more than 60% of their indicators “hit” by an ISTAR item. By Level F2, however, all of the Language Arts standards have more than 60% of their indicators “hit.” A similar result is illustrated for the Kindergarten Mathematics standards in Figure 7. No mathematics standard had 90% of its indicators “hit” at Level B1 of the ISTAR, but at Level F2 all six standards are approaching a 90% hit-rate. Figures 8 and 9 illustrate the increasing level of DOK consistency between ISTAR items and their corresponding indicators in the Kindergarten Standards. At Level F2, items on the ISTAR approached the same DOK stages as the indicators in the Kindergarten Standards, resulting in acceptable (or “weak”) DOK consistency for four out of six Mathematics Standards and six out of seven Language Arts Standards.

Limitations and areas for future research. The panel members who participated in this study were stakeholders (e.g., technical assistance providers and pre-service teacher trainers) in Indiana’s early childhood accountability system.

Table 5. Depth-of-Knowledge Consistency for the ISTAR Mathematics Scales

Standard	Level B1				Level B2				Level F1				Level F2			
	% of Items				% of Items				% of Items				% of Items			
	Below	At	Above	DOK?												
1—Number Sense	90	9	1	NO	78	19	2	NO	68	30	2	NO	55	40	5	WEAK
2—Computation	92	7	1	NO	92	8	0	NO	68	30	2	NO	69	31	0	NO
3—Algebra and Functions	92	8	0	NO	77	22	1	NO	59	37	3	WEAK	70	28	2	NO
4—Geometry	81	18	1	NO	66	26	7	NO	68	29	4	NO	55	34	11	WEAK
5—Measurement	83	14	2	NO	58	39	3	WEAK	45	49	6	YES	33	57	10	YES
6—Data Analysis and Probability	80	20	0	NO	69	31	0	NO	73	27	0	NO	26	74	0	YES

Note: % of items refers to the mean percentage of items coded as “under” the Depth-of-Knowledge (DOK) level of the corresponding indicator, as “at” (the same) DOK level of the corresponding indicator, and as “above” the DOK level of the corresponding indicator.

Attachment C: Promoting Early Learning and Development Outcomes for Children

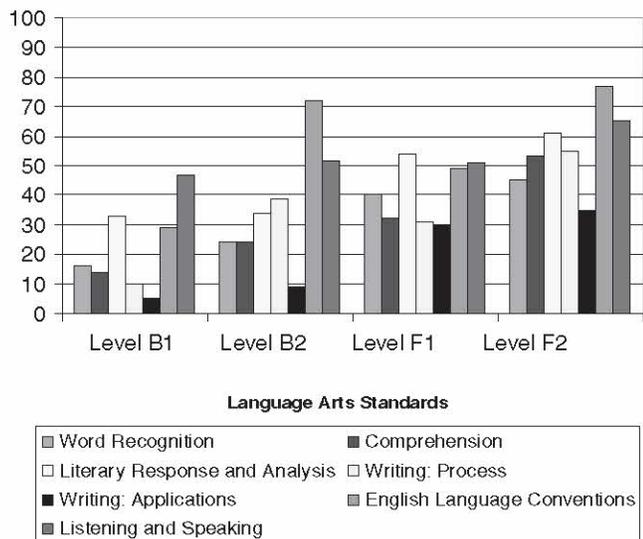


FIGURE 8. Percentage of ISTAR Language Arts items rated at or above the DOK stage of the corresponding indicator.

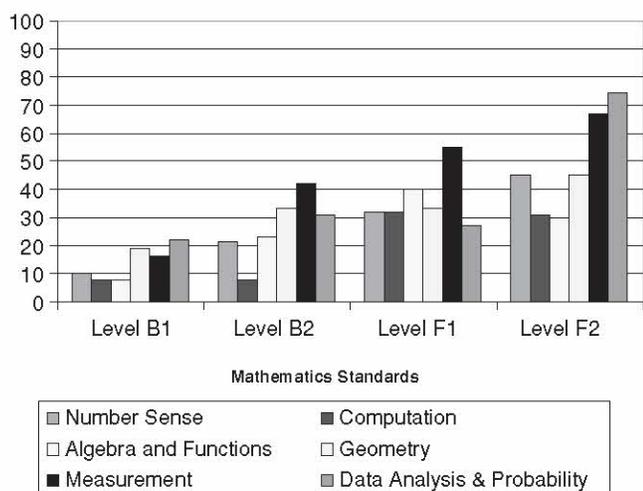


FIGURE 9. Percentage of ISTAR Mathematics items rated at or above the DOK stage of the corresponding indicator.

Although the alignment panel had extensive understanding of early childhood education policy and practice in the state, the addition of other constituencies to the panel may have produced different alignment results. For example, the inclusion of education researchers and practitioners from beyond Indiana on the alignment panel may have provided additional insights into the appropriateness or correspondence between the standards and assessments reviewed.

Replication of the method used in this investigation with other early childhood assessments would provide additional evidence of the utility of this modification of the Webb alignment model in evaluating the ratings scales, checklists, and portfolios generally employed to assess the academic performance of young children. In addition, additional research is required to support the use of this modified Webb model to evaluate assessments of other valued outcomes (e.g., social skills) that may be covered by early childhood standards.

Alignment of an assessment to a state's content standards is only one aspect of creating a meaningful accountability system. In addition to aligning to content standards, early child-

hood accountability measures should be relevant to classroom instruction, measuring what young children are learning and doing in their classrooms and communities (Roach et al., 2005; Ysseldyke & Olsen, 1997). Unfortunately, the curriculum and instruction provided to children in some early childhood contexts may differ significantly from high quality practice. Therefore, researchers and policymakers must determine the alignment of classroom instructional practices to the expectations outlined in early childhood content standards and accountability measures. Strengthening this aspect of alignment will help ensure that young children are included in instructional improvement efforts and standards-based reform in a meaningful way (Roach et al., 2005).

Implications for policy and practice. In both Language Arts and Mathematics, policymakers responsible for the development of the ISTAR were encouraged to consider whether each topic addressed by the indicators on the Kindergarten standards was applicable and appropriate for infants, toddlers and preschool students. For example, in Language Arts, an argument could be made that the conventions of the English language are addressed primarily through listening and speaking activities in early childhood contexts. Similarly, in Mathematics, an argument could be made to collapse the Number Sense and Computation standards into a meta-standard called "Numbers and Operations." This would be particularly useful for toddlers and preschoolers who generally focus on number concepts without explicit attention to basic addition or subtraction facts.

In addition, the ISTAR scales generally demonstrated adequate ROK correspondence with the indicators from Kindergarten Algebra and Functions, and Geometry standards across developmental levels. This result suggests that concepts and skills from these standards can be presented in ways that are accessible and appropriate for young children (e.g., shapes, patterns, "skip counting"), but are less cognitively complex than (or prerequisite to) the curricular indicators intended for Kindergarteners. By providing opportunities and concrete experiences with concepts that appear at subsequent grade levels, early childhood educators may lay the foundation for future academic success.

By aligning ISTAR items to the state's Kindergarten standards, this study provides some indication of its appropriateness as a potential measure of school readiness. "The regular tracking of school readiness...enables policymakers and community leaders to identify areas most in need of intervention, track the results of investments, and monitor trends over time" (Kids Count, 2005). Extensive research indicates that early disparities in language, communication, and other preacademic skills are difficult to remediate during students' K-12 educational careers, suggesting the need for academic-focused interventions during early childhood (National Research Council, 2000, p. 145). Information from the ISTAR can be used by early childhood educators to develop standards-focused strategies that provide students with (or at risk for developing) disability opportunities and support to acquire the skills and concepts critical for early school success. Moreover, the implementation of ISTAR in early childhood programs helps support a "seamless" assessment and accountability system that encourages teachers and other care providers to work with children on prerequisite and entry-level skills linked to the K-12 curriculum and accountability system.

References

- Barnett, W. S. (1995). Long-term effects of early childhood programs on cognitive and school outcomes. *The Future of Children*, 5(3), 25–50.
- Cook, H. G. (2006). Aligning English language proficiency test to English language learning standards. *Aligning assessment to guide the learning of all students*. Washington, DC: Council of Chief State School Officers.
- Council of Chief State School Officers (2002). *Models for alignment analysis and assistance to states*. Available at <http://www.ccsso.org/content/pdfs/AlignmentModels.pdf>.
- Elliott, S. N., Braden, J. P., & White, J. (2001). *Assessing one and all: Educational accountability for students with disabilities*. Arlington, VA: CEC.
- Guralnick, M. J. (1998). The effectiveness of early intervention for vulnerable children: A developmental perspective. *American Journal on Mental Retardation*, 102(4), 319–345.
- Jacobs, S. (2006). *The relationship between the Indiana Standards Tool for Alternate Reporting (ISTAR) and the Indiana Statewide Testing for Educational Progress - Plus (ISTEP+) for students with and without mild disabilities: Implications for policy makers*. Muncie, IN: Ball State University.
- Kagan, S. L., & Scott-Little, C. (2004). Early learning standards: Changing the Parlance and practice of early childhood education? *Phi Delta Kappan*, 85(5), 388–396.
- Kids Count (2005). *Getting reading executive summary*. Providence, RI: National School Readiness Indicators Initiative.
- National Early Childhood Accountability Task Force (2007). *Taking stock: Assessing and improving early childhood learning and program quality*. Philadelphia, PA: The Pew Charitable Trusts.
- National Research Council (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Resnick, L. B., Rothman, R., Slattery, J. B., & Vranek, J. L. (2003). Benchmarking and alignment of standards and testing. *Educational Assessment*, 9, 1–27.
- Roach, A. T., Elliott, S. N., & Webb, N. L. (2005). Alignment of an alternate assessment with state academic standards: Evidence for the content validity of the Wisconsin Alternate Assessment. *Journal of Special Education*, 38, 218–231.
- Roach, A. T., Niebling, B. C., & Kurz, A. (2008). Evaluating the alignment among curriculum, instruction, and assessment: Implications and applications for research and practice. *Psychology in the Schools*, 45, 158–176.
- Scott-Little, C. (2005, March). Early learning guidelines: What's in them and what does it mean for early care and education? Keynote address at the Nebraska Early Childhood Catherine Scott-Little Connections conference, Kearny, NE.
- Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin*, 86, 420–428.
- United States Department of Education (1999). *Peer reviewer guidance for evaluating evidence of final assessments under Title I of the Elementary and Secondary Education Act*. Washington, DC: Author.
- Webb, N. L. (1997). Determining alignment of expectations and assessments in mathematics and science education. *National Institute for Science Education*, 1(2), 3–10.
- Webb, N. L. (2002). *Alignment analysis of State F Language Arts Standards and Assessments Grades 5, 8, and 11*. Washington, DC: Council of Chief State School Officers.
- Webb, N. L., Horton, M., & O'Neal, S. (2002, April). An analysis of the alignment between language arts standards and assessments in four states. Paper presented at the annual meeting of the American Educational Research Association, New Orleans, LA.
- Wise, L. L., & Alt, M. (2006). Assessing vertical alignment. *Aligning assessment to guide the learning of all students*. Washington, DC: Council of Chief State School Officers.
- Ysseldyke, J. E., & Olsen, K. R. (1997). Putting alternate assessments into practice: What to measure and possible sources of data. *Exceptional Children*, 65, 175–186.



IMAGINING
the possibilities.
MAKING THEM HAPPEN.



Indiana
Department of Education

Glenda Ritz, NBCT
Indiana Superintendent of Public Instruction

ISTAR-KR Early Childhood Assessment

Indiana Department of Education

The mission of any early
childhood education program is
to

Improve child outcomes



The Primary Purpose of Assessment

To make ongoing educational decisions:

- ✓ To inform and support learning
- ✓ Show child progress

Early Childhood Program Administrators support accurate child assessments by

Mentoring teachers to

- ❖ Implement accurate observations on a regular basis
- ❖ Document observations (evidence/child data) on a regular basis
- ❖ Use documentation tools that are efficient, accessible, and aligned to the assessment instrument used
- ❖ Designate time to evaluate/analyze evidence/child data by collaborating with colleagues AND family members
- ❖ Use child data to develop intentional lesson plans – those which outline the purpose of an activity, NOT just the activity
- ❖ Complete an assessment rating tool on each child at a minimum of 2x year, preferably quarterly

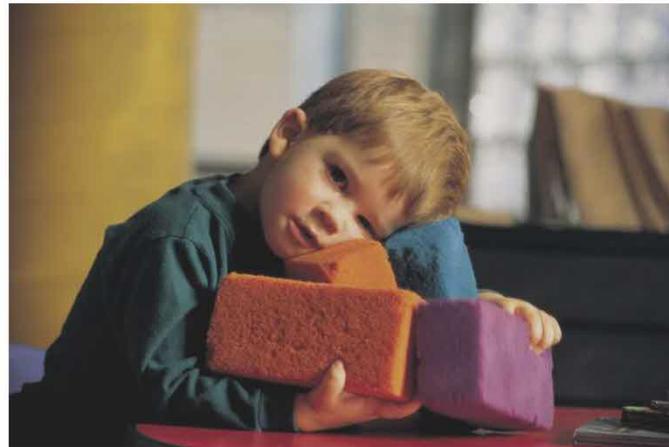
Early Childhood Educators assess a child's development to facilitate improvement of outcomes.

Latin derivative of the word assidere Assessment... *To sit beside and get to know.*

It is an observation of a child to gather evidence of learning/skills.



Evidence is....proof of a child learning!



ISTAR-KR stands for

Indiana

Standards

Tool for

Assessment

Reporting -

Kindergarten **R**eadiness



ISTAR-KR is a direct derivative of



Foundations to the Indiana Academic Standards for Young Children Birth to Age 5

doe.in.gov/achievement/curriculum/early-childhood-education



ISTAR-KR: Web-based Assessment System



- Standards-based software system
- Developed over 10 years ago; Indiana's response to federal mandate to offer alternative to state achievement tests (ISTEP+) for students in special education; case conference committee decision for school age students with IEP's
- 2004 use by public preschool special programs (assessment became a requirement for school corporations to receive funds (Part B) to provide service)
- Developed for ALL children birth – 10th grade, aligned to IN academic standards

- Provided at no cost by Indiana Department of Education (IDOE)
- Teacher rating instrument, based on knowledge of child gained over time
- 2007 available to community early childhood education programs
- 2009 revised and renamed, ISTAR-KR; simpler to use, item content more meaningful to young children, (aligned to Part C and Part B federal outcome reporting)
- 2009 ISTAR-KR Standardization Study completed, assigning age ranges to performance items

ISTAR-KR Academic Standard:

English, Language Arts Matrix = 8 Performance Threads

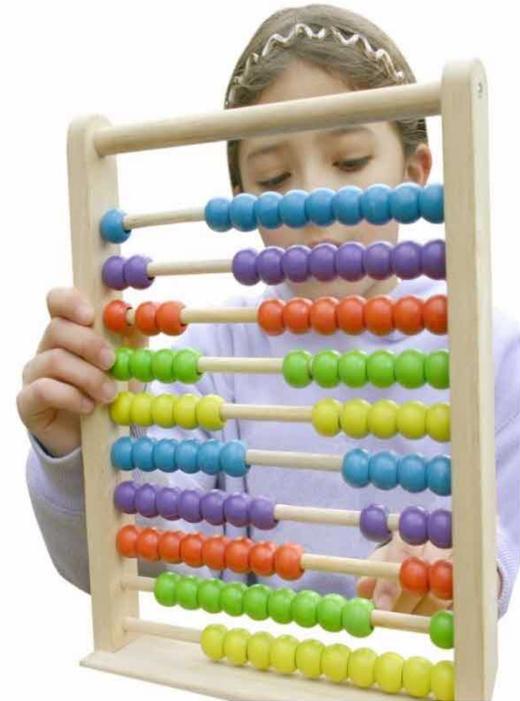
- Awareness of sounds
- Awareness of symbols
- Uses print for pleasure and information
- Comprehends details, events and main ideas
- Writing for a specific purpose and audience
- Writing implements
- Receptive communication
- Expressive communication



ISTAR-KR Academic Standard:

Math Matrix = 6 Performance Threads

- Counting & Quantity
- Computation
- Time
- Location
- Length, Capacity, Weight
- Sorting & Classifying



Social-Emotional Skills Standards Matrix = 6 Performance Threads

- Sense of Self & Others
- Manages Emotions
- Interpersonal Skills
- Responsibility
- Problem Solving
- Learning



Physical Skills Standards Matrix =

5 Performance Threads

- Sensory Integration
- Physical Stability
- Gross Motor Skills
- Object Control
- Precision Hand Skills



Personal Care Skills Standards Matrix = 5 Performance Threads

- Oral Motor Skills
- Self-Feeding
- Dressing/Undressing
- Care of face, hands, nose
- Toileting



2002 - Foundations to the Indiana Academic Standards

Attachment C: Promoting Early Learning and Development Outcomes for Children

2004 *Foundations* utilized for statewide training to Indiana EC Education Community

2004 – ISTAR mandated use for EC students with IEP's



2006 - *GSEG Assessment Validation Study*

ISTAR

AEPS-2



Revisions to state documents

2006 Foundations revised

2007 Indiana Standards revised



2009 *ISTAR-KR Launched*

2010 *ISTAR-KR Standardized*



July, 2011

Stakeholder group begins edits to align the Foundations, ISTAR-KR and Common Core Standard Titles

Highlights of enhancements

- ✓ Table of contents – include 0-3 and 3-5 in each standard area, rather than maintain two separate sections
- ✓ New Social-Emotional chapter
- ✓ Items linked to ISTAR-KR Performance Thread Titles
- ✓ Additions to Introduction section, e.g. Explanation of why the need for this revision, ISTAR-KR, revisions of sections - Exceptional Learners, English Language Learners,
- ✓ Moving a Glossary of Terms to each Standard Area Section, e.g. Introduction, Mathematics, English/Language Arts, etc.
- ✓ Reference the Common Core State Standards for Kindergarten

To Access the ISTAR-KR Assessment

- Programs, staff and children require ISTAR-KR identifying numbers
- Those numbers are uploaded into the ISTAR-KR application
- Requires a users account in the Learning Connection website (username and password protected)
- User accounts must be approved and given access to the ISTAR-KR assessment

- Dashboard
- Classes ▾
- Library ▾
- Grade Book
- Reports
- Profile
- Contacts & Communities ▾
- Apps ▾



Koslan Dewitt - TRAINING

[Profile](#) | [Settings](#) | [Inbox](#)

PLAN LESSONS

- [Add a new lesson](#)
- [Add a new student activity](#)
- [Find published resources](#)

MY CLASSES

[View All Classes](#)

No active classes

LESSONS SCHEDULED FOR TODAY

No lessons are scheduled for today

NOTIFICATIONS

There are no notifications

1 request to join [Delta High - TRAINING](#)

RECENT ANNOUNCEMENTS

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[Creekside Named by Chamber of Commerce as Best Buy](#)
posted on Thu Dec 31 11:47 AM in [Creekside School Corporation - TRAINING](#) by [Koslan Dewitt - DOE](#)

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2 posts. Latest post by [Bob Holms - TRAINING](#) on Thu Jun 23 10:40 PM

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Balanced Literacy for Upper Elementary Classrooms - TRAINING

Learning Connection

ISTAR

 My ISTAR Caseload 
[Add/Find Student](#)
[ISTAR Reports](#)

My ISTAR Caseload

Student Name	School	Grade	Date of Birth	Case Manager	Date Last Assessed	
Barajas, Tim	Brookview Elementary - TRAINING	PK	1/16/2008	Dewitt - TRAINING, Koslan	10/25/2011	     
Campos, Tameka	Brookview Elementary - TRAINING	PK	7/17/2007	Dewitt - TRAINING, Koslan	10/25/2011	      
Flores, Derek H	Delta High - TRAINING	10	3/3/1994	Dewitt - TRAINING, Koslan	3/16/2011	       
Hoover, Joanna P	Brookview Elementary - TRAINING	KG	1/15/2004	Kawasaki - TRAINING, Eustolia		   
Ramirez, Cherie T	Brookview Elementary - TRAINING	01	2/20/2003	Dewitt - TRAINING, Koslan	10/25/2011	       

- ✓ **A Performance Thread Category - continuum of skills/performance items**
- ✓ **For Math and English/Language Arts, the last performance skill is the Kindergarten Standard**

+ Add Attachment

Score Assessment Area

Student Name: Buchanan, Otis School(s): Early Childhood
 Date of Birth: 1/31/2008 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

Cancel Save

Core Standard 1: Number Sense
 Counting and Quantity

Performance Thread Category

No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
			2/17/2011		

Least mature

More mature



- ✓ **Select one performance item per thread/row that reflects child's highest level of mastery**

✓ Attachment C: Promoting Early Learning and Development Outcomes for Children

Mastery is determined by whether or not evidence reflects a child has demonstrated most of the behavior objectives

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

English/Language Arts

Core Standard 1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds

No Evidence	Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words
<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Demonstrates awareness of symbols

No Evidence	Responds to familiar pictures	Labels familiar pictures	Recognizes familiar symbols	Compares combines, and orders letters and letter sounds	Recognizes that letters make words and words make sentences
<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Glossary of terms

Behavior Objectives

Behaviors to define the skill for the thread

- Produces and blends the sounds of letter patterns into recognizable words
- Matches sound that begins own name with sound that begins another words or name
- Identifies words that sound alike
- Identifies words that rhyme
- Produces words that rhyme with oral prompts

Close

Glossary of Terms:

- Auditory = related to hearing
- Compare = identify similarities and differences between item
- Indicate(s) = give a response
- Tactile = related to touch
- When item is a plural = more than one
- Order(s)= arrange a group of things in a line/list from first to last

Close

Core Standard1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds

	0	1	2	3	4	5	
No Evidence		Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words	Do Not this bc below at to be lea
Behavior Objectives		<i>Alerts to/facial expression changes and locates sounds in the environment (e.g. primary caregiver voice, pet, door bell)</i>	<i>Responds to sounds in the environment</i>	<i>Produces a variety of sounds</i>	<i>Produces and blends the sounds of letter patterns into recognizable words</i>	<i>Compares sounds of different words</i>	<i>Distingui. within wo</i>
		<i>Finds hidden sound directly above and behind</i>	<i>Emulates sounds in the environment</i>	<i>Blends individual sounds into words</i>	<i>Matches sound that begins own name with the sound that begins another word or name</i>	<i>Distinguishes sounds within words</i>	<i>Distingui. beginning single-syl</i>
			<i>Repeats sounds from familiar song, book</i>	<i>Repeats words from familiar song or book</i>	<i>Identifies words that sound alike</i>	<i>Identifies a new word from a word with a missing sound</i>	<i>Distingui. sounds in syllable w</i>
			<i>Produces strings of sounds while looking at a book</i>	<i>Repeats a word from a spoken sentence string</i>	<i>Identifies words that rhyme</i>	<i>Identifies the beginning and ending sounds of a word</i>	<i>Distingui. sounds in syllable w</i>
			<i>Acknowledges when sounds are the same or different</i>	<i>Identifies words from a spoken sentence</i>	<i>Produces words that rhyme with oral prompts</i>	<i>Identifies how many sounds are heard</i>	<i>Recognize vowel sou orally sta. syllable w</i>
				<i>Identifies differences in letter sounds</i>		<i>Orders sounds heard</i>	<i>Recognize vowels' se be repres different l</i>
				<i>Blends consonant—vowel-consonant sounds to make words</i>		<i>Identifies changes in three sounds when one sound is added, substituted, omitted, moved or repeated</i>	<i>Creates a rhyming v</i>
							<i>States a li rhyming v</i>

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Attachment C: Promoting Early Learning and Development Outcomes for Children English/Language Arts

Core Standard 1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds

Add Attachment

Cancel Save

No Evidence	Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Demonstrates awareness of symbols

No Evidence	Responds to familiar pictures	Labels familiar pictures	Recognizes familiar symbols	Compares combines, and orders letters and letter sounds	Recognizes that letters make words and words make sentences
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Learning Connection **ISTAR**

[Score Assessment](#)

Student Name: Erickson, Tonia C **School(s):** Brookview Elementary - TRAINING
Date of Birth: 7/9/2006 **Grade:** Pre-Kindergarten Ages 3-5 (PK)

Thread Name: Demonstrates awareness of sounds

Upload file:

Description:

Status:

PREVIOUS ATTACHMENTS



Attachment C: Promoting Early Learning and Development Outcomes for Children

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

English/Language Arts

Core Standard 1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds

Anecdotal Notes

Cancel Save



No Evidence	Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Demonstrates awareness of symbols



No Evidence	Responds to familiar pictures	Labels familiar pictures	Recognizes familiar symbols	Compares combines, and orders letters and letter sounds	Recognizes that letters make words and words make sentences
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Learning Connection | ISTAR

Add Thread Note

Student Name: Barajas, Tim **School(s):** Brookview Elementary - TRAINING
Date of Birth: 1/16/2008 **Grade:** Pre-Kindergarten Ages 3-5 (PK)

Thread Name: *Counting and Quantity*

PREVIOUS COMMENTS

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Score Assessment Area

Student Name: Barajas, Tim School(s): Brookview Elementary - TRAINING
Date of Birth: 1/16/2008 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input checked="" type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 

0/10/2011

10/15/2011 [Eustolia Kawasaki - TRAINING]: Tim identifies that a group of 10 items is larger than a group of 5 items when playing with colored teddy bears. (1 of 1)

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 

9/19/2011

✓ **When a performance item is written in a plural, that means more than one, e.g. Labels familiar objects**

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

English/Language Arts

Cancel Save

Core Standard 1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds



No Evidence	Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words
<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Demonstrates awareness of symbols



No Evidence	Responds to familiar pictures	Labels familiar pictures	Recognizes familiar symbols	Compares combines, and orders letters and letter sounds	Recognizes that letters make words and words make sentences
<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Learning Connection

ISTAR

[My ISTAR Caseload](#)

 Print Draft Report  View Attachment(s)  Delete Assessment

Areas to Assess

Student Name: Barajas, Tim
Date of Birth: 1/16/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input checked="" type="checkbox"/>	8 of 8 threads complete.
English/Language Arts		<input checked="" type="checkbox"/>	8 of 8 threads complete.
Physical Skills		<input checked="" type="checkbox"/>	5 of 5 threads complete.
Personal Care Skills		<input checked="" type="checkbox"/>	5 of 5 threads complete.
Social Emotional Skills		<input checked="" type="checkbox"/>	8 of 8 threads complete.

Finalize Assessment

[Return to My ISTAR Caseload](#)

[Finalize Assessment](#)

All of the required assessments for this student have been

completed.



Assessment Type: Interim
Date of Assessment: 2/17/2011

Student Name: Tucker, Gwendyth
Birth Date: 1/31/2008
Grade: PK
Age in Months: 37

Shaded boxes identify skills that have been demonstrated by this child. White boxes identify skills to be achieved. The numbers between the boxes indicate the age range in months when a typically developing child would have demonstrated the skill in the previous box.

Mathematics

Core Standard 1: Number Sense

Counting and Quantity

No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
4	22	40	49	61	

Ages in Months



Computation

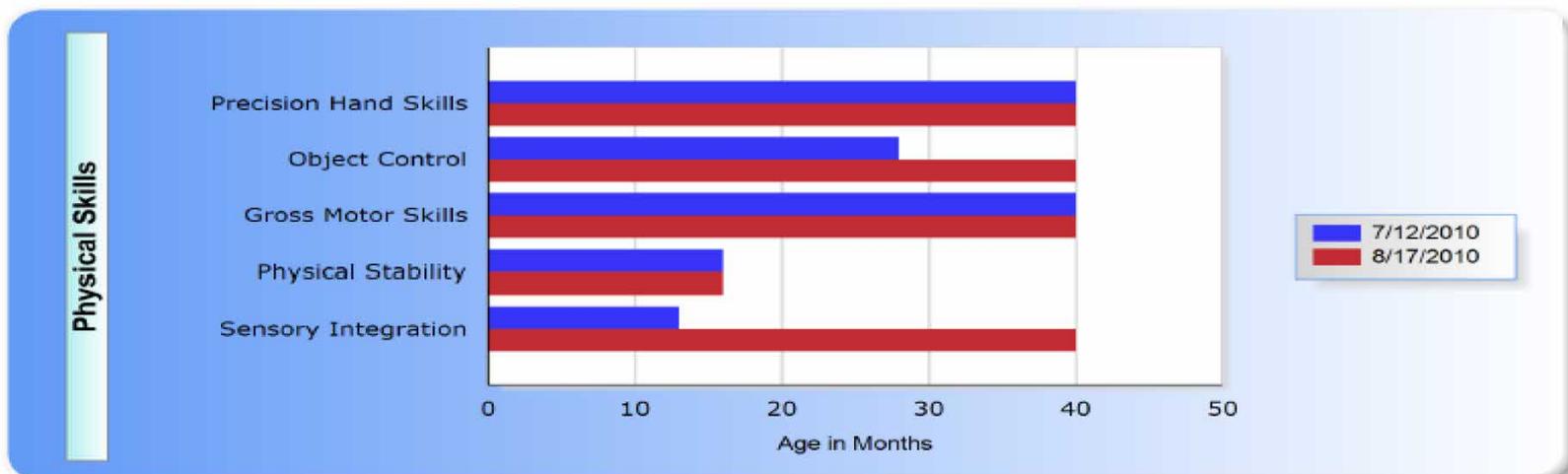
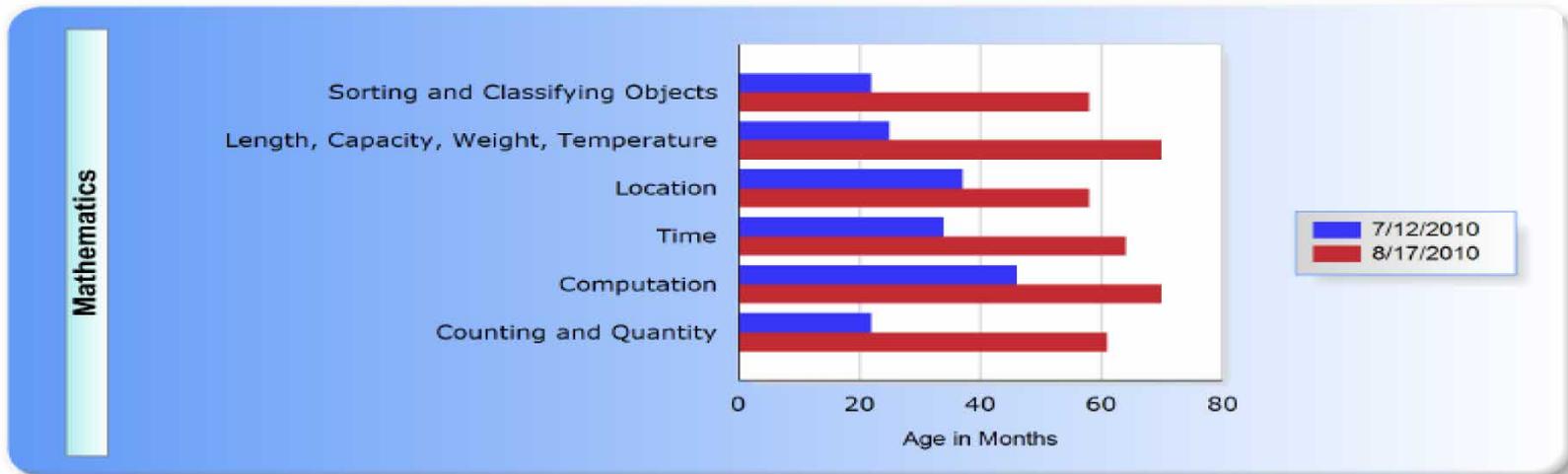
No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
13	31	46	64	70	

Core Standard 2: Geometry and Measurement

Individual KR Assessment Summary Report



This report compares a number of assessments against each other.



Learning Connection

ISTAR

My ISTAR Caseload

Reports Listing

Individual Reports

KR

Monitoring

KR Data Report

KR Entrance-Exit Data Report

Alternate Assessment

Compliance Report

Alternate Data Summary Table

Annual Alternate Student Report

KR Data Report

These reports are Administrative level ONLY

Report Type: Corp School Case Manager

Corp/School/Case Manager:

Start Date 

End Date 

Generate Report

Attachment C: Promoting Early Learning and Development Outcomes for Children
ISTAR-KR Aggregate/Group Data Report

	Corp Name	School Name	Last Name	First Name	Middle Name	Birth Date	Gender	Ethnicity	Exceptionality	Entrance Assessment Date	Entrance Age in Months	Grade Level	Assessment Age in Months	Current Case Manager	Assessment Finalize Date	Counting and Quantity	Computation	Time	Location	Length Capacity Weight Temperature	Sorting and Classifying Objects	Demonstrates awareness of sounds	Demonstrates awareness of symbols	Uses print for pleasure and information	Comprehends details events and main ideas	Writing for a specific purpose and audience	Uses writing implements
2	Creekside School Corporation - TRAININ	Brookview Elementary	Barajas	Tim		1/16/2008 12:00:00 AM	F	5	None	#####	43	PK	43	Eustolia Kawasaki - TRAINING	#####	61	70	64	58	70	58	67	67	61	58	70	67
3	Creekside School Corporation - TRAININ	Brookview Elementary	Barajas	Tim		1/16/2008 12:00:00 AM	F	5	None	#####	43	PK	44	Eustolia Kawasaki - TRAINING	#####	61	70	64	58	70	58	67	67	61	58	70	67
4	Creekside School Corporation - TRAININ	Brookview Elementary	Burgess	Joseph	P	8/1/2008 12:00:00 AM	M	5	None	#####	37	PW	37	Eustolia Kawasaki - TRAINING	#####	61	64	46	58	49	58	67	67	61	58	43	52
5	Creekside School Corporation - TRAININ	Brookview Elementary	Burgess	Joseph	P	8/1/2008 12:00:00 AM	M	5	None	#####	37	PW	37	Eustolia Kawasaki - TRAINING	#####	61	70	64	58	49	58	67	67	46	58	64	67
6	Creekside School Corporation - TRAININ	Brookview Elementary	Calhoun	Miguel		1/24/2008 12:00:00 AM	F	4	None	#####	43	PK	43	Eustolia Kawasaki - TRAINING	#####	40	64	34	25	49	58	22	61	34	49	64	37
7	Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonla	C	7/9/2006 12:00:00 AM	M	2	Developmental Delay	#####	55	PK	55	Eustolia Kawasaki - TRAINING	#####	40	46	34	25	49	40	22	37	46	49	43	37
8	Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonla	C	7/9/2006 12:00:00 AM	M	2	Developmental Delay	#####	55	PK	56	Eustolia Kawasaki - TRAINING	#####	49	64	46	37	49	46	46	61	46	49	64	52
9	Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonla	C	7/9/2006 12:00:00 AM	M	2	None	#####	55	PK	56	Eustolia Kawasaki - TRAINING	#####	49	64	46	25	49	40	46	61	46	49	64	52
10	Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonla	C	7/9/2006 12:00:00 AM	M	2	None	#####	55	PK	57	Eustolia Kawasaki - TRAINING	#####	49	70	46	37	70	46	46	61	46	58	64	52
11	Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonla	C	7/9/2006 12:00:00 AM	M	2	None	#####	55	PK	61	Eustolia Kawasaki - TRAINING	#####	40	64	46	37	49	40	22	61	34	37	28	37

Teachers use child data to

- Determine effectiveness of lesson plan
- Determine child progress and challenges to progress
- Strengthen collaboration with family members
- Inform the next intentional lesson plan

Embedding and Observing Early Learning Standards in everyday classroom practices

The Early Learning Standard:

What is happening in your classroom where the standard might be addressed:

What behaviors and responses children might demonstrate to you:

First Steps towards the standard:

Curriculum activities that can be implemented to support each child's progress level:

Making Progress:

Met the standard:

Adapted from *Make Early Learning Standards Come Alive: Connecting Practice and Curriculum to State Guidelines* by Gaye Gronlund, 2006





What do the steps of progress look like?

Social: Interpersonal Skills - Interacts with others

**First Steps
toward
standard**

**Making
Progress**

**Met the
standard**

**Parallel play, attends to
group activities**

**Participates in group
activities, shares when
prompted, simple pretend
play with peers**

**Begins conversations, greet
others, initiates interactions**

Adapted from *Make Early Learning Standards Come Alive: Connecting Practice and Curriculum to State Guidelines* by Gaye Gronlund, 2006



Assessment Type: Entrance

Date of Assessment: 6/1/2011

STN: 035711171

Student Name: Acevedo, Peter

Birth Date: 1/7/2007

Grade: PK

Age in Months: 53

Shaded boxes identify skills that have been demonstrated by this child. White boxes identify skills to be achieved. The numbers between the boxes indicate the age range in months when a typically developing child would have demonstrated the skill in the previous box.

Time

No Evidence	Anticipates a routine	Uses vocabulary to identify events in a routine	Sequences events	Uses vocabulary that measures time	Uses measuring units for time
	13	22	34	46	64

Location

No Evidence	Demonstrates an awareness of location of objects	Identifies location	Follows directions involving location	Communicates with location words	Uses prepositions to describe location
	7	19	25	37	58

Length, Capacity, Weight, Temperature

No Evidence	Explores measurement attributes	Distinguishes between big and little, hot and cold	Differentiates gradients of size, weight, temperature	Uses common measuring tools in correct context	Makes direct measurement comparisons
	13	25	37	49	70

Sorting and Classifying Objects

No Evidence	Explores attributes (e.g. shape, size, color)	Matches same attributes	Matches opposites	Sorts and patterns by one attribute	Sorts and patterns by more than one attribute
	10	22	40	46	58

Think and Plan with early learning standards/performance indicators in mind

“In order to meet the skill/standard of ____,
we [do/provide/encourage] this [activity]” ____.

Example:

To meet the standard of measurement...we
*provide roads, ramps, balls, cars, marbles in
the Block Center.*

To meet the math skill of measurement, we provide roads, ramps, balls, cars, marbles in the Block Center.



Early Childhood Classroom Weekly Lesson Plan (Include Early Learning Standards per Activity)		
Date _____ Teacher _____		
Child-Directed Activity Exploration		
<u>Blocks</u>	<u>Art</u>	<u>Sensory Table</u>
<u>Dramatic Play</u>		<u>Library</u>
<u>Manipulatives</u>	<u>Ongoing Projects</u>	<u>Writing Center</u>
<u>Reading and Writing</u>	<u>Math Experiences</u>	<u>Scientific Investigations</u>
<u>Strategies to Relationship Building</u>	<u>Individual Student Activity Adjustments</u>	

Intentionality

Focused child observations

Directs adults to implement activity

An account is required To access the online ISTAR-KR Assessment

✓ **Directors of private early childhood program contact Dana Jones to open an ISTAR-KR account**

ISTAR-KR Assessment Database Requires

- ✓ All programs and schools, staff, and students require an IDOE Identifying number
- ✓ Parent Consents Required for Private ECE Program Use
- ✓ ISTAR-KR User Accounts are username and password protected

Documents required for private program ISTAR Accounts

- School Creation Request Form
 - Employee Roster
 - Preschool Roster
 - Parent Consents
- IDOE forwards documents via email to early childhood program administrator

ISTAR Resources: Indiana Department of Education (IDOE) website

- Various presentation slides
- Early Childhood ISTAR-KR Handbook
(with documentation tool samples in word format)
- Paper copies of the assessment matrices
- Parent instructions
- KR Glossary

please go to:

<http://www.doe.in.gov/achievement/assessment/istar-kr>

For questions about the ISTAR-KR contact
Dana Jones
djones@doe.in.gov
Phone: 317-234-6523





IMAGINING
the possibilities.
MAKING THEM HAPPEN.



Indiana
Department of Education

Glenda Ritz, NBCT
Indiana Superintendent of Public Instruction

Early Childhood ISTAR-KR Technical Training: “Computer Step by Steps”

Dana Jones
djones@doe.in.gov

Best Practice tells us that authentic assessment is appropriate for young children

The MisMeasure of Young Children The Authentic Assessment Alternative
Bagnato & Neisworth, 2004



What is Authentic Assessment?

- Observe children **over time** in their typical routines and activities
- Document observations – gather evidence/data
- Use documentation tools aligned to the assessment tool you will use later, efficient, accessible
- Adults collaborate on observations

- Adults need to designate time to think about or interpret their documentation
- Adults use new knowledge/data of child skills to complete an assessment instrument and intentional lesson plans
- This is how to produce accurate assessment of child skills and improve child skills

Accurate assessments of young children are the result of ongoing observation and documentation.



Latin derivative of the word Assessment....



To sit beside and get to know (gather evidence).

ISTAR-KR stands for

Indiana
Standards
Tool for
Assessment
Reporting -
Kindergarten **R**eadiness



ISTAR-KR is a direct derivative of



Foundations to the Indiana Academic Standards for Young Children Birth to Age 5

doe.in.gov/achievement/curriculum/early-childhood-education



ISTAR-KR: Web-based Assessment System



- Standards-based software system
- Developed over 10 years ago; Indiana's response to federal mandate to offer alternative to state achievement tests (ISTEP+) for students in special education; case conference committee decision for school age students with IEP's
- 2004 use by public preschool special programs (assessment became a requirement for school corporations to receive funds (Part B) to provide service)
- Developed for ALL children birth – 10th grade, aligned to IN academic standards

- Provided at no cost by Indiana Department of Education (IDOE)
- Teacher rating instrument, based on knowledge of child gained over time
- 2007 available to community early childhood education programs
- 2009 revised and renamed, ISTAR-KR; simpler to use, item content more meaningful to young children, (aligned to Part C and Part B federal outcome reporting)
- 2009 ISTAR-KR Standardization Study completed, assigning age ranges to performance items

What are the skill groups that lead to school readiness?

National Education Goals Panel (1997)

- Social & emotional
- Approaches to learning
- Language & literacy
- Physical well-being & motor
- Cognition & general knowledge

New research at: iidc@indiana.edu Early Childhood Center, Promoting School Readiness



ISTAR-KR Academic Standard:

English, Language Arts Matrix = 8 Performance Threads

- Awareness of sounds
- Awareness of symbols
- Uses print for pleasure and information
- Comprehends details, events and main ideas
- Writing for a specific purpose and audience
- Writing implements
- Receptive communication
- Expressive communication



ISTAR-KR Academic Standard:

Math Matrix = 6 Performance Threads

- Counting & Quantity
- Computation
- Time
- Location
- Length, Capacity, Weight
- Sorting & Classifying



Social-Emotional Skills Standards Matrix = 6 Performance Threads

- Sense of Self & Others
- Manages Emotions
- Interpersonal Skills
- Responsibility
- Problem Solving
- Learning



Physical Skills Standards Matrix =

5 Performance Threads

- Sensory Integration
- Physical Stability
- Gross Motor Skills
- Object Control
- Precision Hand Skills



Personal Care Skills Standards Matrix = 5 Performance Threads

- Oral Motor Skills
- Self-Feeding
- Dressing/Undressing
- Care of face, hands, nose
- Toileting



ISTAR-KR is located in the IDOE Learning Connection (LC) = username and password protected

- **All Programs, personnel, and students are assigned identifying numbers in the ISTAR-KR database**



Providing data, resources and tools to support student achievement

Username: [Forgot Your Username?](#)

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[About the Learning Connection](#)

Learn how the Learning Connection developed, who is contributing to its development, and how it connects to IDOE's strategic initiatives. And most importantly, find out how to register for an account.

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Explore the progress of students, schools and corporations by examining the results of ISTEP+ tests in the new Indiana Growth Model. Achievement combined with growth gives a better picture of how schools are helping students progress each year.

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[Curriculum Resources](#)

Access multiple resources to support the curriculum work at corporation/school levels in English/Language Arts, Mathematics, Science, and Social Studies, which include assistance in transitioning to Indiana's Common Core (INCC).

[more...](#)



[Academic Standards](#)

Find the academic standards here.

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[Support](#)

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No lessons are scheduled for today

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- Early Childhood (E506)
- Early Childhood (E507)
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- Early Childhood (E512)
- Early Childhood (E513)
- Early Childhood (E514)
- Early Childhood (E515)
- Early Childhood (E516)
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- Early Childhood (E520)
- Early Childhood (E521)
- Early Childhood (E522)
- Early Childhood (E523)
- Early Childhood (E525)
- Early Childhood (E527)

Indiana Early Childhood Educators

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COMMUNITY DESCRIPTION

This forum is for Early Childhood ISTAR-KR assessment users, those in public and private early childhood education settings. This is a forum to post questions, network with colleagues, view announcements and training materials pertinent to enhancing classroom practice.

Administrator(s):
[Sally Reed-Crawford](#)

Professional Interests:

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[WebEx Recordings: Administrator and New Administrator](#)
 posted on Monday, August 30, 2010 at 3:00 PM by [Sally Reed-Crawford](#)
 WebEx recordings now available on the IDOE website, on the ISTEP+ webpage, under the ISTAR link. The two recordings are:
 (1) Administrator Overview of ISTAR Integration to the Learning Connection, and (2) For New Administrators Overview of ISTAR Intergration to the Learning Connection.
 Thank you, Sally Reed Crawford

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Community Name	Average Views	Replies	Last Post	
IDOE ISTAR-KR Educators (702 Members 30 Resources)	2.64	136	9/6/2011 9:05:01 AM	Join Admin Community

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Indiana Early Childhood Educators

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My ISTAR Caseload

Add/Find Student

ISTAR Reports

My ISTAR Caseload

1 2

Student Name	School	Grade	Date of Birth	Case Manager	Date Last Assessed	
Osborne, Kathy	Snacks Crossing Elem Sch	KG	12/30/2001	MOON, FREDDIE		
Yang, Rodney	Snacks Crossing Elem Sch	KG	5/2/2002	MOON, FREDDIE		

1 2

Assessment

Student Files

Student Demographics

Security Log

Security Access

Reassign

Remove Student



Create Assessment

Student Name: Navarro, Dion N School(s):
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment Set-up Info

Assessing at Grade Level	Pre-Kindergarten Ages 3-5
Assessment Type	KR (Early Childhood)
Exceptionality	Developmental Delay
Purpose	
Cognitive Functioning	

[Cancel](#) [Next](#)

- None
- Autism Spectrum Disorder
- Blind or Low Vision
- Mild Cognitive Disability
- Moderate Cognitive Disability
- Severe Cognitive Disability
- Deaf or Hard of Hearing
- Deaf-Blind
- Developmental Delay**
- Emotional Disability
- Language Impairment
- Speech Impairment
- Multiple Disabilities
- Other Health Impaired
- Orthopedic Impairment
- Specific Learning Disability
- Traumatic Brain Injury

NOTE:
Private Preschool
Educators ALWAYS
select NONE

Purpose Options: Entrance, Interim, Exit

Create Assessment

Student Name: Navarro, Dion N School(s):
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment Set-up Info

Assessing at Grade Level	Pre-Kindergarten Ages 3-5
Assessment Type	KR (Early Childhood)
Exceptionality	Developmental Delay
Purpose	Interim KR
Cognitive Functioning	Exit KR
	Interim KR
	Not Applicable

[Cancel](#) [Next](#)

Create Assessment

Student Name: Calhoun, Miguel

School(s):

Date of Birth: 1/24/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment Set-up Info

Assessing at Grade Level

Pre-Kindergarten Ages 3-5 ▼

Assessment Type

KR (Early Childhood) ▼

Purpose

Interim KR ▼

Exceptionality

None ▼

[Cancel](#)

[Next](#)

Create Assessment

Student Name: Navarro, Dion N School(s):
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment Set-up Info

Assessing at Grade Level	Pre-Kindergarten Ages
Assessment Type	KR (Early Childhood)
Exceptionality	Developmental Delay
Purpose	Interim KR
Cognitive Functioning	Not Applicable

Areas to Assess:

- Mathematics
 English/Language Arts
 Physical Skills
 Personal Care Skills
 Social Emotional Skills

[Cancel](#)
 [Previous](#)
 [Next](#)



Create Assessment

Student Name: Calhoun, Miguel
Date of Birth: 1/24/2008

School(s):
Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment Set-up Info

Assessing at Grade Level	Pre-Kindergarten Ages 3-5
Assessment Type	KR (Early Childhood)
Purpose	Interim KR
Exceptionality	None

Areas to Assess:

- Mathematics English/Language Arts Physical Skills
 Personal Care Skills Social Emotional Skills

[Cancel](#)

[Previous](#)

[Next](#)

Create Assessment

Student Name: Calhoun, Miguel

School(s):

Date of Birth: 1/24/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

REVIEW ASSESSMENT CREATION

Assessment Set-up Info

Assessing at Grade Level

Pre-Kindergarten Ages 3-5

Assessment Type

KR (Early Childhood)

Purpose

Interim KR

Exceptionality

None

Areas to Assess:

- Mathematics
- English/Language Arts
- Physical Skills
- Personal Care Skills
- Social Emotional Skills

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[Finish](#)

Learning Connection

ISTAR

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 Print Draft Report  View Attachment(s)  Delete Assessment

Areas to Assess

Student Name: Calhoun, Miguel

School(s): Brookview Elementary - TRAINING

Date of Birth: 1/24/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

Assessment created successfully for **Miguel Calhoun**. Those users with access to the student can now score the assessment.

CATEGORY			
Mathematics		<input type="checkbox"/>	0 of 8 threads complete.
English/Language Arts		<input type="checkbox"/>	0 of 8 threads complete.
Physical Skills		<input type="checkbox"/>	0 of 5 threads complete.
Personal Care Skills		<input type="checkbox"/>	0 of 5 threads complete.
Social Emotional Skills		<input type="checkbox"/>	0 of 8 threads complete.

[Return to My ISTAR Caseload](#)

ONLY USE THE ISTAR FUNCTIONS TO GO BACK TO YOUR CASELOAD

Learning Connection

ISTAR

+ Add Attachment

Score Assessment Area

Student Name: Calhoun, Miguel
Date of Birth: 1/24/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#)
[Save](#)

Rating Instructions

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8/18/2011

Radio Button to select when choosing a skill

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 884

8/18/2011

Score Assessment Area

Student Name: Navarro, Dion N School(s): Snacks Crossing Elem Sch
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

View Behavior Objectives Icon

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

Core Standard 2: Geometry and Measurement

Time



No Evidence	Anticipates a routine	Uses vocabulary to identify events in a routine	Sequences events	Uses vocabulary that measures time	Uses measuring units for time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

*** When a child has demonstrated MOST/MORE THAN HALF of the behaviors consistently and without your assistance, they have MET the skill. Move to the next skill to the right to review those behaviors.**

***If the child has demonstrated less than half of the behaviors in one skill, then the child has mastered the skill to the left and should be selected.**

When the item is written in plural form, this means MORE THAN ONE.

Behaviors to define the skill for the thread

- Engages with others
- Helps and encourages others
- Describes self in positive ways
- Advocates for self
- Cooperates with adults
- Respects the property of others

Close

+ Add Attachment

- TRAINING
3-5 (PK)

performance.

Cancel

Save



others

Demonstrates respect for self and others



View Behavior Objectives

Manages Emotions



No Evidence	Expresses a variety of emotions	Responds to a variety of emotions	Manages emotions with adult assistance	Uses strategies to manage emotions

Common Core State Standard (CCSS): Counting, Cardinality, Operations in Base Ten

KR: Counting and Quantity (number names, count objects, understand value of numbers, e.g. 10 ones in number 10)
The skills below begin on the left with the least mature skills/indicators and progressively advance to the right to KG skills/indicators in the sixth column.

Behavior Objectives

No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	KG Skill: Describes relationships between numbers and quantity (CCSS Objectives to be mastered by end of KG)	First Grade Skills (CCSS) (Objectives to be mastered by the end of 1 st gd)
	<i>Looks at/observes hanging mobile or object held in front of face</i>	<i>Demonstrates awareness of the presence of objects</i>	<i>Identifies more</i>	<i>Uses numbers to compare</i>	<i>Names and orders quantities</i>	<i>Count to 120, starting at any number less than 120. In this range, read and write numerals and represent a number of objects with a written numeral.</i>
	<i>Follows a moving or sound of an object</i>	<i>Indicates desire for "more"</i>	<i>Uses whole numbers up to 5 to describe objects and experiences</i>	<i>Identifies the next number in a series of numbers</i>	<i>Count to 100 by ones and tens</i>	<i>Compare two two-digit numbers based on meanings of the tens and ones digits, recording the results of comparisons with the symbols >, =, and <.</i>
	<i>Shows displeasure when a desirable object is removed</i>	<i>Identifies which amount is "more" (e.g. visually, tactilely, or auditorally)</i>	<i>Touches or points to each object in a sequence only once</i>	<i>Identifies "first" and "last"</i>	<i>Count forward beginning from a given number within the known sequence (begin at 1)</i>	<i>Understand that the two digits of a two-digit number represent amounts of tens and ones. Understand the following as special cases: 10 can be thought of as a bundle of ten ones – called "ten" Page 887</i>
					<i>Write numbers from 0 –</i>	<i>Compare two two-digit numbers</i>

Score Assessment Area

Student Name: Navarro, Dion N School(s): Snacks Crossing Elem Sch
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

Core Standard 2: Geometry and Measurement

Time



No Evidence	Anticipates a routine	Uses vocabulary to identify events in a routine	Sequences events	Uses vocabulary that measures time	Uses measuring units for time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/6/2010

Learning Connection

ISTAR

Score Assessment

Student Name: Navarro, Dion N

School(s): Snacks Crossing Elem Sch

Date of Birth: 12/16/2005

Grade: Pre-Kindergarten Ages 3-5 (PK)

Thread Name: *Demonstrates awareness of sounds*

Upload file:

Browse...

ABC
✓

Description:

Status:

[Cancel](#)

[Attach File](#)

PREVIOUS ATTACHMENTS

Add Attachment

[Assessment Area Map](#)

Score Assessment Area

Student Name: Navarro, Dion N School(s): Snacks Crossing Elem Sch
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					7/6/2010

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					7/6/2010

Core Standard 2: Geometry and Measurement

Time



No Evidence	Anticipates a routine	Uses vocabulary to identify events in a routine	Sequences events	Uses vocabulary that measures time	Uses measuring units for time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					7/6/2010

Add Attachment

Score Assessment Area

Student Name: Willis, Jennie B School(s): Pleasant Run Elementary Sch, Guion Creek Elementary School
 Date of Birth: 6/30/2003 Grade: Kindergarten (KG)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity

No Evidence	Identifies and counts objects	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Glossary of Terms:

Auditory = related to hearing
 Compare = identify similarities and differences between item
 Indicate(s) = give a response
 Tactile = related to touch
 When item is a plural = more than one
 Order(s)= arrange a group of things in a line/list from first to last

[Close](#)

Computation

No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Core Standard 2: Geometry and Measurement

Time

Score Assessment Area

Student Name: Navarro, Dion N School(s): Snacks Crossing Elem Sch
 Date of Birth: 12/16/2005 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					7/6/2010

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
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Core Standard 2: Geometry and Measurement

Time



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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					7/6/2010

Add Thread Note

Student Name: Navarro, Dion N

School(s): Snacks Crossing Elem Sch

Date of Birth: 12/16/2005

Grade: Pre-Kindergarten Ages 3-5 (PK)

Thread Name: Counting and Quantity



[Cancel](#)

PREVIOUS COMMENTS



Score Assessment Area

Student Name: Barajas, Tim School(s): Brookview Elementary - TRAINING
Date of Birth: 1/16/2008 Grade: Pre-Kindergarten Ages 3-5 (PK)

Select one performance skill/box per performance thread/row that best represents the student's highest level of performance.

Mathematics

[Cancel](#) [Save](#)

Core Standard 1: Number Sense

Counting and Quantity



No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
<input type="radio"/>	<input checked="" type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 

0/10/2011

10/15/2011 [Eustolia Kawasaki - TRAINING]: Tim identifies that a group of 10 items is larger than a group of 5 items when playing with colored teddy bears. (1 of 1)

Computation



No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
<input type="radio"/>	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 

9/19/2011

Learning Connection

ISTAR

[My ISTAR Caseload](#)
[Print Draft Report](#) [View Attachment\(s\)](#) [Delete Assessment](#)

Areas to Assess

Student Name: Barajas, Tim
Date of Birth: 1/16/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input type="checkbox"/>	0 of 6 threads complete.
English/Language Arts		<input type="checkbox"/>	0 of 8 threads complete.
Physical Skills		<input type="checkbox"/>	0 of 5 threads complete.
Personal Care Skills		<input type="checkbox"/>	0 of 5 threads complete.
Social Emotional Skills		<input checked="" type="checkbox"/>	6 of 6 threads complete.

[Return to My ISTAR Caseload](#)

Areas to Assess

Student Name: Navarro, Blah-N
Date of Birth: 12/16/2005

School(s): Snodis Crossing Elem Sch
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input type="checkbox"/>	0 of 0 items complete
English/Language Arts		<input type="checkbox"/>	0 of 0 items complete
Physical Skills		<input type="checkbox"/>	0 of 0 items complete
Personal Care Skills		<input type="checkbox"/>	0 of 0 items complete
Social E		<input type="checkbox"/>	0 of 0 items complete

Delete Assessment

You are about to delete the assessment.
Enter the reasoning as to why you are deleting the assessment below and then click Delete to delete.



 **Print Draft Report**  View Attachment(s)  Delete Assessment

Areas to Assess

Student Name: Barajas, Tim
Date of Birth: 1/16/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input type="checkbox"/>	0 of 6 threads complete.
English/Language Arts		<input type="checkbox"/>	0 of 8 threads complete.
Physical Skills		<input type="checkbox"/>	0 of 5 threads complete.
Personal Care Skills		<input type="checkbox"/>	0 of 5 threads complete.
Social Emotional Skills		<input checked="" type="checkbox"/>	6 of 6 threads complete.

[Return to My ISTAR Caseload](#)

**ISTAR KR Assessment**

Assessment Type: Interim

Date of Assessment:

STN: E53509150

Student Name: Barajas, Tim

Birth Date: 1/16/2008

Grade: PK

Age in Months:

DRAFT - This assessment has not been finalized.

Shaded boxes identify skills that have been demonstrated by this child. White boxes identify skills to be achieved. The numbers between the boxes indicate the age range in months when a typically developing child would have demonstrated the skill in the previous box.

Core Standard 4: Responsibility**Responsibility**

No Evidence	Recognizes steps in familiar routines	Follows familiar routines	Follows rules	Applies rules to situations
	7	19	34	46

Core Standard 5: Problem Solving**Problem Solving**

No Evidence	Initiates an action to get a desired effect	Uses trial and error to manipulate objects	Searches for possible solutions	Finds alternative strategies and solutions
	7	22	40	58

Core Standard 6: Learning**Learning**

No Evidence	Demonstrates curiosity	Sustains attention to preferred activities	Sustains attention to a challenging activity	Applies creativity to activities
	4	22	40	52

Areas to Assess

Student Name: Barajas, Tim
Date of Birth: 1/16/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input type="checkbox"/>	0 of 6 threads complete.
English/Language Arts		<input type="checkbox"/>	0 of 8 threads complete.
Physical Skills		<input type="checkbox"/>	0 of 5 threads complete.
Personal Care Skills		<input type="checkbox"/>	0 of 5 threads complete.
Social Emotional Skills		<input checked="" type="checkbox"/>	6 of 6 threads complete.

[Return to My ISTAR Caseload](#)

Learning Connection

ISTAR

Assessment Areas

Score Assessment

Attachments For Assessment

Student Name: Calhoun, Miguel

School(s): Brookview Elementary - TRAINING

Date of Birth: 1/24/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

Edits_intro_pg 5_.docx

9/21/2011

[View](#)

David J.: Writing Sample

[Writing for a specific purpose and audience] [Uses writing implements] [Demonstrates expressive language]

Areas to Assess

Student Name: Barajas, Tim
Date of Birth: 1/16/2008

School(s): Brookview Elementary - TRAINING
Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY			
Mathematics		<input checked="" type="checkbox"/>	8 of 8 threads complete.
English/Language Arts		<input checked="" type="checkbox"/>	8 of 8 threads complete.
Physical Skills		<input checked="" type="checkbox"/>	5 of 5 threads complete.
Personal Care Skills		<input checked="" type="checkbox"/>	5 of 5 threads complete.
Social Emotional Skills		<input checked="" type="checkbox"/>	8 of 8 threads complete.

Finalize Assessment

[Return to My ISTAR Caseload](#)

[Finalize Assessment](#)

All of the required assessments for this student have been

completed.

Learning Connection

ISTAR

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[ISTAR Reports](#)

Student Files

Student Name: Erickson, Tonia C

School(s): Brookview Elementary - TRAINING

Date of Birth: 7/9/2006

Grade: Pre-Kindergarten Ages 3-5 (PK)

..... Tonia Erickson

..... Assessment_31_8182011.pdf

..... Assessment_31_4302011.pdf

..... Assessment_31_3292011.pdf

..... Assessment_31_3292011.pdf

..... Assessment_31_3162011.pdf

..... Assessment_31_272011.pdf



ISTAR KR Assessment

Assessment Type: Entrance

Date of Assessment: 8/18/2011

STN: E53508140

Student Name:

Birth Date:

Grade:

Age in Months

Shaded boxes identify skills that have been demonstrated by this child. White boxes identify skills to be achieved. The numbers between the boxes represent the months when a typically developing child would have demonstrated the skill in the previous box.

Mathematics

Core Standard 1: Number Sense

Counting and Quantity

No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
4	22	40	49	61	

Computation

No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
13	31	46	64	70	

Learning Connection

ISTAR

[My ISTAR Caseload](#)

Create Progress Monitoring Assessment

Student Name: Robbins, Josephine F

School(s):

Moorhead Elementary School, t

Date of Birth: 4/13/2004

Grade:

Pre-Kindergarten Ages 3-5 (PK

Areas to Assess:

- Mathematics English/Language Arts Physical Skills
 Personal Care Skills Social Emotional Skills

[Cancel](#)

[Next](#)

Create Progress Monitoring Assessment

Student Name: Robbins, Josephine F

School(s): Moorhead Elementary School, Central Elementary School

Date of Birth: 4/13/2004

Grade: Pre-Kindergarten Ages 3-5 (PK)

Areas to Assess:

Threads to Assess:

- Mathematics: Core Standard 1: Number Sense - Counting and Quantity
- Mathematics: Core Standard 1: Number Sense - Computation
- Mathematics: Core Standard 2: Geometry and Measurement - Time
- Mathematics: Core Standard 2: Geometry and Measurement - Location
- Mathematics: Core Standard 2: Geometry and Measurement - Length, Capacity, Weight, Temperature
- Mathematics: Core Standard 2: Geometry and Measurement - Sorting and Classifying Objects
- English/Language Arts: Core Standard 1: Word Recognition, Fluency and Vocabulary Development - Demonstrates awareness of sounds
- English/Language Arts: Core Standard 1: Word Recognition, Fluency and Vocabulary Development - Demonstrates awareness of symbols
- English/Language Arts: Core Standard 2 & 3: Reading Informational and Literary Text - Uses print for pleasure and information
- English/Language Arts: Core Standard 2 & 3: Reading Informational and Literary Text - Comprehends details, events and main ideas
- English/Language Arts: Core Standard 4 & 5: Writing Informational and Literary Text - Writing for a specific purpose and audience
- English/Language Arts: Core Standard 6: English Language Conventions - Uses writing implements
- English/Language Arts: Core Standard 7: Listening & Speaking - Demonstrates receptive language
- English/Language Arts: Core Standard 7: Listening & Speaking - Demonstrates expressive language
- Social Emotional Skills: Core Standard 1: Sense of Self and Others - Sense of Self and Others
- Social Emotional Skills: Core Standard 2: Manages Emotions - Manages Emotions
- Social Emotional Skills: Core Standard 3: Interpersonal Skills - Interpersonal Skills
- Social Emotional Skills: Core Standard 4: Responsibility - Responsibility
- Social Emotional Skills: Core Standard 5: Problem Solving - Problem Solving
- Social Emotional Skills: Core Standard 6: Learning - Learning

Create Progress Monitoring Assessment

Student Name:	Robbins, Josephine F	School(s):	Moorhead Elementary School, Central Elementary School
Date of Birth:	4/13/2004	Grade:	Pre-Kindergarten Ages 3-5 (PK)

REVIEW PROGRESS MONITORING

Areas to Assess:

Mathematics

English/Language Arts

Social Emotional Skills

Threads to Assess:

Mathematics: Core Standard 2: Geometry and Measurement - Sorting and Classifying Objects

English/Language Arts: Core Standard 4 & 5: Writing Informational and Literary Text - Writing for a specific purpose and audience

Social Emotional Skills: Core Standard 3: Interpersonal Skills - Interpersonal Skills

[Cancel](#)

[Previous](#)

[Finish](#)

My ISTAR Caseload

Progress Monitoring Areas to Assess

Student Name: Robbins, Josephine F

School(s): Moorhead Elementary School, Central Elementary School

Date of Birth: 4/13/2004

Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY		
Sorting and Classifying Objects		<input type="checkbox"/> 0 of 10 behaviors complete.
Writing for a specific purpose and audience		<input type="checkbox"/> 0 of 5 behaviors complete.
Interpersonal Skills		<input type="checkbox"/> 0 of 7 behaviors complete.

[Progress Monitoring Area Map](#)

Student Name: Robbins, Josephine F

School(s): Moorhead Elementary School, Central Elementary School

Date of Birth: 4/13/2004

Grade: Pre-Kindergarten Ages 3-5 (PK)

Sorting and Classifying Objects

Scoring Definitions

- **Not Evident** - no evidence exists for this item
- **Introduced** - item has been introduced
- **Emerging** - in early stages of developing
- **Developing** - progress is evident
- **Ongoing** - in advanced stage of development
- **Demonstrated** - performs under direction or request
- **Applied** - uses to complete complex tasks or solve problems

SORTS AND PATTERNS BY ONE ATTRIBUTE

Matches opposites	Ongoing
Names groups of objects according to the common attribute	
Identifies geometric shapes (e.g. circles, triangles, squares, rectangles, cubes)	Not Evident
Puts objects into groups with the similar attribute	Introduced
Identify and sort common words in basic categories	Emerging
Copies simple patterns with numbers and shapes	Developing
Identifies patterns.	Ongoing
Predicts what comes next when shown a simple AB pattern of objects	Demonstrated
Compares and sorts by roundness	Applied
Compares and sorts by number of corners	

[Cancel](#)
[Save](#)

My ISTAR Caseload

Progress Monitoring Areas to Assess

Student Name: Robbins, Josephine F

School(s):

Moorhead Elementary School, Central Elementary School

Date of Birth: 4/13/2004

Grade:

Pre-Kindergarten Ages 3-5 (PK)

CATEGORY		
Sorting and Classifying Objects	 <input checked="" type="checkbox"/>	10 of 10 behaviors complete.
Writing for a specific purpose and audience	 <input type="checkbox"/>	0 of 5 behaviors complete.
Interpersonal Skills	 <input type="checkbox"/>	0 of 7 behaviors complete.

Progress Monitoring Areas to Assess

Student Name: Robbins, Josephine F

School(s): Moorhead Elementary School, Central Elementary School

Date of Birth: 4/13/2004

Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY		
Sorting and Classifying Objects		<input type="checkbox"/> 0 of 10 behaviors complete.
Writing for a specific purpose and audience		<input type="checkbox"/> 0 of 5 behaviors complete.
Interpersonal Skills		<input type="checkbox"/> 0 of 7 behaviors complete.

Learning Connection

ISTAR

[My ISTAR Caseload](#)

 Print Draft Report  Delete Progress Assessment

Progress Monitoring Areas to Assess

Student Name: Calhoun, Miguel

School(s): Brookview Elementary - TRAINING

Date of Birth: 1/24/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

CATEGORY		
Uses print for pleasure and information	 <input checked="" type="checkbox"/>	5 of 5 behaviors complete.
Comprehends details, events and main ideas	 <input checked="" type="checkbox"/>	5 of 5 behaviors complete.
Responsibility	 <input checked="" type="checkbox"/>	5 of 5 behaviors complete.
Problem Solving	 <input checked="" type="checkbox"/>	5 of 5 behaviors complete.
Learning	 <input checked="" type="checkbox"/>	7 of 7 behaviors complete.

[Return to My ISTAR Caseload](#)

[Finalize Assessment](#)

Attachment C: Promoting Early Learning and Development Outcomes for Children
Core Standard 2 & 3: Reading Informational and Literary Text

Uses print for pleasure and information



No Evidence	Engages with a book	Imitates proper handling of books	Distinguishes print from pictures	Orients to print in books	Chooses reading activities for meaning
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8/18/2011

Comprehends details, events and main ideas



No Evidence	Reacts to a story or event	Identifies details from a story or picture	Talks about characters and settings	Retells familiar stories	Comprehends and responds to stories
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8/18/2011

Progress Monitoring Rating

Core Standard 4 & 5: Writing Informational and Literary Text

Writing for a specific purpose and audience



No Evidence	Intentionally makes marks or scribbles	Associates writing with purpose	Creates writing with the intention of communicating	Produces recognizable writing that conveys meaning	Gathers ideas for writing for a purpose
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8/18/2011

Core Standard 6: English Language Conventions

Uses writing implements



No Evidence	Grasps writing tools	Imitates specific writing strokes to make a picture	Copies specific writing marks	Approximates writing strings of letters	Writes from left to right, spacing letters correctly
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Distinguishes print from pictures (Progress Scores)

Imitates proper handling of books	Eustolia Kawasaki - TRAINING	Demonstrated	9/19/2011
Tells about pictures on a page using a mix of simple phrases and simple sentences	Eustolia Kawasaki - TRAINING	Ongoing	9/19/2011
Points to words in book while telling a story	Eustolia Kawasaki - TRAINING	Emerging	9/19/2011
Points to letter when asked	Eustolia Kawasaki - TRAINING	Emerging	9/19/2011
Holds book right-side up based on orientation of pictures	Eustolia Kawasaki - TRAINING	Applied	9/19/2011

Close

[Progress Monitoring Area Map](#)

Student Name: Shields, Erika

School(s): Brookview Elementary - TRAINING

Date of Birth: 6/18/2008

Grade: Pre-Kindergarten Ages 3-5 (PK)

Computation

Scoring Definitions

- **Not Evident** - no evidence exists for this item
- **Introduced** - item has been introduced
- **Emerging** - in early stages of developing
- **Developing** - progress is evident
- **Ongoing** - in advanced stage of development
- **Demonstrated** - performs under direction or request
- **Applied** - uses to complete complex tasks or solve problems

DESCRIBES THE APPLICATION OF ADDITION AND SUBTRACTION SITUATIONS

Follows models of addition or subtraction situations	Developing	9/21/2011
Finds the number that is one more than any whole number up to 10	Introduced	9/21/2011
Finds the number that is one less than any whole number up to 10	Introduced	9/21/2011
Compares sets up to 10 objects and determines if they are equal	Not Evident	9/21/2011
Models addition/subtraction by joining sets of objects (for any two sets with fewer than 10 objects when joined)	Not Evident	9/21/2011
Divides sets of 10 or fewer objects into equal groups.	Not Evident	9/21/2011
Makes precise calculations and checks validity of results in context of problem	Not Evident	9/21/2011

Learning Connection

ISTAR

My ISTAR Caseload

ISTAR Reports

My ISTAR Caseload

Student Name	School	Grade	Date of Birth	Case Manager	Date Last Assessed							
Bass, Chanda G	Guion Creek Elementary School	03	2/28/2002	MOON, FREDDIE	7/20/2010							
Bowman, Molly	Snacks Crossing Elem Sch	05	12/23/1999	MOON, FREDDIE	8/6/2010							
Bryan, Shanna B	Snacks Crossing Elem Sch	03	5/6/1998	MOON, FREDDIE	8/3/2010							
Castaneda, Austin D	College Park Elem Sch	01	2/20/2004	MOON, FREDDIE	8/17/2010							
Costa, Raul T	Snacks Crossing Elem Sch	02	6/18/2003	MOON, FREDDIE	8/10/2010							
Dawson, Peter T	Snacks Crossing Elem Sch	PW	3/31/2005	MOON, FREDDIE	8/3/2010							
Drake, Dwight S	Snacks Crossing Elem Sch	05	5/7/1999	MOON, FREDDIE								
Fisher, Otis B	Snacks Crossing Elem Sch	04	12/19/2000	MOON, FREDDIE	8/26/2010							
Glenn, Adam R	Deer Run Elementary	03	4/9/2001	MOON, FREDDIE								
Gutierrez, Faith R	Snacks Crossing Elem Sch	KG	5/3/2000	MOON, FREDDIE								
Guzman, Kara T	Snacks Crossing Elem Sch	05	2/18/1999	MOON, FREDDIE								
Lin, Demetrius	Snacks Crossing Elem Sch	KG	7/27/2001	MOON, FREDDIE								
Mc Intyre, Sherry D	Guion Creek Elementary School	05	3/15/2000	MOON, FREDDIE	8/17/2010							
Mcclain, Loretta	Snacks Crossing Elem Sch	01	2/2/2000	MOON, FREDDIE	7/21/2010							
Navarro, Dion N	Snacks Crossing Elem Sch	PK	12/16/2005	MOON, FREDDIE	7/7/2010							
Nguyen, Christina S	Snacks Crossing Elem Sch	KG	1/4/2001	MOON, FREDDIE								
Osborne, Kathy E	Snacks Crossing Elem Sch	03	12/30/2001	MOON, FREDDIE	7/14/2010							
Parks, Julian B	Snacks Crossing Elem Sch		8/17/2000	MOON, FREDDIE								
Preston, Spencer Y	Snacks Crossing Elem Sch	03	2/19/2002	MOON, FREDDIE	8/10/2010							
Sweeney, Lori P	Snacks Crossing Elem Sch	04	7/26/2000	MOON, FREDDIE	8/26/2010							
Villegas, Kerrie D	Central Elementary School	01	9/4/2003	MOON, FREDDIE	8/25/2010							
Willis, Jennie B	Guion Creek Elementary School	02	6/30/2003	MOON, FREDDIE	7/14/2010							

My ISTAR Caseload

Add/Find Student

Reports Listing 

Individual Reports

KR

Monitoring

KR Data Report

KR Entrance-Exit Data Report

Alternate Assessment

Compliance Report

Alternate Data Summary Table

Annual Alternate Student Report

Reports

Please select the report you want to run from the navigation on the left side of the page.

My ISTAR Caseload

Add/Find Student

Reports Listing

Individual Reports 

KR

Monitoring

KR Data Report

KR Entrance-Exit Data Report

Alternate Assessment

Compliance Report

Alternate Data Summary Table

Annual Alternate Student Report

Individual Reports

Corporation: School:

Case Management Students

Report To Run:

- Assessment Summary
- Comparison Bar Graph (KR Only)
- Progress Monitoring

Learning Connection

ISTAR

My ISTAR Caseload

Reports Listing

Individual Reports 

KR

Monitoring

KR Data Report

KR Entrance-Exit Data Report

Alternate Assessment

Compliance Report

Alternate Data Summary Table

Annual Alternate Student Report

Individual Reports

Corporation: School:

Case Manager: Student:

Report To Run:

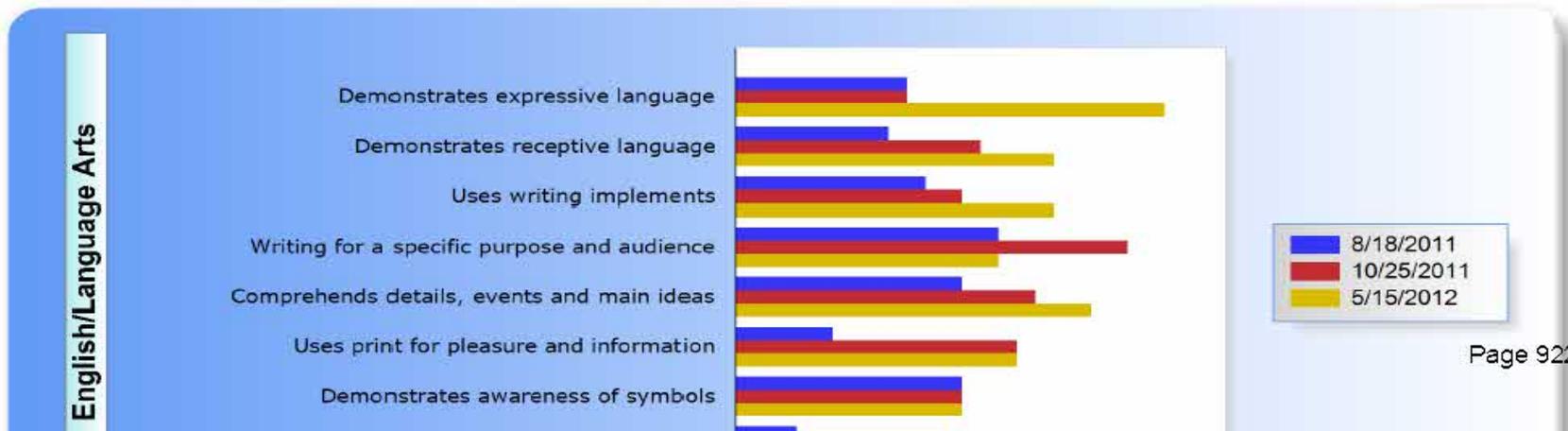
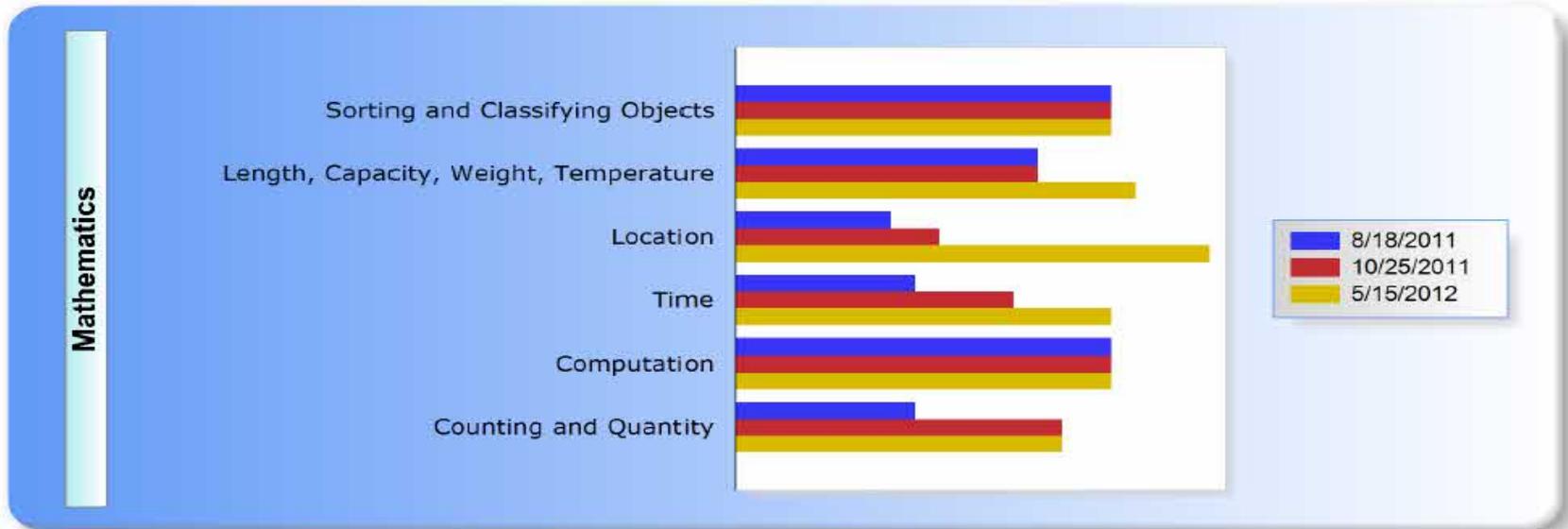
Dates Filter:

- 8/18/2011
- 4/30/2011
- 3/29/2011
- 3/16/2011
- 2/7/2011

Generate Report



This report compares a number of assessments against each other.



Learning Connection

ISTAR

My ISTAR Caseload

Reports Listing

Individual Reports

KR

Monitoring

KR Data Report

KR Entrance-Exit Data Report

Alternate Assessment

Compliance Report

Alternate Data Summary Table

Annual Alternate Student Report

Individual Reports

Corporation: School:

Case Manager: Student:

Report To Run:

Dates Filter:

5/19/2011

4/13/2011

Generate Report



Progress Monitoring

Birth Date: 7/9/2006

Date of Assessment: 4/30/2011

Grade: PK

STN: 405709462

Element	Assessor	Date	Score
Social Emotional Skills			
Core Standard 1: Sense of Self and Others			
Sense of Self and Others			
Demonstrates respect for self and others			
Advocates for self	Kawasaki - TRAINING, Eustolia	5/19/2011	Not Evident
Cooperates with adults	Kawasaki - TRAINING, Eustolia	5/19/2011	Not Evident
Describes self in positive ways	Kawasaki - TRAINING, Eustolia	5/19/2011	Not Evident
Engages with others	Kawasaki - TRAINING, Eustolia	5/19/2011	Introduced
Helps and encourages others	Kawasaki - TRAINING, Eustolia	5/19/2011	Emerging
Respects the property of others	Kawasaki - TRAINING, Eustolia	5/19/2011	Not Evident

Learning Connection

ISTAR

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[Reports Listing](#)

[Individual Reports](#)

[KR](#)

[Monitoring](#)

[KR Data Report](#)

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[Alternate Assessment](#)

[Compliance Report](#)

[Alternate Data Summary Table](#)

[Annual Alternate Student Report](#)

Reports

Please select the report you want to run from the navigation on the left side of the page.

This report is only accessible to Administrators, please ask your ISTAR Administrator to print out your Caseload group report.

Attachment C: Promoting Early Learning and Development Outcomes for Children

ISTAR-KR Aggregate/Group Data Report

Corp Name	School Name	Last Name	First Name	Middle Name	Birth Date	Gender	Ethnicity	Exceptionality	Entrance Assessment Date	Entrance Age in Months	Grade Level	Assessment Age in Months	Current Case Manager	Assessment Finalize Date	Counting and Quantity	Computation	Location	Length Capacity Weight Temperature	Sorting and Classifying Objects	Demonstrates awareness of sounds	Demonstrates awareness of symbols	Uses print for pleasure and information	Comprehends details events and main ideas	Writing for a specific purpose and audience	Uses writing implements	
Creekside School Corporation - TRAININ	Brookview Elementary	Barajas	Tim		1/16/2008 12:00:00 AM	F	5	None	=====	43	PK	43	Eustolia Kawasaki - TRAINING	=====	61	70	64	58	70	58	67	67	61	58	70	67
Creekside School Corporation - TRAININ	Brookview Elementary	Barajas	Tim		1/16/2008 12:00:00 AM	F	5	None	=====	43	PK	44	Eustolia Kawasaki - TRAINING	=====	61	70	64	58	70	58	67	67	61	58	70	67
Creekside School Corporation - TRAININ	Brookview Elementary	Burgess	Joseph	P	8/1/2008 12:00:00 AM	M	5	None	=====	37	PW	37	Eustolia Kawasaki - TRAINING	=====	61	64	45	58	49	58	67	67	61	58	43	52
Creekside School Corporation - TRAININ	Brookview Elementary	Burgess	Joseph	P	8/1/2008 12:00:00 AM	M	5	None	=====	37	PW	37	Eustolia Kawasaki - TRAINING	=====	61	70	64	58	49	58	67	67	46	58	64	67
Creekside School Corporation - TRAININ	Brookview Elementary	Calhoun	Miguel		1/24/2008 12:00:00 AM	F	4	None	=====	43	PK	43	Eustolia Kawasaki - TRAINING	=====	40	64	34	25	49	58	22	61	34	49	64	37
Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonia	C	7/9/2006 12:00:00 AM	M	2	Developmental Delay	=====	55	PK	55	Eustolia Kawasaki - TRAINING	=====	40	46	34	25	49	40	22	37	46	49	43	37
Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonia	C	7/9/2006 12:00:00 AM	M	2	Developmental Delay	=====	55	PK	56	Eustolia Kawasaki - TRAINING	=====	49	64	45	37	49	46	46	61	46	49	64	52
Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonia	C	7/9/2006 12:00:00 AM	M	2	None	=====	55	PK	56	Eustolia Kawasaki - TRAINING	=====	49	64	45	25	49	40	46	61	46	49	64	52
Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonia	C	7/9/2006 12:00:00 AM	M	2	None	=====	55	PK	57	Eustolia Kawasaki - TRAINING	=====	49	70	45	37	70	46	46	61	46	58	64	52
Creekside School Corporation - TRAININ	Brookview Elementary	Erickson	Tonia	C	7/9/2006 12:00:00 AM	M	2	None	=====	55	PK	61	Eustolia Kawasaki - TRAINING	=====	40	64	45	37	49	40	22	61	34	37	28	37

Teacher Next Steps to Using ISTAR-KR

- Register for your LC account
- Familiarize yourself with the ISTAR-KR items
- Think about how the standard areas and performance items are already part of your curriculum planning and included in lesson plans
- Consider activities to promote skill development of performance items

- Set a weekly child observation schedule for adults in each classroom
- Increase the focus of observations by identifying an effective documentation tool to record observations – document daily or weekly – see samples in the EC ISTAR-KR Handbook Appendices
- Regularly review child documentation to adjust curriculum activities
- Use child documentation to support your ISTAR-KR ratings

ISTAR-KR Resources and professional development materials

✓ IDOE Website
www.doe.in.gov

✓ Learning Connection
www.learningconnection.doe.gov

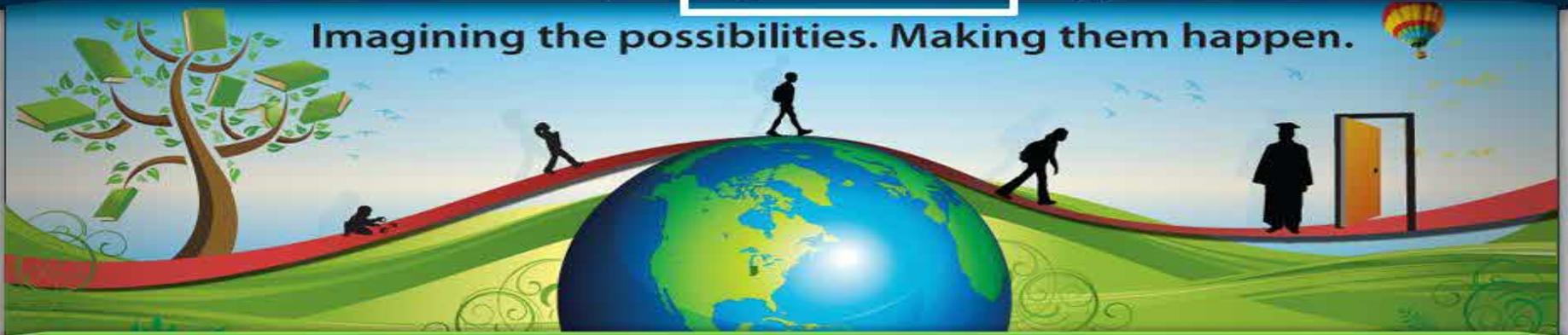
Learning community: IDOE ISTAR-KR Educators – request to join the community



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Monday, December 10, 2012

State funding for full day kindergarten increased by \$107.9 million for the 2012-2013 school year, reaching a total of \$189.8 million. The funds will be distributed December 14 to 338 public school corporations and charter schools for the 79,110 students who enrolled in full day kindergarten programs this year. In 2011-2012, 66,401 students were enrolled in full day kindergarten programs, with a total state funding distribution of \$81.9 million.

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Indiana State Board

MOST RECENT

- Indiana state board of education December 2012 Part 1
- Indiana state board of education December 2012 Part 2

Calendar

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January

- [Office of eLearning... 01/29/2013 - 4:00pm](#)
- [Indiana Digital Lear... 02/01/2013 \(All day\)](#)
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Scheduling

[Schedule a meeting with Indiana State Superintendent of Public Instruction, Glenda Ritz.](#)

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- # school data
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College and Career Readiness

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ISTEP, End of Course Assessments

Individualized Learning

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Office of Student Assessment

The Office of Student Assessment manages multiple statewide assessments which provide measures of student knowledge and understanding and can be used to make informed decisions that help improve student achievement. Click on the assessment links below for more information about Indiana's statewide assessments. The ISTEP+ Program Manual contains policies and procedures for Indiana's assessment system.

[Click here for a quick tour of the Assessment website!](#)

Important Assessment Information

- ▶ [2011-12 ISTEP+ Program Manual](#)
- ▶ [2011-13 Testing Windows](#)

Indiana's Assessments

- ▶ [Acuity \(Grades 3-8 & Algebra I\)](#)
- ▶ [End-of-Course Assessments \(Algebra I, English 10, Biology I\)](#)
- ▶ [IMAST \(Grades 3-8\)](#)
- ▶ [IREAD K-2](#)
- ▶ [IREAD-3](#)
- ▶ [ISTAR](#)
- ▶ [ISTAR-KR](#)
- ▶ [ISTEP+ \(Grades 3-8\)](#)
- ▶ [LAS Links \(K-12\)](#)
- ▶ [mCLASS \(K-2\)](#)
- ▶ [National Assessment of Educational Progress \(NAEP\) - Grades 4, 8, 12](#)
- ▶ [Partnership for Assessment of Readiness for College and Careers \(PARCC\) - aligned to Common Core State Standards](#)

Calendar

Upcoming

- [Acuity Diagnostic 4...](#)
05/09/2012 (All day)
- [ISTEP+ Multiple-Cho...](#)
05/09/2012 (All day)
- [IMAST - Assessment W...](#)
05/09/2012 (All day)

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ISTAR-KR

Posted: Wed, 08/17/2011 - 9:00am Updated: Fri, 03/02/2012 - 4:19pm



Purpose

The purpose of *ISTAR-KR* (*Indiana Standards Tool for Alternate Reporting of Kindergarten Readiness*) is to measure skills in children from infancy to kindergarten. A derivative of Indiana's Early Learning Standards (which are part of the Foundations to Indiana Academic Standards), *ISTAR-KR* is aligned to the Indiana Standards for kindergarten in the areas of English/Language Arts and Mathematics and includes three functional areas: physical, personal care and social-emotional skills. Data from *ISTAR-KR* assessments are used for state reporting for PK students receiving special education. The assessment can be used for local purposes for grades PK through 1.

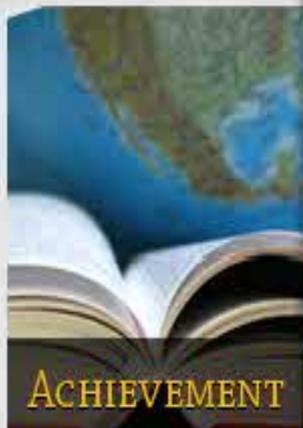
This web-based instrument is rated by teachers based on their ongoing observations of children engaged in typical daily routines and activities. It is available to all public schools in Indiana and to private early childhood education programs at no cost. Assessment results from *ISTAR-KR* can be used to determine which skills a child has mastered and to identify the skills a student needs to learn next.

ISTAR-KR Assessments (Print Versions)

[English/Language Arts](#) 
[Mathematics](#) 
[Personal Care](#) 
[Physical](#) 
[Social-Emotional](#) 

- ▶ [Glossary of Assessment Terms](#) 
- ▶ [Parent Instructions - Children in Special Education](#) 
- ▶ [Parent Instructions - Community Early Childhood Education Programs](#) 

Additional Resources



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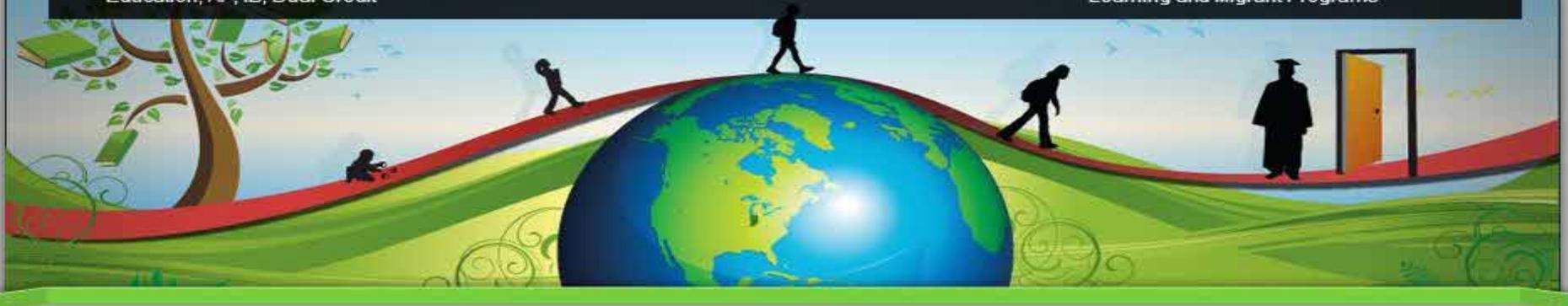
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Curriculum

Indiana's Common Core Standards

To learn more about Indiana's Common Core Standards and Indiana's plans for implementing those standards, please visit our [Resource page for Implementing Indiana's Common Core](#).

Curriculum and Instruction Information on the Learning Connection

For additional information and resources related to Curriculum and Instruction, join the [IDOE - Curriculum and Instruction Community](#) on the Learning Connection.

- ▶ Log in to the [Learning Connection](#)
- ▶ Click on *Find a Community*
- ▶ Type in "IDOE - Curriculum and Instruction"
- ▶ Click on *Join Community*

Content Area Pages

- ▶ [Arts Education](#)
- ▶ [Career and Technical Education](#)
- ▶ [Early Childhood Education](#)
- ▶ [Health & Wellness, Physical Education](#)
- ▶ [Mathematics](#)
- ▶ [Science](#)
- ▶ [Social Studies](#)
- ▶ [World Languages and International Education](#)

Resources for the RISE Evaluation Model

The Office of College and Career Readiness has developed three modules that provide teachers guidance on the implementation of RISE.

- ▶ [Module 1: RISE Overview and Teacher Effectiveness Rubric](#). This module provides an overview of the components of the RISE Evaluation Model as well as specific information about the Teacher Effectiveness Rubric. In addition, two guidance documents are included for teacher support of these RISE components.
- ▶ [Module 2: Student Learning Objectives and Individual Growth Model](#). This module provides essential information around the Student Learning Objectives (SLO) and Individual Growth Model components of RISE. Supporting teacher documents include a Quick Reference Guide for SLOs as well as a timeline for development and evaluations of SLOs.
- ▶ [Module 3: A-F School Accountability in RISE](#). Teacher documents include a Quick Reference Guide for A-F School Accountability, which describes the RISE pie chart and categories to help teachers determine the weight of each component that affects their overall teacher effectiveness rating.

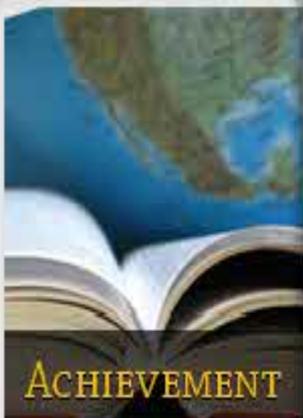
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Early Childhood Education

Posted: Mon, 10/17/2011 - 10:27am Updated: Mon, 04/02/2012 - 8:58am



Early Childhood Education in Indiana includes all children from Birth to Age 8, although often it ends upon a child's entry into kindergarten. Programs include Licensed Centers, Licensed Homes and Unlicensed Registered Child Care Ministries, all of which have oversight by the Bureau of Child Care. The Indiana Department of Education supports the care of young children through various initiatives including: The Foundations to the Indiana Academic Standards, the [Indiana Birth to Age 5 Literacy Framework](#) and the [ISTAR-](#)

[KR Assessment](#)

Foundations to the Indiana Academic Standards

The Foundations to the Indiana Academic Standards for Young Children from Birth to Age Five have been developed by individuals with expertise in children ages birth-5. The Foundations are based on the latest national research and findings for all content areas and domains. By outlining specific skills and concepts and giving examples of instructional strategies, these foundations will support teachers, parents, and caregivers as they develop appropriate experiences for young children to help ensure success in kindergarten. The most recent version, updated in February 2012, is available below.

- ▶ [Indiana Foundations \(February 2012\)](#)
- ▶ [Video: Foundation to the Indiana Standards, Introduction](#)
- ▶ [Video: Foundation to the Indiana Standards, Birth to Three Years](#)
- ▶ [Video: Foundation to the Indiana Standards, Three to Five Years](#)
- ▶ [Archived Foundations Documents](#)

Resources for Parents and Families

- ▶ [Five Domains of School Readiness](#)

When you need help

- LC Accounts, STN/SPN, Completion of ISTAR KR ratings – Dana Jones, djones@doe.in.gov
317 234-6523
- ISTAR **technical** issues -
<https://learningconnection.doe.in.gov/ContactSupport.aspx>
(See Contact Support at the bottom of each LC page, select and send a detailed email message, screen shots help.)

Thank You!



Indiana
Department of Education

Glenda Ritz, NBCT
Indiana Superintendent of Public Instruction



ISTAR KR Assessment

Assessment Type: Entrance

Date of Assessment: 6/1/2011

STN: XXXXXXXXX

Student Name: A, Peter

Birth Date: 1/7/2007

Grade: PK

Age in Months: 53

Shaded boxes identify skills that have been demonstrated by this child. White boxes identify skills to be achieved. The numbers between the boxes indicate the age range in months when a typically developing child would have demonstrated the skill in the previous box.

Mathematics

Core Standard 1: Number Sense

Counting and Quantity

No Evidence	Demonstrates awareness of the presence of objects	Identifies more	Uses numbers to compare	Names and orders quantities	Describes relationships between numbers and quantity
	4	22	40	49	61

6/1/2011 10:50:47 AM - ABBOTT, TERRANCE

Between first day of school and today, the student.....

Computation

No Evidence	Manipulates objects for a purpose	Matches objects and sets	Makes a set of objects smaller or larger	Follows models of addition or subtraction situations	Describes the application of addition and subtraction situations
	13	31	46	64	70

Core Standard 2: Geometry and Measurement



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Time

No Evidence	Anticipates a routine	Uses vocabulary to identify events in a routine	Sequences events	Uses vocabulary that measures time	Uses measuring units for time
	13	22	34	46	64

Location

No Evidence	Demonstrates an awareness of location of objects	Identifies location	Follows directions involving location	Communicates with location words	Uses prepositions to describe location
	7	19	25	37	58

Length, Capacity, Weight, Temperature

No Evidence	Explores measurement attributes	Distinguishes between big and little, hot and cold	Differentiates gradients of size, weight, temperature	Uses common measuring tools in correct context	Makes direct measurement comparisons
	13	25	37	49	70

Sorting and Classifying Objects

No Evidence	Explores attributes (e.g. shape, size, color)	Matches same attributes	Matches opposites	Sorts and patterns by one attribute	Sorts and patterns by more than one attribute
	10	22	40	46	58



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Physical Skills

Core Standard 1: Sensory Integration

Sensory Integration

No Evidence	Responds to sensory input with a variety of behaviors	Tolerates a variety of sensory input	Regulates sensory input with assistance	Applies a strategy to regulate sensory input
	4	7	13	40

Core Standard 2: Physical Stability

Physical Stability

No Evidence	Demonstrates strength in resisting gravity	Demonstrates movement with strength	Demonstrates stability and balance in upright position with assistance	Demonstrates stability, balance and control in upright position
	4	7	10	16

Core Standard 3: Gross Motor Skills

Gross Motor Skills

No Evidence	Rolls	Crawls, creeps	Moves in upright position	Coordinates forward movements	Sustains physical activity
	4	7	13	19	40



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Core Standard 4: Object Control

Object Control

No Evidence	Grasps, reaches and releases objects	Releases objects with control	Uses both hands in middle of body	Throws, catches and kicks objects	Throws, catches, kicks objects with control
	7	10	19	28	40

Core Standard 5: Precision Hand Skills

Precision Hand Skills

No Evidence	Grasps small objects	Isolates one or two fingers	Uses fingers of two hands to complete activities
	7	13	40



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Personal Care Skills

Core Standard 1: Oral Motor

Oral Motor

No Evidence	Coordinates sucking, swallowing, breathing	Swallows pureed or lumpy food	Uses tongue to move and munch solid food	Chews with rotary movement
	4	7	10	16

Core Standard 2: Self-Feeding

Self-Feeding

No Evidence	Cooperates with feeding	Assists in feeding self	Feeds self	Uses utensils and open cup to feed self	Serves self food and drink
	7	10	16	22	37

Core Standard 3: Dressing/Undressing

Dressing/Undressing

No Evidence	Cooperates in dressing/undressing	Assists in dressing/undressing	Completes dressing/undressing
	10	22	40



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Core Standard 4: Care of hands, face, nose

Care of hands, face, nose

No Evidence	Cooperates in personal care routines	Assists in personal care routines	Completes personal care routines
	13	28	40

Core Standard 5: Toileting

Toileting

No Evidence	Demonstrates awareness of toileting	Participates in toileting	Completes toileting independently
	22	31	40



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English/Language Arts

Core Standard 1: Word Recognition, Fluency and Vocabulary Development

Demonstrates awareness of sounds

No Evidence	Responds to sounds in the environment	Produces a variety of sounds	Produces and blends the sounds of letter patterns into recognizable words	Compares sounds of different words	Distinguishes sounds within words
	4	10	22	46	67

Demonstrates awareness of symbols

No Evidence	Responds to familiar pictures	Labels familiar pictures	Recognizes familiar symbols	Compares combines, and orders letters and letter sounds	Recognizes that letters make words and words make sentences
	7	25	37	61	67



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Core Standard 2 & 3: Reading Informational and Literary Text

Uses print for pleasure and information

No Evidence	Engages with a book	Imitates proper handling of books	Distinguishes print from pictures	Orients to print in books	Chooses reading activities for meaning
	7	16	34	46	61

Comprehends details, events and main ideas

No Evidence	Reacts to a story or event	Identifies details from a story or picture	Talks about characters and settings	Retells familiar stories	Comprehends and responds to stories
	16	22	37	49	58

Core Standard 4 & 5: Writing Informational and Literary Text

Writing for a specific purpose and audience

No Evidence	Intentionally makes marks or scribbles	Associates writing with purpose	Creates writing with the intention of communicating	Produces recognizable writing that conveys meaning	Gathers ideas for writing for a purpose
	13	28	43	64	70



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Core Standard 6: English Language Conventions

Uses writing implements

No Evidence	Grasps writing tools	Imitates specific writing strokes to make a picture	Copies specific writing marks	Approximates writing strings of letters	Writes from left to right, spacing letters correctly
	13	31	37	52	67

Core Standard 7: Listening & Speaking

Demonstrates receptive language

No Evidence	Responds to cues in the environment	Responds to familiar gestures and words	Follows a familiar verbal or signed direction	Follows an unfamiliar direction	Follows directions with steps and descriptors
	4	13	25	40	52

Demonstrates expressive language

No Evidence	Uses gestures or sounds to communicate	Uses single words to communicate	Uses two-word phrases or signs	Uses simple phrases and sentences with simple grammatical rules	Uses varied grammar in expression	Shares information and ideas to describe, explain, predict
	10	19	28	37	52	70



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Social Emotional Skills

Core Standard 1: Sense of Self and Others

Sense of Self and Others

No Evidence	Demonstrates self-awareness	Demonstrates independence	Engages with others	Demonstrates respect for self and others
4	22	34	52	

Core Standard 2: Manages Emotions

Manages Emotions

No Evidence	Expresses a variety of emotions	Responds to a variety of emotions	Manages emotions with adult assistance	Uses strategies to manage emotions
4	10	28	46	

Core Standard 3: Interpersonal Skills

Interpersonal Skills

No Evidence	Interacts with caregiver	Engages in parallel play	Interacts with others	Engages in cooperative interactions
7	13	25	40	



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Core Standard 4: Responsibility

Responsibility

No Evidence	Recognizes steps in familiar routines	Follows familiar routines	Follows rules	Applies rules to situations
	7	19	34	46

Core Standard 5: Problem Solving

Problem Solving

No Evidence	Initiates an action to get a desired effect	Uses trial and error to manipulate objects	Searches for possible solutions	Finds alternative strategies and solutions
	7	22	40	58

Core Standard 6: Learning

Learning

No Evidence	Demonstrates curiosity	Sustains attention to preferred activities	Sustains attention to a challenging activity	Applies creativity to activities
	4	22	40	52



Social-Emotional Development of Young Children Training Content

Consensus Statement

Purpose

Young children need regular interactions with emotionally supportive adults in order to develop, learn, and grow in healthy ways. In daily life, a young child may spend time with many different adults: parents, other caregivers, teachers, physicians, nurses, early interventionists, and family friends. Each person has the opportunity to positively influence the child’s development. In order to be most effective, adults who spend time with young children must have the capacity for positive relationships along with sufficient knowledge of early childhood social and emotional development.

Despite its importance, specific instruction in how to support social and emotional development is not always included in the training of those who work with young children. This Consensus Statement has been prepared to guide training across disciplines in Indiana by creating a framework of competencies that can be used by many different providers. The intent of the competencies is to build an early childhood workforce that understands and supports early social and emotional development. These guidelines can be used to improve practice, guide consistent training, identify resources, and perhaps most importantly, to direct public policy. Together, our work will provide a continuum of promotion, prevention, and intervention activities that lead to the emotional wellbeing for all children and families in Indiana.

Overview

Sunny Start is an outgrowth of the Early Childhood Comprehensive Strategic planning initiative. The strategic planning initiative was based on the assumption that, “For the past fifteen years, [the state of] Indiana has demonstrated its commitment to improving the lives of young children and their families through participation in a variety of state and federal initiatives focusing on improving outcomes in early childhood. Indiana recognizes a clear need for improved collaboration and coordination among existing early childhood programs and services. While there is a tremendous number and variety of initiatives and programs, the lack of coordination leads to duplication of efforts that are often not universally applied across the state. Staff is lacking consistent and periodic training regarding all programs resulting in the dissemination of inaccurate information which leads to confusion on the part of families as well as missed opportunities for support and services.” (Indiana State Department of Health Website).

A variety of providers partnering with parents, families and other caregivers in the care of their young children would benefit from continued efforts to

	<p>coordinate training around social-emotional development. To date, several strong efforts have been successful in bringing a variety of training opportunities to Indiana para-professionals and professionals regarding social-emotional development. These efforts are consistent with the vision of the Sunny Start initiative, <i>"In Indiana, children are safe, healthy and reach their full potential."</i> However, these initiatives have not been coordinated across disciplines or geographical areas.</p> <p>The Social and Emotional Training and Technical Assistance Committee of the Sunny Start initiative has been charged with exploring suitable tools for social-emotional screening, determining best practices for dissemination of information about social-emotional development and resources, and developing and implementing a plan for training personnel about social-emotional development and intervention.</p>
<p>Research Background</p>	<p>In recent years it has become increasingly clear that social and emotional skills underlie all other areas of development (Shonkoff & Phillips, 2000). In fact early social and emotional competence is associated with continued competence and may help reduce the risks for later problem behaviors. Personal characteristics including good social skills, positive primary relationships and a supportive social environment have been identified by researchers as the three main conditions that contribute to a child's resilience to certain risk factors. Attainment of positive social and emotional status has been shown to relate to important skills including attention, cooperation, and emotional regulation. These capacities are the building blocks for success in relationships and in education.</p> <p>Research further demonstrates that social and emotional capacities are built in large part through relationships with important adults (Schore, 2001). Routine caregiving interactions affect children's social and emotional capacity by actually influencing the structure and function of the brain. These brain changes may have long lasting effects, including influences on the body's ability to manage stress as adults (Perry, 2001).</p> <p>The Maternal Child Health pyramid describes three levels of services including promotion (universal), prevention (indicated) and intervention (targeted). The majority of children and families are served at the base of this model or in the promotion section. Promotion activities are aimed at the general population and can include education and awareness around topics such as parenting and child development. Prevention activities are more targeted reaching a smaller population considered to be at risk due to biological or environmental risk factors. These activities are intended to prevent diagnoses. The third tier, intervention services, is intended to address children who have a diagnosis, significant delay or disability and require specialized treatment to support their full achievement of quality attachments and relationships (Perry, Kaufmann & Knitzer, 2007).</p> <p>Because experiencing relationships with adults who are warm, nurturing, and consistent is associated with positive child outcomes, effective promotion, prevention, and intervention efforts should include measures that target adults as well as children. By the same token, children are</p>

extremely vulnerable when adults struggle with issues that may reduce their availability, such as mental illness, addiction, and domestic violence. When adults receive support, child-adult relationships are enhanced. Support to children and their families can be provided by many providers, in varying ways, and in multiple settings (Landy & Menna, 2006). Therefore developers of professional training and learning opportunities in disciplines as varied as education, child care, child protection services, and health care, should consider how to infuse knowledge of social and emotional skills, ways to enhance social and emotional development, and ways to support relationships into their curricula.

Intervention aimed at strengthening the parent-child relationship, reducing behavior challenges, and enhancing child and parent social-emotional capacities does exist and can be effective. Examples include Interaction Guidance (McDonough, 2001), Infant-Parent Psychotherapy (Lieberman & Van Horn, 2005), and the Incredible Years Curricula (Webster-Stratton & Reid, 2003). However, it is important to recognize that with higher levels of disturbance, change in parent-child relationships becomes more difficult to achieve. Therefore a continuum of services from promotion and prevention to direct clinical intervention is highly desirable and may save families and their community time, money and distress. In addition to addressing the human costs of distressing symptoms and problematic relationships, evidence reveals that early intervention saves money by significantly reducing future utilization of child welfare, juvenile justice, and other social services (Tolan & Dodge, 2005, Rolnick & Grunewald, 2003).

Promotion of emotional well being and prevention of mental illness and behavioral health problems requires early identification. Some behaviors that are "red flags" for the development of serious problems are easily recognized by well-trained providers. However, reliance solely on clinical judgment identifies fewer than 30% of the children in need of intervention (Glascoe, 2005). Without intervention, these children may develop serious, long lasting emotional and behavioral difficulties. In the last few years well designed screening tools have become available that allow primary care providers and parents to accurately identify children in need of further assessment for social and emotional concerns. These tools function similarly to familiar screening practices such as hearing or vision checks that have been used for decades in public schools. The tools often rely on parent report and require full consent of the parent/caregiver. Use of screening tools by front-line providers is an appropriate and necessary part of a system of care for young children (American Academy of Pediatrics, 2006). Families, providers, and policy-makers need to understand the purpose of screening as it relates to an overall system of care.

Once initial concerns have been identified in primary health care and early child care and educational settings, children and families should be referred to early childhood mental health specialists for full assessment and treatment when needed (American Academy of Pediatrics, 2001 and 2006). In Indiana, as across the country, however, there are serious shortages of qualified personnel (National Mental Health Association, 2003). The

	<p>shortage is particularly acute in rural areas, as most available providers are clustered in more heavily populated areas, such as Marion, Allen, and Lake counties. Good efforts have been made to increase providers through continuing education events. However, the shortage cannot be fully addressed because Indiana has no formal graduate training programs in early childhood mental health.</p> <p>Finally, payment sources are another barrier to early childhood mental health services. In most cases third party payers require an identified patient with a specified diagnosis to document the need for services. Mental health diagnoses used with older children and adults may be inappropriate or inadequate for young children. Providers may also be reluctant to use a particular diagnosis due to unfamiliarity with this population or concerns about stigma (Carter, Briggs-Gowan & Davis, 2004). Furthermore, many young children present with emotional, behavioral, or relationship concerns that do not meet current criteria for specific diagnosis but who would benefit from intervention. One step toward addressing these concerns is the implementation of the Child and Adolescent Needs Survey (CANS) across child service systems. Indiana is utilizing a state specific version for ages birth to four that identifies children’s social-emotional needs in the context of their family in order document the level of care needed. In other states, use of the Diagnostic Criteria 0-3-Revised (Zero to Three, 2005) has been recommended to provide diagnoses that are appropriate for very young children. The DC0-3R is unique in that it considers child behavior in the context of development and relationships. Crosswalks that connect the DC0-3R diagnoses with diagnoses and acceptable billing codes from the DSM and ICD systems have been used in other states for several years. Recently the IAITMH’s IMH Task Force created the Indiana Crosswalk, which links the DC0-3R diagnoses with both DSM IV TR and the ICD 9 CM.</p>
<p>Overview of Competency Frameworks in Early Childhood Mental Health</p>	<p>Indiana, along with several other states has devoted significant effort toward identifying and developing a set of competencies for providers who work with very young children with the focus on social-emotional development. Several other related groups have established competencies and skill sets as well. (See the accompanying summary table with a general comparison of nine different competency frameworks). Recognizing the value of these previous efforts, Sunny Start’s Social and Emotional Training and Technical Assistance Committee’s first step in developing a consensus statement was to review existing systems. The next section of this Consensus Statement identifies the competency systems that were utilized in developing the Indiana proposal.</p> <p>In Indiana, the Indiana Association of Infant and Toddler Mental Health (IAITMH) was established in 2000 as an outgrowth of a SPRANS grant administered by the Indiana State Department of Health. The association has as its mission “to advance conditions that provide an early start toward optimal mental health.”</p> <p>One of the association’s earliest products was the development of a set of infant mental health competencies for early childhood providers (IAITMH, n.d.). These competencies were presented to the First Steps (Indiana’s Part</p>

C early intervention system) as a framework for training providers in the area of social-emotional development and intervention. These competencies were also used in the development of a mentorship program to support interdisciplinary groups desiring more information and skills for supporting young children's social-emotional growth and development.

In the development of this Consensus Statement, other state's efforts to define competencies for promotion, prevention and intervention of social-emotional issues in very young children were collected and reviewed. Many states have been working on the development of core competencies and the identification of associated skills for supporting young children and their families in the area of social-emotional development. Models considered for Indiana are reviewed briefly here.

The Michigan Association for Infant Mental Health (MI-AIMH) has the longest standing credentialing program that is based on competencies across four incremental levels of service provision (MI-AIMH, 2003). These levels include: 1 – Infant Family Associate; 2 – Infant Family Specialist; 3 – Infant Mental Health Specialist; and 4 – Infant Mental Health Mentor. The credential is open to anyone who wishes to participate in the process which requires testing and documentation of experience and supervision. Although the credential has been limited primarily to Michigan providers, several Indiana providers have attained a Level 3 or Level 4 standing. The MI-AIMH has expressed interest in sharing this credentialing system with other states for a fee.

In Florida, the Harris Institute for Infant Mental Health Training is analyzing data from a project in which a panel of experts was asked to rank order a list of skills related to infant mental health service provision. (H. Quay, personal communication, July 17, 2006). The initial data of this project is available and the Harris Institute is currently analyzing and interpreting the results. The skills are grouped into seven competency areas.

In Wisconsin, the Interdisciplinary Training Institute, through its Initiative for Infant Mental Health project has prepared a three tiered system based in large part on the work completed in Florida (Wisconsin Infant and Early Childhood Mental Health Plan, 2004). The Wisconsin draft model identifies three levels which include: 1 – Front line caregivers; 2 – Developmental Professionals; and 3 – Licensed mental health practitioners. The skills are grouped into five categories. The workgroup is continuing to use the ranked skills from Florida in identifying appropriate skills for each of the three levels across the five categories.

There are several other related efforts in developing competencies. The national Child Development Associate credentialing program identifies six competency goals that include a focus on child development (Council for Professional Recognition, 2005). One of the six goals specifically addresses social and emotional development. The field of family support has identified eight areas of competence with associated skills (C. O'Connor, n.d.). The National Association for the Education of Young Children has established

competencies for early child care settings (NAEYC, 2005). There are ten areas covering issues such as child growth and development, observation and assessment, children with special needs, and family and community relationships. Finally the Infant Mental Health Promotion Project in Canada identifies eight competency areas that are arranged in a somewhat different fashion but contain similar content (Infant Mental Health Promotion Project, 2002).

After review of these earlier competency skill sets, members of the Social and Emotional Training and Technical Assistance Committee selected a format and set of competencies that would be sensitive to Indiana's workforce and system of service delivery. Next, the Social and Emotional Training and Technical Assistance Committee as a whole, which represents a wide range of constituents, reviewed and approved the following competencies as presented. This document was approved by the Core Partners of the Sunny Start Early Childhood Comprehensive System initiative. This interdisciplinary effort has resulted in a document that provides a basis for collaboration in training and service delivery efforts for Indiana's youngest citizens.

Recommendations:

The Sunny Start Core Partners and the Social Emotional Training Committee recommend that:

- Early childhood provider constituents utilize the following set of competencies when providing training to the wide variety of staff and providers serving young children;
- These competencies be used in planning for training, mentoring and supervision activities;
- When planning training sessions trainers and presenters select, modify and create curricula that support the acquisition of skills relative to the appropriate categories of service provision;
- Early childhood professionals and service providers use this document to identify what current training exists that supports these competencies;
- Additional training is developed collaboratively to address any voids in the existing systems;
- All constituents collaborate in the delivery of training to enrich training outcomes and subsequent service delivery to children and families; and that
- Preservice and continuing education programs specializing in social-emotional development and intervention are established.

**Indiana’s System of Mental Health Services for Young Children (birth to five) and their Families
Social-Emotional Development Training Competencies and Service Levels**

** These competencies are not exclusive to the identified levels but rather build progressively. As such it is intended that providers in levels 2 and 3 have mastered previous competencies*

LEVEL 1 -PROMOTION-	LEVEL 2 (includes all competencies in level 1) -PREVENTION-	LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-
PRIORITY POPULATION	PRIORITY POPULATION	PRIORITY POPULATION
All children and families	Children at risk for social-emotional developmental concerns and families	Children with persistent mental health challenges and families
<u>Caregivers serving all children and families such as:</u> <ul style="list-style-type: none"> • Parents/Grandparents/Other relatives • Early child care/education professionals • Primary health care providers • Para-professionals • Religious institution nursery/education providers 	<u>Developmental professionals serving children at risk for social-emotional developmental concerns and families such as:</u> <ul style="list-style-type: none"> • Healthy Families/Home visitors/Parent educators • Foster parents • Early interventionists (e.g., First Steps providers) • Head Start/Early Head Start • Public health nurses • Social Workers (LSW) • Early Childhood Special Education personnel • Legal system personnel • Public safety personnel • Pediatricians; Developmental-Behavioral Pediatricians 	<u>Licensed mental health professionals serving children with persistent mental health challenges and their families such as:</u> <ul style="list-style-type: none"> • Psychologists (HSPP or School Psychologist) • Social workers (LCSW) • Psychiatrists • Marriage and Family therapists (LMFT) • Licensed Mental Health Counselors • Psychiatric Nurse Practitioner • Developmental-Behavioral Pediatricians

LEVEL 1 -PROMOTION-	LEVEL 2 (includes all competencies in level 1) -PREVENTION-	LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-
COMPETENCIES		
A. PARENTING, FAMILY FUNCTIONING, & CHILD/PARENT RELATIONSHIPS		
Recognizes the importance of parent/caregiver physical and emotional availability	Understands the infant/young child’s use of the parent as a secure base under conditions of stress and for explorations of the environment	Demonstrates appropriate strategies for enhancing parent/caregiver – young child relationships
Recognizes the role of caregivers as models for the development of behavior in young children (e.g. coping, anger management)	Communicates with parents/caregivers the importance of appropriate models for behavior and supports behavioral changes when indicated	Supports parents’ capacity to reflect on their own behavior as it relates to their relationship with their child, their child’s development, and their child’s behaviors and to make necessary changes
Supports the unique parent-child relationship	Demonstrates knowledge that parenting is a developmental process	Demonstrates knowledge of family dynamic (systems, relationships) and family composition including relationships with caregiver, sibling, and extended family
Respects the parent’s relationship with child as primary	Uses interviews with parents/caregivers to listen carefully, obtain information, and begin to develop trust	Establishes and maintains a therapeutic alliance with parent/caregiver
Demonstrates sensitivity to cultural issues that impact family interactions, relationships, and parenting	Utilizes diverse cultural beliefs about development in understanding parent-child interaction and family expectations	Understands the impact of the client’s culture, values, and education on their own behavior and reaction to the therapist
Understands that a parent’s own experiences in childhood influence parenting behaviors	Identifies parent practices that put the child at risk and provides alternatives	Develops corrective attachment relationship with the parent with the goal of improving the parent/child relationship
Identifies supportive and challenging family interactions that affect healthy social-emotional development	Partners with families to integrate services and supports into daily routines and activities with sensitivity to the families questions and priorities	Uses family centered approaches when designing supports and services to enhance healthy functioning of the family unit

<p style="text-align: center;">LEVEL 1 -PROMOTION-</p>	<p style="text-align: center;">LEVEL 2 (includes all competencies in level 1) -PREVENTION-</p>	<p style="text-align: center;">LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-</p>
B. CHILD DEVELOPMENT		
<p>Understands the importance of positive social interactions and relationships to overall development</p>	<p>Describes the developmental sequence of attachment behaviors of infants and toddlers (signaling and greeting behaviors, separation distress, secure base behavior and social referencing)</p>	<p>Demonstrates expertise with concepts of security and insecurity of attachment relationships and different types of attachment disorders in parent/child dyads</p>
<p>Describes typical development across all areas including: communication, physical, adaptive/self-help, cognitive, and social/emotional</p>	<p>Identifies strategies for relating to toddlers to support their autonomy, learning, cooperation, needs for security and a secure base from which to explore in order to facilitate development in all areas.</p>	<p>Differentiates between typical challenging behaviors and disordered behaviors</p>
<p>Describes the influence of environment on the child’s development</p>	<p>Describes everyday strategies for supporting family coping with stressful environments and experiences</p>	<p>Identifies effects of traumatic experiences on a child’s development and appropriate interventions</p>
<p>Recognizes when infant/child demonstrates behavior that does not conform with expected development</p>	<p>Describes delayed or atypical behaviors in all areas of development</p>	<p>Describes atypical behaviors, reactions, and responses, using formal diagnoses from current DSM and DC 0-3 systems when appropriate</p>
<p>Uses adaptations and special methods as instructed to support young children with special needs to participate in various settings</p>	<p>Identifies strategies for supporting young children with delayed or atypical development to participate and increase skills in various settings</p>	<p>Develops, implements, and evaluates the effectiveness of interventions to modify atypical behaviors and increase children’s ability to participate in various settings</p>
<p>Adjusts daily routine based on the child’s temperament and understands & responds to baby cues</p>	<p>Understands and utilizes the concept of “goodness of fit” with regard to temperament styles in observing and supporting adult/child interactions</p>	<p>Uses strategies to address potential problems in the developing parent-child relationship brought about by a temperament mismatch of parent and child</p>

<p style="text-align: center;">LEVEL 1 -PROMOTION-</p>	<p style="text-align: center;">LEVEL 2 (includes all competencies in level 1) -PREVENTION-</p>	<p style="text-align: center;">LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-</p>
C. BIOLOGICAL AND PSYCHOSOCIAL INFLUENCES		
<p>Aware of self regulation including sleep/ wake pattern</p>	<p>Understands the impact of environment and experiences on parent-child relationship and development</p>	<p>Demonstrates knowledge of the effects of stressful life events on family functioning and emotional development of infants and toddlers (e.g., separation/divorce, death of a family member, hospitalization, chronic illness, violence & abusive relationships)</p>
<p>Knows about nutritional needs and methods of feeding at different stages of development</p>	<p>Understands the impact of chronic poor nutrition on development</p>	<p>Differentiates between typical and problematic feeding interactions; understand the importance of interactions during feeding,; is familiar with available treatment/service options</p>
<p>Knows how social and physical environments and experiences affect brain growth and development</p>	<p>Describes how brain growth and development are affected by traumatic events</p>	
<p>Describes how one’s own experience of being parented may affect current parent/child relationships</p>	<p>Explains how mental health issues and environmental risk can disrupt parent/child relationships</p>	<p>Describes adult mental health diagnoses, common treatment methods, and the long term impact of adult mental health challenges on parenting</p>
<p>Identifies strengths of the child’s family situation</p>	<p>Identifies and utilizes the concept of resilience and those factors which support its development</p>	<p>Uses family, parent, and child strengths as a starting point when formulating a treatment plan and implementing therapeutic activities</p>
<p>Recognizes and respects differing settings where children spend time including child care, play groups, and home</p>	<p>Adapts methods and strategies to support child development in a variety of settings</p>	<p>Demonstrates consultation skills with parents and professionals who support children in a variety of settings</p>

LEVEL 1 -PROMOTION-	LEVEL 2 (includes all competencies in level 1) -PREVENTION-	LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-
D. OBSERVATION, SCREENING, ASSESSMENT, DIAGNOSIS & INTERVENTIONS		
Uses appropriate, recommended screening tools	Articulates the features of the various tools and the appropriate use of each tool	Uses observation and appropriate tools necessary for formal diagnoses of disorders in mental health using current DSM and DC-0-3 criteria
Knows how and when to refer for evaluation	Understands role of different professionals in making appropriate referrals	Accepts referrals and communicates back with referral sources and appropriate providers
Observes the infant/young child's behavior, ability to soothe, self-regulation, and sensitivities	Notices and can describe the parent's behavior to soothe, regulate, and redirect the infant/young child	Uses a variety of formal and informal assessment methods, tools and techniques to describe the parent-child relationship
Describes environmental risk factors which might result in multiple challenges for families	Understands and empathizes with multi-challenged families with respect to how they interpret need for services, receive information and follow through with parenting strategies	Engages in specific therapeutic methods of interviewing, listening and assessing parents' need for additional resources including formal and informal services and basic crisis intervention skills
Relates and interacts comfortably with infants/young children	Knows how to support infant/young child and parent relationships as described in the early childhood mental health literature	Provides intervention based on early childhood mental health literature
Knows how to help parents identify goals and activities that contribute to pleasurable interaction with the infant/young child	Can be empathic and sympathetic while not over identifying with the parents	Organizes, synthesizes, and interprets information from all sources and communicates the need and strength of the infant/young child to parents in a fashion to facilitate their understanding and cooperation in treatment
Demonstrates techniques for soothing, limit setting, & protection and can discuss the meaning of these with parents	Promotes parental competence in areas such a resolving and forestalling crises and solving family conflicts	Assesses parents' current coping strategies and supports families in developing a plan for best coping

LEVEL 1 -PROMOTION-	LEVEL 2 (includes all competencies in level 1) -PREVENTION-	LEVEL 3 (includes all competencies in levels 1 & 2) -INTERVENTION-
D. OBSERVATION, SCREENING, ASSESSMENT, DIAGNOSIS & INTERVENTIONS (CONTINUED)		
Supports the child and family in the proper use of prescribed medications	Is familiar with frequently-used psychotropic medications for both children and adults	Observes and evaluates, with parent/caregiver, the effectiveness of prescribed medications
Understands when challenging behaviors interfere with healthy development	Identifies common toddler behaviors that challenge caregivers and best practice strategies for supporting toddlers as they master their impulses and feelings	Supports parents/caregivers to identify and implement behavioral techniques for problems in sleeping, eating, and self-control
E. INTERDISCIPLINARY COLLABORATION		
Knows about resources in the community and can discuss various options with parents in a non-threatening manner		Makes targeted referrals related to the diagnosis
Works as a member of a team: practice openness to new information, ability to communicate clearly one’s own position and value, ability to hold multiple viewpoints and reflect upon them, resolve conflicts, etc.		
F. ETHICS / SUPERVISION		
Demonstrates knowledge of applicable state and agency regulations and policies with respect to such issues as confidentiality, reporting of child abuse, and others that may arise		
Works within the regulation and code of ethics of their profession		
Understands the impact of his/her own cultural and educational background and values on the client		
Uses regularly scheduled time for reflective supervision, recognizes his/her own limitations, and seeks support & supervision as needed		
Demonstrates respect for boundaries of practice		
Aware of boundaries in working with families	Demonstrates sensitivity to professional role as a collaborating partner with the family and advocates for parents without becoming over-involved or taking over from parents	Understands the concepts of transference and counter-transference and how they may impact the ongoing treatment

Note: The following sources were consulted in the drafting of these social-emotional competencies: Indiana Association for Infant and Toddler Mental Health, Interdisciplinary Training Institute (Constance Lillas), Center for Prevention and Early Intervention Policy, Florida State University, Michigan Association Infant Mental Health, Florida Association for Infant Mental Health, Harris Institute for Infant Mental Health Training/Florida State University, Initiative for Infant Mental Health Training/Interdisciplinary Training Institute/Wisconsin.

References

- American Academy of Pediatrics. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics, 118*(1), 405-420.
- American Academy of Pediatrics - Committee on Children with Disabilities (2001). Developmental surveillance and screening of infants and young children. *Pediatrics, 108*, 192-196.
- Carter, A., Briggs-Gowan, M.J., & Davis, N.O. (2004). Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology and Psychiatry, 45*(1), 109-134.
- Cohen, J., Onunaku, N., Clothier, S., & Poppe, J. (2005). *Helping Young Children Succeed: Strategies to promote early childhood social and emotional development*. Zero to Three Early Childhood Research and Policy Report.
- Council for Professional Recognition. (2005). The Child Development Associate National Credentialing Program: Making a difference in the early care and education of young children. Washington, DC. Retrieved July 7, 2006 from www.cdacouncil.org.
- Glascoc, F. P. (2005). Screening for developmental and behavioral problems. *Mental Retardation and Developmental Disabilities Research Reviews, 11*, 173-179.
- Indiana Association for Infant and Toddler Mental Health. (n.d.). Infant mental health curriculum topics: Training guidelines. Indianapolis, Indiana.
- Infant Mental Health (n.d.). *Thinking Anew: The Catharsis of Change*. Indianapolis: Indiana State Department of Health.
- Infant Mental Health Promotion Project. (2002). Competencies for practice in the field of infant mental health. Toronto, Canada.
- Landy, S. & Menna, R. (2006). *Early intervention with multi-risk families: An integrative approach*. New York: Brookes.
- Lieberman, A. & Van Horn, P. (2005). *"Don't hit my mommy!" A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, DC: Zero to Three Press.
- McDonough, S. C. (1999). Interaction guidance: An approach to difficult-to-engage families. In C. Zeanah (Ed.) *Handbook of infant mental health*, (2nd ed.) (pp. 485-493). New York: Guilford.
- Michigan Association for Infant Mental Health. (2003). MI-AIMH Endorsement Competencies. Southgate, MI.
- National Association for the Education of Young Children. (2005). NAEYC Accreditation Performance Criteria. Retrieved July 7, 2006 from

www.naeyc.org.

National Mental Health Association. (2003). *Can't make the grade*. Alexandria, VA: Author. (Retrieved August 9, 2006 from <http://www.nmha.org/cantmakethegrade/report.pdf>).

O'Connor, C. (n.d.). Core competencies in the field of family support. Children's Trust Fund. Retrieved July 7, 2006 from www.wcif.state.wi.us.

Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky & E. Benedek (Eds.). *Textbook of child and adolescent forensic psychiatry*. Washington, DC: American Psychiatric Press.

Perry, D., Kaufmann, R. & Knitzer, J. (2007) *Social and Emotional Health in Early Childhood: Building Bridges between Services and Systems*. Baltimore: Brookes Publishing.

Rolnick, A.J. & Grunewald, R. (2003) Early childhood development: Economic development with a high public return. *Fedgazette*, Federal Reserve Bank, Minneapolis, MN. Retrieved January 18, 2007 from <http://www.minneapolisfed.org/pubs/fedgaz/03-03/earlychild.cfm>

Schore, A. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 7-66.

Shonkoff, J. P. & Phillips, D. A. (Eds.) (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

Tolan, P. H. & Dodge, K. A. (2005). Children's mental health as a primary care and concern: A system for comprehensive support and service. *American Psychologist*, 60(6), 601-614.

Webster-Stratton, C., & Reid, J.M. (2003). The Incredible Years parents, teachers, and child training series: A multi-faceted treatment approach for young children with conduct problems. In A. Kazdin & J. Weisz (Eds.) *Evidenced-based psychotherapies for children and adolescents* (pp. 224-240.). New York: Guilford.

Wisconsin Early Childhood Mental Health Plan. (2004). Retrieved July 17, 2006 from www.wiimh.org/plan.htm.

ZERO TO THREE. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood: Revised edition (DC:0-3 R)*. Washington, DC: ZERO TO THREE Press.

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The State of the
Young Hoosier Child

Environmental Health Report



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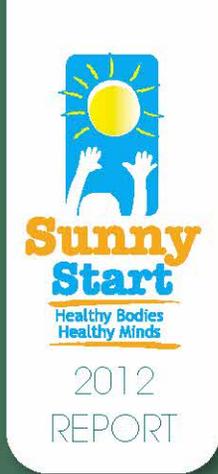
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Indiana Department of Environmental
Management, Office of Compliance Support

Indiana Rural Community Assistance Program
Indiana State Chemist
Indiana State Department of Health, Chronic
Disease Prevention and Control
Indiana State Department of Health,
Environmental Public Health
Indiana State Department of Health,
Lead and Healthy Homes Program
Indiana State Department of Health,
Maternal and Child Health
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and Urban Development

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The State of the Young Hoosier Child

Environmental Health Report

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Chapter 1

Introduction



Introduction

When it comes to the environment and health, children should not be treated as “little adults.” Children face greater harm from environmental threats because they are still growing and developing and they behave differently than adults.

From conception through early childhood, children’s bodies and brains are growing and developing rapidly. For example, the brain reaches four-fifths of its adult size by age 2, but still has not made all the internal connections needed to make sense of the world. The nervous system is still maturing. The immune system has not yet developed fully to protect the child from disease. Children’s inner organs, including their reproductive organs, are also maturing throughout childhood.¹

Because children are growing, their metabolism is higher than an adult’s. On a pound-for-pound basis, children breathe more air, drink more water and eat more food than adults.² For example, an average newborn drinks 2.7 ounces of human milk or formula per pound each day (which would be almost 22 ounces for an 8-pound newborn). A 180-pound adult would have to drink 3.8 gallons (about 40 12-ounce cans) to equal this amount. Compared to adults, infants also have greater skin surface area that absorbs chemicals more readily. Some air pollutants within a room can concentrate near the floor, where children breathe. Therefore, children can face greater harm from polluted or contaminated air, water and food than an adult living in the same home and eating the same food.³

The behavior of infants and small children also exposes them to more chemicals in the environment. Children love to play in dirt and explore the world by putting everything in their mouths. Infants and children spend more time on the floor, carpets and grass, where they might be exposed to bug sprays, weed killers or lead-contaminated dust. Also, children lack the experience and thinking ability to recognize dangers in the environment.⁴ Today’s children spend 80-90 percent of their time indoors, making a healthy indoor environment an important key to children’s overall health.⁵

Links between the Environment and Children’s Health

Extensive studies have documented health problems caused by prenatal and early childhood exposure to environmental toxins.

Scientists believe that the timing of exposure to a chemical can be very important. In the mother’s womb, the developing fetus passes through “critical windows of exposure.”⁶ For example, exposure to mercury or lead during critical periods of brain and nervous system development can lead to mental retardation or life-long learning disabilities. Similar windows exist for the lungs, heart, reproductive system and other organs.⁷

Much more needs to be known about how environmental chemicals contribute to disabilities such as asthma, birth defects, attention deficit/hyperactivity disorder, autism and related diseases. These disabilities can be life-long, affecting a child’s family relationships, the ability to fit into society and future ability to earn a living. A National Children’s Study of 100,000 children from age 0 to 21 is underway to look at environmental exposures that might contribute to these chronic diseases.⁸

Studies of animals and children indicate that small changes in normally occurring hormones and the presence of toxic agents such as lead, mercury or polychlorinated biphenyls (PCBs) can permanently affect the developing brain, nervous system or reproductive system. Such research has been used to improve many children's lives. For example, federal and state laws, regulations and programs to reduce lead in the environment have dramatically reduced lead poisoning among U.S. children since the 1970s. If we understand how environmental factors affect children's health, we can take steps to reduce many more diseases and disorders. We may even prevent some disabilities from holding back a child's full potential.⁹

Researchers are still trying to understand how genes and environmental factors work together to influence the risk of getting a disease or affect its severity or outcome. One child exposed to a toxic substance might end up with life-long disabilities, while another shows little or no harm. Environment, behavior, genetics and diet may all play a role in the development and prevention of disease.¹⁰

It's impossible to completely avoid toxic chemicals in the environment. New technologies, world population growth and appetites for consumer products have led to thousands of new products and chemicals. During the past 50 years, researchers have created more than 80,000 man-made chemical compounds, and many of them are used in common household products with little or no testing for human health effects. Each year, the U.S. Environmental Protection Agency receives 2,000–3,000 new chemicals for review. Of high-volume chemicals now in use, 43 percent have been tested for potential human toxicity, and just 7 percent have been studied for possible effects on child development.¹¹

Even naturally occurring substances, such as lead and mercury, can harm our children. Lead and mercury became a greater threat to children in the 20th century because we unearthed them for use in consumer products, such as leaded gasoline, lead-based paint and mercury-based thermometers, thermostats and electrical switches. Since the 1970s, U.S. environmental laws have helped reduce lead and mercury in these consumer products. Mercury is also found in coal, and is released into the environment when we burn coal to make electricity. Federal regulations adopted in 2011 will reduce mercury emitted by power plants.

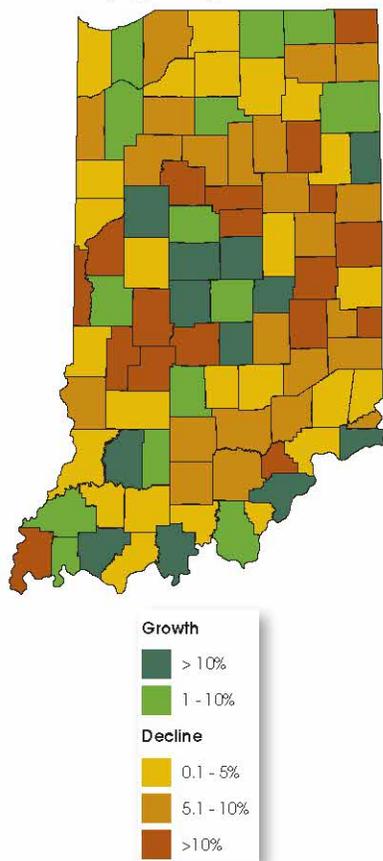
Lead, mercury, herbicides, insecticides, toxic air pollutants, and other harmful chemicals are commonplace in the modern world – easily found in our homes, schools, indoor and outdoor air, and in consumer products we use every day.¹² **This report seeks to document what we know – and don't know – about the environment in which Indiana's young children grow, play and learn. It also seeks to give parents and caregivers advice on how to prevent or reduce common childhood exposures to environmental threats.**

Where Young Hoosier Children Live

According to the 2010 census, there were 434,075 children in Indiana between birth and age 4: 6.7 percent of the state population. Indiana's population of children age 0-4 grew by 2.6 percent between 2000 and 2010.

The environments in which Indiana's young children live are important for policymakers to understand. Much of the growth in the child population from 2000-10 was concentrated in a handful of large metropolitan areas, college communities and counties with large Amish populations. Only 26 of Indiana's 92 counties saw their young child population grow from 2000-2010, as shown in Figure 1-1. Counties in dark and light green saw growth in the number of children in the 0-4 age group, while counties in yellow, orange and red recorded a decline in their young child population. Table 1-1 shows the data for the 10 Indiana counties with the fastest growing young child populations from 2000-2010, and the 10 counties with the fastest decline.

**Figure 1-1:
County Changes
in Child Population
(Age 0-4), 2000-2010**



Source: U.S. Census Bureau

Table 1-1: Indiana Counties Leading in Growth and Decline of Young Child Populations, 2000-2010			
10 Fastest Growing Young Child Populations (Ages 0-4)			
	2000	2010	% Growth
Switzerland County	574	789	37.5
Hendricks County	7,580	10,221	34.8
Hamilton County	16,578	21,609	30.3
Tippecanoe County	8,771	11,030	25.8
Adams County	2,702	3,186	17.9
Daviess County	2,275	2,672	17.5
Hancock County	3,754	4,396	17.1
Boone County	3,354	3,925	17.0
Perry County	1,021	1,152	12.8
Johnson County	8,585	9,625	12.1
10 Fastest Declining Young Child Populations (Ages 0-4)			
	2000	2010	% Decline
Tipton County	1,013	822	-18.9
Rush County	1,245	1,031	-17.2
Blackford County	913	759	-16.9
Randolph County	1,835	1,542	-16.0
Vermillion County	1,050	893	-15.0
Fountain County	1,191	1,017	-14.6
Union County	514	441	-14.2
Steuben County	2,199	1,888	-14.1
Posey County	1,718	1,476	-14.1
Howard County	5,978	5,170	-13.5

Source: <http://www.stats.indiana.edu/topic/census.asp>

In 2010, 54 percent of Indiana's young children lived in just 11 counties (Table 1-2). These counties include Indiana's largest cities (Indianapolis, Fort Wayne, Evansville, and South Bend) as well as Northwest Indiana (Lake-Porter counties), Lafayette-West Lafayette (Tippecanoe), and the largest Indianapolis suburban counties (Hamilton-Hendricks-Johnson).¹³

"Many of Indiana's rural or mid-sized communities are aging rapidly while a few metropolitan areas remain relatively young as they attract young adults and families," said Matt Kinghorn, an analyst with the Indiana Business Research Center at Indiana University's Kelley School of Business.¹⁴

County	2000	2010	% of IN Total
Marion County	63,640	68,160	15.7
Lake County	34,639	33,258	7.7
Allen County	25,440	26,524	6.1
Hamilton County	16,578	21,609	5.0
St. Joseph County	18,673	17,749	4.1
Elkhart County	14,800	16,039	3.7
Vanderburgh County	10,688	11,639	2.7
Tippecanoe County	8,771	11,030	2.5
Hendricks County	7,580	10,221	2.4
Porter County	9,488	9,792	2.3
Johnson County	8,585	9,625	2.2

Source: <http://www.stats.indiana.edu/topic/census.asp>

How This Report is Organized

This report, **The State of the Young Hoosier Child Environmental Health Report**, gathers together a number of indicators of children's environmental health in Indiana. Most of this data has been previously published by various agencies, but never put together in a single report.

Chapter 2 reviews what we know about children's health issues that have an environmental cause or link, including birth defects, preterm and low-birthweight births, lead poisoning and cancer.

Chapter 3 looks at the air children breathe, both indoors and outdoors, and what we know about the quality of Indiana's air.

Chapter 4 looks at the water children drink, swim and play in, and where their caregivers might fish. It takes a look at where drinking water comes from and what we know about the health of Indiana's waterways.

Chapter 5 reviews information about housing and neighborhoods that children live in.

Chapter 6 looks at the quality of Indiana's child care facilities.

Chapter 7 presents key findings and recommendations from the Sunny Start Environmental Committee.

An electronic version of this document is available on-line at sunnystart.in.gov/eh. It includes links to data sources and websites where policymakers, parents and caregivers can find more information.

Sources

- ¹American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 3: Children's Unique Vulnerabilities to Environmental Hazards.
- ²Pediatric Environmental Health 2009, by Rose Goldman, MD, MPH; Michael Shannon, MD, MPH; Alan Woolf, MD, MPH (New England Pediatric Environmental Health Specialty Unit) Accessed at http://www.aoec.org/pehsu/documents/pediatric_environmental_health_goldman_2009.pdf
- ³American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 3: Children's Unique Vulnerabilities to Environmental Hazards.
- ⁴American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 3: Children's Unique Vulnerabilities to Environmental Hazards.
- ⁵American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 5: Taking an Environmental History and Anticipatory Guidance.
- ⁶There is a good summary of existing research into critical windows of development in the June 2000 issue of Environmental Health Perspectives: <http://ehp03.niehs.nih.gov/article/browse/issue.action?issue=info:doi/10.1289/issue.ehp.v108.is3>
- ⁷American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 3: Children's Unique Vulnerabilities to Environmental Hazards.
- ⁸<http://www.ncbi.nlm.nih.gov/pubmed/17079592>
- ⁹Greater Boston Physicians for Social Responsibility. In Harm's Way: Toxic Threats to Child Development, May 2000. Available at <http://www.igc.org/psr/>
- ¹⁰American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 4: Individual Susceptibility To Environmental Toxicants
- ¹¹Perera F, Viswanathan S, Whyatt R, et al. Children's Environmental Health Research—Highlights from the Columbia Center for Children's Environmental Health. Ann NY Acad Sci. 1076: 15-28 (2006). Doi:10.1196/annals.1371.018. Accessed at: <http://onlinelibrary.wiley.com/doi/10.1196/annals.1371.018/pdf>
- ¹²American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011.
- ¹³<http://www.stats.indiana.edu/topic/census.asp>
- ¹⁴<http://newsinfo.iu.edu/news/page/normal/18698.html>





Chapter 2

Indicators of Children's Environmental Health

Introduction

Several indicators can help us draw a picture of children’s environmental health in Indiana. Some childhood illnesses, such as lead poisoning, have a clear environmental cause. Other health problems, such as birth defects or cancer, may carry an increased risk due to environmental exposures. Environmental conditions also can contribute to preterm or low-birthweight babies and asthma attacks that lead to the need for hospitalization.

This chapter looks at several childhood health problems that may have an environmental cause or link: preterm birth, birth defects, low birthweight, lead poisoning, asthma and childhood cancers.

Research identifies many factors that contribute to a child’s environmental health. Illnesses described in this chapter can result from a variety of interrelated factors, including environmental exposure, genetics, diet and social factors, such as poverty and the stress that often comes with it.¹

Also, two children exposed to the same environmental hazard may have very different outcomes. One child may be harmed for life, while the other shows little or no effect. These differences may be due to a child’s age at the time of exposure, size, genetics, diet or the health of their immune system.²

Figure 2-1: Five Most Common Birth Defects per 10,000 Live Births, Indiana, 2004-2008



Source: Indiana State Department of Health (ISDH)

Birth Defects

The Indiana Birth Defects and Problems Registry (IBDPR) collects information to prevent birth defects and improve quality of life. The IBDPR collects information on birth defects and birth problems for all children in Indiana from birth to 3 years old (5 years old for autism and fetal alcohol syndrome). This information is used to determine how many children are born with birth defects, to develop strategies for

preventing them, and to offer resources to families.

For most birth defects, scientists cannot find a single cause. Both genes and environment can play a role, but much is still unknown. One example is hypospadias, a male birth defect in which the urine “exit hole” is on the underside of the penis, instead of its tip. Some studies show a higher rate of hypospadias among boys whose mothers had higher exposure to phthalates, a type of hormone-disrupting chemical. Phthalates are added to some personal care products such as makeup and shampoo, paints, pesticides, and to plastics to make them flexible, transparent, durable or longer-lasting. According to the American Academy of Pediatrics, animal studies have linked exposure to phthalates to fetal malformations, brain

and spinal cord defects and reduced infant growth.³ However, scientists haven't fully studied their effects on humans and the topic remains controversial.

Figure 2-1 shows the five most common birth defects recorded in Indiana from 2004-08. Of these, two are defects of the urinary tract (hypospadias in boys and blockages of the urinary tract). Two others are heart defects (ventricular and atrial septal defects). The fifth, pyloric stenosis, is a narrowing of the opening between the stomach and small intestine.

Birth defects have been linked to some environmental causes, including tobacco smoke, alcohol, certain medications, cocaine, mercury, lead, and exposure to organic solvents, found in such products as paints, varnishes, lacquers, adhesives, glues, and degreasing/cleaning agents.⁴ For example, pregnant women who drink alcohol or sniff glue have a greater risk of having a baby with a birth defect.⁵

A more recent concern is the effect of hormone-disrupting chemicals on children's health. Some laboratory studies have concluded that certain chemicals, such as phthalates, disrupt animal endocrine systems, which regulate hormone levels in the body. Phthalates are used as softeners in PVC and vinyl products, including children's toys, decorating and building products, and a wide range of consumer products, including cosmetics, personal care products, wood finishes and insecticides. Scientists have found strong evidence that hormone-disrupting chemicals have affected the development and fertility of fish and wildlife. There is growing evidence of similar links between environmental exposures and human diseases of the endocrine system; however, full cause-and-effect relationships have not been established yet.⁶

Preterm Births

In Indiana, preterm birth and low birthweight are the leading causes of infant death. A full-term pregnancy lasts 40 weeks. Infants that are born at least three weeks before their due date (earlier than the 37th week) are considered preterm. Preterm babies can have trouble breathing, swallowing and sucking.

They can have heart trouble and are more likely to die of sudden infant death syndrome (SIDS). When they reach school age, preterm children are also more likely to have attention and behavior problems and are more likely to need special education.⁹

From 1999-2008, Indiana's rate of preterm births has been somewhat higher than the U.S. rate (Figure 2-2), though the gap has narrowed in recent years.¹⁰



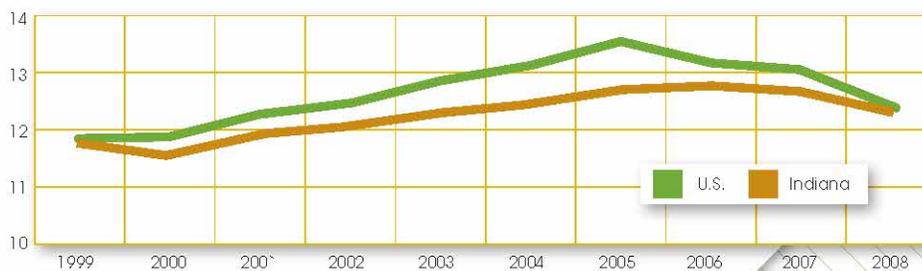
What Families Need to Know

According to the March of Dimes, a woman can reduce the risk of having a child with birth defects by following this advice:

- Avoid drinking alcohol.
- Quit smoking.
- Stay away from cocaine and other illicit drugs and prescription drugs not prescribed for her.
- Fully cook all meat.
- Avoid contact with all rodents, including pet hamsters, mice and guinea pigs, and don't change a cat's litter box.
- Avoid sitting in hot tubs and saunas.
- Avoid hazardous chemicals, such as solvents (substances that dissolve other substances, like paint thinner).
- Avoid eating fish that can be high in mercury, such as shark, swordfish, king mackerel and tilefish.⁷

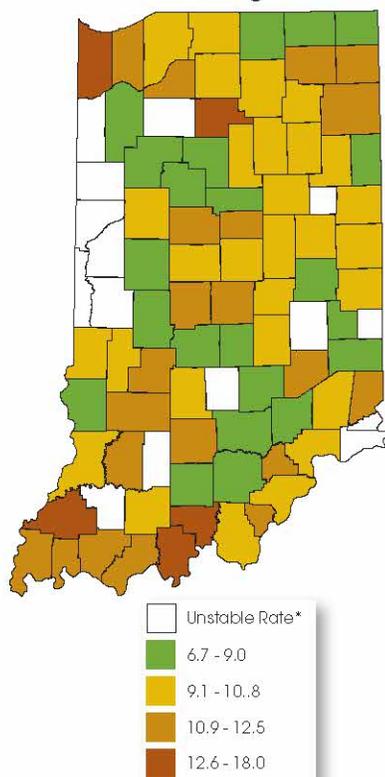
Hoosier women should also limit eating fish caught in some Indiana waters, due to concerns over mercury and PCBs. See the Indiana Fish Consumption Advisory for information about specific fish and waterways.⁸

Figure 2-2: Indiana Preterm Birth Rate, 1999-2008



Source: ISDH Maternal and Child Health Division

**Figure 2-3:
Preterm Birth Rates
by County, 2005-2008
Average**

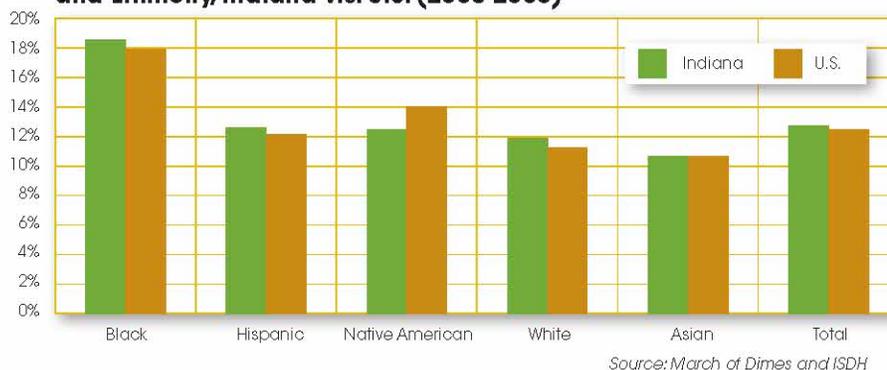


Source: ISDH
* Unstable rate due to fewer than 20 births

Figure 2-3 shows a map of average preterm birth rates from 2003-08 by county, with counties shaded in dark red having the highest rate of preterm births and light green counties having the lowest rates.

At 18.7 percent, black infants had the highest rate of preterm births in Indiana from 2006-08 (Figure 2-4). Indiana's black infants are about 50 percent more likely than white infants to be born preterm.

Figure 2-4: Percent of Preterm Births by Race and Ethnicity, Indiana v.s. U.S. (2006-2008)



What Families Need to Know

According to the March of Dimes, a number of factors put women at greater risk of preterm labor and birth.¹¹ These include:

- Late or no prenatal care
- Smoking
- Drinking alcohol
- Using illegal drugs
- Domestic violence, including physical, sexual or emotional abuse
- Lack of social support
- Stress
- Long working hours with long periods of standing
- Exposure to certain environmental pollutants, such as cigarette smoke, lead, insecticides, rodent poisons, weed killers, alcohols, degreasers, paint thinners and stain and varnish removers
- Exposure to the medication DES, which may affect women born between 1940 and 1971, when DES was used to prevent miscarriage, premature labor and other problems in pregnancy

Avoiding these dangers, including environmental exposures, and providing medical care and support to pregnant women can reduce the risk of preterm birth.

Low Birthweight

Low birthweight babies can be the result of preterm births, but not all low birthweight infants are born before 37 weeks gestation.

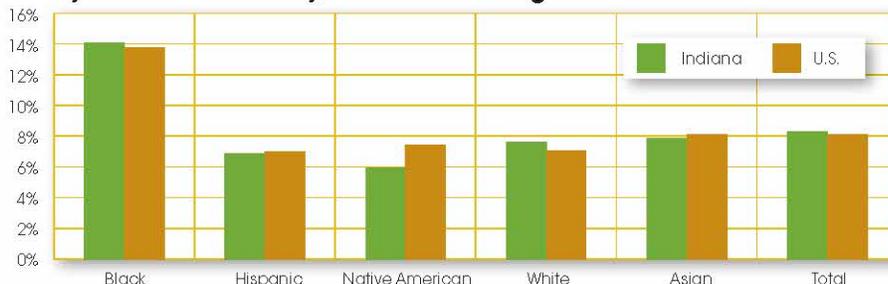
Infants weighing between three pounds, five ounces and five pounds, eight ounces at birth are considered low birthweight. Very low birthweight infants weigh three pounds, four ounces or less at birth. From 2006-2008, 8.4 percent of Indiana babies were born with a low birthweight, and 1.4 percent had a very low birthweight (Figures 2-5 and 2-6). This is comparable to national rates of 8.2 percent and 1.5 percent.

The environment can play a role in a baby’s birthweight. Women who smoke during pregnancy have a much higher chance of delivering a baby with a low birthweight.¹²

Figures 2-5 and 2-6 show that black women in Indiana have the highest rate of infants with low or very low birthweights, and are nearly twice as likely as white women to have low birthweight infants. Among black infants from 2006-08, 14.1 percent were born with a low birthweight and 3.2 percent had a very low birthweight.

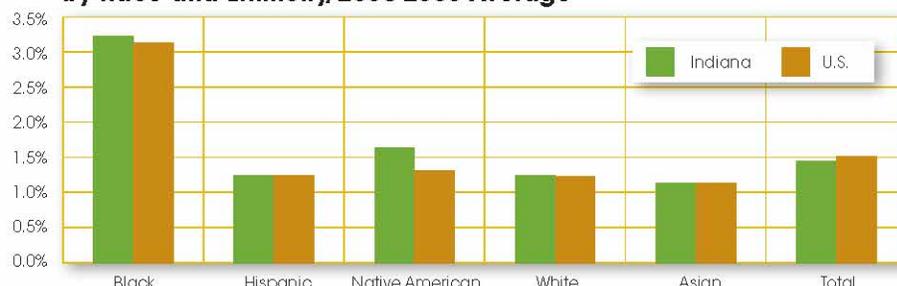
Over time, Indiana’s trends for very low birthweight infants show very little change.

Figure 2-5: Percent of Low Birthweight Babies by Race and Ethnicity, 2006-2008 Average



Source: March of Dimes and ISDH

Figure 2-6: Percent of Very Low Birthweight Babies by Race and Ethnicity, 2006-2008 Average



Source: March of Dimes and ISDH



What Families Need to Know

The most important thing women can do to prevent low birthweight infants is to quit smoking and avoid second-hand smoke during pregnancy.

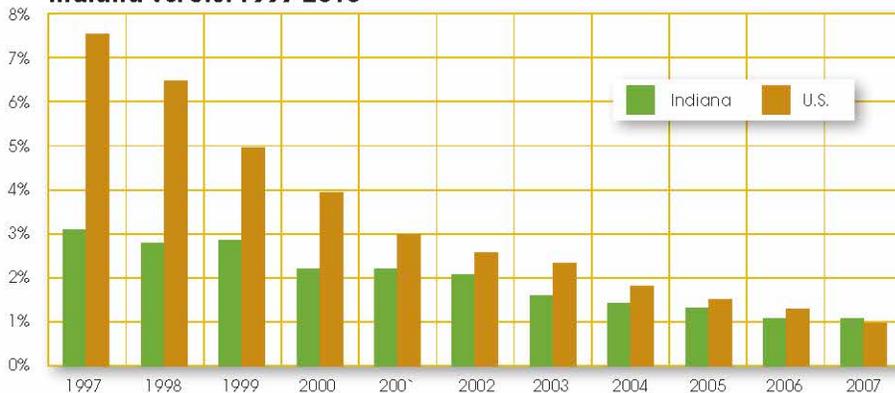
Lead Poisoning

According to the U.S. Centers for Disease Control and Prevention, lead poisoning is the number one preventable environmental cause of illness in children.

Children between the ages of 1 and 3 are at the greatest risk of lead poisoning because their nervous systems are still developing, their bodies absorb more lead than adults, and they use hand-to-mouth activity to explore their world.¹³

When lead enters the brains of children younger than 7, it can disrupt brain development at a time when the young brain is making important connections. The disruption is potentially severe and the damage is permanent. A child who has been lead poisoned can lose 4-7 IQ points, can have trouble paying attention and is more likely to need special education. Later in life, that child is less likely to graduate from high school, more likely to be incarcerated for violent crime and more likely to have a low-wage, low-skill job.^{14,15,16}

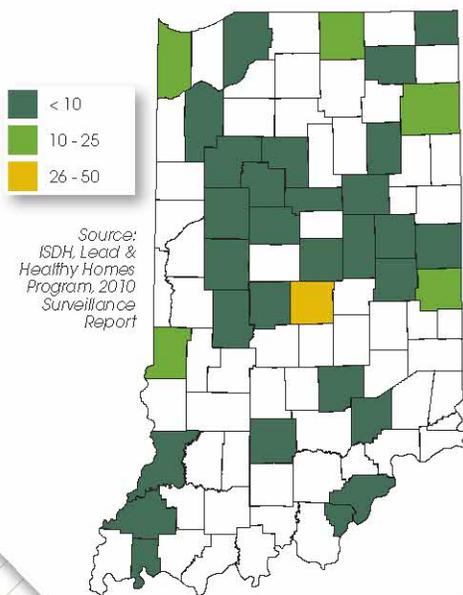
Figure 2-7: Children with Elevated Blood-Lead Levels, Indiana vs. U.S. 1997-2010



Source: ISDH, Lead & Healthy Homes Program, 2010 Surveillance Report

Lead poisoning in Indiana is defined as having 10 micrograms of lead per deciliter of blood. However, no level of lead in a child's blood has been found to be safe.¹⁷ The U.S. Centers for Disease Control in May 2012 lowered its threshold for lead poisoning to 5 micrograms/deciliter. A national expert panel convened in November 2010 by the Centers for Disease Control and Prevention recognized that blood-lead levels as low as 5 micrograms/deciliter are associated with neurological effects in children, reduced

Figure 2-8: Where Lead-Poisoned Children Were Found in Indiana, 2010



Source: ISDH, Lead & Healthy Homes Program, 2010 Surveillance Report

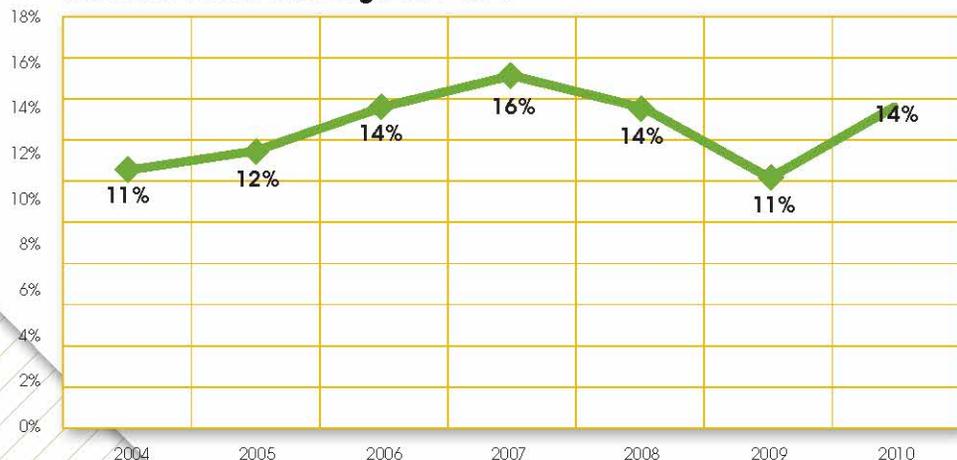
fetal growth and lower birth weight. The CDC's response to the ACCLPP recommendations may be found at [http://www.cdc.gov/nceh/lead/ACCLPP/CDC Response Lead Exposure Recs.pdf](http://www.cdc.gov/nceh/lead/ACCLPP/CDC%20Response%20Lead%20Exposure%20Recs.pdf).¹⁸

Rates of lead poisoning have dropped dramatically since the 1970s, when leaded gasoline and lead paint in housing were banned. Figure 2-7 shows decline since 1997 in the percentage of Indiana and U.S. children with blood-lead levels above 10 micrograms per deciliter. Data for the United States were not available for 2008-10.

Lead-based paint remains the leading source of lead poisoning today. In older homes, deteriorating lead-based paint puts children at risk of inhaling or ingesting lead paint particles. Renovation and repair projects in older homes can generate dangerous lead dust if lead-safe work practices are not followed, as required by federal law.¹⁹

In Indiana, 74 percent of housing units were built prior to 1980 – reflecting nearly 2 million homes that could be carrying lead-based paint. Trends show that lead poisoning is declining in Indiana and nationally (Figure 2-7), but poisoned children are still found at higher rates in counties and neighborhoods with a large percentage of older housing (Figure 2-8). According to ISDH, lead poisoning rates increase when older housing is poorly maintained and paint is allowed to deteriorate.

Figure 2-9: Percent of Medicaid-eligible Children Age 0-7 Tested for Lead Poisoning, 2004-2010



Source: ISDH Maternal and Child Health Division

Unfortunately, we know we are not identifying all Indiana children with lead poisoning because so few of them are screened. Although all Medicaid children are required to be screened at their 12-month and 24-month checkups, just 27.3 percent of Medicaid-eligible children in the 12-to-36-month age group had been screened in 2010. Children enrolled in Medicaid are considered at higher risk for lead poisoning because they often live in substandard housing. Of the Indiana children identified with elevated blood-lead levels in 2010, 63 percent were Medicaid recipients. Figure 2-9 shows lead screening rates for Indiana children age 0-7 who were Medicaid recipients.

Lead poisoning is also more likely to affect children of color. In Indiana, black children and immigrants from Asia are at highest risk (Figures 2-10 and 2-11). Although black children make up only 13.7 percent of Indiana's age 0-7 population, they comprised at least 24 percent of children with known lead poisoning in 2010. Black children are more likely to live in substandard housing and in urban areas, where soil-lead levels tend to be higher.

Higher rates of lead poisoning have been found among Burmese refugee populations living in Allen County. Investigators there found dangerous levels of lead and arsenic in folk medicines used as digestive aids for these Burmese children. For this reason, Asian children made up 22 percent of the known lead poisoning cases in Indiana in 2010, though Asian children represented only 2.2 percent of the state's 0-7 population. However, lead does not discriminate based on race, ethnicity or income status. Any child exposed to lead dust or lead-contaminated products can be poisoned.

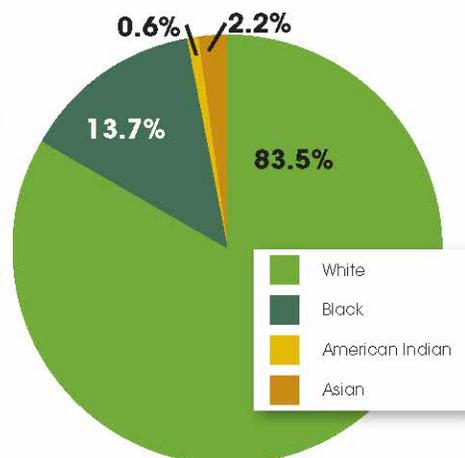


Figure 2-10: Indiana's Children Age 0-7 by Race, 2010

Source: Easy Access to Juvenile Populations: 1990-2010. Available at: <http://www.ojdp.gov/ojstatbb/ezcap/>

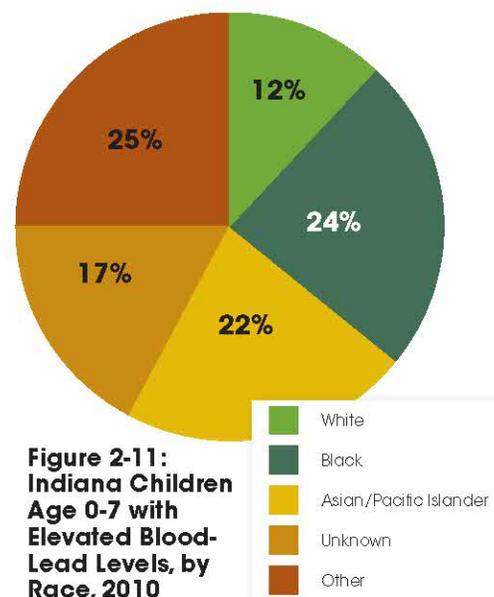


Figure 2-11: Indiana Children Age 0-7 with Elevated Blood-Lead Levels, by Race, 2010

Source: ISDH, Lead & Healthy Homes Program, 2010 Surveillance Report



What Families Need to Know

Families living in older homes and urban neighborhoods can prevent lead poisoning by following these steps:

- Get your young children tested for lead, even if they seem healthy.
- Wash children's hands, bottles, pacifiers, and toys often.
- Make sure children eat healthy, low-fat foods high in iron and calcium, such as dark greens and dairy products.
- Get your home checked for lead hazards. Your local health department may provide this service.
- Regularly clean floors, window sills, and other surfaces.
- Wipe soil off shoes before entering house.
- Talk to your landlord about fixing surfaces with peeling or chipping paint. Keep children away from paint chips.
- Avoid exposure to lead dust when remodeling or renovating (call 1-800-424-LEAD or visit www.leadssafekids.org for guidelines).
- Don't use a belt-sander, propane torch, high temperature heat gun, scraper, or sandpaper on painted surfaces that may contain lead.
- Don't try to remove lead-based paint yourself.

Asthma

Asthma is a chronic disease that affects the airways and lungs, and is the leading cause of hospitalization among children under age 17 in Indiana. The cause of asthma is not known, although researchers suspect a combination of genetic and environmental factors reacting with immune system deficiencies.

Many environmental factors have been identified as triggers for asthma episodes. These include pollen, mold, dust mites, tobacco smoke, household cleaners and air pollution.

According to the National Heart, Lung, and Blood Institute, most children who have asthma develop their first symptoms before 5 years of age. However, asthma in young children can be hard to diagnose. Sometimes it can be difficult to tell whether a child has asthma or another condition, such as a cold or respiratory infection.²⁰

Figure 2-12: Prevalence of Lifetime Asthma Among Children Age 0-4 (2005-2010)

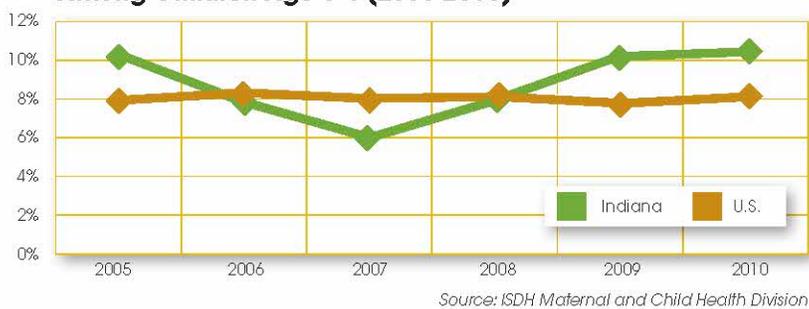


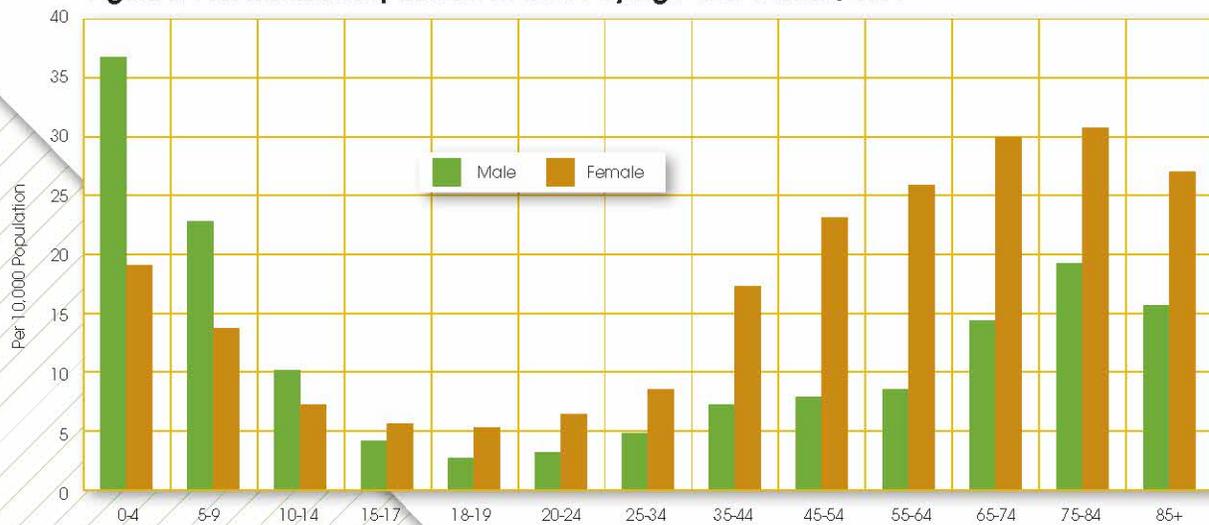
Figure 2-12 shows the percent of Indiana children age 0-4 who have ever been diagnosed with asthma in Indiana, according to an annual telephone survey conducted by the Indiana State Department of Health. Because the survey represents a sample of Indiana’s population, it shows variations from year to year. Since 2007, the percent of children who have been diagnosed with asthma has risen and is now higher than national levels.²¹

Among all children age 0-17, asthma is the third leading cause of hospitalization in Indiana. Nearly 15 percent of children age 0-17 said they had been diagnosed with asthma at some point in their lives. The Indiana State Department of Health has identified children as the number one priority population for reducing the asthma burden.²²

Asthma that is not managed properly can result in visits to the emergency department. Figure 2-14 shows the rate of emergency department visits by age and gender in 2009. Children ages 0-9 visited the emergency department due to asthma more than any other age group. Boys age 0-4 had the highest rates asthma-related emergency department visits.

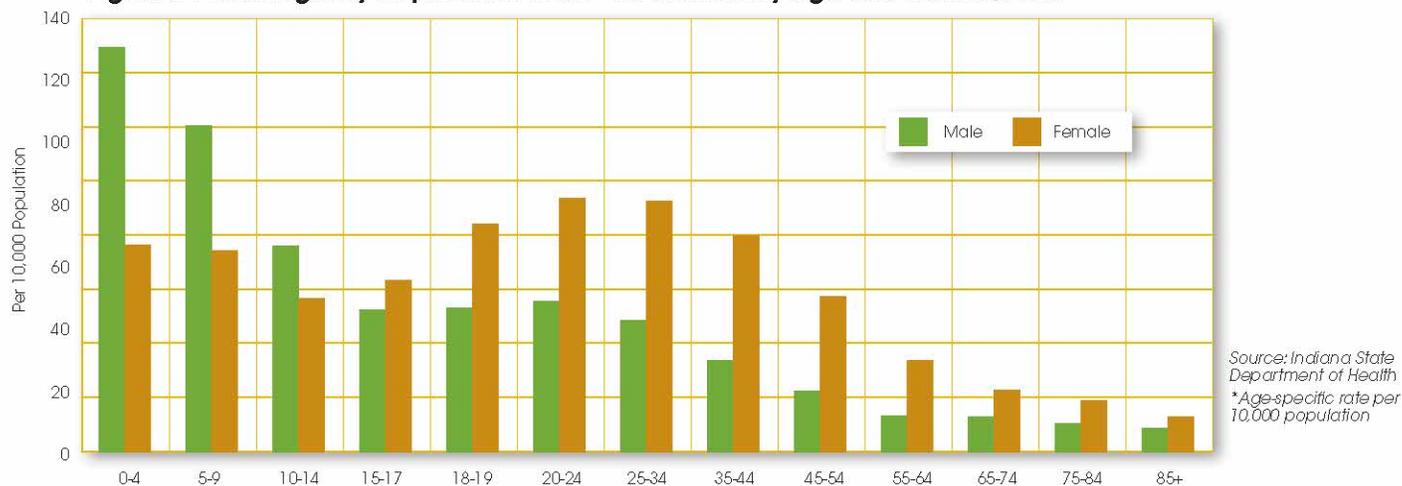
When an asthma attack is severe, sometimes the patient must be admitted to the hospital. Asthma is the third leading cause of hospitalization among children under age 17, and the highest rates of hospitalization are in male children ages 0-4. (Figure 2-13) While asthma-related

Figure 2-13: Asthma Hospitalization Rates by Age and Gender, 2009



Source: Indiana State Department of Health

Figure 2-14: Emergency Department Visits* for Asthma by Age and Gender, 2009

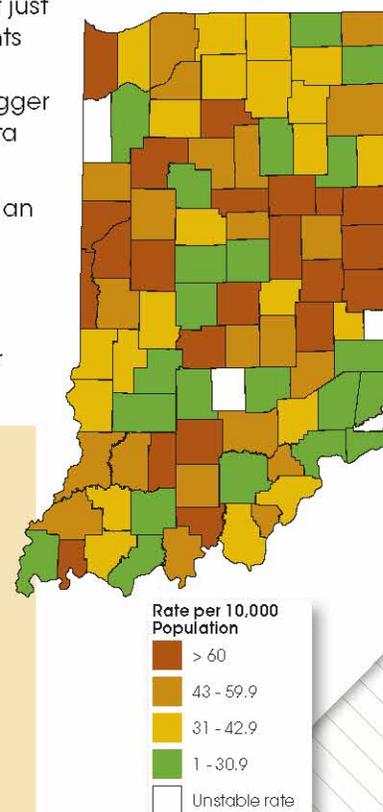


hospitalization rates have been declining nationally since 2007, they have been increasing in Indiana.²³

Asthma-related visits to the emergency department vary by county, as shown in Figure 2-15. The map shows all asthma-related visits for children and adults, not just those by children age 0-4. According to the State Department of Health, patients can reduce asthma attacks and emergency department visits by having an asthma management plan and by reducing things in the environment that trigger their attacks. However, patients may not always have these tools. Although data are not available for children 0-5, among Hoosier adults with asthma in 2007:

- About 69 percent said they had been taught how to recognize early signs of an asthma attack
- Only 33 percent had received an asthma action plan from a health care provider
- Only about 40 percent had been advised to change things at home, work or school to avoid asthma triggers.²⁴

Figure 2-15: Asthma Emergency Department Visits per 10,000 Population by County, 2009



What Families Need to Know

The key to preventing asthma attacks is having good medical care and knowing and avoiding things that trigger an attack. Asthma triggers are different for every child. The American Lung Association offers these tips for parents of children with asthma:

- Secondhand smoke is harmful to everyone, especially children with asthma. Keep your home and car smoke-free, and try to avoid smoky public places.
- Pets with fur and feathers can be an asthma trigger for many people. Think carefully before adding a dog, cat or bird to your household. If you already have a pet like this you may need to make some changes. The child’s bedroom at least should be a pet-free zone.
- Another common trigger for children is exercise. If your child has trouble with sports or other physical activity, talk to your doctor about the possibility of prescribing medicine for use before exercising.
- Keep an eye on the pollen and air quality forecast in your area, and limit the amount of time your child plays outdoors on bad air days. Go to airnow.gov to look up the forecast for your ZIP code each day.
- Remember that children can not always control their own environment, and may need you to advocate for them.²⁵

Figure 2-16: Indiana Childhood Cancer Death Rates, 1985-2010



Source: ISDH Maternal and Child Health Division

3,000 cancer cases for children age 0-19 were reported to Indiana's Cancer Registry.

Childhood Cancer

About 1 in 4,000 Hoosier children age 0-5 are diagnosed each year with some type of cancer. While relatively few children get cancer, cancer causes more childhood deaths than any other disease. The rate of childhood cancer in Indiana has remained stable from 1998 to 2007; however, the cancer death rate has fluctuated. During that time period, nearly

Table 2-1: Indiana Childhood Cancer Rates, 2003-2007

	Age-Specific Cancer Rates per 100,000 Children	
	<1 Year Old	1-4 Years
All Tumors	27.53	22.33
Females	32	21.92
Males	23.28	22.72
Black	23.98	14.15
White	26	23.21

Source: Indiana State Department of Health

Children under age 5 and adolescents between 15 and 19 tended to have more cancers than children ages 5-14. Childhood cancer-related death rates fell between 1987 and 2007, as shown in Figure 2-16. Figure 2-16²⁶ shows cancer rates for all children, ages 0-19, not just young children age 0-5.

Table 2-1 shows the rates of cancer in Indiana from 2003-07 for children under 1 year old and children ages 1-4, based on 100,000 children. This table shows that white children have higher cancer rates than black children – 64 percent higher than black children in the 1-4 age category.



What Families Need to Know

Since scientists don't know what causes childhood cancer, there's no guaranteed way to prevent the disease. However, there are things you can do to reduce children's cancer risks. Health experts recommend avoiding exposure to tobacco smoke, pesticides, solvents and household chemicals during pregnancy and early childhood. To avoid sun damage and skin cancer later in life, always use sunscreen when young children are playing outside.

In 2003-2007, the most common cancer types in Indiana children under age 5 were the leukemias (blood cell cancers), central nervous system tumors, and the neuroblastoma and peripheral nervous system tumors. These are also the most common childhood cancers found nationwide, although the age groups for peak susceptibility show some differences.

The causes of childhood cancer remain largely unknown. According to the National Cancer Institute, many factors contribute to childhood cancer, including genetics, diet, lifestyle, hormones, viruses, and the environment.²⁷ Scientists are conducting a number of studies examining the possible links between childhood cancers and environmental toxins, such as pesticides, solvents, and household chemicals.²⁸

We know that some illnesses and chronic diseases can be prevented by avoiding exposure to environmental threats. The following chapters will look at the environments in which Hoosier children live, learn and play, and environmental threats that might be found there. We can achieve a healthier future for Indiana by working to reduce threats that affect young children and women of child-bearing age.

Sources

- ¹ American Academy of Pediatrics Council on Environmental Health, [Individual Susceptibility to Environmental Toxicants], In: Etzel, RA, ed. Pediatric Environmental Health, 3rd Edition Elk Grove Village, IL: American Academy of Pediatrics; 2012
- ² Ibid.
- ³ American Academy of Pediatrics. Technical Report: Pediatric Exposure and Potential Toxicity of Phthalate Plasticizers. PEDIATRICS Vol. 111 No. 6 June 2003, pp. 1467-1474 Retrieved from: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/6/1467>
- ⁴ Am. Academy of Peds. Pediatric Environmental Health, Chapter 44
- ⁵ Greater Boston Physicians for Social Responsibility, In Harm's Way, 2000. Retrieved from: <http://www.psr.org/chapters/boston/resources/in-harms-way-report-download.html>. In 1962, more than 10,000 babies were born with deformed arms and legs as a consequence of their mothers taking the drug thalidomide. This tragedy led to the creation of the national birth defects registry, which collects information on structural birth defects.
- ⁶ Crisp, Thomas M., et al. Special Report on Environmental Endocrine Disruption: An Effects Assessment and Analysis, Prepared for the Risk Assessment Forum, U.S. Environmental Protection Agency. Retrieved from: <http://www.epa.gov/raf/publications/pdfs/ENDOCRINE.PDF>
- ⁷ Retrieved from March of Dimes website at: http://www.marchofdimes.com/pregnancy/getready_indepth.html
- ⁸ Safe fish eating guidelines can be found at <http://fn.cfs.purdue.edu/fish4health/> or at http://www.in.gov/isdh/files/2010_SafeEatingGuidelines.pdf
- ⁹ Bradburn, Niceta and Kirkpatrick, Debra. Early Births in Indiana: The Incidence and Short and Long-term Consequences - What can we do? Accessed through <http://www.indianaperinatal.org>
- ¹⁰ Preterm birth is the delivery of a live infant prior to 37 weeks gestation. Gestational age is calculated based on the last menstrual period.
- ¹¹ http://www.marchofdimes.com/pregnancy/preterm_indepth.html
- ¹² Child Trends Data Bank. (2010). Low and Very Low Birth Weight Infants. Retrieved from http://www.childtrendsdatabank.org/pdf/57_PDF.pdf
- ¹³ U.S. Environmental Protection Agency, Office of Children's Health Protection, 2003. America's Children and the Environment: Measures of Contaminants, Body Burdens, and Illnesses. EPA 240-R-03-001 http://www.epa.gov/economics/children/publications/ace_2003.pdf
- ¹⁴ U.S. EPA, U.S. HUD and U.S. CPSC, Protect Your Family from Lead in Your Home
- ¹⁵ Greater Boston Physicians for Social Responsibility, In Harm's Way, 2000.
- ¹⁶ Nevin, (2009) Trends in preschool lead exposure, mental retardation, and scholastic achievement: Association or causation? Environmental Research, 109, Pages 301-310.
- ¹⁷ Indiana State Department of Health, Lead and Healthy Homes Program, 2010 Surveillance Report
- ¹⁸ U.S. Department of Health and Human Services: <http://healthfinder.gov/news/newsstory.aspx?Docid=660452>
- ¹⁹ Indiana State Department of Health, Lead and Healthy Homes Program, 2010 Surveillance Report
- ²⁰ National Heart, Lung, and Blood Institute.
<http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/diagnosis.html>
- ²¹ Indiana State Department of Health, Behavioral Risk Factor Surveillance System Survey
- ²² Indiana State Department of Health, 2011 Burden of Asthma in Indiana. Accessed at http://www.in.gov/isdh/files/BR_Asthma_5-11-11gw.pdf
- ²³ Indiana State Department of Health, 2011 Burden of Asthma in Indiana. Accessed at http://www.in.gov/isdh/files/BR_Asthma_5-11-11gw.pdf
- ²⁴ Indiana State Department of Health, 2011 Burden of Asthma in Indiana. Accessed at http://www.in.gov/isdh/files/BR_Asthma_5-11-11gw.pdf
- ²⁵ Retrieved from <http://www.lungusa.org/lung-disease/asthma/living-with-asthma/parents-with-children.html>
- ²⁶ Indiana State Department of Health, Childhood Cancer in Indiana: 1998-2007, Indra N. Frank, M.D., January 2011.
- ²⁷ Ries LAG, Smith MA, Gurney JG, Linet M, Tamra T, Young JL, Bunin GR (eds). Cancer Incidence and Survival among Children and Adolescents: United States SEER Program 1975-1995, National Cancer Institute, SEER Program. NIH Pub. No. 99-4649. Bethesda, MD, 1999. Gloeckler Ries, Lynn, et al. Chapter 1, Introduction.
- ²⁸ National Cancer Institute. Fact Sheet: Childhood Cancers. 2008.
<http://www.cancer.gov/cancertopics/factsheet/Sites-Types/childhood>





Chapter 3

The Air Children Breathe

Introduction

Whether they are indoors or outside, children can breathe in pollutants that can affect their airways and lungs, causing symptoms such as coughing, shortness of breath, and inflammation of the lungs.¹

Breathing unhealthy air can also aggravate conditions such as asthma, bronchitis and lung disease.

Physically, children are more sensitive to air pollution than adults because their lungs are still developing, their airways are narrower, they breathe more rapidly, and – pound for pound – they inhale more air, and therefore pollutants, than adults.²

Because children spend a lot of time indoors where air filtration and ventilation may be poor, they are often exposed to pollution levels 2-5 times greater than outdoor environments.³

Outdoors, children are exposed to more air pollution because they are generally more active than adults. Common sense tells us that a child playing on a playground is breathing in much more air than an adult watching him from a park bench.

Indoor Air Quality

Children spend an estimated 80 to 90 percent of their time indoors at home, school, or child care settings. Therefore, healthy indoor air is vital for a healthy child.⁴ Indoor air pollutants include tobacco smoke, gases from stoves, and gases and vapors from furnishings and construction materials. Home cleaning supplies, insect sprays, air fresheners and candles can also emit gases that affect a child's lungs.

Smoking During Pregnancy

When a mom smokes while she is pregnant, there's a higher risk her baby will have a low birthweight, be born too early, or fall victim to miscarriage or infant death.

Smoking during pregnancy also can impact a child's health and development into adulthood.⁵ Even moms exposed to secondhand smoke during pregnancy are putting their baby at risk. Studies show these babies have lower thinking skills at age 2, compared to children of mothers who lived in smoke-free homes during pregnancy.⁶

Since 1990, prenatal smoking in Indiana has been declining. However, when compared to the rest of the nation, Indiana is falling behind. From 1999 – 2008 smoking during pregnancy declined by 11 percent in Indiana compared to a 21 percent decline in the U.S. (Figure 3-1). Additionally, while Indiana's prenatal smoking rates are declining overall, the State Department of Health says some geographic areas show no significant improvement since 1990.⁷

Figure 3-1: Smoking during Pregnancy: Indiana vs. United States, 1999-2008



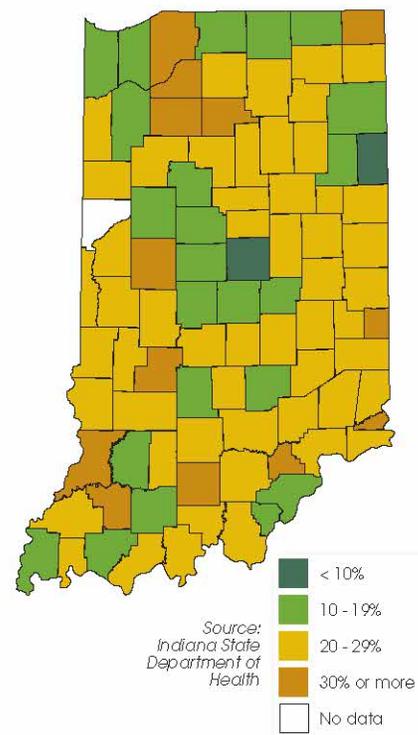
Source: ISDH. Note: Because of changes to birth certificates, 2007-08 tobacco data are not strictly comparable with data from prior years.

**Figure 3-2:
Smoking during
Pregnancy by County,
2008**

Pregnant Women and Smoking by County

In Indiana, the counties with the highest rates of prenatal smoking are primarily in the rural areas (Figure 3-2). In 14 mostly rural counties, more than 30 percent of new mothers said they had used cigarettes while pregnant in 2008:

- Steuben (35.4 percent)
- Ohio (35.1)
- Starke (34.5)
- Crawford (34.4)
- Pike (33.8)
- Scott (33.6)
- Orange (33.5)
- Pulaski (33.5)
- Owen (32.0)
- Union (31.0)
- Fulton (30.9)
- LaPorte (30.9)
- Montgomery (30.7)
- Knox (30.4)



In comparison, fewer women smoke during pregnancy in urban counties. Marion (Indianapolis) was at 15.7 percent, Allen (Fort Wayne) reported 16.5 percent and Lake (part of the Chicago metropolitan area) was at 13.5 percent. The lowest prenatal smoking rate in Indiana was in Hamilton County (4.3 percent).

Additionally, while prenatal smoking rates are lowering across the rest of the state, the rates in rural counties remain unchanged. The Indiana State Department of Health (ISDH) has found that most counties with high smoking rates are rural, located in the southern half of the state, and have shown no significant improvement in their prenatal smoking rates since the early 1990s.⁸

**Pregnant Women and Smoking:
Race and Ethnicity**

White mothers in Indiana are more likely to smoke during pregnancy than black mothers (Figure 3-3).

Non-Hispanic women are also more likely to smoke during pregnancy than Hispanic women (Figure 3-4).

From 1990 to 2004, prenatal smoking in Indiana declined by 32 percent, compared to a 45 percent decline in the national rate. During that time period, the gap between the prenatal smoking rates in Indiana and the U.S. widened, with Indiana being 44 percent above the national rate in 1990 and 77 percent above the national rate by 2004.⁹

Figure 3-3: Smoking during Pregnancy by Race, 1998-2007

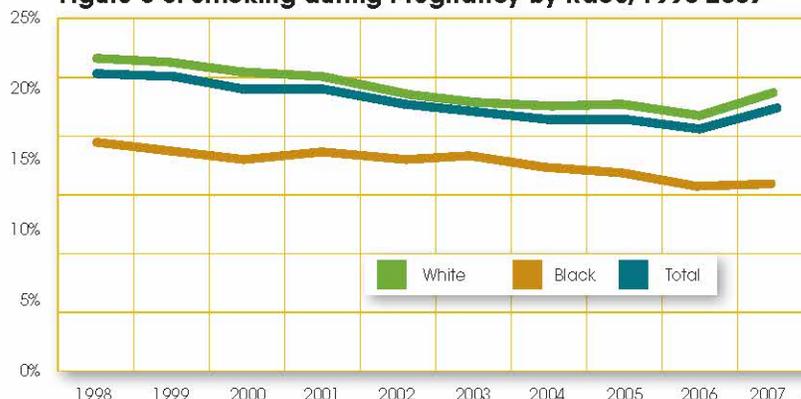
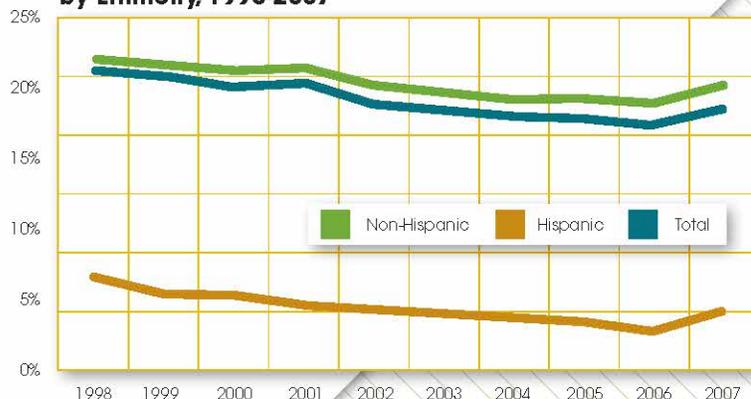


Figure 3-4: Smoking during Pregnancy by Ethnicity, 1998-2007



Source: Indiana State Department of Health, ERC, Data Analysis Team, 2011

Second-Hand Smoke

Second-hand smoke includes both exhaled smoke and smoke released directly from cigarettes, cigars and pipes. It contains more than 4,000 chemical compounds and is known to cause cancer in people.¹⁰

Tobacco smoke is one of the most common sources of indoor air pollution and one of the most important indicators of unhealthy air for children. Children exposed to secondhand smoke have higher rates of pneumonia, bronchitis, fluid behind the eardrum, and sudden infant death syndrome (SIDS). Secondhand smoke can cause children with asthma to experience more severe symptoms and more frequent attacks. Overall, breathing in secondhand smoke during childhood may increase the risk of developing cancer, both in childhood and adulthood.¹¹

According to ISDH, at least 1,426 adults, children and infants in Indiana died in 2008 from diseases definitively tied to secondhand smoke by the US Surgeon General. Secondhand smoke cost Indiana \$1.3 billion in healthcare costs and loss of life.¹²

The adult smoking rate in Indiana is at an historic low of 21.2 percent, but it remains one of the highest adult smoking rates in the nation.¹³ While much progress has been made, 420,000 children in Indiana are still exposed to second-hand smoke at home.¹⁴ According to the American Academy of Pediatrics, in 2009 an estimated 43 percent of U.S. children 2 months to 11 years of age lived in homes with at least one smoker.

Fortunately, an increasing number of homes in Indiana are smoke-free. Between 2002 and 2008, the proportion of households that converted from smoking to smoke-free doubled.¹⁵

Indiana's statewide smoke-free law goes into effect July 1, 2012. It bans smoking in most workplaces, but carves out exceptions for casinos, bars, private clubs, tobacco stores and cigar/hooka bars. Pregnant women working in these establishments will be exposed to secondhand smoke.

Under the new law:

- Children are allowed in nonprofit private clubs and fraternal organizations that vote to allow smoking. However, children must be in an enclosed area with a ventilation system. The organizations must vote every two years to continue to allow smoking.
- Smoking is banned at charity gaming events, such as bingo games at churches and schools.
- Smoking is allowed for at-home businesses, as long as only people who live in the home work at the business.

Smoke-Free Laws

Smoke-free laws make a difference in indoor air quality.

Across three Indiana cities, studies showed fine particles in indoor air fell 94 percent in venues required to be smoke-free compared to those where smoking was permitted. Where smoking was not restricted by law, full-time bar and restaurant employees were exposed on the job to more than seven times the annual limit of fine particulate air pollution recommended by the EPA.

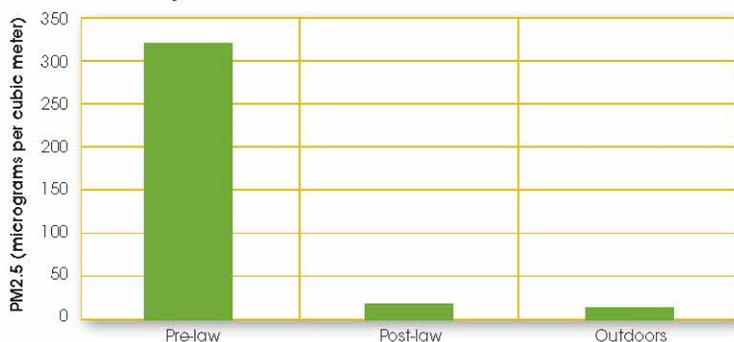
For example, a 2007 smoke-free ordinance in Fort Wayne showed significant improvement in indoor air quality in workplaces that are now smoke-free.

The average level of fine particle indoor air pollution declined 94 percent after the Fort Wayne ordinance went into effect. (Figure 3-5)

Before the law, a full-time employee’s average annual exposure to small particle pollution was more than five times U.S. EPA’s annual limit.

After the smoke-free air law, those same workers were exposed to safe levels of small particles.

Figure 3-5: Indoor Air Pollution Before and After Fort Wayne Smoke-Free Ordinance



Source: ISDH Tobacco Prevention and Cessation: http://www.in.gov/isdh/tpc/files/factsheet_AMstudies_7_6_2011.pdf

Outdoor Air Quality

The quality of the outdoor air children breathe can have an immediate impact on their airways.

Many of the pollutants found in outdoor air cause symptoms such as coughing, shortness of breath, and asthma attacks. Some recent studies show long-term effects of exposure to outdoor air pollution, such as reduced lung growth and chronic lung disease in adults who lived in more polluted areas as a child.¹⁷

Outdoor air pollutants come from sources such as cars and trucks, emissions from power plants and other industrial operations. For some pollutants, such as lead or sulfur dioxide, being closer to the source increases the risk of exposure. Other pollutants, such as ozone, can impact a much wider area. Additionally, the risk of exposure can be influenced by factors such as weather, with greater risks during certain seasons or even at a particular time of day.



What Families Need to Know

According to the American Academy of Pediatrics, you can reduce indoor air pollution by following these steps:

- Do not allow smoking in your home.
- Keep children away from secondhand smoke.
- Have a working carbon monoxide detector on each sleeping level in your home.
- Keep your home dry and promptly fix water leaks to reduce or prevent mold.
- Keep the door between the house and an attached garage tightly closed.
- Have wood stoves and fireplaces checked every year by a professional.
- Do not use gas ovens to heat your home.
- Keep children away from mothballs.
- Avoid using air fresheners.¹⁶

Figure 3-6: Indiana's Air Monitoring Network

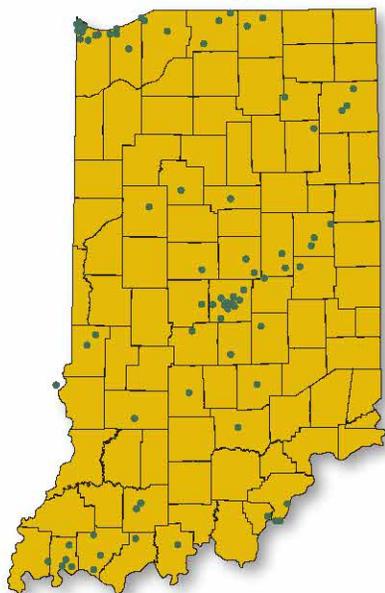
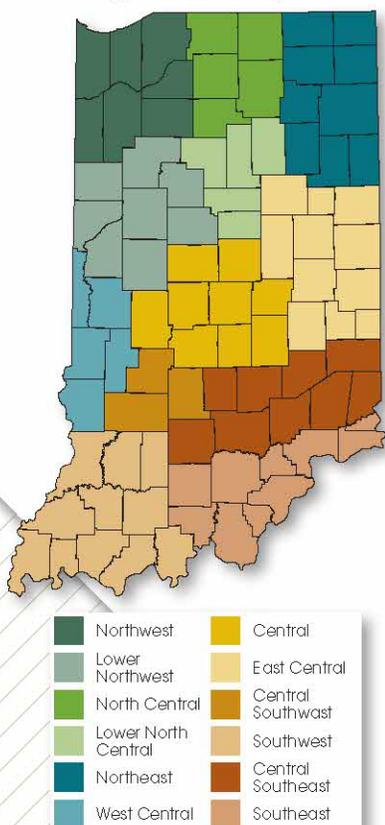


Figure 3-7: Indiana Regional Air Map



Source: Indiana Department of Environmental Management

Indiana's overall air quality has improved and most of the state now meets federal standards for outdoor air quality. Recent research, however, has suggested there may be health effects from outdoor air at pollution levels previously considered "safe."¹⁸ We know there are still some days when Indiana's air is less safe, particularly for sensitive groups such as children, the elderly and those with asthma or other breathing difficulties.

Indiana operates a network of air monitors placed around the state to monitor for different pollutants. Figure 3-6 shows where these monitors are located. Many parts of the state have no monitors. In these areas, the state uses computer programs to estimate pollution levels. For this report, we've used monitoring data in the regions shown in Figure 3-7 to review air quality conditions around Indiana.¹⁹

U.S. EPA's Air Quality Index is used to indicate how clean or polluted the air is. The index uses the colors shown in Table 3-1 to indicate health concerns when authorities issue air pollution forecasts or warnings. Some sensitive groups face greater risk from air pollution. These groups include children, the elderly and people with respiratory disease, such as asthma. You can visit airnow.gov to see an air quality forecast for today and tomorrow in your area, or anywhere in the United States. You also can view real-time air pollution levels at Indiana monitors at in.gov/idem/airfacts/.

Sulfur Dioxide

Sulfur dioxide causes the most frequent problems with meeting current health-based air quality standards in Indiana. Sulfur dioxide, or SO₂, is formed when fuel that contains sulfur (mainly coal and oil) is burned. SO₂ also forms during metal smelting, oil refining, and other industrial processes.

High concentrations of SO₂ can affect breathing, cause lung disease, and aggravate existing cardiovascular diseases. Children, the elderly, and people with asthma, cardiovascular disease, or chronic lung disease (such as bronchitis or emphysema) are most susceptible.²⁰

SO₂ also causes acid rain, which leads to acidification of soils, lakes, and streams and can accelerate damage to trees, crops, buildings, and monuments. In addition, sulfur contributes to fine particles in the air, which is a significant health concern.

The highest concentrations of SO₂ are found near large industrial facilities. Coal-fired power plants account for most SO₂ emissions in Indiana. Many Indiana power plants have reduced SO₂ emissions by using low-sulfur coal and investing in air pollution control equipment, such as scrubbers. However, some older plants have not been improved.

IDEM's monitoring shows that annual measures of the 1-hour sulfur dioxide levels have generally fallen from 2000-2010. However, a number of counties frequently have sulfur dioxide levels considered unhealthy under a new federal standard.

Table 3-1: National Air Quality Index		
"Air Quality Index Levels of Health Concern"	Numerical Value	Meaning
Good	0-50	Air quality is considered satisfactory, and air pollution poses little or no risk.
Moderate	51-100	Air quality is acceptable; however, for some pollutants there may be a moderate health concern for a very small number of people who are unusually sensitive to air pollution.
Unhealthy for Sensitive Groups, including Children	101-150	Members of sensitive groups, such as children and people with asthma, may experience health effects. The general public is not likely to be affected.
Unhealthy	151-200	Everyone may begin to experience health effects; members of sensitive groups may experience more serious health effects.
Very Unhealthy	201-300	Health alert; everyone may experience more serious health effects.
Hazardous	> 300	Health warnings of emergency conditions. The entire population is more likely to be affected.

Source: U.S. Environmental Protection Agency

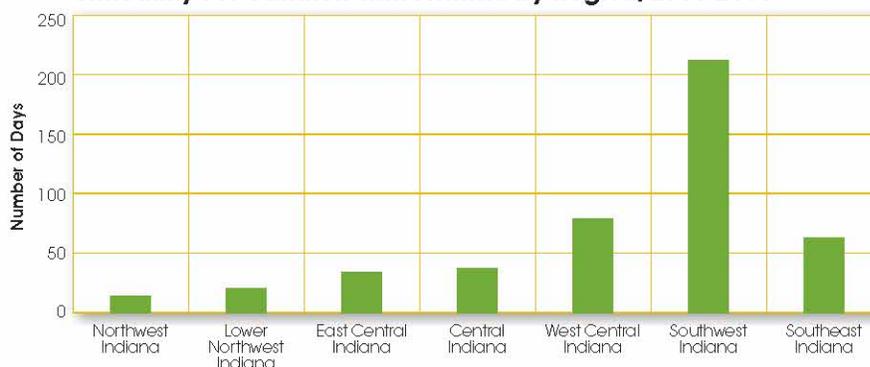
Figure 3-8 shows the number of days in different Indiana regions where SO₂ reached levels considered unhealthy for children and adults with asthma from 2008-10. Southwest Indiana had more than 200 days when SO₂ reached levels considered unhealthy for sensitive groups, and West Central and Southeast Indiana each had more than 50. These regions also have the highest number of coal-fired power plants in the state.

In 2011, U.S. EPA announced a new health-based 1-hour standard for SO₂ in the air. The revised standard improves public health protection, especially for children, the elderly, and people with asthma, by reducing their exposure to high short-term SO₂ concentrations. The Indiana Department of Environmental Management (IDEM) predicts that portions of seven Indiana counties will not meet this new standard, as shown in Figure 3-9.²¹ Those areas are:

- Wayne Township in Wayne County
- Harrison Township in Vigo County
- Center, Perry and Wayne Townships in Marion County
- Clay and Washington Townships in Morgan County
- Veale Township in Daviess County
- Washington Township in Pike County
- New Albany Township in Floyd County

Areas not meeting the new standard may face stricter air permit requirements and other measures to reduce air pollution. Because SO₂ levels are falling overall due to federal regulations, IDEM says some of these areas may meet the new standard before final decisions are made on nonattainment status.

Figure 3-8: Days with Sulfur Dioxide Values Considered Unhealthy For Children with Asthma by Region, 2008-2010



Source: Indiana Department of Environmental Management

Note: The following regions do not have monitors: North Central, Lower North Central, Northeast, Central Southwest, Central Southeast



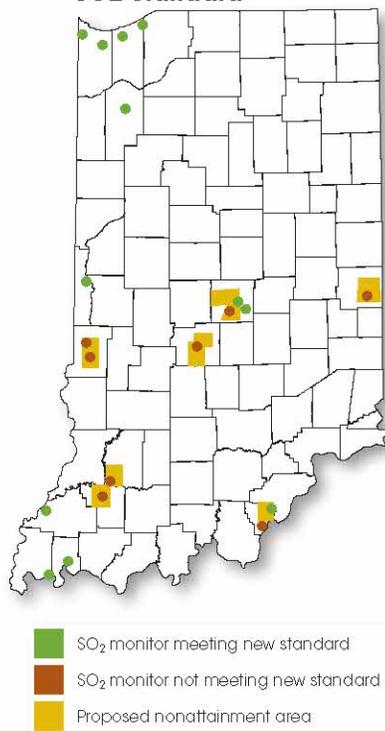
What Families Need to Know

Monitor your local air quality forecast at airnow.gov.

Also, you can reduce air pollution from power plants by:

- Reducing your electricity usage. Visit energizingindiana.com for free help.
- Supporting cleaner forms of energy in Indiana, such as wind and solar.

Figure 3-9 Indiana Areas Not Meeting New Federal SO2 Standard



Source: Indiana Department of Environmental Management

Particle Pollution

Particulate matter includes small pieces of aerosol mists, dust, dirt, and soot found in the air. Some particles are large or dark enough to be seen as soot or smoke. Others are so small they can be detected only with a microscope.

Studies show the smallest particles pose the most serious particle-related health threat because they can be inhaled more deeply into the lungs and are more difficult to exhale. The smallest particles are known as PM_{2.5}. Elevated levels of PM_{2.5} are associated with increased hospital admissions and emergency room visits for heart and lung disease. In children, these tiny particles can aggravate asthma and allergies, reduce lung development and lead to more hospital and doctor visits.²²

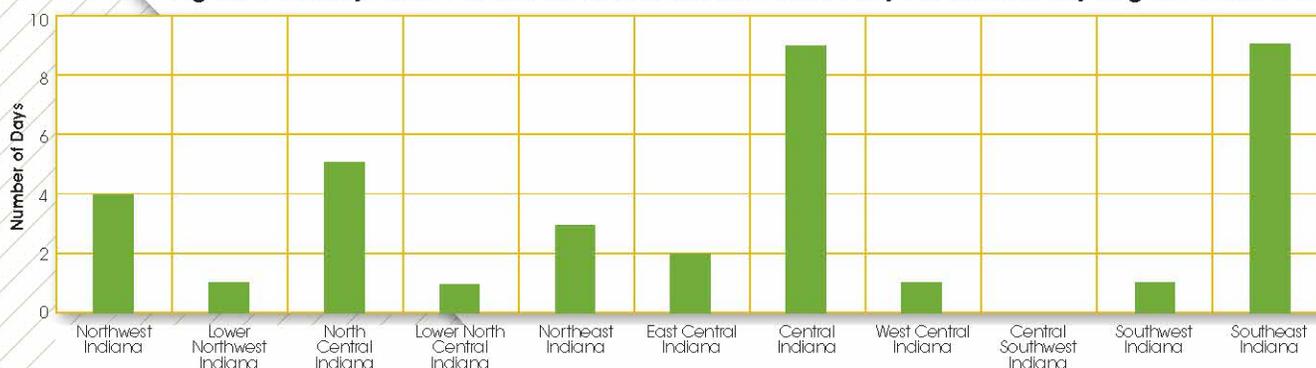
Particle pollution comes from cars, trucks, power plants, fires and wood stoves. Some larger or "coarse" particles are made up of dust that is formed when rock or soil breaks down.

In addition to health problems, elevated levels of PM_{2.5} are the major cause of hazy skies in many parts of the United States. Haze impairs visibility in many scenic overlooks, national parks, and even from tall buildings in urban areas.

Indiana's PM_{2.5} air quality meets federal standards established to protect the health of all citizens, including those in sensitive groups. However, there are times when short-term peaks pose some risk to people with asthma and other heart and lung diseases.

Figure 3-10 shows the number of days from 2008-10 that different regions of Indiana had fine particle levels classified as "unhealthy for sensitive groups." On these days, U.S. EPA advises children and people with respiratory disease, such as asthma, to reduce outdoor activities that cause harder-than-normal breathing. This includes any day in which the highest PM_{2.5} values were above the federal standard. Central Indiana and Southeast Indiana experienced the most days when particulates reached levels considered unhealthy for sensitive groups.

Figure 3-10: Days with PM2.5 Values Classified as Unhealthy For Children by Region, 2008-2010



Ozone

Ozone (or O₃) is a gas that forms in the atmosphere by a chemical reaction between nitrogen oxides (NO_x) and volatile organic compounds (VOC) in the presence of sunlight. Ozone can be good or bad depending on its location in the atmosphere. Ozone in the upper atmosphere provides protection from the sun's radiation. Ozone at ground-level can trigger a variety of health problems. Ozone is an air quality problem in the summer months when temperatures are high, daylight hours are long, and there is little to no wind.

VOCs come from cars and trucks, gasoline, some solvents and cleaners, and paints. NO_x emissions mostly come from the burning of fossil fuels in cars, trucks, power plants, and industrial boilers. Emissions of NO_x from tall sources, such as smokestacks, are more likely than emissions near the ground (e.g. motor vehicles) to travel downwind and increase ozone levels in surrounding areas and even other states.

High levels of ozone can damage lung tissue, reduce lung function, and make the lungs more sensitive to other irritants. When inhaled, ozone can cause acute respiratory problems such as shortness of breath, chest pain, wheezing, coughing, and can aggravate asthma. In addition, breathing air with elevated ozone can impair the body's immune system, making people more susceptible to respiratory illness, including bronchitis and pneumonia. Repeatedly breathing air with elevated ozone for several months may cause permanent structural damage to the lungs.²³

Indiana's ozone air quality meets federal standards established to protect the health of all citizens, including those in sensitive groups. However, there are times when short-term peaks pose some risk to people with asthma and other lung diseases. Figure 3-12 (on the next page) shows the number of days from 2008-2010 when peak ozone reached levels considered unhealthy for children and other sensitive groups. During these times, sensitive children and people with respiratory disease, such as asthma, are advised to limit outdoor activities that cause harder-than-normal breathing. Central, Southwest and Southeast Indiana had the most days when ozone reached levels considered unhealthy for sensitive groups.

 **What Families Need to Know**

Reduce driving and save electricity to reduce air pollution.

Never burn trash and reduce the use of wood-burning stoves and fireplaces.

Monitor your local air quality forecast at airnow.gov.

Figure 3-11: How Ozone Forms in the Air

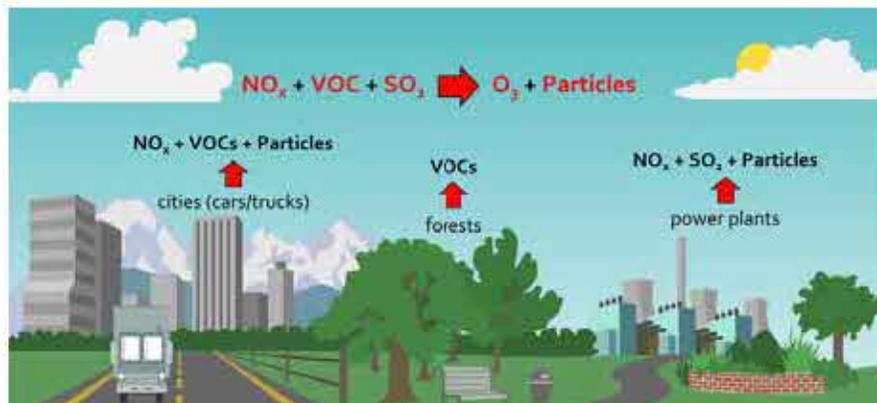
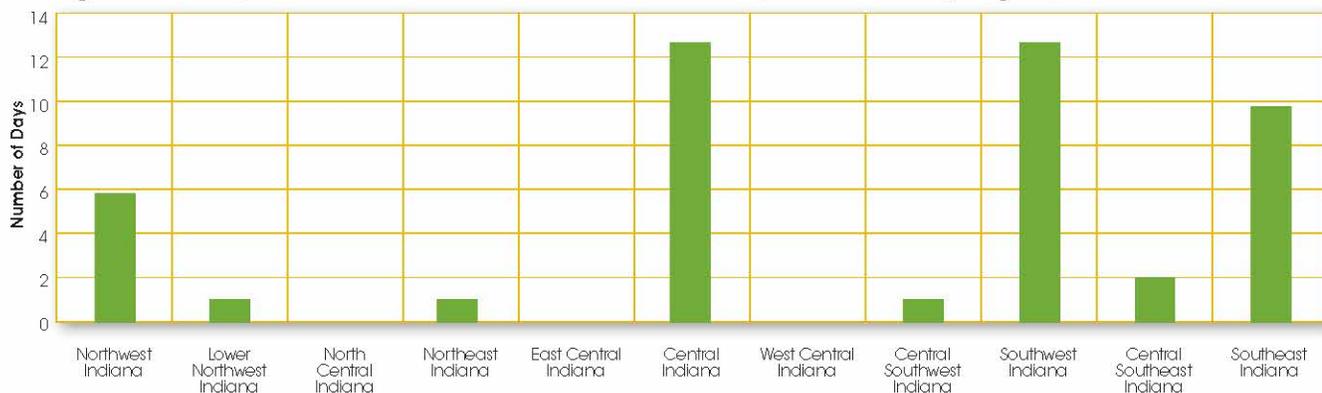


Figure 3-12: Days with Ozone Values Considered Unhealthy for Children by Region, 2008-2010



Source: Indiana Department of Environmental Management
 Note: The following region does not have an ozone monitor: Lower North Central



What Families Need to Know

Check the ozone levels in your area at airnow.gov. U.S. EPA recommends that children should limit outdoor activities that cause harder-than-normal breathing when the ozone Air Quality Index levels exceed 100.²⁶

Help reduce ozone pollution by taking action on Ozone Action Days: Drive your car less or not at all. Never leave your engine running when the car is not moving. Avoid mowing your lawn or filling up your gas tank until after 6 p.m.

While high ozone levels are relatively rare, because ozone forms in hot, sunny weather, anyone who spends a lot of time outdoors during the summer is at some additional risk, particularly children, moderate exercisers, and outdoor workers. Children are at greater risk because their respiratory systems are still developing and are more susceptible to environmental threats. Sensitive people, such as those with existing lung disease, asthma, chronic bronchitis, and emphysema, are at particular risk from high ozone levels.

High levels of ozone also interfere with the ability of plants to produce and store food. Ozone has been shown to reduce agricultural yields for many important crops such as soybeans, kidney beans, corn, wheat, and cotton.²⁴

While harmful ozone concentrations are typically formed in more urban areas, wind can carry ozone pollutants hundreds of miles away from their original sources, putting rural areas at risk.²⁵

Lead

Lead is a toxic metal that is emitted into the air as small particles. As noted earlier in Chapter 2, excessive exposure to lead can cause mental and physical damage, especially to children. Exposure occurs mainly through inhaling lead in the air or ingesting lead in food, water, soil, dust, or paint chips. Even at low doses, lead exposure is associated with damage to the nervous systems of fetuses and young children, resulting in learning problems and lower IQ.

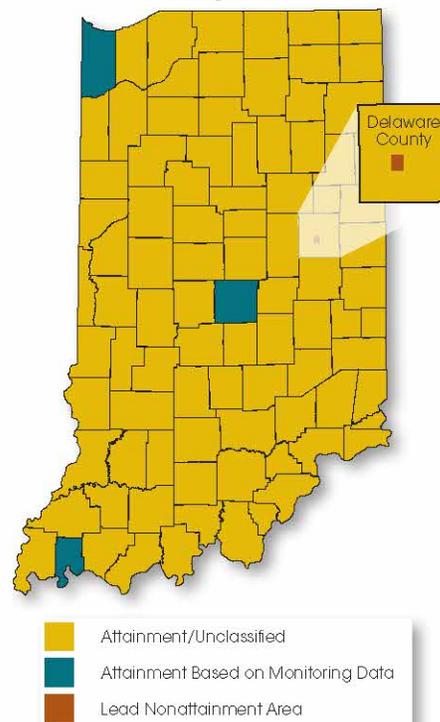
When gasoline had lead in it, cars and trucks were the major source of lead in the atmosphere. Between 1975 and 1986, the U.S. EPA required phasing lead out of gasoline. Since then, the amount of lead released to the air from cars and trucks has declined dramatically. However, lead remains in the soil near roadways, especially in older neighborhoods.

Today, metal processing, which uses lead to manufacture finished products, is one of the major sources of lead emissions in Indiana. The highest concentrations of lead in the air are found around lead smelters. In Indiana, lead smelters recycle material that contains lead and other substances, such as batteries, and processes the raw materials into usable products.²⁷

In 2010, U.S. EPA made the lead standard 10 times more stringent by changing it from 1.5 micrograms per cubic meter to 0.15 micrograms per cubic meter. The only area not meeting the new lead standard for outdoor air in Indiana is an area on Muncie's south side, in Delaware County (Figure 3-13). This area is near a facility that is a large maker and recycler of lead acid batteries. The facility is working to reduce its emissions to bring that neighborhood into compliance with the Clean Air Act.

Lead also remains a concern in soil and dust in and around older housing and along roadways. These issues will be discussed further in the Healthy Housing chapter.

Figure 3-13: Portion of Muncie Not Meeting Lead Standards



Source: Indiana Department of Environmental Management, accessed at http://www.in.gov/ideem/files/nonattain_lead_final_rec.pdf



What Families Need to Know

Don't let children play in bare dirt, especially in urban areas and along roadways.

Learn other ways to protect children from lead poisoning at leadfreekids.org.

Sources

- ¹ American Academy of Pediatrics. Pediatric Environmental Health. 3rd. Edition. 2011.
- ² Children's Environmental Health Network. An Introduction to Children's Environmental Health. http://www.cehn.org/introduction_childrens_environmental_health
- ³ Children's Environmental Health Network. Eco-Healthy Child Care: Air Quality.
- ⁴ American Academy of Pediatrics. Pediatric Environmental Health. 3rd Edition. 2011
- ⁵ Indiana State Department of Health, The State of the Young Hoosier Child. May 2011.
- ⁶ Indiana Youth Institute. Kids Count in Indiana 2010 Data Book.
- ⁷ Indiana State Department of Health. Smoking During Pregnancy in Indiana. 2006.
- ⁸ Indiana State Department of Health. Smoking During Pregnancy in Indiana. October 2006. (Accessed at: http://www.in.gov/isdh/files/Smoking_Report_july2006.pdf)
- ⁹ Indiana State Department of Health. Smoking During Pregnancy in Indiana. 2006.
- ¹⁰ American Academy of Pediatrics. Pediatric Environmental Health. 3rd. Edition. 2011.
- ¹¹ American Academy of Pediatrics. Environmental Tobacco Smoke: A Hazard to Children. 1997.
- ¹² Zollinger, T.; Saywell, R.; Lewis, C. Estimating the Economic Impact of Secondhand Smoke on Indiana in 2010. Bowen Research Center, Department of Family Medicine – IU School of Medicine. Accessed at http://www.in.gov/isdh/tpc/files/ExecSummary_SHS_EconImpact_state_2012.pdf
- ¹³ Campaign for Tobacco-Free Kids. The Toll of Tobacco in Indiana. From: http://www.tobaccofreekids.org/facts_issues/toll_us/indiana
- ¹⁴ Campaign for Tobacco-Free Kids. The Toll of Tobacco in Indiana. From: http://www.tobaccofreekids.org/facts_issues/toll_us/indiana
- ¹⁵ Indiana Tobacco Prevention and Cessation. TEN YEARS AFTER Working Toward A Tobacco Free Indiana. 2010.
- ¹⁶ American Academy of Pediatrics. Pediatric Environmental Health. 3rd. Edition. 2011.
- ¹⁷ American Academy of Pediatrics. Pediatric Environmental Health. 3rd. Edition. 2011. Chapter 21
- ¹⁸ American Academy of Pediatrics. Pediatric Environmental Health. 3rd. Edition. 2011. Chapter 21
- ¹⁹ Indiana Department of Environmental Management, <http://www.in.gov/idem/5342.htm>
- ²⁰ Indiana Department of Environmental Management, Office of Air Quality
- ²¹ See <http://www.in.gov/idem/6686.htm>
- ²² U.S. Environmental Protection Agency, <http://www.epa.gov/air/particlepollution/health.html>
- ²³ Indiana Department of Environmental Management, Office of Air Quality
- ²⁴ Indiana Department of Environmental Management, Office of Air Quality
- ²⁵ US Environmental Protection Agency. Taken from: <http://www.epa.gov/air/ozonepollution>.
- ²⁶ US Environmental Protection Agency. Air Quality Guide for Ozone.
- ²⁷ Indiana Department of Environmental Management, Office of Air Quality





Chapter 4

The Water Children Drink, Bathe & Play In

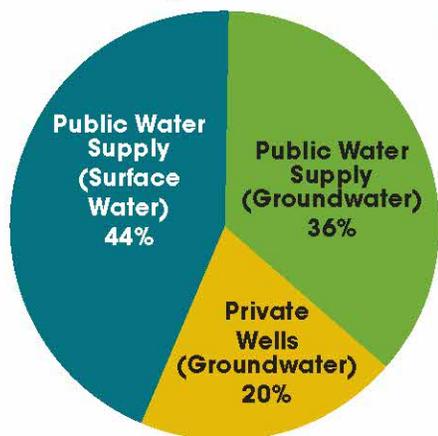
Introduction

Water is an essential part of a child’s health, but it can also present risks for exposure to waterborne illnesses and other pollutants. Because children’s bodies and immune systems are still developing, they are more susceptible to waterborne chemicals that affect learning, motor skills and hormones during important stages of growth. Additionally, children drink more water per pound of body weight than adults do, are more likely to swallow bath water, and more frequently swim and play in public pools and waterways.¹

While federal regulations are designed to ensure safe drinking water and sewage treatment, problems can sometimes occur during severe weather, such as flooding, and during the treatment process, allowing contaminants to enter waterways and the drinking water supply. Swallowing water with bacteria and viruses can cause sudden health effects, such as vomiting and diarrhea.

Children and pregnant women who eat fish from contaminated water can be exposed to toxins such as mercury and PCBs. Public beaches, waterways and pools are also sources of waterborne illnesses and exposure to contaminants. Children face greater risks because they are more likely than adults to swim and play in these areas.²

Figure 4-1: Where Hoosiers Get their Drinking Water, 2010



Source: Indiana Department of Environmental Management

Drinking Water

Public Water Systems

About 5 million Hoosiers (more than 80 percent) get their drinking water from a public water system. These systems are usually operated by a city, town or private water company. Water companies can draw water from either water underground (groundwater) or from surface water in Indiana’s lakes, rivers or streams. Figure 4-1 shows the percent of Indiana’s population served by different types of drinking water systems. Public water must be monitored, tested, and treated to meet drinking water standards.³

According to the Indiana Department of Environmental Management (IDEM), 99 percent of the population served by a community public water system in Indiana drank water that met health standards in 2010. However, about 28 percent of systems – mostly small providers – had violations for not meeting sampling and reporting requirements. Eight percent of systems violated health-based standards.⁴ These systems only serve a small percentage of the population, but ensuring consumers have safe supplies of water is important so each of them was required to correct the problem or supply bottled water to their customers.

More than half of Indiana’s 4,200 public water systems serve less than 100 people. Some of these systems serve small towns, while others are “noncommunity” systems – such as schools, businesses, campgrounds or gas stations that have their own water supply, usually a well. According to IDEM, small systems often face challenges such as lack of funding and management capacity. Drinking water systems require regular maintenance and improvements to prevent problems, as well as knowledge of treatment options to remove contaminants. Problems in communities can include failure to raise funding to meet the cost of service, lack of maintenance schedule, no plan to replace aging equipment, and lack of attention to the water utility.

Because federal rules continue to place additional requirements on these small systems, many need help with the technical, managerial and financial details of ensuring safe drinking water. IDEM helps these small drinking water suppliers by analyzing their capabilities and shortcomings, sending staff to assist them, reminding them of sampling and reporting deadlines, and paying for testing and reporting for small systems that qualify. With more than 4,000 of these small systems, it is difficult for IDEM staff to provide on-site assistance to each one.

Private Wells

About 1 million Hoosiers get their drinking water from private wells. Most rural families rely on untreated groundwater from private wells for their drinking water. Private wells are also still found in cities, isolated suburbs and other communities that haven't fully extended drinking water service to their residents.

Private wells do not have to be monitored and treated, as required for public wells used for drinking water. Any contamination in the groundwater can migrate into a private drinking water well.

According to the U.S. Geological Survey (USGS) and IDEM, groundwater contamination can come from septic systems, fertilizers and pesticides, landfills, salt-storage piles, natural contaminants, underground storage tanks, chemical spills and concentrated animal feedlots. For families with young children in Indiana, the main concerns are pathogens, nitrates, pesticides and natural contaminants such as arsenic.

Pathogens: Pathogens are disease-causing organisms such as bacteria, viruses and parasites that can be found in inadequately treated drinking water. Pathogens can be a very serious concern to families on private wells. Pathogens can come from failed septic systems or from surface water runoff that carries waste from livestock, pets or wildlife.

Pathogens are more likely to contaminate a well if the well is shallow, the well casing is cracked or the well is located too close to a feedlot, septic system, farm field where manure is spread or other pollution sources. Under normal conditions, soil naturally filters pathogens from rainwater and snowmelt before it reaches the groundwater supplying a private well. During heavy rains or flooding, soils cannot keep up and wells can become contaminated rapidly.

Private wells need to be monitored, maintained and located away from potential contamination. If testing finds pathogens, the well must be disinfected immediately. Contact a certified well driller or your local health department for help with disinfection.⁶



What Families Need to Know About Fluoride in Drinking Water

Fluoride has been proven to prevent cavities when taken in small amounts on a regular basis. In the 1960s, the federal government recommended that fluoride be added to drinking water, with the final decision made by each community. In 2008, 95 percent of people served by community water systems in Indiana were getting fluoridated water either naturally or through fluoride additions.

These statistics don't include families on private well water, but some Indiana well water contains natural fluoride. If your drinking water comes from a private well, consider having the well tested to determine how much fluoride is naturally present in the water. Then, ask your dentist if you need fluoride supplements.

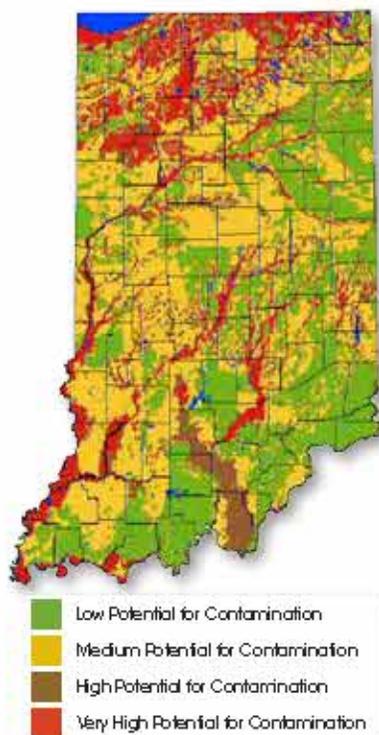
Today, fluoride is available in toothpaste, mouth rinses and other dental products. Because of this, the federal government is lowering its recommended dose of fluoride in drinking water.

While fluoride has proven to be safe and effective, children under 6 have a poor swallowing reflex and tend to swallow much of the toothpaste on their brush. Too much fluoride in children under age 8 can discolor and cause pits in their teeth. To help prevent both tooth decay and excessive fluoride in young children, the Centers for Disease Control and Prevention (CDC) recommends:

- You can use fluoridated water for preparing infant formula. However, if formula with fluoridated water is the only thing your baby drinks, he may be getting too much fluoride that might affect his developing teeth.
- As soon as the first tooth appears, begin cleaning by brushing without toothpaste with a small, soft-bristled toothbrush and plain water after each feeding.
- Begin using toothpaste with fluoride when the child is 2 years old. Use toothpaste with fluoride earlier if your child's doctor or dentist recommends it.
- Do not brush your child's teeth more than 2 times a day with fluoride toothpaste.
- Apply no more than a pea-sized amount of toothpaste to the toothbrush.
- Supervise your child's tooth brushing, encouraging the child to spit out toothpaste rather than swallow it.⁵

Additional information is available on-line: www.cdc.gov/oralhealth/publications/factsheets/brushup.htm.

Figure 4-2: Indiana Groundwater Vulnerable to Nitrates



Source: Purdue University Agricultural Engineering. Accessed at <https://engineering.purdue.edu/SafeWater/drinkfor/nitrate.html>, page 110 of page 116.

Nitrates: Nitrates are a serious concern to families with young children. Nitrates rob the blood of its ability to carry oxygen. Too many nitrates in drinking water can cause blue baby syndrome, a potentially fatal illness. A tell-tale sign of blue baby syndrome is blue-tinted skin, especially in the fingers, toes and lips. Other symptoms include fatigue, low tolerance for exercise, difficulty breathing or eating, and heart murmurs. The child may also fail to gain weight and appear lethargic for no apparent reason.

Nitrates also have been linked to miscarriages. In 1996, the U.S. Centers for Disease Control and Prevention linked high nitrates in well water to six miscarriages in three women in LaGrange County, Ind. The three women became sick from well water polluted by a hog farm, according to the CDC. A fourth woman also miscarried twice, and her well was found to be contaminated with nitrates from a septic system.⁷ Not all studies agree, however. A more recent review suggested that there is not enough evidence to prove a link between nitrates in drinking water and problem pregnancies.⁸

Data collected by IDEM and USGS indicate that about 4 percent of Indiana wells exceed the nitrate standard. Most wells tested safe.

Where do nitrates come from? Groundwater can be contaminated with nitrates from fertilizers, crop residues and animal manure.

Some areas of the state are more vulnerable than others to nitrate pollution. Risks are higher for wells in sandy or gravelly soils, shallow groundwater, shallow or poorly sealed wells, and wells near septic systems, fertilizer and livestock wastes. IDEM monitors nitrates through Indiana's Groundwater Monitoring Network, which includes more than 150 public drinking water wells and 200 residential wells. Nitrate levels that don't meet safe drinking water standards have been found in some parts of the state. Drinking water compliance information for 2011 indicated that 21 public water systems (0.5 percent of all systems) detected nitrate above the federal maximum contaminant level. About 4 percent of wells tested in the ground water monitoring network in 2010 exceeded the drinking water standard.

The map in Figure 4-2 was prepared by Purdue University to identify parts of Indiana vulnerable to nitrate contamination due to these risk factors. Communities and well owners in high-risk areas should take extra precautions to protect wells from contamination. At a minimum, all well water should be tested at least once per year.¹⁰

Arsenic: Arsenic occurs naturally in rocks, soil, water, air, plants and animals. It can also be released into the environment through erosion of rocks and forest fires, or through human actions, such as burning coal containing arsenic. Higher levels of arsenic are more likely to be found in groundwater than surface water. Arsenic can leach out of rock formations and into drinking water wells. IDEM estimates that approximately 10 percent of private wells may have arsenic levels higher than U.S. EPA's maximum contaminant level for safe drinking water.

Exposure to arsenic can cause both short and long-term health effects. Long-term exposure to arsenic has been linked to cancer of the bladder, lungs, skin, kidneys, nasal passages, liver and prostate. Exposure to high levels of arsenic is unlikely from Indiana drinking water, but long-term exposure to lower levels of arsenic can occur. Results of IDEM's groundwater sampling for arsenic can be found on the agency's website (www.in.gov/idem/6762.htm).¹¹ Owners of private wells should have their well water tested for arsenic. Public water supplies are required to routinely test for arsenic and keep arsenic at safe levels.

Pesticides: A pesticide is any substance designed to prevent, kill, repel or control a pest. Pests include insects, mice, rats, weeds, birds, animals or disease that might harm property, cause disease or cause a nuisance. Some examples include weed killers, mice or rat poisons, and insect sprays, powders or baits. Pesticides can serve a useful purpose if used according to directions and only when other control methods have failed. However, it's important to remember that using pesticides as a first solution can be risky, especially for young children.

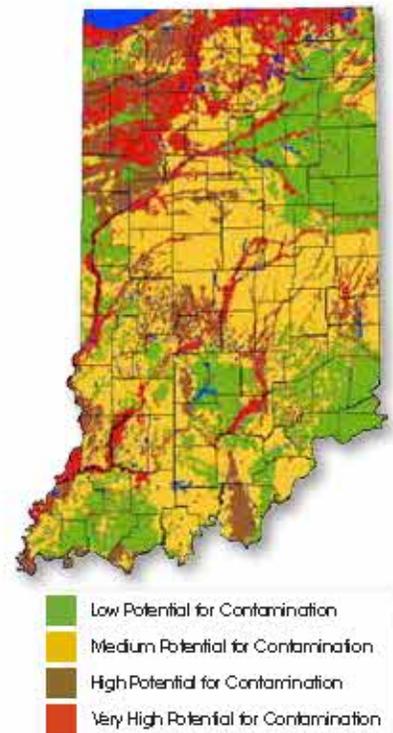
The toxic effects used by some pesticides to kill pests can also harm or kill human beings, if used improperly. Because pesticides are found in food, homes, schools, yards and parks, children are frequently exposed. Children face increased risks if their parents are farmers or farm workers, pesticide applicators, or landscapers or if they live next to agricultural areas. Children and teenagers may work or play in farm fields, where they may be exposed to pesticides.¹² Dogs and cats can also bring pesticides into the home, and pesticide residues can remain on food purchased at the grocery store.

Nearly 70 percent of Indiana's land is devoted to agricultural usage, and nearly 60 percent of Hoosiers rely on groundwater as a water source. From 1984-1992, state and federal agencies collaborated to look for pesticides in groundwater in 82 of Indiana's 92 counties. The agencies took samples from wells used for community drinking water as well as by individual homeowners. At least one pesticide was detected in 11 percent of wells and springs. The most common pesticides found were weed killers, such as alachlor, atrazine, and 2,4-D. Several pesticides were found at levels that exceeded the U.S. Environmental Protection Agency's standards for safe drinking water.¹³

More recently, IDEM monitored 223 Indiana wells for pesticides in 2010. Pesticides were detected in two wells, and in both cases the pesticide was below the federal maximum contaminant level. In 2011, public water systems reported seven pesticide detections (0.6 percent of systems sampling for pesticides) in ground water systems. One of these samples was above the maximum federal level.

As with nitrates, some groundwater is more vulnerable to pesticides. Purdue University has mapped areas in Indiana that are vulnerable to groundwater contamination from pesticides. Groundwater can be more vulnerable to pesticides if the water table is high, soils are porous or ground surface is flat. The map (Figure 4-3) shows that approximately 30 percent of Indiana's groundwater is highly or very highly vulnerable to pesticide contamination. Approximately 80 percent of groundwater pesticide detections in Indiana have been found in these highly or very highly vulnerable areas. The state's Pesticide Management Plan recommended best management practices, restrictions or, in some cases, bans on pesticide use where necessary to protect vulnerable groundwater.¹⁴

Figure 4-3: Indiana Groundwater Vulnerable to Pesticide Contamination



Source: Purdue University Agricultural Engineering. Accessed at http://www.wis.co.purdue.edu/pesticide/omp/omp_summary.pdf page 11 of pdf file.



What Families Need to Know

If you pay a water bill you are served by a public water system. Your water company must notify you when contaminants are in the water that may cause illness or other problems. You should also receive an annual consumer confidence report.

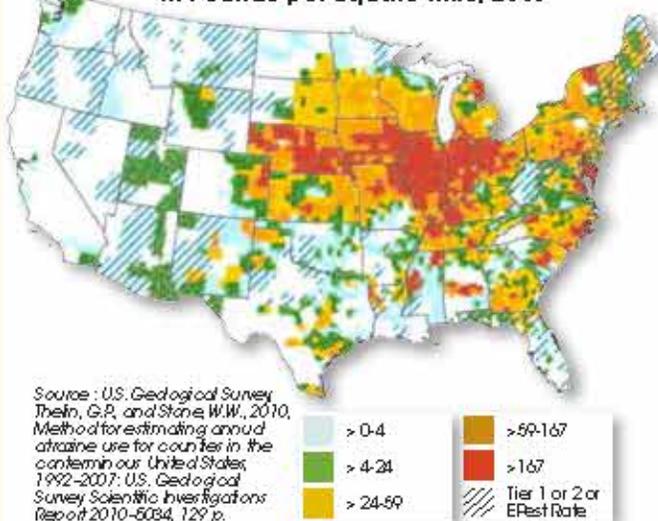
If you get drinking water from a private well, you are responsible for the safety of your drinking water. Contamination can cause blue baby syndrome, hepatitis, dysentery, cancer, or food poisoning.

- If you have a young child, it's important to get your well water tested. If your baby drinks formula, test your well for nitrates before you bring the baby home. Or, use bottled water instead of well water to mix the formula.
- Test your well water for bacteria each year.
- Inspect the condition of your well, making sure there are no cracks in the casing.
- Properly maintain your septic system by having it inspected and pumped every three to five years.
- Be aware of your well's proximity to potential contaminants, such as livestock, crops treated with pesticides, fertilizer used on lawns, and septic systems. Consider testing your well for pesticides if your well is near farm fields or other areas where pesticides are used.
- Have your drinking water tested for lead. Lead can come from older piping and plumbing in your home, or from city water lines in some instances. To reduce lead exposure from pipes in an older home, run your water for 30 seconds before using it for drinking or cooking.
- Contact your local health department or the State Department of Health (317-921-6874) to ask for a water testing kit.

Atrazine in Indiana Water

Atrazine is the most commonly applied herbicide in the United States, according to the U.S. Geological Survey. Approximately 21-27 percent of Indiana's land is planted each year with corn, and more than 85 percent of this area is treated with atrazine to kill weeds.¹⁶ Most atrazine applications in Indiana occur during April and May which coincides with heavy spring rains. When it rains, atrazine moves out of farm fields and into nearby streams and reservoirs.¹⁶ Figure 4-4 shows annual atrazine application by county in the United States in 2007, with the highest amounts applied in the "Corn Belt" states of Indiana, Illinois, Ohio, and Iowa.¹⁷

Figure 4-4: Estimated Atrazine Use on Corn in Pounds per Square Mile, 2007



Source: U.S. Geological Survey, Thelin, G.P., and Stone, W.W., 2010, Method for estimating annual atrazine use for counties in the conterminous United States, 1992-2007; U.S. Geological Survey Scientific Investigations Report 2010-5084, 129 p.

Concerns have been raised about atrazine because it is the most heavily used pesticide in Indiana, is the pesticide most frequently detected in waterways, and some researchers are concerned that it may cause health problems in infants. Purdue researchers studying 19 water systems in Indiana from 1993 to 2007 found that atrazine in drinking water during the third trimester was linked to a 17-19 percent increase in the number of low birthweight babies.¹⁸ Other researchers have found that birth defects are more common in children conceived during the months of April, May, June or July - when pesticide levels in surface water and drinking water are higher. This study did not prove a cause-and-effect relationship, but did raise questions about atrazine and its effects on children's health.¹⁹

Like other farm, garden and lawn chemicals, atrazine finds its way to Indiana's rivers, lakes and reservoirs. According to USGS, atrazine is found at elevated concentrations in both streams and groundwater in agricultural areas in Indiana and throughout the Midwest. The greatest concern is atrazine in drinking water, because pregnant women and infants are most likely to be exposed through drinking water than surface water.

In the 1990s, the federal government became concerned about atrazine found in some Indiana drinking water systems. U.S. EPA set up a special monitoring program in communities with an atrazine history and found the pesticide in 47 percent of finished water samples. Between 1992-2003, eight public water supplies in Indiana were identified with atrazine concentrations that violated federal drinking water standards. These suppliers were required to install new treatment techniques to reduce atrazine levels.²⁰ The last time an Indiana public water system exceeded the atrazine maximum contaminant level was in 2005.

Smaller drinking water systems that use surface water are required to test only quarterly for atrazine, which may not be an ideal schedule since atrazine levels peak during the April-July months and are typically not seen the rest of the year. In 2010, IDEM worked with five small to medium water systems to test more frequently and treat incoming water when atrazine was detected. With IDEM's on-site assistance and free test kits, all five systems avoided any detected atrazine in their finished water.²¹

The Indiana State Chemist has recommended that Indiana farmers make adjustments to reduce atrazine runoff into waterways. For example, they say farmers should establish grass buffer strips along waterways; never mix, load or apply atrazine near a river or lake; and avoid applying atrazine when rain is on its way. Farmers that follow these recommendations can help make Indiana's drinking water safer.

Surface Water: Lakes, Reservoirs, Rivers and Streams

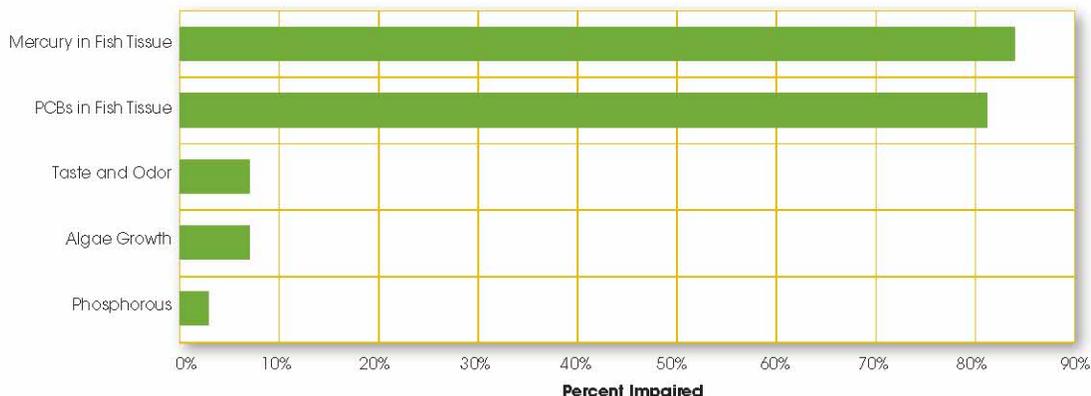
Indiana has a plentiful water supply which includes 35,673 miles of rivers and streams, more than 276,000 acres of lakes, reservoirs and ponds and 59 miles of Great Lakes shoreline.²² These waterways can have an impact on children's health. Water from lakes, rivers and reservoirs is treated and then used for drinking water by about 40 percent of Indiana's population, including people living in Indianapolis and its suburbs, Fort Wayne, Evansville, Muncie, Hammond, East Chicago, Michigan City, Bloomington, Kokomo and several other cities.²³ Young children may also swim or play in Indiana's lakes, reservoirs or small neighborhood streams.

The Indiana Department of Environmental Management is responsible for monitoring the health of Indiana's waterways. Its scientists look for both water chemistry, such as bacteria and chemicals in the water, and the health of fish and other living things that make their home in the water. Indiana's goal is that all waterways should support swimming, safe drinking water, and provide healthy water for fish, wildlife and other water creatures.

Lakes, Reservoirs and Ponds

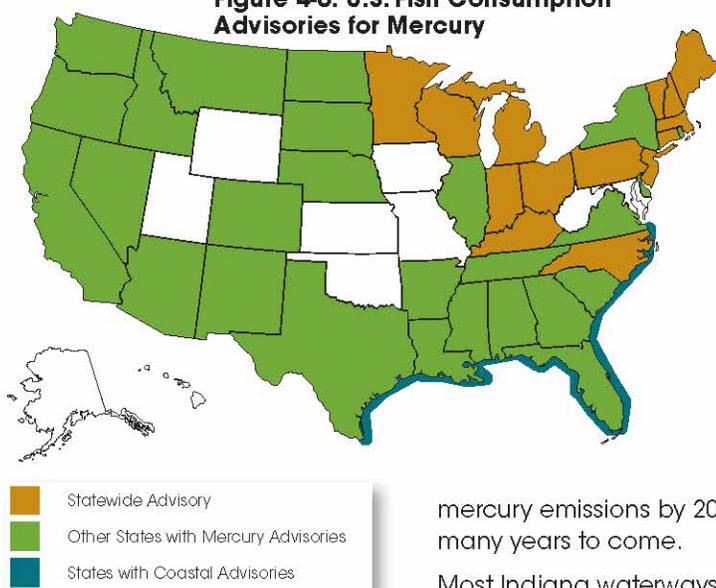
Young children can be exposed to water from lakes, reservoirs and ponds on a day at the beach, while learning how to fish, or when eating fish caught in Indiana waters. Indiana has approximately 1,500 lakes, reservoirs and ponds (approximately 122,303 acres), not including Lake Michigan. IDEM has monitored 198 of these (almost 73,076 acres) and has found 140 of them (72.2 percent) to be impaired. The most common problems are shown in Figure 4-5 (on the next page): mercury and PCBs found in fish that swim in these lakes. Generally, children under 15 and women planning to have children are cautioned not to eat more than one meal of fish per week to avoid mercury exposure. In some waterways and with some type of fish, children and women are cautioned to eat no more than one meal per month or to avoid fish altogether. To find out about the safety of fish in a waterway near you, go to fish4health.net.

Figure 4-5: Top Five Causes of Impairment in Indiana Lakes, Reservoirs and Ponds, 2010



Source: U.S. EPA, Indiana Assessment Data for 2010, accessed at <http://iaspub.epa.gov/waters10/attains.state.report.control?p.state=IN&p.cycle=2010&p.report.type=A>

Figure 4-6: U.S. Fish Consumption Advisories for Mercury



Source: <http://www.epa.gov/cst/fish>

Mercury

Mercury, which damages the brain and nervous system of children in the womb, is found naturally in the environment. IDEM has found mercury in 90 percent of all fish tissues sampled in Indiana waterways. Mercury accumulates as it moves up the food chain. Large sport fish, such as largemouth bass and walleye, have the highest concentrations of mercury. Small minnows and sunfish have very low levels compared to these large predators. The largest source of mercury in Indiana's waterways comes not from a water source, but from human-caused air pollution from power plants and industry.²⁴ New federal regulations will require coal-fired power plants to reduce

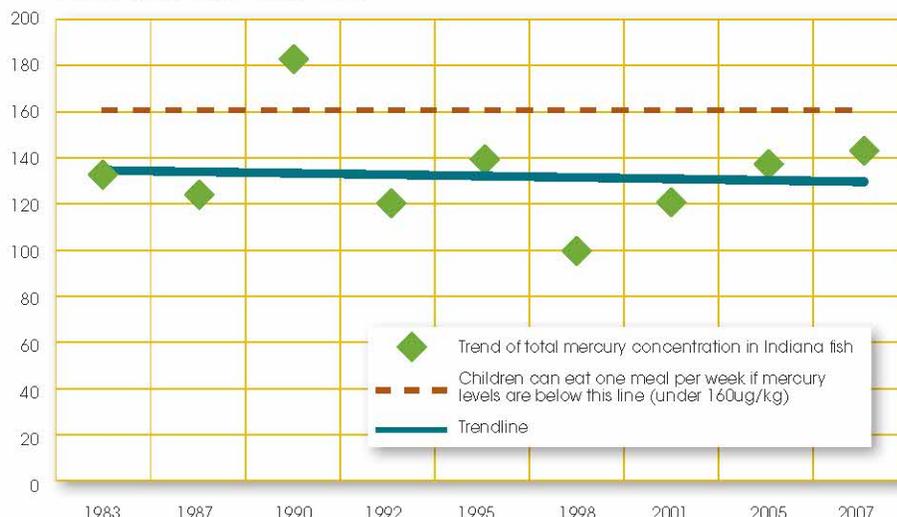
mercury emissions by 2016, but mercury will persist in our environment for many years to come.

Most Indiana waterways are under a fish consumption advisory due to mercury. To view information about a waterway near you, go to IDEM's website at in.gov/idem/nps/3474.htm. This site contains an interactive map allowing you to find whether an Indiana waterway is safe for fishing, swimming or aquatic life. Indiana is not the only state with high mercury levels in fish. Figure 4-6 below shows that most states in the Midwest and Northeast have a statewide advisory for mercury.

A statewide consumption advisory for mercury does not mean that all Indiana fish have high levels of mercury. Statewide advisories are used to communicate the widespread nature of mercury across species of fish and provide health risk information to the general public. Midwestern states have been leaders in collecting data supporting Fish Consumption Advisories and informing the public in a consistent way across the Great Lakes region.

Figure 4-7 shows that average mercury levels in Indiana fish have remained relatively flat since the 1980s, according to data compiled from IDEM sampling results from 1983-2008. The graph shows median concentrations for all fish in all waters. While the median concentration is below the dotted line, that doesn't mean that all fish are safe for children to eat. See the fish consumption advisory to know if a specific fish from an Indiana waterway is safe to eat.

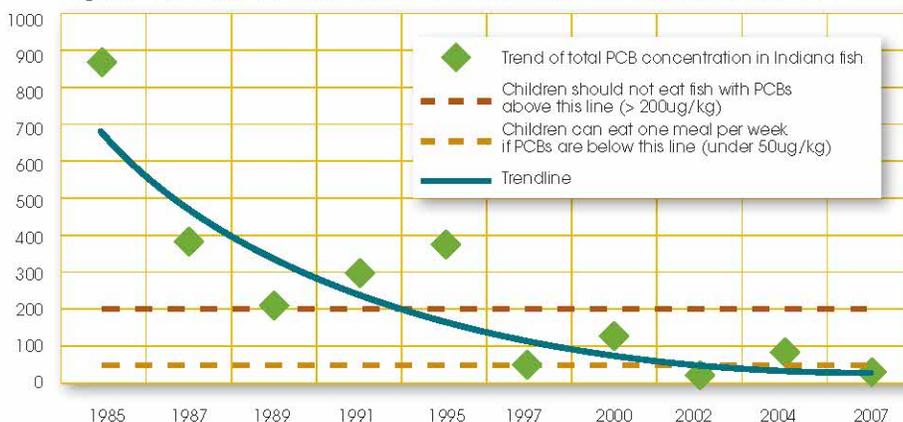
Figure 4-7: Trends of Total Mercury Concentration in Indiana Fish, 1983-2007



PCBs

Unlike mercury, PCBs – polychlorinated biphenyls – are manmade. Polychlorinated biphenyls, or PCBs, were used primarily in the electrical industry as insulators or coolants. They were banned in the 1970's in the United States due to their toxicity, but they persist in the environment today. Studies show that pregnant women exposed to low levels of PCBs had decreased birth weight in their newborns, decreased motor skills in infants and toddlers, and negative effects on short-term memory and IQ scores in young children.²⁵ PCBs are still found in older products, such as fluorescent lighting fixtures, old hydraulic oils and electrical devices using PCB capacitors. PCBs remain persistent in Indiana's fish, but Figure 4-8 shows their levels have been declining since PCBs were banned in 1979.

Figure 4-8: PCB Concentrations in Indiana Fish Tissue, 1986-2008



Source: Indiana Department of Environmental Management

Table 4-1: 2011 Blue-Green Algae Health Alerts

Waterway	"Public Beach or Sampling Location"	High Risk Health Alerts (above 100,000 cells/mL)
Cecil M. Hardin Reservoir	Raccoon Lake State Recreation Area	4
Hardy Lake	Hardy Lake State Recreation Area	4
Lake James	Pokagon State Park	0
Lake Mississinewa	Miami State Recreation Area	0
Long Lake		0
Monroe Reservoir	Paynetown State Recreation Area	4
Monroe Reservoir	Fairfax State Recreation Area	2
Monroe Reservoir	Hardin Ridge U.S. Forest Service Recreation Area	2
Raccoon Lake	Raccoon Lake State Recreation Area	0
Salamonie Reservoir	Lost Bridge West State Recreation Area	2
Sand Lake	Chain 'O Lakes State Park	1
Summit Lake	Summit Lake State Park	0
Whitewater Lake	Whitewater Memorial State Park	1
Worster Lake	Potato Creek State Park	5

Source: Indiana Department of Environmental Management

Algae Growth

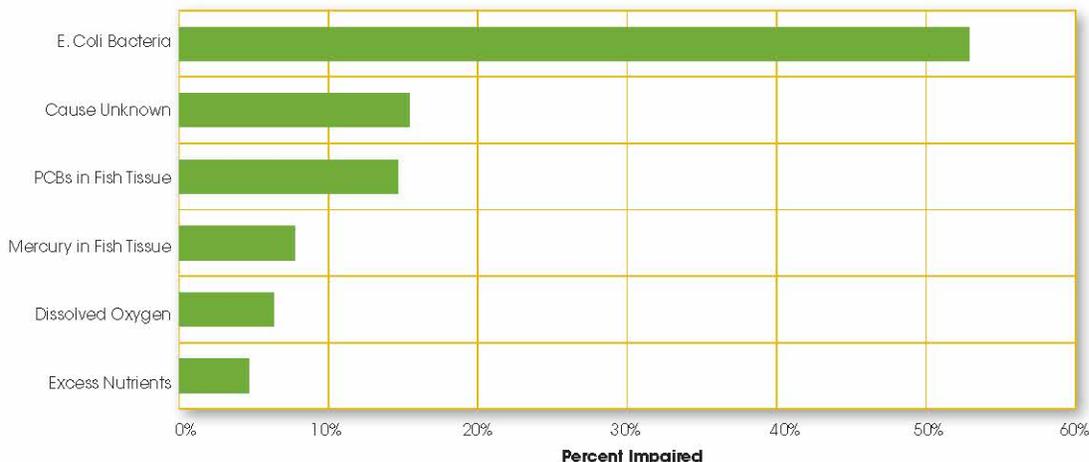
Algae growth is another problem identified in Indiana's lakes, ponds and reservoirs. Algae naturally occur in the water, but large algal blooms can create problems for drinking water and recreation. Algae are fed by warm temperatures and runoff carrying fertilizers or human or animal waste.

A growing concern in Indiana is blue-green algae, which are bacteria that may grow in many types of water. Some species produce toxins that are harmful to humans and animals. Late in the summer of 2007, ISDH issued a health advisory limiting recreational use on Geist Reservoir based on high concentrations of potentially toxic blue-green algae. Blue-green algae are of particular concern when found in reservoirs used for drinking water supply, boating and swimming. While not always visible, blue-green algae can form "blooms" that look like foam, scum or mats of algae on the surface. These blooms are most likely to form in warm, slow-moving waters that contain fertilizer runoff or septic tank overflows.

Exposure to blue-green algae – also known as cyanobacteria – can occur through skin contact, inhaling water droplets and swallowing water that contains blue-green algae. People who swim, wade or water ski in waters affected by some blue-green algal toxins can suffer from rashes, skin or eye irritation, nausea, stomach aches, and tingling in fingers and toes. Other blue-green algal toxins can cause liver poisoning, kidney poisoning, and neurotoxicity. Children swimming or wading in lakes and reservoirs, especially during summer months, face higher risks because they will be exposed to a larger dose of toxin for their body weight.²⁶ IDEM recommends that people wash off after swimming in these waters and avoid areas with heavy concentrations of algae.

During the summer, IDEM monitors blue-green algae levels at swimming beaches at selected state parks and reservoirs. The Indiana State Department of Health recommends a high-risk health alert when levels get above 100,000 cells per milliliter. During the summer of 2011, high-risk alerts were issued at some point for nine beaches (Table 4-1). For more information about blue-green algae in Indiana, visit www.algae.in.gov.

Figure 4-9: Top Six Causes of Impairment - Indiana Rivers and Streams 2010



Rivers and Streams

Of the 28,790 river and stream miles assessed by IDEM as of 2012, 71 percent are considered “impaired” because they don’t meet one or more of the state’s fishable and swimmable goals or they do not adequately support aquatic life.

As shown in Figure 4-9, E.coli bacteria are the most common reason a river or stream is impaired. Other known problems include mercury and PCBs in fish, lack of dissolved oxygen and excess nutrients.

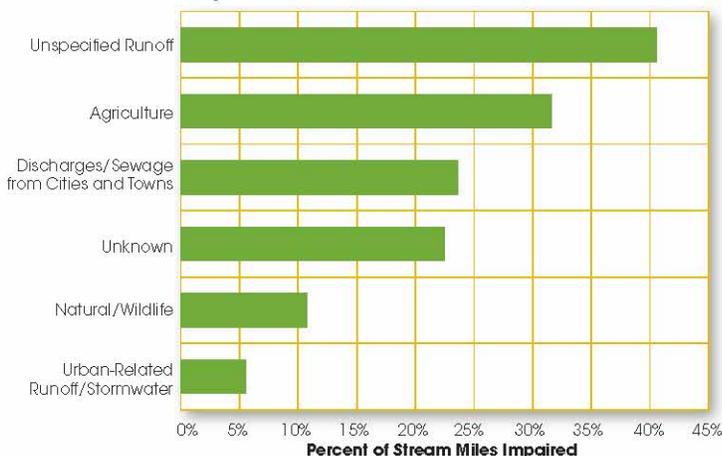
E.coli Bacteria

E.coli provides an indication that water contains untreated human or animal waste.

Human sewage can carry many other pathogens that can cause illness, especially in young children. When rain falls or snow melts, untreated waste may wash into creeks, rivers, streams or lakes. Children can be exposed to E.coli if they swim or play in these waters, or use them as a source of untreated drinking water. Taking in too much of certain strains of E. coli or other pathogens can cause severe diarrhea and stomach cramps. E.coli can also contribute to ear, eye, nose or throat infections. Figure 4-10 shows probable causes of impaired streams in Indiana, including those with elevated bacteria. According to IDEM’s 2010 assessment, the most prominent cause of impaired streams was “unspecified runoff” – rainwater running off the ground and into waterways, followed by agriculture and sewage-related discharges or runoff from cities and towns. Some causes are unknown, while others come from wildlife and other natural sources.

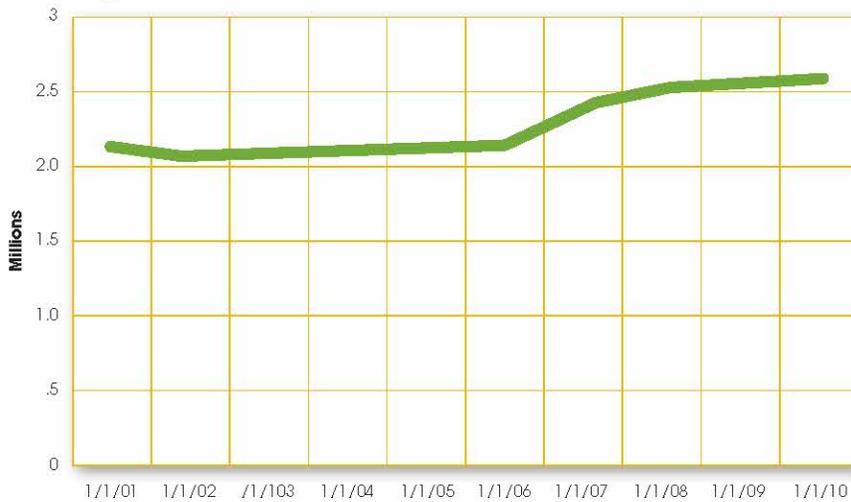
Runoff: Both urban and agricultural runoff can carry bacteria and pathogens into a waterway. Pets and farm animals generate waste, which, if handled or stored improperly, can end up in waterways. Runoff also carries waste from ducks, geese, deer and other wildlife into our waterways. However, there are no good statewide data on pathogens in rainwater runoff throughout Indiana.

Figure 4-10: Probable Causes of Impaired Rivers and Streams, 2010



Source: U.S. EPA, Indiana Assessment Data for 2010, accessed at http://iaspub.epa.gov/waters10/attains_state_report_control?p_state=IN&p_cycle=2010&p_report_type=A

Figure 4-11: Total Animal Units on Regulated Farms in Indiana: 2001-2010



Source: Indiana Department of Environmental Management

Runoff is the most difficult type of water pollution to control, since it comes from virtually every acre of land in Indiana. Some communities are implementing controls that can capture and treat stormwater runoff, or let it percolate into the ground rather than running straight into a waterway. Rain gardens, green roofs, permeable pavement and other “green infrastructure” can be used to slow down runoff and remove pollutants using vegetation, soils and natural processes.

Agriculture: Indiana is a farming state, with 62,000 farms and nearly 15 million acres of farmland covering about 63

percent of the state’s total land area.²⁷ A major pork producing state, Indiana has 3.65 million hogs producing 5 percent of the nation’s pork each year. In the past 50-60 years, farming has changed from small farms raising a few animals of several species to larger farms known as confined feeding operations (CFOs), which generally raise large numbers of a single animal species.

IDEM designates farms as CFOs when they maintain large numbers of animals in buildings, barns or outdoor lots covered with less than 50 percent vegetation. The number of animals is based on species, since this determines the land size and controls needed to safely apply their manure to surrounding fields. CFOs are defined as farms with at least 300 cattle, 600 swine or sheep, or 30,000 poultry.²⁸ Figure 4-11 shows that the number of animals housed in CFOs had risen to more than 2.5 million animal units by January 2010. An “animal unit” is the equivalent of a 1,000 pound cow. It takes 2.5 hogs or 30 laying chickens to equal one animal unit.

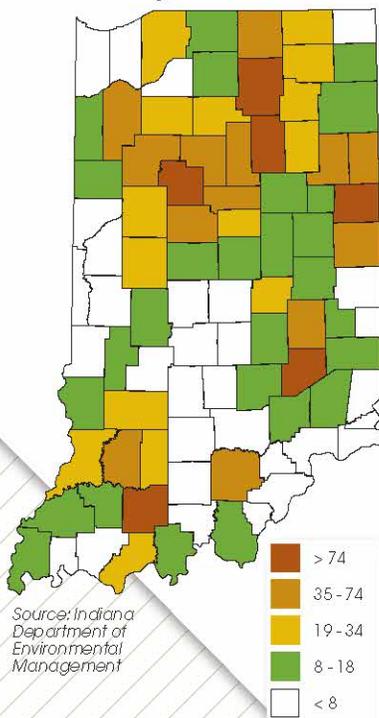
Confined feeding operations collect manure and wastewater and store it in pits, tanks, lagoons and other storage devices. The manure is then applied to area fields as fertilizer. When stored and applied properly, manure can provide a natural source of nutrients for crop production. Improperly operated confined feeding operations, however, can also harm the environment:

- Manure can leak or spill from storage pits, lagoons or tanks
- Improper application of manure to the land can contaminate local rivers and streams and groundwater

New manure application rules for large farms were passed by the Indiana Water Pollution Control Board and go into effect in July 2012. They will restrict land application of manure based on phosphorus limits and land application to frozen or snow-covered ground. Some farms will be required to get individual permits. IDEM data from July 2011 show that most confined feeding operations were concentrated in the north-central region of the state, as shown in Figure 4-12. Counties with 50 or more CFOs in July 2011 were:

Dubois	103	Decatur	75
Carroll	100	Daviess	64
Jay	88	Adams	63
Wabash	80	White	63
Kosciusko	75	Rush	50

Figure 4-12: IDEM Regulated Confined Feeding Farms by County, 2011



Source: Indiana Department of Environmental Management

Some scientists also have raised concern that the routine use of antibiotics in confined animal feed is contributing to the spread of antibiotic-resistant bacteria.²⁹ Antibiotics are fed to animals not just to treat disease, but to prevent disease and promote growth in animals confined closely together. A federal judge ruled in March 2012 that the U.S. Food and Drug Administration must decide whether this practice is a threat to human health and, therefore, should be banned.³⁰ The FDA in April 2012 announced a voluntary initiative to encourage veterinarians and farmers to use certain antibiotics only to control disease and health problems.³¹

Municipal Sewage Discharges: Untreated human sewage carries dangerous pathogens and diseases. One of the great public health advances of the 20th Century was the invention of modern water and sewage treatment, which put an end to cholera, dysentery and other sewage-borne diseases in developed countries throughout the world. Unfortunately, even today in the 21st Century, untreated human sewage enters Indiana's rivers and streams – often because our sewage infrastructure is inadequate, poorly designed or poorly maintained.

Sewer Overflows: More than 100 Indiana communities have systems that transport sewage and storm water through the same pipes. These are called combined sewer systems and were common practice prior to the 1970s. When it rains, combined systems can overflow and release excess storm water and untreated sewage into nearby waterways, known as a combined sewer overflow (CSO). Federal law requires these communities to prepare a plan to control CSO discharges. One hundred five of Indiana's 108 CSO communities have begun implementing such plans, or have a legal agreement with IDEM to do so, and 31 communities have completed projects required to reduce or eliminate combined sewer discharges. Figure 4-13 shows where CSO discharges occur in Indiana, with each dot representing an overflow pipe.

Unlike a combined sewer, a sanitary sewer is designed only to carry sewage, and stormwater is carried in separate pipes. However, many sanitary systems overflow on occasion, particularly during very large storms. Sanitary sewer overflows (SSOs) have a variety of causes, including blockages, broken pipes, sewer defects that allow stormwater and groundwater to overload the system, poor sewer system operation and maintenance, power failures, inadequate sewer design and vandalism. The untreated sewage from these overflows can contaminate waterways or back up into basements, causing property damage and threatening public health.³² Communities are required to report each SSO event, clean up the area, investigate the reasons for the discharge, and take action to prevent them in the future. Due to the nature of SSOs, municipalities find it difficult to report the exact number of gallons released. IDEM has some SSO data available on-line at: www.in.gov/idem/5105.htm

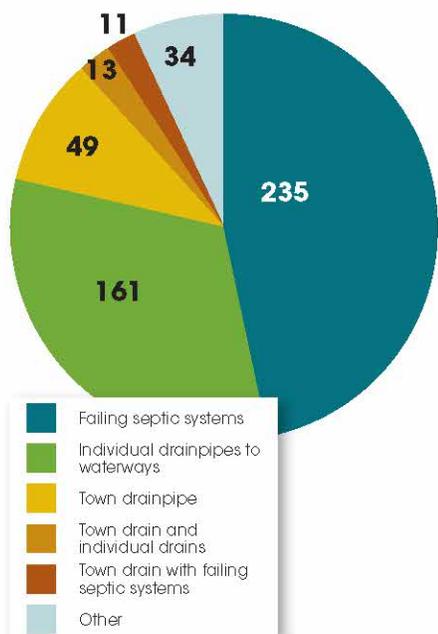
Unsewered Communities: A number of small rural communities rely on either aging individual septic systems or pipes that discharge untreated sewage directly to waterways or drainage ditches. Septic systems are designed to treat sewage from a home or business by letting it percolate through the soil. When septic systems fall into disrepair or reach capacity, the sewage can leak into nearby waterways. In many parts of Indiana, soils are too sandy or full of clay to effectively treat septic system

Figure 4-13: Combined Sewer Discharge Locations in Indiana, 2008



Source: IUPUI Center for Earth and Environmental Science

Figure 4-14: 2011 Survey of Unsewered Communities: Current Sewage Disposal



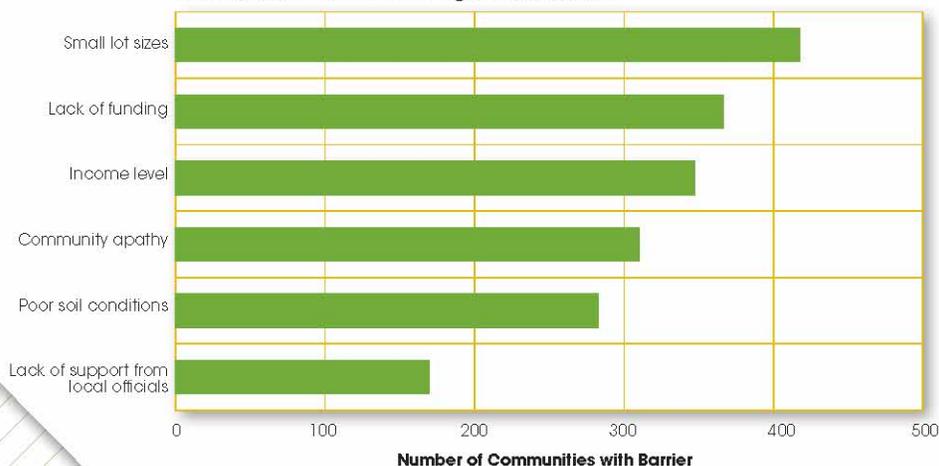
Source: Indiana Rural Community Assistance Program

drainage, and nearby waterways have problems with algae and bacteria. Some individual homes, rural communities and subdivisions have illegal drain pipes that transfer untreated waste directly from septic tanks to a river, lake or drainage ditch.

In 2011, the Indiana State Department of Health and the Indiana Rural Community Assistance Program surveyed county health departments to identify needs of unsewered communities. This survey revealed serious problems in 503 unsewered communities serving more than 47,000 homes and 1,200 businesses. As small as 25 homes and as large as 4,000 homes, these communities include small towns, subdivisions, lakeside communities and other small neighborhoods. Sixty-three percent are in unincorporated areas, although 20 percent fell within incorporated areas or regional sewer districts.

Forty-six percent of these communities had failing septic systems or other failing on-site treatment systems (Figure 4-14). Many are located on poor soils or have lots too small to build a proper septic drainage field. Nearly 15 percent of communities used a "town drain" that discharges untreated sewage directly into a local waterway or ditch, while 35 percent had individual drains from residences or businesses. These pipes are illegal, but still exist due to lack of funding, low incomes and community apathy, according to the survey results (Figure 4-15). Sixty-six percent of these communities get their drinking water from individual wells – wells that, as a result, carry a high risk of contamination with nitrates and bacteria. Often, small lots place drinking water wells too close to the septic system, violating a state rule requiring 50 feet of separation. Fifty-three percent were upstream from an impaired waterway.³³

Figure 4-15: 2011 Survey of Unsewered Communities: Barriers to Better Sewage Treatment



For the most part, unsewered communities are small and poor. Indiana has estimated that 88 percent of its unsewered communities have 200 homes or fewer, and 51 percent have fewer than 50 homes. Ninety percent of Indiana residents in unsewered communities earn a low-to-moderate income, and more than 48 percent qualify as “low-income.” It is difficult for these communities to afford the needed infrastructure to collect and treat their waste. Unsewered, unwatered communities also have no experience financing, owning, and managing such infrastructure, which makes it difficult for them to organize and implement projects. If they do receive grants or loans to build a small treatment plant, they often lack the expertise, funding and staff to maintain them. In the absence of managerial, technical, and financial capacity, such systems fall into disrepair and may fail or default on their loans.³⁴



What Families Need to Know

You can protect your child and your family’s health by taking these steps to protect water quality in Indiana:

- Use lawn and garden fertilizers without phosphorous to prevent algae in our waterways.
- Properly dispose of pet waste, which can contain bacteria, viruses, and parasites, and contaminate the environment.
- Have your septic tank regularly checked and emptied to prevent overflows or leaks.
- Do not feed shorebirds. Feeding shorebirds increases waste along shoreline and can contribute to water contamination.
- Find out which beaches are regularly monitored and have posted advisories. Exposure to polluted water is less likely at regularly monitored beaches.
- In areas not monitored regularly, choose swimming sites in less developed areas with good water circulation.
- Avoid swimming at beaches with visible discharge pipes or at urban beaches after a heavy rainfall.
- Don’t flush medications down the toilet or pour dangerous chemicals down the drain. Take them to safe disposal sites. Look for hazardous waste dropoff sites at www.indianarecycling.org. Find a place to dispose of unwanted medicine at www.in.gov/recycle/6141.htm



For Information about Your Watershed:

You can view statistics and reports about your local waterways on the EPA website:

http://ofmpub.epa.gov/tmdl_waters10/attains_state.report_control?p_state=IN&p_cycle=2010&p_report_type=A

At IDEM’s website, you can also navigate an interactive map showing water quality assessments at Indiana streams and lakes: www.in.gov/idem/nps/3474.htm

Attachment C: Promoting Early Learning and Development Outcomes for Children

Sources

- ¹ EPA Children and Drinking Water Standards: accessed at http://water.epa.gov/learn/kids/drinkingwater/upload/2005_03_10_kids_kidshealth_brochure_childrenstandards.pdf
- ² CDC Healthy Swimming Fast Facts, accessed at http://www.cdc.gov/healthywater/swimming/fast_facts.html
- ³ Learn more about your local drinking water at the U.S. EPA website: <http://water.epa.gov/drink/local/in.cfm>
- ⁴ Indiana Department of Environmental Management, 2010 Annual Compliance Report for Indiana Public Water Supply Systems, June 2011. Accessed at http://www.in.gov/idem/files/annual_compliance_report_2010.pdf
- ⁵ http://www.cdc.gov/fluoridation/fact_sheets/cwf_ga.htm#17
- ⁶ For information on well disinfection see: <https://engineering.purdue.edu/SafeWater/drinkinfo/welldisinfection.pdf>
- ⁷ Spontaneous Abortions Possibly Related to Ingestion of Nitrate-Contaminated Well Water -- LaGrange County, Indiana, 1991-1994. Morbidity and Mortality Weekly Report: July 05, 1996 / 45(26); 569-572. Accessed at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00042839.htm>
- ⁸ <http://www.ncbi.nlm.nih.gov/pubmed/16507452> "Current literature does not provide sufficient evidence of a causal relationship between exposure to nitrates in drinking water and adverse reproductive effects."
- ⁹ To view nitrate sampling results, visit IDEM's website at <http://www.in.gov/idem/6762.htm>
- ¹⁰ Frankenberger, Jane. Nitrate and Groundwater in Indiana: Awareness needed but not alarm. Purdue University, Department of Agricultural Engineering. Accessed at <https://engineering.purdue.edu/SafeWater/drinkinfo/nitrate.html>
- ¹¹ <http://www.in.gov/idem/6762.htm>
- ¹² American Academy of Pediatrics, Children's Environmental Health. 3rd Edition. 2011. Chapter 37: Pesticides.
- ¹³ Risch, M. R. 1994. A Summary of Pesticides in Ground-Water Data Collected by Government Agencies in Indiana, December 1985 to April 1991. U.S. Geological Survey
- ¹⁴ Office of Indiana State Chemist and Seed Commissioner. Ground Water Protection Generic Pesticide Management Plan. Accessed at http://www.isco.purdue.edu/pesticide/pmp/pmp_summary.pdf
- ¹⁵ Ochoa-Acuña H, Frankenberger J, Hahn L, Carbajo C 2009. Drinking-Water Herbicide Exposure in Indiana and Prevalence of Small-for-Gestational-Age and Preterm Delivery. Environ Health Perspect 117:1619-1624. <http://dx.doi.org/10.1289/ehp.0900784>
- ¹⁶ Indiana State Chemist Office, Atrazine and Drinking Water: Understanding The Needs of Farmers and Citizens, Accessed at http://www.isco.purdue.edu/pesticide/pest_pdf/atrazine_and_drinking_water.pdf
- ¹⁷ Thelin, G.P., and Stone, W.W., 2010, Method for estimating annual atrazine use for counties in the conterminous United States, 1992-2007: U.S. Geological Survey Scientific Investigations Report 2010-5034, 129 p.
- ¹⁸ Ochoa-Acuña H, Frankenberger J, Hahn L, Carbajo C 2009. Drinking-Water Herbicide Exposure in Indiana and Prevalence of Small-for-Gestational-Age and Preterm Delivery. Environ Health Perspect 117:1619-1624. <http://dx.doi.org/10.1289/ehp.0900784>
- ¹⁹ Ochoa-Acuña H, Frankenberger J, Hahn L, Carbajo C 2009. Drinking-Water Herbicide Exposure in Indiana and Prevalence of Small-for-Gestational-Age and Preterm Delivery. Environ Health Perspect 117:1619-1624. <http://dx.doi.org/10.1289/ehp.0900784> <http://newsinfo.iu.edu/web/page/normal/10833.html>
- ²⁰ Indiana State Chemist Office, Atrazine and Drinking Water: Understanding The Needs of Farmers and Citizens, Accessed at http://www.isco.purdue.edu/pesticide/pest_pdf/atrazine_and_drinking_water.pdf
- ²¹ Report to the Governor: The Effectiveness of Indiana's Capacity Development Strategy for Existing Public Water Systems, September 2011
- ²² Indiana Water Resources Research Center, <http://www.iwrrc.org/>
- ²³ See if your community gets its drinking water from surface water at <https://engineering.purdue.edu/~frankenb/Indiana/map/#>
- ²⁴ U.S. Geological Survey, Mercury in Indiana Watersheds: Retrospective for 2001-2006 (<http://pubs.usgs.gov/pp/pp1780/>)
- ²⁵ American Academy of Pediatrics. Children's Environmental Health. 3rd Edition. 2011.
- ²⁶ Center for Disease Control. Facts About Cyanobacteria & Cyanobacterial Harmful Algal Blooms. <http://www.cdc.gov/hab/cyanobacteria/default.htm>
- ²⁷ http://www.nass.usda.gov/Statistics_by_State/Ag_Overview/AgOverview_IN.pdf
- ²⁸ <http://www.incontext.indiana.edu/2008/march/1.asp>
- ²⁹ Davies, J and Davies, D. Review: Origins and Evolution of Antibiotic Resistance. Microbiol. Mol. Biol. Rev. September 2010 74:417-433; doi:10.1128/MMBR.00016-10 Accessed at <http://mmlbr.asm.org/content/74/3/417.full#sec-17>
- ³⁰ <http://www.cnn.com/2012/03/23/health/antibiotics-livestock/index.html>
- ³¹ <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm299802.htm>
- ³² http://cfpub.epa.gov/npdcs/home.cfm?program_id=4
- ³³ Indiana Rural Community Assistance Program
- ³⁴ Wallace, Scott; Nivala, Jaime; and Brandt, Ryan. "Unsewered Communities." Onsite Water Treatment: The Journal for Decentralized Wastewater Treatment Solutions, November-December 2006.





Chapter 5

Healthy Housing and Neighborhoods

Introduction

Young children spend 80-90 percent of their time indoors – in their own home, a relative’s home or a child care facility. We think of a child’s home as a safe place, but environmental threats in the home can include lead hazards, mold, secondhand smoke and other indoor air pollutants. A structurally sound, well-maintained home can lead to better health for the children living there.

According to the 2010 U.S. Census, Indiana had nearly 2.8 million housing units, with 10.5 percent of those homes being vacant. This represented an almost 50 percent increase in the amount of vacant homes, compared to 2000. Homeownership is strong in Indiana, with nearly 70 percent of Hoosier housing units occupied by the owner, compared to 65 percent of U.S. homes.

Equally important is the neighborhood where the child’s home is located. Is it healthy and safe? Does the child have safe places to play outdoors, or is he surrounded by abandoned homes, vacant properties and contaminated soil? Green space is also important. Research has demonstrated that exposure to parks, nature and trees can improve a child’s health:

- Pregnant women living in areas with more trees had better birth outcomes;
- Children’s built environments influence their access to nutritious foods and physical activity;
- Children with ADHD who regularly play in natural settings have milder symptoms than children who play in built outdoor and indoor settings;
- Play in natural environments improves kindergarten children’s motor abilities; and
- Street trees may help prevent early childhood asthma.¹

According to the Center for Housing Policy and National Housing Conference, stable, affordable housing may help children succeed in school. For example, well-constructed, maintained, and managed affordable housing can help families address or escape housing-related health hazards, such as lead poisoning and asthma.²

Substandard housing can contribute to student absenteeism, and poorer performance on standardized tests. Poor housing conditions — particularly the persistent presence of cockroaches, pesticides, and mold — can lead to asthma-related absences, even among children whose asthma is mild or moderate. Stable, affordable housing also may reduce a family’s need to move frequently, reducing unwanted moves that can disrupt learning and home life.

Unfortunately, we don’t have comprehensive data on the condition of housing for families with young children in Indiana. A few indicators of housing health are shown in this section of the report.

Lead Hazards

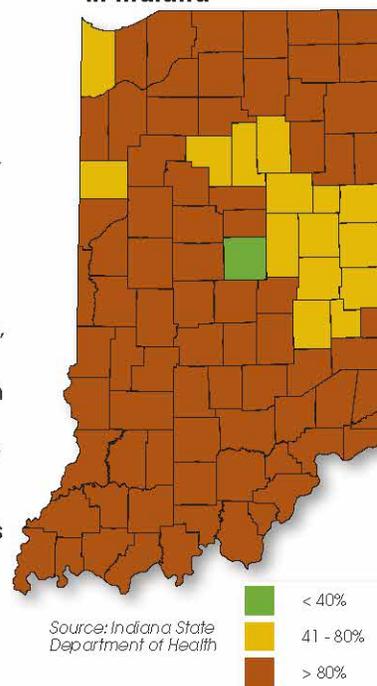
Since lead paint was banned for residential use in 1978, a key risk factor for lead poisoning is housing built prior to 1978. According to the 2009 American Community Survey estimates, 74 percent of Indiana's available housing was built in 1979 or earlier. Figure 5-1 shows the distribution of pre-1980 housing in Indiana by county, according to the 2009 American Community Survey. Only Hamilton County, shown in green, has less than 40 percent of its housing stock built prior to 1980. Eighty-two percent of Indiana's 92 counties have 41-80 percent of their housing stock built before 1980; 16 counties have more than 80 percent pre-1980 housing.

Lead paint in good condition may not pose a risk to children in the home, unless it is disturbed through renovation, damage to the paint or normal wear and tear. Disturbance of lead paint can create lead dust, which can be extremely harmful to a young child. Just a few particles of dust from lead-based paint are enough to poison a child. And the effects could last a lifetime.

- Lead dust can be released when painted surfaces rub together, such as when doors, windows or drawers are opened and closed.
- Home improvements that involve scraping, sanding or otherwise disturbing old paint can release toxic lead dust.

A lead inspection or risk assessment can be used to identify actual or potential lead hazards in a home and provide recommendations to reduce those hazards. Unfortunately, these assessments are typically done only when a child has already been lead-poisoned or when a dwelling receives funding through the U.S. Department of Housing and Urban Development. Under federal law, only a lead-safe certified firm may be used in any renovation, repair or painting project that disturbs more than six square feet of interior surface in a pre-1978 home or child-occupied facility. Contractors performing work that disturbs lead-based paint without proper certification and training could face tens of thousands of dollars in fines.

Figure 5-1: Distribution of Pre-1980 Housing Stock in Indiana



What Families Need to Know

If your home was built before 1978, test your home for lead-based paint and learn about potential lead hazards.

- Keep painted surfaces well-maintained and fix any chipping or peeling paint. Use a lead-safe certified contractor for renovation, repair or painting jobs.
- Keep your home clean and as free of dust as possible – particularly around areas where painted surfaces rub together, such as windows, doors and painted drawers.
- Wipe up any paint chips or visible dust with a wet sponge or rag.
- Hire an EPA lead-safe certified firm before renovating, repairing or painting your home. Find one in your area at www.leadfreekids.org
- If you are a do-it-yourselfer, learn how to work lead-safe at www.epa.gov/lead/pubs/renovaterightbrochure.pdf.
- Wash children's hands, bottles, pacifiers and toys often.
- Teach children to remove their shoes, and wash their hands after playing outdoors.
- Ensure that your family members eat well-balanced meals.³



Statewide Data Not Available

The only widely available data on the condition of Indiana housing is the **American Housing Survey, conducted by the U.S. Department of Housing and Urban Development.** Data for large metropolitan areas are collected through in-person or telephone interviews about every six years. In Indiana, data are only available for the Indianapolis Metropolitan Area, which in 2004 was based on a survey of 4,733 housing units in the nine-county area of Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan and Shelby counties. Data on Indiana's remaining 83 counties are not available, although Dearborn County is surveyed periodically because it belongs to the metropolitan area surrounding Cincinnati, Ohio.

According to the 2004 American Housing Survey, about 14 percent of housing in the 9-county Indianapolis area housed children 6 years old or younger. However, the data presented here represent all housing surveyed in the 9-county Indianapolis area, and not just housing where young children live.

Housing Stock

Health is not simply the result of a doctor's visit, but instead begins in children's families, schools, playgrounds, parks, the air they breathe, and the water they drink. Scientists have found that the conditions in which Americans live and work have an enormous impact on our health. Unfortunately, low-income communities are isolated and self-contained on all three levels—physical, psychological, and social. They are often physically isolated in locations that lack resources necessary to live a healthy life.⁴

Poor housing conditions have been associated with poor growth and development in both children and adults. Housing insecurity – defined by crowding or multiple moves during the previous year – is associated with poor health, lower weight, and developmental risk among young children. For example, very young children in households with multiple moves had worse caregiver-reported health status, increased developmental risk, and lower weight than expected for their age.⁵ When families with young children lack access to affordable, safe housing, they are more likely to move multiple times or rely on friends or family members to share housing.

Indiana law sets basic requirements for construction of new housing but does not provide minimum health or safety requirements for existing housing. And while the State Health Commissioner and local health officers have general authority to order unhealthy conditions to be remediated or, in extreme cases, to order that housing be vacated, most local health departments do not have clear, specific and adequate authority to order that unhealthful or dangerous conditions in housing be fixed.

How Indianapolis Area Housing Ranks

The National Center for Healthy Housing (NCHH) published a State of Healthy Housing report that compared American Housing Survey data from metropolitan areas around the country. This study ranked the 9-county Indianapolis area 24th out of 45 metro areas for healthy housing. It also compared the central city of Indianapolis to other cities and ranked the health of Indianapolis's housing 19th out of 44 cities.⁶ Nationally, the most common housing problems are water leaks from the outside (11%) and inside (8%), roofing problems (6%), damaged interior walls (5%) and signs of mice (5%).

NCHH identified several areas where the Indianapolis area lags behind: "Compared to the national average, Indianapolis has more homes with water leaks from the inside and outside, sewage disposal breakdown, and siding problems. Central city homes were likelier than the national average to have flush toilet breakdowns and rooms without electrical outlets. Areas outside the central city have a higher average for window and foundation problems.⁷ Owner-occupied homes had more problems than the national average for open cracks or holes in walls, signs of mice, heating equipment breakdown, and roofing and foundation

problems.” On a positive note, compared to the national average, the Indianapolis metro area had fewer homes with signs of rats and fewer room heaters without flues to vent dangerous gases outside.

Table 5-1 compares housing conditions in the entire metropolitan area to those only inside Marion County and in the surrounding counties. Housing in Indianapolis is more likely to have water leaks and flush toilet and sewage disposal breakdowns. Approximately 49 percent of housing units in the City of Indianapolis had some healthy housing problem, compared with 37 percent in surrounding communities.⁹

Structural Conditions

Structural defects – such as missing shingles, holes in the roof, broken windows and crumbling foundations – can create moisture problems and invite pests into a home.

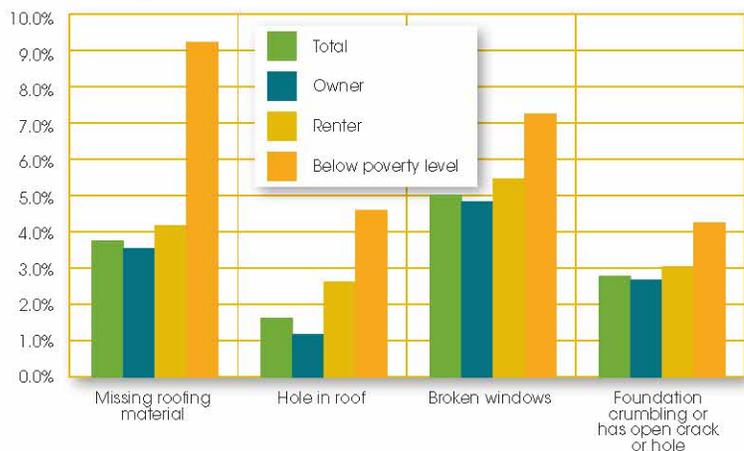
Moisture in the home can lead to mold, a common cause of asthma attacks and allergies. Pests can shed allergens or lead to the misuse of pesticides – risk factors that can trigger asthma attacks and other health problems in children. Uncontrolled moisture can also damage drywall and other surfaces where lead-based paint might be present, causing the paint to peel, chip and fall onto floors, yards and windowsills.

According to the 2004 American Housing Survey for the 9-county Indianapolis metro area, structural problems such as missing roofing material, holes in the roof, broken windows and foundation defects were found in less than 5 percent of the housing units surveyed (Figure 5-2). However, families living below the poverty level had more than twice the roofing defects when compared to the entire 9-county area. Broken windows and foundation defects were also more likely to be found in low-income homes than in others.⁹

Table 5-1 Comparison of Housing Data in Indianapolis Metropolitan Area, 2004			
	Percent of Surveyed Homes with Problem		
	9-County Metro Area	Marion County	Surrounding Counties
Basic Housing Quality			
Severe physical problems	1.1	1.3	0.9
Moderate physical problems	2.7	4.1	1.5
Interior Problems			
Holes in floors	0.8	1.2	0.4
Open cracks or holes in walls	5.3	6.7	4
Broken plaster/peeling paint	2	2.7	1.3
Signs of rats	0.3	0.5	0.1
Signs of mice	5.8	6.7	5
Water leaks from inside	10.5	12.8	8.5
Water leaks from outside	16.7	19	14.7
Water supply stoppage	3.3	3.2	3.4
Flush toilet breakdown	2.5	3.7	1.5
Sewage disposal breakdown	2.2	2.9	1.5
Lacking complete plumbing	0.7	0.9	0.6
Heating equipment breakdown	3.2	3.4	3.1
Room heater without flue	0.4	0.2	0.5
Exposed wiring in unit	0.4	0.5	0.2
Rooms without working elect. outlet	1.7	2.4	1.1
Lacking kitchen facilities	1.3	2.1	0.6
Exterior Problems			
Roofing problems	6	7.2	5
Siding problems	3.9	4.9	3
Window problems	4.9	5.4	4.4
Foundation problems	2.6	2.7	2.5
Any Identified Problem	42.6	48.7	37.2

Source: National Center for Healthy Housing. State of Healthy Housing. Accessed at: <http://www.nchh.org/Policy/State-of-Healthy-Housing/Location-Summary/tabid/346/msa/18/Default.aspx>

Figure 5-2: External Building Conditions - Indianapolis Metropolitan Area, 2004



Families living below the poverty level are more likely to live in homes with structural problems and undesirable neighborhood conditions. Poverty thresholds are set by the U.S. Department of Agriculture and are based on income and the number of people living in the household. In 2004, the poverty threshold for a family of two adults and two children was an annual income below \$19,157.

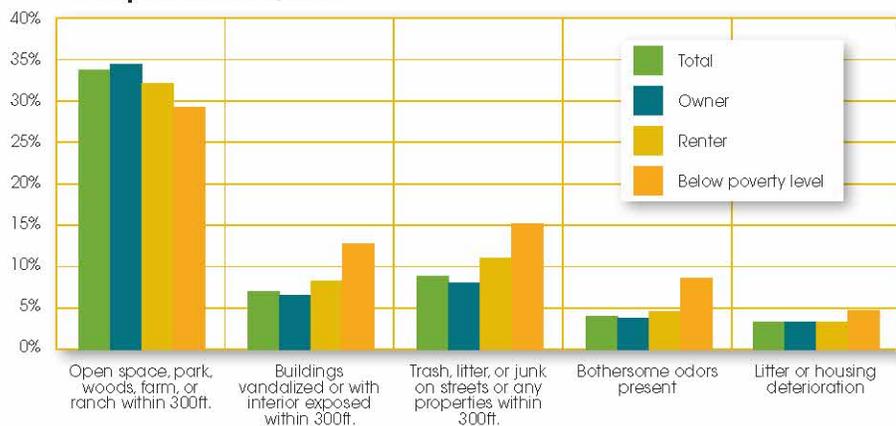
Neighborhood Conditions

The health of a neighborhood can influence whether it is safe for a child to play outside. Neighborhoods with persistent odors, littering, abandoned homes and housing deterioration make it unsafe or unhealthy for children to

play and explore the outdoor environment, even when their parents or other caregivers are present. Conversely, neighborhoods with open space, parks or woods can give children more opportunities to play in nature and green space.

Families living below the poverty level in the Indianapolis metro area are more likely to report bothersome odors, vandalized buildings, litter or housing deterioration within 300 feet of their home, as shown in Figure 5-3.¹⁰ Low-income families also are less likely to live near open space, parks or woods. Bothersome

Figure 5-3: Neighborhood Conditions - Indianapolis Metropolitan Area, 2004



Source: American Housing Survey for Indianapolis, IN Metropolitan Area, 2004

neighborhood conditions also are more likely to be found near rental properties than owner-occupied homes.

Rural, suburban and urban neighborhoods can present vastly different environments for a young child to grow up. Unfortunately, the American Housing Survey does not provide data specific to Indiana's rural areas.

Internal Housing Defects

Maintenance problems inside the home can also contribute to unhealthy conditions. Open cracks or holes in walls can contribute to moisture and pest problems. Broken plaster or peeling paint can contain lead hazards for a young child. Holes in floors can harbor pests or pose a safety hazard to a young child just learning to walk. Water leaks contribute to mold and peeling paint.

As shown in Figure 5-4, open cracks or holes inside a home were the most common interior maintenance problems found in Indianapolis area housing. Cracks, holes, broken plaster and peeling paint are more likely to be found in housing for renters and families living below poverty than in owner-occupied housing.¹¹

Water leakage was a frequent occurrence in all housing categories in the Indianapolis area, as shown in Figure 5-5.^{12,13} Water leakage can come from both inside and outside the building. The most common areas where water leaks enter a home are the roof, basement, walls, closed windows or doors. The most common internal sources are leaking pipes and plumbing backups or overflows. Water leakage affects all income levels and both owners and renters.

Rodents can contribute to disease and asthma attacks. Mice were sighted more frequently than rats in all housing categories; both were more likely to be found in homes where families lived below the poverty level.¹⁴ The survey counted actual sightings of mice or rats or signs of them inside the house or building during the previous 3 months. Signs of mice and rats include droppings, holes in the wall, or ripped or torn food containers.

Figure 5-4: Internal Housing Defects - Indianapolis Metropolitan Area, 2004

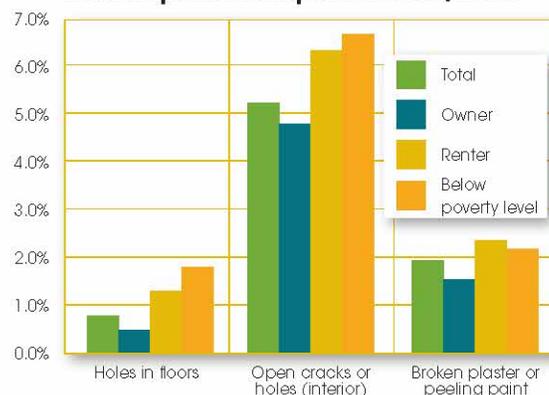


Figure 5-5: Water Leakage in Housing - Indianapolis Metropolitan Area, 2004

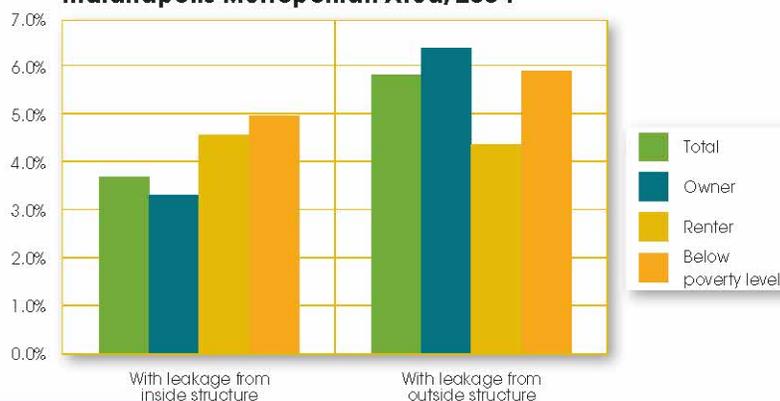


Figure 5-6: - Signs of Rodents in Housing - Indianapolis Metropolitan Area, 2004



Source: American Housing Survey for Indianapolis, IN Metropolitan Area, 2004



What Families Need to Know

- 1. Maintain Your Home:** Keeping your home well-maintained will improve your family's health. Follow the Seven Principles for a Healthy Home found at the end of this chapter. Low and moderate-income Hoosiers may qualify for home improvement assistance from various government and non-profit programs. Visit this link to find one in your area: <http://portal.hud.gov/hudportal/HUD?src=/states/indiana/homeownership/homerepairs>
- 2. Know Your Rights as a Renter:** If you rent your home, your landlord is responsible for providing a safe and healthy home for you and your family. Learn more about your rights as a tenant at this link: <http://portal.hud.gov/hudportal/HUD?src=/states/indiana/renting/tenantrights/klrch>
- 3. Support Stronger Local Housing Codes:** Most Indiana counties and cities lack an adequate housing code to ensure that existing housing meets basic health and safety requirements. Improving Kids' Environment has developed a Model Healthy Homes Code from which local governments can develop their own codes. To learn more, visit ikecoalition.org/healthy_homes.



What Families Need to Know

Prevent Suffocation: Always place your baby to sleep on his back and on a firm sleep surface. Keep pillows, stuffed toys, loose bedding, or any soft objects out of the crib. Don't sleep in the same bed as your baby. Babies who sleep in the same bed as their parents are at risk of SIDS, suffocation, or strangulation. Make sure your baby is immunized and keep him away from smokers.

Be Safe Around Fire: Keep matches and lighters away from children. Don't leave the kitchen while cooking. Have your furnace inspected each year. Install screens on fireplaces and wood stoves and dispose of ashes in metal containers after they've cooled. Keep candles out of reach of children and pets, and don't leave a lit candle unattended. Keep a fire extinguisher in high risk areas, such as the kitchen and furnace room. Install smoke alarms and replace batteries once a year. Have an escape plan and share it with your children. Teach children about fire safety at www.survivealive.org.

Prevent Poisonings: Lock chemicals and potential poisons way from children's reach. Keep products

in their original containers. Swallow medicine out of sight of children and never call medicine "candy." Keep the Indiana Poison Prevention hotline number next to all phones in your house: 800-222-1222. If the person who is poisoned can't wake up, is having trouble breathing or is having seizures, call 911.

Prevent Falls and Brain Injury: Do not place toys or items that attract children on top of furniture. Place furniture away from windows. Secure heavy furniture and TVs to the wall with anchor straps. Install safety gates at the top and the bottom of staircases. Hold a toddler's hands when climbing up or down stairs. Keep windows locked when they're closed. Keep infants strapped into high chairs, baby carriers, swings and strollers. Learn more at www.safekids.org.

Prevent Traffic Injuries: Always put young children in car seats and make sure they are fastened correctly and securely. Four out of five child car seats are used improperly. Children should be kept in a 5-point harness until they are 4 years old or weight 40 pounds. Keep infants rear-facing as long as possible. Make sure children wear a helmet when riding a bicycle. Learn more at www.preventinjury.org

You can find many more tips about making your home safe for young children at www.safekids.org.

Childhood Injuries

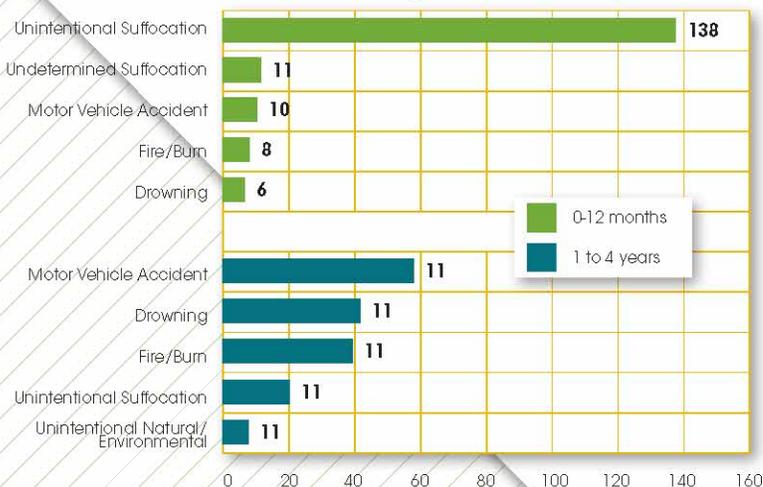
According to the Centers for Disease Control and Prevention (CDC), in 2006, injury was the fifth leading cause of death in the United States and the leading cause of death for children and young adults between 1 and 44 years of age.¹⁵

Infants (age 0-12 months) are at greater risk for many injuries because they are completely dependent on adults for their care. They also are less

able to identify and avoid unsafe environments. From 2003 to 2006, 227 infants died in Indiana due to unintentional and intentional injuries. More than two-thirds of all injury-related infant deaths were due to suffocation (Figure 5-7). The rate of injury death for black infants was 175.7 per 100,000, more than three times higher than the rate for white infants (53.4 per 100,000).

Preschool children (age 1-4) are also at greater risk of injury. Young children are naturally curious and like to explore their environment. At the same time, they lack judgment and coordination, making them prone to falls and accidents. Preschool children accounted for more than half of Indiana's fatal injuries from motor vehicle accidents and drowning in 2003-2006. Fires and suffocation are also common causes of injury-related deaths for children age 1 to 4.¹⁶ Suffocation includes choking on

Figure 5-7: Five Leading Causes of Injury-Related Death, Age 0-4 in Indiana, 2003-2006



Source: Table 7, ISDH Indiana Injury Report, 2003-06

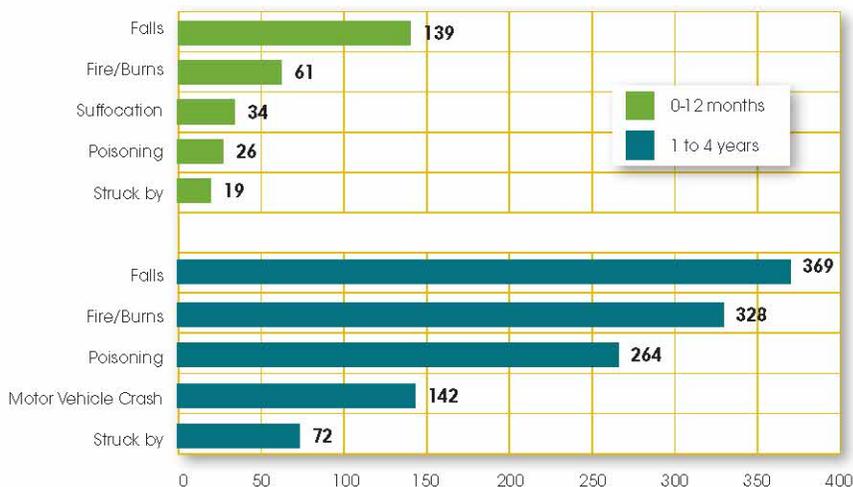
food or other objects that cut off breathing, as well as strangulation and suffocation by plastic bags or bedding.

Hospitalizations: Each year, hundreds of Indiana children are hospitalized due to injury. Injuries accounted for more than half of hospital inpatient admissions in Indiana in 2003-06 for ages 1-4. Falls were the primary cause of hospital admissions for infants during this time period, accounting for 25.6 percent of all infant hospitalizations.¹⁷ The top three causes of hospital admissions for 1-4 year olds in 2003-06 were falls, fire and poisoning. Falls accounted for 23.2 percent of hospitalizations, followed by fire with 20.6 percent and poisoning at 16.6 percent. Figure 5-8 shows the leading causes of injury-related hospitalizations in Indiana from 2003-06 for children age 0-4. The fifth leading cause of hospital admissions for Age 1-4, "Struck by," refers to being struck by or against a human, animal, or object other than a vehicle or machinery.

Programs to reduce childhood injuries have been demonstrated to yield significant benefits:

- Child safety seat distribution, at a cost of \$46 per seat, yields a total benefit to society¹⁸ of \$1,900 per seat (Children's Safety Network, 2005).
- At a cost of \$10 per child, counseling by a physician on injury prevention yields a total benefit to society of \$86 (Children's Safety Network, 2005).¹⁹

Figure 5-8: Five Leading Causes of Injury-Related Hospital Admissions, Age 0-4 in Indiana, 2003-2006



Source: Table 7, ISDH Indiana Injury Report, 2003-2006



Seven Principles of a Healthy Home

The National Center for Healthy Housing has identified seven guidelines for creating a safe and healthy home. By following these principles, you can reduce allergens, chemical exposures, safety hazards and indoor air pollution. Learn more at www.nchh.org.

- **Keep it Dry:** Damp houses are inviting environments for mites, roaches, rodents, and molds, all of which are associated with asthma.
- **Keep it Clean:** Clean homes help reduce pest infestations and exposure to contaminants.
- **Keep it Pest-Free:** Recent studies show a link between exposure to mice and cockroaches and asthma episodes in children; yet using pesticides improperly can also cause health problems, since

chemical exposures can cause neurological damage and cancer.

- **Keep it Safe:** Most childhood injuries happen in the home. Falls are the most frequent cause, followed by injuries from objects in the home, burns, and poisonings.
- **Keep it Contaminant-Free:** Chemical exposures include lead, radon, pesticides, volatile organic compounds, and tobacco smoke. Concentrations of asbestos particles, radon gas, carbon monoxide, and second-hand tobacco smoke are far higher indoors than outside.
- **Keep it Ventilated:** Increasing the fresh air supply in a home improves the health of your lungs.
- **Keep it Maintained:** Poorly-maintained homes are at risk for moisture and pest problems. Deteriorated lead-based paint in older housing is the primary cause of lead poisoning, which affects some 240,000 U.S. children.

Sources

- ¹ Children & Nature Network. Health Benefits to Children from Contact with the Outdoors and Nature. Accessed at <http://www.childrenandnature.org/downloads/C&NNHealthBenefits2012.pdf>
- ² Brennan, Maya. 2011. "The Impacts of Affordable Housing on Education: A Research Summary." Center for Housing Policy: Insights from Housing Policy Research. http://www.nhc.org/media/files/Insights_HousingAndEducationBrief.pdf
- ³ To learn more, visit www.leadfreekids.org
- ⁴ Robert Wood Johnson Foundation, Vulnerable Population Portfolio, "A New Way to Talk About the Social Determinants of Health." 2010.
- ⁵ Diana Becker Cutts, et al., "US Housing Insecurity and the Health of Very Young Children." American Journal of Public Health. Aug. 2011: Vol 101, No. 8. Accessed at <http://www.medscape.com/viewarticle/747683>
- ⁶ National Center for Healthy Housing. State of Healthy Housing, accessed at: <http://www.nchh.org/Policy/State-of-Healthy-Housing/Location-Summary/tabid/346/mca/18/Default.aspx>
- ⁷ National Center for Healthy Housing. State of Healthy Housing. Accessed at: <http://www.nchh.org/Policy/State-of-Healthy-Housing/Location-Summary/tabid/346/mca/18/Default.aspx>
- ⁸ Source: National Center for Healthy Housing. State of Healthy Housing. Accessed at: <http://www.nchh.org/Policy/State-of-Healthy-Housing/Location-Summary/tabid/346/mca/18/Default.aspx>
- ⁹ U.S. Department of Housing and Urban Development and U.S. Census Bureau, Current Housing Reports, Series H170/04-50, American Housing Survey for the Indianapolis Metropolitan Area: 2004
- ¹⁰ U.S. Department of Housing and Urban Development and U.S. Census Bureau, Current Housing Reports, Series H170/04-50, American Housing Survey for the Indianapolis Metropolitan Area: 2004
- ¹¹ U.S. Department of Housing and Urban Development and U.S. Census Bureau, Current Housing Reports, Series H170/04-50, American Housing Survey for the Indianapolis Metropolitan Area: 2004
- ¹² Water leakage must have occurred during the 12 months prior to the interview to be included in the American Housing Survey data.
- ¹³ U.S. Department of Housing and Urban Development and U.S. Census Bureau, Current Housing Reports, Series H170/04-50, American Housing Survey for the Indianapolis Metropolitan Area: 2004
- ¹⁴ U.S. Department of Housing and Urban Development and U.S. Census Bureau, Current Housing Reports, Series H170/04-50, American Housing Survey for the Indianapolis Metropolitan Area: 2004
- ¹⁵ Indiana State Department of Health. Injuries in Indiana 2003-2006: A Report on Injury-Related Deaths and Hospitalizations. Published July 2009.
- ¹⁶ Indiana State Department of Health. Injuries in Indiana 2003-2006: A Report on Injury-Related Deaths and Hospitalizations. Published July 2009.
- ¹⁷ Indiana State Department of Health. Injuries in Indiana 2003-2006: A Report on Injury-Related Deaths and Hospitalizations. Published July 2009.
- ¹⁸ Total Benefit to Society: Amount interventions saved by preventing injuries- including medical costs, other resource costs (police, fire services, property damage, etc.), work loss, and quality of life costs. These estimates are in 2004 dollars.
- ¹⁹ Indiana State Department of Health. Injuries in Indiana 2003-2006: A Report on Injury-Related Deaths and Hospitalizations. Published July 2009.





Chapter 6

Healthy Child Care

Introduction

High-quality early childhood programs help children achieve later success in school, work and life. From birth through age 5, a child's brain is developing and building connections in response to the child's experiences and environment. The child care environment needs to be safe, healthy and filled with opportunities to learn and grow.

Studies indicate parents consider a number of factors when choosing child care, including their own family values and what's available in their community. In numerous studies, parents rank safety, caregiver warmth, and support of learning as most important. Parents also take into account practical considerations such as cost and convenience. Their options also are limited to what is available within a manageable distance from home or work. Families in rural and other sparsely populated communities typically have fewer options.¹

According to the National Association of Child Care Resource and Referral Agencies (NACCRRA), in 2011 Indiana had 327,253 children younger than age 6 needing child care while one or both parents worked. Child care facilities had space for approximately 233,500 children. Remaining children likely were cared for by relatives or other caregivers in a home-based setting.

Indiana categorizes regulated child care facilities into three main groups:

- Licensed child care centers
- Licensed child care homes (home-based child care businesses caring for at least six children not related to the business owner)
- Unlicensed, registered child care ministries (day care provided as an extension of a tax-exempt church or religious ministry)

These categories do not include license-exempt providers, such as licensed exempt home child care providers, part-time programs such as preschools and parent day out programs, and before- and after-school programs. License-exempt providers that accept federal Child Care and Development Fund (CCDF) revenue must meet certain eligibility standards even though they are not licensed.

A Healthy Child Care Environment

The child care setting can contain the same types of indoor and outdoor environmental health issues as a child's home. The American Academy of Pediatrics (AAP) notes that, when it comes to environmental hazards in child care settings, parents should be most concerned about indoor air quality, secondhand smoke, lead, and pesticides.

Indoor Air. Indoor air pollution concerns include carbon monoxide, secondhand tobacco smoke, molds, and volatile organic compounds. Indoor air hasn't been studied in Indiana, but in rural counties of New York State, a study of child care facilities observed high levels of pollutants such as lead, radon, carbon monoxide, asbestos, and mold.²

Lead. Children can also be exposed to lead in the child care setting. The First National Environmental Health Survey of Child Care Centers, published in 2005, surveyed 168 licensed randomly selected child care facilities to measure lead in soil and dust samples. Twenty-eight percent of the surveyed facilities contained lead-based paint, and 14 percent contained one or more significant lead-based hazards. Facilities in which most children were black were four times more likely to have significant lead-based paint hazards than facilities where the majority of children were white.³

Pesticides. Children are highly vulnerable to pesticides. The first national survey of pesticide exposures in child care facilities found between one and 10 pesticides in 63 percent of surveyed centers. Pesticides were applied as often as 107 times annually in one center. In Colorado, health inspectors found that toxic chemicals were accessible to children in 68 percent of child care settings. According to the American Academy of Pediatrics, pesticides are not safe to use in child care settings. Parents should ask about the type of pesticides and other chemicals used in their child's child care facility.⁴

Child Care Standards

Parents have little control or knowledge of what goes on in a child care facility when they are not there. The American Public Health Association and American Academy of Pediatrics (AAP) recommend that child care settings be required to meet standards published in *Caring for Our Children: National Health and Safety Performance Standards—Guidelines for Out-of-Home Child Care Programs*.⁵

Not all child care facilities in Indiana meet these standards. In Indiana, safety standards for child care facilities depend upon the type of facility, with licensed centers having to meet the most stringent requirements and registered ministries facing the fewest requirements for ensuring health and safety of children. License-exempt providers have no requirements, unless they accept CCDF funding. Some examples:

Tobacco Smoke: Indiana does not allow smoking in licensed child care centers and child care homes when children are present, but registered ministries and legally licensed exempt facilities may allow smoking by staff or visitors, unless they accept CCDF funding.⁶

Chemicals: In licensed centers, poisons, chemicals, and any item that states "fatal if swallowed" must be in locked storage and not accessible to children. In child care homes, the caregiver is required to keep poisonous or hazardous materials that would harm children in "areas inaccessible to children," but the materials are not required to be locked up. There are no such requirements for child care ministries or legally licensed exempt child cares, unless they accept CCDF funding.

Pesticides: In licensed centers, chemicals for lawn care and insect and rodent control may not be applied when children are present in the child care center. There are no such requirements for child care homes or ministries. The Indiana Pesticide Review Board passed a rule in 2010 restricting the use of pesticides in K-12 schools, but there is no similar rule for child care facilities. The Board does have a voluntary policy that they encourage facilities to adopt. Other states, such as Illinois, have begun requiring integrated pest management in child care facilities to reduce exposure to pesticides. For more information about safer pest control alternatives, visit Purdue University's IPM School Technical Resource Center at <http://extension.entm.purdue.edu/schoolipm/1kid/kid1.htm>

Peeling Paint: Peeling paint and paint dust can be a sign of lead-based paint hazards in facility built before 1978. Licensed centers must make peeling paint inaccessible to children until the material is tested for lead. Child care homes and ministries do not have to test peeling paint for lead, although a state inspector can cite them for peeling paint under general requirement that facilities must be structurally sound, in good repair and maintained in a clean, safe, and sanitary condition.⁷

Rodents and Roaches: Child care centers must report rodents and roaches to the state and to parents and take steps to remove them. Child care homes and ministries do not have to report these health hazards to the state or parents, but can be cited by a state inspector for failing to maintain facilities in a clean, safe and sanitary condition.⁸ The state can shut down licensed home providers until the infestation has been dealt with.

Parents choosing a child care facility should ask questions about these issues before enrolling their child. See a suggested list of questions at the end of this chapter.

Most Common Violations

Licensed and registered child care facilities are subject to scheduled and random inspections by staff from the Indiana Family and Social Services Administration (FSSA) Bureau of Child Care. Table 6-1 shows the most common citations given to child care facilities in Indiana in 2011. Several of the most common citations involve the health and safety of the child care facility.

Parents can search for violations at a specific child care facility at www.childcareindiana.org.

Table 6-1 Most Common Citations in Indiana's Regulated Child Care Facilities, 2011	
Licensed Child Care Centers	
Failure to document that all staff were free of tuberculosis	137
Failure to follow guidelines for assembling, installing and anchoring playground equipment	130
Failure to store cleaning equipment, cleaning agents, aerosol cans and other dangerous items in a place inaccessible to children	127
Failure to maintain all interior and exterior surfaces in a safe condition, free of sharp points or jagged edges, splinters, protruding nails or wires, loose parts, rusty parts, or materials containing poisonous substances	104
Failure to keep complete admission records for each child	101
Licensed Child Care Homes	
Failure to document that caregivers and adult family members were free of tuberculosis	584
Failure to maintain documentation of certification of a current first aid course, training in Universal Precautions, and annual CPR certification by direct child care providers	469
Failure to have a written statement signed by a physician or a certified nurse practitioner allowing the child to participate in the child care home's activities	452
Failure to have required fire extinguishers	356
Failure to have physical examination and tuberculosis tests on all child care providers and household members having direct contact with children.	355
Registered Ministries	
Failure to maintain interior surfaces, equipment, materials, furnishings, and objects with which children will come in contact in a clean and sanitary condition, and of nontoxic durable construction	569
Failure to meet standards for restrooms (i.e., flush toilets with toilet paper dispensers, handwashing sinks, adequate water, soap and disposable paper towels in dispensers.)	254
Failure to conduct diapering in a clean and sanitary manner.	233
Employing a person or volunteer who has a history of child abuse or neglect	227
Failure to have proof of each child's immunization against whooping cough.	225
<i>Source: Indiana Family and Social Services Administration, Bureau of Child Care</i>	

Paths to QUALITY™

In order to improve the quality of child care programs, Indiana established a quality rating and improvement system known as Paths to QUALITY™. More than 2,000 child care programs serving 83,000 children have voluntarily joined this system, which gives families an easy-to-recognize tool for evaluating child care programs.

Paths to QUALITY™ has four levels. Starting with Level 1, child care programs must meet basic health and safety standards. They may progress to the highest level, Level 4, achieving national accreditation. The four levels indicate:

- **Level One:**
Health and safety needs of children met.
- **Level Two:**
Environment supports children’s learning.
- **Level Three:**
Planned curriculum guides child development and school readiness.
- **Level Four:**
National accreditation (the highest indicator of quality) is achieved.

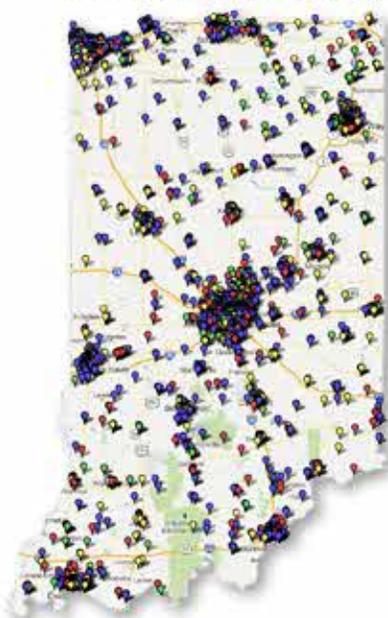
Level One is the only level with requirements related to the child care environment (health, safety, food and nutrition). The requirements include keeping harmful poisons and chemicals in a locked janitor’s closet and keeping other cleaning supplies and hazardous materials out of children’s reach. However, Paths to Quality does not have requirements to ensure a facility is lead-safe, has healthy indoor air quality or does not apply pesticides when children are present. For more information on Paths to QUALITY™ please visit the <http://www.childcareindiana.org> website.

The map in Figure 6-1 shows where Paths to Quality facilities are located throughout Indiana. The map indicates the level of each facility as of February 2012 by color:

- Level 1 = Blue
- Level 2 = Red
- Level 3 = Yellow
- Level 4 = Green

You can also search on-line for a specific facility at www.childcareindiana.org or use the interactive map at http://rac.iaccrr.org/map/pta_map.htm

Figure 6-1: Paths to Quality Facilities in Indiana, 2012



Source: Indiana Association for Child Care Resource & Referral

Voluntary Program: IDEM Five-Star Environmental Recognition Program

Another voluntary program does recognize child care facilities that have taken extra steps to create a safe and healthy environment for Indiana children. The Indiana Department of Environmental Management's Five-Star Environmental Recognition Program for Child Care Facilities helps parents select an environmentally healthy child care; one that promotes healthy development in young children free from pesticides, harmful chemicals, lead paint hazards, radon, and other often invisible environmental health threats.

In order to achieve recognition, child care facilities must submit an application and must pass review by IDEM staff and a review committee. Each facility director decides how many stars to apply for.

As of February 2012, 86 child care facilities in Indiana had achieved recognition through IDEM's program. Figure 6-2 below shows where they are located. Because there are only a few facilities that have achieved this recognition, many parents do not have access to the peace of mind a 5-Star rating can provide. For more information, including a complete list of requirements, visit the program website at www.in.gov/idem/childcare

Figure 6-2: Indiana Five Star Environmental Child Care Facilities (February 2012)



Source: Indiana Department of Environmental Management, Office of Pollution Prevention and Technical Assistance

IDEM Five-Star Child Care Requirements

To achieve one star, the facility is required to:

- Complete a self-assessment
- Ensure the building is clean and well-maintained
- Provide hazard communication training for employees
- Flush cold-water pipes 30 seconds daily before first use
- Never store pesticides at the facility

To achieve three stars, the facility is required to:

- Meet all one star requirements
- Implement a 100 percent tobacco-free facility and grounds
- Perform a radon test
- Implement integrated pest management strategies
- Check for lead hazards in water, soil, dust, and paint chips
- Discourage idling vehicles near entrances/exits
- Contact utility company to identify PCB-containing transformers

To achieve five stars, the facility is required to:

- Meet all one and three star requirements
- Remove pets with fur or feathers
- Recycle
- Replace disposable utensils and plates with reusable dishware



What Families Need to Know

The American Academy of Pediatrics recommends that you ask these questions when evaluating a child care environment for your child:

- Is the setting smoke-free? Is there a smoke-free policy? Is smoking allowed when children are not present? Is smoking allowed in other parts of the building?
- Does the facility appear clean, in good repair, and without water-marked areas or areas of peeling and chipping paint?
- Is there evidence of water damage or mold? Have flooding or plumbing problems occurred? Are there musty odors?
- Are the rooms adequately ventilated?
- Has the child care center or home been tested for radon?
- Are fuel-burning furnaces, stoves, or other equipment in use?
- Are medications and chemical products properly labeled and stored in areas away from children and food? Are staff members trained in the safe use of chemical products and medications?
- Are arts and crafts supplies free of hazardous substances?
- Are the kitchen and bathroom areas meeting local health department regulations?
- Are hand-washing policies followed and monitored? Are soap and clean towels always available? Paper towels, rather than cloth towels, generally are preferred in child care settings. Individual cloth towels may be used for each child but must be changed frequently.
- Are indoor and outdoor storage closets and sheds locked children cannot get in? All maintenance, lawn care and other hazardous equipment, and chemical products (such as gasoline, paints, pesticides, and cleaning products) must be stored away from children.
- Is a carbon monoxide detector present and in working order?
- If the building was built before 1978, has it been assessed for lead paint, dust, and soil hazards? Homes and other buildings built before 1978 may contain lead, and those built before 1950 have the most lead. If remodeling or renovation work is under way, have lead and asbestos hazards been identified, and have children been protected from lead dust and asbestos particles?



Sources for More Information:

U.S. EPA Healthy Child Care:

<http://www.epa.gov/childcare/>

FSSA Bureau of Child Care:

<http://www.in.gov/fssa/2552.htm>

Indiana Association for Child Care Resource and Referral: <http://www.iaccrr.org>

- Is there standing water?
- Is integrated pest management used?
- Are there enough shady areas for play outside?

Sources

¹ U.S. Department of Health and Human Services, Understanding Parents' Child Care Decision-Making: A Foundation for Child Care Policy Making, Research-to-Policy, Research-to-Practice Brief OPRE 2011-12 February 2011. Accessed at http://www.acf.hhs.gov/programs/opre/cc/childcare_technical/reports/parents_childcare.pdf

² American Academy of Pediatrics (AAP) Council on Environmental Health. Child Care Settings. In: Etzel, RA, ed. Pediatric Environmental Health, 3rd Edition Elk Grove Village, IL: American Academy of Pediatrics; 2012:115.

³ AAP. Pediatric Environmental Health, p. 115

⁴ AAP. Pediatric Environmental Health, pp. 116-7

⁵ American Public Health Association, American Academy of Pediatrics. Caring for Our Children: National Health and Safety Performance Standards. Guidelines for Out-of-Home Child Care Programs. 2nd ed. Washington, DC: American Public Health Association; and Elk Grove Village, IL: American Academy of Pediatrics; 2002. Accessible at <http://nrckids.org/CFOC3/index.html>

⁶ Registered ministries that take CCDF funding (and therefore meet provider eligibility standards) may not allow smoking. IC 12-17.2-3.5-12.1

⁷ 470 IAC 3-4.5-4 for registered ministries and 470 IAC 3-4.8-1 for homes

⁸ 470 IAC 3-4.5-4 for registered ministries and 470 IAC 3-4.8-1 for homes

⁹ AAP. Pediatric Environmental Health, p. 121





Chapter 7

Key Findings

Young children age 0-5 are more susceptible to environmental threats because they are still growing and developing and their behaviors – crawling, playing in dirt, putting objects in their mouths – are different than adults. Studies have shown that young children can face life-long physical problems and learning disabilities if they are exposed to toxins during critical times of development. One child exposed to a toxic substance might end up with life-long disabilities, while another shows little or no harm. Environment, behavior, genetics and diet may all play a role in the development and prevention of disease.

The environments in which Indiana's young children live are important for policymakers to understand. Urban children can be exposed to more environmental toxins in their air, soil and poorly maintained housing. Rural children face risks from untreated drinking water, poor sewage treatment and exposure to agricultural chemicals. Paying attention to environmental conditions in communities can help ensure Indiana's children are healthy and ready to learn by age 5.

Environmental exposures may contribute to birth defects among Indiana infants, but more research is needed. Both genes and environment can influence birth defects, but much is still unknown.

Improving medical care and reducing prenatal alcohol, smoking and drug use can help reduce low birth weight babies. From 2000-2008, Indiana's rate of preterm births was higher than the U.S. rate. Also, Indiana's black infants are more likely than white infants to be born preterm or with low birth weights. Pregnant women can help reduce preterm births and low birth weights by avoiding alcohol, drugs, smoking and other environmental exposures and getting good medical care and support during their pregnancy.

Rates of lead poisoning have dropped dramatically since the 1970s, but children with lead poisoning are still found at higher rates in neighborhoods with older housing that is not well maintained. Indiana does not have universal screening for lead poisoning. Although all Medicaid-covered children are required to be screened at their 12-month and 24-month checkups, just 27.3 percent of Medicaid-eligible children in the 12-to-36-month age group had been screened in 2010.

Since 2007, the percent of children who have been diagnosed with asthma has risen and is now higher than national levels. Among all children age 0-17, asthma is the third leading cause of hospitalization in Indiana. Boys age 0-4 have the highest rates of asthma-related emergency department visits in the state.

While relatively few children get cancer, cancer causes more childhood deaths than any other disease. About 1 in 4,000 Hoosier children age 0-5 are diagnosed each year with some type of cancer. National studies are examining the possible links between environmental causes and childhood cancer.

Children spend an estimated 80 to 90 percent of their time indoors at home, school, or child care settings. Therefore, healthy indoor air is vital for a healthy child. Indoor air pollutants include tobacco smoke, gases from stoves, and gases and vapors from furnishings and construction materials. Home cleaning supplies, insect sprays, air fresheners and candles can also emit gases that affect a child's lungs.

While much progress has been made, an estimated 420,000 children in Indiana are still exposed to second-hand smoke at home. The adult smoking rate in Indiana is at an historic low of 21.2 percent, but it remains one of the highest adult smoking rates in the nation.

Indiana's outdoor air quality has improved and most of the state now meets most federal standards for outdoor air quality. However, there are still some days when Indiana's air is unhealthy, particularly for sensitive groups such as children and those with asthma or other breathing difficulties. Parents can monitor air quality by visiting airnow.gov, which provides air quality forecasts for anywhere in the United States.

About 1 million Hoosiers get their drinking water from private wells, which face greater risk of contamination by pathogens, nitrates, arsenic and pesticides. Most rural families rely on untreated groundwater from private wells for their drinking water. Private wells are also still found in cities, isolated suburbs and other communities that haven't fully extended drinking water service to their residents.

About 5.5 million Hoosiers receive drinking water from a community water system, and 99 percent of them drank water that met health standards in 2010. However, more than half of Indiana's 4,200 public water systems serve less than 100 people. According to IDEM, small systems often face challenges to provide safe drinking water, such as lack of funding and management capacity.

Concerns have been raised about atrazine because it is the most heavily used pesticide in Indiana, is the pesticide most frequently detected in waterways, and studies have linked it to health problems in infants. Several Indiana public water suppliers have been required to install new treatment systems to reduce atrazine levels. Small drinking water systems also have received assistance from IDEM to reduce atrazine levels during the peak spring season, when atrazine is applied to farm fields. The last time an Indiana public water system exceeded the federal atrazine standard was in 2005.

Young children eating fish from Indiana's lakes, reservoirs and ponds have a high risk of exposure to mercury and PCBs. Of the 231,000 acres of lakes, reservoirs and ponds monitored by the state, 84 percent are impaired because of high levels of mercury in fish and 81 percent have high PCBs in fish. To find out about the safety of fish in a waterway near you, go to www.fish4health.net.

Children swimming or wading in lakes and reservoirs, especially during summer months, face a risk of exposure to blue-green algae – also known as cyanobacteria. In 2011, high-risk health alerts for blue-green algae were issued for nine beaches at Indiana state parks and reservoirs. Children are more vulnerable to cyanobacteria because they can be exposed to a larger dose of toxin for their body weight.

Of the 28,790 river and stream miles assessed by IDEM as of 2012, 71 percent are considered “impaired” because they don’t meet the state’s fishable and swimmable goals or they don’t adequately support aquatic life. E.coli bacteria are the most common reason a river or stream is impaired. High levels of E. coli can indicate that there is untreated human or animal waste in a waterway, and therefore disease-causing bacteria, viruses and other pathogens.

A growing number of large farm operations in Indiana are producing an increasing amount of animal manure each year, and that manure must be carefully managed to protect waterways and children’s health. When not properly managed, manure can leak or spill from storage pits on these farms into local waterways. Improper application of manure to the land can contaminate local rivers and streams. New state rules go into effect in July 2012 to restrict manure application.

Untreated human sewage enters Indiana’s rivers and streams on a regular basis – often because our sewage infrastructure is inadequate, poorly designed or poorly maintained. Sewer overflows also can be caused by blockages, broken pipes, sewer and manhole cracks, poor sewer system operation and maintenance, power failures, inadequate sewer design and vandalism. The untreated sewage from these overflows can contaminate waterways or back up into basements, causing property damage and threatening public health.

Sewage treatment is a serious problem in small rural communities, many of whom rely on either aging individual septic systems or pipes that send untreated sewage directly to waterways or drainage ditches. A 2011 survey of unsewered communities by the Indiana Rural Community Assistance Program revealed serious problems in 503 communities serving more than 47,000 homes and 1,200 businesses. Forty-six percent of these communities had failing septic systems or other failing on-site treatment systems. More investments need to be made to help these communities install, maintain and operate proper sewage treatment facilities.

Environmental threats in the home can include lead hazards, mold, secondhand smoke and other indoor air pollutants. A structurally sound, well-maintained home can lead to better health for the children living there. Indiana law sets basic requirements for construction of new housing but does not provide minimum health or safety requirements

for existing housing. While the State Health Commissioner and local health officers have general authority to order unhealthy conditions to be remediated or, in extreme cases, to order that housing be vacated, most local health departments do not have clear, specific and adequate authority to order that unhealthful or dangerous conditions in housing be fixed.

There is a lack of comprehensive data on the condition of housing in Indiana. The only widely available data is the American Housing Survey, and its data are only available for the nine-county Indianapolis Metropolitan Area. The data that are available show a need for improvement in Indiana's housing in the following areas: water leaks from the inside and outside; sewage disposal breakdown; siding problems; flush toilet breakdowns; and window and foundation problems.

Young children are naturally curious and like to explore their environment. At the same time, they lack judgment and coordination, making them prone to falls and accidents. Many of these injuries could be prevented. From 2003 to 2006, 227 infants died in Indiana due to unintentional and intentional injuries. For infants, more than two-thirds of all injury-related deaths were due to suffocation. Among young children age 1-4, the most common causes of injury-related death are motor vehicle accidents, drowning, fires and suffocation. The top three causes of hospital admissions for 1-4 year olds in 2003-06 were falls, fire and poisoning.

From birth through age 5, a child's brain is developing and building connections in response to the child's experiences and environment. The child care environment needs to be safe, healthy and filled with opportunities to learn and grow. Not all child care facilities in Indiana meet the basic health and safety standards recommended by the American Public Health Association and American Academy of Pediatrics (AAP). In Indiana, safety standards for child care facilities depend upon the type of facility, with licensed centers having to meet the most stringent requirements and registered ministries facing the fewest requirements for ensuring health and safety of children.

Indiana does recognize child care facilities that have taken extra steps to create a safe and healthy environment for Indiana children. The Indiana Department of Environmental Management's Five-Star Environmental Recognition Program for Child Care Facilities helps parents select an environmentally healthy child care; one that promotes healthy development in young children free from pesticides, harmful chemicals, lead paint hazards, radon, and other often invisible environmental health threats. As of February 2012, 86 child care facilities in Indiana had achieved recognition through IDEM's program.

Glossary

Acidification: the ongoing decrease in the pH and increase in acidity

Asthma: a disorder that causes the airways of the lungs to swell and narrow, leading to wheezing, shortness of breath, chest tightness, and coughing

Bronchitis: inflammation of the main air passages to the lungs

Chronic obstructive lung disease (COPD): refers to a group of lung diseases that block airflow as you exhale and make it increasingly difficult for you to breathe. Emphysema and chronic asthmatic bronchitis are the two main conditions that make up COPD.

Coliform: a broad class of bacteria found in our environment, including the feces of humans and other warm-blooded animals; the presence of coliform bacteria in drinking water may indicate a possible presence of harmful, disease-causing organisms

Dysentery: a general term for a group of disorders characterized by inflammation of the intestines

Endocrine system: the system of glands, each of which secretes a type of hormone directly into the bloodstream to regulate the body

Food chain: a series of organisms interrelated in their feeding habits, the smallest being fed upon by a larger one, which in turn feeds a still larger one, etc.

Gestation: the period of development in the uterus from conception until birth; pregnancy

Inorganic compounds: compounds that lack carbon and hydrogen atoms and are synthesized by the agency of geological systems

Lung disease: refers to many disorders affecting the lungs, such as asthma, chronic obstructive pulmonary disease, infections like influenza, pneumonia and tuberculosis, lung cancer, and many other breathing problems

Metabolism: the chemical reactions in the body's cells that convert the fuel from food into the energy needed to do everything from moving to thinking to growing

Neuroblastoma: a malignant (cancerous) tumor that develops from nerve tissue

Nontransient community water system: water provided to permanent, consistent buildings and the families or businesses that reside there

Nontransient noncommunity water system: water provided to a permanent population that changes day to day, such as campgrounds, hotels, rest areas, and restaurants with their own water supplies

Organic solvents: substances containing carbon and hydrogen atoms that dissolve other substances

Particle settling: the falling of suspended particles through a liquid

Peripheral nervous system (PNS): consists of the nerves and ganglia outside of the brain and spinal cord

Photosynthesis: a chemical process that converts carbon dioxide into organic compounds, especially sugars, using the energy from sunlight

Phthalates: a class of chemicals used as softeners, or plasticizers, in polyvinyl chloride (PVC, vinyl) products, including children's toys, decorating and building products, blood bags, and solvents and other additives in a wide range of consumer products, including cosmetics, personal care products, wood finishes and insecticides.

Pollutant: any substance as certain chemicals or waste products, that renders the air, soil, water, or other natural resource harmful or unsuitable for a specific purpose

Prenatal smoking: smoking existing or occurring before birth

Secondhand smoke: environmental tobacco smoke that is inhaled involuntarily or passively by someone who is not smoking

Volatile organic compounds (VOC): organic chemicals that have a high vapor pressure at ordinary, room-temperature conditions

Watershed: the area of land where all of the water that is under it or drains off of it goes into the same place; that area of land, a bounded hydrologic system, within which all living things are inextricably linked by their common water course and where, as humans settled, simple logic demanded that they become part of a community



List of Acronyms

AAP – American Academy of Pediatrics

ADHD – Attention Deficit Hyperactivity Disorder

CCDF – Child Care and Development Fund

CDC – Center for Control and Prevention

CFO – Confined Feeding Operations

CSO – Combined Sewer Overflow

ED – Emergency Department

U.S. EPA – United States Environmental Protection Agency

FSSA – Family & Social Services Administration

IDEM – Indiana Department of Environmental Management

ISDH – Indiana State Department of Health

NACCRRRA – National Association of Child Care Resource and Referral Agencies

NCHH – National Center for Healthy Housing

Nox – Nitric Oxide

O3 – Ozone

PCB – Polychlorinated Biphenyl

SIDS – Sudden Infant Death Syndrome

SO2 – Sulfur Dioxide

SSO – Sanitary Sewer Overflow

USGS – U.S. Geological Survey

VOC – Volatile Organic Compounds

**This report is
available on-line at
sunnystart.in.gov/eh**

The Sunny Start Vision:

**In Indiana, children are safe, healthy
and reach their full potential.**

The Sunny Start: Healthy Bodies, Healthy Minds Initiative is a comprehensive, collaborative, statewide effort to support a coordinated system of resources and supports for young children from birth through age five and their families in Indiana. The goal of the project is to ensure that Indiana's children arrive at school healthy and ready to learn.

For More Information, go to sunnystart.in.gov



Sunny Start

Indicator Definitions and Data Sources



The following indicators are included in the county pages. Data year definitions are as follows:

SFY	State Fiscal Year: July 1 – June 30
FFY	Federal Fiscal Year: October 1 – September 30
CY	Calendar Year: January 1 – December 31

County Level Population

Child Population Under 5 (CY)

Definition: Total estimated number of children age 0 through 5.

Data Source: Puzanchara, C., Sladky, A. and Kang, W. (2012). "Easy Access to Juvenile Populations: 1990-2007." <http://www.ojjdp.gov/ojstatbb/ezapop/>

% of Total Population who are Ages 0 to 5 (CY)

Definition: The percentage of the total population that is made up by children 5 and younger.

Data Source: Puzanchara, C., Sladky, A. and Kang, W. (2012). "Easy Access to Juvenile Populations: 1990-2007." <http://www.ojjdp.gov/ojstatbb/ezapop/>

% of All Children Under Age 18 who are Ages 0 to 5 (CY)

Definition: The percentage of the total child population that is made up by children 5 and younger.

Data Source: Puzanchara, C., Sladky, A. and Kang, W. (2012). "Easy Access to Juvenile Populations: 1990-2007." <http://www.ojjdp.gov/ojstatbb/ezapop/>

Physical Health and Well-Being

of Live Births (CY)

Definition: The total number of live births to women of all ages.

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. <http://www.in.gov/isdh/19095.htm>

Teen Birth Rate per 1,000 Females Age 15-17 (CY)

Definition: The number of births to mothers age 15 through 17 per 1,000 females in this age group.

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. <http://www.in.gov/isdh/19095.htm>

% of Mothers who Received 1st Trimester Prenatal Care (CY)

Definition: The percent of pregnant women who began prenatal care during the first three months of pregnancy. Due to a change in data collection, current data should not be compared to those prior to 2006.

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. <http://www.in.gov/isdh/19095.htm>

% of Mothers who Reported Smoking During Pregnancy (CY)

Definition: The percent of women who reported they had smoked during pregnancy. Due to a change in data collection, current data should not be compared to those prior to 2006.

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. <http://www.in.gov/isdh/19095.htm>

Physical Health and Well-Being (cont.)

% of Low Birthweight Babies (CY)

Definition: The percent of infants born at a weight of less than 2,500 grams (about 5.5 pounds).

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team.
<http://www.in.gov/isdh/19095.htm>

Infant Mortality Rate per 1,000 Live Births (CY)

Definition: The number of infant (children under 1) deaths per 1,000 live births.

Data Source: The Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team.
<http://www.in.gov/isdh/19096.htm>

of Children Under 6 on Public Health Insurance (SFY)

Definition: The number of children under 6 who receive public health insurance.

Data Source: Indiana Office of Medicaid Policy and Programming. <http://www.in.gov/fssa/2408.htm>

of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0-5 (CY)

Definition: The number of children whose blood lead level is ten micrograms of lead or more per deciliter of blood ($\geq 10\mu\text{g/dL}$). The elevated level has been confirmed by a venous test or a second capillary test.

Data Source: Indiana State Department of Health, Indiana Lead and Healthy Homes Program.
<http://www.in.gov/isdh/19137.htm>

Social and Emotional Development

Child Abuse and Neglect Rate per 1,000 Children Under Age 18 (SFY)

Definition: The rate of substantiated cases of child abuse and neglect per 1,000 children younger than age 18. A case is considered substantiated when an investigation reveals credible evidence of abuse or neglect.

Data Source: Indiana Department of Child Services. <http://www.in.gov/dcs/2329.htm>

Early Childhood—School Readiness

of Licensed Child Care Centers (SFY)

Definition: The number of child care centers licensed by the Indiana Family and Social Services Administration. A child care center is a non-residential home where at least one child receives child care from a provider.

Data Source: Indiana Family and Social Services Administration, Bureau of Child Care.
<http://www.in.gov/fssa/carefinder/4083.htm>

of Licensed Child Care Homes (SFY)

Definition: The number of child care homes licensed by the Indiana Family and Social Services Administration. A child care home is a residence in which at least 6 children at any time receive child care from a provider.

Data Source: Indiana Family and Social Services Administration, Bureau of Child Care.
<http://www.in.gov/fssa/carefinder/4083.htm>

of Registered Child Care Ministries (SFY)

Definition: The number of child care ministries licensed by the Indiana Family and Social Services Administration. A child care ministry is a child care program operated by a church or another tax exempt religious institution.

Data Source: Indiana Family and Social Services Administration, Bureau of Child Care.
<http://www.in.gov/fssa/carefinder/4083.htm>

Early Childhood—School Readiness (cont.)

of Licensed Child Care Slots per 100 Children, Age 0-4 (SFY)

Definition: The capacity of licensed child care centers and homes in the county (or state) per 100 children ages 0-4. This figure does not include child care ministries.

Data Sources: Indiana Family and Social Services Administration, Bureau of Child Care.

<http://www.in.gov/fssa/carefinder/4083.htm>; Puzanchera, C., Sladky, A. and Kang, W. (2011). "Easy Access to Juvenile Populations: 1990-2010." <http://www.ojjdp.gov/ojstatbb/ezapop/>

of Children Receiving Child Care Vouchers (FFY)

Definition: The number of children whose child care arrangements were supported through Indiana's CCDF Child Care Voucher program. The voucher program subsidizes child care costs for low income families who work or attend school.

Data Source: Indiana Family and Social Services Administration, Bureau of Child Care.

<http://www.in.gov/fssa/carefinder/4083.htm>

Monthly Avg # of Children on Waiting List for Child Care (FFY)

Definition: The average number of children who are on a waitlist for financial assistance for child care support through Indiana's CCDF Child Care Voucher program.

Data Source: Indiana Family and Social Services Administration, Bureau of Child Care.

<http://www.in.gov/fssa/carefinder/4083.htm>

of Early Head Start and Head Start Funded Enrollment Slots (SFY)

Definition: The number of funded enrollment slots available for participation in Early Head Start or Head Start programs. Early Head Start and Head Start are open to pregnant women as well as children 0-3 and 3-5, respectively. An individual is eligible for Head Start or Early Head Start if he/she is homeless, a TANF or SSI recipient, in foster care, or if their family income falls below federal poverty guidelines.

Data Source: Indiana Head Start State Collaboration Office. <http://www.in.gov/fssa/dfr/3292.htm>

of First Steps Children Served (SFY)

Definition: The number of children with an Individualized Family Service Plan (IFSP) served by the First Steps Early Intervention program at any point during the last fiscal year. First Steps is open to children from birth to age 3 with disabilities, developmental delays, or at significant risk for disabilities or delays.

Data Source: Indiana Family and Social Services Administration, First Steps.

<http://www.in.gov/fssa/ddrs/2812.htm>

Family Support

% of Children in Poverty, Age 0-17 (CY)

Definition: The percent of children younger than age 18 living in households with incomes below the federal poverty thresholds as reported by the Small Area Income and Poverty Estimates. The federal poverty threshold is calculated annually and differs according to the size and composition of the household.

Data Source: U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch. <http://www.census.gov/did/www/saipe/county.html>

of Women, Infants, and Children (WIC) Participants (FFY)

Definition: The number of women, infants and children receiving nutrition education and dietary supplements through the WIC Program. To be eligible for WIC, an individual must be an Indiana resident and be part of a group serviced by WIC [pregnant women, breastfeeding women (up to 1st birthday), non-breastfeeding post-partum women (up to 6 months), infants up to 1 yr, and children up to 5 yrs].

Data Source: Indiana State Department of Health, Indiana Women, Infants, and Children Program.

<http://www.in.gov/isdh/24849.htm>



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Indiana

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	524,027	523,858	521,320	517,921
% of Total Population who are Ages 0 to 5 (CY)	8.2%	8.1%	8.0%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.5%	32.5%	32.5%	32.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	89,719	88,679	86,126	83,867
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	22.0	20.5	20.8	18.5
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.5	66.6	66.1	68.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	18.5	18.5	18.2	17.1
% of Low Birthweight Babies (CY)	8.5	8.3	8.3	8.0
Infant Mortality Rate per 1,000 Live Births (CY)	7.5	6.9	7.8	7.5
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	309,023	323,279	326,991	325,642
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	351	222	222	245

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.6	15.6	14.5	12.2

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	594	597	612	598
# of Licensed Child Care Homes (SFY)	3,051	3,040	2,994	2,874
# of Registered Child Care Ministries (SFY)	701	714	739	721
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.4	23.5	24.1	23.5
# of Children Receiving Child Care Vouchers (FFY)	55,360	52,307	46,730	53,041
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	8,488	10,612	13,652	7,358
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	14,598	15,966	15,967	15,893
# of Children Served by First Steps (SFY)	18,847	21,291	20,853	20,056

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.9	21.6	22.6	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	287,133	291,126	283,474	277,568

Data Gathered by:



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Adams County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,722	3,783	3,804	3,757
% of Total Population who are Ages 0 to 5 (CY)	10.9%	11.0%	11.1%	10.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	35.1%	35.4%	35.5%	35.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	667	673	643	661
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.6 U	12.3 U	9.8 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	45.1	45.3	40.0	39.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	9.7	8.6	10.7	9.7
% of Low Birthweight Babies (CY)	9.7	6.1	7.0	7.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,224	1,238	1,302	1,272
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.8	9.2	9.1	6.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	7	7	8	6
# of Registered Child Care Ministries (SFY)	6	6	7	8
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	5.2	5.2	5.5	4.8
# of Children Receiving Child Care Vouchers (FFY)	41	41	56	55
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	2	3	5	3
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	71	80	80	80
# of Children Served by First Steps (SFY)	94	106	101	98

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	26.5	29.6	28.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,243	1,289	1,294	1,206

Data Gathered by:



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Allen County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	31,905	32,013	31,937	31,826
% of Total Population who are Ages 0 to 5 (CY)	9.1%	9.1%	9.0%	8.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.4%	33.4%	33.3%	33.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	5,448	5,506	5,463	5,312
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	20.3	22.5	24.0	19.7
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	71.8	72.9	66.2	58.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.0	16.5	14.7	12.7
% of Low Birthweight Babies (CY)	8.6	9.4	9.1	8.3
Infant Mortality Rate per 1,000 Live Births (CY)	7.7	9.8	9.2	7.3
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	18,344	19,480	20,131	19,941
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	55	18	18	25

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.5	11.5	9.8	7.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	34	31	32	29
# of Licensed Child Care Homes (SFY)	184	195	195	194
# of Registered Child Care Ministries (SFY)	42	41	42	42
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.1	22.0	22.2	21.6
# of Children Receiving Child Care Vouchers (FFY)	4,735	4,382	3,719	4,576
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	823	1,034	1,459	543
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	700	746	746	746
# of Children Served by First Steps (SFY)	1,125	1,239	1,271	1,206

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	20.2	19.8	24.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	18,012	18,207	18,012	17,848

Data Gathered by:



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Bartholomew County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	6,315	6,318	6,315	6,251
% of Total Population who are Ages 0 to 5 (CY)	8.3%	8.3%	8.2%	8.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.4%	32.5%	32.7%	32.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,086	1,095	1,023	1,013
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	30.6	31.2	26.5	20.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	62.2	59.8	60.8	64.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	18.1	18.9	19.0	19.1
% of Low Birthweight Babies (CY)	8.7	7.9	7.2	8.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,350	3,551	3,486	3,434
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.9	12.7	11.0	9.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	7	6	6	8
# of Licensed Child Care Homes (SFY)	33	31	30	28
# of Registered Child Care Ministries (SFY)	8	7	6	7
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.1	21.9	23.5	27.5
# of Children Receiving Child Care Vouchers (FFY)	382	355	311	289
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	97	91	73	83
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	78	142	142	142
# of Children Served by First Steps (SFY)	301	315	309	286

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.6	22.0	19.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	3,240	3,304	3,196	3,069

Data Gathered by:



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Benton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	734	742	745	715
% of Total Population who are Ages 0 to 5 (CY)	8.3%	8.5%	8.4%	8.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.7%	32.7%	32.6%	32.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	104	119	92	96
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	11.3 U	11.4 U	*	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.3	66.4	63.0	69.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.2	21.0	25.0	17.7 U
% of Low Birthweight Babies (CY)	5.8	2.5	5.4 U	7.3 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	463	453	441	434
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.7	16.0	14.3	11.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	9	9	7	7
# of Registered Child Care Ministries (SFY)	1	1	1	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	26.7	25.0	22.7	22.7
# of Children Receiving Child Care Vouchers (FFY)	40	31	28	22
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	6	4	5
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	51	42	42	42
# of Children Served by First Steps (SFY)	26	27	22	16

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.2	17.5	17.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	436	410	395	381

Data Gathered by:



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Blackford County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	898	897	902	904
% of Total Population who are Ages 0 to 5 (CY)	6.9%	7.0%	7.1%	7.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.4%	30.3%	31.0%	31.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	156	148	142	151
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	43.1 U	25.6 U	23.9 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	77.6	64.2	66.9	71.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	32.7	29.1	36.6	23.2
% of Low Birthweight Babies (CY)	9.0	6.1	9.9 U	6.0 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	650	708	689	708
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.4	23.4	20.3	10.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	2	2	2
# of Licensed Child Care Homes (SFY)	10	9	9	9
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.4	16.9	19.8	19.8
# of Children Receiving Child Care Vouchers (FFY)	92	64	50	57
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	7	20	10
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	139	97	111	111
# of Children Served by First Steps (SFY)	33	42	27	31

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.9	24.3	24.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	616	659	667	670

Data Gathered by:



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Boone County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,654	4,756	4,775	4,798
% of Total Population who are Ages 0 to 5 (CY)	8.5%	8.5%	8.4%	8.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.8%	30.0%	29.9%	30.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	708	741	706	660
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	16.3 U	14.7 U	7.1 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	81.2	77.5	79.5	80.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	16.1	15.1	14.7	12.4
% of Low Birthweight Babies (CY)	5.9	8.1	6.5	6.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,492	1,571	1,572	1,554
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.9	9.4	8.4	5.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	8	9	9	7
# of Licensed Child Care Homes (SFY)	17	20	21	24
# of Registered Child Care Ministries (SFY)	4	4	5	6
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	27.8	33.1	33.8	30.1
# of Children Receiving Child Care Vouchers (FFY)	199	192	148	184
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	46	31	105	37
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	48	48	48	48
# of Children Served by First Steps (SFY)	234	240	249	249

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	9.3	9.6	9.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,269	1,286	1,238	1,235

Data Gathered by:



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Brown County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	941	932	895	871
% of Total Population who are Ages 0 to 5 (CY)	6.2%	6.1%	5.9%	5.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.7%	28.8%	28.4%	28.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	137	137	139	100
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	3.7 U	24.0 U	23.8 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.1	70.1	61.9	72.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.1	28.5	18.7	23.0
% of Low Birthweight Babies (CY)	7.3	7.3	5.8 U	*
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	0.0	0.0	0.0

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	618	588	583	580
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	13.5	14.5	14.3	8.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	5	4	4	4
# of Registered Child Care Ministries (SFY)	1	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.8	10.4	11.4	11.4
# of Children Receiving Child Care Vouchers (FFY)	55	60	57	58
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	15	8	4	6
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	18	18	18	18
# of Children Served by First Steps (SFY)	33	33	26	25

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.6	21.0	21.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	466	474	454	449

Data Gathered by:



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Carroll County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,481	1,463	1,479	1,385
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.3%	7.3%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.5%	29.5%	29.9%	28.9%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	230	227	219	214
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.2 U	5.3 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	61.7	62.6	68.0	71.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	23.5	19.8	19.2	20.6
% of Low Birthweight Babies (CY)	5.2	5.7	8.2 U	7.0 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	649	747	747	720
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	7.8	8.4	8.1	8.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	1	1
# of Licensed Child Care Homes (SFY)	2	1	3	3
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	5.9	4.7	4.9	4.9
# of Children Receiving Child Care Vouchers (FFY)	11	12	24	36
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	5	9	16
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	24	24	24	24
# of Children Served by First Steps (SFY)	33	39	45	50

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.3	16.3	17.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	741	699	641	666

Data Gathered by:



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The State of The Young Hoosier Child



Cass County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,283	3,233	3,189	3,168
% of Total Population who are Ages 0 to 5 (CY)	8.4%	8.3%	8.2%	8.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.3%	32.0%	31.6%	31.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	545	539	517	494
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	26.9 U	27.3 U	19.9 U	28.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	64.0	62.2	65.4	67.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.3	25.4	22.2	20.4
% of Low Birthweight Babies (CY)	7.3	5.0	9.1	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,180	2,265	2,339	2,324
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	5

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.8	12.9	11.8	17.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	1	1	1
# of Licensed Child Care Homes (SFY)	10	9	8	7
# of Registered Child Care Ministries (SFY)	5	5	5	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	9.6	7.9	7.6	7.1
# of Children Receiving Child Care Vouchers (FFY)	291	302	196	194
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	35	46	120	55
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	102	102	102	102
# of Children Served by First Steps (SFY)	87	87	108	135

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.2	25.5	22.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,571	2,508	2,461	2,421

Data Gathered by:



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The State of The Young Hoosier Child



Clark County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	8,586	8,613	8,710	8,844
% of Total Population who are Ages 0 to 5 (CY)	8.0%	7.9%	7.9%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.4%	33.3%	33.3%	33.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,450	1,479	1,525	1,407
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	33.2	28.2	25.1	25.0
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	69.5	69.2	67.9	71.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	18.9	16.8	17.2	14.7
% of Low Birthweight Babies (CY)	9.0	7.7	7.9	7.5
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	4,615	5,106	5,267	5,098
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	20.5	24.1	17.9	18.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	11	12	15	16
# of Licensed Child Care Homes (SFY)	30	35	33	28
# of Registered Child Care Ministries (SFY)	9	11	12	12
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.2	25.3	25.7	25.4
# of Children Receiving Child Care Vouchers (FFY)	955	968	762	921
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	131	115	265	186
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	290	362	362	362
# of Children Served by First Steps (SFY)	436	476	477	457

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	17.3	19.1	18.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,621	4,909	4,914	4,812

Data Gathered by:



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The State of The Young Hoosier Child



Clay County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,010	1,936	1,907	1,862
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.2%	7.1%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.3%	29.9%	29.7%	29.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	291	330	294	328
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.5 U	10.9 U	26.9 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.9	71.5	71.4	70.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.2	21.2	22.8	22.3
% of Low Birthweight Babies (CY)	6.2	7.3	5.8 U	4.9 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,247	1,363	1,351	1,356
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	5.6	10.6	10.2	6.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	1
# of Licensed Child Care Homes (SFY)	13	10	12	12
# of Registered Child Care Ministries (SFY)	3	3	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	15.6	13.3	14.9	14.9
# of Children Receiving Child Care Vouchers (FFY)	210	197	171	174
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	28	28	35	21
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	121	105	105	105
# of Children Served by First Steps (SFY)	73	87	68	63

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	21.1	22.2	21.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,480	1,452	1,435	1,390

Data Gathered by:



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The State of The Young Hoosier Child



Clinton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,043	3,055	2,983	2,984
% of Total Population who are Ages 0 to 5 (CY)	9.1%	9.2%	9.0%	9.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	34.1%	34.4%	33.8%	33.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	534	518	487	444
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	28.1 U	34.7	33.9 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	59.0	55.4	61.8	64.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.7	19.3	19.1	20.3
% of Low Birthweight Babies (CY)	6.6	10.4	6.4	8.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,024	2,100	2,104	2,074
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.9	17.7	18.4	16.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	2	2
# of Licensed Child Care Homes (SFY)	6	6	6	6
# of Registered Child Care Ministries (SFY)	3	3	4	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	11.7	12.7	9.5	9.5
# of Children Receiving Child Care Vouchers (FFY)	111	120	124	145
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	30	54	64	38
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	85	85	85	85
# of Children Served by First Steps (SFY)	93	106	130	123

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.3	21.5	24.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,177	2,077	1,946	1,994

Data Gathered by:



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The State of The Young Hoosier Child



Crawford County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	825	792	788	742
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.4%	7.3%	7.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.5%	31.4%	31.6%	30.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	124	122	121	106
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	35.2 U	9.2 U	*	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	72.6	70.5	73.6	68.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	34.7	34.4	26.4	34.0
% of Low Birthweight Babies (CY)	7.3	10.7	14.0 U	4.7 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	0.0	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	530	559	571	547
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	30.3	30.8	20.1	18.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	5	4	5	4
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	17.6	14.1	18.5	15.2
# of Children Receiving Child Care Vouchers (FFY)	36	31	27	24
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	7	2	1
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	52	70	70	70
# of Children Served by First Steps (SFY)	20	25	25	20

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	28.3	28.0	29.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	498	523	515	555

Data Gathered by:



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The State of The Young Hoosier Child



Daviess County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,054	3,179	3,212	3,164
% of Total Population who are Ages 0 to 5 (CY)	9.9%	10.1%	10.1%	9.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	34.6%	35.3%	35.2%	34.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	547	536	512	501
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.7 U	31.2 U	18.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.8	60.4	60.0	58.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.9	15.9	15.4	14.6
% of Low Birthweight Babies (CY)	5.7	9.3	7.6	6.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,510	1,533	1,495	1,517
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	16.7	21.7	24.0	13.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	21	23	22	24
# of Registered Child Care Ministries (SFY)	3	3	4	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.8	14.3	15.1	16.2
# of Children Receiving Child Care Vouchers (FFY)	256	235	182	168
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	34	37	41	23
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	94	120	121	121
# of Children Served by First Steps (SFY)	59	91	120	105

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	24.3	23.7	23.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,279	1,222	1,230	1,243

Data Gathered by:



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The State of The Young Hoosier Child



Dearborn County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,770	3,785	3,786	3,626
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.6%	7.6%	7.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.9%	30.1%	30.3%	29.6%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	602	641	372	521
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.1 U	13.5 U	9.1 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	72.8	74.7	71.2	80.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.3	26.5	36.6	18.0
% of Low Birthweight Babies (CY)	7.8	8.9	4.3	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,774	1,813	1,863	1,820
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.4	16.0	15.3	10.2

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	7	7	7	7
# of Licensed Child Care Homes (SFY)	8	7	7	9
# of Registered Child Care Ministries (SFY)	2	2	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	21.6	22.4	24.0	23.4
# of Children Receiving Child Care Vouchers (FFY)	202	179	144	147
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	31	17	50	16
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	115	132	132	132
# of Children Served by First Steps (SFY)	91	113	106	93

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	12.8	14.2	13.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,838	1,669	1,625	1,593

Data Gathered by:



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The State of The Young Hoosier Child



Decatur County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,081	2,030	2,011	1,965
% of Total Population who are Ages 0 to 5 (CY)	8.1%	7.9%	7.8%	7.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.5%	31.0%	30.7%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	318	361	315	305
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	19.3 U	12.6 U	23.0 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	65.4	64.8	56.8	58.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.9	26.9	22.9	26.2
% of Low Birthweight Babies (CY)	9.4	7.5	6.7	8.2
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,205	1,253	1,256	1,194
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	22.6	21.4	19.7	31.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	9	9	8	9
# of Registered Child Care Ministries (SFY)	1	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	15.5	16.0	15.7	16.6
# of Children Receiving Child Care Vouchers (FFY)	105	88	60	61
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	23	22	24	16
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	36	36	36	36
# of Children Served by First Steps (SFY)	151	171	125	82

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.4	21.7	21.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,245	1,199	1,203	1,162

Data Gathered by:



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The State of The Young Hoosier Child



DeKalb County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,466	3,420	3,453	3,367
% of Total Population who are Ages 0 to 5 (CY)	8.2%	8.1%	8.2%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.6%	30.6%	31.1%	30.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	571	522	565	534
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	24.7	24.7	14.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.7	70.7	70.6	65.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	31.3	28.0	28.0	22.8
% of Low Birthweight Babies (CY)	6.7	8.0	6.7	6.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,919	2,042	2,100	2,026
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	27.3	42.3	42.0	11.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	5	5	5	5
# of Licensed Child Care Homes (SFY)	11	13	12	10
# of Registered Child Care Ministries (SFY)	4	4	4	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.2	13.9	14.1	13.4
# of Children Receiving Child Care Vouchers (FFY)	158	123	90	70
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	34	32	42	19
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	173	199	199	199
# of Children Served by First Steps (SFY)	99	115	116	136

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	14.5	15.6	18.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,602	1,822	1,812	1,779

Data Gathered by:



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The State of The Young Hoosier Child



Delaware County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	7,674	7,709	7,571	7,575
% of Total Population who are Ages 0 to 5 (CY)	6.6%	6.6%	6.4%	6.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.4%	32.4%	32.4%	32.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,340	1,268	1,307	1,245
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	14.7	13.1	14.6	10.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	78.7	77.3	73.7	79.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	20.6	24.9	25.1	22.8
% of Low Birthweight Babies (CY)	8.9	9.2	9.7	8.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	5,126	5,420	5,595	5,563
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	9	0	0	5

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.2	22.3	20.8	11.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	13	12	13	13
# of Licensed Child Care Homes (SFY)	35	34	32	31
# of Registered Child Care Ministries (SFY)	9	9	11	13
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	32.8	31.4	31.6	32.4
# of Children Receiving Child Care Vouchers (FFY)	1,266	1,170	1,061	1,083
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	83	101	117	97
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	257	305	305	257
# of Children Served by First Steps (SFY)	213	266	264	239

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.5	27.5	26.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,668	4,883	4,785	4,660

Data Gathered by:



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The State of The Young Hoosier Child



Dubois County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,385	3,334	3,308	3,323
% of Total Population who are Ages 0 to 5 (CY)	8.1%	8.0%	7.9%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.4%	31.3%	31.1%	31.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	539	543	533	515
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.1 U	14.9 U	13.1 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	81.4	78.6	79.4	79.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	11.7	12.5	18.6	14.2
% of Low Birthweight Babies (CY)	5.9	8.7	6.9	6.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,356	1,430	1,414	1,372
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	8.2	7.4	8.0	5.2

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	31	28	29	26
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.6	21.4	21.7	21.6
# of Children Receiving Child Care Vouchers (FFY)	158	149	123	116
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	28	28	46	12
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	62	61	61	61
# of Children Served by First Steps (SFY)	120	107	108	121

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	8.8	9.9	10.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,490	1,576	1,521	1,401

Data Gathered by:



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The State of The Young Hoosier Child



Elkhart County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	19,828	19,462	19,264	19,121
% of Total Population who are Ages 0 to 5 (CY)	10.0%	9.9%	9.8%	9.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	34.8%	34.5%	34.4%	34.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	3,557	3,430	3,163	3,006
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	32.2	31.6	30.8	26.5
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	51.8	53.0	56.1	63.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.0	14.5	13.4	13.8
% of Low Birthweight Babies (CY)	6.9	7.3	7.2	8.0
Infant Mortality Rate per 1,000 Live Births (CY)	**	8.5	**	8.3
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	13,700	13,671	13,436	12,894
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	17	14	14	11

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.8	10.6	9.0	8.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	10	11	11	10
# of Licensed Child Care Homes (SFY)	50	51	46	39
# of Registered Child Care Ministries (SFY)	22	19	20	18
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	9.4	10.8	10.4	9.2
# of Children Receiving Child Care Vouchers (FFY)	1,340	1,170	1,047	1,154
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	135	280	304	151
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	442	556	556	556
# of Children Served by First Steps (SFY)	501	675	550	517

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	21.8	26.8	27.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	13,089	12,814	12,317	11,652

Data Gathered by:



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The State of The Young Hoosier Child



Fayette County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,890	1,854	1,814	1,779
% of Total Population who are Ages 0 to 5 (CY)	7.8%	7.6%	7.5%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.3%	31.5%	31.2%	31.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	304	281	278	262
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	41.5 U	17.9 U	52.0	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	72.0	82.9	76.3	74.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	33.6	28.1	36.0	35.9
% of Low Birthweight Babies (CY)	9.9	7.5	8.3 U	7.3 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,475	1,500	1,484	1,426
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	20.2	20.7	11.1	12.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	10	9	10	10
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.8	13.1	13.7	13.7
# of Children Receiving Child Care Vouchers (FFY)	242	215	185	203
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	21	20	41	22
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	184	179	180	187
# of Children Served by First Steps (SFY)	53	82	89	75

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	27.1	25.5	30.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,329	1,397	1,252	1,084

Data Gathered by:



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The State of The Young Hoosier Child



Floyd County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	5,411	5,517	5,514	5,384
% of Total Population who are Ages 0 to 5 (CY)	7.3%	7.4%	7.4%	7.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.0%	30.8%	30.8%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	878	918	853	912
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.2	13.5	17.4	21.8
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.2	73.6	69.9	77.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	20.8	14.9	11.1	10.5
% of Low Birthweight Babies (CY)	7.6	8.5	8.2	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,010	3,093	3,255	3,132
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	9.5	12.9	7.3	7.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	11	11	9	9
# of Licensed Child Care Homes (SFY)	65	66	70	67
# of Registered Child Care Ministries (SFY)	12	13	14	13
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	42.8	44.2	41.4	40.1
# of Children Receiving Child Care Vouchers (FFY)	879	887	698	873
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	133	135	231	128
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	276	276	276	276
# of Children Served by First Steps (SFY)	220	240	228	227

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.0	19.3	18.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,602	2,595	2,528	2,613

Data Gathered by:



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The State of The Young Hoosier Child



Fountain County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,216	1,217	1,217	1,223
% of Total Population who are Ages 0 to 5 (CY)	7.0%	7.1%	7.1%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.3%	29.2%	29.2%	30.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	209	223	217	190
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	31.0 U	22.2 U	26.0 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	46.9	55.6	46.5	57.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.2	21.5	23.0	33.7
% of Low Birthweight Babies (CY)	8.1	6.3	4.1 U	6.8 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	739	780	818	803
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.5	18.8	14.5	15.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	3	4	5	3
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	7.9	8.9	10.3	7.9
# of Children Receiving Child Care Vouchers (FFY)	7	18	19	19
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	2	4	13	8
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	77	78	78	78
# of Children Served by First Steps (SFY)	34	25	32	39

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.2	19.5	18.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	846	829	819	749

Data Gathered by:



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The State of The Young Hoosier Child



Franklin County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,793	1,838	1,783	1,669
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.9%	7.7%	7.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.7%	29.9%	29.7%	28.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	310	254	137	245
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	16.6 U	8.5 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	65.5	79.5	65.0	73.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	11.0	21.3	29.2	22.0
% of Low Birthweight Babies (CY)	7.4	5.9	10.2 U	4.9 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	860	925	947	912
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	18.0	14.2	11.4	6.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	14	13	14	13
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	12.6	12.0	13.7	12.8
# of Children Receiving Child Care Vouchers (FFY)	97	84	84	87
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	15	13	15	12
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	50	52	52	52
# of Children Served by First Steps (SFY)	59	53	48	41

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	14.9	18.4	16.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	714	716	701	658

Data Gathered by:



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The State of The Young Hoosier Child



Fulton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,570	1,627	1,624	1,628
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.8%	7.8%	7.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.9%	31.2%	31.5%	32.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	267	285	279	261
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	35.4 U	36.1 U	23.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	69.7	61.1	69.9	73.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	34.8	30.9	28.0	28.4
% of Low Birthweight Babies (CY)	5.6	8.8	7.9	8.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,080	1,074	1,107	1,061
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.6	24.9	21.7	23.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	12	14	13	12
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	16.2	17.9	16.8	16.0
# of Children Receiving Child Care Vouchers (FFY)	150	123	83	91
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	18	11	23	15
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	51	51	51	51
# of Children Served by First Steps (SFY)	49	52	45	57

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.5	21.6	23.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,142	1,134	1,026	973

Data Gathered by:



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The State of The Young Hoosier Child



Gibson County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,696	2,704	2,647	2,590
% of Total Population who are Ages 0 to 5 (CY)	8.1%	8.1%	7.9%	7.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.0%	33.2%	32.5%	32.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	452	377	404	396
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.9 U	9.6 U	20.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	77.2	82.8	80.2	83.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	22.6	26.5	25.7	21.5
% of Low Birthweight Babies (CY)	7.1	9.0	6.7	8.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	0.0	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,342	1,376	1,373	1,367
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	5	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	26.2	21.8	24.0	21.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	4	4	5	5
# of Licensed Child Care Homes (SFY)	27	26	25	22
# of Registered Child Care Ministries (SFY)	1	1	1	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	33.3	32.0	34.3	32.5
# of Children Receiving Child Care Vouchers (FFY)	188	167	124	111
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	27	42	46	18
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	80	82	82	82
# of Children Served by First Steps (SFY)	117	125	99	98

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	14.6	15.9	15.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,211	1,200	1,184	1,108

Data Gathered by:



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The State of The Young Hoosier Child



Grant County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,880	4,905	4,775	4,826
% of Total Population who are Ages 0 to 5 (CY)	6.9%	7.0%	6.8%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.5%	32.0%	31.6%	32.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	866	816	840	778
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	27.2	26.1	21.5	19.8
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	65.7	61.5	68.6	66.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.3	28.9	31.1	28.1
% of Low Birthweight Babies (CY)	9.7	8.7	9.6	9.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,640	3,816	3,898	3,882
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	13.0	14.8	14.0	10.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	1
# of Licensed Child Care Homes (SFY)	26	21	18	21
# of Registered Child Care Ministries (SFY)	7	5	5	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	10.8	9.8	8.9	7.4
# of Children Receiving Child Care Vouchers (FFY)	465	362	304	286
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	41	37	89	33
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	206	274	260	260
# of Children Served by First Steps (SFY)	155	185	205	187

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	25.1	29.7	25.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	3,504	3,650	3,565	3,515

Data Gathered by:



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The State of The Young Hoosier Child



Greene County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,408	2,349	2,378	2,327
% of Total Population who are Ages 0 to 5 (CY)	7.3%	7.1%	7.2%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.7%	29.8%	30.2%	30.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	401	369	376	353
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	24.4 U	21.1 U	19.1 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.8	73.2	72.1	73.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.9	27.6	28.7	27.8
% of Low Birthweight Babies (CY)	7.5	8.4	6.4	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,424	1,468	1,492	1,453
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.7	27.2	23.3	13.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	33	31	27	26
# of Registered Child Care Ministries (SFY)	2	2	2	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.8	21.8	19.5	18.9
# of Children Receiving Child Care Vouchers (FFY)	153	161	108	109
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	36	29	41	27
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	64	58	53	53
# of Children Served by First Steps (SFY)	62	83	79	83

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.3	20.7	21.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,388	1,410	1,318	1,273

Data Gathered by:



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The State of The Young Hoosier Child



Hamilton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	25,793	26,089	26,462	25,949
% of Total Population who are Ages 0 to 5 (CY)	9.8%	9.7%	9.6%	9.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.4%	31.9%	31.7%	31.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	3,926	3,910	3,861	3,787
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	6.2	7.9	5.9	5.1
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	82.6	82.7	83.2	83.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	4.5	4.3	4.6	3.9
% of Low Birthweight Babies (CY)	7.8	6.8	7.3	6.8
Infant Mortality Rate per 1,000 Live Births (CY)	5.6	**	5.4	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	4,722	5,285	5,412	5,498
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	3.8	3.2	3.0	2.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	37	40	41	40
# of Licensed Child Care Homes (SFY)	70	61	63	67
# of Registered Child Care Ministries (SFY)	12	12	13	13
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	33.1	33.8	35.3	34.4
# of Children Receiving Child Care Vouchers (FFY)	504	482	450	691
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	104	176	264	101
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	146	153	153	153
# of Children Served by First Steps (SFY)	1,215	1,416	1,401	1,362

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	7.0	6.3	6.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,238	4,309	4,311	4,192

Data Gathered by:



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Hancock County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	5,291	5,253	5,316	5,153
% of Total Population who are Ages 0 to 5 (CY)	7.8%	7.6%	7.6%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.3%	28.8%	29.0%	28.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	897	848	810	757
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	14.9 U	14.1 U	17.0	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	80.2	76.9	78.3	79.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	16.2	14.7	17.9	15.3
% of Low Birthweight Babies (CY)	7.6	8.5	7.5	8.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,880	2,030	2,080	2,139
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	7.8	9.9	7.6	6.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	42	38	29	28
# of Registered Child Care Ministries (SFY)	10	9	10	10
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	19.2	18.2	16.3	16.1
# of Children Receiving Child Care Vouchers (FFY)	274	248	196	213
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	70	98	57	34
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	58	58	53	53
# of Children Served by First Steps (SFY)	334	299	305	259

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	9.0	10.6	10.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,601	1,620	1,677	1,693

Data Gathered by:



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The State of The Young Hoosier Child



Harrison County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,844	2,906	2,877	2,819
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.4%	7.3%	7.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.8%	31.2%	31.0%	30.9%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	473	481	436	400
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	9.6 U	9.8 U	17.8 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	78.6	80.2	74.3	81.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	22.2	21.8	19.3	16.5
% of Low Birthweight Babies (CY)	7.4	7.3	10.1	7.8
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,442	1,471	1,540	1,471
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.8	19.2	17.8	10.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	2	2	2
# of Licensed Child Care Homes (SFY)	25	29	27	22
# of Registered Child Care Ministries (SFY)	3	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	20.8	24.5	24.3	21.5
# of Children Receiving Child Care Vouchers (FFY)	183	220	172	161
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	24	24	38	24
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	52	90	90	90
# of Children Served by First Steps (SFY)	101	120	111	80

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.9	16.5	16.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,457	1,520	1,446	1,372

Data Gathered by:



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The State of The Young Hoosier Child



Hendricks County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	12,170	12,432	12,384	12,133
% of Total Population who are Ages 0 to 5 (CY)	8.6%	8.6%	8.5%	8.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.1%	31.2%	31.0%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,859	1,844	1,787	1,728
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	6.8 U	11.6	15.1	11.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	78.1	77.8	78.8	75.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	10.4	12.9	10.3	10.5
% of Low Birthweight Babies (CY)	9.0	7.1	6.8	6.7
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,131	3,594	3,715	3,611
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	7.4	10.8	6.6	2.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	15	17	17	17
# of Licensed Child Care Homes (SFY)	47	50	53	52
# of Registered Child Care Ministries (SFY)	10	12	12	15
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	27.8	29.6	30.5	30.6
# of Children Receiving Child Care Vouchers (FFY)	303	307	278	383
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	57	82	165	62
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	71	75	75	75
# of Children Served by First Steps (SFY)	528	551	585	612

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	6.5	8.0	7.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,600	2,685	2,665	2,644

Data Gathered by:



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The State of The Young Hoosier Child



Henry County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,299	3,346	3,265	3,170
% of Total Population who are Ages 0 to 5 (CY)	6.7%	6.8%	6.6%	6.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.4%	30.0%	29.6%	29.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	506	541	544	463
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.6 U	25.3	29.5	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	82.2	80.4	74.8	79.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.3	29.6	28.7	27.9
% of Low Birthweight Babies (CY)	7.9	8.5	8.5	7.8
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,213	2,349	2,338	2,312
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	5	5	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	20.8	21.8	17.1	10.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	21	22	19	18
# of Registered Child Care Ministries (SFY)	3	5	5	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	16.1	15.4	14.3	14.2
# of Children Receiving Child Care Vouchers (FFY)	181	183	161	136
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	29	31	45	24
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	158	158	131	131
# of Children Served by First Steps (SFY)	129	148	128	119

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	20.5	23.5	24.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,175	2,177	2,039	1,979

Data Gathered by:



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The State of The Young Hoosier Child



Howard County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	6,391	6,251	6,176	6,166
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.6%	7.5%	7.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.7%	31.6%	31.6%	32.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,131	1,122	994	1,000
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	24.7	21.8	23.9	29.0
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	66.1	66.6	60.8	66.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.2	24.9	28.0	24.5
% of Low Birthweight Babies (CY)	8.0	8.5	7.6	6.8
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	4,133	4,311	4,434	4,429
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	5

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.2	20.2	21.2	18.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	7	7	8	7
# of Licensed Child Care Homes (SFY)	23	25	23	25
# of Registered Child Care Ministries (SFY)	13	16	15	14
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	17.3	24.3	25.1	24.3
# of Children Receiving Child Care Vouchers (FFY)	966	933	731	785
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	157	188	308	58
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	311	436	436	436
# of Children Served by First Steps (SFY)	274	293	316	304

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.8	24.5	24.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,244	4,442	4,461	4,310

Data Gathered by:



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The State of The Young Hoosier Child



Huntington County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,769	2,725	2,711	2,651
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.3%	7.3%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.9%	30.8%	30.9%	30.6%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	488	453	423	417
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	9.3 U	9.7 U	10.0 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.0	77.9	76.6	74.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.6	25.6	26.0	25.2
% of Low Birthweight Babies (CY)	10.0	8.4	10.4	5.3
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,493	1,533	1,562	1,520
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.3	11.8	12.8	11.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	14	15	14	12
# of Registered Child Care Ministries (SFY)	8	7	8	8
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	15.5	17.8	16.3	15.4
# of Children Receiving Child Care Vouchers (FFY)	145	99	86	79
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	6	9	23	20
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	72	148	148	148
# of Children Served by First Steps (SFY)	114	117	124	125

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	14.8	15.8	17.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,581	1,553	1,455	1,394

Data Gathered by:



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The State of The Young Hoosier Child



Jackson County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,365	3,290	3,299	3,395
% of Total Population who are Ages 0 to 5 (CY)	8.1%	7.9%	7.7%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.3%	31.8%	31.6%	32.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	584	583	551	564
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	37.2	43.2	28.3	29.0
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	66.4	74.6	72.8	81.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	23.8	22.5	23.2	22.2
% of Low Birthweight Babies (CY)	7.2	7.2	4.7	7.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,084	2,166	2,159	2,167
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	21.5	22.2	22.9	18.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	31	29	27	23
# of Registered Child Care Ministries (SFY)	5	5	5	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.0	14.4	13.5	12.1
# of Children Receiving Child Care Vouchers (FFY)	265	218	186	144
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	39	55	19	25
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	70	70	70	70
# of Children Served by First Steps (SFY)	117	121	110	101

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	17.4	18.9	20.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,298	2,325	2,279	2,346

Data Gathered by:



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The State of The Young Hoosier Child



Jasper County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,679	2,640	2,639	2,536
% of Total Population who are Ages 0 to 5 (CY)	8.1%	7.9%	7.9%	7.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.1%	30.9%	30.7%	30.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	430	387	397	405
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.0 U	14.8 U	13.8 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.7	70.5	68.0	77.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	22.6	16.0	26.2	21.2
% of Low Birthweight Babies (CY)	7.2	6.7	8.1	6.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,348	1,474	1,456	1,395
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	5.4	9.2	9.1	6.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	1	1
# of Licensed Child Care Homes (SFY)	6	5	6	4
# of Registered Child Care Ministries (SFY)	0	0	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	9.3	9.5	7.4	6.3
# of Children Receiving Child Care Vouchers (FFY)	114	85	74	81
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	20	33	22	21
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	58	58	58	58
# of Children Served by First Steps (SFY)	72	97	106	84

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.9	13.9	14.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,454	1,421	1,299	1,156

Data Gathered by:



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The State of The Young Hoosier Child



Jay County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,800	1,799	1,765	1,796
% of Total Population who are Ages 0 to 5 (CY)	8.4%	8.4%	8.3%	8.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.9%	31.5%	31.4%	31.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	320	285	307	296
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.9 U	22.5 U	28.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	61.9	64.9	59.0	56.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.1	24.9	21.5	21.6
% of Low Birthweight Babies (CY)	10.6	8.8	6.5	4.7 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,038	1,099	1,150	1,140
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.2	11.7	13.9	12.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	10	12	10	11
# of Registered Child Care Ministries (SFY)	1	1	2	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	8.3	10.1	8.5	9.3
# of Children Receiving Child Care Vouchers (FFY)	79	65	48	45
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	4	7	16	6
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	40	54	54	54
# of Children Served by First Steps (SFY)	47	59	57	59

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	24.7	26.0	27.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	954	952	954	945

Data Gathered by:



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The State of The Young Hoosier Child



Jefferson County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,289	2,287	2,267	2,200
% of Total Population who are Ages 0 to 5 (CY)	7.0%	7.0%	7.0%	6.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.4%	30.8%	31.1%	30.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	383	381	391	353
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	15.7 U	13.6 U	13.8 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.1	75.9	77.7	74.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.1	29.7	26.6	25.8
% of Low Birthweight Babies (CY)	8.9	6.6	7.2	9.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,459	1,559	1,582	1,534
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.1	20.7	13.6	14.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	1	2	2
# of Licensed Child Care Homes (SFY)	29	28	28	26
# of Registered Child Care Ministries (SFY)	3	3	3	3
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	25.2	23.7	25.1	24.5
# of Children Receiving Child Care Vouchers (FFY)	132	120	91	96
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	22	26	17	13
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	132	124	124	124
# of Children Served by First Steps (SFY)	77	93	105	120

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	20.0	22.8	22.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,476	1,490	1,410	1,354

Data Gathered by:



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The State of The Young Hoosier Child



Jennings County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,291	2,299	2,273	2,158
% of Total Population who are Ages 0 to 5 (CY)	8.0%	8.1%	8.0%	7.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.9%	30.3%	30.3%	29.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	371	374	370	337
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	41.3	31.0 U	27.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	66.0	63.4	65.4	66.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.5	25.4	27.3	28.8
% of Low Birthweight Babies (CY)	7.8	9.4	6.8	6.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,557	1,687	1,703	1,612
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.3	39.9	43.3	30.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	16	15	15	14
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	15.8	15.6	16.0	15.8
# of Children Receiving Child Care Vouchers (FFY)	192	171	120	135
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	38	25	29	29
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	52	52	52	52
# of Children Served by First Steps (SFY)	98	100	105	88

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.0	22.4	21.6	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,874	1,902	1,838	1,759

Data Gathered by:



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The State of The Young Hoosier Child



Johnson County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	11,614	11,726	11,664	11,477
% of Total Population who are Ages 0 to 5 (CY)	8.5%	8.5%	8.3%	8.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.6%	31.8%	31.6%	31.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,913	1,913	1,861	1,776
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.5	14.1	19.3	11.2
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.4	68.3	72.8	73.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	19.0	18.7	19.6	20.0
% of Low Birthweight Babies (CY)	6.5	7.0	7.7	6.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	5,103	5,365	5,514	5,531
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	5	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	5.4	8.1	10.5	11.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	17	17	17	16
# of Licensed Child Care Homes (SFY)	28	28	29	28
# of Registered Child Care Ministries (SFY)	6	7	7	6
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.5	23.7	24.2	22.9
# of Children Receiving Child Care Vouchers (FFY)	501	573	436	638
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	126	147	131	125
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	112	120	120	120
# of Children Served by First Steps (SFY)	503	592	537	489

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	12.7	14.8	13.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,344	4,434	4,404	4,373

Data Gathered by:



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The State of The Young Hoosier Child



Knox County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,784	2,727	2,697	2,702
% of Total Population who are Ages 0 to 5 (CY)	7.2%	7.1%	7.0%	7.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.2%	33.0%	33.0%	33.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	497	481	424	459
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	20.9 U	16.2 U	21.9 U	26.9
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	82.5	78.4	81.4	82.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	30.4	30.4	30.7	28.3
% of Low Birthweight Babies (CY)	8.7	7.5	7.8	8.5
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,826	1,796	1,841	1,827
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	27.8	26.8	28.9	27.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	6	6	7	7
# of Licensed Child Care Homes (SFY)	28	28	26	27
# of Registered Child Care Ministries (SFY)	3	4	3	3
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	32.7	35.3	36.1	36.6
# of Children Receiving Child Care Vouchers (FFY)	349	277	203	203
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	48	27	64	38
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	283	290	303	303
# of Children Served by First Steps (SFY)	83	109	113	108

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	24.2	22.9	27.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,682	1,642	1,610	1,615

Data Gathered by:



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The State of The Young Hoosier Child



Kosciusko County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	6,590	6,578	6,399	6,278
% of Total Population who are Ages 0 to 5 (CY)	8.5%	8.5%	8.3%	8.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.7%	32.8%	32.4%	32.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,099	1,154	1,000	977
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	27.4	22.2	21.0	21.5
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	63.6	65.2	65.6	58.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	20.9	21.0	16.1	18.3
% of Low Birthweight Babies (CY)	6.9	7.8	6.7	7.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,358	3,633	3,682	3,525
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.0	10.8	9.2	6.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	5	7	7	7
# of Licensed Child Care Homes (SFY)	27	23	21	24
# of Registered Child Care Ministries (SFY)	8	9	8	9
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	12.2	12.8	12.7	13.7
# of Children Receiving Child Care Vouchers (FFY)	282	260	179	200
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	34	54	73	55
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	216	215	215	215
# of Children Served by First Steps (SFY)	137	148	148	170

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	16.0	19.7	16.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,852	2,991	3,021	2,947

Data Gathered by:



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The State of The Young Hoosier Child



LaGrange County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,517	4,516	4,447	4,376
% of Total Population who are Ages 0 to 5 (CY)	12.1%	12.2%	12.0%	11.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	35.3%	35.1%	34.8%	34.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	783	787	714	791
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	14.7 U	13.5 U	7.9 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	37.3	37.9	35.6	38.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	12.4	11.9	9.7	7.5
% of Low Birthweight Babies (CY)	5.5	4.6	6.0	5.3
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,041	1,121	1,096	1,051
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.5	8.4	8.9	8.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	8	7	7	8
# of Registered Child Care Ministries (SFY)	3	3	3	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	4.0	3.5	3.6	4.0
# of Children Receiving Child Care Vouchers (FFY)	27	35	36	27
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	15	25	11	10
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	54	54	54	54
# of Children Served by First Steps (SFY)	48	63	69	66

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	20.7	26.9	21.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,117	1,105	1,061	960

Data Gathered by:



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The State of The Young Hoosier Child



Lake County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	41,101	40,694	40,127	39,591
% of Total Population who are Ages 0 to 5 (CY)	8.3%	8.2%	8.1%	8.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.8%	31.8%	31.6%	31.6%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	6,759	6,663	6,724	6,488
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	22.6	21.7	24.6	24.2
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	59.6	56.3	59.4	64.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	13.0	13.5	13.3	12.7
% of Low Birthweight Babies (CY)	10.6	10.2	9.8	9.6
Infant Mortality Rate per 1,000 Live Births (CY)	9.9	8.6	7.9	6.8
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	28,472	28,655	28,395	27,737
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	27	<5*	18	21

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	7.3	9.8	11.3	11.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	46	45	49	49
# of Licensed Child Care Homes (SFY)	260	265	265	250
# of Registered Child Care Ministries (SFY)	46	52	57	49
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.7	23.5	24.8	24.2
# of Children Receiving Child Care Vouchers (FFY)	6,870	6,574	6,064	6,287
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	688	910	1,120	935
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	1,171	1,296	1,296	1,296
# of Children Served by First Steps (SFY)	1,151	1,447	1,374	1,464

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	24.8	26.0	30.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	26,463	26,439	25,140	23,880

Data Gathered by:



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The State of The Young Hoosier Child



LaPorte County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	8,208	8,115	7,973	7,943
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.3%	7.2%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.7%	31.7%	31.5%	31.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,438	1,411	1,380	1,309
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	33.3	30.1	30.3	22.5
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.1	62.3	58.9	58.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.2	30.9	27.3	27.3
% of Low Birthweight Babies (CY)	11.1	9.0	9.9	9.5
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	5,991	6,189	6,200	6,126
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	8

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.0	6.6	7.8	6.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	8	7	7	7
# of Licensed Child Care Homes (SFY)	70	70	80	86
# of Registered Child Care Ministries (SFY)	5	3	3	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	20.6	20.2	21.9	22.6
# of Children Receiving Child Care Vouchers (FFY)	1,141	1,055	1,007	1,145
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	162	197	166	135
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	311	347	367	347
# of Children Served by First Steps (SFY)	249	280	238	201

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.0	25.0	25.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	5,668	5,561	5,350	5,294

Data Gathered by:



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The State of The Young Hoosier Child



Lawrence County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,341	3,337	3,298	3,262
% of Total Population who are Ages 0 to 5 (CY)	7.2%	7.2%	7.1%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.4%	30.6%	30.4%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	507	522	513	485
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	26.4	30.1	24.8	29.6
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.1	72.2	76.0	77.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.2	28.4	32.4	29.3
% of Low Birthweight Babies (CY)	7.9	9.6	8.0	12.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,134	2,208	2,211	2,116
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.9	16.8	12.0	8.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	39	35	31	24
# of Registered Child Care Ministries (SFY)	4	4	4	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	25.3	23.1	19.7	18.4
# of Children Receiving Child Care Vouchers (FFY)	319	250	217	185
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	24	50	36	11
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	203	226	226	226
# of Children Served by First Steps (SFY)	110	111	113	121

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.4	22.6	23.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,942	1,931	1,868	1,846

Data Gathered by:



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The State of The Young Hoosier Child



Madison County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	9,851	9,917	9,752	9,616
% of Total Population who are Ages 0 to 5 (CY)	7.5%	7.5%	7.4%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.0%	32.4%	32.2%	32.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,674	1,598	1,631	1,612
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	30.2	29.6	21.9	21.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.2	66.0	63.7	71.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.7	24.5	22.7	21.9
% of Low Birthweight Babies (CY)	8.1	7.5	9.9	7.3
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	6,491	6,933	7,205	7,145
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	6	5	5	6

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	16.9	16.6	18.5	16.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	7	7	6	6
# of Licensed Child Care Homes (SFY)	52	55	53	52
# of Registered Child Care Ministries (SFY)	11	12	15	14
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	15.2	16.1	15.1	14.9
# of Children Receiving Child Care Vouchers (FFY)	912	731	630	790
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	76	147	180	184
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	502	515	515	515
# of Children Served by First Steps (SFY)	390	459	489	452

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	21.5	27.7	29.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	5,807	5,855	5,775	5,808

Data Gathered by:



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The State of The Young Hoosier Child



Marion County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	79,747	80,249	80,892	83,085
% of Total Population who are Ages 0 to 5 (CY)	9.0%	8.9%	8.9%	9.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	35.7%	35.6%	35.7%	36.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	15,401	15,333	15,346	14,583
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	35.5	31.5	32.3	24.3
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	60.6	60.4	60.9	63.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.4	15.7	15.3	15.3
% of Low Birthweight Babies (CY)	9.4	9.4	9.7	9.6
Infant Mortality Rate per 1,000 Live Births (CY)	9.1	8.1	11.5	9.7
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	63,534	66,827	67,821	68,473
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	65	53	53	59

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.9	22.2	21.7	19.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	111	113	123	124
# of Licensed Child Care Homes (SFY)	480	483	487	461
# of Registered Child Care Ministries (SFY)	180	190	205	204
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	27.0	31.0	33.2	33.0
# of Children Receiving Child Care Vouchers (FFY)	14,561	13,933	13,516	16,435
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	2,549	3,751	4,063	2,044
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	1,901	2,060	2,060	2,060
# of Children Served by First Steps (SFY)	3,331	3,855	3,896	3,815

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	28.4	30.7	31.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	53,137	55,774	55,048	54,534

Data Gathered by:



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The State of The Young Hoosier Child



Marshall County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,052	3,962	3,901	3,838
% of Total Population who are Ages 0 to 5 (CY)	8.6%	8.4%	8.3%	8.2%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.6%	30.9%	30.9%	30.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	667	621	619	575
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.3 U	22.0	23.2	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	64.9	62.0	65.9	63.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.3	20.1	20.8	20.2
% of Low Birthweight Babies (CY)	7.2	3.9	9.4	6.1
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,204	2,272	2,244	2,192
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.1	11.8	7.1	11.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	24	23	23	19
# of Registered Child Care Ministries (SFY)	7	7	7	7
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	9.9	9.9	10.4	8.7
# of Children Receiving Child Care Vouchers (FFY)	129	112	95	108
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	37	33	26	17
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	85	108	88	88
# of Children Served by First Steps (SFY)	101	110	111	128

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.2	19.0	17.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,044	2,013	1,975	1,983

Data Gathered by:



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The State of The Young Hoosier Child



Martin County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	829	811	813	781
% of Total Population who are Ages 0 to 5 (CY)	8.0%	7.9%	7.9%	7.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.2%	33.1%	32.8%	31.9%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	140	146	123	116
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	31.6 U	26.2 U	28.4 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.7	76.0	77.2	80.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.4	20.5	22.0	23.3
% of Low Birthweight Babies (CY)	7.1	5.5	6.5 U	8.6 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	430	401	429	449
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.4	34.5	21.1	14.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	9	8	7	7
# of Registered Child Care Ministries (SFY)	0	0	0	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	31.4	27.6	22.3	21.7
# of Children Receiving Child Care Vouchers (FFY)	56	43	62	42
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	8	7	6
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	38	40	40	40
# of Children Served by First Steps (SFY)	20	42	37	28

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.5	18.9	20.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	448	442	415	449

Data Gathered by:



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The State of The Young Hoosier Child



Miami County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,735	2,681	2,543	2,464
% of Total Population who are Ages 0 to 5 (CY)	7.3%	7.2%	6.9%	6.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.4%	31.2%	30.5%	30.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	433	416	406	390
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	24.6 U	16.0 U	27.3 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.8	73.1	74.1	75.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.9	29.1	22.7	28.2
% of Low Birthweight Babies (CY)	9.5	10.8	11.1	6.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,752	1,782	1,790	1,752
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	7	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	21.0	30.2	31.4	28.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	6	6	7	6
# of Registered Child Care Ministries (SFY)	8	8	8	7
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	4.0	4.5	5.2	4.6
# of Children Receiving Child Care Vouchers (FFY)	226	185	153	162
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	43	60	87	52
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	60	88	88	88
# of Children Served by First Steps (SFY)	82	104	81	95

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.5	23.8	22.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,735	1,678	1,552	1,557

Data Gathered by:



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The State of The Young Hoosier Child



Monroe County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	7,684	7,643	7,700	7,692
% of Total Population who are Ages 0 to 5 (CY)	5.7%	5.6%	5.6%	5.5%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	34.5%	34.4%	34.7%	34.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,388	1,298	1,281	1,318
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	5.5	5.5	5.0	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.2	73.7	74.0	78.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	18.8	16.9	18.0	15.3
% of Low Birthweight Babies (CY)	6.3	7.7	6.7	7.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	4,004	4,276	4,181	4,203
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.8	21.0	17.8	10.2

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	20	19	21	19
# of Licensed Child Care Homes (SFY)	69	64	63	63
# of Registered Child Care Ministries (SFY)	12	12	13	11
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	38.9	37.7	37.5	34.0
# of Children Receiving Child Care Vouchers (FFY)	769	664	541	612
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	179	160	205	77
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	235	324	324	324
# of Children Served by First Steps (SFY)	225	232	231	236

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	17.6	18.1	17.6	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	3,766	3,848	3,749	3,676

Data Gathered by:



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The State of The Young Hoosier Child



Montgomery County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,947	2,974	2,925	2,968
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.8%	7.7%	7.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.3%	32.0%	32.1%	32.6%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	493	453	508	445
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	34.5	11.7 U	24.5 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	65.9	64.7	59.4	67.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	31.4	30.7	34.6	29.4
% of Low Birthweight Babies (CY)	7.5	8.2	9.3	10.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,756	1,828	1,829	1,814
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	19.0	27.9	29.5	18.2

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	10	10	11	12
# of Registered Child Care Ministries (SFY)	6	6	5	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.5	13.0	13.5	13.6
# of Children Receiving Child Care Vouchers (FFY)	229	260	185	179
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	43	39	37	22
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	77	87	87	87
# of Children Served by First Steps (SFY)	103	124	126	106

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.8	22.9	24.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,775	1,761	1,691	1,792

Data Gathered by:



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The State of The Young Hoosier Child



Morgan County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	5,339	5,167	5,188	5,066
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.5%	7.5%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.0%	29.7%	30.0%	29.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	877	863	807	772
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.7	23.9	12.6 U	15.1
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	66.0	68.7	66.5	68.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.1	28.7	30.2	26.3
% of Low Birthweight Babies (CY)	8.1	8.6	6.1	8.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,967	3,216	3,246	3,162
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.5	12.0	8.0	5.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	7	6	7	6
# of Licensed Child Care Homes (SFY)	15	14	11	13
# of Registered Child Care Ministries (SFY)	8	8	8	9
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.4	13.8	13.9	13.2
# of Children Receiving Child Care Vouchers (FFY)	291	250	191	210
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	26	21	75	53
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	135	125	125	125
# of Children Served by First Steps (SFY)	150	188	194	176

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.0	18.1	17.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,619	2,601	2,443	2,398

Data Gathered by:



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The State of The Young Hoosier Child



Newton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	995	971	970	921
% of Total Population who are Ages 0 to 5 (CY)	6.9%	6.8%	6.8%	6.5%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.3%	29.4%	29.6%	29.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	138	162	137	140
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	29.1 U	15.0 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	62.3	71.0	64.2	72.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.0	27.2	25.5	23.6
% of Low Birthweight Babies (CY)	5.1	8.0	8.8 U	*
Infant Mortality Rate per 1,000 Live Births (CY)	**	0.0	0.0	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	593	693	687	672
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	19.3	27.3	12.9	13.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	2	2	3	4
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	3.4	3.0	4.7	6.3
# of Children Receiving Child Care Vouchers (FFY)	15	17	17	17
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	8	9	2	3
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	54	54	54	54
# of Children Served by First Steps (SFY)	34	28	20	20

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.8	16.8	22.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	587	583	526	569

Data Gathered by:



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The State of The Young Hoosier Child



Noble County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,292	4,184	4,157	4,049
% of Total Population who are Ages 0 to 5 (CY)	9.0%	8.8%	8.8%	8.5%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.9%	32.4%	32.5%	32.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	703	703	642	595
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.7 U	19.8 U	17.5 U	25.9
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	67.3	68.8	63.4	63.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.5	22.5	24.3	24.0
% of Low Birthweight Babies (CY)	8.8	7.8	6.4	7.6
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,293	2,331	2,304	2,239
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.7	15.6	15.7	13.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	4	5	4	3
# of Licensed Child Care Homes (SFY)	9	8	8	8
# of Registered Child Care Ministries (SFY)	2	2	2	3
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.5	14.7	12.8	10.2
# of Children Receiving Child Care Vouchers (FFY)	101	93	83	88
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	34	46	42	17
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	74	90	90	90
# of Children Served by First Steps (SFY)	95	135	117	105

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.0	19.4	18.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	2,117	2,110	2,076	2,062

Data Gathered by:



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The State of The Young Hoosier Child



Ohio County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	376	370	369	352
% of Total Population who are Ages 0 to 5 (CY)	6.2%	6.0%	6.0%	5.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	27.1%	27.5%	28.5%	27.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	60	57	53	56
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	0.0 U	9.7 U	*	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.0	63.2	67.9	89.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	23.3	35.1	41.5	26.8 U
% of Low Birthweight Babies (CY)	8.3	10.5	*	*
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	179	203	184	168
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.8	8.6	16.5	15.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	1	1	1	1
# of Registered Child Care Ministries (SFY)	1	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	10.6	10.6	11.5	11.5
# of Children Receiving Child Care Vouchers (FFY)	20	24	22	22
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	1	4	1	1
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	20	20	20	20
# of Children Served by First Steps (SFY)	10	4	8	9

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	14.9	14.3	17.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	206	195	190	197

Data Gathered by:



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The State of The Young Hoosier Child



Orange County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,475	1,487	1,457	1,426
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.5%	7.4%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.8%	30.0%	30.0%	29.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	264	224	237	216
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.7 U	13.4 U	13.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	72.3	72.3	73.0	72.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.5	33.5	30.0	32.9
% of Low Birthweight Babies (CY)	10.6	6.3	9.3	8.8 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,058	1,094	1,082	1,017
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.3	17.9	19.9	15.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	20	21	18	17
# of Registered Child Care Ministries (SFY)	0	0	1	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	21.5	23.7	20.6	20.6
# of Children Receiving Child Care Vouchers (FFY)	114	102	90	76
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	18	25	17	4
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	58	51	51	51
# of Children Served by First Steps (SFY)	54	52	48	34

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	24.5	26.5	25.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,115	1,062	1,010	1,001

Data Gathered by:



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The State of The Young Hoosier Child



Owen County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,500	1,506	1,471	1,412
% of Total Population who are Ages 0 to 5 (CY)	6.9%	7.0%	6.8%	6.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.0%	29.9%	29.4%	28.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	249	259	236	249
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	27.0 U	20.0 U	20.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.3	68.0	69.5	71.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	32.9	32.0	29.7	31.3
% of Low Birthweight Babies (CY)	9.2	5.8	6.8 U	9.2
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	0.0	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,031	1,044	1,023	994
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.0	32.1	21.2	12.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	11	11	8	8
# of Registered Child Care Ministries (SFY)	1	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.1	14.2	10.8	10.8
# of Children Receiving Child Care Vouchers (FFY)	87	83	83	71
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	10	14	20	10
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	53	54	54	54
# of Children Served by First Steps (SFY)	46	79	65	41

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.0	22.5	25.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	891	954	914	825

Data Gathered by:



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The State of The Young Hoosier Child



Parke County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,234	1,202	1,177	1,165
% of Total Population who are Ages 0 to 5 (CY)	7.1%	6.9%	6.8%	6.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.1%	32.0%	31.8%	32.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	204	187	188	192
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.6 U	22.3 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	64.7	62.0	50.0	61.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.4	22.5	19.7	16.7
% of Low Birthweight Babies (CY)	5.4	7.0	6.9 U	8.3 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	614	680	684	681
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.1	7.1	9.5	6.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	13	12	11	9
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.3	22.0	21.3	18.8
# of Children Receiving Child Care Vouchers (FFY)	101	107	94	72
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	18	9	11	7
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	46	58	58	58
# of Children Served by First Steps (SFY)	22	37	44	29

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	27.8	27.5	28.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	565	571	554	606

Data Gathered by:



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The State of The Young Hoosier Child



Perry County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,378	1,386	1,366	1,366
% of Total Population who are Ages 0 to 5 (CY)	7.1%	7.2%	7.1%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.8%	33.6%	33.1%	33.6%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	223	209	221	214
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.9 U	19.9 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	71.7	72.2	72.4	70.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	30.9	28.7	26.2	30.8
% of Low Birthweight Babies (CY)	8.5	12.0	10.4	5.6 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	695	757	749	707
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	29.5	23.4	29.0	17.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	2
# of Licensed Child Care Homes (SFY)	8	8	9	8
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.3	21.8	23.5	16.1
# of Children Receiving Child Care Vouchers (FFY)	130	99	80	55
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	17	16	15	4
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	92	110	110	110
# of Children Served by First Steps (SFY)	33	37	34	38

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	16.8	17.3	17.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	685	735	700	677

Data Gathered by:



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The State of The Young Hoosier Child



Pike County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	941	932	921	888
% of Total Population who are Ages 0 to 5 (CY)	7.2%	7.3%	7.2%	7.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.1%	32.1%	32.0%	31.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	152	138	145	149
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.3 U	8.8 U	22.0 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	82.9	76.1	73.8	83.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	23.7	33.3	31.0	21.5
% of Low Birthweight Babies (CY)	12.5	6.5	14.5	4.0 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	0.0	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	462	507	496	486
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	37.7	44.9	37.9	32.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	11	12	10	11
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.9	24.4	22.8	24.4
# of Children Receiving Child Care Vouchers (FFY)	48	48	48	33
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	7	10	7
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	31	32	32	32
# of Children Served by First Steps (SFY)	36	30	29	24

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.9	20.1	17.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	441	453	482	457

Data Gathered by:



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The State of The Young Hoosier Child



Porter County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	12,206	11,981	11,828	11,534
% of Total Population who are Ages 0 to 5 (CY)	7.5%	7.3%	7.2%	7.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.5%	30.0%	29.7%	29.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,886	1,868	1,772	1,728
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	11.3	7.6	10.0	9.5
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	71.7	70.2	74.0	79.2
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.9	16.1	16.6	16.0
% of Low Birthweight Babies (CY)	7.7	7.5	7.2	5.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	5,021	5,383	5,455	5,384
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	8.0	13.0	9.4	5.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	13	12	12	12
# of Licensed Child Care Homes (SFY)	27	25	24	25
# of Registered Child Care Ministries (SFY)	14	13	11	8
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.9	13.2	16.2	16.1
# of Children Receiving Child Care Vouchers (FFY)	752	736	597	702
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	98	144	236	116
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	148	172	172	172
# of Children Served by First Steps (SFY)	412	474	473	402

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	10.0	13.5	14.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,651	4,710	4,497	4,500

Data Gathered by:



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The State of The Young Hoosier Child



Posey County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,739	1,759	1,796	1,727
% of Total Population who are Ages 0 to 5 (CY)	6.7%	6.8%	6.9%	6.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	27.5%	28.3%	29.4%	29.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	250	284	283	272
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	20.3 U	14.8 U	15.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	79.2	78.5	74.9	81.6
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.6	18.7	23.3	23.2
% of Low Birthweight Babies (CY)	8.4	7.0	7.4	6.6 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	706	828	861	851
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	13.1	19.9	18.2	13.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	8	8	8	7
# of Registered Child Care Ministries (SFY)	2	2	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	27.2	25.2	25.7	24.6
# of Children Receiving Child Care Vouchers (FFY)	161	137	124	116
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	23	30	20	15
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	66	91	91	91
# of Children Served by First Steps (SFY)	61	72	62	63

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	11.3	13.5	16.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	607	665	644	602

Data Gathered by:



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The State of The Young Hoosier Child



Pulaski County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,010	1,030	954	951
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.6%	7.1%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.7%	30.9%	30.0%	30.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	160	161	166	149
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	17.7 U	7.1 U	24.3 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.8	70.2	60.8	75.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	30.0	33.5	38.0	28.2
% of Low Birthweight Babies (CY)	5.6	10.6	6.0 U	4.0 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	0.0

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	613	620	605	555
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.1	14.1	16.3	12.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	8	6	7	6
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	11.8	9.2	10.7	9.1
# of Children Receiving Child Care Vouchers (FFY)	48	47	41	41
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	12	15	16	2
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	36	36	36	36
# of Children Served by First Steps (SFY)	16	17	21	21

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.9	21.6	20.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	695	667	603	468

Data Gathered by:



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The State of The Young Hoosier Child



Putnam County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,404	2,362	2,332	2,294
% of Total Population who are Ages 0 to 5 (CY)	6.3%	6.2%	6.1%	6.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.2%	29.1%	29.3%	29.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	418	405	383	353
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	15.4 U	14.2 U	18.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	74.6	75.3	70.0	74.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	32.5	25.9	22.5	19.0
% of Low Birthweight Babies (CY)	7.7	5.7	7.8	6.5
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,348	1,417	1,407	1,378
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	15.7	18.1	12.6	9.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	17	15	14	14
# of Registered Child Care Ministries (SFY)	4	4	4	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	21.1	21.3	21.1	20.5
# of Children Receiving Child Care Vouchers (FFY)	102	113	105	103
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	26	33	42	18
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	71	92	92	92
# of Children Served by First Steps (SFY)	94	113	105	86

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	17.0	17.6	17.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,542	1,484	1,402	1,293

Data Gathered by:



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The State of The Young Hoosier Child



Randolph County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,903	1,907	1,844	1,808
% of Total Population who are Ages 0 to 5 (CY)	7.2%	7.3%	7.1%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.2%	29.4%	29.0%	28.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	338	324	291	312
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	23.1 U	26.3 U	18.3 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	77.8	78.7	77.0	76.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	25.7	28.4	29.2	28.2
% of Low Birthweight Babies (CY)	8.6	9.3	11.0	9.9
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,294	1,367	1,402	1,362
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	9.6	15.5	17.5	11.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	0	0	0
# of Licensed Child Care Homes (SFY)	6	5	4	5
# of Registered Child Care Ministries (SFY)	3	3	3	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	6.8	3.8	3.2	3.9
# of Children Receiving Child Care Vouchers (FFY)	82	85	52	41
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	9	9	11	6
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	71	55	55	55
# of Children Served by First Steps (SFY)	61	63	66	72

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	26.7	26.2	26.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,209	1,289	1,272	1,236

Data Gathered by:



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The State of The Young Hoosier Child



Ripley County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,332	2,281	2,285	2,248
% of Total Population who are Ages 0 to 5 (CY)	8.2%	7.9%	7.9%	7.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.8%	30.0%	30.2%	30.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	369	384	352	374
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	16.6 U	25.9 U	19.5 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.6	74.2	64.2	67.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	26.6	27.6	23.9	22.2
% of Low Birthweight Babies (CY)	6.5	6.8	6.8	7.0
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,152	1,205	1,219	1,230
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	5	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	19.1	18.2	13.6	9.9

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	5	5	4	3
# of Licensed Child Care Homes (SFY)	14	16	15	13
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	32.4	32.4	31.8	26.4
# of Children Receiving Child Care Vouchers (FFY)	84	91	88	74
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	21	24	23	13
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	69	54	54	54
# of Children Served by First Steps (SFY)	77	80	88	82

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	15.8	15.1	16.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,304	1,302	1,323	1,215

Data Gathered by:



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The State of The Young Hoosier Child



Rush County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,331	1,266	1,236	1,181
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.3%	7.1%	6.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.8%	28.7%	28.8%	28.2%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	223	197	164	176
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	38.8 U	26.0 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.1	72.1	73.2	76.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	26.9	28.9	25.6	26.1
% of Low Birthweight Babies (CY)	9.9	9.1	7.3	6.8 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	777	792	764	710
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	26.8	38.3	15.5	10.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	9	9	9	10
# of Registered Child Care Ministries (SFY)	1	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	10.5	10.9	11.5	12.7
# of Children Receiving Child Care Vouchers (FFY)	41	38	47	29
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	10	18	9	5
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	54	54	86	86
# of Children Served by First Steps (SFY)	52	56	51	34

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	18.5	20.5	20.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	691	647	632	554

Data Gathered by:



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The State of The Young Hoosier Child



Scott County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,839	1,788	1,767	1,750
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.4%	7.3%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.1%	30.3%	30.5%	30.9%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	346	327	283	278
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	43.2 U	30.4 U	20.5 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	57.8	64.2	58.0	69.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	36.4	33.6	36.7	32.0
% of Low Birthweight Babies (CY)	9.8	9.8	8.1	9.0
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,300	1,331	1,364	1,323
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	34.8	42.3	36.8	30.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	11	10	9	8
# of Registered Child Care Ministries (SFY)	1	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	17.8	19.1	18.5	17.0
# of Children Receiving Child Care Vouchers (FFY)	199	156	123	83
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	18	13	12	8
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	62	70	70	70
# of Children Served by First Steps (SFY)	74	72	76	65

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	25.7	28.8	34.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,409	1,429	1,419	1,340

Data Gathered by:



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The State of The Young Hoosier Child



Shelby County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	3,394	3,354	3,318	3,251
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.5%	7.5%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.7%	30.5%	30.7%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	572	538	503	532
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	29.9	19.5 U	15.7 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.6	69.9	69.8	66.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.6	25.5	27.6	27.4
% of Low Birthweight Babies (CY)	7.5	8.0	7.2	4.7
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	2,070	2,148	2,164	2,103
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	13.7	14.4	13.5	11.5

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	2	2
# of Licensed Child Care Homes (SFY)	15	16	17	14
# of Registered Child Care Ministries (SFY)	1	2	2	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.6	15.6	16.4	15.2
# of Children Receiving Child Care Vouchers (FFY)	188	179	154	157
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	37	39	31	20
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	68	68	68	68
# of Children Served by First Steps (SFY)	166	169	159	141

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.1	18.9	18.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,790	1,848	1,895	1,796

Data Gathered by:



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The State of The Young Hoosier Child



Spencer County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,448	1,513	1,491	1,436
% of Total Population who are Ages 0 to 5 (CY)	6.9%	7.2%	7.1%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.4%	29.7%	29.6%	28.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	247	245	214	218
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	14.8 U	13.0 U	17.6 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	79.4	79.6	71.0	77.1
% of Mothers Who Reported Smoking During Pregnancy (CY)	16.2	20.8	23.8	20.2
% of Low Birthweight Babies (CY)	6.9	6.5	8.4 U	8.3 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	0.0
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	658	720	714	704
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	12.2	14.2	12.0	15.4

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	10	11	14	13
# of Registered Child Care Ministries (SFY)	3	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	20.5	22.9	26.3	25.3
# of Children Receiving Child Care Vouchers (FFY)	111	100	100	81
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	9	12	8	8
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	68	101	101	101
# of Children Served by First Steps (SFY)	43	52	51	52

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.9	15.2	14.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	655	673	654	646

Data Gathered by:



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The State of The Young Hoosier Child



St. Joseph County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	21,800	21,496	21,370	21,155
% of Total Population who are Ages 0 to 5 (CY)	8.2%	8.1%	8.0%	7.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.7%	32.6%	32.5%	32.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	3,762	3,832	3,565	3,500
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	25.0	22.4	19.2	17.8
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	64.3	62.9	63.7	67.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	15.7	15.1	12.4	11.9
% of Low Birthweight Babies (CY)	8.4	8.4	7.9	8.6
Infant Mortality Rate per 1,000 Live Births (CY)	9.6	7.3	10.1	8.6
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	13,784	14,275	14,557	14,570
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	37	17	17	33

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	16.8	17.7	13.6	9.3

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	25	27	25	25
# of Licensed Child Care Homes (SFY)	132	136	127	123
# of Registered Child Care Ministries (SFY)	33	33	33	30
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	22.6	25.8	24.2	23.9
# of Children Receiving Child Care Vouchers (FFY)	2,801	2,600	2,475	2,830
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	341	346	608	274
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	631	594	594	594
# of Children Served by First Steps (SFY)	762	870	803	737

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.1	24.1	29.6	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	12,571	12,501	12,001	12,009

Data Gathered by:



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The State of The Young Hoosier Child



Starke County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,727	1,742	1,761	1,699
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.5%	7.5%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.7%	30.6%	31.0%	30.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	317	307	280	277
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	26.7 U	18.8 U	21.4 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.2	69.4	68.9	74.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	31.9	34.5	30.7	27.8
% of Low Birthweight Babies (CY)	6.6	7.5	7.9	6.1 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,326	1,405	1,369	1,314
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	16.4	15.8	10.8	13.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	4	3	2	4
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	3.4	2.7	2.3	4.0
# of Children Receiving Child Care Vouchers (FFY)	64	65	55	59
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	14	17	18	8
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	137	114	134	134
# of Children Served by First Steps (SFY)	65	56	42	55

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.0	30.2	25.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,271	1,284	1,191	1,178

Data Gathered by:



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The State of The Young Hoosier Child



Steuben County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,353	2,340	2,280	2,189
% of Total Population who are Ages 0 to 5 (CY)	6.9%	6.8%	6.7%	6.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.1%	29.2%	29.2%	29.0%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	411	387	359	354
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.9 U	26.3 U	18.3 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.6	71.3	68.5	66.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.5	35.4	26.7	24.0
% of Low Birthweight Babies (CY)	6.8	8.8	6.1	8.5
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,430	1,505	1,563	1,487
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	21.8	24.9	22.8	18.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	13	12	11	11
# of Registered Child Care Ministries (SFY)	6	5	5	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	13.3	13.5	13.5	13.4
# of Children Receiving Child Care Vouchers (FFY)	116	101	84	100
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	17	17	46	27
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	133	133	133	133
# of Children Served by First Steps (SFY)	55	79	80	83

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.3	19.9	21.0	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,640	1,699	1,682	1,686

Data Gathered by:



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The State of The Young Hoosier Child



Sullivan County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,385	1,395	1,381	1,336
% of Total Population who are Ages 0 to 5 (CY)	6.4%	6.5%	6.4%	6.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.7%	30.4%	30.2%	30.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	216	235	214	239
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	5.2 U	18.2 U	28.9 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	78.7	71.5	65.0	71.5
% of Mothers Who Reported Smoking During Pregnancy (CY)	27.3	26.8	26.6	24.7
% of Low Birthweight Babies (CY)	9.7	6.4	4.7 U	9.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	892	929	920	960
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	15.9	14.7	17.7	18.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	20	19	18	14
# of Registered Child Care Ministries (SFY)	0	1	1	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	25.2	23.3	22.2	16.6
# of Children Receiving Child Care Vouchers (FFY)	146	134	98	93
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	14	13	18	12
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	41	34	25	25
# of Children Served by First Steps (SFY)	40	45	38	37

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	22.4	21.0	22.6	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	829	790	792	825

Data Gathered by:



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The State of The Young Hoosier Child



Switzerland County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	895	956	914	935
% of Total Population who are Ages 0 to 5 (CY)	8.6%	9.1%	8.6%	8.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.5%	35.2%	33.6%	35.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	135	133	136	132
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	36.3 U	31.4 U	37.8 U	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	66.7	66.2	64.7	75.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.6	27.8	30.1	27.3
% of Low Birthweight Babies (CY)	9.6	6.0	4.4 U	6.8 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	0.0	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	471	502	520	506
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	18.4	23.8	13.9	9.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	4	4	4	5
# of Registered Child Care Ministries (SFY)	2	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	7.4	6.6	6.7	8.2
# of Children Receiving Child Care Vouchers (FFY)	48	31	39	45
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	7	1	11	8
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	40	36	36	36
# of Children Served by First Steps (SFY)	17	18	9	12

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	27.3	27.3	29.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	477	421	393	401

Data Gathered by:



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The State of The Young Hoosier Child



Tippecanoe County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	12,816	13,155	12,908	13,107
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.7%	7.5%	7.5%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	36.5%	36.8%	36.6%	36.8%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	2,324	2,320	2,230	2,149
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	13.6	11.2	13.8	12.7
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	62.5	62.7	61.5	64.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	16.2	14.9	15.7	15.3
% of Low Birthweight Babies (CY)	8.4	7.2	6.3	6.4
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	7,220	7,550	7,672	7,783
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	14.8	14.3	12.2	10.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	21	23	22	21
# of Licensed Child Care Homes (SFY)	76	66	65	66
# of Registered Child Care Ministries (SFY)	23	21	23	25
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	27.8	27.7	27.5	27.5
# of Children Receiving Child Care Vouchers (FFY)	1,596	1,648	1,348	1,521
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	426	349	576	227
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	330	360	360	360
# of Children Served by First Steps (SFY)	577	579	568	507

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.0	20.1	20.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	7,940	7,935	7,704	7,675

Data Gathered by:



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The State of The Young Hoosier Child



Tipton County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,096	1,046	1,026	936
% of Total Population who are Ages 0 to 5 (CY)	6.8%	6.5%	6.5%	5.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.9%	27.9%	27.9%	26.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	173	160	126	158
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	16.8 U	20.6 U	29.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.7	63.1	67.5	75.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	17.3	20.6	18.3	15.2
% of Low Birthweight Babies (CY)	11.6	7.5	5.6 U	10.1 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	510	557	570	591
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	9.8	13.2	9.3	8.1

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	2	2	0	0
# of Registered Child Care Ministries (SFY)	3	3	2	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	2.7	2.9	0.0	0.0
# of Children Receiving Child Care Vouchers (FFY)	30	37	50	47
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	9	5	8	9
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	12	10	10	10
# of Children Served by First Steps (SFY)	36	37	39	45

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.1	14.5	13.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	436	432	466	417

Data Gathered by:



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The State of The Young Hoosier Child



Union County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	527	538	532	529
% of Total Population who are Ages 0 to 5 (CY)	7.1%	7.2%	7.1%	7.0%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	28.2%	28.9%	28.2%	28.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	82	87	35	84
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.4 U	23.3 U	*	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	65.9	64.4	68.6	75.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	8.5	31.0	17.1 U	33.3
% of Low Birthweight Babies (CY)	3.7	3.4	*	7.1 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	0.0	**	0.0

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	392	379	366	361
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	19.1	28.7	24.2	21.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	0	0	0	0
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	24.5	17.2	18.1	18.1
# of Children Receiving Child Care Vouchers (FFY)	3	6	15	6
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	1	2	1	1
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	77	117	97	84
# of Children Served by First Steps (SFY)	7	10	14	16

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	21.3	20.1	22.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	336	354	335	300

Data Gathered by:



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The State of The Young Hoosier Child



Vanderburgh County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	13,797	13,887	13,895	13,812
% of Total Population who are Ages 0 to 5 (CY)	7.7%	7.8%	7.7%	7.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	34.8%	34.9%	34.9%	34.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	2,468	2,326	2,349	2,346
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	26.1	19.2	21.4	20.1
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	70.1	71.2	71.6	76.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	22.5	21.7	23.1	21.5
% of Low Birthweight Babies (CY)	9.8	10.1	9.5	8.0
Infant Mortality Rate per 1,000 Live Births (CY)	8.9	**	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	8,484	8,702	8,798	8,750
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	11	5	5	9

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.4	15.7	22.7	20.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	21	21	21	21
# of Licensed Child Care Homes (SFY)	129	133	134	126
# of Registered Child Care Ministries (SFY)	20	21	18	18
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	35.9	37.4	37.3	35.7
# of Children Receiving Child Care \ *Counts of fewer than 5 incidences, including	2,238	2,156	1,914	2,139
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	364	378	479	287
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	514	487	487	487
# of Children Served by First Steps (SFY)	581	642	627	669

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.1	25.1	22.1	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	6,929	6,843	6,391	6,187

Data Gathered by:



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The State of The Young Hoosier Child



Vermillion County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,184	1,146	1,093	1,088
% of Total Population who are Ages 0 to 5 (CY)	7.2%	7.0%	6.8%	6.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.8%	30.0%	29.4%	29.3%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	175	154	194	172
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	27.5 U	18.0 U	*	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	72.6	61.7	58.2	72.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	29.7	29.9	30.4	26.2
% of Low Birthweight Babies (CY)	11.4	6.5	8.2 U	8.7 U
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	740	767	765	763
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.2	13.3	19.2	28.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	7	8	9	7
# of Registered Child Care Ministries (SFY)	1	1	2	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	19.4	21.4	23.2	20.9
# of Children Receiving Child Care Vouchers (FFY)	72	73	65	63
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	15	23	24	12
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	42	48	48	48
# of Children Served by First Steps (SFY)	27	39	41	33

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	20.5	20.2	20.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	691	686	640	668

Data Gathered by:



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The State of The Young Hoosier Child



Vigo County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	7,426	7,526	7,534	7,453
% of Total Population who are Ages 0 to 5 (CY)	6.9%	7.0%	7.0%	6.9%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	32.4%	32.7%	32.9%	32.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	1,338	1,321	1,255	1,308
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	21.4	17.8	25.1	17.8
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.2	70.8	67.4	67.4
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.9	22.9	23.5	21.3
% of Low Birthweight Babies (CY)	8.3	7.8	7.8	6.3
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	5,369	5,503	5,558	5,579
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	9	9	7

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	10.4	11.4	16.1	11.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	8	8	8	7
# of Licensed Child Care Homes (SFY)	160	167	168	160
# of Registered Child Care Ministries (SFY)	11	8	8	7
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	41.3	44.2	45.1	42.5
# of Children Receiving Child Care Vouchers (FFY)	1,756	1,802	1,546	1,695
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	256	180	379	261
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	304	304	304	304
# of Children Served by First Steps (SFY)	263	324	297	244

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	28.7	27.0	25.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	4,670	4,654	4,528	4,507

Data Gathered by:



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The State of The Young Hoosier Child



Wabash County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,272	2,259	2,261	2,225
% of Total Population who are Ages 0 to 5 (CY)	6.8%	6.8%	6.9%	6.8%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.1%	30.0%	30.4%	30.5%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	377	390	354	354
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	12.1 U	19.7 U	11.2 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	73.2	74.9	74.3	76.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	28.6	27.9	30.2	25.4
% of Low Birthweight Babies (CY)	12.2	8.5	8.8	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	0.0	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,456	1,543	1,550	1,544
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	15.6	16.2	16.5	21.7

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	3	3
# of Licensed Child Care Homes (SFY)	9	9	9	9
# of Registered Child Care Ministries (SFY)	7	6	5	5
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	11.0	10.9	11.7	11.7
# of Children Receiving Child Care Vouchers (FFY)	151	96	69	81
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	8	5	43	18
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	51	51	51	51
# of Children Served by First Steps (SFY)	76	69	73	76

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	19.2	18.4	23.4	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,452	1,491	1,460	1,472

Data Gathered by:



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The State of The Young Hoosier Child



Warren County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	633	605	599	562
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.1%	7.0%	6.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.3%	30.0%	30.1%	29.1%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	78	99	88	91
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	5.8 U	0.0 U	*	*
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	76.9	57.6	58.0	64.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	17.9	16.2	26.1	23.1
% of Low Birthweight Babies (CY)	6.4	5.1	8.0 U	7.7 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	0.0	0.0

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	301	326	322	339
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	9.7	16.0	13.9	14.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	1	1	0	1
# of Registered Child Care Ministries (SFY)	0	0	0	0
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	23.0	21.3	19.5	22.0
# of Children Receiving Child Care Vouchers (FFY)	21	17	16	12
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	8	7	10	3
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	36	36	36	36
# of Children Served by First Steps (SFY)	15	18	16	17

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.5	16.1	15.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	324	307	330	322

Data Gathered by:



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The State of The Young Hoosier Child



Warrick County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	4,529	4,696	4,659	4,545
% of Total Population who are Ages 0 to 5 (CY)	7.8%	7.9%	7.8%	7.5%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.8%	30.4%	30.2%	29.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	685	701	676	715
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	7.7 U	11.3 U	9.7 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	79.4	76.9	73.7	82.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	13.4	17.4	18.0	15.4
% of Low Birthweight Babies (CY)	8.0	7.8	8.3	9.7
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,611	1,798	1,796	1,741
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	7.6	11.7	10.8	7.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	5	5	5	5
# of Licensed Child Care Homes (SFY)	49	54	53	48
# of Registered Child Care Ministries (SFY)	3	3	4	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	24.8	25.3	25.2	23.8
# of Children Receiving Child Care Vouchers (FFY)	298	254	177	223
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	39	45	118	48
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	100	100	100	100
# of Children Served by First Steps (SFY)	176	205	196	182

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	11.2	10.4	12.3	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,543	1,598	1,598	1,478

Data Gathered by:



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The State of The Young Hoosier Child



Washington County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,103	2,094	2,102	1,993
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.4%	7.4%	7.1%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	29.0%	29.3%	29.5%	28.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	328	318	319	305
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	12.9 U	24.7 U	30.7 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	64.9	64.8	61.8	64.3
% of Mothers Who Reported Smoking During Pregnancy (CY)	31.4	24.5	23.8	18.4
% of Low Birthweight Babies (CY)	6.7	5.0	10.3	8.2
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,265	1,348	1,359	1,296
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	<5*

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	17.1	12.6	15.8	9.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	2	2	1	2
# of Licensed Child Care Homes (SFY)	28	27	28	27
# of Registered Child Care Ministries (SFY)	1	0	0	1
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	32.1	31.4	29.0	29.3
# of Children Receiving Child Care Vouchers (FFY)	160	170	162	136
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	19	18	33	19
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	42	46	46	46
# of Children Served by First Steps (SFY)	67	68	74	66

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	23.6	24.6	24.2	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,220	1,276	1,183	1,170

Data Gathered by:



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The State of The Young Hoosier Child



Wayne County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	5,266	5,298	5,273	5,247
% of Total Population who are Ages 0 to 5 (CY)	7.6%	7.7%	7.7%	7.6%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	33.1%	33.4%	33.3%	33.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	886	882	875	823
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	20.8	24.4	25.4	24.7
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	69.2	66.0	69.0	70.0
% of Mothers Who Reported Smoking During Pregnancy (CY)	24.0	23.8	24.1	19.7
% of Low Birthweight Babies (CY)	7.2	7.7	7.5	7.9
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	3,711	3,798	3,852	3,790
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	12	12	12	11

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	22.9	24.5	11.5	9.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	10	9	10	10
# of Licensed Child Care Homes (SFY)	36	32	32	30
# of Registered Child Care Ministries (SFY)	9	11	8	7
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	21.5	19.8	20.2	19.8
# of Children Receiving Child Care Vouchers (FFY)	503	480	429	497
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	27	75	122	67
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	306	378	378	378
# of Children Served by First Steps (SFY)	149	165	155	157

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	28.4	29.8	33.5	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	3,597	3,706	3,678	3,506

Data Gathered by:



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The State of The Young Hoosier Child



Wells County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,154	2,183	2,164	2,145
% of Total Population who are Ages 0 to 5 (CY)	7.8%	7.9%	7.8%	7.7%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.7%	31.5%	31.4%	31.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	305	359	331	338
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	10.5 U	21.9 U	15.9 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	74.1	75.5	72.5	60.9
% of Mothers Who Reported Smoking During Pregnancy (CY)	18.7	18.9	22.1	15.7
% of Low Birthweight Babies (CY)	9.2	8.4	6.6	8.0
Infant Mortality Rate per 1,000 Live Births (CY)	0.0	**	0.0	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	941	980	1,009	989
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	<5*	<5*	<5*	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	13.2	13.2	15.1	11.6

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	0	0	0	0
# of Licensed Child Care Homes (SFY)	13	11	10	8
# of Registered Child Care Ministries (SFY)	5	5	5	4
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	8.5	6.8	5.7	5.3
# of Children Receiving Child Care Vouchers (FFY)	50	61	56	45
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	7	16	6
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	37	20	20	20
# of Children Served by First Steps (SFY)	70	58	67	80

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	13.1	14.5	15.9	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	941	926	963	943

Data Gathered by:



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The State of The Young Hoosier Child



White County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	1,846	1,797	1,794	1,811
% of Total Population who are Ages 0 to 5 (CY)	7.4%	7.3%	7.3%	7.3%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	30.5%	30.2%	30.2%	30.7%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	330	280	328	297
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	18.0 U	20.7 U	35.3 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	68.8	70.4	65.5	66.7
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.5	21.4	24.7	26.3
% of Low Birthweight Babies (CY)	8.8	7.1	6.4	6.1 U
Infant Mortality Rate per 1,000 Live Births (CY)	**	**	**	**
	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,070	1,153	1,185	1,202
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	11.7	13.0	8.9	11.0

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	1	1	1	1
# of Licensed Child Care Homes (SFY)	14	15	15	12
# of Registered Child Care Ministries (SFY)	3	2	2	2
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	14.0	15.2	15.0	12.6
# of Children Receiving Child Care Vouchers (FFY)	32	32	35	40
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	5	6	12	11
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	41	41	41	41
# of Children Served by First Steps (SFY)	53	48	45	55

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	16.3	18.4	18.8	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,262	1,318	1,305	1,287

Data Gathered by:



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The State of The Young Hoosier Child



Whitley County

County Level Population	2008	2009	2010	2011
Population Ages 0 to 5 (CY)	2,582	2,543	2,496	2,456
% of Total Population who are Ages 0 to 5 (CY)	7.8%	7.7%	7.5%	7.4%
% of All Children Under Age 18 who are Ages 0 to 5 (CY)	31.4%	31.2%	30.5%	30.4%

Physical Health and Well-Being	2007	2008	2009	2010
# of Live Births (CY)	449	390	412	409
Teen Birth Rate per 1,000 Females Ages 15 to 17 (CY)	14.6 U	18.3 U	14.1 U	U
% of Mothers Who Received 1st Trimester Prenatal Care (CY)	75.7	77.4	72.1	65.8
% of Mothers Who Reported Smoking During Pregnancy (CY)	21.6	20.8	18.0	18.3
% of Low Birthweight Babies (CY)	8.5	6.9	9.0	7.3
Infant Mortality Rate per 1,000 Live Births (CY)	**	0.0	**	**

	2009	2010	2011	2012
# of Children Under 6 on Public Health Insurance (SFY)	1,077	1,156	1,165	1,106
# of Children w/ Confirmed Elevated Blood Levels of Lead, Ages 0 - 5 (CY)	0	0	0	0

Social and Emotional Development	2008	2009	2010	2011
Child Abuse/Neglect Rate per 1,000 Children Under Age 18 (SFY)	6.2	6.2	5.9	7.8

Early Childhood - School Readiness	2009	2010	2011	2012
# of Licensed Child Care Centers (SFY)	3	3	2	2
# of Licensed Child Care Homes (SFY)	9	8	6	6
# of Registered Child Care Ministries (SFY)	3	3	3	3
Rate of Licensed Child Care Slots per 100 Children Ages 0-4 (SFY)	21.8	21.2	19.6	19.6
# of Children Receiving Child Care Vouchers (FFY)	67	70	56	63
Monthly Avg # of Children on Wait List for Child Care Vouchers (FFY)	26	25	32	14
# of Early Head Start and Head Start Funded Enrollment Slots (SFY)	34	44	44	44
# of Children Served by First Steps (SFY)	65	88	81	76

Family Support	2009	2010	2011	2012
% of Children Under 18 Living in Poverty (CY)	11.0	13.4	13.7	N.A.
# of Women, Infants, and Children (WIC) Participants (FFY)	1,176	1,144	1,051	1,075

Data Gathered by:



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INDIANA'S COMPREHENSIVE
Nutrition & Physical Activity Plan, 2010-2020

For more information, please contact:

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For more information on the Indiana Healthy Weight Initiative or to download this document or sections of this document, please visit www.inhealthyweight.org.

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LETTER FROM THE COMMISSIONER

December 2010

Dear Partners,

The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting, and providing for the health of Hoosiers in their communities. Vital to that mission is our goal to improve health behaviors and reduce the incidence of obesity and chronic disease in Indiana.

Let's review the key facts about obesity in Indiana: almost two thirds of adults, about one fourth of high school students, and nearly one third of children ages 10-17 are overweight and obese. Many of us do not consume the recommended amounts of fruits and vegetables or engage in the recommended levels of physical activity to maintain a healthy weight and overall good health. Our communities are unhealthy, too. Access to cheap, high-fat, sugar- and sodium-laden food is too commonplace. In addition, access to safe places to walk, bicycle, and simply play are not available or difficult to find.

The good news is there have been state and local efforts implemented in the last few years to address obesity and remove the barriers to healthy eating and physical activity. The launch of Governor Mitch Daniels' health initiative, INShape Indiana (INShape), in July 2005 was a key milestone in Indiana's efforts to encourage Hoosiers to eat healthy, move more, and avoid tobacco. Under the leadership of the Governor, Indiana also published its first trails and greenways plan, *Hoosiers on the Move*, in 2006. The plan seeks to unite current trail systems and build new trails, putting every Hoosier within 15 minutes (7.5 miles) of a trail opportunity.

With these efforts still going strong, in 2008, we came together to develop *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, a collaborative effort involving a large and diverse group of individuals and organizations located throughout Indiana. This Plan provides the bold and dynamic framework for action needed across all sectors of Indiana to address poor nutrition, sedentary behaviors, and obesity. We focus on approaches that target the specific needs of Indiana and support the latest research for improving nutrition and increasing physical activity. This Plan consists of eight focus areas: breastfeeding, early childhood/child care, schools, health care, worksites, older adults, faith-based organizations, and communities.

Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020, provides the opportunity for all of us to work together to alter the course of health in our state so that all Hoosiers can be healthier, happier, and more productive. The Plan's strategic approach will require commitment and engagement from all of our partners, including you. I look forward to working with you to improve the health of Indiana.

Sincerely,

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STATE HEALTH COMMISSIONER

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EXECUTIVE SUMMARY

Over the past three decades, the impact and prevalence of overweight and obesity among people have increased at an alarming rate in both Indiana and the nation. The obesity epidemic is real. In Indiana, 29% of adolescents and 65% of adults are overweight and obese.^{1,2} Poor nutrition and sedentary behaviors are contributing to this epidemic. In Indiana, only 41% of adolescents and 64% of adults meet the recommended levels for physical activity.^{1,2} There has been little success to increase fruit and vegetable consumption—16% of adolescents and 21% of adults consume the recommended servings of fruits and vegetables.^{1,2}

Many factors lead to being inactive, eating poorly, and obesity and chronic diseases. While it is true that, overall, the residents of Indiana often fail to eat the recommended number of fruits and vegetables or meet the recommended amount of daily physical activity—two behaviors directly linked to weight and overall good health and well-being—many other factors impact weight. The places where we live, learn, work, and play influence whether or not the healthy nutrition or physical activity choice is even an option. How can people eat fruits and vegetables if they live in a neighborhood without access to grocery stores or farmers' markets? How can people get enough physical activity if half of their day is spent in a setting—be it child care, school, or work—with environments and systems that do not support physical activity? How can mothers continue to breastfeed if workplaces fail to offer the facilities or social environment that allows them to continue?

Now, more than ever, Indiana is positioned to address fully the larger policy, environment, and system factors that make healthy eating and active living possible. The Indiana Healthy Weight Initiative is Indiana's public health response to the growing need and desire for more communities and settings that support good nutrition and physical activity for all of Indiana's residents. The Initiative seeks to enhance the health and quality of life for all Indiana residents by promoting good nutrition, regular physical activity, and a healthy weight through policy, environment, and lifestyle change.

By building on the state's previous efforts while creating new partnerships, the Indiana Healthy Weight Initiative Task Force was established. The Task Force is a diverse group of stakeholders positioned throughout Indiana, representing nutrition, physical activity, transportation, academics, business, professional organizations, and state and local governments. Since December of 2008, the Task Force has been working to develop *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, and to create the infrastructure to support the Plan's implementation and evaluation. Using professional and personal resources and the Initiative's speakers bureau and Website, the Task Force and a growing network of additional partners have developed the framework for what needs to be done across all sectors of Indiana to address poor nutrition, sedentary behaviors, and obesity with an intensity and reach never seen before in Indiana.

The ultimate purpose of the Plan and the work of the Task Force and other partners is to achieve six goals:

- Increase access to and consumption of healthy foods and beverages.
- Increase opportunities for and engagement in regular physical activity.
- Increase efforts aimed at enabling people to achieve and maintain a healthy weight across the lifespan.
- Reduce environmental and policy-related disparities for breastfeeding, nutrition, physical activity, overweight, obesity, and chronic disease.
- Increase the capacity of communities and settings within those communities (e.g., schools, worksites, faith-based organizations, etc.) to develop and sustain environmental and policy support systems that encourage healthy eating and active living.
- Increase state and local strategic partnerships to more effectively coordinate efforts, share resources, and identify and reach priority populations.

The Initiative will measure progress towards achieving these goals by tracking improvements in the following overarching objectives based on decreasing the prevalence of obesity in Indiana and fostering improvement in the national priority target areas:

Healthy Weight and Obesity

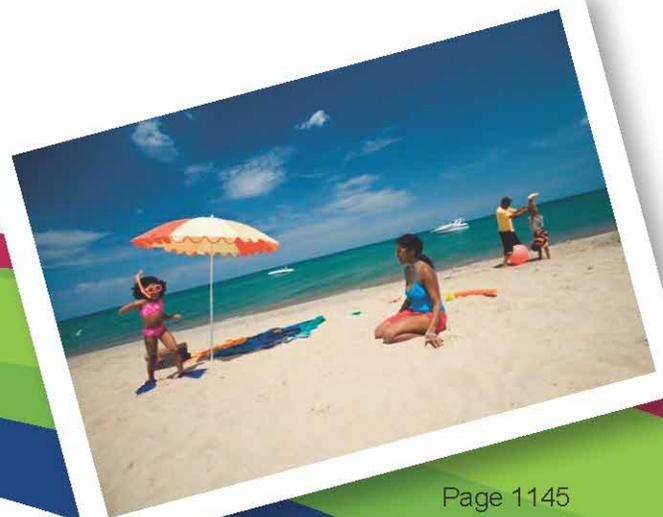
- Increase the percentage of adults who are at a healthy weight from 35% to 38% by 2020.
- Increase the percentage of high school students who are at a healthy weight from 71% to 76% by 2020.
- Decrease the percentage of adults who are obese from 30% to 25% by 2020.
- Decrease the percentage of high school students who are obese from 13% to 10% by 2020.

Physical Activity

- Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 68% by 2020.
- Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 55% by 2020.

Fruit and Vegetable Consumption

- Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 24% by 2020.
- Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables per day from 16% to 21% by 2020.



Breastfeeding

- Increase the percentage of mothers who breastfeed their babies from 71% to 75% by 2020.
- Increase the percentage of mothers who breastfeed their babies exclusively at 3 months from 29% to 40% by 2020.
- Increase the percentage of mothers who breastfeed their babies at 6 months from 38% to 50% by 2020.
- Increase the percentage of mothers who breastfeed their babies at 12 months from 17% to 25% by 2020.

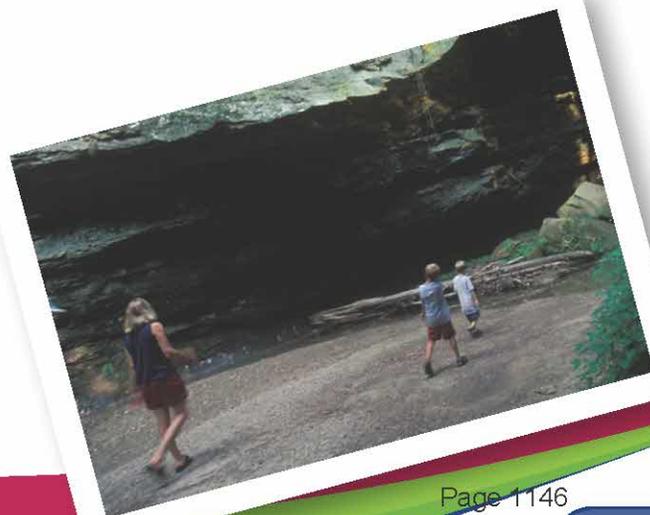
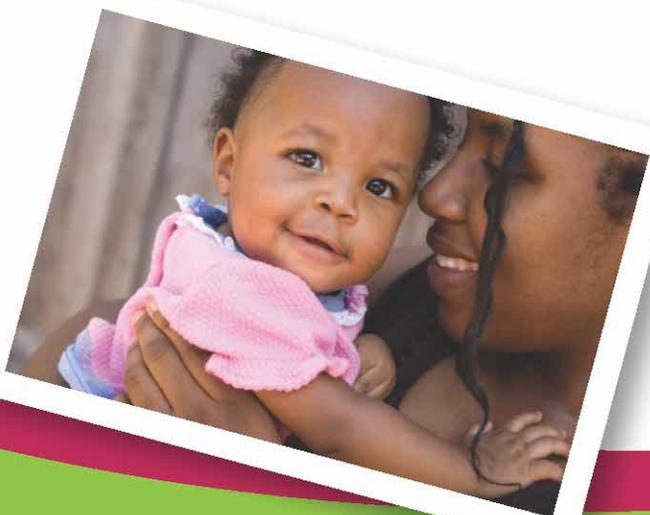
Sugar-Sweetened Beverage Consumption

- Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 59% by 2020.
- Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 22% by 2020.

The overarching objectives will be achieved by addressing the contexts in which people engage in these behaviors. The Plan includes an additional 50 objectives that address improving the policies, environments, and systems that can positively

influence nutrition and physical activity. The Plan organizes the objectives based on the setting they affect—child-care settings, schools, health care facilities, worksites, faith-based settings, and communities, with special sections related to older adults and breastfeeding. As a whole, the objectives seek to increase access and awareness and to change policies and environments to support the occurrence of healthier behaviors. A set of strategies that partners across Indiana can do accompanies each of the 50 objectives. The strategies include conducting assessments, increasing awareness, changing policies, creating healthier environments, developing partnerships, and advocating for improved policies and practices.

Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020, is a call to action for individuals and organizations to collaborate and coordinate efforts to reach a common vision—an Indiana where *all* residents practice and enjoy a lifestyle of healthy eating and physical activity within an environment that supports health, wellness, and vitality. The Plan will require the efforts and resources of many. As people who care about the health of Indiana's residents and about the health of our communities, let us all work together to achieve the goals of this Plan. Together, we can realize our vision of all residents enjoying the benefits of a more active and healthy Indiana.



INTRODUCTION

Our Challenge

There are still some who think the obesity epidemic has been blown out of proportion; yet as the facts have unfolded over the last 20 to 30 years, the reality is that our collective weight status as a state and nation has been slowly and dangerously inching up and spreading year after year, almost as if it is infectious. There is no boundary. Regardless of age, race, gender or income, this issue has engulfed all population groups. As is often the case, the risks are much greater for our most vulnerable and disadvantaged residents. *With the majority of our population either overweight or obese and those who are not struggling to maintain a healthy weight, we are at risk of becoming a state with a burden so great that it will cripple our productivity, severely impact our economy, and completely change our quality and way of life. The epidemic is real. What has been “out of proportion” is the insufficient response to addressing the magnitude of this issue.*

Although the ever-growing challenges with increasing body weight may seem to have come from out of the blue, the reality is that they have been creeping up on us for some time. In fact, the change across our population has seemed to be so gradual that, collectively, we have been lulled somewhat into a numbed state about what is “normal” or healthy. The problem goes well beyond weight status alone. Across all age groups and both genders, statewide and nationally, we have become more and more sedentary and, on more occasions than not, most of us consume high-fat, sugar- and sodium-laden food, oftentimes without even being aware of it. These habitual daily behaviors further underscore the magnitude of this health issue. Namely, in addition to the exponential risks associated with being overweight, there is also risk for those at a “normal weight” but who are physically inactive and who do not eat a nutritious diet. Carrying more weight than recommended, being inactive and eating poorly—combined and separately—*all* lead to preventable and life-threatening diseases, drastically increasing

our health care costs and, in due time, crippling our independence and quality of life. As a nation, we take pride in our independence, strength and resourcefulness. Being a captive to the ill effects of obesity is not the future any of us envisioned for our families or ourselves. *All told, this is not just about obesity prevention; it is about the overall health, well-being and future of our communities and our entire population.*

Over the last 20 to 30 years, our community environments have changed drastically. As our communities have changed, so have we. Who would have ever known that, in combination, our improved and ever-growing technologies, expanded roadways and subdivisions and access to food at all hours, along with a long list of other mostly man-made factors, would ultimately create a fertile and seemingly “contagious” environment for weight gain and poor health behaviors? Never before in our history have we faced an issue that cuts to the very core of our cherished American and Hoosier lifestyles. Driving, eating, drinking and sitting in front of a screen for endless hours are deep-seated behaviors that are central to our social and economic way of life. With ongoing assessment and analysis of the related issues, it is clear that no one factor has created this enormous and complex health burden and, as importantly, no one factor is going to reverse it.

“If you ‘go-with-the-flow’ in American society today, you will end up overweight.”

Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention (CDC)

With an overabundance of low-nutrient, easily affordable (and often “value-priced”) food, a dependence on automobile transportation and an ever-growing interest in modern conveniences that require little or no movement, the American lifestyle has tipped the scale to an unhealthy imbalance on the “in” side of the energy balance equation—more calories “in” than the number of calories “used.” As more and more of us gradually succumb to the ever-present temptations to overeat and move less, it is evident that this issue is much more than a lack of individual willpower. While some of these factors are within individual control, many are not.

The challenges and solutions to this complex issue lie in the food and physical activity choices, or lack thereof, that are available to us in our day-to-day life experiences and environments. How often do we encounter situations where there is no healthy choice available? Or, when there is a healthy option, how often is it either too hard to identify or access, too expensive, or not an appealing or safe option? What is certain is the food and physical activity choices we have largely influence the choices we make. If making a healthy choice is too hard, unappealing or, worse yet, not even available, it significantly reduces the likelihood that individuals will make a healthy choice or go out of their way to find a healthy option.

“It is unreasonable to think that people are going to change their behavior easily when so many forces in the social, cultural and physical environment conspire against that change.”

Institute of Medicine, 2000⁹

Our Charge

Although a multitude of factors influence body weight, physical activity and nutrition play a dominant role. Because active lifestyles and good nutrition not only affect body weight but also *provide essential protection against many chronic diseases on their own*, promoting these two behaviors and creating environments where they can be accomplished easily are of paramount importance. As noted by Dr. William Dietz, Director of the Division of Nutrition, Physical Activity and Obesity at the CDC, one of our primary aims must be to promote “health at any weight.” Regardless of a person’s size or weight classification, regularly participating in these two behaviors can have a substantial beneficial impact on overall health status and quality of life.

The challenge is looming. With the large majority of the population of Indiana impacted by overweight issues, poor nutrition and lack of physical activity, the magnitude of change needed to counter these harmful factors is like nothing we have ever faced before. Traditionally, programs aimed at changing individual behaviors have addressed these issues. While some programs have proven effective during the duration of the program and shortly thereafter, evidence consistently reveals that once the program ends or the funding ceases, it is very difficult for people to sustain the targeted behaviors, and, within time, most return to their prior patterns. Now, there is growing recognition that *where* people live, learn, work and play significantly impacts their health behaviors. Due to the complexity and scope of these issues, a broader public health approach is essential. Unlike health care and medicine, which focus on treating individuals, public health action focuses on *preventing* disease and *promoting* the health of entire populations and communities through policy, environment and systems change. While health care is a critical piece of the overall health system, we need a public health approach to address the complex web of social and environmental factors outside and around the individual.

What is a Public Health Issue?

An issue that...

- Affects the health, function, and well-being of entire populations;
- Threatens the well-being of communities or the social fabric of society;
- Results in chronic disability or premature death for a large proportion of the population;
- Will get worse, spread, and affect greater numbers if it is not addressed as a community responsibility.

In the past decade particularly, we have become more aware that social and physical environments and policies either directly or indirectly promote healthy behaviors or, as importantly, actually encourage unhealthy behaviors to occur. Without an accompanying change in the environment or policies that negatively influence behavior every day, it will be very difficult for individuals to accomplish or maintain positive changes in these behaviors. Given this understanding and the enormity of the health issues facing Indiana, it is clear we need an environmental and policy focus to influence widespread, meaningful and sustainable change. Dr. Dietz of the CDC captures this concept by adding that it is not only important for us to promote “health at any weight” but to “create environments where health can happen.”

While policies and environmental changes may be necessary to ensure healthy options are available, the choice will still remain with the individual. Therefore, it will continue to be important to equip individuals with the knowledge to make healthier choices as well as provide them with skills to confidently prepare and eat healthy foods and participate in active behaviors. However, providing individuals with health information and increasing their knowledge is only one aspect of behavior change. As described earlier, without a supportive environment, knowledge will not be enough to sustain these behaviors. Combined, knowledge, skills and environments are the critical factors necessary for sustainable change in health behaviors.

The concept of intervening at different levels of influence is captured and described by the Socio-ecological Model (See Figure 1).⁵ Public health practice often uses this model to assess and guide the development of interventions intended to impact complex behaviors and whole populations. This model identifies individuals at the core but aptly illustrates the layers of the larger environment and levels of influence (sectors) around the individual that make up our society. The embedded layers of influence illustrated in the model emphasize that targeting one or two levels of influence may be insufficient to forge large-scale change. Instead, there is a greater understanding that addressing related factors in each layer of influence can lead to the level of impact needed to affect change at a population level.

What is Policy and Environmental Change?

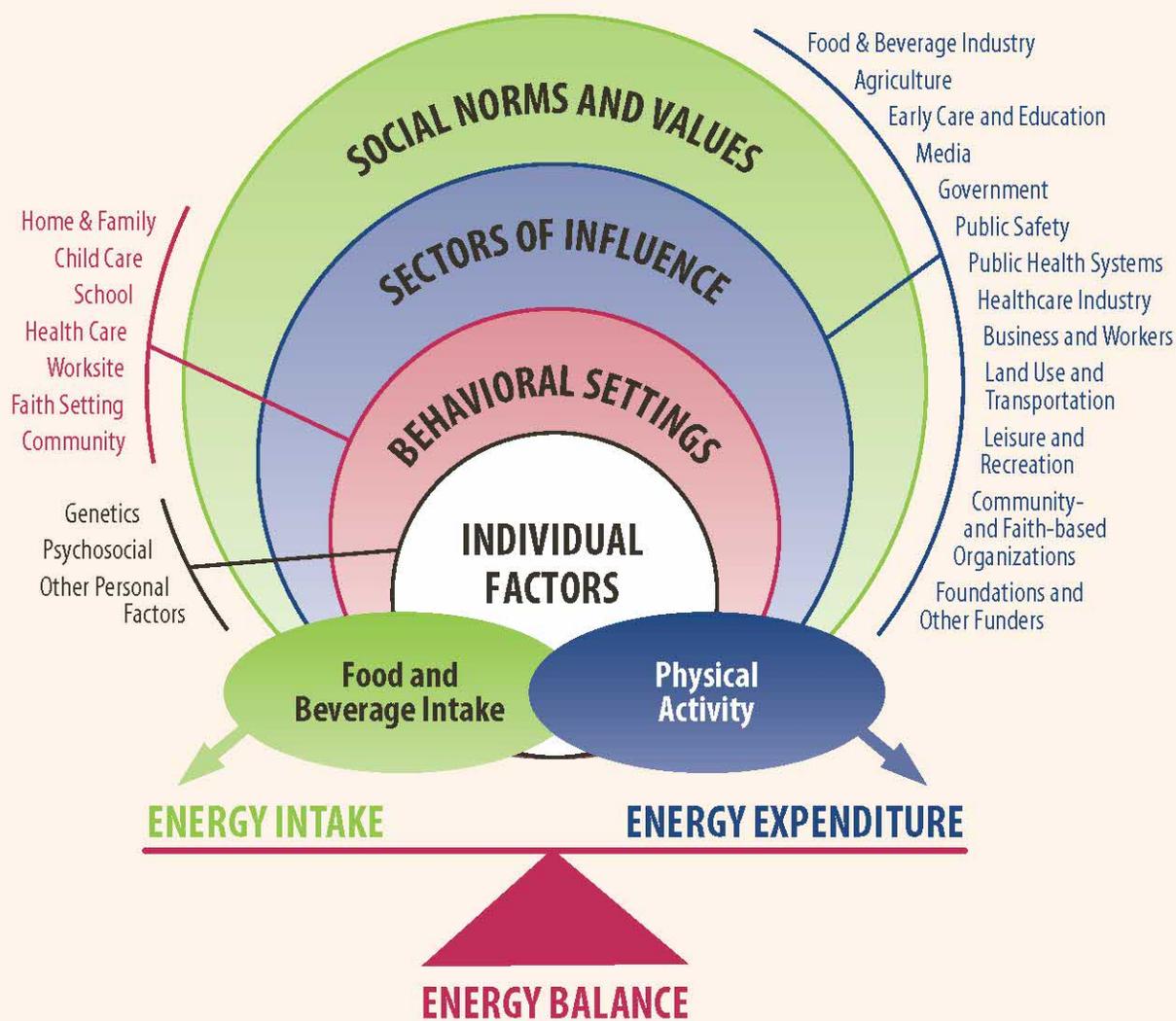
- *Policies* are defined as rules, regulations (both formal and informal) and laws.
- *Environmental interventions* are changes to the economic, social or physical environment.



The epidemic is real. The challenge is on. While the road ahead may seem long and daunting, we are poised as a state to meet this challenge and change the trajectory of the health, economic impact and quality of life of Indiana residents. The good news is that, to date, there is a promising and sizeable evidence base, as well as sound guidance and technical assistance available, to direct state and local efforts. There is no uncertainty about

the direction. As noted by Dr. Thomas Frieden, Director of the CDC, "It's not for us to do the things we think might work, but to implement proven strategies that we *know* will work." Armed with this knowledge and the support of committed partners and citizens across Indiana, and more yet to join in these efforts, the time has come to implement an aggressive, coordinated and comprehensive plan of action.

Figure 1: Socio-ecological Model



Adapted from Eat Smart, Move More: North Carolina's Plan to Prevent Overweight, Obesity, and Related Chronic Disease, Caidwell, et al, 2006 and Preventing Childhood Obesity, Institute of Medicine, 2005.

Our Direction

Background and History

It is important to acknowledge that overweight, obesity and chronic disease prevention efforts have been going on across the state of Indiana for some time. The valiant efforts of our many state and local partners have laid the groundwork for further developing a plan of action. Although it is impossible to identify or detail the breadth of successful programs and policies that have been launched to date, these foundational efforts have been vital to establishing a more coordinated and credible response.

At the state level, organized efforts began in 2004 when a group of committed professionals came together from a variety of disciplines around Indiana to develop the first committee to attempt to address obesity specifically. From that point through late 2007, the process led to the development of a few early resource documents, the first development of a task force and, subsequently, an initial draft plan. These early efforts proved to be extremely advantageous because they allowed internal state health department staff and external statewide partners to gain valuable experience and knowledge about the process, which has facilitated the development of a more strategic, coordinated and comprehensive direction.

A key milestone in Indiana's efforts to improve its health outcomes was the launch of Governor Mitch Daniels' health initiative, INShape Indiana (INShape), in July 2005. INShape began with a Website to provide Indiana residents with information on nutrition, physical activity, and tobacco cessation to help them engage in healthier behaviors. More than 86,000 Indiana residents have registered online to receive health tips and information from INShape. The initiative has hosted six statewide health summits, focusing on obesity, tobacco cessation, school health, and worksite wellness. INShape collaborated with state

universities for three of these annual summits. In addition, INShape has served as the impetus for a variety of programs—including DNR Day (annual event allowing free admission to state parks), 10 in 10 competitions, SummerFit, Swim Day, and Walk Across Indiana—aimed at helping Indiana residents eat better and move more.

INShape has also played a leading role in worksite wellness, developing short-term programming with a worksite emphasis. In 2008, INShape joined Anthem and Kroger to create the "Indiana Worksite Wellness Partnership." The initial group of 25 employers from throughout the state, representing 120,000 employees, has grown to more than 40.

While INShape focuses on individual behavior change, it has also inspired programs and activities aimed at motivating entire communities to help make the healthy choice the easy choice. Examples of this include INFLUENCE (Indiana Female Leaders Unite) and INside Out. INFLUENCE provides an avenue by which powerful women in Indiana (leaders in government, business, health care, education, media, and faith-based and community organizations) are educated about critical women's health issues, given a charge to educate about and advocate for women's health in their own spheres of influence, and provided toolkits to help them accomplish this goal. INside Out encourages minority school children to become involved in promoting the principles of INShape: eat better, move more, and avoid tobacco.

The strength of INShape Indiana lies in the many partnerships it has created or inspired over the years. As a result, we have laid the groundwork for Indiana to focus more on addressing overweight and obesity through policy and environmental change.

In January of 2008, the Indiana State Department of Health (ISDH) committed to a more robust focus on this area and took steps to provide the leadership, support and expertise needed for public health impact statewide. Consequently, the Agency formed the Division of Nutrition and Physical Activity (DNPA). From the beginning, the Division took painstaking efforts to build and enhance the foundation, infrastructure and capacity necessary to lead and support *effective and sustainable* efforts. Because of the combined activities and progress from the early committee and task force, INShape Indiana, and the newly formed DNPA, the ISDH was privileged to be 1 of 23 states to be awarded a cooperative agreement from the CDC for nutrition, physical activity and obesity prevention efforts in June of 2008. Since that time, the capacity of the DNPA has increased exponentially with essential infrastructure development, an infusion of staff with subject matter and setting expertise, a focus on training and professional development by both receiving and providing technical assistance, and renewed and expanded partnerships.

Given the magnitude, severity and potential impact of public health issues related to nutrition, physical activity and weight management, having a dedicated division and staff to manage and lead state efforts is crucial. The role of this division is not only to provide leadership and resources to reduce the burden of disease related to nutrition and physical activity but, as importantly, to aggressively lead the promotion of these vital health behaviors and development of environments where these behaviors can be practiced easily. To expound further on these responsibilities, the role of the Division of Nutrition and Physical Activity is to:

- Provide statewide leadership for priority nutrition and physical activity policies and environmental changes across all settings and special populations
- Serve as a central coordinating body for all nutrition and physical activity related activities for the state of Indiana with a focus on increasing collaboration and sharing of resources and reducing duplication
- Plan, implement and evaluate in collaboration with partners a comprehensive state plan to promote nutrition and physical activity and prevent overweight, obesity and related chronic disease
- Serve as a resource and provide technical assistance as needed to statewide partners
- Leverage and increase local, state and federal investment and resources for nutrition and physical activity promotion
- Maintain a comprehensive surveillance system for the ongoing, systematic collection of nutrition, physical activity and obesity data as well as policy and environmental change information

Indiana Healthy Weight Initiative

The Division of Nutrition and Physical Activity committed leadership and coordination to launch a reinvigorated state planning process—the *Indiana Healthy Weight Initiative*—in late 2008. The staff deliberately chose the name “Healthy Weight” to clarify and emphasize that the focus of the initiative and plan was not solely about preventing obesity. As noted earlier, with the large majority of our state population impacted by some combination of poor diet, physical inactivity and weight-related issues, the initiative extends beyond obesity prevention and underscores the concept of “health at any weight.”

One of the first strategic activities conducted by the DNPA to initiate the development of a State Plan was to delineate further the stages and steps necessary to develop, organize and lead a formal state-represented task force. After much research and discussion, the DNPA identified and established eight workgroups to inform the development of the Plan. The workgroups included Breastfeeding, Early Childhood/Child Care, Schools, Health Care, Worksites, Faith-Based Organizations, Senior Settings/Mature Adults, and Communities. Establishing specific workgroups within the overall Task Force facilitated the development of setting- and behavior-specific policy and environmental recommendations. It also provided a more meaningful way to engage the expertise and experience of Task Force members. Most importantly, the workgroups ensured efforts had the greatest “reach” (i.e., number and extent of the population potentially exposed to changes) possible. In addition to these workgroups, the DNPA also formed a Physical Activity Advisory Group, because physical activity was identified as an area least represented across settings and, therefore, in need of additional expertise. DNPA staff members led the workgroups through the duration of the planning process, with one staff person per workgroup.

From that point, the DNPA strategically identified, recruited, and engaged a wide range of statewide partners to assist with the development of the Plan. In addition, numerous partners and citizens across the state contacted the DNPA to volunteer their time to developing the plan. The Task Force eagerly welcomed their help.

In the fall of 2008, the DNPA convened an expanded and renewed Indiana Healthy Weight Initiative Task Force to begin the in-depth planning process for state plan development. The primary focus of the first Task Force meeting was to brief the partners on the six target areas identified and prioritized by the CDC to guide state efforts across the nation. The six priority target areas include:

- Increasing the consumption of fruits and vegetables
- Decreasing the consumption of high-energy dense foods
- Decreasing the consumption of sugar-sweetened beverages
- Decreasing television viewing time
- Increasing physical activity
- Increasing the initiation, duration, and exclusivity of breastfeeding

During this initial meeting, DNPA staff translated and presented detailed research information from the CDC for each priority target area to set the stage for the planning process. The six priority target areas helped guide the development of goals and objectives for each specific workgroup.

Over the course of state plan development, the Task Force met five times, and the workgroups held numerous meetings and conference calls in between. Early in the process, workgroups worked diligently to review and digest assessment information and develop Indiana-specific “problem

statements” summarizing the issues relative to specific settings, breastfeeding and older adults. In addition, the Task Force assisted with the development of a mission and vision statement for the initiative and identified overarching goals and objectives for the Plan. Using available assessment information, problem statements and any additional identified data, along with information related to the CDC priority target areas, each workgroup further developed SMART (Specific, Measurable, Achievable, Realistic and Time-bound) objectives to be accomplished statewide in the next 5 to 10 years.

While this account greatly simplifies a very complicated and involved process, much of the credit for the development of this Plan goes to the Task Force and specific workgroups. Although the list of participating partners—including organizations, non-profit associations, government agencies, service industries, along with many more individuals and groups—is too long to mention here, these vital partners are recognized in the Acknowledgments section (See Appendix A) of this document. This influential group of partners, representing both traditional and non-traditional health fields, has evolved and strengthened over the course of the initiative and will be instrumental in assisting with implementation and evaluation of various objectives of the Plan. Along with recognizing these partners in print, it is important to extend a note of gratitude for the time and expertise that each partner shared to develop and fine-tune this Plan.

Vision, Mission and Goals

Vision

- All Hoosiers practice and enjoy a lifestyle of healthy eating and physical activity within an environment that supports health, wellness and vitality.

Mission

- To enhance the health and quality of life of Hoosiers by promoting good nutrition, regular physical activity and a healthy weight through policy, environment and lifestyle change.

Goals

- Increase access to and consumption of healthy foods and beverages.
- Increase opportunities for and engagement in regular physical activity.
- Increase efforts aimed at enabling people to achieve and maintain a healthy weight across the lifespan.
- Reduce environmental and policy-related disparities for breastfeeding, nutrition, physical activity, overweight, obesity, and chronic disease.
- Increase the capacity of communities and the settings within those communities (e.g., schools, worksites, faith-based organizations, etc.) to develop and sustain environmental and policy support systems that encourage healthy eating and active living.
- Increase state and local strategic partnerships to more effectively coordinate efforts, share resources, and identify and reach priority populations.

Indiana Healthy Weight Initiative Website

Paralleling the work of the Task Force and adding significantly to the infrastructure needed to support state and local efforts, the DNPA developed a comprehensive and supplemental Website, www.inhealthyweight.org. The Indiana Healthy Weight Initiative Website provides a dedicated portal of resources, technical assistance and training for statewide partners. Currently, the Website offers extensive resources for all settings, specific priority target areas, surveillance data and much more. Ultimately, the Website will function as a data collection tool featuring interactive assessment information, evaluation tools and matrices of specific community level activities shared by state and local partners. The site provides a powerful complement to implementation activities of the Plan as well as offering an instrumental venue for partners and communities to communicate on a timely basis about success stories and lessons learned.

Indiana's Comprehensive Nutrition and Physical Activity Plan

After an intensive planning and development process, *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, is ready to be put into action. The goals, objectives and strategies of the Plan feature an emphasis on policy and environmental approaches informed by state-specific data and information and the latest scientific evidence. While there is a role for individual behavior change, the primary focus will be on decreasing negative influences and environmental barriers and increasing support systems for healthy food choices and physically active lifestyles. The Plan provides a framework for what needs to be done across all sectors in Indiana, as well as serves as a resource guide for all who are interested in the promotion of physical activity and nutrition, with a connection to the technical resources necessary to make the recommended changes. The strategies provided with each objective highlight current and potential activities based on best practices, but are not an exhaustive list of options. This is a dynamic Plan that will be evaluated and modified continuously as objectives are met or a change in direction is needed based on evaluation.

INDIANA'S CALL TO ACTION

Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020, outlines in detail the policy, systems and environmental strategies needed to change the trajectory of health in Indiana. The guidelines in this Plan are intended to inspire swift, committed and long-term action across Indiana, paving the way for a new way of thinking about health, a new way of living and, ultimately, a new generation of communities.

No one individual, group, organization, agency or community can implement this Plan and achieve the targeted objectives alone. It will require coordinated and collaborative efforts across multiple levels of influence and a willingness by cross-sector groups to cooperate in ways that they have not attempted before. While the impetus for change is coming from a “top-down” broad approach of evidence-based policy, systems and environmental strategies, to be implemented effectively, it must come alive and be set in motion from the “ground up.” Moving from the ground up will require that statewide partners and local communities take collective responsibility for addressing the issues and work together to forge the needed change.

To all residents, groups, organizations, and sectors in Indiana, this is your call to action. Using this Plan as a road map and working together, we can achieve the ultimate vision for Indiana—a state where all residents practice and enjoy a lifestyle of healthy eating and physical activity within an environment that supports health, wellness and vitality.

INDIANA'S COMPREHENSIVE NUTRITION AND PHYSICAL ACTIVITY PLAN, 2010-2020

An estimated 3.2 million adults in Indiana are overweight and obese (for specific definitions please see Appendix B). Even more frightening is that the remaining 1.7 million adults are at risk of becoming overweight and obese if they are unable to maintain a healthy lifestyle that includes healthy eating and regular physical activity. *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, contains 14 "overarching objectives" that focus on decreasing the prevalence of obesity in Indiana and improving outcomes within the majority of the Centers for Disease Control and Prevention's (CDC) priority target areas (See page 10). These overarching objectives cover the intermediate and long-term outcomes desired through implementation of the workgroup objectives and strategies as a collective whole over the next 10 years (To see the entire list of overarching objectives for the Plan, please go to Appendix C).

Data from a variety of sources were compiled and reviewed to determine the progress toward meeting the overarching objectives. In addition, a variety of methods were undertaken to determine the final targets for these objectives. One was looking at the statistically significant change, the second used current trends, and the third was looking at yearly (or biyearly) progress needed to meet *Healthy People 2010* goals within predefined timeframes. In addition, translating the percent of increase or decrease into actual numbers of individuals in Indiana the objective would have to affect was considered before finalizing the target.

Meeting the target of each overarching objective is important to achieving the goals of this Plan. The Plan targets adults and high school students for change within these overarching objectives, because many of the workgroup objectives and strategies work toward creating environments that support their health behaviors in the long-term. There are workgroup objectives and strategies that

focus on children; however, there are limitations in the availability of reliable, comparative data for this population as they relate to obesity and the CDC priority target areas. For this reason, there are no overarching objectives targeting young children. In addition, overweight status was not included as an overarching objective, because the numbers in that category fluctuate due to some individuals entering overweight status after gaining weight (from a healthy weight) and others entering overweight status after losing weight (from an obese status). However, data do not identify those individuals who have lost weight and who fall in the overweight category, so it would not be a good indicator of weight gain occurring in the population.

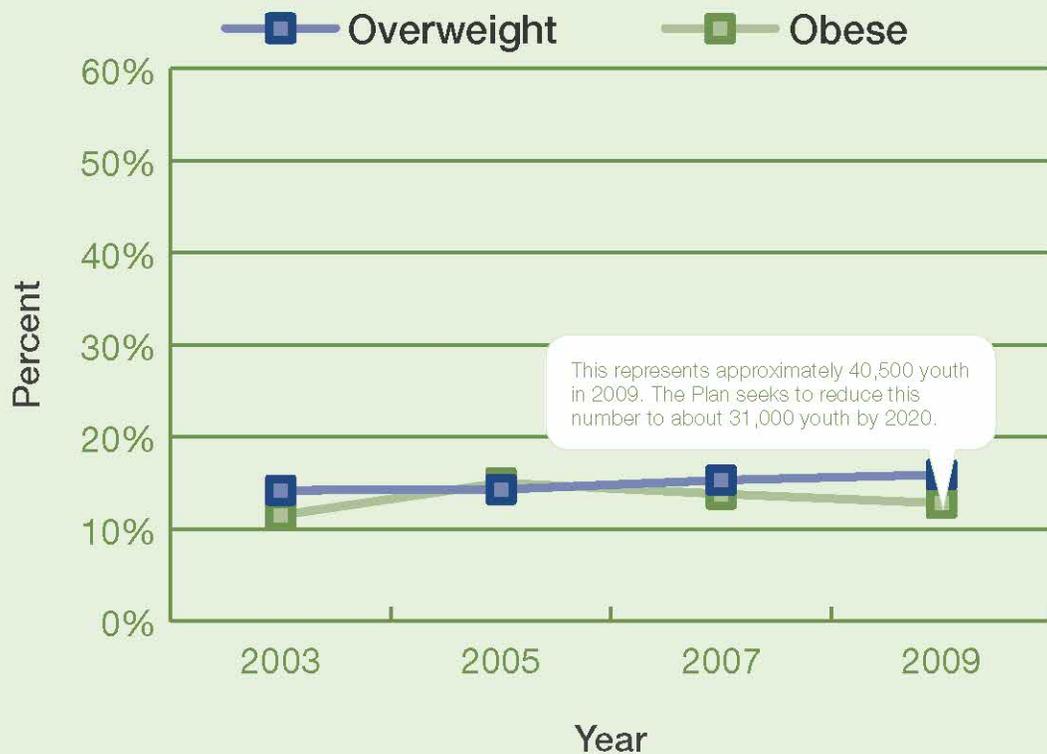
Overweight and Obesity in Indiana

In the United States, being overweight or obese is a problem among all stages of the human lifecycle, beginning with infancy and continuing to late adulthood. For Indiana children under the age of 5, data are not available for overweight and obesity other than what is collected through the Centers for Disease Control and Prevention (CDC) Pediatric Nutrition and Surveillance System (PedNSS). These data evaluate health parameters of participants only in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and do not represent the state population as a whole. The 2009 PedNSS results for Indiana show that the weight trends of children aged 2-5 closely mirror national trends. From 1999 to 2009, overweight and obesity in Indiana for children aged 2-5 increased slightly from 15% to 17% and 12% to 14%, respectively. Nationwide, during this same timeframe, the same increase (15% to 17%) was noted for overweight in children aged 2-5; however, obesity was slightly higher, going from 13% to 15%.⁶

The National Survey of Children's Health (NSCH) evaluates parameters related to the health of youth in the general population for ages 6 to 17 years. According to the 2007 NSCH, approximately 30% of Indiana's children ages 10-17 years are overweight or obese, which is close to the national rate of 32%.⁷ The Youth Risk Behavior Survey

(YRBS) gathers information on the health behaviors of high school students in grades 9-12. Indiana students showed a small increase in obesity, going from 12% in 2003 to 13% in 2009 (See Figure 2). Combined, overweight and obesity rose from 26% in 2003 to 29% in 2009.¹

Figure 2: Percent of High School Students by Overweight & Obesity* Indiana, 2003-2009[†]

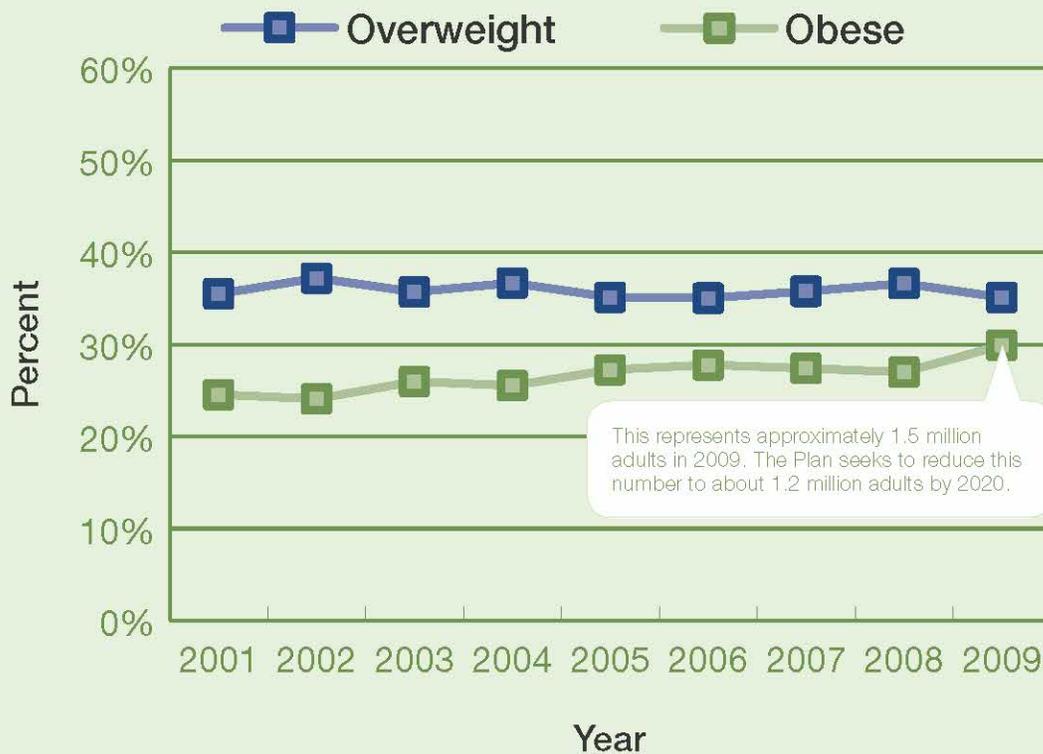


* Overweight is a BMI at the 85th to less than the 95th percentile and obesity is a BMI at or above the 95th percentile.
 † Data are for high school students in grades 9-12.
 Source: Youth Risk Behavior Surveillance System (YRBS).

In the United States, adults (defined as those 18 years of age and older) who are obese rose 10 percentage points between 1995 and 2009. These same results showed that approximately two thirds

of Indiana's adults are overweight or obese (65%), which is similar to the national rate (63%).² The rise in obesity significantly increased from 2001 to 2009 (See Figure 3).²

**Figure 3: Percent of Adults by Overweight & Obesity*
Indiana, 2001-2009†**



* Overweight is defined as a BMI between 25 and 29.9 and obesity is defined as a BMI of 30 or higher.

† Data are for residents ages 18 years and older.

Source: Behavioral Risk Factor Surveillance System (BRFSS).

Overweight rates did not significantly change during the same time period, though a slight decrease was seen from 36% in 1995 to 35% in 2009.² Unfortunately, for adults of healthy or low-weight status (neither overweight nor obese), the numbers have decreased by 9% in the same timeframe to 35% in 2009.² This suggests that the decrease in overweight adults was due to more adults becoming obese. To see additional prevalence estimates for various demographic subgroups, please see Appendix D. Here are the Plan's objectives and targets for improving weight status in the next 10 years:

Overarching Objectives for the Plan:

Healthy Weight and Obesity

- Increase the percentage of adults who are at a healthy weight from 35% to 38% by 2020.*
- Increase the percentage of high school students who are at a healthy weight from 71% to 76% by 2020.†
- Decrease the percentage of adults who are obese from 30% to 25% by 2020.*
- Decrease the percentage of high school students who are obese from 13% to 10% by 2020.†

* Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS)

† Data Source: 2009 Youth Risk Behavior Survey (YRBS)

Improvement Needed in Health Behaviors

Physical Activity

For younger age groups, data from PedNSS show physical activity levels for children aged 2-5 at 14% in 2007, while the NSCH data for children aged 6 to 17 show physical activity levels at 31%.^{6,7} For high school students, according to the Indiana YRBS, meeting the recommended levels of physical activity showed a slight decrease for all students in grades 9-12 combined from 2007 (44%) to 2009 (41%).¹ According to the BRFSS, from 2001 to 2009, meeting the recommended levels of physical activity for adults varied only slightly, going from 65% to 64%.⁸ Here are the Plan's objectives and targets for improving physical activity in the next 10 years:

Overarching Objectives for the Plan:

Physical Activity

- Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 68% by 2020.*
- Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 55% by 2020.†

* Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS)

† Data Source: 2009 Youth Risk Behavior Survey (YRBS)

Fruit and Vegetable Consumption

At this time, data for fruit and vegetable consumption for children younger than high school age are not available. Unfortunately, looking at YRBS results, high school students who met the recommended fruit and vegetable intake in 2003 was at 20% and declined significantly to 16% in 2009.¹ Adults who met the recommended fruit and vegetable consumption (5 times or more per day) had remained the same as in 1996 (21%) according to the 2009 Indiana BRFSS. Though there has been a slight increase, the rate has never exceeded 24% (reported in 1998).² Here are the Plan's objectives and targets for improving fruit and vegetable consumption in the next 10 years:

Overarching Objectives for the Plan:

Fruit and Vegetable Consumption

- Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 24% by 2020.*
- Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables per day from 16% to 21% by 2020.†

* Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS)

† Data Source: 2009 Youth Risk Behavior Survey (YRBS)

Breastfeeding

In Indiana, breastfeeding at discharge has steadily increased from 1997 (54%) to 2006 (67%).⁹ However, duration of breastfeeding has not fared as well, so work will continue on targets for initiation and duration of breastfeeding. State data available for breastfeeding at 6 months show no major change between 2006 and 2007, remaining at 38% for each of the two years. Breastfeeding at 12 months, on the other hand, went from 21% down to 17% for 2006 and 2007, respectively.¹⁰ Here are the Plan's objectives and targets for improving breastfeeding in the next 10 years:

Overarching Objectives for the Plan:

Breastfeeding

- Increase the percentage of mothers who breastfeed their babies from 71% to 75% by 2020.*
- Increase the percentage of mothers who breastfeed their babies exclusively at 3 months from 29% to 40% by 2020.†
- Increase the percentage of mothers who breastfeed their babies at 6 months from 38% to 50% by 2020.†
- Increase the percentage of mothers who breastfeed their babies at 12 months from 17% to 25% by 2020.†

* Indiana State Department of Health, PHPC, ERC, Data Analysis Team

† Data Source: Centers for Disease Control and Prevention 2007 National Immunization Survey

Sugar-Sweetened Beverage Consumption

Looking at the YRBS, the change in soda consumption among high school students decreased significantly between 2007 and 2009, going from 36% to 30%, respectively.¹ In 2009, for the first time, the Indiana BRFSS contained a question to measure adult consumption of sugar-sweetened beverages. Adult consumption of 1 or more sugar-sweetened beverages per day for 2009 was 69% in Indiana.⁸ Here are the Plan's objectives and targets for decreasing sugar-sweetened beverage consumption in the next 10 years:

Overarching Objectives for the Plan:

Sugar-Sweetened Beverages

- Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 59% by 2020.*
- Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 22% by 2020. †

* Data Source: 2009 Behavior Risk Factor Surveillance System, Indiana (BRFSS). Sugar-sweetened beverages include regular soda, sweet tea, energy drinks, specialty coffee drinks, sports drinks, and fruit drinks containing less than 50% juice. Diet beverages are not included.

† Data Source: 2009 Youth Risk Behavior Survey (YRBS)

Workgroup Objectives and Strategies

The Indiana Healthy Weight Initiative Task Force workgroups developed 50 objectives with accompanying strategies to achieve the positive and major changes in Indiana that the goals and overarching objectives reflect. Some objectives and strategies focus on training and technical assistance and the identification or creation of tools (e.g., assessments). These efforts are needed to increase the knowledge and skills of individuals, groups, and organizations throughout Indiana to successfully plan, advocate for, and implement policy and environmental changes. Other objectives and strategies focus on specific policy, environmental, and system changes with the strongest potential to succeed by leveraging current and future resources. These policy, environmental, and system changes will influence widespread, meaningful, and sustainable change for the state and for local communities.

Breastfeeding

Breast milk is the natural first food for babies. The American Academy of Family Physicians recommends, “all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life. Breastfeeding should continue with the addition of complementary foods throughout the second half of the first year. Breastfeeding beyond the first year offers considerable benefits to both mother and child, and should continue as long as mutually desired.”¹¹ In addition to providing energy and nutrients, breastfeeding can lower the risks of health problems in infants, children, and mothers. It is a critical health choice. Breastfeeding also can save on health care costs, contribute to a more productive workforce, and be better for the environment.¹²

Despite the well-known benefits of breastfeeding, many Indiana mothers choose not to breastfeed exclusively or prematurely discontinue breastfeeding. According to the Centers for Disease Control and Prevention (CDC) 2007 National Immunization

Survey, 71% of Indiana mothers breastfed their babies. However, breastfeeding rates at 6 and 12 months fell (38% and 17%, respectively).¹³ At first glance, it may seem that all mothers have an equal opportunity to breastfeed their babies. However, breastfeeding rates vary widely by a mother’s age, race, and county of residence. A mother’s experience during her hospital stay, the support she receives at home and within the community, and the barriers she faces upon returning to work or choosing a child-care center often make it difficult for her and her family to meet breastfeeding goals.¹⁴

BREASTFEEDING OBJECTIVE 1

By 2015, enhance and maintain a diverse, state-wide network of local breastfeeding partnerships/coalitions and professional breastfeeding experts.

Strategies

- Continue providing resources and support for a statewide breastfeeding coordinator.
- Provide support, mentoring, training opportunities, and technical assistance to increase and sustain local breastfeeding partnerships/coalitions.
- Encourage the use of International Board Certified Lactation Consultants (IBCLC) to assist the mother-infant pair, create and administer lactation programs, educate other health professionals, and advocate for breastfeeding.
- Offer financial assistance to qualified candidates to attend IBCLC training and to take the IBCLC exam.
- Offer financial assistance to qualified candidates to attend the United States Breastfeeding Committee’s biannual national conference.
- Encourage local partnerships/coalitions throughout Indiana working on obesity prevention initiatives to include professional breastfeeding experts among their memberships.

BREASTFEEDING OBJECTIVE 2

By 2020, increase the percentage of mothers who breastfeed their babies at 6 months from 37% to 50%.

Strategies

- Educate mothers (especially first-time mothers) and their networks of support about the benefits of exclusive and continued breastfeeding.
- Encourage hospital marketing practices that support and promote exclusive breastfeeding.
- Provide information to health professionals on the importance of early, exclusive, and continued breastfeeding; lactation management; and how breastfeeding mothers can incorporate breastfeeding into their lives.
- Provide information to health professionals on the services that the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) offers to support breastfeeding in the community.
- Advocate for better family, peer, and community support for mothers who choose to breastfeed their babies.
- Encourage the implementation of policy and environmental change interventions across settings (e.g., child-care, schools, health care, worksites, faith-based organizations, and communities) that support continued breastfeeding at 3, 6, and 12 months.
- Recognize public venues (e.g., restaurants, stores, schools, faith-based organizations, libraries, parks, etc.) within the community that provide a supportive environment for breastfeeding mothers and their families.

BREASTFEEDING OBJECTIVE 3

By 2020, increase the percentage of Black* mothers who initiate breastfeeding from 49% to 66%.

Strategies

- Convene statewide partners, including Black mothers who are currently or who have breastfed their babies, to identify and address barriers to breastfeeding among Black mothers.
- Work with statewide partners to develop an action plan to increase breastfeeding among Black mothers.
- Launch a social marketing campaign to promote early, exclusive, and continued breastfeeding and increase cultural and social support for breastfeeding among Black mothers.
- Encourage and support faith-based initiatives aimed at increasing breastfeeding among Black mothers.



BREASTFEEDING OBJECTIVE 4

By 2020, increase the number of “Baby Friendly” designated hospitals from 3 to 10.

Strategies

- Sponsor a summit for key decision-makers from hospitals providing maternity care to highlight best practices and evidence-based interventions for breastfeeding and the role hospitals and birth centers play in supporting breastfeeding mothers.
- Provide additional mentoring, training, and support to hospitals seeking the World Health Organization/United Nation's Children Fund (WHO/UNICEF) “Baby Friendly” designation.
- Maintain collaboration with the Indiana State Department of Health (ISDH) (i.e., WIC, Maternal and Child Health [MCH], Division of Nutrition and Physical Activity [DNPA]) and the Indiana Perinatal Network (IPN) to develop, implement, and promote the *Indiana Can Do 5 Program* to encourage hospital practices supportive of breastfeeding.
- Encourage hospitals to have and routinely communicate a breastfeeding policy to staff and provide training to all health care staff to assist in implementing the policy.
- Develop partnerships among hospitals and birth centers and breastfeeding support networks such as WIC, La Leche League, local breastfeeding partnerships/coalitions, and community drop-in clinics to facilitate patient referrals.

Early Childhood/Child Care

The number of children in some form of child care and the amount of time children spend in the care of someone other than a parent/guardian are at an all-time high. Enabling child-care settings to support healthy eating and physical activity, as well as encouraging child-care providers to model healthy behaviors, may help jump-start children into learning and adopting healthy behaviors. Opportunities exist to improve nutrition and physical activity in child-care settings via professional development for early care and education providers and parents, changes in regulating child care, enhancing quality rating systems for child care and improving nutrition services offered in child-care settings.

There are a variety of child-care settings available in Indiana, e.g., centers, homes, ministries, and pre- and after-school programs. The Indiana Family and Social Services Administration (FSSA), Bureau of Child Care (BCC), reported 606 licensed child-care centers, 3,057 licensed child-care homes, and 716 unlicensed registered child-care ministries in state fiscal year 2009.¹⁶ No information is currently available on the number of children cared for by someone other than a parent/guardian, not in licensed or registered care, and in pre- and after-school programs in Indiana.



CHILD-CARE OBJECTIVE 1

By 2014, provide training and technical assistance to parents, early care and education providers, and others that focus on nutrition, physical activity, and lactation support in child-care settings.

Strategies

- Engage the Indiana Association for the Education of Young Children, Inc. (Indiana AEYC), Indiana Association for Child Care Resource and Referral (IACCRR), FSSA, Indiana Head Start Collaboration Office, Indiana Head Start Association, provider support organizations, parents, early care and education providers, and others to identify training needs.
- Update the Indiana Healthy Weight Initiative Website with best practices and evidence-based nutrition, physical activity, and breastfeeding interventions for child-care settings.
- Build upon existing training resources and activities to provide a variety of offerings using multiple methods of dissemination.
- Support and promote nutrition, physical activity, and lactation support training at the Indiana Early Childhood Conference, Indiana Head Start Conference, and other statewide and/or regional conferences for early care and education providers.
- Continue the partnership between the IPN and FSSA by developing a breastfeeding toolkit and training module on the safe and appropriate handling of breast milk and how to care for breastfed babies.
- Ensure training provides credit hours or continuing education credit for early care and education providers.
- Increase funding for professional development and educational materials.

CHILD-CARE OBJECTIVE 2

By 2014, add nutrition, physical activity, and television viewing recommendations for early childhood settings into the formal and non-formal Child Development Associate (CDA) training.

Strategies

- Engage organizations and colleges statewide that are offering training courses for the CDA National Credential.
- Encourage developing or updating a training course(s) that focuses on early childhood obesity, providing early care and education providers with practical strategies to address nutrition, physical activity, and television viewing in child-care settings.
- Ensure training increases knowledge and skills that support and promote evidence-based or best practice strategies.
- Encourage the Indiana AEYC to include the training course(s) in the Indiana Non Formal CDA Project as part of the training requirements.
- Promote the training course(s) statewide as a resource for early care and education professionals and a means to complete 120 clock hours of formal and non-formal child-care education.

CHILD-CARE OBJECTIVE 3

By 2020, encourage the addition of nutrition, physical activity, and television viewing to the licensing requirements for child-care providers.

Strategies

- Provide information to early care and education providers, policymakers, and other key leaders on the importance of changing policies and environments to create healthier licensed and registered child-care settings.
- Maintain an interagency collaboration among the FSSA, ISDH, and the Indiana Department of Education (IDOE) to support and promote healthy eating and physical activity in early care and education programs.
- Identify and address barriers to the adoption and implementation of nutrition and physical activity standards in licensed and registered child-care settings.
- Recommend regulatory changes to ensure that all children in licensed and registered child-care settings have access to healthy foods and beverages and opportunities for physical activity while in care.
- Provide training and technical assistance to help early care and education providers comply with regulatory changes.
- Update the interpretative guide for licensed and registered child-care providers to support the updated regulatory changes.

CHILD-CARE OBJECTIVE 4

By 2016, include basic nutrition and physical activity requirements for unlicensed child-care providers in the Child Care and Development Fund (CCDF) voucher program provider eligibility standards.

Strategies

- Provide information to early care and education providers, policymakers, and other key leaders on the importance of changing policies and environments to create healthier child-care settings.
- Maintain an interagency collaboration between the FSSA and ISDH to support and promote healthy eating and physical activity in child-care settings.
- Advocate for requirements to ensure that all children in any child-care setting have access to healthy foods and beverages and opportunities for physical activity while in care.
- Increase the number of legislators, child-care advocates, and early care and education providers who support strengthening standards for nutrition and physical activity.
- Set standards for nutrition, physical activity, and television viewing.
- Provide training and technical assistance to help early child and education providers comply with the new standards.

CHILD-CARE OBJECTIVE 5

By 2014, include standard nutrition, physical activity, and television viewing requirements in the Paths to QUALITY (PTQ) rating system standards.

Strategies

- Advocate for nutrition, physical activity, and television viewing criteria in child-care centers, homes, and ministries that support and promote healthy child development.
- Convene statewide partners, including the ISDH, Cooperative Extension Service Nutritionists, Indiana AEYC and the IACCRR, to develop nutrition and physical activity standards and criteria for PTQ.
- Ensure nutrition and physical activity criteria meet national accreditation best practices.
- Identify and address barriers to the adoption and implementation of the nutrition and physical activity criteria in child-care centers, homes, and ministries.
- Submit standards with criteria to the FSSA, Bureau of Child Care, for review and consideration.
- Identify resources needed to adopt properly the criteria into PTQ.
- Provide training to FSSA, Bureau of Child Care; IAIEYC; TCC; and IACCRR staff who assist with the implementation of PTQ.

CHILD-CARE OBJECTIVE 6

From 2010 through 2016, increase participation in the Child and Adult Care Food Program (CACFP) among licensed child-care centers, licensed child-care homes, and unlicensed registered ministries by 2% each year.

Strategies

- Maintain an interagency collaboration between the FSSA and IDOE to identify licensed child-care centers, licensed child-care homes, and unlicensed registered ministries that are not CACFP participants.
- Develop brochures for each type of facility that include eligibility requirements, meal reimbursement, and information providers can return to IDOE expressing interest in the program.
- Conduct *New Sponsor Workshops* by IDOE as needed with the possibility of doing so throughout Indiana.
- Send materials to facilities not participating in the CACFP based on weekly updates from IACCRR identifying open and closed facilities.
- Give CACFP flyers/brochures to FSSA staff to distribute as they visit sites for approval.
- Provide training for licensed child-care centers and licensed child-care homes to participate in CACFP, e.g., food safety training, and include benefits of CACFP participation.
- Provide nutrition training for CACFP participants about improving nutrition and physical activity and the importance of modeling healthy behaviors.

School (Kindergarten through Grade 12)

In Indiana, there are more than 2,100 public and state accredited non-public kindergarten through grade 12 schools. Indiana's schools enroll more than 95% of Indiana's school-age population, with more than 1 million children attending public schools. In addition to the large student population, Indiana's public schools employ more than 11,300 full-time teachers and administrators.¹⁶

Schools are important partners in efforts to improve the health of Indiana's residents. Given their dedication to educating children and youth to become healthy, productive citizens, schools are prime settings for efforts to prevent obesity and improve overall health. By establishing healthy environments and cultures, schools can improve the health of Indiana's children, education workforce, and all whose lives are impacted by schools.

SCHOOL OBJECTIVE 1

By 2015, establish a state-level system for the collection, assessment, reporting, improvement, and implementation of school wellness policies in Indiana.

Strategies

- Maintain an interagency collaboration between the IDOE and ISDH to support the collection, assessment, reporting, improvement, and implementation of school wellness policies.
- Establish an online location for school corporations to submit their school wellness policies.
- Encourage a periodic assessment of the strength and comprehensiveness of Indiana's school wellness policies and promote strategies for improvement.
- Identify and share tools to assist in the collection, assessment, reporting, improvement, and implementation of school wellness policies.
- Create and share a sample school wellness policy for Indiana.
- Provide information to school board members, Coordinated School Health Advisory Council (CSHAC) members, school personnel, and parents on federal legislation dealing with school wellness policy.
- Collect and share information on the effective strategies of Indiana school corporations for developing, assessing, and implementing a school wellness policy.
- Use the corporation's CSHAC and other partnerships to facilitate the development and implementation of a strong school wellness policy.
- Advocate for resources to support the development and implementation of school wellness policies.
- Amend existing law that outlines the responsibilities of a CSHAC to include posting the school wellness policies to an online location.



SCHOOL OBJECTIVE 2

By 2013, establish a system for childhood obesity surveillance using annual statewide, school-based body mass index collection among students in at least three representative grades.

Strategies

- Maintain an interagency collaboration between the IDOE and ISDH to support annual school-based body mass index (BMI) collection and reporting.
- Develop and share a tool to assist schools in the collection, analysis, and reporting of student BMIs.
- Provide information to school board members, CSHAC members, school personnel, and parents on the importance and benefits of measuring and reporting student BMIs.
- Collect and share information on the effective protocols and successful strategies of Indiana schools and other states for collecting student BMIs and sharing results.
- Establish partnerships among schools, local health professionals, and community organizations to facilitate the collection, analysis, and reporting of student BMIs and to create a referral network for students with unhealthy BMIs.
- Include language regarding the annual collection, analysis, and reporting of student BMIs in local school wellness policies.
- Encourage the standardized administration and reporting of annual school-based collection of BMIs to a lead governmental agency for childhood obesity surveillance.
- Enact legislation that requires annual BMI collection in schools and reporting results to a lead governmental agency for childhood obesity surveillance.
- Use BMI measurements to monitor geographic distribution, trends, and progress in reducing childhood obesity.

SCHOOL OBJECTIVE 3

By 2015, increase the percentage of secondary schools that have ever used an evidence-based instrument to assess school policies, activities, and programs related to nutrition from 37% to 41% and related to physical activity from 34% to 41%.

Strategies

- Provide training to school board members, CSHAC members, school personnel, and parents on evidence-based tools and use of assessment results to develop a school health improvement plan.
- Provide technical assistance for conducting an assessment and using the results to prepare grant applications and applications for awards, such as the Healthy Hoosier School Award and the HealthierUS School Challenge.
- Provide information to school board members, CSHAC members, school personnel, and parents on the importance and benefits of assessing school policies, activities, and programs related to nutrition and physical activity.
- Provide resources and incentives to schools to encourage conducting an assessment and to support the development and implementation of an action plan based on the assessment results.
- Establish partnerships between CSHAC members and school personnel to facilitate the completion of a school assessment.
- Select an evidence-based tool to assess school nutrition and physical activity policies, activities, and programs.
- Conduct a school assessment as a first step in developing and implementing a school health improvement plan.

SCHOOL OBJECTIVE 4

By 2015, increase the percentage of schools that report having a corporation-level or school-level Coordinated School Health Advisory Council² (CSHAC) from 71% to 78%.

Strategies

- Provide information to school board members, CSHAC members, school personnel, and parents on federal school wellness policy and Indiana CSHAC requirements.
- Identify and share best practices for starting, organizing, and utilizing a CSHAC.
- Recognize school corporations with high performing CSHACs.
- Provide and promote a central location for schools to share CSHAC activities and receive training and ongoing technical assistance.
- Identify school corporations that do not have a CSHAC and provide direct assistance in establishing one.
- Identify champions to promote the development and ongoing activities of CSHACs.
- Establish and facilitate partnerships among schools, parents, and community organizations to start a CSHAC or to enhance an existing council.

SCHOOL OBJECTIVE 5

By 2015, increase the percentage of lead health education teachers in secondary schools who have received training on physical activity within the previous 2 years from 40% to 55%; and by 2017, increase the percentage who have received training on nutrition within the previous 2 years from 23% to 44%.

Strategies

- Support the efforts of health education teachers to pursue ongoing professional development in nutrition and physical activity.
- Offer sessions on school nutrition, physical activity, and obesity prevention at statewide and/or regional conferences.
- Provide training to teachers on utilizing the Health Education Curriculum Analysis Tool (HECAT) to improve the quality of health education programs.
- Develop and promote online training and professional development opportunities that allow teachers to receive the latest nutrition and physical activity information without interrupting curriculum delivery.

SCHOOL OBJECTIVE 6

By 2020, increase by 50 the number of schools that implement policies, activities, or infrastructure improvements supportive of walking and bicycling to school.

Strategies

- Establish a statewide network of representatives from IDOE, ISDH, and the Indiana Department of Transportation (INDOT), as well as bicycle, pedestrian, health, school, and parent advocacy groups, for the promotion of walking and bicycling to school.
- Advocate for increased public and private funding to support local and state walking- and bicycling-to-school initiatives.
- Promote and support the INDOT Safe Routes to School Program.
- Provide information to school board members, CSHAC members, school personnel, and parents on the benefits and feasibility of children walking and bicycling to school.
- Conduct a walkability and bikeability assessment to identify safety issues and build community support.
- Include language supportive of walking and bicycling to school in local school wellness policies.
- Provide training, resources, and ongoing technical assistance to schools and other entities wishing to implement or maintain active transportation-to-school initiatives, especially in low-income communities and/or underserved geographic areas.

SCHOOL OBJECTIVE 7

By 2020, increase by at least 15 rural schools and 5 urban the number of schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours.

Strategies

- Collect and share information on effective protocols and successful strategies for joint use agreements to allow the use of schools for recreation by the public during non-school hours.
- Provide training to school personnel and community organizations on developing partnerships, facilities, and risk-management plans to support the public use of school facilities for physical activity.
- Conduct an assessment of built and social environments related to physical activity to identify school and community needs for physical activity spaces, especially in low-income communities and underserved geographic areas.
- Develop and disseminate a toolkit to support establishing joint use agreements in Indiana that includes a model joint use agreement template.
- Include language that ensures access to school physical activity spaces and facilities for all persons outside of normal school hours in local school wellness policies.
- Include the establishment of joint use agreements, especially in low-income communities and/or underserved geographic areas, as part of a community's initiative to address obesity.
- Establish and facilitate partnerships among schools, parents, and community organizations to develop and promote physical activity opportunities at local schools that are available to the general public.

SCHOOL OBJECTIVE 8

By 2020, amend existing law that supports daily physical activity in elementary schools to specify at least 30 minutes of daily physical activity.

Strategies

- Provide information and resources to school board members, CSHAC members, school personnel, and parents on the relationship between physical activity, health, and academic performance and how to incorporate physical activity throughout the school day.
- Collect and share success stories and effective strategies from schools and school corporations that provide active, daily recesses and incorporate physical activity into lesson plans.
- Incorporate physical activity into lesson plans.
- Include language recommending at least 30 minutes a day of physical activity in elementary schools in local school wellness policies.
- Include language in local school wellness policies recommending an active, daily recess for elementary schools that teachers/administrators cannot take away as punishment.

SCHOOL OBJECTIVE 9

By 2019, increase the percentage of secondary schools that do not sell soda pop or non-100% fruit juice to students from vending machines or school stores from 57% to 74%.

Strategies

- Provide information to school board members, CSHAC members, school personnel, and parents on the importance, benefits, and financial incentives of offering healthier beverages.
- Collect and share information on effective protocols and successful strategies for healthy vending.
- Create and share a list of healthier beverages and vendors, manufacturers, brokers, and distributors from whom schools can purchase healthier options.
- Establish and facilitate partnerships among beverage providers, school personnel, and CSHAC members to develop contracts that support offering only healthy vending options.
- Include language specifying that schools will sell only non-flavored water, milk, and 100% fruit juice in local school wellness policies.
- Provide healthier beverage options to students including free, potable drinking water.
- Promote the availability and benefits of healthy beverages to students and school personnel.

SCHOOL OBJECTIVE 10

By 2019, increase the percentage of secondary schools that do not sell less healthy food and drink options* from vending machines or school stores from 31% to 46%.

Strategies

- Provide information to school board members, CSHAC members, school personnel, and parents on the importance, benefits, and financial incentives of offering healthier foods and beverages.
- Collect and share information on effective protocols and successful strategies for healthy vending.
- Create and share a list of healthier food and beverage items and vendors, manufacturers, brokers, and distributors from whom schools can purchase healthier options.
- Establish and facilitate partnerships among food and beverage providers, school personnel, and CSHAC members to develop contracts that support offering only healthy vending options.
- Include language specifying that schools will sell only healthier food and beverage options that meet or exceed Institute of Medicine's (IOM) guidelines in local school wellness policies.
- Provide only healthier food and beverage options that meet or exceed IOM guidelines to students.
- Promote the availability and benefits of healthy foods and beverages to both students and staff.

SCHOOL OBJECTIVE 11

By 2020, increase the number of schools with a Farm to School program from 1 to 100.

Strategies

- Establish an interagency working group of the Indiana State Department of Agriculture (ISDA), IDOE, and ISDH to support Farm to School programs.
- Establish an information-sharing network to inform Farm to School stakeholders of available grants to support Farm to School initiatives and equipment, as well as federal and state legislative and regulatory changes that influence Farm to School activities.
- Assess Indiana's food system to determine the feasibility of Farm to School initiatives throughout Indiana.
- Gather information on the interest, capacity, and needs of vendors and school food service personnel to identify opportunities and barriers to increasing Farm to School activities in Indiana.
- Provide training on the safe handling of fresh produce to vendors, school food service personnel, and other school staff.
- Develop, maintain, and disseminate to school personnel a listing of local food producers, distributors, and processors able to participate in a Farm to School program.
- Establish and facilitate partnerships between schools and local food producers.
- Use earned media opportunities to advocate for greater access to fruits and vegetables through Farm to School programs.
- Recognize local Farm to School partnerships and activities through the National Farm to School Network's Website.

SCHOOL OBJECTIVE 12

By 2020, increase the number of venues offering the summer food service program from 81 to 91.

Strategies

- Continue outreach efforts to schools that qualify based on their Free/Reduced Lunch percentages.
- Continue training efforts in the spring of each year for schools interested in providing summer feeding sites.
- Provide information to school board members, CSHAC members, school personnel, and parents on the summer food service program and existing summer food service venues.
- Collect and share success stories from new and established sponsors, via the IDOE newsletter, in the spring of each year before the start of the promotion period.
- Establish partnerships between schools and community organizations for summer programs to use school facilities or equipment.

SCHOOL OBJECTIVE 13

By 2020, increase the percentage of high school students who participate in daily school physical education from 28% to 33%.

Strategies

- Provide information to school board members, CSHAC members, school personnel, and parents on the positive effects of daily physical education and physical activity on academic performance and health.
- Encourage students to enroll in physical education regardless of participation in a school sport or other school activity or club.
- Advocate that school corporations offer daily physical education in grades kindergarten-12.
- Recommend time requirements for 150 minutes per week of physical education in elementary schools and 225 minutes per week of physical education for middle and high schools.
- Recommend schools develop and implement comprehensive school policies to support the provision of high-quality daily physical education in grades kindergarten-12.

SCHOOL OBJECTIVE 14

By 2020, increase the percentage of high school students who spend more than 20 minutes of school physical education class time being physically active.

Strategies

- Assess the amount of time Indiana high school students spend being physically active in physical education class through the Youth Risk Behavior Survey.
- Conduct an evaluation of physical education course curricula using a tool, such as the Physical Education Curriculum Analysis Tool (PECAT), to improve the quality of physical education programs.
- Provide support to under-resourced schools to ensure schools have the necessary materials to provide high-quality physical education and physical activity programming.
- Encourage that certified, highly qualified physical education teachers be employed in local schools in accordance with national guidelines for physical education teacher education, such as those published by the National Association for Sport and Physical Education.
- Provide the opportunity and resources for training, professional development, and ongoing technical assistance to all staff responsible for providing physical education.
- Collect, monitor, and track students' health-related fitness data and use the results to make improvements to physical education courses.
- Create and use a system for monitoring corporation compliance with meeting physical education time requirements.
- Advocate for pre-kindergarten through grade 12 physical education curriculum that addresses time, class size, and Indiana standards.
- Encourage state and local standards that emphasize the provision of high levels of physical activity in physical education that facilitates students spending 50% of physical education class time in moderate-to-vigorous physical activity.

SCHOOL OBJECTIVE 15

By 2020, increase the average daily student participation among students who qualify for free, reduced, and paid meals in the school breakfast program from 20% to 25%.

Strategies

- Provide training to schools on breakfast promotion and alternative serving options.
- Provide information to school board members and school personnel on alternative breakfast serving options.
- Provide information to school board members, CSHAC members, school personnel, and parents on the benefits of breakfast and its impact on health and academics.
- Encourage transportation schedules that allow children to arrive at school early enough to eat a school breakfast.
- Ensure children can participate in school breakfast when scheduling before-school activities.
- Limit access to competitive foods during before-school hours to encourage students to eat the school breakfast.
- Offer appealing and healthy food and beverage options at school breakfasts that meet or exceed IOM recommendations.
- Include language supportive of access to breakfast for all students in local school wellness policies.
- Establish and facilitate partnerships between schools and community organizations to provide universal free breakfast to all students.

SCHOOL OBJECTIVE 16

By 2020, increase the average daily student participation among students who qualify for free, reduced, and paid meals in the school lunch program from 68% to 75%.

Strategies

- Provide training to school board members, CSHAC members, and school personnel on offering healthy and appealing meal choices.
- Provide training on IOM findings and reauthorization for meal pattern changes.
- Offer foods and beverages that meet or exceed IOM recommendations for the school meal program.
- Limit access to competitive foods during school hours to encourage students to eat the school lunch.
- Include language supportive of healthier food choices and limiting unhealthy competitive foods in local school wellness policies.

Health Care

Health care professionals are a trusted source of health information and guidance for the general population, spanning all age ranges. In a given month, an estimated 20% of the U.S. population visits a physician's office, offering an opportunity for individual assessment of Body Mass Index (BMI), discussion about physical activity levels and diet, and referral to appropriate resources. Health care settings, especially hospitals, are in a unique position to provide leadership within their communities, modeling a healthy work environment for employees and the public. Hospitals also have an ongoing commitment to community engagement that improves the public's health, making them perfectly situated to affect policy and environmental change on a broader scale.



HEALTH CARE OBJECTIVE 1

By 2015, develop and disseminate a protocol for use by health care providers to integrate obesity prevention into office practice.

Strategies

- Work closely with professional associations representing health professionals, individual health care providers, and other stakeholders to identify and/or develop a protocol for the prevention and assessment of overweight/obesity.
- Research existing implementation models, such as Indiana Tobacco Prevention Cessation's (ITPC) "Ask, Advise, Refer" for integrating obesity prevention into office practice.
- Provide training and technical assistance to health care providers and office staff to ensure the effective integration of obesity prevention into office practice.
- Promote the use of existing resources such as *Exercise is Medicine* prescription, *Ounce of Prevention 12 Well-Child Visit* prescriptions, and the American Academy of Pediatrics (AAP) *Healthy Active Living* prescription.
- Maintain and distribute a comprehensive chart with insurance reimbursement codes for federal- and state-funded insurance plans (i.e., Medicare, Medicaid, and Children's Health Insurance Program) for the prevention and assessment of overweight/obesity.

HEALTH CARE OBJECTIVE 2

By 2013, offer and promote annual continuing education opportunities for health professionals focused on evidence-based nutrition, physical activity, breastfeeding, and obesity prevention practices.

Strategies

- Encourage health professionals to maintain current knowledge of national, evidence-based nutrition, physical activity, and breastfeeding recommendations such as the *Dietary Guidelines for Americans* and the *2008 Physical Activity Guidelines for Americans*.
- Identify and promote evidence-based continuing medical education/continuing education (CME/CE) programs that address obesity prevention, assessment, and treatment.
- Promote the Obesity Society's newly established "Certified Obesity Medical Physician" certification to eligible health care professionals.
- Encourage use of the AAP *Breastfeeding Residency Curriculum*.
- Work with colleges and universities to include competencies in nutrition, physical activity, breastfeeding, and obesity prevention in programs that train future health professionals.

HEALTH CARE OBJECTIVE 3

By 2015, increase by 10 the number of hospitals that provide and promote healthier food and beverage options for food served or sold to staff and visitors on their hospital campuses.

Strategies

- Convene key personnel to assess the current food and beverage procurement practices and policies for food served or sold to staff and visitors on hospital campuses.
- Update the Indiana Healthy Weight Initiative Website with evidence-based recommendations and strategies for improving healthy food and beverage access, availability, and affordability on hospital campuses.
- Encourage farm to hospital programs (e.g., purchasing locally grown products, hosting a farmers' market or community-supported agriculture program on hospital grounds, or creating hospital gardens).
- Encourage hospitals, especially Critical Access and Disproportionate Share that reach disparately impacted populations in rural and low-income areas, to adopt food/beverage policies that serve as model policies for the community.
- Share success stories with hospitals throughout Indiana to expand adoption of healthy food/beverage policies.

HEALTH CARE OBJECTIVE 4

By 2015, increase by 20 the number of hospitals focused on obesity prevention in their community benefit/community outreach initiatives.

Strategies

- Provide information to hospital personnel on the importance of changing policies and environments to create healthier communities.
- Assess current efforts by hospitals to address obesity prevention at the community level.
- Collect and share information on the effective strategies of hospitals for developing and implementing their community benefit/community outreach initiatives that focus on obesity prevention.
- Promote the use of the Indiana Hospital Association's obesity prevention toolkit and implementation plan.
- Encourage hospitals to participate in local community initiatives to maximize resources and support their obesity prevention efforts.
- Encourage hospitals to collaborate with local agencies and organizations to provide nutrition, physical activity, and other obesity-related programs and services in low-income communities and/or underserved geographic areas.

Worksite

With modern day advances in technology, the landscape of today's workplace looks much different than it did a few decades ago. In many of today's workplaces, employees are sitting at a desk for the majority of their workday with limited opportunities for physical activity. Today's workplace can also be a challenging environment for employees to find healthy, low-cost foods served in cafeterias, vending machines, and in meetings.

Despite these challenges, worksites can be an ideal setting to improve health and prevent overweight, obesity, and other associated chronic diseases. Working adults spend a significant portion of their day at the workplace. In 2010, approximately 2.9 million people were employed in Indiana.¹⁷ Some of Indiana's largest employers include manufacturing, government and government enterprises, retail trade, and health care/social assistance. To help improve their bottom line, employers are finding that implementing obesity prevention strategies can lead to reduced health care costs, lower absenteeism, and increased productivity.



WORKSITE OBJECTIVE 1

By 2013, identify and disseminate a worksite-assessment tool that evaluates the current policies and environmental supports for nutrition, physical activity, and lactation in worksites.

Strategies

- Review existing worksite-assessment tools to determine if an established tool can be adopted for use. Develop a new worksite-assessment tool if needed.
- Post the worksite-assessment tool on the Indiana Healthy Weight Initiative Website and disseminate through other means.
- Partner with employers, professional organizations (e.g., Indiana Chamber of Commerce, local chambers of commerce, the Wellness Council of Indiana, Healthiest Employers of Indiana, Indiana Worksite Wellness Partnership, etc.), INShape Indiana, coalitions, and other stakeholders to promote the worksite-assessment tool and its benefits to employers.
- Provide technical assistance to employers on how best to use information from the worksite-assessment tool to improve policy and effect environmental changes.
- Provide a means for employers to give feedback on the tool and conduct internal review of the tool to improve it as needed.
- Recognize worksites using the worksite-assessment tool.

WORKSITE OBJECTIVE 2

By 2013, provide training and technical assistance to employers, local business groups, and coalitions on improving nutrition, physical activity, and lactation support at worksites.

Strategies

- Update the Indiana Healthy Weight Initiative Website with best practices and/or evidence-based interventions for worksites.
- Develop, disseminate, and promote an Indiana-specific worksite toolkit tailored to the needs, issues, and assets of small worksites across the state.
- Engage state and local business groups and coalitions to identify training needs and opportunities. Ensure training includes a focus on small employers and/or employers with a low-income workforce.
- Develop and execute a training plan that provides a variety of offerings using different methods of dissemination.
- Partner with organizations, such as the Indiana Chamber of Commerce, local chambers of commerce, Healthiest Employers of Indiana, the Wellness Council of Indiana, and local health care providers, to offer training opportunities.

WORKSITE OBJECTIVE 3

By 2020, increase by 200 the number of employers that have implemented 1 or more evidence-based policies and/or environmental change strategies to support nutrition, physical activity, and breastfeeding.

Strategies

- Provide information to employers on the importance of changing policies and environments to create healthier worksites.
- Encourage the use of assessment data (from the worksite-assessment tool) to drive implementation of policy and/or environmental change strategies.
- Connect at the design/construction level for new business buildings to provide education/tools for initiating an environment conducive to healthy choices.
- Promote the Indiana Small Employer Worksite Wellness Tax Credit online and with earned media opportunities.
- Encourage the use of the U.S. Department of Health and Human Services *Business Case for Breastfeeding: Steps for Creating a Breastfeeding Friendly Worksite* comprehensive plan.
- Collaborate with partners, such as the Indiana Chamber of Commerce, local chambers of commerce, Healthiest Employers of Indiana, the Indiana Wellness Council, and local health care providers, to recognize Indiana employers who are creating healthier work environments.
- Identify and promote evidence-based nutrition, physical activity, and weight loss/management programs that include a social support component.
- Encourage employers to participate in local community initiatives to maximize resources and support their obesity prevention efforts.

WORKSITE OBJECTIVE 4

By 2014, implement additional efforts to provide and promote healthier food and beverage options and physical activity by state agencies and/or state-owned facilities.

Strategies

- Convene key personnel from state agencies and state-owned facilities to assess the current nutrition and physical activity environment in facilities.
- Ensure that state agencies and/or state-owned facilities with cafeterias and vending options have strong nutrition standards in place wherever foods and beverages are sold or available.
- Promote the availability of healthier foods and beverages in cafeterias and vending options located in state agencies and/or state-owned facilities.
- Provide information to key decision-makers and institutional buyers on purchasing healthier foods, including locally grown foods.
- Encourage the use of nutrition standards for foods and beverages available in government-run or regulated programs and/or facilities.
- Ensure state agencies and/or state-owned facilities promote programs among employees that support walking and bicycling for health during breaks and for transportation.
- Ensure state agencies and/or state-owned facilities promote the use of stairs by employees and visitors where applicable.

Older Adults

Indiana's older adult (65 years and older) population will substantially increase in the coming years. In 2009, the state's older adult population was estimated at 828,591 (13% of the state's population).¹⁸ By 2030, this figure is projected to climb to over 1.3 million (20% of the state's population).¹⁹ This substantial increase in Indiana's older adult population presents new challenges, as older adults typically have one or more chronic conditions and become less physically active as they age.

Where and how we live can affect healthy aging. As more older adults choose to age in place, having neighborhoods that offer access to healthy foods, safe places to walk, easy access to public transit, shops, services, gathering places, and homes built closer together will help promote and support healthy behaviors among older adults. City planners, government officials, developers, community organizations, park and recreation departments, and non-profit groups are just a few of the many groups that play a vital role in creating environments where older adults can live a healthy, active life.



OLDER ADULT OBJECTIVE 1

By 2013, conduct a statewide assessment and provide recommendations to help older adults achieve and/or maintain a healthy lifestyle.

Strategies

- Identify the resources and expertise needed to conduct an assessment.
- Convene statewide partners and other stakeholders that provide programs, resources, facilities, and services to older adults to help contribute information.
- Ensure assessment information highlights access and affordability issues for healthy foods and places for physical activity in underserved and/or low-income communities where older adults live.
- Distribute assessment results and recommendations to all statewide partners and other stakeholders via the Indiana Healthy Weight Initiative Website, as well as presentations at meetings, conferences, etc.
- Provide information to state and local stakeholders, decisions-makers, and the public about the current state of access and affordability issues for healthy foods and places for physical activity for older adults.
- Advocate for policies and environments that improve access to and affordability of healthy foods and places for physical activity for older adults.

OLDER ADULT OBJECTIVE 2

By 2015, launch a multi-year, statewide initiative to promote healthy eating and physical activity among older adults.

Strategies

- Convene statewide partners, including older adults, and use assessment information and recommendations to determine key strategies.
- Ensure the initiative promotes the following:
 - » Increased opportunities for healthy eating and physical activity through policy and environmental change strategies,
 - » Expansion of community programs and services to address healthy eating and physical activity among older adults,
 - » Increased awareness of the benefits of healthy eating and physical activity among older adults.
- Include activities and messaging that are consistent with the Indiana Healthy Weight Initiative and INShape Indiana.
- Identify specific ways individuals and organizations can participate in the initiative.
- Provide training and technical assistance for health, aging, urban/community planning, transportation, recreation, social service, and public and private sector organizations on the importance of creating healthier environments for older adults.
- Increase the number of community-wide campaigns to improve healthy eating and physical activity that includes older adults as a priority population.
- Encourage linkages between health professionals and local communities to facilitate referrals to local nutrition and physical activity resources.

Faith-Based

In Indiana, there are more than 7,000 congregations representing over 3 million members.²⁰ Faith-based organizations (FBO) serve in many capacities. In addition to places of worship, FBOs offer programs such as child care and/or pre- or after-school programs, food pantries, soup kitchens, and community gardens. Regardless of congregation size or religious affiliation, FBOs offer the opportunity to support and promote nutrition, physical activity, and breastfeeding among their memberships and programs.

Engaging FBOs in community obesity prevention initiatives is good practice. Communities, particularly in distressed areas, trust faith-based leaders and the organizations, themselves. They create and provide community leadership; they can access human and financial resources. FBOs serve as community and cultural anchors in areas where they have long been located, and they can provide access to low-income and/or minority populations.²¹ As part of a greater community effort, FBOs can advocate for and make changes that promote the health and wellness of community members.

FAITH-BASED OBJECTIVE 1

By 2014, provide four training opportunities for leaders of faith-based organizations (FBO) to raise awareness and understanding of how FBOs can participate in state and/or local obesity prevention initiatives.

Strategies

- Identify specific conferences and/or events as venues for providing training to leaders of FBOs.
- Provide information to FBOs on the importance of promoting and advocating for healthy foods and beverages, physical activity, and breastfeeding to improve the health of congregations and communities.
- Develop and disseminate a guide(s) for FBOs that provides recommendations for nutrition, physical activity, and breastfeeding for faith-based settings.
- Update the Indiana Healthy Weight Initiative Website with best practices and/or evidence-based nutrition, physical activity, breastfeeding, and/or health disparities interventions for FBOs.
- Identify and promote best practices and/or evidence-based nutrition, physical activity, and weight loss/management programs that include a social support component.

FAITH-BASED OBJECTIVE 2

By 2020, increase by 20 the number of state and/or local partnerships/coalitions that include the faith-based community in obesity initiatives.

Strategies

- Facilitate collaborative faith and community partnerships.
- Partner with state agencies and organizations (e.g., the ISDH Office of Minority Health, Indiana Minority Health Coalition, and the Office of Faith-Based and Community Initiatives) to facilitate collaboration with minority congregations.
- Encourage FBOs to participate in local community initiatives to maximize resources and support their obesity prevention efforts.
- Disseminate information and resources to FBOs on state and/or local initiatives and opportunities.

Community

Where people live, learn, work, and play does affect health. People are more likely to eat healthy and be physically active in a community that promotes and supports those behaviors.²² There are 92 counties in Indiana, which include 120 cities and 447 towns comprising a mix of urban, suburban, and rural communities. Each has its own government entity. Additionally, there are 1,008 townships that cover the entire state.^{23,24} Changing the social and physical environments of local communities as well as the settings within these communities (e.g., schools, worksites, child-care facilities, etc.) to better support healthy eating and physical activity will be no small task. However, implementing interventions within communities is good practice because of their many assets, including human resources, member knowledge and understanding of the community, the influence of local leaders on local policymakers, the ability to bring people together for a common cause, and the sharing of common problems.²⁵

COMMUNITY OBJECTIVE 1

By 2014, provide at least 10 training and/or technical assistance opportunities for local partnerships/coalitions that focus on nutrition, physical activity, breastfeeding, policy and advocacy, coalition development, and/or health disparities.

Strategies

- Engage members of local partnerships/coalitions throughout Indiana to identify training and technical assistance needs.
- Develop a training plan that provides a variety of offerings using different methods of dissemination.
- Develop and implement an evaluation plan for the training events.
- Update the Indiana Healthy Weight Initiative Website with best practices and evidence-based nutrition, physical activity, breastfeeding, and health disparities interventions for communities.
- Promote the Healthy Communities database to share resources and information on model policies and local examples of policy and environmental changes.

COMMUNITY OBJECTIVE 2

By 2017, increase by 30 the number of communities (i.e., counties and/or cities) that have assessed built and social environments related to nutrition and physical activity.

Strategies

- Educate community members and groups about the need to identify local needs, opportunities, and resources.
- Build or use an existing local partnership/coalition to plan and implement an assessment.
- Update the Indiana Healthy Weight Initiative Website with evidence-based assessment tools and methodologies to collect information and data.
- Provide technical assistance to train community members on how to conduct the assessment.
- Ensure that information and data highlight nutrition and physical activity accessibility and affordability issues in low-income and/or underserved geographic areas.
- Identify strategies for evidence-based nutrition and physical activity policy and environmental change and base them on the community's needs.
- Develop a Community Action Plan (CAP) that includes strategies, action steps, potential funding sources, and a timeline for implementation of strategies.
- Complete an assessment such as a Health Impact Assessment (HIA) of the potential health impacts of identified policies or environmental changes.
- Communicate local needs, priorities, and strategies to key community leaders and other stakeholders to assist in adoption, implementation, and funding of the CAP.

COMMUNITY OBJECTIVE 3

By 2020, increase by 40 the number of communities that have implemented 1 or more evidence-based policy and/or environmental change strategies to support nutrition and physical activity.

Strategies

- Provide information to community leaders on the importance of policy and environmental change strategies that support nutrition and physical activity to create a healthy and economically viable environment.
- Encourage the use of a CAP (based on assessment data) to drive implementation of policy and/or environmental change strategies.
- Ensure the implementation of policy and environmental change strategies focuses on increasing access to and the affordability of healthy foods and places for physical activity in underserved geographic areas (e.g., rural communities) and high-risk populations within the community.
- Develop and enhance local partnerships/coalitions to support implementation and evaluation of the CAP.
- Identify key leaders, champions, and resources needed to promote and implement strategies within the CAP.
- Implement community-wide campaigns to support policy and/or environmental change.
- Develop a network of peer mentoring among communities via the Indiana Healthy Weight Initiative Website and other means to share information, lessons learned, and model policies.

COMMUNITY OBJECTIVE 4

By 2020, implement community-wide campaigns in at least 20 communities to improve nutrition and increase physical activity.

Strategies

- Develop and secure funding for a campaign as a means to support and promote a larger, coordinated community (i.e., county and/or city) initiative focused on improving the health of its residents and creating a healthier environment.
- Build or use an existing partnership/coalition that includes a diverse group of local agencies and organizations that plan and implement nutrition- and physical activity-related activities. Ask partners representing different settings (e.g., child care, schools, worksites, faith-based organizations, etc.) to offer activities and events as part of the campaign.
- Identify the priority audience, including underserved children and adults, and conduct the campaign based on formative research.
- Develop an evaluation program for the campaign.
- Ensure the campaign delivers messages through a variety of media such as television, radio, and newspapers; social media; and through community-level programs, activities, policies, and environmental supports.
- The campaign should have a clear and standardized “brand” as well as nutrition, physical activity, and healthy weight messaging that is consistent with the Indiana Healthy Weight Initiative and INShape Indiana.
- Recruit key individuals and organizations in the community to commit to help promote the campaign, including local celebrities, local media, and local government.

COMMUNITY OBJECTIVE 5

By 2014, establish a large, diverse statewide network of professionals with competence and expertise in physical activity and health to promote and support state and community-based physical activity policy and environmental changes.

Strategies

- Educate state and local community leaders, decision-makers, and others on equally supporting and promoting physical activity and healthy eating to achieve and maintain a healthy community.
- Advocate for state and local public health, professional, and community-based organizations to invest resources equitably in physical activity to promote overall good health and reduce the burden of obesity and other chronic diseases.
- Encourage state and local public health, professional, and community-based organizations to hire and retain competent/qualified physical activity professionals to assist with obesity and chronic disease initiatives.
- Encourage local partnerships/coalitions throughout Indiana working on nutrition, physical activity, and obesity-related initiatives to include physical activity professionals or paraprofessionals among their memberships.
- Provide statewide training and technical assistance opportunities for physical activity practitioners and paraprofessionals, including the Physical Activity in Public Health Specialist (PAPHS) Certification.
- Develop a statewide speakers bureau consisting of physical activity professionals to communicate effectively the importance of policy and environmental changes that address physical activity.

COMMUNITY OBJECTIVE 6

By 2020, increase the number of Complete Streets policies at the Metropolitan Planning Organization (MPO) and/or local level from 3 to 15.

Strategies

- Promote streets planned, designed, and maintained to accommodate all types of transportation including transit, cars, pedestrians, and cyclists, as well as accessible and safe for older adults, children, and those with disabilities.
- Provide information to stakeholders at the state, regional, and local level about the health, financial, economic development, and design benefits that can result from finished complete streets projects.
- Provide training for planners and engineers in balancing the needs of diverse users.
- Encourage the adoption and implementation of Complete Streets through a variety of methods that may include executive orders from elected officials, internal memos from directors of transportation agencies, inclusion in comprehensive plans, rewrite of design manuals, and/or ordinances and resolutions.
- Encourage that recommended elements for a Complete Streets policy from the National Complete Streets Coalition be considered when developing a policy.
- Encourage local partnerships/coalitions to include Complete Streets policy in the development, renovation, and maintenance of trails as part of their community's initiative to address obesity.

COMMUNITY OBJECTIVE 7

By 2017, increase the number of Indiana counties with at least 20 acres of public local outdoor recreation land per 1,000 residents from 22 counties to 32 counties.

Strategies

- Promote moderate, fun physical activity daily, including outdoor activities whenever possible.
- Encourage investment in the development, renovation, and maintenance of parks, playgrounds, trails, and recreation facilities.
- Encourage non-traditional funding for the development, renovation, and maintenance of parks, playgrounds, trails, and recreation facilities.
- Encourage local partnerships/coalitions to include the development, renovation, and maintenance of parks, playgrounds, trails, and recreation facilities as part of a community's efforts to address obesity.
- Adopt and implement strategies that improve access to and the safety and security of parks, playgrounds, trails, and recreation facilities, especially in low-resource and high-crime neighborhoods.
- Encourage programs in parks, recreation, fitness, and sports that are appropriate for individuals of all ages and genders, diverse cultures, abilities, developmental stages, and needs and that have demonstrated positive physical activity outcomes.

COMMUNITY OBJECTIVE 8

By 2020, increase by 20% the mileage of trails available throughout Indiana and promote their use as a means to increase physical activity, recreation, and transportation.

Strategies

- Educate the public and private sectors about the benefits that a statewide trails system will bring to their communities in terms of health, fitness, tourism, active transportation infrastructure, and economic advantages.
- Improve the coordination of trail development, planning, funding, design, and construction at local, state, and federal levels.
- Encourage continued investment in the development, renovation, and maintenance of the statewide trail network.
- Create and maintain information about trail locations, access points, types of physical activity associated with the trail, safety information, and accessible destinations via the trail for distribution via the Web or easy-to-use maps.
- Plan incentives and social support activities for a variety of existing or potential trail users (e.g., families, walking groups, youth, older adults, bicycle and running clubs, etc.) to encourage use of trails.
- Encourage local partnerships/coalitions to include the development, renovation, and maintenance of trails as part of their community's initiative to address obesity.
- Advocate that trails be included as part of a larger active transportation system to connect the places where people live, learn, work, shop, and play.

COMMUNITY OBJECTIVE 9

By 2013, establish at least one food policy council at the state, regional, or local level.

Strategies

- Educate statewide partners on the role and benefits associated with having a food policy council.
- Establish a strong, diverse network of stakeholders from many sectors of the food system (e.g., production, consumption, processing, distribution, and waste recycling) to participate.
- Apply national recommendations and best practices for the structure and practices of food policy councils.
- Ensure information garnered from an assessment of the food system drives the priorities and activities of the food policy council.
- Identify additional resources to expand capacity and infrastructure to support food policy councils.
- Once established, monitor the effects of the council's policies and/or activities.

COMMUNITY OBJECTIVE 10

By 2014, increase the number of farmers' markets statewide licensed to accept Supplemental Nutrition Assistance Program (SNAP) benefits (e.g., Hoosier Works card) from 1 to 20.

Strategies

- Advocate for greater access to fruits and vegetables for low-income persons through farmers' markets.
- Establish a partnership of public and private agencies such as the ISDH, FSSA, ISDA, Purdue University Cooperative Extension Service, and the Indiana Cooperative Development Center (ICDC) to promote and support the number of farmers' markets licensed to accept the Hoosier Works card.
- Create and promote an online resource, *Hoosier Works Card Program at Farmers' Markets*, for market managers and farmers to assist them with the licensing process to accept the Hoosier Works card.
- Provide educational sessions on the licensing process throughout Indiana at events such as the Farmers' Market Boot Camps and the Indiana Horticulture Congress.
- Promote resources such as the United States Department of Agriculture's (USDA) *Know Your Farmer, Know Your Food* Website, the ISDA Website, and the *Ag Grant Guru* to locate funding opportunities.
- Create and promote a farmers' market food assistance partnership to share information and lessons learned about initiating and maintaining a Hoosier Works card program.
- Support and promote the farmers' market and direct-marketing farmers already licensed to accept the Hoosier Works card.
- Ensure that having a licensed farmers' market to accept SNAP benefits is part of a community's initiative to address obesity.

COMMUNITY OBJECTIVE 11

By 2012, conduct a food system assessment to increase awareness of Indiana's current food system and to provide recommendations for improvement.

Strategies

- Identify the resources and expertise needed to conduct a food system assessment in Indiana.
- Involve statewide partners and other stakeholders that comprise the many sectors of Indiana's food system to help contribute information.
- Identify and collect the data needed for the assessment.
- Disseminate assessment results to all statewide partners and other stakeholders via the Indiana Healthy Weight Initiative Website and other means.
- Use assessment results to inform and educate state and local stakeholders, decision-makers, and the public about the current state of Indiana's food system.
- Use assessment results to advocate and influence policies that will strengthen Indiana's food system.

COMMUNITY OBJECTIVE 12

By 2013, provide technical assistance and education to support and promote the availability of nutrition information and the availability of healthier food options in restaurants.

Strategies

- Convene statewide partners, including the Indiana Restaurant Association (IRA), to identify and/or create resources and to disseminate key messages.
- Ensure the initiative focuses on:
 - » Using calorie information to achieve and maintain a healthy weight,
 - » Advocating for restaurants to offer more fresh, locally grown produce; more forms of fruits and vegetables; nutritionally balanced meals for children and adults; and smaller, more economical portions of food,
 - » Recognize leaders in the food industry that offer healthier food options.
- Establish a working group that includes the IRA, culinary institutes, and chefs' associations to begin a dialogue on how chefs can become more engaged in addressing obesity.
- Collaborate with the IRA and the IDOE to work with future culinary and food management leaders to expand the "Pro-Start" curriculum to include a greater emphasis on healthy nutrition innovation.
- Collaborate with the IRA and the Indiana Dietetic Association to provide guidance and assist restaurant operators with how to modify recipes and adopt menus to accommodate healthier food choices.



NEXT STEPS

Implementation

Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020, should serve as a roadmap directing individuals, groups, and organizations toward the creation of healthier environments to support improvements in health behaviors among Indiana's residents. It is not the Plan's purpose to provide the necessary, detailed steps to achieve the objectives and strategies. The Plan's success will greatly depend on the ability of the Indiana Healthy Weight Initiative Task Force, the Division of Nutrition and Physical Activity (DNPA), and other partners to take on the responsibility of implementing the objectives and strategies as part of their day-to-day activities. The Plan is a working document; and although there are already specific planned activities, the Plan will continue to evolve throughout the next 10 years to promote and ensure its widespread implementation.

It will be vital for all of us to entrench the objectives and strategies into the goals, objectives, and priorities of our individual programs and organizations. To successfully implement this Plan and make sustainable progress, it will not be enough to realize the objectives and strategies. We must be committed beyond the life of this Plan. The Plan's objectives and strategies are not meant to duplicate current efforts or future efforts. Rather, the institutionalization of the Plan should complement and enhance existing strategic and/or statewide plans, initiatives, and activities that focus on improving the health of Indiana's residents, especially as they relate to nutrition, physical activity, obesity, and chronic disease.

The charge and official work of the Indiana Healthy Weight Initiative Task Force will go from planning to implementation and evaluation of *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*. The DNPA will work with current members to assess Task Force needs and

resources as the group moves into implementation activities. The Task Force may experience some changes in leadership, membership, structure, and roles and responsibilities during this time of transition. The Plan's successful implementation will require the experience and expertise of many more individuals and organizations than currently involved in the Task Force. The DNPA will work with Task Force leadership to recruit new members and ensure existing members and new members are committed to the new charge of the Task Force and to working collaboratively for change.

Each year, the Indiana Healthy Weight Initiative Task Force, the DNPA, and other partners will develop an implementation plan. This plan will include:

- The specific objectives for implementation
- The groups and organizations needed to complete the objectives and strategies
- The resources needed to complete the objectives and strategies
- The specific process for monitoring and tracking progress
- A system to ensure the quality of implementation of interventions
- A timeline showing milestones along with expected completion dates

There is no one funding source that will support the Plan's implementation. Again, implementation will be a coordinated and collaborative effort shared by many individuals, groups, and organizations. Therefore, adequate funding and other resources needed for implementation will be a collective responsibility among many. Putting the Plan into action will require committing existing resources, shifting resources from activities and initiatives

proven ineffective or not evidence-based, advocating for new funding, and identifying new resources.

Throughout the Plan's implementation, the Indiana Healthy Weight Initiative Website and speakers bureau, as well as other resources, will acknowledge and share the successes and lessons learned by those implementing the Plan. Because the Plan's scope of work is great and requires statewide and local action, we must keep individuals, groups, and organizations connected and inspired to achieve success. Those of us involved in implementation and those interested in adopting a certain objective or strategy for implementation will need to know about the commitment and work of our state's champions, learn about the innovative ideas put into action that are transforming our state and local communities, and have a source of guidance for our own efforts. As we all gather experience from implementing the objectives and strategies over the next 10 years, we will find common ground on what works best and what does not. This valuable information will help increase the efficiency and effectiveness of our work and the use of our resources.

Evaluation

Evaluation has been an important, integrated function of the development of *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*. It is an ongoing process and will continue throughout the life of this Plan. As we move into implementation, we want to monitor and measure the progress of the workgroup objectives and strategies to ensure that specific policy, environmental, and system changes occur statewide and within our communities to ultimately improve health behaviors and reduce obesity and chronic disease. Evaluation will help our work

stay focused, commemorate successes, and identify areas in need of corrective measures early in the process to ensure success. The Division of Nutrition and Physical Activity (DNPA) initiated evaluation activities early on in the planning process to keep the development of the Plan on task and to help the Indiana Healthy Weight Initiative Task Force produce a quality, meaningful plan for Indiana. These activities included completion of a partnership interest survey, Task Force meeting evaluations, and a partnership satisfaction survey. These activities helped to gauge subject area interest, as well as satisfaction within workgroups and with Task Force meetings.

Information from the partnership interest survey helped to identify Task Force members with expertise and/or an interest in evaluation. The DNPA used guidance from the CDC's Division of Nutrition, Physical Activity, and Obesity Evaluation Team to form the Evaluation Advisory Group (EAG). This group of Task Force members focused on evaluation of the implementation of this Plan. The DNPA Epidemiologist provided leadership and coordination for the EAG. The EAG identified three areas of focus during the development process of the Plan: developing logic models, setting baselines and creating targets, and creating evaluation plans of the implementation process. The logic model for the Plan shows the main components of the Plan and their relationship to each other (Figure 4). The intermediate-term outcomes and long-term outcomes in the logic model reflect what the workgroup objectives and strategies intend to affect and will guide evaluation activities. Additionally, the logic model shows the suggested sequence of actions needed to improve nutrition and physical activity and reduce obesity and chronic disease.

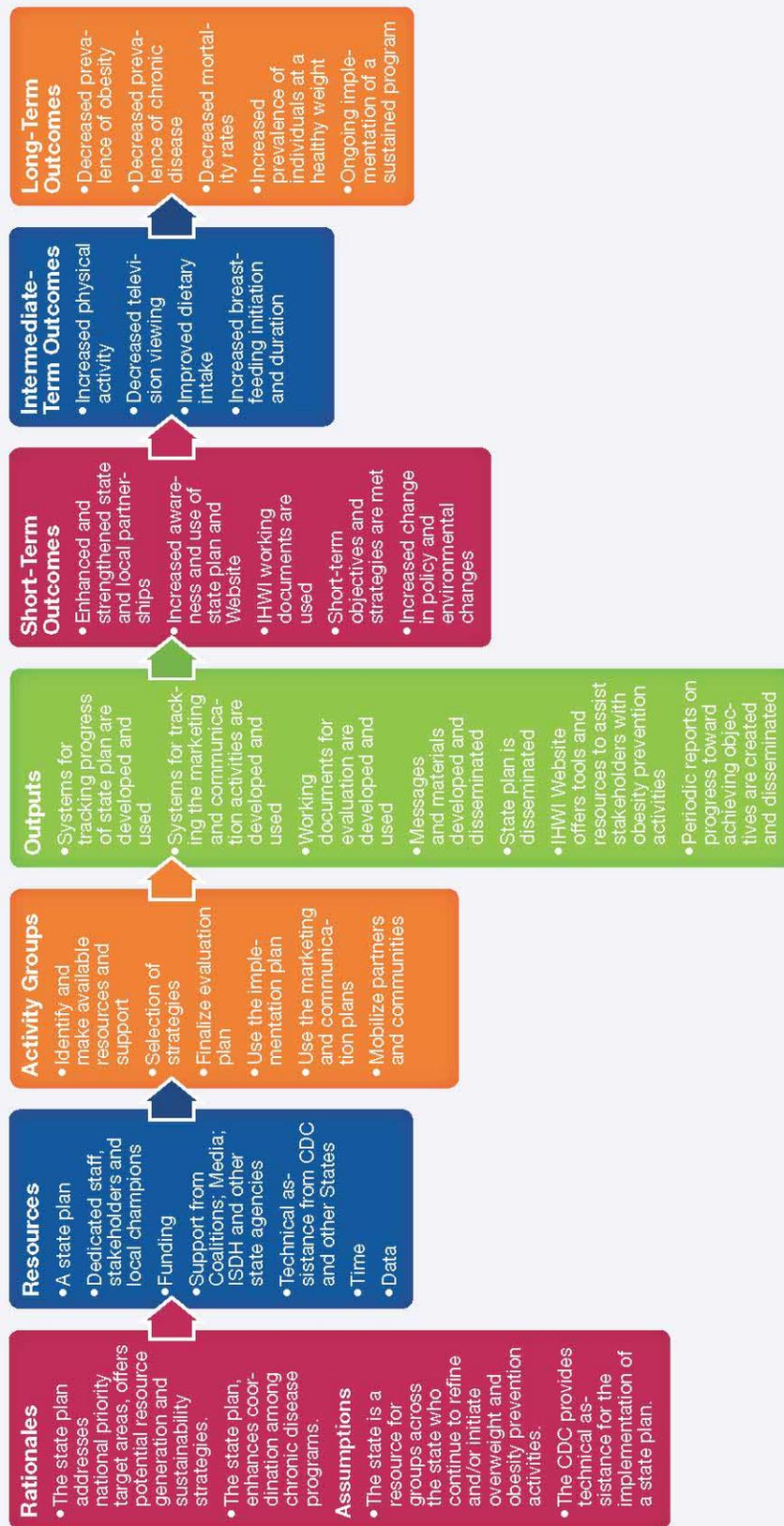
Figure 4: Logic Model

Problem Statement

The rising prevalence of overweight and obesity over the past decade is alarming for adults, adolescents, and children in all ethnic and racial groups. It has had a negative impact on both the health of Hoosiers and the economy of Indiana.

Goal

A state plan is used to guide the work of individuals, organizations, communities, and other sectors so that their activities in the prevention and control of overweight and obesity are synchronized, efficient and successful.



Specific questions that an evaluation can answer are developed to provide a foundation for measurement. Some questions guiding *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, evaluation include:

1. Who are the individuals and organizations engaged in the implementation of the Plan and to what extent?
2. What progress is Indiana making in achieving the objectives of the Plan?
3. What resources were used to implement the Plan?
4. Were stakeholders satisfied with the progress of the Plan?

The evaluation questions will help us monitor both processes and outcomes, and form the framework for evaluation during implementation of the Plan. Measurement of the Indiana Healthy Weight Initiative Task Force and other partnership evolution and satisfaction, increased awareness and knowledge of the Plan, Indiana Healthy Weight Initiative Website usage, objective and strategy implementation, and behavioral indicators and health outcomes will comprise the bulk of evaluation activities. We will track progress using existing data sources such as the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey

(YRBS), School Health Profiles, and the National Immunization Survey (NIS). We may develop and/or implement other surveys to assist with evaluation and will use additional methodologies such as interviews, focus groups, and observation to gather data and information.

Like the Indiana Healthy Weight Initiative Task Force, the EAG membership, structure, and roles and responsibilities may change during implementation; however, the group will help coordinate and guide evaluation activities and provide technical assistance during implementation. Each year, the EAG will select a subset of objectives in this Plan for rigorous evaluation by the group with assistance from the Indiana Healthy Weight Initiative Task Force, while other objectives and strategies may undergo evaluation by the individuals, groups, and/or respective organizations working on them directly. Additional evaluation questions and data sources, as well as the interpretation of the evaluation results, will also be determined based on the subset of objectives selected. The EAG will determine a process for disseminating evaluation results to the Indiana Healthy Weight Initiative Task Force, the DNPA, and other key stakeholders and will ensure informed decision-making and appropriate action are taken as implementation of the Plan continues.

GLOSSARY

Active Transportation

Any method of travel that is human powered, most commonly walking and bicycling.

Baby-Friendly Hospital

A designation given by the World Health Organization and the United Nations Children Fund to hospitals that promote, protect, and support breastfeeding.

Body Mass Index

A statistical measure of body weight based on a person's weight and height. Though it does not actually measure the percentage of body fat, it is used to estimate a healthy body weight based on a person's height. Due to its ease of measurement and calculation, it is the most widely used diagnostic tool to identify weight problems within a population, usually whether individuals are underweight, overweight, or obese.

Child and Adult Care Food Program

A program from the United States Department of Agriculture that provides nutritious meals and snacks in child-care centers, family child-care homes, Head Start programs, after-school programs, shelters, and adult day-care centers, as well as reimbursement for food and meal preparation costs, ongoing training on the nutritional needs of children, and on-site assistance in meeting the program's strong nutritional requirements.

Child Care and Development Fund

A federal program that assists low-income families, families receiving temporary public assistance, and those transitioning away from public assistance in obtaining child care so they can work or attend needed training/education.

Child Development Associate

A credential awarded to individuals who have completed a list of requirements, including 120 hours of training, set forth by the Council for Professional Recognition to work with infants, toddlers, or preschoolers.

Complete Streets

Streets designed and operated to enable safe access along and across the street for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities.

Competitive Foods

Foods and beverages offered at school, other than meals and snacks served through the federally reimbursed school lunch, breakfast, and after-school snack programs.

Community-Wide Campaign

A large-scale, multi-component campaign that delivers messages by using media such as television, radio, newspaper columns, and inserts.

Coordinated School Health Advisory Council

Indiana Code 20-26-9-18 mandates that all Indiana school corporations participating in the National School Lunch and/or Breakfast Programs shall establish a Coordinated School Health Advisory Council to review annually the corporation's wellness policy and to perform other school health-related functions.

Energy Density

The number of calories in a particular amount or weight of food.

Environmental Change

An alteration or change to the physical, social, or economic environment designed to influence people's behaviors.

Exclusive Breastfeeding

The infant receives breast milk only, with no additional food or drink, not even water.

Farm to School

A school-based program that connects schools K-12 and local farms with the objective of serving healthy meals in school cafeterias; improving student nutrition; providing agriculture, health, and nutrition education opportunities; and supporting local and regional farmers.

Food Policy Council

A group of stakeholders from public, private, and non-profit sectors who represent a wide array of interests—including nutrition, health, agriculture, education, policy, community design, and commerce—that support and advise residents and governments in developing policies and programs to improve the local food system with the goal of increasing consumer access to and the availability of affordable, healthy food, such as fruits and vegetables.

Food Systems

A local, regional, national, or global system that includes the production, processing, packaging, distribution, marketing, consumption, and waste disposal of food and food-related items.

Hoosier Works Card

A plastic debit card, designed to replace paper food stamp coupons and checks, that allows low-income households to use electronic benefits to purchase food at most grocery stores.

Joint-Use Agreement

An agreement between two or more entities, such as a school and a city or private organization, that establishes the sharing of indoor and outdoor spaces like gymnasiums, athletic fields, and playgrounds.

Licensed Child Care Center

A nonresidential building where at least 1 child receives child care from a provider while unattended by a parent, legal guardian, or custodian; for regular compensation; and for more than 4 hours but less than 24 hours in each of 10 consecutive days per year, excluding intervening Saturdays, Sundays, and holidays.

Licensed Child Care Home

A residential structure in which at least 6 children (not including the children for whom the provider is a parent, stepparent, guardian, custodian, or other relative or any child who is at least 14 years of age and does not require child care) at any time receive child care from a provider while unattended by a parent, legal guardian, or custodian; for regular compensation; and for more than 4 hours but less than 24 hours in each of 10 consecutive days per year, excluding intervening Saturdays, Sundays, and holidays.

Obesity

Classified as an adult body mass index of 30 or higher.

Overweight

Classified as an adult body mass index between 25 and 29.9.

Paths to QUALITY

Indiana's voluntary quality rating system that validates programs and child-care providers for ongoing efforts to achieve higher standards of quality and provides incentives and awards for success.

Physical Activity

Any bodily movement produced by the contraction of skeletal muscle that increases energy expenditure.

Physical Education

A planned, sequential pre-kindergarten-12 program of curricula and instruction that helps students develop the knowledge, attitudes, motor skills, self-management skills, and confidence needed to adopt and maintain physically active lifestyles.

Policy

Laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be either legislative or organizational in nature.

Secondary Schools

Middle and high schools.

School Wellness Policy

A formal document required in all school corporations that participate in the National School Lunch and/or Breakfast Programs that outlines the corporation's mission to provide curriculum, instruction, and experiences that support nutrition, physical activity, health, and lifelong learning.

Social Marketing Campaign

The application of commercial advertising and marketing concepts to the planning, implementation, and evaluation of programs designed to influence voluntary behavior of target audiences in order to improve their personal welfare and that of society.

Sugar-Sweetened Beverage

Any beverage that has been calorically sweetened either by industry processing or by consumer preparation.

Systems Change

A permanent change to the policies, practices, and decisions of related organizations or institutions in the public and/or private sector.

Unlicensed Registered Child Care Ministry

Child care operated by a church or religious ministry that is a religious organization exempt from federal income taxation under Section 501 of the Internal Revenue Code.

Universal Free Breakfast

A breakfast offered through the School Breakfast Program that is available to all students at no cost.

Walkability and Bikeability Assessment

An assessment of the ease and safety with which people can walk and bicycle within a community.

Worksite Wellness Tax Credit

Indiana Code 6-3.1-31.2 provides a state tax credit of 50% of the costs incurred by an Indiana small business (2-100 employees) for providing a qualified wellness program for employees during the taxable year that addresses three components: employee-appropriate weight loss, smoking cessation, and the pursuit of preventive health care services.

APPENDICES

Appendix A: Acknowledgements

The Indiana Healthy Weight Initiative would like to thank the many people and organizations whose expertise, time, and passion made this Plan possible.

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Appendix B: Defining Overweight and Obesity

Often, the terms overweight or obese are used interchangeably in everyday discussion with the implication that they describe the same thing. However, there are different clinical definitions for overweight and obesity. This is important to clarify and understand while reading the Plan. While it is true that *overweight* and *obese* refer to a person's overall body weight being too high, there are defining boundaries for each. For adults, overweight and obesity are determined by Body Mass Index (BMI), which is calculated by comparing an individual's weight with the individual's height. Overweight is defined as having a BMI of 25.0 to 29.9, while obesity is defined as having a BMI of 30.0 and above. For most people, BMI provides a reliable indicator of body fatness.

Weight Status Category	BMI
Underweight	Below 18.5
Healthy Weight	18.5 - 24.9
Overweight	25.0 - 29.9
Obese	30.0 and Above

For infants, children and adolescents, BMI status for age and gender (i.e., BMI-for-age) is used to determine whether or not a healthy weight is being met when compared to others of the same age and sex. A percentile ranking is applied and is the most commonly used indicator to assess the size and growth patterns of individual children. Overweight is defined as having a weight for height (BMI) greater than or equal to the 85th percentile but below the 95th percentile. Obesity is defined as having a weight for height greater than or equal to the 95th percentile.

Weight Status Category	Percentile
Underweight	Less than the 5th percentile
Healthy Weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

Appendix C: Indiana's Comprehensive Nutrition & Physical Activity Plan, 2010-2020

Overarching Objectives

Healthy Weight and Obesity

- Increase the percentage of adults who are at a healthy weight from 35% to 38% by 2020.
- Increase the percentage of high school students who are at a healthy weight from 71% to 76% by 2020.
- Decrease the percentage of adults who are obese from 30% to 25% by 2020.
- Decrease the percentage of high school students who are obese from 13% to 10% by 2020.

Physical Activity

- Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 68% by 2020.
- Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 55% by 2020.

Fruit and Vegetable Consumption

- Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 24% by 2020.
- Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables per day from 16% to 21% by 2020.

Breastfeeding

- Increase the percentage of mothers who breastfeed their babies from 71% to 75% by 2020.
- Increase the percentage of mothers who breastfeed their babies exclusively at 3 months from 29% to 40% by 2020.
- Increase the percentage of mothers who breastfeed their babies at 6 months from 38% to 50% by 2020.
- Increase the percentage of mothers who breastfeed their babies at 12 months from 17% to 25% by 2020.

Sugar-Sweetened Beverages (Soda Consumption)

- Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 59% by 2020.
- Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 22% by 2020.

Appendix D: Indiana Prevalence Estimates for Weight Status of Selected Populations

		Underweight	Healthy Weight	Overweight	Obese	Total
Children 2-5 Years[†]	Total	2.7%	63.9%	16.8%	14.3%	75,673
	Gender					
	Male	2.6%	63.3%	17.0%	14.8%	36,258
	Female	2.7%	64.5%	16.5%	13.7%	35,533
	Race/Ethnicity					
	White, Not Hispanic	3.2%	69.9%	16.7%	13.4%	42,358
	Black, Not Hispanic	4.6%	75.7%	14.3%	10.0%	12,760
	Hispanic	2.1%	60.6%	19.0%	20.4%	16,084
American Indian/ Alaska Native	2.4%	§	§	§	77	
Children and Youth 10-17 Years[‡]	Total	5.2%	64.8%	15.3%	14.6%	865
	Gender					
	Male	5.8%	65.3%	11.5%	17.4%	432
	Female	4.8%	64.3%	19.2%	11.7%	433
	Race/Ethnicity					
	White, Non-Hispanic	6.3%	66.2%	14.1%	13.4%	610
	Black, Non-Hispanic	0.4%	66.2%	12.4%	21.0%	116
	Multiracial, Non-Hispanic	0.6%	41.5%	41.3%	16.6%	42
Other, Non-Hispanic	9.5%	69.5%	11.4%	9.7%	13	
Hispanic	1.8%	56.9%	18.8%	12.0%	36	
		Neither Overweight nor Obese	Overweight	Obese	Total	
High School Students^{**}	Total	71.3%	15.9%	12.8%	1,443	
	Gender					
	Male	70.3%	14.0%	15.7%	733	
	Female	72.4%	17.9%	9.7%	710	
	Race/Ethnicity					
	White, Non-Hispanic	73.7%	14.9%	11.4%	1,117	
	Black, Non-Hispanic	62.4%	21.0%	16.6%	104	
Hispanic/Latino	62.6%	18.1%	19.3%	108		
Adults >=18 Years^{††}	Total	34.8%	35.2%	30.0%	8,863	
	Gender					
	Male	30.6%	39.7%	29.7%	3,455	
	Female	39.1%	30.7%	30.2%	5,408	
	Race/Ethnicity					
	White, Non-Hispanic	35.2%	35.0%	29.8%	7,196	
	Black, Non-Hispanic	28.8%	36.8%	34.5%	1,109	
Other/Multiracial, Non-Hispanic	37.3%	42.4%	20.3%	199		
Hispanic	38.8%	29.0%	32.2%	258		

* See Appendix B for definitions of weight status for children, adolescents and adults.

† 2009 Pediatric Nutrition Surveillance System.

§ Percentages are not calculated if <100 records are available for analysis after exclusions.

‡ 2007 National Survey of Children's Health.

** 2009 Youth Risk Behavior Survey.

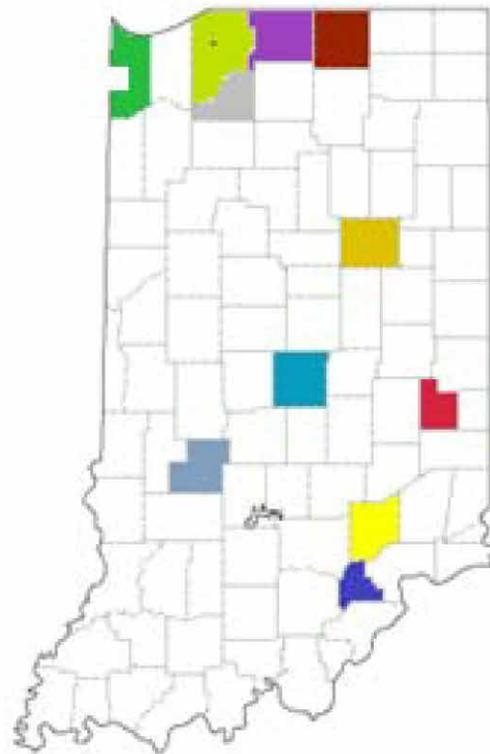
†† Indiana State Department of Health, PHPC, ERC, Data Analysis Team, 2009 Behavioral Risk Factor Surveillance System.

References

1. Centers for Disease Control and Prevention. (2010). Youth Risk Behavior Surveillance – United States, 2009.
2. Centers for Disease Control and Prevention. (2010). 2009 Behavioral Risk Factor Surveillance System survey data. Retrieved May 28, 2010 from www.cdc.gov/brfss/index.htm.
3. Smedley, B.D., & Syme, S.L., eds. (2000). A social environmental approach to health and health interventions. Promoting health: Intervention strategies from social and behavioral research. Washington, D.C.: Institute of Medicine. p. 1-32.
4. Keener, D., Goodman, K., Lowry, A., Zaro, S., & Kettel Khan, L. (2009). Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
5. Koplan, J.P., Liverman, C.T., & Kraak, V.I., eds. (2005). Preventing childhood obesity: Health in the balance. Washington, D.C: Institute of Medicine.
6. Indiana State Department of Health. (2009). 2009 Pediatric Nutrition Surveillance System, Indiana.
7. Department of Health and Human Services, Maternal and Child Health Bureau of the Health Resources and Services Administration. (2007). National Survey of Children's Health.
8. Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team. (2010). Behavioral Risk Factor Surveillance System survey data.
9. Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team. (2007). 2006 vital statistics.
10. Centers for Disease Control and Prevention. (2010). Breastfeeding Report Card – United States, 2010.
11. American Academy of Family Physicians. (2007). Breastfeeding (position paper).
12. U.S. Department of Health and Human Services, Office of Women's Health. Why breastfeeding is important. Retrieved March 8, 2010 from www.womenshealth.gov/breastfeeding/why-breastfeeding-is-important.
13. Centers for Disease Control and Prevention. (2007). 2007 National Immunization Survey.
14. Shealy, K.R., Li, R., Benton-Davis, S., & Grummer-Strawn, L.M. (2005). The CDC guide to breastfeeding interventions. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
15. Indiana Family and Social Services Administration, Bureau of Child Care. (2010). Internal data source.
16. Indiana Department of Education. (2010). Indiana K-12 education data. Retrieved March 18, 2010 from mustang.doe.state.in.us/TRENDS/trends1.cfm?var=enr.
17. Stats Indiana. (2009). Labor force estimates. Retrieved February 9, 2010 from www.stats.indiana.edu/sjp/work/work_all_18.html.
18. U.S. Census Bureau Population Division. (2009). Estimates of the resident population by selected age groups for the United States and Puerto Rico. Retrieved September 10, 2009 from www.census.gov/popest/states/asrh/tables/SC-EST2009-01.xls.
19. Stats Indiana. Indiana population projections. Retrieved August 11, 2010 from www.stats.indiana.edu/topic/projections.asp.
20. Association of Statisticians of American Religious Bodies. (2000). Religious congregations and membership in the United States, 2000. Retrieved February 9, 2010 from www.theARDA.com.
21. Goldsmith, S., Emicke, B., & Pineda, C. (2006). Faith-based organizations versus their secular counterparts: A primer for local officials. Retrieved February 18, 2010 from www.innovations.harvard.edu/showdoc.html?id=11120.
22. Prevention Institute. (2008). Promising strategies for creating healthy eating and active living environments. Retrieved February 3, 2010 from http://www.convergencepartnership.org/atf/cf/%7b245A9B44-6DED-4ABD-A392-AE583809E350%7d/CP_Promising%20Strategies_printed.pdf.
23. U.S. Census Bureau, Population Division. (2008). Annual estimates of the population for incorporated places in Indiana, listed alphabetically: April 1, 2000 to July 1, 2007 (SUBEST2007-04-18). Retrieved March 7, 2010 from factfinder.census.gov.
24. U.S. Census Bureau. Indiana. Retrieved March 7, 2010 from www2.census.gov/govs/cog/2007/in.pdf.
25. Economos, C.D., & Irish-Hauser, S. (2007). Community intervention: A brief overview and their application to obesity epidemic. *Journal of Law, Medicine & Ethics*, 35(1), 131-137.



Indiana's Needs Assessment for the Maternal, Infant and Early Childhood Home Visiting Program



September 2010

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The 2000 release of *From Neurons to Neighborhoods* by the National Research Council and the Institute of Medicine provided the scientific evidence of the complexity of early childhood development and its importance in ensuring that children arrive at school ready to learn. As a result of this seminal document, expanding research and growing public awareness of the critical importance of a “good start” for young children in developmental, educational and emotional areas underscore what policy makers in Indiana have been working toward for a long time. Indiana has demonstrated its commitment to a high quality, comprehensive early childhood system that promotes a positive environment and promotes health, development and positive parent child relationships for the maternal, infant and early childhood populations, especially for those who are the most at-risk for poor outcomes.

Part 1: State of the State

Indiana became the 19th state of the United States in 1816. Often referred to as the “Crossroads of America”, Indiana has a population of 6,423,113 (2009 est.) which represents a 5.6% growth since the 2000 census. Indiana has a total of 35,867 square miles with a population density of 179.1 per square mile. Indiana is the smallest state in the continental United States west of the Appalachian Mountains. Its capital and largest city is Indianapolis which ranks as the 13th largest city and 11th largest metropolitan area in the United States. Seventy percent of the population lives in a metropolitan area while the remaining 30% live in rural areas.

The median age in Indiana based on 2009 population estimates is 36.8. Thirty-nine percent (39%) of the population is 45 and older. The preschool population represents 6.9% and the school age population represents 17.8% of the total population.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of 94.5%. Indiana's overall Hispanic population is 5.5%, its white, non-Hispanic population is 87.8%, and its black non-Hispanic population just over 9.2%. This contrasts highly with Indiana's largest county, Marion County, which has a black population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

While Indiana is primarily considered a manufacturing state, there is a significant agricultural component to its economy. Indiana is located within the U.S. corn and grain belts with corn and soybeans as major cash crops. Indiana is also home to the international headquarters of Eli Lilly, a major pharmaceutical company which is the state's largest corporation. Indiana is also the world headquarters of Mead Johnson Nutritionals. Indiana ranks fifth among all states in total sales and shipments of pharmaceutical products and the second highest in the number of biopharmaceutical related jobs. Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufacturers than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%).

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of "at will" employment, whereby an employer can terminate an employee for any or no reason, is in force. Indiana is also home to many insurance home offices and has a high rate of self insured policies.

Family Economic Self-sufficiency

While Indiana has not experienced as severe an economic crisis as other states, the challenges faced by Indiana families is significant. The 2009 state unemployment rate was 10.1% with a range of 6% to 18%. In 2008, 17.9% of children lived in poverty. In 2009, 41.8% of children qualified for free or reduced lunch and 34.31% of children (birth to six) were enrolled in Medicaid. In 2009, 11.09% of families qualified for food stamps and 1.73% of families were on Temporary Assistance for Needy Families (TANF). Ten percent (10%) of Indiana families were single parent households.

Education is a major factor in economic well-being. In Indiana, 73% of adults have graduated from high school. The percentage of adults with a college education is 22%. The 2009 drop-out rate for grades 7-12 was 13.86%.

Birth Outcomes

In Indiana, from 2002 through 2006, there has been a decline in the percentage of women who have received prenatal care within the first trimester each year in all races and ethnicities. The overall percentage dropped from 80.6% in 2003 to 77.6% in 2006. The percentage for whites decreased from 82.1% in 2003 to 79.2% in 2006 while the percentage for blacks decreased from 68.2% in 2003 to 65.6 % in 2006. The Hispanic population actually alternated between increases and decreases each year, but in 2006 was lower (62.8%) than the percentage in 2003 (64.6%)

Another way of defining prenatal care is the Kotelchuck Index, also known as the Adequacy of Prenatal Care Utilization (APNCU) Index. The Kotelchuck Index combines the month prenatal care began with the number of prenatal visits from the start of prenatal care up to the delivery and compares it with a standard number of visits. The overall percentage of women in Indiana who received Adequate/Adequate Plus Care declined from 2002 to 2006. The rate in 2002 was 74.3%, but the average over the next three years from 2003-2005 was below that number at 72.6%. In 2007 the rate dropped to 70.3%, and provisional 2008 data shows even a further drop to 69.8% of Indiana residents having adequate prenatal care. In the white population, the 2002 rate was 76.9%, but decreased over the next three years with the 2003-2005 average being 76.4% of women receiving Adequate/Adequate Plus Care in Indiana. The APNCU of the black population also decreased over this time period from 64.2% to 63% of women receiving Adequate/Adequate Plus Care in Indiana. The Hispanic population is the most unstable group, with their percentage moving up and down over this time, but the 2003-2005 average was a very low 58.2% of women receiving Adequate/Adequate Plus Care in Indiana.

Using the same Kotelchuck Index, Indiana has a high rate of women receiving Inadequate Care, which is less than 50% of expected visits. Over 1 out of 4 (25.5%) Hispanic women in Indiana did not receive adequate care between 2003 and 2005. Nearly one out of four (22.9%) black women in Indiana also received inadequate care in these years. One out of ten white women (10.2%) received Inadequate Care between 2003 and 2005 in Indiana. The overall percentage of women who received inadequate care in Indiana from 2003-2005 was 12.9%.

In 2003 the percentage of women in Indiana who smoked while pregnant was 18.5, and decreased to 17.3 in 2006, before increasing back to 18.5% in 2007. The white prenatal smoking population decreased between 2002 and 2006 from 19.9% to 18.1%, before increasing to 19.6% in 2007, and is still the highest among race and ethnicity. The black population made in improvement between 2003 and 2007 from 15.2% to 13.3%. The Hispanic is once again the lowest among race and ethnicity with 3.8% in 2003 and 4.1% smoking while pregnant in 2006.

Another population that has a high smoking rate is the percent of pregnant women on Medicaid. This is alarming since 51% of pregnant women in Indiana were on Medicaid in 2007. For 2007, birth records for Medicaid recipients were reviewed. Women that indicated smoking during pregnancy were grouped according to the county of residence on the Medicaid eligibility file at time of pregnancy. The majority of counties (68 out of 92) have 30% or more women attesting to smoking during pregnancy in 2007. The overall percentage of women on Medicaid who smoked during pregnancy was 27%, compared to 17.3% for all pregnant women in Indiana.

Indiana has shown a steady increase in the rate of mothers who ever breastfed their infants between 1990 and 2007. In 1990, less than half of new mothers (47.2%) breastfed their infants. In 2007, the rate grew to 67.1%. The rate of black mothers who ever breastfed their infants grew from 34.5% in 1990 to 47.6% in 2007.

In 2006, 89,404 infants were born to Indiana residents. The number of live births represents a 2.7% increase from 2005 (87,088). In 2006, there were 9,726 live births to mothers under 20 years of age—10.9% of the total number of live births. Of these, 7,618 were born to white women under age 20 (9.9% of the white births) and 2,038 were born to black women under age 20 (19.6% of the black births). The age-specific birth rate for women ages 15-19 was slightly higher in 2006 (43.8%) than in 2005 (43.2%). Slightly over two fifths (41.2%) of all live births in Indiana in 2006 were to unmarried parents. Significantly more black mothers (78.2%) than white mothers (36.8%) were not married to the infant's father at the time of the birth. In FFY 2010, Indiana's Office of Medicaid policy and Planning reported that 14.9% (36,902) of women enrolled in Medicaid gave birth. Of that number, 2,554 women (6.9%) received prenatal care coordination.

Indiana has shown an increase in low birth weight (infants born less than 2500 grams) over the past 5 years. In 2003, the percentage of babies born low birth weight was 7.9%, but then steadily increased up to 8.3% in 2005 before increasing more to 8.5% in 2007. The white population shows the same trend as the total, increasing from 7.2% in 2003 up to 7.6% in 2005 before increasing more to 7.8% in 2007. The black low birth weight percentages have steadily increased every year from 13.3% in 2003 up to 14.4% in 2007. The Hispanic rate also has steadily increased from 5.9% in 2003 slightly up to 7.2% in 2007.

Indiana's total percentage of infants being born at very low birth weight stayed steady between 2002 and 2006 at 1.4% before increasing to 1.5% in 2007. Both the white (1.4% in 2002 and 2006) and the Hispanic (1.2% in 2002 to 1.1% in 2006) also stayed steady, until 2007, (white 1.3%, Hispanic 1.3 %.) The black very low birth weight percentage did increase significantly between 2002 and 2007 from 2.6% to 3.3%.

In 2006, 13.2% of live births in Indiana were premature. This represents a 23% increase from 1996. The rate of preterm birth in Indiana is highest for black infants at 18.6% followed by Hispanics at 13% and whites at 11.3%.

The Infant Mortality Rate (IMR) in Indiana showed an increase in 2004 to 8.1 from 7.4 in 2003 and stayed steady through 2006. In 2007 the IMR decreased to 7.5 in Indiana. The white IMR in Indiana increased between 2003 and 2005 from 6.4 up to 6.9, and then decreased to 6.5 in 2007. The black IMR in Indiana increased every year, from 15.9 in 2003 to 18.1 in 2006, before decreasing to 15.7 in 2007. The Hispanic IMR in Indiana fluctuated every year between 2003 and 2007, peaking at 9.0 in 2004 and dropping to as low as 5.2 in 2006, but then increasing to 6.8 in 2007.

Child Health and Safety

There are 313,049 children age 0-5 who are enrolled in Medicaid. Of that number, 93.5% (292,768) have a primary care provider and 56.7% (177,372) received an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen.

From 2003 to 2006 in Indiana, 227 infants died due to unintentional and intentional injuries. More than two-thirds of all injury deaths (68.3% or 155/227) were due to suffocation. Of the suffocation deaths, 89.0% (138/155) were unintentional. The rate of injury death for black infants during 2003-2006 was 175.7 per 100,000, which is more than three times higher compared to white infants (53.4 per 100,000). The primary cause of hospital admissions for infants was falls. Injuries due to falls accounted for 25.6% of all hospitalizations (139/543).

In the 2006-07 school year, data were collected from 1833 schools in Indiana. Data collection included information on 255,346 kindergarten, first grade, and sixth grade students. This covered over 85% of the schools in Indiana. Ninety-six percent of students enrolled at reporting schools completed the immunizations necessary according to state requirements. There was an increase of five percentage points from the previous assessment year.

In the 2009 Youth Risk Behavior Surveillance System (YRBSS) report for Indiana, 12.8% of youth reported they are obese (at or above the 95th percentile for their age, sex and Body Mass Index (BMI), which is down from 15% in 2005. The data show that 15.9% of youth are overweight (between 85th and 94th percentile), which is a full percent and a half higher than the 14.3% in 2005. The 2009 YRBSS report also showed a decrease in the number of youth who ate five or more servings of fruits and vegetables in the past week (16.1%), compared to 2003 data (20.3%). This change was significant. Milk consumption has also decreased since 2003 from 21.2% to 14.2%, which is also a significant change. The data also show that over a third (35.6%) of youth drank at least one serving of soda a day over the past week in 2007, but decreased to 29.7% in 2009. This result is also statistically significant.

In 2007, there was a significant increase in students in Indiana who were physically active at least 60 minutes a day, 5 days a week at 43.7%. This compares to 32.2% in 2005 but decreased in 2009 to 40.6%, which was a significant decrease. The percentage of students (29.0%) who reported watching three or more hours of television per day in 2009 also decreased compared to 2003, which was 32.9%.

In Indiana, over the past three years, there has been a slight decrease in the prevalence of asthma in children under 18 years of age. In both 2005 and 2006 the prevalence was 8.4% of children in Indiana currently suffered from asthma. In 2007 that percentage dropped to 8.0%. The percentage of white children also decreased over these years from 9.2% in 2005 to 7.6% in 2007. The percentage of black children with asthma has increased over this time period from 12.7% in 2005 to 15.2% in 2007.

From 2003 to 2006, the leading cause of injury death in Indiana for preschool aged children (ages 1 to 4) was unintentional injuries (185 deaths). Preschool aged children received more than half of the fatal injuries from motor vehicle traffic-related incidents and drowning (58 deaths and 41 deaths, respectively). The rate of death for males was 18.6 per 100,000, while the female rate of death was slightly less at 16.3 per 100,000. The top three causes of hospital admissions for 1 to 4 year olds were falls, fire and poisoning. Each cause accounted for 23.2% (369/1,592); 20.6% (328/1,592); and 16.6% (263/1,592), respectively of all hospitalizations.

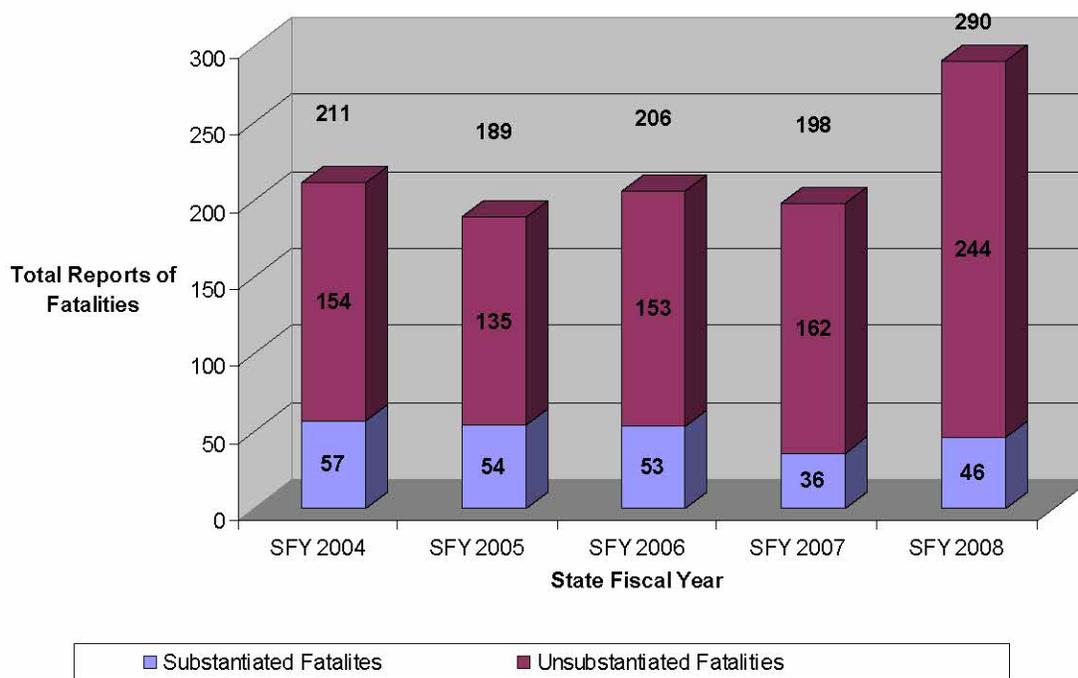
Elementary school age children (ages 5 to 9 years) are more susceptible to motor vehicle crashes, bicycle crashes, pedestrian injuries, and dog bites. Children in this age group are often unable to judge if an environment is safe and are more likely to demonstrate risky behaviors stimulated by impulse. From 2003 to 2006, there were 121 injury deaths for elementary school age children. Children aged 5 to 9 had the lowest age-specific rate of death compared to all other age groups. Males aged 5 to 9 had an age-specific death rate of 8.1 per 100,000, and females had an age-specific death rate of 5.8 per 100,000. The leading cause of death was unintentional injuries (100 deaths). Elementary school aged children received more fatal injuries from motor vehicle traffic-related incidents, which accounted for 25.9% of all unintentional injury deaths (48/185). Although fall-related injuries within this age group accounted for approximately one-third (27.9% or 375/1,345) of hospitalizations, this injury mechanism is not among the top five leading causes of death. Motor vehicle crash (MVC) injuries were the 2nd leading cause of inpatient hospitalization and accounted for 21.0% of all injuries in this age group (282/1,345).

Child Abuse and Neglect

Between July 1, 2008 and June 30, 2009, there were 114,907 reports of abuse or neglect. Of the total number of reports, 21.5% or 24,754 reports were substantiated. Of the 114,907 reports,

31,641 were for suspected abuse. Thirteen percent (7,053) of the suspected abuse reports were substantiated. This is a decline from 20.9% in 2008. There were 83,266 reports for neglect and 17,701 reports (21.2%) were substantiated. In 2008 the percentage of substantiated neglect reports was 18.8%. In 2008 the child abuse and neglect rate per 1000 children was 11.1. In 2008, there were 3,895 children served in domestic violence emergency shelters.

There were 46 abuse and neglect fatalities substantiated in State Fiscal Year (SFY) 2008. Of the 46 fatalities, 24 (52%) were due to abuse and 22 (48%) were due to neglect. This reflects an overall increase in the total number of fatalities from SFY 2007 in both abuse and neglect. However, when looking at the trend over five years, there has been an overall decrease in fatalities resulting from abuse or neglect [2004 (57), 2005 (54), 2006 (53), 2007 (36), 2008 (46)]. Child fatalities from abuse increased from 17 in SFY 2007 to 24 in SFY 2008, while child fatalities from neglect increased from 19 in SFY 2007 to 22 in SFY 2008.



Seventy-eight percent (78%) of the abuse and neglect fatalities for SFY 2008 occurred among children 5 and under. Further, 85% occurred amongst children ages 8 and younger. As was true in the prior year, the majority of abuse and neglect victims for SFY 2008 were under 1 year of age. However, SFY 2008 reflected a percentage decrease in victims under 1 year of age compared to SFY 2007. Overall, child victims under one year of age comprised 30% of the total

46 fatalities in SFY 2008 compared to 39% in SFY 2007. Children within this age range accounted for 8 of the total 24 abuse deaths in SFY 2008 compared to 7 in SFY 2007. Child victims under one year of age accounted for 6 of the total 22 neglect deaths in SFY 2008. This is a slight decrease from SFY 2007, which reported 7 within this age range.

Public Safety/Risky Behaviors

There were 43,902 total juvenile arrests in 2007 representing 3.8% of the juvenile population. There were 2,587 juvenile possession arrests for a rate of 224 arrests per 100,000 people and there were 50 juveniles arrested for a driving under the influence offense. The rate of violent crime in 2007 is 143 violent crime arrests per 100,000 people (9,127 arrests). The rate of property crime was 550 property crime arrests per 100,000 people (34,931 property crime arrests).

Domestic violence is also an issue in Indiana. In the year that ended in June of 2009, there were 3,895 children served in domestic violence emergency shelters. There were 4,461 adults served in the shelters. In the same time frame, 1,574 domestic violence victims were denied shelter. There were 101,679 calls to domestic violence crisis lines.

In the 2009 YRBSS report for Indiana, high school students were asked about their tobacco, alcohol and drug use. The percentage of teens who reported they had ever tried cigarettes was 52.2%. The percentage of students who reported they has smoked cigarettes on at least one day during the 30 days prior to the survey was 23.5% and 11.8% reported they smoked cigarettes on 20 or more days in the same time frame. The percentage of students who reported that they smoked cigarettes, smoked cigars, cigarillos, or little cigars or used chewing tobacco, snuff or dip on at least one day in the 30 day time frame before the survey was 29.3%. When asked whether they had ever had at least one drink of alcohol, 69.2% indicated that they had. Thirty-eight percent (38.5%) indicated they had at least one drink of alcohol during the 30 days prior to the survey and 24.9% indicated they had five or more drinks of alcohol in a row within a couple of hours on at least one day. The percentage of students who reported they had used marijuana one or more times in the 30 days prior to the survey was 20.9%. The percentage of students reporting they had used any form of cocaine in the same time frame was much lower at 2.7%. When asked about sniffing glue, inhaling paints or sprays or breathing contents of aerosol spray, 16% of the students indicated they had engaged in that behavior at least once in their lives.

Finally, 25.5% of the students indicated that they had been offered, sold or given an illegal drug by someone on school property in the 12 months prior to completing the survey.

Early Childhood

As of 2008, there were 4,333 licensed child care facilities - 598 Licensed Centers, 3,067 Licensed Homes and 668 Registered Ministries. There are 99,327 slots available in these facilities. There were 19,159 families and 36,321 children authorized to receive child care vouchers in July 2010. There were 8,885 families and 14,864 children on wait lists.

In 2007, the Indiana Bureau of Child Care initiated a statewide quality rating system titled *Paths to QUALITY*. This initiative is designed to improve the quality of early childcare and education and to aid parents in selecting a high-quality early care and education provider. As of July 2010, there were 1,916 providers participating in *Paths to QUALITY*. There were 468 Licensed Centers, 1,420 Licensed Homes and 28 Regulated Ministries. The total capacity of the providers is 70,527. Of the children receiving child care vouchers in Indiana, 52.25% of them are participating in a program enrolled in *Paths to QUALITY*.

Young children with disabilities participate in either the First Steps (Part C of IDEA) system or in preschool special education (Part B of IDEA, Section 619). In 2008, First Steps served 9,756 children from birth to three (3.64% of the population). There were 18,834 children served in preschool education which represents 7.2% of the population.

Indiana currently has 2,636 funded Early Head Start slots and 13,690 funded slots for Head Start. The cumulative waitlist for both the Early Head Start and Head Start programs in the spring of 2010 was an estimated 7,000 families statewide.

Part 2: Alignment of State Home Visiting Needs Assessment with Head Start, CAPTA and Title V

The Affordable Care Act identified six desired outcomes for the Maternal, Infant and Early Childhood Home Visiting Program:

- a. Improved maternal and newborn health;
- b. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
- c. Improvement in school readiness and achievement;
- d. Reduction in crime or domestic violence;
- e. Improvements in family economic self-sufficiency; and
- f. Improvements in coordination and referrals for other community resources and supports.

As a function of conducting the needs assessment required for home visiting, Indiana's collaborating agencies reviewed and analyzed the strategic plans and needs assessments of the agencies identified in the *Supplemental Information Request*. The overall findings are that the identified outcomes for home visiting are in alignment with state agencies and programs that serve young children and families in Indiana. A description of these plans and needs assessments follows.

Indiana Head Start State Collaboration Office

Source Document: Needs Assessment Survey 2009

Established in 1965, Head Start is a program of the United States Department of Health and Human Services that is charged to provide comprehensive education, health, nutrition, and parent involvement services to low-income (100% of the federal poverty level) children, age three to five and their families. Other enrollment priorities include children with disabilities and children who are homeless. In 1994, the program was expanded to serve the birth to three population and entitled Early Head Start.

The Head Start philosophy is based on three key points. These are:

- Comprehensive child development services;
- Parent involvement; and
- Community partnerships and community-based services.

In late 2008, the Indiana State Collaboration Office contracted with the Indiana Head Start Association to “conduct the required assessment that addresses the needs of Head Start agencies

in the State with respect to collaboration, coordination and alignment.” A comprehensive survey was distributed to all Head Start and Early Head Start agencies in Indiana. The survey focused on nine priority areas:

- Early Childhood Education and Transition;
- Professional Development;
- Child Care;
- Health Care;
- Family Literacy;
- Welfare and Child Welfare;
- Services to Children with Disabilities;
- Services to Children Experiencing Homelessness; and
- Community Services.

The needs assessment examined critical findings related to relationships and difficulties for each priority area, and established goals and objectives. The following table aligns the intended outcomes for home visiting with the Head Start goals and objectives based on the needs assessment.

Home Visiting Intended Outcomes	Head Start Goal	Head Start Objective
Improvement in school readiness and achievement	Through focus on quality, quantity and professionalism, improve and increase education services for young children	Continue building linkages at the state and local levels between early education programs, the Indiana Head Start Association, Department of Child Services, Division of Family Resources, Indiana Department of Education, and other state and local early childhood education organizations.
	Through focus on quality, quantity and professionalism, improve and increase early childhood education services for young children.	Promote and support state and local efforts to set in place professional standards for persons in the early child education professions.
	Through focus on quality, quantity and professionalism, improve	Continue building linkages at the state and local levels between the

Home Visiting Intended Outcomes	Head Start Goal	Head Start Objective
	and increase high quality child care services for young children.	Department of Child Services, Division of Family Resources, Indiana Association for Child Care Resource & Referral, the Indiana Head Start Association and other state and local early care and education organizations.
Improved maternal and newborn health	Expand and increase availability of needed health care services for low- income children and families.	Increase program ability to assist families to secure health care services for pregnant women and children birth to five.
Improvements in family economic self-sufficiency	Build a systemic approach for statewide awareness of and access to family literacy.	To encourage full implementation of family literacy including child development, adult education, parent education and interactive opportunities for parents and children together.
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	Establish sustainable early education linkages with the state's public assistance services and welfare reform.	The Collaboration Office continues to promote and build linkages between Early Head Start/Head Start programs and state public assistance agencies.
Improvement in school readiness and achievement	Continue and sustain efforts to ensure that children with disabilities will have opportunities to develop to their potential.	Promote inclusive programming for children with disabilities.
Improvement in school readiness and achievement	Strengthen and improve conditions for homeless families through coalition building.	Ensure homeless children receive needed services as a result of coalitions.
Improvements in the coordination and referrals	Head Start programs continue to increase their involvement with community service activities.	Support and promote Head Start programs utilization and involvement with local, state, and federal community service resources and activities.

Strategies have been established in the Head Start strategic plan to achieve each of the identified goals.

Department of Child Services/CAPTA

Source Document: Five Year Strategic Plan 2010-2014

The Department of Child Services (DCS) was established in 2005 as a separate cabinet-level Agency with responsibility for overseeing both child welfare services and child support enforcement. The Department of Child Services protects children and strengthens families through services that focus on family support and preservation. DCS administers child support, child protection, adoption and foster care throughout the state of Indiana.

Mission: The Indiana Division of Child Services (DCS) protects children from abuse and neglect. DCS does this by partnering with families and communities to provide safe, nurturing, and stable homes.

Vision: Children thrive in safe, caring, supportive families and communities.

Values:

- We believe every child has the right to be free from abuse and neglect.
- We believe every child has the right to appropriate care and a permanent home.
- We believe parents have the primary responsibility for the care and safety of their children.
- We believe the most desirable place for children to grow up is with their own families, when these families are able to provide safe, nurturing and stable homes.
- We believe in personal accountability for outcomes, including one's growth and development.
- We believe every person has value, worth and dignity.

In its strategic plan for 2010-2014, DCS established four overarching goals for the programs it administers including:

- Developing staff to have assessment skills and competencies that determine the risks and needs of children and their families;
- Ensuring that individualized programs and services are delivered to families and children in order to achieve safety, permanency and well-being outcomes;
- Ensuring that services are developed and planned in partnership with families and communities to protect children in their community through cooperation and communication; and
- Creating an infrastructure that will support and sustain all components of delivery within the child welfare system.

To address the requirements for the Child Abuse Prevention and Treatment Act (CAPTA) State Plan, DCS identified a series of activities from the fourteen prescribed in the legislation. The following activities will be the focus of CAPTA during the next five years:

- The intake, assessment, screening, and investigation of reports of abuse and neglect;
- Creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations;
- Improving legal preparation and representation, including—
 - a. Procedures for appealing and responding to appeals of substantiated reports of abuse and neglect; and
 - b. Provisions for the appointment of an individual appointed to represent a child in judicial proceedings;
- Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;
- Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols;
- Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange;
- Developing, strengthening, and facilitating training including—

- a. Training regarding research-based strategies to promote collaboration with the families;
 - b. Training regarding the legal duties of such individuals; and
 - c. Personal safety training for case workers.
- Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers;
 - Developing and facilitating research-based strategies for training individuals mandated to report child abuse or neglect;
 - Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect;
 - Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level;
 - Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;
 - Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.

The following table aligns the DCS goals and CAPTA activities with the intended outcomes of home visiting.

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
<p>Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits</p> <p>Reduction in crime or domestic violence</p>	<ul style="list-style-type: none"> • Development of staff to have assessment skills and competencies that determine the risks and needs of children and their families. • Ensure that individualized programs and services are delivered to families and children in order to achieve safety, permanency and well-being outcomes. 	<ul style="list-style-type: none"> • The intake, assessment, screening, and investigation of reports of abuse and neglect • Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers; • Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols; • Developing, strengthening, and facilitating training including— <ul style="list-style-type: none"> ○ Training regarding research-based strategies to promote collaboration with the families; ○ Training regarding the legal duties of such individuals; and ○ Personal safety training for case workers.

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
<p>Improvements in coordination and referrals for other community resources and supports.</p>	<ul style="list-style-type: none"> • Ensure that services are developed and planned in partnership with families and communities to protect children in their community through cooperation and communication. 	<ul style="list-style-type: none"> • Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families • Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems; • Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of

Home Visiting Intended Outcomes	DCS Goals	CAPTA Activities
		substantiated child maltreatment reports

Title V Maternal Child Health Services

Source Document: Title V Needs Assessment 2010

The Indiana State Department of Health administers the Title V grant through Maternal and Child Health (MCH), a division of the Health and Human Services Commission (HHS). MCH administered programs include: Prenatal Substance Use Prevention Program, Indiana Perinatal Network, SIDS, Preventive and Primary Child Health Care, Indiana RESPECT (Reducing Early Sex and Pregnancy by Educating Children and Teens), Family Care Coordination, Prenatal Care Services, Prenatal Care Coordination, Adolescent Health Centers, Family Planning Services, the Genomics/Newborn Screening Program which includes Early Hearing Detection and Intervention (EHDI) Newborn Heel Stick Program, and Sickle Cell Program. MCH also administers Children's Special Health Care Services (CSHCS), the state program for children with special health care needs, and Oral Health Services. Title V also supports programs administered within ISDH including: Indiana Childhood Lead Poisoning Prevention Program, Injury Prevention, and Nutrition and Physical Activity. MCH collaborates with many other programs within ISDH such as WIC and Office of Primary Care.

Vision / Purpose: To improve the health status of families in the State of Indiana and to ensure that all children within the context of their family and culture will achieve and maintain the highest level of physical, mental, and emotional health in order to realize their human potential to the fullest. The goal of MCH is to make services available to all residents of Indiana. Emphasis is placed on ensuring services to childbearing women, infants, children, and adolescents (including children with special health care needs, low income populations, those with poor nutritional status and those who do not have access to health care). This vision is carried out in collaboration with local communities, other state agencies, organizations and

individuals concerned with the health and well-being of families, women, infants, children, and adolescents.

Mission Statement: In order to accomplish its mission, the Indiana Maternal & Child Health Services will:

1. Promote the delivery of high quality, comprehensive, family-centered health services for women, infants, children, and adolescents.
2. Identify and assess the health factors and conditions of families that adversely affect their social, economic, and health status.
3. Monitor relevant health status indicators to identify, assess, and proactively plan for current and future areas of need, including proposals for regulatory change.
4. Promote early prenatal care, treatment for substance abuse, breastfeeding, provision of nutritious food, health education and referrals in preventative and primary health care services to improve pregnancy outcome and child health.
5. Develop and promote effective outreach and identification, including the provision of culturally sensitive and competent care coordination and management.
6. Establish policy and standards of care, and promote quality preventative health care services that emphasize early evaluation, prevention of regression of health status and promotion of maximum function.
7. Strengthen outreach, educational and marketing efforts including communications to target high-risk populations, local agencies, and community organizations.
8. Provide technical assistance to local communities to assure the development of systems of health, nutrition education and special health care services.
9. Develop standards for health and nutrition services to evaluate the quality and outcomes of initiatives and to evaluate local project operations and management.
10. Procure and appropriately utilize funds and other resources to improve the health of families, with emphasis on women, infants, children, adolescents and children with special health care needs.

Values: The underlying values of Maternal & Child Health Services are:

1. MCH is committed to comprehensive Family Centered Health Care that is culturally sensitive.
2. Preventive Health Care Services; and Early Identification, Diagnosis, & Treatment are the most effective and efficient methods to safeguard the public’s health.
3. MCH operates in collaboration with local communities, other state agencies, organizations and individuals concerned with the health and well-being of families, women, infants, and children.

In July of 2010, Indiana MCH submitted the required five-year needs assessment for FY 2011-2015. The goals of the Indiana Title V Needs Assessment process were to (1) identify health needs for the maternal, infant, child, adolescent and children with special healthcare needs (CSHCN) populations in Indiana; (2) improve working relationships with collaborative partners; and (3) provide a roadmap for improving health outcomes for the same populations.

Ten priority areas were identified for the populations served by MCH. For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding.

For infants, two areas were identified that require a special focus: prematurity rates and accidental suffocation under one year of age.

Concerns involving children and adolescents centered on lead poisoning, STIs, obesity, and social-emotional health of very young children.

Based on the findings of the needs assessment, ten performance measures were identified for action in the next five years. The table below aligns the priorities with outcomes established for home visiting.

Home Visiting Intended Outcomes	Indiana Title V Performance Measures
Improved maternal and newborn health	1. Decrease the percentage of pregnant women on Medicaid who smoke (SPM 3)

Home Visiting Intended Outcomes	Indiana Title V Performance Measures
	<ol style="list-style-type: none"> 2. Increase the percentage of black women (15-44) with a live birth whose prenatal visits were adequate (SPM 4) 3. Increase the percentage of women who initiate exclusive breastfeeding (SPM 2) 4. Decrease the percentage of preterm births (SPM 7) 5. Decrease the percentage of births occurring within 18 months of a previous birth to the same birth mother (SPM 6) 6. Decrease the rate of suffocation deaths of infants (SPM 1)
Improvement in school readiness and achievement	<ol style="list-style-type: none"> 1. Decrease the percentage of children age 0-72 months with blood levels greater than or equal to 10 micrograms per deciliter (SPM 5) related to lead poisoning. 2. Decrease the percentage of high school students who are obese (SPM 8) 3. Decrease the percentage of high school students who become infected with an STI (SPM 9) 4. Increase capacity for promoting social-emotional health in children 0 to 5 (SPM 10)

Conclusion

In reviewing the needs assessments and strategic plans, Indiana's collaborating agencies identified a clearly documented effort to comprehensively address the needs of high risk pregnant women, families and children. The goals and strategies of each agency are in alignment with the outcomes identified in statute for the home visiting initiative. Alignment of goals is critical to the long term sustainability of efforts to improve outcomes for this vulnerable population. Each agency specifically discussed the importance of communication and collaboration across agencies and programs to achieve the desired outcomes. This degree of cooperation and collaboration will enhance the ability of Indiana to achieve the desired outcomes for home visiting.

Part 3: Indiana Home Visiting Capacity

A variety of home visiting programs have emerged in recent years to serve Indiana communities with the growing awareness of the value that home visiting interventions bring to addressing health, safety and literacy needs. The Indiana Department of Child Services has more than a decade long commitment to home visiting in the form of Healthy Families Indiana (HFI). HFI serves families in all 92 Indiana counties. In addition to HFI, additional programs have emerged including Even Start, Early Head Start, and Parents as Teachers (PAT). Diverse funding streams and outcome objectives, expanding eligibility criteria and targeted population have driven the growth of programs. Existing Indiana home visiting programs offer ongoing services to individuals primarily in a home setting, although many offer group services as well. Services are delivered by trained home visiting professionals or paraprofessionals with the goal of addressing specific issues based upon the individual family's eligibility for the program.

For the purposes of this needs assessment, the following overview of Indiana's home visiting programs will include those programs meeting the aforementioned criteria. Programs not included are those delivering services as part of federal IDEA Part C requirements, programs providing one-time home visits and programs that do not provide routine and sustained home visits.

The discussion below summarizes home visiting programs in Indiana and describes in detail each individual home visiting program in the state. To the extent possible, program descriptions include the program components, scope of service, number and type of individuals and families served, ability of the programs to meet the needs of eligible families, and the individual program gaps and concerns.

Early Head Start

Early Head Start (EHS) is a national evidence-based multi-service early childhood, community-based program for low-income families with infants and toddlers and pregnant women. Early Head Start strives to:

- Promote healthy prenatal outcomes for pregnant women;

- Enhance the development of children ages birth to three; and
- Support healthy family functioning.

EHS is administered by the Office of Head Start (OHS), Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (DHHS). EHS's home visiting component provides – through the use of home visitors – comprehensive services to promote school readiness and enhance children's physical, dental, nutritional, social/emotional, and cognitive development.

In FY09, Indiana had 15 Early Head Start program sites. ARRA funding provided a significant expansion to the capacity of Early Head Start in Indiana with the creation of 1,037 new slots. Eleven additional sites were funded with some existing sites expanding enrollment. Indiana currently has 2,636 EHS slots in 26 programs. Program design and service delivery models vary from home visitation, social groups and classroom services to a combination of these models. Many sites designate slots from various program models to best meet the needs of the families served. The estimated cost of the Early Head Start home visiting program differs significantly from site to site ranging from approximately \$7,000 to \$14,000 per child. While the current waitlist for the EHS home visiting component is unknown, the cumulative waitlist for both the EHS and HS programs in the spring of 2010 was an estimated 7,000 families statewide. Program administrators feel that demand exceeds enrollment capacity for EHS and similar programs, and that more resources need to be dedicated to programs serving at-risk populations.

Healthy Families Indiana

Healthy Families Indiana (HFI) is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. HFI awards grants from the Indiana Department of Child Services (DCS) to single county and cluster site grantees that provide assessment and home visiting services in all 92 Indiana counties. HFI serves eligible families of children prenatally to age three. Currently to qualify for services, a family's income must be at or below 250% of the federal poverty line and the family must score 40 or higher on the Kempe Family Stress Checklist. At the onset of services, each enrolled family is visited a minimum of once a week for a minimum of six months. Thereafter, based on well-defined criteria regarding family

need, progress, and engagement in the program the required number of visits per family per month may be increased or decreased. The maximum cost per family per year is \$4,500.

The HFI program uses a variety of curricula based on the needs of the families and their personal learning styles. Curricula and educational materials used are PCI activity-based, sequential and include an instruction manual for home visitors. Curricula currently approved for use in HFI programs include:

- Great Beginnings- Prenatal;
- Healthy Start;
- MELD New Middle of the Night;
- MELD - Nueva Familia;
- MELD - Young Families at Home;
- Mom Project Prenatal Curriculum;
- Nurturing Program for Prenatal Families;
- Nurturing Program for Families with Special Needs;
- Nurturing Program for Teen Parents;
- Nurturing Program - Birth to Five;
- Nurturing Program - 4 to 12;
- PAT, 0-3;
- PAT, 3-K;
- Partners for a Healthy Baby – Prenatal;
- PIPE;
- Resource Mother's Handbook;
- Ezparenting; and
- Partners for a Healthy Baby-Birth to 3.

From July 1, 2009 to June 30, 2010, HFI served 22,739 families, providing home visiting to 14,475 families statewide with a total budget of \$34,436,323. HFI programs are not permitted to develop waitlists for services, yet there are capacity limitations which require that families who are eligible but not enrolled in HFI be referred to other services to meet their needs. Significant

reductions of funding are now limiting enrollment to families with a score 40 or higher on the Kempe Family Stress Checklist rather than the previously required minimum score of 25.

Healthy Families E-Parenting Project (EPP)

The E-Parenting Project is an ongoing, multi-state research project funded by the Centers for Disease Control and Prevention involving 420 Indiana families. One third of the families are in a control group and are not receiving any services. The other two-thirds are enrolled in two Healthy Family Indiana programs: HFI Allen County (SCAN) and the MOM Project in Marion County. The EPP curriculum is eight 20-30 minute sessions provided on a laptop touch screen computer as part of a regularly scheduled HFI home visit. These evidence-based interventions are designed to reduce risk factors for child maltreatment. The components include:

- 1) Motivational interviewing related to:
 - a. Participation in home visiting;
 - b. Domestic (interpersonal) violence;
 - c. Substance Use (drugs and alcohol); and
 - d. Mental Health – primarily depression.
- 2) Cognitive retraining that focuses on changing inappropriate maternal attributions for infant behaviors to appropriate attributions; and
- 3) Project Safe Care (health & safety behaviors to prevent neglect).

Families in this study who are receiving services are provided either regular HFI home visiting (using curriculum selected by HFI) or regular HFI home visiting augmented with E-Parenting on eight of the home visits that occur between birth and six months. The intent of the study is to determine if a computer-based program that incorporates evidence-based interventions can improve outcomes of families who participate in Healthy Families America home visiting. If E-Parenting is more effective than traditional home visiting there are several advantages to this technology including: 1) consistent implementation, 2) ease of dissemination, and 3) negligible additional cost. Moreover, E-Parenting can be continually monitored and evaluated in order to improve implementation, acceptance and effectiveness. For example, E-parenting can be enhanced by incorporating new evidence-based interventions as they become available.

EPP study participants are limited to English-speaking mothers age 18 and older. Mothers in the study include Non-Hispanic White, Hispanic, Black, Asian and Mixed/Other populations.

Parents as Teachers (PAT)

Parents as Teachers (PAT), a national evidence-based home visiting model, provides family-centered services that help to increase parent knowledge, promote optimal child development, and increase school readiness. Grounded in research, PAT developed the *Born to Learn* evidence-based curriculum that supports and encourages school readiness and the improvement of child health. The *Born to Learn* curriculum includes a health assessment, annual developmental screen, and referrals to support parents in their role as their child's first and best teachers. Supporting parents using the BTL curriculum can help to improve parenting practices, provide early detection of developmental delays and health issues including nutrition and wellness, prevent child abuse and neglect, and ensure children are ready to learn.

PAT's funding sources vary significantly across Indiana. The most current published data for July 2008 through June 2009 reports on the outcomes and progress of the 44 Indiana Parents as Teachers programs. Several communities have stand-alone Parents as Teachers programs that are funded by a combination of foundation dollars, local public resources and donations. Other Indiana programs that use PAT as part of home visiting programs and that are funded with federal or state dollars include Healthy Families Indiana (26 of the programs), Early Head Start (3), and Even Start (1). In total, 5,688 Indiana families received at least one PAT home visit during the 2008-09 program year.

The Newborn Individualized Developmental Care and Assessment Program

The Newborn Individualized Developmental Care and Assessment Program (NIDCAP) offers an individualized and nurturing approach to the care of infants in neonatal intensive care units (NICU) and special care nurseries (SCN). NIDCAP is a relationship-based, family-centered approach that promotes the idea that infants and their families are collaborators in developing an individualized program of support to maximize physical, mental, and emotional growth and health and to improve long-term outcomes for pre-term and high medical risk newborns.

The NIDCAP approach uses methods of detailed documentation of an infant's ongoing communication to teach parents and caregivers skills in observing an individual infant's

behavioral signals. These sometimes subtle signals provide the basis for interpreting what the infant is trying to communicate and can be used to guide parents and caregivers to adapt all interaction and care to be supportive of the infant's behavior. Suggestions for care are made in support of the infant's self-regulation, calmness, well-being and strengths, and the infant's sense of competence and effectiveness. Such suggestions begin with support, nurturance and respect for the infant's parents and family, who are the primary co-regulators of the infant's development. These suggestions should extend to the atmosphere and ambiance of nursery space, the organization and layout of the infant's care space, and the structuring and delivery of specific medical and nursing care procedures and specialty care. These practices ensure that a developmental perspective and the infant's environment are incorporated into the infant's care.

The St. Vincent NICU in Indianapolis previously utilized the NIDCAP program. The staffing and training requirements of the program lead the hospital to translate the key concepts of the approach to a more global staffing and environment effort, ensuring that all bedside caregivers are trained to support healthy, positive infant development.

Even Start

The purpose of the William F. Goodling Even Start Family Literacy Program (Even Start) is to provide intensive family literacy services to help break the cycle of poverty and illiteracy by improving the educational opportunities of low-income families. The Indiana Department of Education administers federal Even Start funding, making competitive grants available to local applicants. In program year 2009-10, \$1,048,648 in funding supported six program sites. Indiana Even Start programs provide a year-round unified family literacy program which integrates child and adult literacy or basic education, parenting, and parent/child literacy activities. While program formats vary by site, each program is required to include a home visitation component to ensure parenting and family literacy is extended beyond the classroom and into the natural home environment. In addition to monthly home visits conducted by program staff, it is expected that families will carry out literacy activities and parenting strategies discussed. Curriculum is chosen by the local program but must be a scientifically based. The Creative Curriculum, those offered by Steck-Vaughn and the High Scope curriculum have all been used at sites in Indiana. Funded sites are required to ensure that the families selected for Even Start are those most in need of the full range of services offered. To be eligible for Even Start parents

must be 16 years of age or older, not be enrolled or required to be enrolled in secondary school, and lack sufficient mastery of basic educational skills to function effectively in society. To participate in an Even Start program, a family must have at least one eligible parent and one eligible child participating together in the full scope of the project. Enrolled children range from birth to eight years of age. During the 2009/2010 reporting year 204 families were served at six sites in six Indiana Counties.

Indiana Even Start sites do not maintain a waiting list. When space is no longer available to serve all eligible applicants, programs refer families to other community resources that may address some of the family needs until space opens. The IDOE identifies that there is considerable unmet need for Even Start as the state currently only operates six programs and many other communities likely have literacy needs that could be met effectively by this program. The IDOE continues to receive requests for additional programs however no additional funds are currently available.

Healthy Start

Indiana hosts two of the 104 Health Resources and Services Administration (HRSA) funded Healthy Start projects. Healthy Start provides community-based, culturally competent, family-centered, and comprehensive perinatal health services to women, infants, and their families in communities with very high rates of infant mortality. The target population is pregnant or parenting women who reside in communities with infant mortality rates 1.5 - 2.5 times the national average. The majority of population served is Medicaid eligible. Services provided include outreach, health education, case management, depression screening and referral, and interconception care.

Health and Hospital Corporation of Marion County is the grantee for the Indianapolis Healthy Start Project grant, while Northwest Indiana Health Department Cooperative is the grantee for Northwest Indiana Healthy Start Project. Both Indiana Healthy Start projects provide case management (which includes risk assessment), coordination services, home visitation, health education, counseling, and guidance.

Healthy Start receives 100% of its funding from HRSA. In FY09, case-managed home visiting services were provided to 568 families in Marion County and 554 in Lake County. The projects

provided outreach to 32,916 families in Marion County and 58,211 families in Lake County. Community Education reached 19,883 families in Lake County and 21,664 families in Marion County. Families receiving case management are served at a cost of \$1,125 in Marion County and \$1,040 in Lake County per family annually. HRSA flat funding of Healthy Start for the past thirteen years has limited the opportunity to expand this program.

First Steps

First Steps, Indiana's program for infants and young children with disabilities or who are developmentally vulnerable (Part C of IDEA), is a comprehensive statewide program of early intervention services for infants and toddlers with disabilities and their families. Families who are eligible to participate in the Indiana First Steps system have children under the age of three who: are experiencing developmental delays of 25% or -2 standard deviations from the mean in one or more developmental domains; are experiencing developmental delays of 20% or -1.5 standard deviations from the mean in two or more developmental domains; or have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. First Steps services are provided at no cost to eligible families whose income is under 250% of the federal poverty line; families with income greater than 250% pay cost participation fees on a sliding scale. Indiana's Family and Social Services Administration (FSSA) serves as the lead agency and administrator of the program, and is advised and assisted by an Interagency Coordinating Council (ICC). Ten regional contractors provide intake, eligibility determination and service coordination for families. Individual Family Services Plans (IFSPs) outline services which may include Assistive Technology, Occupational Therapy, Audiology, Developmental Therapy, Physical Therapy, Health Services, Psychology, Interpreter Services, Social Work, Medical, Speech Therapy, Nursing, Vision, Nutrition and other services and are provided to the extent possible in the children's natural environment, often their homes.

Between April 1, 2009, and March 31, 2010, 20,997 children were served by First Steps statewide at a total cost of \$51,231,737.62.

Part 4: Substance Abuse Counseling and Treatment Capacity

Indiana has made significant efforts to prevent substance abuse as well as provide treatment options to support individuals who wish to address abuse issues. Indiana's Strategic Prevention Framework State Incentive Grant (SPF-SIG) is a five-year project awarded to the Office of the Governor and has an overall goal to reduce substance abuse and use over the lifespan of Hoosiers. Funding for this project comes from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP). As a part of this project the Governor has appointed a Governor's Advisory Council (GAC) whose role is to collect and analyze data to help direct the strategic efforts of the state. The state plan summarizes Indiana's epidemiological profile regarding alcohol as follows:

“Alcohol is the most frequently used drug in both Indiana and the United States. According to estimates from the 2004 National Survey on Drug Use and Health, NSDUH (Substance Abuse and Mental Health Services Administration, SAMHSA, 2006), 47.37% of Indiana residents 12 years and older currently consume alcohol (U.S.: 50.71%). Risky consumption patterns, such as binge and heavy drinking, as well as underage drinking, are of particular interest. The most recent 2004 NSDUH estimates report, 21.70% of Hoosiers 12 years and older engaged in binge drinking in the past month, i.e., they had five or more drinks on the same occasion (U.S.: 22.69%); and 40.60% reported heavy use, or consumption of five or more drinks on the same occasion on at least 5 different days in the past 30 days (U.S.: 41.30%). Especially, young adults between the ages of 18 and 25 seemed to be at risk, with 43.47% stating to have engaged in binge drinking within the last 30 days (U.S.: 41.39%). The Behavioral Risk Factor Surveillance System, BRFSS (Centers for Disease Control and Prevention, CDC, 2005), shows that in 2005, 30.30% of all adults (18 years and older) reported binge drinking in the past month (U.S.: 23.50%).” According to the Youth Risk Behavior Surveillance System, YRBSS (CDC, 2006a), 41.4% of Indiana high school students had consumed at least one alcoholic beverage in the past 30 days.

Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents Survey, ATOD (Indiana Prevention Resource Center, IPRC, 2006) and Monitoring the Future Survey, MTF (National Institute on Drug Abuse, 2006a) report that in 2005, alcohol consumption in Indiana

for 8th, 10th, and 12th grade students combined was as follows: lifetime use 49.0% (U.S.: 41.0%), annual use 39.0% (U.S.: 33.9%), monthly use 21.1% (U.S.: 17.1%), daily use 1.8% (U.S.: 0.5%), and binge drinking 11.6% (U.S.: 10.5%).

Heavy alcohol use can lead to alcohol abuse and dependence and is associated with unsafe behaviors, such as smoking cigarettes, illicit drug use, and risky sex. According to the Treatment Episode Data System, TEDS (Substance Abuse and Mental Health Data Archive, SAMHDA, n.d.), 7.6% of Indiana residents were diagnosed with alcohol abuse and/or dependence in 2004 (U.S.: 7.5%). Another serious, long-term consequence of chronic alcohol use is liver disease. The Alcohol-Related Disease Impact (ARDI) database (CDC, 2004) estimated that in 2001, 8.0% of all deaths in Indiana were alcohol-related (U.S.: 8.0%). Furthermore, alcohol seems to be a contributing factor in fatal motor vehicle accidents, certain types of crime (e.g., aggravated assaults, sexual assaults, robberies, driving under the influence, liquor law violations, and public intoxication), and even homicides and suicides.

Further, the Indiana Perinatal Network (*Source: www.indianaperinatal.org/*) contends that nearly 20 percent of women in Indiana use tobacco, while 10 percent use alcohol and 5 percent use other drugs during pregnancy. A critical step to prevent poor outcomes associated with substance use during pregnancy is to verbally screen all pregnant women for alcohol, tobacco and other drug use. The 2007 White House Office of National Drug Control Policy estimates that savings from verbal screening and brief interventions are \$2.50 for every \$1 spent. The estimated lifetime costs of caring for a baby exposed to alcohol, tobacco and other drugs range from \$750,000 to \$1.4 million.

The SPF-SIG planning grant has provided Indiana with an opportunity to assess, coordinate and plan efforts to identify and address substance abuse issues in the state. The Division of Mental Health and Addiction (DMHA) oversees Indiana's efforts in addressing substance abuse. DMHA closely works with the Criminal Justice Institute (ICJI) to coordinate efforts with the criminal justice system in Indiana. The ICJI seeks to create a healthier and safer environment in Indiana by linking resources to communities. Indiana also enjoys the Indiana Resource Prevention Center (IPRC) located in Bloomington which serves as a clearinghouse for information and resources regarding alcohol, tobacco and drugs. The IPRC coordinates Indiana's annual survey of Children and Adolescents for Alcohol, Tobacco and Other Drug Use. At the county level Indiana has 92

Local Community Councils (LCC’s) that are charged with developing a strategic plan at the local level to address substance abuse issues.

The result of the SPF-SIG planning efforts identified target areas for recommending allocation of funding to the highest need communities. The top needs identified indicate resources should be allocated to reducing the use/abuse of alcohol. These recommendations were based on a ranking of counties using six indicators. Twenty counties are identified as “high need” for alcohol-related SPF-SIG funding. These include (with highest need listed first) Lake, Tippecanoe, Marion, Allen, La Porte, St. Joseph, Vanderburgh, Floyd,

High need counties for prevention funding as identified by Indiana’s SPF-SIG project		
<i>* signifies counties in more than one category</i>		
<i>**signifies counties in all three categories</i>		
Alcohol	Cocaine	Methamphetamine
Lake*	Marion	Gibson
Tippecanoe**	Wayne	Bartholomew
Marion*	St. Joseph	Vigo
Allen*	Howard	Daviess
La Porte	Allen	Warrick
St. Joseph*	Grant	Greene
Vanderburgh*	Elkhart	Vanderburgh
Floyd	Lake	Tippecanoe
Vigo*	Tippecanoe	Elkhart
Madison		Hamilton
Porter		
Elkhart*		
Shelby		
Wayne*		
Delaware		
Jasper		
Kosciusko		
Marshall		
Monroe		
Newton		

Vigo, Madison, Porter, Elkhart, Shelby, Wayne, Delaware, Jasper, Kosciusko, Marshall, Monroe, and Newton. Nine counties are identified as “high need” for cocaine-related SPF-SIG funding. These include (with highest need listed first) Marion, Wayne, St. Joseph, Howard, Allen, Grant, Elkhart, Lake, and Tippecanoe. Ten counties are identified as “high need” for methamphetamine-related SPF-SIG funding. These include (with highest need list first) Gibson, Bartholomew, Vigo, Daviess, Warrick, Greene, Vanderburgh, Tippecanoe, Elkhart, and Hamilton.

In Indiana there is a long-term, focused approach on substance abuse prevention. The Indiana Prevention Resource Center (IPRC) was established in 1987 to assist Indiana based alcohol, tobacco and other drug (ATOD) prevention practitioners improve the quality of their services. In

recent years IPRC's purview has expanded to include problem gambling prevention and ATOD treatment. The IPRC, located in Bloomington, is part of the Department of Applied Health Science at Indiana University. The primary target audience is the community of prevention professionals and volunteers, and government officials who are providing or monitoring delivery of ATOD and problem gambling prevention and treatment services to Indiana residents. The IPRC enables prevention and treatment professionals to deliver evidence based programs, policies and practices to the general public.

The IPRC mission is to strengthen prevention and treatment efforts through education, resources and research. The center works to bring together research and practice and thereby better ensure that Indiana's residents receive state of the art prevention technology. The project website offers a host of useful search tools to gather information about specific counties and the prevalence of substance abuse, admission to a variety of treatment modalities as well as multiple demographic variables. The center is available to support local/county efforts to assess current statistics and how to use the data to support prevention and intervention efforts. These resources are available at www.drugs.indiana.edu.

Treatment Resources

Indiana has a great number of substance abuse counseling and treatment resources throughout the state. While there are more resources located around larger metropolitan communities, there is some level of resource available in most Indiana counties. It is noted that substance abuse can affect anyone, anywhere; it is a condition that does not discriminate for age, sex, gender, educational level, economic status or geographic location.

The Family Social Service Administration, Division of Mental Health and Addictions oversees substance abuse services. A variety of certifications/licenses is available. These include 1) Addiction Services Certification, Residential Care Provider Certification, 3) Supervised Group Living and Sub Acute Licenses, 4) Community Mental Health Center Certification, 5) Managed Care Provider Certification, and 6) Private Mental Health Institution (Hospital) Certification. To receive various funding to support treatment services and be included in the state and national listing of treatment resources, programs must hold the appropriate certification or licensure. More information about FSSA/DMHA certification and licensure is available at

<http://www.in.gov/fssa/dmha/4560.htm>. The DMHA statewide treatment resource locator is available at <http://www.in.gov/fssa/dmha/2578.htm>.

According to the Indiana State Department of Health's 2007 report of substance report treatment facilities, there are treatment service facilities located in all but 5 Indiana counties. Metropolitan areas tend to house multiple programs although most programs will serve clients from any county. A listing of substance abuse programs in Indiana compiled by SAMHSA indicates at least 150 different programs in the state. A 2007 report compiled by the Indiana State Department of Health Geographic Information Systems provides a useful, interactive map of Indiana with a representation of substance abuse treatment services by type and payment source. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a national database of substance abuse and mental health services. This listing is generally considered the best and most convenient, accurate source of information regarding available services. The SAMHSA listing is updated regularly for current, up-to-date information about specific resources. The SAMHSA national treatment resource locator is available at <http://dasis3.samhsa.gov/Default.aspx>.

Of particular interest to the home visiting perspective are programs serving adolescents, women and pregnant women. Fifty-three (53) programs provide services to adolescents with eleven programs having multiple sites. Eight offer inpatient services, three offer residential services, 13 offer partial hospitalization/day services, and 49 offer outpatient services. It should be noted that some programs provide more than one type of service and may therefore be represented more than once in these statistics.

Twenty (20) programs provide services to pregnant women with four programs having multiple sites. Of these programs four offer residential services, three offer partial hospitalization/day treatment, and 15 offer outpatient services. It should be noted that some programs provide more than one type of service and may therefore be represented more than once in these statistics.

Fifty-eight (58) programs provide services to women with nine programs having multiple sites. Of these programs two offer inpatient services, two offer partial hospitalization/day services, six offer residential services and 48 offer outpatient services. It should be noted that some programs

provide more than one type of service and may therefore be represented more than once in these statistics.

Description of Services Provided

Indiana facilities providing substance abuse treatment services offer a variety of services. These facilities offer services such as inpatient, detoxification, residential, outpatient, and programs for special populations. Some programs cater to special populations such as adolescents and women. Others offer services for people who speak Spanish and American Sign Language. Services are paid for by a variety of payment sources including Medicaid, Medicare, state financing, private health insurance, military insurance, self-payment, and sliding fee schedules.

Projects of special interest for special populations

- a) The Indiana Access to Recovery (ATR) is a SAMHSA Center for Substance Abuse Treatment discretionary grant aimed at expanding the chemical dependency recovery infrastructure in the state to include both faith-based and community organizations that have traditionally not been involved in chemical dependency recovery. Indiana ATR funds are available for adults at or below 200% of the federal poverty level, residing in **Allen, Elkhart, Lake, Marion, St. Joseph, Vanderburgh, and Vigo** counties. The program is designed to eliminate barriers to treatment and recovery services for adults dealing with substance abuse and addiction issues. The three target populations are: adults transitioning into the community after incarceration, women who are pregnant or who have dependent children and adults with a history of Methamphetamine use. Each client enrolled in ATR works with a Recovery Consultant who helps them assess their recovery needs and guides them in the development of their Individualized Recovery Plan. The Recovery Consultant authorizes vouchers allowing the client to access ATR funded services and also helps the client to connect with any non-ATR services they may require. ATR approved providers are both secular and faith-based, giving the client the option of selecting the provider they are most comfortable with. When a client accesses services at an ATR provider organization, that organization will then be reimbursed by the state. Adults enrolled in ATR must be residents of one of the seven designated counties. However, ATR

- clients may access services at any certified ATR Provider, which could be located in a non-ATR county. Source: <http://www.in.gov/fssa/dmha/6942.htm>
- b) Project HOME (Midtown Community Mental Health Center, Indianapolis) provides specialized services for pregnant women with infant up to age 6 months. The program is offered through Midtown Addictions Clinic and available to Marion county residents. Services are paid for primarily through Medicaid and Wishard Health Advantage funds. Women are referred to Project HOME when receiving addictions services. The program offers a wide variety of supports in an effort to assure these pregnant women/mothers are successfully treated. Services include case management with weekly or biweekly home visits. The focus of the home visit depends upon the specific needs of the client. The provider may offer counseling as needed using the Motivational Interviewing model. Clients may also receive services such as transportation and child care in order to maximize success. Source: Interview with Project HOME staff. More information is available at <http://www.wishard.edu/Midtown>.
- c) Tara Treatment Center is located in Franklin. The program offers detoxification, residential, transitional residential, intensive outpatient, outpatient, aftercare, education, and family programming. Tara is licensed for a 13 bed residential/transitional residential program especially designed for women. These beds are available for a residential program (typical length of stay is 30 to 42 days) and for a transitional residential program (typical length of stay is three to six months). Tara receives referrals by telephone and does an initial screening to be sure the center is an appropriate source for treatment. If admission is suggested, women make an appointment to visit the center for a full psycho-social evaluation. Pregnant women are also referred to an OBGYN for a physical and to coordinate care. Many women are referred to other local community and state resources. For women who have children, they are allowed to visit weekly. Tara also offers a monthly parenting class offering tools and strategies to support positive parenting techniques. Source: Interview with Tara Center staff. More information is available at www.taracenter.com.
- d) Fairbanks is located in Indianapolis, IN and has over 60 years experience in treatment substance abuse issues. The program offers inpatient/detox, partial hospitalization,

intensive outpatient services, and a Supported Living Program (SLP). Fairbanks offers services to adolescents and adult men and women. Currently women and men participate in educational programming together for the inpatient/detox and the partial hospitalization programs. There is a specialized Intensive Outpatient Program (IOP) for women. The IOP is 3 hours a day for 3 days a week for a total of 6 six weeks. This program is offered both during day and evening hours. The SLP or halfway house program is housed at an apartment complex near the Fairbanks facility and offered at \$130 per week. Fairbanks is currently considering some targeted programming to meet the specific needs of women in need of substance abuse treatment and intervention.

Source: Interview with Fairbanks staff. Additional information available at www.fairbanks.cd.org.

- e) Amethyst House is a Bloomington, IN based not-for-profit United Way agency that provides residential and outpatient services for people with drug and alcohol addiction with an additional outpatient office in Evansville, Indiana. The Women's halfway program serves up to 10 women. This halfway house expects residents to have been clean and sober for at least 2 weeks prior to admission. Applicants must prove they are homeless and are asked to make a commitment to stay for a minimum of six months and to maintain work in order to pay for their stay. While in the program women participate in weekly meetings with a case manager to monitor progress and make appropriate referrals. Residents participate in a 12 week outpatient treatment program (weekly) and attend self help/support group meetings. Applications can be accessed online and the average wait to get into the program is 3 to 4 weeks. *Source: Interview with staff. More information is available at www.amethysthouse.org.*
- f) The John P. Craine House is an alternative sentencing program for non-violent female offenders and their pre-school age children. This facility is one of six in existence in the country and the only one in the Midwest. The Craine House Residential program allows women from within Marion and surrounding counties to serve out their executed sentence with their children, in lieu of jail or prison. The program offers structure and guidance with individualized goals for the women. Craine House offers an array of programs to better serve each woman's needs; parenting, GED classes,

tutoring, health and nutrition, substance abuse programs, employment resources, and faith-based opportunities. *Source: <http://www.craighthouse.org/>*

- g) Stepping Stones - Southwest IN Mental Health Center is located in Evansville. The program offers 26 residential treatment beds for individuals 18 and older. The program offers detoxification, residential (typical length of stay 21 – 28 days), intensive outpatient, outpatient, groups, and individual counseling. Stepping Stones has two dedicated beds for women transitional residential (or halfway house) services with a length of stay up to six months. This program has a strong connection with local community services for long term/halfway house services needs such as the YWCA and Ruth House (a faith based program). Stepping Stones considers pregnant women or women using IV and/or meth as high priority admissions. *Source: Interview with Stepping Stones staff; www.southwestern.org*

Substance Abuse Screening – Home visiting programs may be particularly interested in evidence based screening tools to support home visitors in identifying potential substance abuse issues and making appropriate referrals. Several resources have been identified including an Indiana project current being funded to research a specific screening tool’s validity.

- a) Screening, Brief Intervention, and Referral to Treatment (SBIRT) – This project is a collaborative effort between the IU School of Medicine, Wishard Health Services, and Midtown Community Mental Health Center funded by SAMHSA. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. It uses a screening tool that attempts to identify those with “hazardous” substance abuse and provides an effective intervention prior to the need for more targeted, in-depth treatment. The model is currently being evaluated for its effectiveness. It is possible this tool could be adapted for use by home visitors. *Source: Dean Babcock, ACSW, LCSW, Associate Vice President, Midtown Community Mental Health Center.*
- b) Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) – This is a model for helping staff of public and private agencies respond to families affected by substance use disorders. It was developed by the National Center on

Substance Abuse and Child Welfare (NCSACW), a training and technical assistance resource center established jointly by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration and the Office on Child Abuse and Neglect of the Administration for Children and Families. Both agencies are part of the U.S. Department of Health and Human Services. The tool and model were developed to help caseworkers screen parents for potential substance abuse disorders in order to make decisions about children's safety. The authors admit that no single tool can provide all of the information caseworkers need to make important decisions around the safety of children, however they support the idea of a collaborative approach among professionals in using a variety of tools such as those discussed in this model. The 300+ publication describing this model and how to implement it can be accessed electronically through <http://www.ncsacw.samhsa.gov>.

- c) Substance Abuse Subtle Screening Inventory (SASSI) The SASSI Institute was formed in 1998 when it published its first screening/inventory tool. The institute has become a leading publisher in tools that specialize in screening instruments for substance abuse. The current adult screening tool (SASSI-3) is targeted for individuals aged 18 and higher, with a reading grade level of 3.2, an accuracy score of 94%, and can be administered and scored in 15 minutes. The adolescent screening tool (SASSI-A2) is targeted for youth age 12 to 18, with a minimum reading grade level of 4.4, an accuracy score of 94% and administered and scored in 15 minutes. There is an adult Spanish version with a reading grade level of 5 and a lower accuracy rate of 84% with a similar administration/scoring time of 15 minutes. More information about the tools and research efforts to validate these tools can be found at www.sassi.com.
- d) The Indiana Perinatal Network offers for sale a provider training video titled "Integrating Screening and Treatment of Substance Use into General Prenatal Care". The DVD training is designed specifically for health care professionals including home visitors. It features James Nocon, MD, a physician with Wishard Hospital and the IU School of Medicine. The training video includes practical role-play scenarios with clinical and research-based material and interventions. More information about this video presentation is available at http://www.indianaperinatal.org/sections/substance_use.php.

- e) The National Resource Center for Permanency and Family Connection lists a variety of resources regarding substance abuse and child welfare. The web listing includes a variety of resources, curricula and presentations. This listing is available at http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/substance-abuse-and-child-welfare.html.
- f) Addictions Licensure – In 2010 the Indiana Legislature passed SB 0096 which requires individuals providing substance abuse treatment services to acquire a license. The management of the licensure process has been placed in the newly named Behavioral Health and Human Services Licensing Board. The licensure provides for a two-tier system including a Licensed Clinical Addiction Counselor (LCAC) and a Licensed Addiction Counselor (LAC). The intent of this legislation is to assure a high quality of substance abuse treatment services to Indiana residents. The LCAC will be required to have master or doctorate degree with specific coursework as outlined in the law as well as supervision and experience. Passage of an exam is also required. The LAC requires at least a bachelor degree including specific coursework and a supervised practicum along with supervised experience and passage of an exam. There are provisions to grandfather in current providers who meet minimum established criteria with an application deadline of July 1, 2011. More information is available at www.in.gov/pla/3050.htm.

Part 5: Methodology Used to Identify High Risk Communities

Indiana's growing population of 6,423,113 (2009 est.) is spread unevenly among its 92 counties. Population patterns reflect the distinct rural and urban communities within the state with 70% of the population living in metropolitan areas and 30% in rural areas. These population patterns require that communities of risk be identified using a variety of variables. For the purpose of this needs assessment, the term community will refer to specific geographic area. In some areas of the state an entire county is a community, while in other counties the community will be defined as a city – which is both a population hub and an area of need – and still in other counties, communities will be defined at the neighborhood level within a city. Marion County, in central Indiana, hosts the largest city in Indiana, Indianapolis. Lake County, which is the furthest northwest county, just outside Chicago, consists of multiple large cities in Indiana, including

East Chicago and Gary. Because a few counties within Indiana hold so much of the population, crude numbers per county do not give an accurate account of the situation in these counties. In order to consider all communities of Indiana for inclusion in the identification of need, data that reflects rates of need were used rather than merely incidence calculations. As the first step in identifying the highest risk communities, Indiana's collaborating agencies identified sixty-five indicators that were linked to the established home visiting outcomes. As the data were gathered and analyzed, the list of indicators was narrowed to forty which were then utilized to determine the high risk status of counties in Indiana. The list of final indicators used for establishing risk can be found in Figure 1.

In deciding which counties were at the highest risk, the forty indicators with established rates and percentages were used to rank the 92 counties. Indiana ranked all 92 counties in the 40 different measures, individually. For example, for the infant mortality rate, all the counties were ranked from 1 through 92, with 92 representing the county with the worst rate. The same process was repeated for each of the indicators. A ranking was identified for each county regarding each indicator. All the measures were given equal weight. Once all the measures were completed, the overall scores for each county were combined, then divided by the overall measures to give a score ranking the counties overall for all the measures, with the possibility of being 1 through 92. Through this process the county with the highest risk score across all indicators, is Marion County with the score of 70.35. To see the overall scores, please refer to Figure 2.

To see how the rankings separate the counties, the scores are divided into quartiles. Eleven counties in the highest quartile are targeted as the highest risk counties, all with a score above 60. To see the map of Indiana divided into quartiles, please refer to Figure 3. There were a few surprises in the final results. Owen County, Fayette County, Jennings County and Scott County are all small rural counties, but have very high risk scores. Not surprising high risk scores along with Marion County were Lake County, La Porte County, St. Joseph County, and Elkhart County, which are all located in the northern part of Indiana and have large, diverse populations much like Marion County. The final two counties at the highest risk are Starke County, which is also in northern Indiana, and Grant County, which is home to the city of Marion.

The next step for the final home visiting application process is to drill down within these eleven high risk counties to find the cities and towns that have the highest risk. The rural counties, such as Scott, Fayette, Jennings, Starke and Owen, cannot be analyzed any further than the county level. In Grant County, the city of Marion represents the majority of the county's population, so Marion will be analyzed to identify whether the city as a whole or a specific neighborhood will be identified as high risk. This can also be said for Elkhart, which is the largest city in Elkhart County, and South Bend, which is the largest city in St. Joseph County. When looking at Lake County, the two cities furthest north, and just outside Chicago are also the highest risk cities, East Chicago and Gary. Even though they have very similar rates in negative outcomes, more resources are available to Gary. This will play a role when looking into the communities of East Chicago and Gary. Much like Lake County, La Porte County has two large cities that both have high risk areas in Michigan City and La Porte. The negative outcome rates are higher in Michigan City than La Porte, so when looking at the community level, this will be taken into account. The final county is of course Marion, which is represented by Indianapolis, the largest city and capital of Indiana. Because of the size and number of high risk areas in Indianapolis, the city will be analyzed in different segments, then communities. To see a chart of the counties and cities of the highest risk, please refer to Figure 4.

While analyzing the scores, the fear of all the major populated cities being at the highest risk was not realized. In fact, of the 35 largest cities in Indiana, only eight made the list of highest risk areas. Indiana's second and third largest cities, Evansville and Fort Wayne, (located in Vanderburgh and Allen Counties) did not rank in the top 15. This shows that Indiana does have a need in many rural counties, along with urban, high populated counties. The next step will be to work with the local area health departments and partners in these rural counties and large cities, to determine which communities are at the highest risk.

Indiana's collaborating agencies are committed to connecting with communities as a part of future analysis as the target communities of need are identified. The next step will be to work with local area health departments and partners in these rural counties and large cities to determine which specific communities are at the highest risk.

Figure 1: Indicators Used to Assess Risk

Indicators
% Low Birth weight
% Very Low Birth weight
% Preterm Birth
Rate of Infant Deaths
Rate of Neonatal Deaths
Rate of Post Neonatal Deaths
% of Women with Late or No Prenatal Care
% of Women Smoking during Pregnancy
% of Adult Smokers
% of Births to First Time Mothers
Birth Rates (15-19)
% of Pregnant Women on WIC
% of Women Breastfeeding at Discharge
% of Births to Unmarried Parents
% of Births to Mothers w/o High School Degree
% of substantiated child abuse
% of substantiated child neglect
% of Immunizations
% of Adult obesity
% of binge drinking
% of uninsured children
% of children with confirmed EBL>10
% of schools meeting Annual Yearly Progress (AYP)
Number of slots available in licensed child care per 100 Age 0-4
% of children in public schools with limited English proficiency
% of public school dropouts
% of 4 th graders passing their ISTEP tests
% of unemployment
% of unemployment annual average
% of children in poverty
% of children receiving free or reduced lunch
% of households on food stamps
% of households on TANF
% of high school graduates
% of adults with a college education
% single parent households
% of children birth to 6 receiving Medicaid
Helpline Calls

Figure 2: Overall County Scores

High Risk Counties	Score	Rank	Average
Marion	2814	92	70.35
Lake	2626	91	65.65
Scott	2538	90	63.45
Elkhart	2533	89	63.325
St Joseph	2512	88	62.8
Fayette	2477	87	61.925
Jennings	2466	86	61.65
Starke	2444	85	61.1
LaPorte	2434	84	60.85
Grant	2422	83	60.55
Owen	2409	82	60.225
Madison	2365	81	59.125
Cass	2354	80	58.85
Switzerland	2333	79	58.325
Wayne	2225	78	55.625
Randolph	2220	77	55.5
Vanderburgh	2199	76	54.975
Clark	2183	75	54.575
Jefferson	2178	74	54.45
Vigo	2170	73	54.25
Wabash	2169	72	54.225
Noble	2161	71	54.025
Blackford	2158	70	53.95
Allen	2156	69	53.9
Washington	2132	68	53.3
Crawford	2116	67	52.9

High Risk Counties	Score	Rank	Average
Clinton	2112	66	52.8
White	2102	65	52.55
Orange	2074	64	51.85
Rush	2071	63	51.775
Vermillion	2061	62	51.525
Sullivan	2059	61	51.475
Fulton	2044	60	51.1
Miami	2037	59	50.925
Fountain	2036	58	50.9
Steuben	2026	57	50.65
Henry	2013	56	50.325
Montgomery	2012	55	50.3
Jackson	2006	54	50.15
Howard	1979	53	49.475
Jay	1969	52	49.225
Clay	1960	51	49
Delaware	1956	50	48.9
Newton	1942	49	48.55
Pulaski	1904	48	47.6
Lawrence	1903	47	47.575
Greene	1892	46	47.3
Shelby	1874	45	46.85
Marshall	1865	44	46.625
Decatur	1865	43	46.625
Kosciusko	1858	42	46.45
Daviess	1835	41	45.875
Morgan	1834	40	45.85
Union	1820	39	45.5

High Risk Counties	Score	Rank	Average
Parke	1819	38	45.475
Knox	1810	37	45.25
Perry	1809	36	45.225
Floyd	1802	35	45.05
Putnam	1798	34	44.95
Tippecanoe	1793	33	44.825
Adams	1788	32	44.7
Martin	1786	31	44.65
Harrison	1767	30	44.175
Bartholomew	1756	29	43.9
Huntington	1725	28	43.125
Ohio	1717	27	42.925
Jasper	1712	26	42.8
Ripley	1707	25	42.675
Pike	1683	24	42.075
Warren	1657	23	41.425
LaGrange	1642	22	41.05
Whitley	1614	21	40.35
DeKalb	1549	20	38.725
Wells	1528	19	38.2
Porter	1484	18	37.1
Monroe	1483	17	37.075
Franklin	1471	16	36.775
Benton	1460	15	36.5
Dearborn	1455	14	36.375
Tipton	1445	13	36.125
Brown	1441	12	36.025
Posey	1410	11	35.25

High Risk Counties	Score	Rank	Average
Spencer	1371	10	34.275
Johnson	1371	9	34.275
Carroll	1262	8	31.55
Warrick	1248	7	31.2
Gibson	1234	6	30.85
Dubois	1185	5	29.625
Hancock	1177	4	29.425
Hendricks	1113	3	27.825
Hamilton	948	2	23.7
Boone	940	1	23.5

Figure 3: Indiana County Score Map by Quartiles

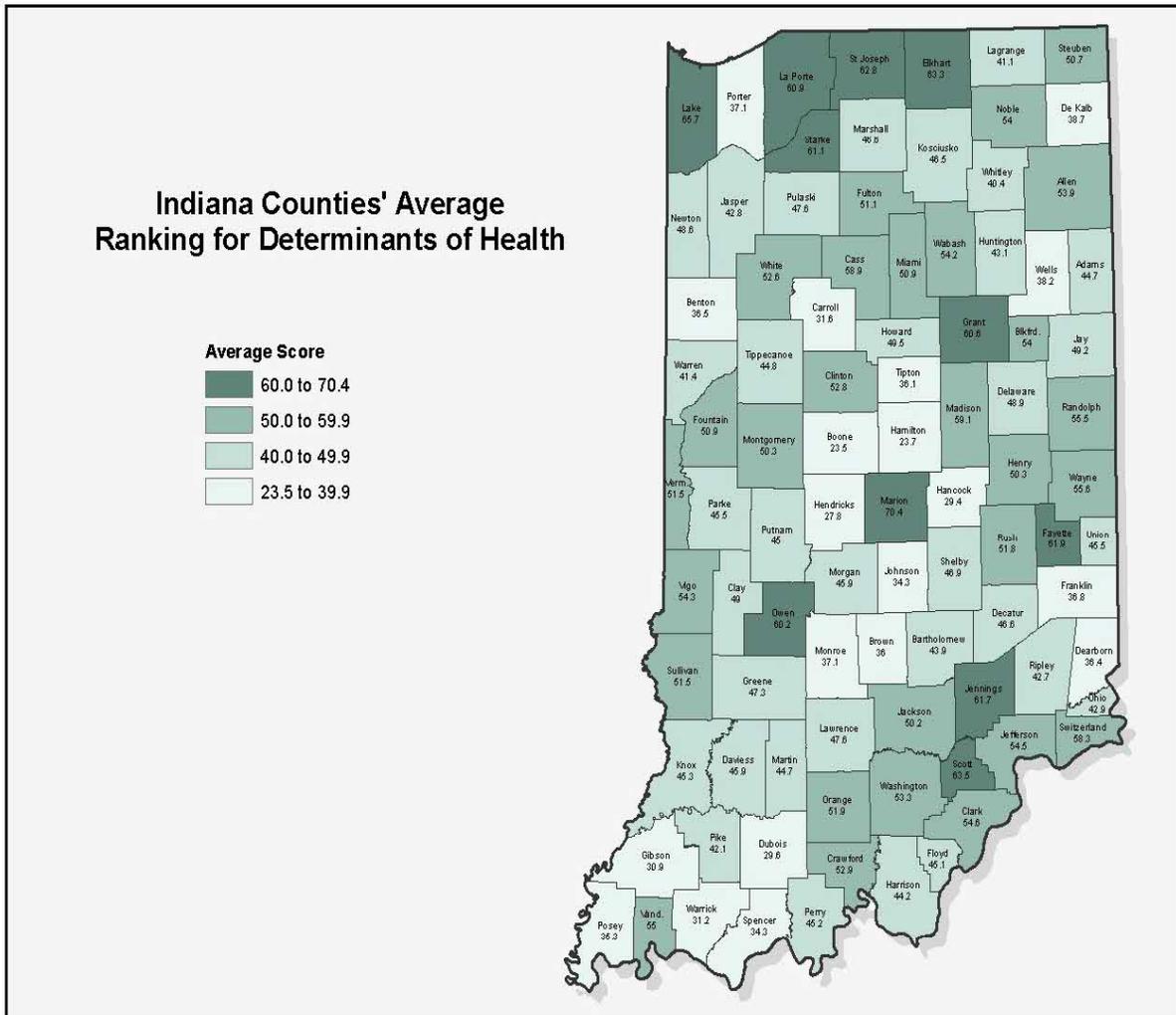
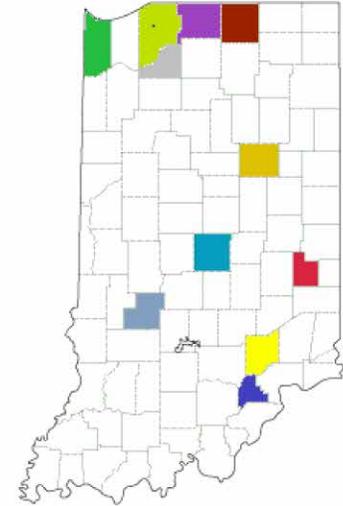


Figure 4: Community Selection Plan

County	City	Community
<i>Marion</i>	Indianapolis	
<i>Lake</i>	East Chicago	
	Gary	
<i>Scott</i>		
<i>Elkhart</i>	Elkhart	
<i>St. Joseph</i>	South Bend	
<i>Fayette</i>		
<i>Jennings</i>		
<i>Starke</i>		
<i>La Porte</i>	Michigan City	
	La Porte	
<i>Grant</i>	Marion	
<i>Owen</i>		

Figure 5: Capacity in High Risk Communities for Home Visiting and Substance Abuse Treatment Resources



	Healthy Families	Healthy Families with E-Parent	Early Head Start	Even Start	Parents as Teachers	Healthy Start	NIDCAP
Elkhart	X		X		X		
Fayette	X						
Grant	X		X				
Jennings	X						
La Porte	X		X		X		
Lake	X		X		X	X	
Marion	X	X	X	X	X	X	
Owen	X		X		X		
Scott	X				X		
St. Joseph	X		X		X		
Starke	X		X				

County	Substance Abuse	Detoxification	Halfway House	Outpatient	Partial Hosp/Day Tx	Residential	Hospital	Adolescents	Pregnant Women	Women
Elkhart	X	X		X	X		X		X	X
Fayette	X			X				X		
Grant	X	X		X	X	X	X	X	X	X
Jennings	X			X						
La Porte	X			X				X		
Lake	X	X	X	X	X	X	X	X	X	X
Marion	X	X	X	X	X	X	X	X	X	X
Owen		X			X					X
Scott	X			X						
St. Joseph	X	X	X	X		X	X		X	X
Starke	X			X				X		

Part 6: Statewide Gaps in Maternal, Infant and Early Childhood Home Visiting Programs

Indiana has an array of home visiting programs across the state designed to address high risk populations and high risk issues such as family literacy, school readiness, economic self-sufficiency, maternal depression, abuse and child development. Despite this foundation, there are significant gaps in maternal, infant and early childhood home visiting in Indiana.

Identified Themes through the Needs Assessment Process

Funding Stability:

Indiana home visiting programs currently draw from a variety of funding streams. The current economic environment has created strains on all funding sources, while at the same time programs report increases in numbers and needs of eligible families. Programs specifically noted the following areas of concern:

- Need to utilize Medicaid billing effectively when appropriate; and
- Lack of mental health clinicians/Long waiting lists.

Maternal Mental Health:

Indiana home visiting programs consistently noted the need to increase services for women in the postpartum period. Programs specifically noted the following areas of concern:

- Postpartum/Maternal depression; and
- Lack of mental health clinicians/Long waiting lists.

Family Economic Self-Sufficiency:

Indiana home visiting programs consistently noted the need to increase services for homeless families and to bolster economic self-sufficiency programming. Specifically:

- Transportation resources to support families' access to services, employment opportunities and community resources;

- Housing resources to include financial assistance with deposits and arrearages (increasing rent and foreclosure rates have impacted target populations that consistently relocate);
- Career and workforce development support; and
- Food security.

Comprehensive System of Care:

Indiana home visiting programs voiced concern about the need to increase collaborations within home visiting programs and with other family support programs into a seamless structure of family services. Programs also noted the increased need for:

- A comprehensive approach to data collection and data sharing in order to avoid duplication of services, and to provide clear and consistent information;
- Improved awareness of potential partnering programs to ease referrals and meet needs beyond an individual program's capacity;
- Increased need for fiscal resources in order to provide on-going training opportunities for home visitors;
- Continuity of care for families transitioning into and out of home; and
- Coordination of program evaluation.

Non-Traditional Populations:

Indiana home visiting programs consistently noted the need to increase services to non-traditional populations who typically are not targeted for services in the parent, infant and early childhood spectrum. Among the population groups identified as underserved were:

- Fathers;
- Immigrant populations including Hispanic and Burmese ;
- Amish;
- Grandparents who are parenting; and
- Teen parents.

Part 7: Indiana’s Plan to Address the Gaps

The collaborating agencies have developed preliminary responses to the identified gaps as a result of the needs assessment. As the high risk communities are further delineated, the responses will be adjusted to reflect the specific needs of each community.

Funding Stability:

The *overarching mission* of the Indiana Office of Medicaid Policy and Planning (OMPP) is to improve the quality and quantity of Hoosier lives in an outcome and value driven health care system. This mission is in alignment with the established outcomes for home visiting. The collaborating agencies will seek to partner with OMPP to ensure sustainability of Indiana’s home visiting system in order to achieve shared outcomes for pregnant women, young children and their families. The presumptive eligibility policies of OMPP have supported timely entry into prenatal care for pregnant women in Indiana. A focus on evidence based programming that meets the requirements of OMPP for reimbursement will support programmatic sustainability and expansion of home visiting to other high risk counties.

Maternal Mental Health:

Research confirms the critical importance of the mental health and well-being of pregnant women and mothers. As indicated in the position paper developed by the Indiana Perinatal Network *“Women need to be screened for signs and symptoms of depression during and after pregnancy so early identification and prompt intervention can be offered. Postpartum depression can occur within days to one year after giving birth—but usually occurs within the first three months. Women with a previous history of depression have up to a 50% risk of developing postpartum depression and should be counseled before conception that they are at risk for recurrent depression during pregnancy and the postpartum period.”* The collaborating agencies are committed to continue programming that focuses on training for health care and social services providers.

Addressing the social-emotional development of young children has been a priority outcome for Sunny Start, the Indiana response to the Early Childhood Comprehensive System (ECCS)

initiative. Recognizing the importance of the mother child dyad is critical to positive child and family outcomes. Sunny Start has focused its efforts on workforce development to ensure there is provider capacity to meet the mental health needs of the pediatric population. In the coming year, Indiana will implement the Michigan Infant Toddler Mental Health Credential. This voluntary credential will be part of continuing education efforts for personnel in Early Head Start, Head Start, Child Care, mental health center providers and early childhood providers. This initiative is being funded and supported by the collaborating agencies for this home visiting effort.

Family Economic Self-Sufficiency:

The Indiana Commission on Childhood Poverty is charged with presenting an implementation plan that includes procedures and priorities for implementing strategies and biennial benchmarks to achieve the reduction of childhood poverty by 50% in Indiana by 2020. The plan must include provisions for improving the following for parents and children living in poverty:

- Workforce training and placement to promote career progression;
- Education opportunities, including higher education opportunities and literacy programs;
- Affordable housing;
- Child care and early education programs;
- After school programs and mentoring programs;
- Access to affordable health care, including access to mental health services and substance abuse programs; and
- Streamlining services through public and private agencies providing human services to low income children and families.

These provisions are aligned with the outcomes for home visiting.

An additional resource available for incorporation into the home visiting initiative is the Goodwill Guides initiative, an innovative approach to wrap-around services and supports to ensure all those who influence the child's growth are effectively empowered in a family strengthening process. This resource builds a platform that provides a holistic, whole family continuum of health, education, employment and social services within the community, using existing services as much as possible.

Sunny Start has also provided resources to support family self-sufficiency through the Early Childhood Meeting Place Family Page. This internet resource covers all 92 Indiana Counties and provides information related to Community resources, Child Care and Early Education, Health and Safety, Parenting and Families and Financial Resources. There are a series of 20 fact sheets related to public programs and resources that help families access resources that they may be eligible for. The fact sheets have been developed in both English and Spanish.

Comprehensive System of Care:

Across the identified statewide gaps speak to the need for a statewide system of home visiting. While Healthy Families Indiana has a well developed statewide programmatic system of home visiting and collaborates with other programs, there is no statewide consortium that brings together all providers of home visiting to comprehensively address infrastructure and service delivery needs for high risk pregnant women, fathers, and young children.

The development of a consortium would increase the ability of Indiana home visiting programs to:

- Establish shared outcomes for home visiting;
- Share training resources;
- Maximize the limited available state and local resources;
- Identify a common set of data elements across programs;
- Create common evaluation criteria; and
- Improve communication across programs.

Operating as a consortium does not require that any program change its model. The shared opportunities and activities can strengthen and enhance each program's existing model. The ability to share, learn from each other and work with common purpose can only improve the outcomes for children and families.

Evaluation

As the project evaluation design is developed, a key component will be the assessment of how well the project addresses the gaps that have been identified through the needs assessment. A comprehensive plan that includes formative and summative evaluation components with clearly defined objectives and instrumentation will be part of the next phase of the application process.

Appendix A: Data Charts

Geographic Area: Indiana

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	8.5%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	7.5%					
Poverty -# residents below 100% FPL/total # residents (Children)	17.2%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.8%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					1.3 per 1,000 Sheltered	Indiana Coalition Against Domestic Violence
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.55%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month16 - Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month - Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month				Binge Alcohol 17.41% Marijuana Use 6.26% Illicit Drug 4.2% Non-Prescription Painkiller 6.04%	Binge Alcohol 14.1% (Indiana Youth Institute)	
Unemployment -Percent: # unemployed and seeking work/total workforce					19.1%	Workforce Development
Child maltreatment -Rate of reported of substantiated - maltreatment - (substantiated/indicated/alt response victim)17-Rate of reported substantiated maltreatment by type		20% (Neglect) 16% (Abuse)				
Percentage Prenatal Care 1 st trimester	67.5%					

Geographic Area: Marion County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	12.0					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.4					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	9.1					
Poverty -# residents below 100% FPL/total # residents (children)	24%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					6.2%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					18.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		31% (Neglect) 9% (Abuse)				
Percentage Prenatal Care 1 st trimester	60.6%					

Geographic Area: Lake County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.7					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	10.6					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	9.9					
Poverty -# residents below 100% FPL/total # residents (Children)	24.7%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					4.1%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.5%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					24.2%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		18% (Neglect) 6% (Abuse)				
Percentage Prenatal Care 1 st trimester	59.6%					

Geographic Area: Scott County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.7%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	7.5%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	24.7%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					2.4%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					1.0%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					8%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.7%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		19% (Neglect) 14% (Abuse)				
Percentage Prenatal Care 1 st trimester	57.8%					

Geographic Area: Elkhart County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	8.5%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	6.9%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	18%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					4.8%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.6%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					13%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					16.1%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		18% (Neglect) 23% (Abuse)				
Percentage Prenatal Care 1 st trimester	51.8%					

Geographic Area: Fayette County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	12.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.9%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	21.3%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.9%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.8%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					17%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					26.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		12% (Neglect) 10% (Abuse)				
Percentage Prenatal Care 1 st trimester	72.0%					

Geographic Area: Jennings County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	8.9%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	7.8%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	18.1%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					2.6%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.2%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					16%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					19.4%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		25% (Neglect) 14% (Abuse)				
Percentage Prenatal Care 1 st trimester	66.0%					

Geographic Area: Starke County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	7.9%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	6.6%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	24.1%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					3.2%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					1.4%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					N/A	
Unemployment -Percent: # unemployed and seeking work/total workforce					28.5%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		23% (Neglect) 20% (Abuse)				
Percentage Prenatal Care 1 st trimester	73.2%					

Geographic Area: La Porte County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.4%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	11.1%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	19%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					9.6%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					18%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.6%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		8% (Neglect) 8% (Abuse)				
Percentage Prenatal Care 1 st trimester	67.1%					

Geographic Area: Grant County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	13.7%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.7%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	25.6%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					5.1%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					.7%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					11%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					22.9%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		16% (Neglect) 16% (Abuse)				
Percentage Prenatal Care 1 st trimester	65.7%					

Geographic Area: Owen County

Indicator	Title V	CAPTA	Head Start	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	10.8%					
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.2%					
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	Unstable					
Poverty -# residents below 100% FPL/total # residents (Children)	21.6%					
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000juveniles age 0-19					1.5%	Indiana State Police
Domestic violence -As determined by each State in conjunction with the State agencies administering the FVPSA					Unstable	
School Drop-out Rates -Percent high school drop-outs grades 9-12 -Other school drop-out rates as per State/local calculation method					2.0%	DOE
Substance abuse -Prevalence rate: Binge alcohol use in past month -Prevalence rate: Marijuana use in past month -Prevalence rate: Nonmedical use of prescription drugs in past month -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month					21%	Indiana Youth Institute
Unemployment -Percent: # unemployed and seeking work/total workforce					23.7%	Workforce Development
Child maltreatment -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) 17-Rate of reported substantiated maltreatment by type		27% (Neglect) 8% (Abuse)				
Percentage Prenatal Care 1 st trimester	70.3%					

Appendix B: Outcomes and Indicators Matrix

Intended Outcome	Data Indicators
Improved Maternal and Newborn Health	% low birthweight
	% preterm births
	% very low birthweight
	Rate of Infant Deaths
	Rate of Neonatal Deaths
	Rate of Post Neonatal Deaths
	% of women with late or no prenatal care
	% women smoking during pregnancy
	% women smoking during child bearing years
	% births to first time mothers
	Birth rates (10-14)/ Birth rates (15-19)
	% of pregnant women on WIC
	% of children on WIC
	% women using alcohol during pregnancy
	% women breastfeeding at discharge
	% of births to unmarried parents
	Child spacing
	% of births to first time mothers
	Rate of maternal Mortality
	% of children with special health care needs
% of women receiving treatment for depression through Medicaid	
Intended Outcome	Data Indicators
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	% of substantiated abuse
	% of substantiated neglect
	Infant Deaths due to neglect
	Rate of child fatalities due to abuse or neglect
	Asthma Hospitalizations Rate
	% of immunizations
	% of children receiving an EPSDT
	% of childhood obesity
	% of uninsured children
	Rate of unintentional injuries
Lead Poisoning Rates	
Intended Outcome	Data Indicators
Improvement in school readiness and achievement	% of B – 3 enrolled in Early Intervention
	% of 3-5 enrolled in Preschool Special Ed
	% of children enrolled in Early Head Start
	% of children enrolled in Head Start
	% of schools not meeting AYP

Intended Outcome	Data Indicators
	% of children in subsidized child care settings that participate in QRS
	Rate of high school dropouts
	% of children on wait lists for subsidized child care
	% of teens smoking (grades 9-12)
	% of teens report drinking alcohol(9-12)
	% of teens using marijuana (9-12)
	% of 4th graders passing their ISTEP test
	Truancy rate
Intended Outcome	Data Indicators
Reduction in crime or domestic violence	Rate of violent crime
	% of people arrested under 18
	Rate of property crime
	Rate of teens arrested for possession of drugs
	Rate of teens arrested for driving under the influence of alcohol
	Domestic violence
Intended Outcome	Data Indicators
Improvements in family economic self-sufficiency	% of children living in homes where head of household is unemployed
	% of children living in families with incomes under 100% of the poverty level
	% of children receiving free or reduced lunch
	% of families on food stamps
	% of high school dropouts
	% of women giving birth who are on public assistance
	% of children who are homeless
	% of adults with college education
	% of mothers without a high school degree
Intended Outcome	Data Indicators
Improvements in the coordination and referrals for other community resources and supports	% of children with primary care provider
	Medically underserved areas
	% women on Medicaid receiving prenatal care coordination
	% of families with ESL
	Health Professional Shortage
	Helpline calls
	Connect to help – United Way

Appendix C: Support Letters



Indiana State
Department of Health
An Equal Opportunity Employer

Mitchell E. Daniels, Jr.
Governor

Gregory N. Larkin, M.D., F.A.A.F.P.
State Health Commissioner

September 10, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Ms. Yowell:

As Indiana's state health commissioner, I continue to fully support Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. The Indiana State Department of Health, the state's Title V agency, is pleased to submit this Statewide Needs Assessment in collaboration with the Indiana Department of Child Services (DCS). Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the needs assessment methodology, and the identification of high risk communities.

The mission and vision statement of the Indiana State Department of Health includes achieving a healthier Indiana through focus on data-driven policy to determine appropriate evidence-based activities; evaluation activities to ensure measureable results, and collaboration with intra-agency program in policy-making and programming. I support the Statewide Needs Assessment and look forward to working with HRSA throughout this grant process.

Sincerely,

(b)(6)

STATE HEALTH COMMISSIONER

(b)(6)

The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.

Mitchell E. Daniels, Jr., Governor
(b)(6) Director



Indiana Department of Child Services

(b)(6)

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

September 16, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Ms. Yowell:

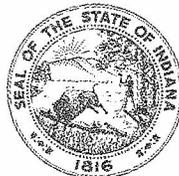
The Indiana Department of Child Services (DCS) is writing this letter to represent our continued support for the Maternal, Infant, and Early Childhood Home Visiting program of the Indiana State Department of Health (ISDH). DCS has worked diligently and collaboratively with ISDH concerning the required statewide needs assessment.

Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

DCS has been a long term collaborator with ISDH and is committed to partnering with ISDH for the Maternal, Infant, and Early Childhood Home Visiting program.

Sincerely,

(b)(6)



Protecting our children, families and future

Mitchell E. Daniels, Jr., Governor
State of Indiana



"People helping people help themselves"

Division of Mental Health and Addiction

(b)(6)

September 16, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

This letter is an expression of Indiana's Family and Social Service Administration Division of Mental Health and Addiction's (DMHA) continued support for the Maternal, Infant and Early Childhood Home Visiting program. DMHA has worked diligently and collaboratively on the required statewide needs assessment. Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

The Family and Social Services Administration Division of Mental Health and Addiction (DMHA), as the Single State Agency, supports the Indiana State Department of Health, Maternal and Child Health Division's (ISDH MCHD) partnership with the Indiana Department of Child Services (DCS) in their application submission for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. DMHA provides oversight to all mental health and addiction providers throughout the state of Indiana targeted by this application. We recognize the importance of collaboration among agencies to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The Department of Child Services has been a long term collaborator with DMHA. This initiative is another way in which we can work together to improve outcomes through the provision of home visiting services to at-risk children and families.

We are excited about working with DCS in this effort. Specifically, DMHA will be working with DCS to integrate/coordinate this initiative with the mental health and substance abuse providers in the state of Indiana.

Again, we are pleased to support DCS's application for the ACA Maternal, Infant and Early Childhood Home Visiting Program. If we can provide other input or comments, please do not hesitate to contact Gina Eckart, Director of the Division of Mental Health and Addiction at Gina.Eckart@fssa.in.gov.

Sincerely,
(b)(6)

Director





"People
helping people
help
themselves"

Susan E. Lightle, Director
Indiana Head Start State Collaboration Office

Indiana Family and Social Services Administration
402 W. Washington Street, W361
Indianapolis, IN 46204

September 13, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

This letter is an expression of the Indiana Head Start State Collaboration Office's continued support for the Maternal, Infant and Early Childhood Home Visiting program. IHSSCO has worked diligently and collaboratively on the required statewide needs assessment. Specific collaborative activities have included the collection and analysis of data across agencies, joint development of the methodology for conducting the needs assessment, and participation in the process to identify high risk communities.

The Indiana Head Start State Collaboration Office is pleased to continue partnering with the Indiana Department of Health, Maternal and Children's Health and fully supports their application for the ACA Maternal, Infant and Early Childhood Home Visiting Program. If we can provide other input or comments, please do not hesitate to contact me at 317-233-6837, susan.lightle@fssa.in.gov.

Best regards,

(b)(6)

(b)(6) Director

Indiana Head Start State Collaboration Office





State Profile

A SNAPSHOT OF HOW THE TITLE V MATERNAL AND CHILD HEALTH BLOCK GRANT WORKS IN YOUR STATE

Indiana

Maternal and Child Health Block Grant 2013

The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is the only federal program devoted to improving the health of all women, children and families. Title V provides funding to state maternal and child health (MCH) programs, which serve 44 million women and children in the U.S. To learn more about Title V, visit www.amchp.org.

MCH Block Grant Funds to Indiana

FY 2012	FY 2013 (Estimate)	Difference in Federal Funds*
\$11,565,001	\$12,182,378	\$617,377

Title V Administrative Agency:

Indiana State Department of Health
Health and Human Services Commission
Estimated State Funds, FY 2013: \$15,795,389

*States must provide a three dollar match for every four Federal dollars allocated.

Protecting and Improving the Health of Indiana's Families

Children with Special Health Care Needs — Children's Special Healthcare Services (CSHCS) is supported by Title V and State funds. The program provides a comprehensive continuum of medical and support services to children zero to 21 years old who are both medically and financially eligible. The system of care is a statewide, integrated network of providers that includes local, regional and tertiary care facilities. The services include reimbursement to providers for primary, medical, oral health and specialty care. Providers and families are supported through the CSHCS Care Coordination management system which is open to all CYSHCN in the state.

Integrated Services for Children & Youth with Special Health Care Needs (ISCYSHCN) —

Indiana's Child Health Improvement

Partnership, CHIP IN for

Quality, has been established to continue the work completed through the State Implementation Grants for Integrated Community Systems for CYSHCN. CHIP IN for Quality and its core partners have identified improved neurodevelopmental and behavioral health care as one of the top three health priorities needed for the state of Indiana's children. Indiana's CYSHCN Division is partnering with CHIP IN for Quality to improve developmental screening for Autism among pediatric providers in the state. Indiana's CYSHCN Division is also partnering with the Indiana Resource Center for Autism and the Indiana Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program to promote the *Learn the Signs. Act Early. Campaign* in collaboration with the Centers for Disease Control and Prevention and AMCHP around early screening and diagnosis. The initiative has produced a *Roadmap to Services* brochure that identifies the steps families should take if they are concerned their child has an Autism Spectrum Disorder. CHIP IN for Quality will be using the brochure and CDC materials to help educate the practices and the practice families.



Indiana was 1 of 4 states to recently receive a mini-grant through AMCHP, in conjunction with the National Center for Ease of Use of Community-Based Services, to create an Action Learning Collaborative (ALC) around Ease of Use of Services for Latino Families Who Have CYSHCN. Data from the National Survey of Children with Special Health Care Needs (2009-10) indicates that Latino families who have CYSHCN are less likely than their non-Latino counterparts to find services easy to use and often have unmet health care needs. It is our goal to create a strategic action plan and implementation schedule in order to address these issues. This will lead to an enhanced coordinated, comprehensive system of care for these families that is family-centered, linguistically and culturally competent, and that is outcome focused. The initiative is currently surveying families to identify their challenges in accessing the

Attachment C: Promoting Early Learning and Development Outcomes for Children
 services they need. Analysis of this data will help guide our strategic planning process.

Newborn Screening/Genomics — The Newborn Screening Program ensures that all infants born in Indiana are screened for 45 designated inherited disorders and hearing loss. The program also monitors and maintains a centralized program to ensure that children with positive newborn screens receive appropriate and timely confirmatory testing, follow-up services, family counseling, and support. In 2008, 99.99% of infants received a newborn screen and 100% of infants with positive newborn screens received appropriate follow-up care.

The mission of the Genomics Program includes assuring that all Indiana families have equal access to services and educating the public and health care providers about genetic disorders and available services. The goals of the Genomics Program are accomplished with the assistance of genetics services providers throughout the state. The Maternal and Child Health Block Grant partially supports the regional genetics centers. In 2009, a total of 5,932 families were served by the regional genetic centers.

Adolescent Health — With leadership from the Indiana State Department of Health, the Indiana Coalition to Improve Adolescent Health published the state's first adolescent health plan, *Picturing a Healthier Future*, in May 2009. The plan highlights ten health priorities (related to access to care or prevention issues) that impact the health and well-being of Hoosier adolescents. The plan is available on-line by visiting the Coalition's Web site at www.INadolescenthealth.org

Prenatal Substance Use Prevention — This program began in 1988 to help pregnant women quit their use of alcohol, tobacco and drugs during pregnancy. The program provides services in 23 of 92 counties in Indiana. Of the 4,545 pregnant women who participated in the program in 2007, 83.6 percent quit using alcohol, 46.1 percent stopped smoking, and 67.5 percent stopped using drugs.

The Sunny Start: Healthy Bodies, Healthy Minds Initiative — is a comprehensive, collaborative, statewide effort to support a coordinated system of resources and supports for young children from birth through age five and their families in Indiana. With funding from the Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems grant, the goal of the project is to ensure that Indiana's children arrive at school healthy and ready to learn.

addition, the MCH Block Grant provided direct services to the following individuals:

7,427	pregnant women
86,126	infants under one
42,632	children and adolescents
5,603	children with special health care needs
19,372	others
161,160	total served

*2011 State/Jurisdiction Annual Reports Submitted to the Maternal and Child Health Bureau

Health Needs in Indiana

- Decrease the percentage of high school students who become infected with an STI.
- Decrease the percentage of high school students who are obese.
- Increase capacity for promoting social-emotional health in children 0 – 5 years of age
- Decrease the percentage of children less than 72 months of age with blood lead levels greater or equal to 10 micrograms per deciliter.
- Decrease the rate of suffocation deaths of infants.
- Decrease the percentage of smoking for pregnant women (14 through 44) on Medicaid.
- Increase the percentage of black women (15 through 44) with a live birth whose prenatal visits were adequate.
- Increase the percentage of women who initiate exclusive breastfeeding.
- Decrease the percentage of preterm births.
- Decrease the percentage of births occurring within 18 months of a previous birth to the same mother.

People Served by the Indiana MCH Program*

Title V population-based preventive and systems building services benefit all women and children in the state. In





State Profile

A SNAPSHOT OF HOW THE TITLE V MATERNAL AND CHILD HEALTH BLOCK GRANT WORKS IN YOUR STATE

For more information, contact:

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Grants to Indiana*

Integrated Community Systems for CSHCN

INDIANA STATE DEPARTMENT OF HEALTH
Indianapolis, IN
\$300,000
(Integrated Community Systems for CSHCN)

State Implementation Grants for Integrated Community Systems for CSHCN

INDIANA STATE DEPARTMENT OF HEALTH
Indianapolis, IN
\$300,000
(State Implementation Grants for Integrated Community Systems for CSHCN)

Healthy Tomorrows Partnership for Children Program

INDIANA UNIVERSITY HEALTH, INC.
Indianapolis, IN
\$49,053
(Healthy Tomorrows Partnership for Children Program)

INDIANA STATE DEPARTMENT OF HEALTH DATA LINKAGE GRANT

INDIANA STATE DEPARTMENT OF HEALTH
Indianapolis, IN
\$25,083
(State Systems Development Initiative)

First Time Motherhood/New Parents Initiative

INDIANA STATE DEPARTMENT OF HEALTH
Indianapolis, IN
\$418,604
(First Time Motherhood/New Parents Initiative)

Family Professional Partnership/CSHCN

FAMILY TO FAMILY INC
Granger, IN
\$95,700
(Family Professional Partnership/CSHCN)

Leadership Education in Adolescent Health

TRUSTEES OF INDIANA UNIVERSITY
Indianapolis, IN
\$406,097
(Leadership Education in Adolescent Health)

Leadership Education in Neurodevelopmental and Related Disorders Training Program

TRUSTEES OF INDIANA UNIVERSITY
Indianapolis, IN
\$632,046
(Leadership Education in Neurodevelopmental and Related Disorders Training Program)

Leadership Training in Pediatric Nutrition

TRUSTEES OF INDIANA UNIVERSITY
Indianapolis, IN
\$188,090
(Leadership Training in Pediatric Nutrition)

Heritable Disorders

INDIANA STATE DEPARTMENT OF HEALTH
Indianapolis, IN
\$400,000
(Heritable Disorders)

*These grants were awarded in FY 2011. For a complete list of Title V Grantees:
<https://perfddata.hrsa.gov/mchb/TVISReports/Snapshot/SnapShotMenu.aspx>

ISDH State Repository – Integrated Data System (IDS)

The ISDH Integrated Data System (IDS) is an operational database that serves two purposes:

- 1.) Integrates **person** centric data from various agency data sources.
- 2.) Stores agency application **event and application** data (Data Store).

Person centric data sources are loaded into the IDS by automated and manual services to meet the Maternal and Child Health (MCH) objective of the Child Health Information Profile (CHIP).

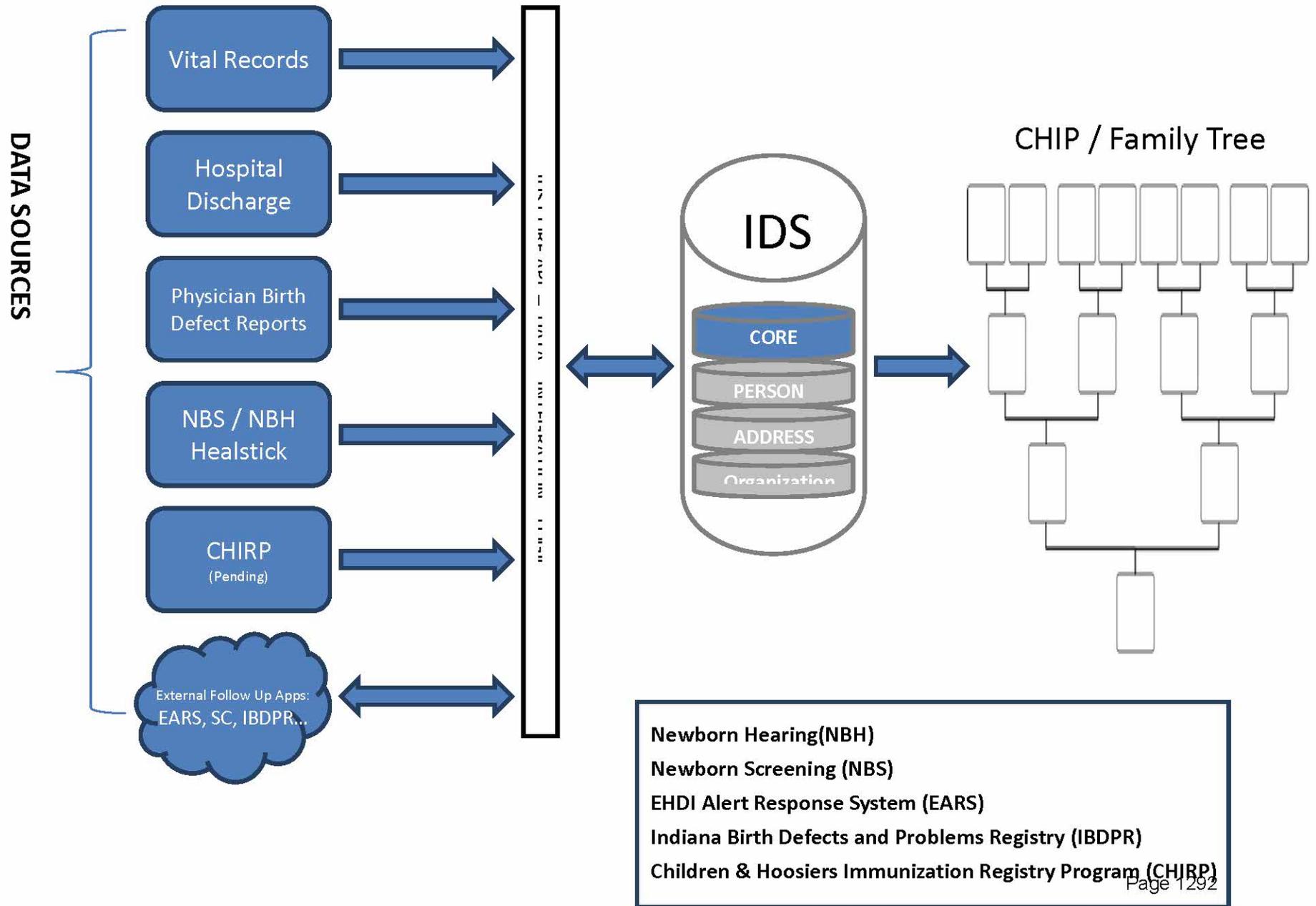
Current Data Sources:

- Vital Records Birth and Death
- Newborn Hearing and Newborn Screening
- Early Hearing Detection & Intervention
- Physician birth defect reporting
- Hospital discharge records
- Indiana Birth Defects and Problems Registry chart audits
- Notification of Pregnancy (NOP) – via Medicaid
- Immunizations – (work in progress)

Data Integration Benefits:

- Improves the state’s accessibility, quality, and timeliness of data by integrating data from multiple sources.
- Builds a more complete personal health profile for statistical and informatics purposes.
- Connects children with special health care needs to appropriate early intervention and health care services, as well as a medical home.
- Provides greater ability to analyze and disseminate information about the health status of Indiana residents.
- Enhances criminal investigations at Indiana Intelligence Fusion Center (IIFC) using the IDS Search “family tree / CHIP” web application.
- Provides Vital Records death certificate data to the Indiana State Police for traffic related deaths.

Child Information Health Profile (CHIP) and IDS Data Integration



ISDH Data Sources Stored in the State Repository Database

Early Hearing Detection and Intervention (EHDI) Program

The EHDI program is designed to help assure that children and families in our state receive the best possible care related to Universal Newborn Hearing Screening (UNHS). The main goals of the EHDI Program are to:

- Screen all babies by one month of age prior to discharge whenever possible,
- Provide diagnostic evaluations for all children not passing UNHS before three months of age,
- Enroll all children with confirmed hearing loss into early intervention by six months of age and
- Ensure that children with risk factors associated with delayed onset of hearing loss receive repeat testing between the ages of 9 and 12 months and every six months until age three.

The EHDI Alert Response System (EARS) has improved the overall functioning of the Early Hearing Detection and Intervention program. EARS, through its alert mechanism, enables the EHDI staff to communicate in a timely and effective manner with families, hospitals, First Steps early intervention system (Part C) personnel, audiologists, physicians, and EHDI programs in other states. All Indiana birthing facilities and audiologists (participating in EHDI) have been trained to use this system. The application allows users to utilize data within ISDH Repository to assess and improve current standards of care for Indiana children diagnosed with hearing screening, and expanding awareness and providing education related to EHDI to health care professionals and parents.

Indiana Newborn Screening (NBS)

Newborn screening is a special set of tests that help identify babies who are at risk for certain conditions. A newborn baby may look healthy, but can have a serious condition that cannot be seen. These conditions can be treated if found early.

Indiana's newborn screening law requires that every baby born in Indiana be tested for 47 conditions (including sickle cell anemia, cystic fibrosis, hearing loss, and critical congenital heart disease). Newborn screening must be done before the baby leaves the hospital. Babies born at home must have newborn screening within one week of birth.

The Indiana Newborn Screening Tracking and Education Program (INSTEP) application is a web-based application for collecting, managing, and sharing health information (including that related to short- and long-term follow-up outcomes) with improved access to

integrated, population-based, real-time data for state birthing facilities, primary care providers, state-contracted newborn screening follow-up care providers, and federal, regional, state, or local agencies. Like EARS, the application allows users to utilize data within ISDH Repository to assess and improve current standards of care for Indiana children diagnosed with newborn screening conditions, and expanding awareness and providing education related to INSTEP and newborn screening among health care professionals and parents.

Indiana Birth Defects and Problems Registry (IBDPR)

IBDPR collects information on birth defects and birth problems for all children in Indiana from birth to 3 years old (5 years old for autism and fetal alcohol syndrome). This information is used to determine the number of children born with birth defects, to plan intervention and prevention strategies, and to offer resources to families.

IBDPR is a population-based surveillance system designed to aid in the prevention of birth defects and childhood developmental disabilities and to enhance the quality of life of affected Indiana residents.

Birth defects are conditions present at birth that affect the structure or function of an infant's body. They can cause physical, mental, and medical problems. Some birth defects, such as cleft lip or club foot, are easy to observe, but others, such as heart defects, can only be identified using special tests such as echocardiograms. About one out of every 33 babies in the United States is born with a major birth defect. Birth defects are the leading cause of death in infants. Some of these defects are entirely preventable, while others could be identified early and treated or managed in order to improve the quality of life of affected infants and their families.

Data from the IBDPR is used to detect trends in birth defects and suggest areas for further study; to identify epidemiological factors associated with birth defects; to address community concerns about the environmental effects on birth outcomes; to evaluate education, screening, and prevention programs; and to establish efficient referral systems that provide special services for the children with identified birth defects and their families.

Children's Special Health Care Services (CSHCS)

Indiana Children's Special Health Care Services provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age, who meet the program's financial and medical criteria, pay for treatment related to their child's condition. More specific information is available by selecting from the menu tree on the left of this screen. If you have questions please contact us at 317-233-1351 or 1-800-475-1355, or via email at

Lead and Health Healthy Homes Program (ILHHP)

The mission of the Indiana Lead and Healthy Homes Program (ILHHP) is to eliminate the incidence of childhood lead poisoning in Indiana. This is being accomplished through screening for lead poisoned children, treatment of children who are lead poisoned, follow-up case management, and the remediation of the environmental causes of the disease.

Lead poisoning is a silent menace which often does not manifest itself until the damage is done. The disease can permanently and irreversibly damage the developing brains and other organs of young children. Serious effects can include lowered intelligence, behavior disorder, and slowed physical development. Once poisoned, a young child's chances for academic, social and occupational success are significantly diminished.

Deteriorated lead-based paint in the child's home environment is the primary source of lead poisoning. Young children, who are most vulnerable to the effects of lead poisoning, pick up lead dust from the floor and ingest it through hand to mouth activity. In recent years other sources of lead poisoning have come to light. Consumer products, such as children's toys or inexpensive jewelry, often imported from countries where there are few restrictions on the use of lead, have resulted in some notorious cases of lead poisoning and even death. Still, any child living in a house built prior to 1978 is at the greatest risk of lead poisoning. The older the home the more likely there is lead paint.

Other ISDH Baseline Core Data Systems

Indiana Vital Records

Real-time data pertaining to vital events information such as birth, death, and fetal death information. Birth information includes certain birth defects, and pregnancy and labor complications.

Indiana Immunizations

Real-time state database pertaining to child immunizations used to help protect all children from vaccine preventable diseases.

Indiana Disease Surveillance

The Indiana National Electronic Disease Surveillance System (I-NEDSS) is a web-based application that promotes the collection, integration, and sharing of data at federal, state, and local levels. The purpose of I-NEDSS is to automate the current process for reportable diseases. The system will include lab reports, communicable disease reports (CDR), and case investigations. Benefits of I-NEDSS include increased speed, accuracy, and accountability with reportable disease surveillance, since all reporting and investigation forms are accessed, completed, and submitted electronically.



INDIANA CORE KNOWLEDGE AND COMPETENCIES

First Edition, 2013

For all professionals serving infants,
toddlers, preschoolers, children, youth,
and their families

Welcome

The Indiana Early Care and Education and Youth Core Knowledge and Competencies (infants, toddlers, preschoolers, children, and youth) provides general direction for what educators need to know and be able to do in order to work effectively with children/ youth and their families. It also includes expectations for assessment and evaluation across five levels, from entry into the field to professionals with an advanced degree.

The Indiana Core Content plan is intended to be comprehensive and descriptive, but also fluid and flexible to allow needed changes over time. The plan is created to:

- Allow for multiple pathways for entering the field and for existing at various terminal points
- Include a mechanism for linking the various education and training programs
- Provide for continuous progress in professional development

Information about the Indiana Core Knowledge and Core Competencies content is available at www.childcarefinder.in.gov

History and Process of Indiana Core Knowledge and Competencies

In July 2011 the Indiana Family and Social Services Administration, Bureau of Child Care and Indiana Head Start State Collaboration Project formed a networking partnership of all early childhood professionals in Indiana. It was the goal of the network to bring to the table everyone who served the needs of young children/youth in the state. The partnership eventually became the Indiana Professional Development Network and developed the following Vision and Mission:

Vision

All professionals serving infants, toddlers, preschoolers, children, youth, and their families have the competence, skills and knowledge to prepare Indiana's next generation to thrive.

Mission

The Network coordinates, strengthens, and promotes a system of cross-sector partners and resources for the professional development, career advancement, and recognition of individuals serving infants, toddlers, preschoolers, children and youth.

In carrying out the vision, five sub-committees were formed: Credentials, Pathways and Qualifications, Core Knowledge and Competencies, Quality Assurance, Funding, and Systems Alignment. The Core Knowledge and Competency sub-committee met in July 2011 and identified seven core knowledge areas. These core knowledge areas were used as a starting point to research existing competencies for professionals working with young children and youth. Development of the first draft of Indiana Core Knowledge and Competencies was charged to the Indiana Professional Development Network (IPDN) leadership team in July 2012. The leadership team includes members from Indiana Association for Child Care Resource and Referral, Indiana Association for the Education of Young Children, Inc., Higher Education (2-year degree college and 4-year degree university), Indiana Department of Education,

Indiana First Steps, Infant/Toddler Specialists of Indiana, Head Start, Bureau of Child Care, School Age and Youth Development agencies and is funded by the Indiana Head Start Collaboration Office.

Primary resources have been the work done in Arkansas, Illinois, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New Mexico, Pennsylvania, and West Virginia on the Common Core Content, NAEYC's Guidelines for the Preparation of Early Childhood Professionals, the CDA Competency Manual, Foundations to the Indiana Academic Standards for Young Children Birth to Age 5, Indiana Youth Development Credential, Indiana Early Childhood Program Administrator Credential, Head Start Performance Standards, and Division of Early Childhood (DEC) Standards.

Feedback has been received from the IPDN subcommittee of Core Knowledge and Competencies and IPDN Leadership Team. IPDN members provided feedback on this document before publishing.

This document will be reviewed one year after the roll-out in April 2013.

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Introduction

Overview and History of Indiana Professional Development Systems

Indiana Professional Development System (IPDS)

In 1998, the Indiana Professional Development System (IPDS) was originally created to promote professionalism in the field of early care and education in Indiana. The early care and education community created IPDS to provide a way for people who work with children to get the credit they deserve. The IPDS stated that training counts when practitioners take the IPDS approved courses available through 2-and-4- year colleges, high schools and community organizations throughout Indiana. In addition, the IPDS career lattice offered certification at entry level and all professional levels.

Indiana Early Childhood Conference

The Indiana Early Childhood Conference is an annual event that brings together an average of 4,000 early childhood professionals. The three day event provides for presentations from experts on child development, early intervention, school readiness, effective communication between the school/child care center and home, sound money management strategies for child care centers and homes and more early childhood related topics.

Indiana Association for Child Care Resource and Referral

The Indiana Association for Child Care Resource and Referral has a long history of delivering high quality professional development experiences for the early childhood and school age care workforce. Since its incorporation in 1991, local, community based CCR&Rs have trained thousands of child care providers and assisted them in attaining their Child Development Associate (CDA) Credential. Training translates into both clock hours for CDA and continuing education units for CDA renewals. Local, community based agencies work with their local community colleges to create pathways from professional development activities into community college systems, and beyond.

Indiana Early Childhood Higher Education Forum (IECHEF)

IECHEF is an Indiana Association for the Education of Young Children, Inc. strategic group that works to:

- 1) increase networking and coordination among Indiana Early Childhood Higher Education professionals;
- 2) increase articulation across Indiana Early Childhood Higher Education programs for child development and teacher preparation;
- 3) discuss Early Childhood teacher licensure and make recommendations to policy makers;
- 4) collect and share information about Early Childhood Higher Education research and initiatives at the state and national levels; and
- 5) advocate for best practices in the preparation of Early Childhood professionals Early Childhood teacher licensure.

In 2009, the IECHEF recommended NAEYC's core competencies be used to plan and implement early childhood teacher preparation programs in Indiana colleges and universities.

Indiana Non-Formal CDA Project

In 2004, the Indiana Association for the Education of Young Children, Inc. received financial support from the Indiana Family and Social Services Administration, Division of Family Resources, and the Bureau of Child Care to support the Indiana Non-Formal CDA Project. The Indiana Non-Formal CDA Project helps to improve the quality of child care by increasing the education and skills of providers through attainment of the Child Development Associate (CDA) Credential. The CDA is a national credential which indicates that individuals are prepared to meet the specific needs of children by nurturing their physical, social, emotional, and intellectual growth. Credentials received through the Indiana Non-Formal CDA Project articulate 9 college credits into the community college associate degree. An exemplary feature of this project is that all instructors must meet or exceed specific competence and qualifications.

Indiana Department of Education - Indiana Vocational High School

In 2011, the Indiana Department of Education worked on education and human services career pathways ensuring that high school vocational students have four courses that aligned with the Indiana Ivy Tech Community College curriculum for 12 credit hours, and that these students would be eligible to apply for the CDA Credential.

Indiana First Steps

In 1986, Congress enacted P.L. 99-457 which mandated free public education for children 3-5 years and provided a new section which gave states an option to extend services to infants and toddlers (IDEA, Part H). Indiana created First Steps in 1987. The Indiana legislature enacted rules to develop and implement its early intervention system in 1994. Indiana's first child count in 1996 showed 4,379 children received services. In 1996, Indiana began development of a comprehensive professional development system. First Steps brought together leaders from early intervention, Indiana Department of Education, Indiana University-Indiana Institute on Disability and Community, Indiana State University-Bloomberg Center, Riley Child Development Center, In*Source, the Indiana Parent Information Network (now About Special Children-ASK) and others to develop a comprehensive and coordinated system of professional development, which became known as the Unified Training System (UTS). In 1997, a centralized UTS Connect Office and Early Childhood Meeting Place was established to assist in locating and registering for training. Soon after, Indiana First Steps developed a provider credentialing system in which providers are required to submit initial and annual documentation of related early intervention education and experiences. Today, Indiana First Steps offers an online registration, training and learning management system through UTS. Indiana was awarded a General Supervision Enhancement Grant (GSEG) from the Office of Special Education in April of 2006. The GSEG project performed alignment and validation studies of the Indiana Standards Tool for Alternate Reporting (ISTAR) for infants through pre-school to provide Indiana a comprehensive assessment system for children from birth through graduation. The project result was the ISTAR-KG which measures skills in children from infancy through kindergarten. Designed for use with all children, the ISTAR-KG is also used in over 100 early childhood centers.

Indiana Youth Development (IYD) Credential

The Indiana Youth Development Credential Core Competencies outline the best practices for individuals who work with children/youth. Individuals who earn an IYD Credential are able to demonstrate skills, knowledge, and implementation abilities in a specific program setting. The IYD Credential established a common ground that all personnel who work with children/youth need a common set of skills, knowledge and abilities or competencies no matter what program area they serve. Based on this idea the IYD Credential process was initiated by the Indiana School-Age Consortium (ISAC) in the fall of 2003. On January 1, 2007 ISAC became the Indiana YouthPRO Association.

Paths to QUALITY™ Provider Resources Professional Development Subcommittee

In 2008, Indiana launched its quality rating and improvement system, Paths to QUALITY™ (PTQ). PTQ is built on the licensing regulations at Level 1 and includes the requirements for increased professional development and the completion of a CDA Credential or the equivalent. One of the PTQ subcommittees is Provider Resources Professional Development (PRPD). This subcommittee was charged to meet two objectives: 1) to coordinate professional development resources to support Paths to QUALITY™, during the rollout period, and 2) to design, implement and evaluate a long term comprehensive professional development system that supports Paths to QUALITY™ for early care and education providers. This subcommittee became known as the Indiana Professional Development Network, created in 2011.

Indiana Professional Development Network

The Indiana Early Childhood Professional Development Network has a strong commitment to expand the Indiana professional development system beyond the traditional settings of early care and education to all settings where professionals care and educate children/youth and families. The Indiana Early Childhood Professional Development Network encompasses and supports those working with children from birth through age 18 in a variety of community-based settings, including center-based and family child care, out-of-school time programs, and home visiting programs. The network has historically provided training and support for professionals serving children/youth from birth through age 13 in early care and education settings. The network has now expanded to include youth professionals working with school age youth up to age 18 and those working in out-of-school time and school-based programs. Therefore, as Indiana early care and education and youth development core knowledge and competencies are written, the term *early care and education and youth development* will emerge. Early care and education and youth development serves as a marker for staff from programs involved in the Indiana Professional Development Network.

Infant-Toddler Specialists of Indiana (ITSI)

The need for high quality child care, education, and early intervention services for Indiana children birth to 3 years has increased dramatically in the past 20 years. Yet the preparation of professionals who are qualified to plan and supervise services for infants and toddlers has lagged behind. Purdue University and Indiana University are working in partnership with the state of Indiana and other organizations to promote sharing and development of new resources for Indiana professionals who work with infants and toddlers in Indiana. The purpose of the Infant-Toddler Specialists of Indiana (ITSI) network is to

enhance existing resources and the professional identity of Infant-Toddler Specialists in Indiana. The initiative has created an ongoing statewide professional development network of infant toddler specialists - community leaders providing high quality services to infants, toddlers, and their families (<http://www.cfs.purdue.edu/ITSI/overview.php>).

T.E.A.C.H. Early Childhood® INDIANA

In 1998, the Indiana Association for the Education of Young Children (IAEYC) received financial support from the Indiana Child Care Fund to launch the T.E.A.C.H. (Teacher Education and Compensation Helps) Early Childhood® INDIANA Project. The T.E.A.C.H. Early Childhood® INDIANA Project serves as an umbrella for a variety of educational scholarship opportunities for professionals working in licensed, registered or exempt child care centers and homes in Indiana. Five scholarship models are currently available: the Child Development Associate (CDA) Training Scholarship, the Child Development Associate (CDA) Assessment Scholarship, the Child Development Associate (CDA) Renewal Scholarship, the Early Childhood Associate Degree scholarship, and the Bachelor Degree Scholarship.

Term Definitions

Early Childhood Education Professional Development

"...is a continuum of learning and support activities designed to prepare individuals for work with, and on behalf, of young children and their families, as well as ongoing experiences to enhance this work. These opportunities lead to improvements in the knowledge, skills, practices, and dispositions of early education professionals. Professional development encompasses education, training, and technical assistance ..."

(NAEYC/NACRRA PD Training and TA Glossary, 2011, p. 5)

The Early Childhood Education Workforce

"...includes those working with young children (infants, toddlers, preschoolers, and school-age children in centers, homes, and schools) and their families or on their behalf (in agencies, organizations, institutions of higher education, etc.), with a primary mission of supporting children's development and learning"

(NAEYC/NACRRA PD Training and TA Glossary, 2011, p. 5)

Youth development

"...the ongoing growth process in which all youth are engaged in attempting to (1) meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and (2) to build skills and competencies that allow them to function and contribute in their daily lives."

(Pittman, 1993, p. 8)

Early Care and Education

"...term that refers to educational programs and strategies geared toward children from birth to age eight. This time period is widely considered the most vulnerable and crucial stage of a person's life...it focuses on guiding children through play; the term often refers to preschool or infant/child care programs"

(National Research Council, 2001, p.231)

Document Design

This document allows for ***Specialty Core Knowledge and Core Competencies***; Indiana professionals who work with a specific age group or hold a specific position will use this document as a basis and be able to use their specialty core knowledge and core competencies; i.e. Indiana Youth Development Credential, Indiana Early Childhood Program Administrator Credential, Mental Health Specialists, Early Interventionists etc. In addition, this document will be reviewed by IPDN members annually to ensure current practices are included as they emerge in the field.

In this document, glossary references will be marked in the following way: ⁶¹. This refers to the glossary reference number 1. The Glossary can be found on page 59.

Indiana Core Knowledge and Competencies Guiding Principles

(Adapted from the National after School Association Core Knowledge and Competencies)

The goal of this document is to create a framework that:

- Applies to professionals working in a variety of settings and positions
- Applies to professionals working with infants, toddlers, preschoolers, school age and youth
- Is based on current research
- Reflects the field

The Need for Core Knowledge and Core Competencies

Core knowledge and competencies (CKCs) refers to the expectations for what the workforce should know (content) and be able to do (skills) in their role working with and/or on behalf of children and their families. Indiana does not have a cross-sector foundation of core knowledge and core competencies for professionals working with children/youth.

- Core knowledge and competencies define a range of knowledge and competency skills that professionals need to possess to be able to provide high quality early care and education and youth development (infants, toddlers, preschoolers, children and youth) and facilitate child/youth learning and development
- Core knowledge and competencies serve as foundations for decisions and practices carried out by professionals in all settings of early care and education and youth development (infants, toddlers, preschoolers, children and youth)
- Core knowledge and competencies provide guidelines for education, coursework and training programs in meeting the needs of professionals in the field of early care and education and youth development (infants, toddlers, preschoolers, children and youth)
- Core knowledge and competencies serve to support the identification and delivery of high quality, comprehensive, coordinated, and family-centered services and supports that help all children reach their full potential (DEC, 2007)
- Core knowledge and competencies serve as a means for incorporating new research findings and knowledge into practice in early care, education and youth development (infants, toddlers, preschoolers, children and youth)
- Core knowledge and competencies establish a set of standards for early care and education and youth development (infants, toddlers, preschoolers, children and youth) that promotes recognition of the significance and professional nature of the field

Different Ways to Use Core Knowledge and Competencies

(Adapted from Minnesota Competencies for School age and Early Childhood, Kentucky Early Childhood Core Knowledge, Michigan Early Childhood Core Knowledge and Kansas Core Knowledge)

For Professionals, Teachers, Practitioners

- Indiana early care and education and youth development professionals will use core knowledge and competencies to self-assess levels of knowledge and skill in each of the eight content areas

- Indiana early care and education and youth development professionals will use core competencies to self-identify specific areas for future professional development (training and education needs)

For Directors, Program Administrators

- Indiana early care and education and youth development directors and program administrators will use core knowledge and competencies to create job descriptions and performance review instruments
- Indiana early care and education and youth development directors and program administrators will use core knowledge and competencies to specify education and training requirements for staff positions
- Indiana early care and education and youth development directors and program administrators will use core knowledge and competencies to guide, plan, and implement pre-service training for staff
- Indiana early care and education and youth development directors and program administrators will use core knowledge and competencies to develop staff education and training plans and policies
- Indiana early care and education and youth development directors and program administrators will use core knowledge and competencies to establish a salary scale based on levels of competency achieved by employee
(NAEYC/NACRRA PD Training and TA Glossary, 2011)

For Paths to QUALITY™

- The Standards for Paths to QUALITY™ provide a basis for the core knowledge areas; connecting these standards to all levels of the core knowledge and core competencies supports a continuum of professional growth and development
- The core knowledge and competencies provides a basis for what individuals providing early care and education experiences should know and be able to do. This critical alignment can support practitioners in attaining education that supports their abilities to plan and to implement higher quality early care and education and youth development environments and experiences

For Trainers, Mentors, Coaches, Technical Assistance (TA)/Training Organizations

- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will use core knowledge and competencies to plan and organize training and education to meet specific and consistent competencies
- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will use core knowledge and competencies to promote training and education opportunities that meet specific and consistent competencies
- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will design professional development using evidence-based best

practices, consistent with the principles of adult learning, and structured to promote linkages between research, theory, and practice

- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will design professional development that addresses the continuum of young children's abilities and needs
- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will design professional development responsive to each learner's background (including cultural, linguistic, and ability), experiences, and the current context of her role and professional goals.
- Indiana early care and education and youth development trainers, mentors, coaches and TA/training organizations will design professional development that includes resources to ensure access for all

For Higher Education Faculty, Staff, and Administrators

- Indiana early childhood and youth development higher educators will use core knowledge and competencies to coordinate and design course content to facilitate transfer of credits and articulation agreements
- Indiana early childhood and youth development higher educators will use core knowledge and competencies to assess and modify programs' current content

For State and Local Agencies

- Indiana Professional Development Network will use core knowledge and competencies to create the framework for a broad-scale career development system that provides access to competency-based training/education, ensure compensation commensurate with educational achievement and experience, and allows professionals to achieve recognition in the field (National After School Association)
- Indiana early care and education and youth development agencies will use core knowledge and competencies to develop and implement policies that will enhance professionalism in the field
- Indiana early care and education and youth development agencies will use core knowledge and competencies to link core competencies to efforts to support success of each child at each early care and education program/school age/youth program
- Indiana early care and education and youth development agencies will use core knowledge and competencies as one tool to assess the quality of the early childhood education and care system and youth development system
- Indiana early care and education and youth development agencies will promote use of core knowledge and competencies across programs, agencies, and higher education
- Indiana early intervention services will use core knowledge and competencies as a basis for the establishment of the early intervention credential process, which is a professional portfolio of academic degrees, experience, and professional development

Definitions of Core Knowledge Areas

Research states that prepared professionals must have knowledge about: child development and learning; the traits of the individual child, including strengths, interests, approaches to learning, and abilities based on prior experiences; and the social and cultural contexts in which a child lives (NAEYC, 2009). Indiana Core Knowledge and Competencies are driven from research, and evidence suggests they are important for the workforce to know and be able to do.

1) **Child/Youth Growth and Development:**

This area describes the extent to which an early care and education and youth development professional is expected to provide experiences for any child/youth, regardless of age. Experiences must be planned around the child's/youth's developmental abilities. A professional must understand how children/youth acquire language and develop physically, cognitively, emotionally and socially and demonstrate basic understanding of normative (or typical) patterns of development, as well as common delays and disabilities.

2) **Health, Safety and Nutrition:**

This area describes the extent to which an early care and education and youth development professional is expected to provide an environment for the overall physical and psychological well-being of all children/youth and adults. Professionals must adhere to relevant laws and regulations; furthermore establish and maintain an environment that ensures children's/youth's health, safety, and nourishment needs are met.

3) **Child/Youth Observation and Assessment^{G1} * to Meet Individual Needs:**

This area describes the extent to which an early care and education and youth development professional is expected to use ongoing assessment to help evaluate all areas of a child's/ youth's growth and development. Professionals must be able to observe, document, assess, interpret children's/youth's skills and behavior, and to set goals for the child with other staff and family members. A professional must be able to observe and assess what children/youth know and can do in order to provide curriculum and plan instruction and services that address their developmental and learning goals. All professionals working with child/youth and family work collaboratively to enhance development and inclusion in the family, classroom and community, i.e. provide therapeutic intervention.

4) **Learning Environment and Curriculum^{G7}:**

This area describes the extent to which an early care and education and youth development professional needs to understand and utilize strategies that are characteristic of high quality environments, such as consistent scheduling and routines, transition between activities and settings^{G24}, provision of interesting materials and activities appropriate for age groups and how to arrange environments to enhance children's/youth's learning. A professional must know, understand, be familiar with, and be able to implement a variety of developmentally appropriate curriculum models to prepare young children/youth for school.

* ^{G1} refers to glossary reference number 1. See Glossary on page 59 for definition

5) Developmentally Appropriate Content:

This area describes the extent to which an early care and education and youth development professional needs to provide and create materials that demonstrate acceptance of all children's/youth's age, gender, race, language, culture and special needs. A professional must incorporate, to the greatest possible extent, native language and linguistically diverse routines relative to individual children/youth and families.

6) Family⁶⁹ and Community Partnership:

This area describes the extent to which an early care and education and youth development professional must know and understand that the family and community are integral to each child's/youth's optimal learning and development. A professional knowledge and understanding of diverse family structures and influences will enable the support of individual children/youth and families in positive ways. A professional must be able to build respectful and reciprocal relationships with families, as well as know how to provide meaningful family and community involvement. A professional must be aware of community resources and opportunities, and know how to make collaborative connections to benefit children/youth and families.

7) Management and Administration:

This area describes the extent to which an early care and education and youth development professional understands the importance of personal interactions and leadership in creating a nurturing environment for children/youth and adults. They understand that effective leadership across systems⁶²⁵ in early care and education and youth development is based upon strong caring relationships fostered between and among all involved. A professional must understand effective management of human and financial resources, and understand and be able to use principles of effective supervision. Professionals must know regulations, policies, and quality standards that apply to the program and how to organize, evaluate, and implement regulations and standards that enable a quality environment.

8) Professionalism:

This area describes the extent to which an early care and education and youth development professional knows and uses ethical guidelines and other professional standards related to his/her practice. A professional must be a continuous collaborative learner who demonstrates and shares knowledge, reflects on and has a critical perspective of his/her work, makes informed decisions, and integrates knowledge from a variety of sources. A professional must be a role model and advocate for best educational practices and policies.

Each Core Knowledge Area has three to six core competency areas. Each of these competency areas is divided into five levels that follow a progression of knowledge, skills, and abilities. The levels build on one another, with the intent that a person working on competencies at Level 3 has already mastered the competencies at Levels 1 and 2. These levels of competencies are not credentials or certificates, but may complement existing certificates or credentials.

Levels of Core Competencies

Professional practices develop over time with experience, training, and higher education. In recognition of this progression, the competencies are grouped by level in each core knowledge content area. Each level is a prerequisite to the next, with knowledge and skill development generally progressing from knowing and following practices to planning and implementing activities and procedures to eventually analyzing and evaluating programs and practices. However in some instances, skills and knowledge are not completely linear and not all begin at the entry level, so some skills may seem similar across different levels (adapted from the *National after School Association & Indiana Professional Development System "IPDS"*).

Level 1 (Pre-entry Level Credentials; i.e. CDA, IYD, etc.)

Level 1 includes the knowledge and skills expected for a practitioner new to the early care and education and youth development field with minimal specialized training or education. In this level, professionals are developing an awareness of Core Content Knowledge Areas. Competence may be reflected by knowledge, skills and abilities such as: recognize, observe, encourage, and support learning environment and experiences.

Level 2 (Entry Level Credential; i.e. CDA, IYD, etc.)

Level 2 includes the knowledge and skills of Level 1 plus knowledge and skills commensurate with Child Development Associate (CDA) Credential, CDA Process Certificates, IYD Credential or equivalent training, education, and relevant experience. Professionals are able to articulate Core Content Knowledge Areas. Competence may be reflected by knowledge, skills and abilities such as: describe, discuss, explain, and interpret learning environment and experiences.

Level 3 (Associate Level in early childhood/child development/youth development, human services or appropriate field)

Level 3 includes the knowledge and skills of Levels 1 and 2 plus knowledge and skills commensurate with an associate degree in early childhood education or child development or human services or youth development and experience working with infants, toddlers, preschoolers, children, and youth. Professionals are able to apply Core Content Knowledge areas. Competency may be reflected by knowledge, skills, and abilities such as: demonstrate, implement, and apply learning environment and experiences.

Level 4 (Bachelor Level in early childhood/child development/youth development, human services or appropriate field)

Level 4 includes the knowledge and skills of Levels 1, 2 and 3 plus knowledge and skills commensurate with a bachelor degree in early childhood education or child development or human services or youth development and experience working with infants, toddlers, preschoolers, children, and youth. Professionals are able to analyze and create based upon Core Content Knowledge Areas. Competency may be reflected by knowledge, skills and abilities such as: developing, creating, and modifying learning environment and experiences.

Level 5 (Masters and Beyond in early childhood/child development/youth development, human services or appropriate field)

Level 5 includes the knowledge and skills of Levels 1, 2, 3 and 4 plus knowledge and skills commensurate with an advanced degree in early childhood education or child development or human services or youth development and extensive experience working with infants, toddlers, preschoolers, children, and youth. Professionals are able to judge and advocate for Core Content Knowledge Areas. Competence may be reflected by knowledge, skills, and abilities such as: assess, advocate, and ensure learning environment and experiences.

Aligning Indiana Core Knowledge and Competencies to Indiana Common Core Academic Standards

Development of the Indiana Core Knowledge and Core Competencies is based on alignment with Indiana Common Academic Standards. This system alignment will create clarity for teachers and professionals and seamless transitions for students. The early care and education and youth development program , K-12, and higher education communities in Indiana must collaborate to create aligned, coherent systems that demonstrate a logical progression of learning that prepares all students for success (see Crosswalk Section, Table 5).

Core Knowledge Areas

Core Knowledge 1 Area: Child/Youth Growth and Development

This area describes the extent to which an early care and education and youth development professional is expected to provide experiences for any child/youth, regardless of age. Experiences must be planned around the child's/youth's developmental abilities. A professional must understand how children/youth acquire language and develop physically, cognitively, emotionally and socially and demonstrate basic understanding of normative (or typical) patterns development, as well as common delays and disabilities

Competency A: Demonstrate understanding of development, growth, and learning of children/youth and how to connect knowledge to developmentally appropriate practices for the specific age group.

Competency B: Demonstrate knowledge of how children/youth differ in their development and learning styles and use this knowledge to support development and learning of individual children/youth.

Competency C: Demonstrate knowledge of the interaction between development and environmental factors⁶⁸ such as physical, social, psychological and cultural factors⁶⁶ on healthy growth and development of the child/youth.

Child/Youth Growth and Development	
Competency A: Demonstrate understanding of development, growth, and learning of children/youth and how to connect knowledge to developmentally appropriate practices for the specific age group	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize how children/youth develop including the roles of both growth and learning in their development <input type="checkbox"/> Observe children/youth of various ages and describe general characteristics of children's/youth's growth and development <input type="checkbox"/> Recognize the specific children's/youth's developmental domains: physical, social, emotional, language, and cognitive development
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Observe and be able to describe major milestones, typical behaviors and general learning processes for children or youth with respect to familial backgrounds <input type="checkbox"/> Provide opportunities to support children's /youth's physical, social, emotional, language, and cognitive development <input type="checkbox"/> Use Foundations to the Indiana Academic Standards for Young Children from Birth to Age 5 and the Indiana Afterschool and Youth Development Standards.
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Apply knowledge of developmental stages, processes and theories of child/youth development and learning as the basis for planning decisions and implementing practices in setting and program <input type="checkbox"/> Explain the connection between theory and practice in early childhood education or youth development
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Create programs that are developmentally appropriate for each child, youth and family utilizing personal observation of individual children/youth and families, professional experiences and recognized theories of child/youth growth and development as the basis for all planning decisions and implantation of practices
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate and revise programs and services that are optimally appropriate for all children/youth and families by utilizing critical analysis of observations, experiences, learning and current research theories in child and youth growth and development as the basis for planning decision-making and implementation of practices

Child/Youth Growth and Development	
Competency B: Demonstrate knowledge of how children/youth differ in their development and learning styles and use this knowledge to support development and learning of individual child	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize differences and similarities in abilities and skills in children's/youth's developmental domains within each individual child and among children <input type="checkbox"/> Recognize variability in children's/youth's learning styles and recognize how these variances impact children's/youth's participation in program
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate an understanding of children's/youth's varying patterns of growth and development <input type="checkbox"/> Interpret the differences in abilities and skills of children/youth <input type="checkbox"/> Recognize the role of the professional in providing appropriately supportive learning environments <input type="checkbox"/> Describe and discuss how differences in abilities and skills require a variety of responses from professionals and environments
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Structure learning experiences to accommodate the individual child's/youth's varying patterns of growth and development <input type="checkbox"/> Implement learning environments and projects supportive of the development of children/youth with different learning needs and styles
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Develop programs that encourage a holistic approach in supporting the development of all learning styles <input type="checkbox"/> Design learning experiences to enhance the development of the individual child's/youth's unique abilities <input type="checkbox"/> Create learning environments based on observation and assessment, which stimulate the optimal development of children/youth to display a wide range of abilities
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate the effectiveness of experiences intended to enhance the development of the individual child's/youth's unique abilities and recommend changes as needed <input type="checkbox"/> Assess the effectiveness of learning environments in stimulating the optimal development of children/youth who display a wide range of abilities <input type="checkbox"/> Advocate to the larger community the need for programs that implement the adoption of appropriate approaches that support optimal development of all learning

Child/Youth Growth and Development	
Competency C: Demonstrate knowledge of the interaction between growth and environmental factors⁶⁸ such as physical, social, psychological and cultural factors on healthy growth and development of the child/youth	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize that there are growth and environmental factors that will contribute to and influence the development of the child/youth <input type="checkbox"/> Recognize some specific environmental factors that support healthy growth and development of children/youth
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Describe how various growth and environmental factors might interact and influence children's/youth's healthy growth and development <input type="checkbox"/> Discuss ways to influence the effects of these factors to promote healthy growth and development of children/youth <input type="checkbox"/> Utilize knowledge of how growth and environmental factors can support positive interactions and influences and reduce negative behaviors
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Understand and use knowledge of the interplay of genetics⁶⁹ and environment in practice (nature/nurture) in brain development <input type="checkbox"/> Transfer knowledge of developmental and environmental factors that contribute to and influence the development of each child/youth to the planning of programs and management of groups of children/youth <input type="checkbox"/> Share knowledge with families about the influence of growth and environmental factors on healthy growth and development of children/youth
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Modify learning environments to support positive interactions and influences and reduce negative factors <input type="checkbox"/> Design programs based on knowledge of maturational and environmental factors to support healthy growth and development of children/youth <input type="checkbox"/> Educate families to foster healthy growth and development of each child/youth
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Research and evaluate activities that influence the interaction between growth and environmental factors <input type="checkbox"/> Inform the larger community about issues related to growth and environmental factors that affect the healthy growth and development of children/youth <input type="checkbox"/> Advocate for practices that promote positive interactions and influences from growth and environmental factors

Core Knowledge Area 2: Health, Safety and Nutrition

This area describes the extent to which an early care and education and youth development professional is expected to provide an environment for the overall physical and psychological well-being of all children/youth and adults. Professionals must adhere to relevant laws and regulations; furthermore establish and maintain an environment that ensures children's/youth's health, safety, and nourishment needs are met.

Competency A: Demonstrate knowledge of child/youth abuse and neglect, safety routines and regulations, health routines and regulations, and nutrition routines and regulations.

Health Safety and Nutrition	
Competency A: Demonstrate knowledge of child/youth abuse and neglect, safety routines and regulations, health routines and regulations, and nutrition routines and regulations	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Follow regulations and best practices regarding health, safety and sanitation across settings⁶²³ <input type="checkbox"/> Verbalize and use procedures for supervising children's/youth's activities to prevent illness and injury <input type="checkbox"/> Follow proper techniques for preventing communicable diseases, including hand washing, diapering, cleaning and sanitizing <input type="checkbox"/> Follow regulations/written policies to administer medications <input type="checkbox"/> Perform a daily health check⁶¹² and identify potential health concerns <input type="checkbox"/> Follow and communicate basic principles of oral health care with children/youth <input type="checkbox"/> Follow and practice healthy sleep practices for children/youth <input type="checkbox"/> Follow procedures for emergencies including first aid and CPR <input type="checkbox"/> Identify, document, and report suspected child/youth abuse and neglect to appropriate person/staff/agency <input type="checkbox"/> Follow regulations for appropriate response to, and documentation of, children's/youth's injuries <input type="checkbox"/> Monitor safe use of indoor and outdoor equipment by children/youth <input type="checkbox"/> Follow procedures for the following situations: fire, tornado, earthquake and manmade disaster <input type="checkbox"/> Recognize USDA guidelines for nutrition⁶²⁶ <input type="checkbox"/> Follow regulation for food storage, preparation, serving and clean-up <input type="checkbox"/> Support implementation of plans such as Individual Family Service Plan (IFSP)⁶¹⁶, Individual Educational Plan (IEP)⁶¹⁵ for children/youth with developmental, emotional and/or physical health care concerns or needs
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Describe and check for safe environments and potential health hazards <input type="checkbox"/> Describe and participate in techniques and strategies that support physical and emotional health of children/youth and professionals that work with them <input type="checkbox"/> Identify indicators of potential mental and physical health problems and report indicators to supervisor <input type="checkbox"/> Use basic nutrition concepts and follow recommendations of the USDA guidelines for nutrition <input type="checkbox"/> Implement with supervision, appropriate feeding⁶¹¹ procedures that include adaptations for cultural preferences and special needs <input type="checkbox"/> Identify current health trends in society using research-based knowledge and information

<p>Level 3 All items in Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Apply health promotion concepts in children/youth and staff through health, safety and nutrition practices <input type="checkbox"/> Participate in planning for special health needs <input type="checkbox"/> Implement in consultation with health personnel daily health checks for identification of health concerns <input type="checkbox"/> Implement in consultation with health personnel, appropriate procedures for documenting children/youth injuries <input type="checkbox"/> Develop procedures for storing, administering, and documenting use of medications <input type="checkbox"/> Implement in consultation with health personnel, appropriate procedure for a comprehensive oral health care program <input type="checkbox"/> Develop a written plan for responding to emergencies for children/youth who have been identified as having special health needs and react appropriately <input type="checkbox"/> Create menu plans for children including children/youth with special dietary concerns, that are age appropriate and meet USDA guidelines for nutrition <input type="checkbox"/> Identify nutritional issues appropriate to the age and special needs of children/youth including feeding procedures, food choices and amounts, and cultural preferences
<p>Level 4 All items in Level 1,2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Design and implement health, safety, and nutrition education for families, children/youth and staff <input type="checkbox"/> Implement appropriate health assessments and recommend referral and ongoing follow-up to appropriate community and health services <input type="checkbox"/> Develop, or update as needed, health, safety, nutrition, and sanitation policies and procedures <input type="checkbox"/> Collaborate with specialists and families to develop and implement plans such as Individual Family Service Plan (IFSP), Individual Educational Plan (IEP) for children/youth with developmental, emotional and/or physical health care concerns or needs <input type="checkbox"/> Incorporate appropriate practices into program in response to current health trends
<p>Level 5 All items in Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Collaborate with advisory groups or other community groups to identify health, safety, nutrition, and sanitation issues that impact children/youth <input type="checkbox"/> Analyze, evaluate, and apply current theory and research to health, safety, nutrition and sanitation policies, procedures, and practices

Core Knowledge Area 3: Child/Youth Observation and Assessment to Meet Individual Needs

This area describes the extent to which an early care and education and youth development professional is expected to use ongoing assessment to help evaluate all areas of a child's/youth's growth and development. Professionals must be able to observe, document, assess, interpret children's/youth's skills and behavior, and to set goals for the child with other staff and family members. A professional must be able to observe and assess what children/youth know and can do in order to provide curriculum and plan instruction and services that address their developmental and learning goals. All professionals working with child/youth and family, work collaboratively to enhance development and inclusion in the family, classroom and community, i.e. provide therapeutic intervention

Competency A: Demonstrate ability to use ongoing assessment to help evaluate all areas of a child's/youth's growth and development which include:

- knowledge of children/youth with special needs including disabilities, developmental delays, emotional disorders and special abilities
- knowledge of observation techniques, collecting information, and documenting child's/youth's development, interests, and particular ways of responding to people and events
- knowledge of appropriate record keeping on individual children's/youth's development and behavior that safeguard confidentiality and privacy
- understanding and use of formal and informal screening and assessment of children/youth
- Understanding of the influence of environmental factors, cultural and linguistic differences, and different ways of learning on assessment outcomes

Competency B: Demonstrate knowledge of approaches to involve and collaborate with family members in assessing child's/youth's development, strengths and needs, to set goals for children/youth

Competency C: Demonstrate knowledge of enhancing development and inclusion in the family, classroom and community

Child/Youth Observation and Assessment to Meet Individual Needs	
Competency A: Demonstrate ability to use ongoing assessment to help evaluate all areas of child's/youth's growth and development	
<p>Level 1</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize that each child/youth develops at her/his own rate <input type="checkbox"/> Assist with collection of information about each child's/youth's development <input type="checkbox"/> Raise concerns about child's/youth's development to supervisors <input type="checkbox"/> Maintain confidentiality between the program and families regarding each child's/youth's observation and assessment <input type="checkbox"/> Follow appropriate use of techniques for assessing children/youth (observation and anecdotal records⁶¹⁸)
<p>Level 2</p> <p>All items on Level 1, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Use appropriate assessment tool for age group <input type="checkbox"/> Participate with supervision in developmental screening and classroom/instructional assessment of children's/youth's social, emotional, physical, communicative, and cognitive development <input type="checkbox"/> Observe, collect, and record information about children/youth across all areas of development and their families in a non-judgmental and unbiased manner <input type="checkbox"/> Model and implement appropriate methods for assessment for children's/youth's social/emotional, physical, communication and cognitive development
<p>Level 3</p> <p>All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure the collection and recording of information about children/youth <input type="checkbox"/> Establish criteria, procedures, and documentation methods for assessment that is systematic, multidisciplinary, and based on everyday tasks <input type="checkbox"/> Plan for, and supervise the children's/youth's assessment on social/emotional, physical, communication, and cognitive development domains
<p>Level 4</p> <p>All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Integrate informal assessment information with formal assessment data <input type="checkbox"/> Ensure that authentic⁶² procedures have been used during assessment <input type="checkbox"/> Select, create, adapt and use multiple models and methods of assessment that are sensitive to the unique cultural and learning needs of each child/youth <input type="checkbox"/> Select, administer, and evaluate instruments and procedures for a continuous assessment system, based on program goals and compliance with established criteria and standards, taking into consideration special exceptions

<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"><input type="checkbox"/> Communicate major theories, research, and issues relevant to observation and assessment<input type="checkbox"/> Ensure the selection and administration of assessment instruments and procedures for a continuous assessment system based on program goals and established criteria and standards
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Child/Youth Observation and Assessment to Meet Individual Needs	
Competency B: Demonstrate knowledge of approaches to involve and collaborate with family member in assessing child's/youth's development, strengths and needs, to set goals for children/youth	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Participate as a team member in planning, coordinating and implementing assessment procedures
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Collect and maintains records from appropriate assessment sources concerning progress in growth, health, and behavior in each area of development <input type="checkbox"/> Participate and collaborate as a team member with other professionals in conducting family-centered assessments for all children/youth, including children/youth with exceptional learning needs <input type="checkbox"/> Communicate assessment information to families
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Involve families in assessing and planning for all children/youth
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Collaborate with appropriate personnel in the administration of assessments <input type="checkbox"/> Promote and demonstrate team collaboration in planning, coordinating, implementing, and evaluating assessment procedures <input type="checkbox"/> Serve as a team member in implementing and evaluation IFSPs, IEPs, and other plans <input type="checkbox"/> Assist families in identifying resources, priorities, and concerns related to their child's/youth's development <input type="checkbox"/> Communicate and document to families how assessment information is embedded into daily activities and routines <input type="checkbox"/> Monitor, summarize, and evaluate the achievement of child/youth and family outcomes as outlined in the IFSP, IEP or other plans
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Identify and ensure the existence of structures supporting IFSPs, IEPs, and other plans <input type="checkbox"/> Ensure staff is sharing assessment information and relevant activities that may be embedded into the family's daily activities and routines <input type="checkbox"/> Maintain ongoing communication with families about implementation of IFSPs, IEPs, and other plans

Child/Youth Observation and Assessment to Meet Individual Needs	
Competency C: Demonstrate knowledge of enhancing development and inclusion in the family, classroom and community	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize that children's/youth's developmental stages are benchmarks and indicators of child/youth growth and development
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Use multiple sources to identify growth and development in physical, language, social/emotional, and cognitive domains <input type="checkbox"/> Utilize knowledge of children's/youth's growth and development to make adaptations and support an inclusive philosophy⁶¹³ <input type="checkbox"/> Recognize atypical variations in development and make appropriate referral
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Adapt practices to facilitate every child's/youth's development and learning based on individual needs <input type="checkbox"/> Recognize characteristics of developmental delay and specific disabilities, including causation, characteristics, and classification of common disabilities in children/youth <input type="checkbox"/> Highlight the importance and impact of early identification of developmental delay or disability <input type="checkbox"/> Identify roles and processes of multi-disciplinary teams in the assessment and evaluation of children/youth <input type="checkbox"/> Recognize and communicate the impact of disability or developmental delay on child/youth development and learning <input type="checkbox"/> Demonstrate strategies for integrating typically developing peers so children/youth with disabilities or other special learning needs can learn, develop, and form positive relationships <input type="checkbox"/> Ensure that children/youth of all abilities are guided in a positive way <input type="checkbox"/> Describe the benefits of inclusion for children, families, practitioners, and communities <input type="checkbox"/> Communicate to families and practitioners current evidence-based trends related to teaching and nurturing children/youth with disabilities or other special learning needs <input type="checkbox"/> Locate and share sources of support, resources, and information about developmental delays and disabilities for families <input type="checkbox"/> Explain policies and procedures pertaining to screening, evaluating, and assessing children/youth with a suspected disability <input type="checkbox"/> Identify processes associated with grief, loss, and coping with disabilities <input type="checkbox"/> Follow federal and state regulations for identifying young children with disabilities or other special learning needs <input type="checkbox"/> Apply knowledge of laws related to access and special education as they apply to children/youth with special needs and their families

<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate the impact of disability or developmental delay on the family, the child/youth, and the community <input type="checkbox"/> Analyze the relationship between family beliefs, culture and decisions regarding care and services for their child/youth with special needs <input type="checkbox"/> Demonstrate strategies for designing flexible learning environments and activities and providing multiple and varied formats for instruction to promote engagement and accommodate individual learning differences <input type="checkbox"/> Select goals, services, and settings that facilitate embedded learning within daily activities and routines <input type="checkbox"/> Design and implement intentional teaching strategies (frequency, intensity, methods) based on individualized plans that align with goals and services listed in IFSPs, and IEPs <input type="checkbox"/> Use assistive technology, augmentative and alternative communication, and adaptive technology to facilitate participation of all children/youth in inclusive settings <input type="checkbox"/> Take part in frequent, regularly scheduled, communication and collaboration among practitioners, specialists, administrators, parents, and community members to facilitate a coordinated team process
<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Integrate individualized plans, accommodations and supports, specialized instruction, and therapies into daily activities and routines and across environments, materials, and people <input type="checkbox"/> Develop and demonstrate targeted and individualized supports for promoting social/emotional skills and addressing challenging behavior <input type="checkbox"/> Adapt screening, evaluation, and assessment methods and measures for children/youth with varying physical and sensory abilities <input type="checkbox"/> Employ systems/tools for measuring the quality of inclusive programs and services <input type="checkbox"/> Utilize data, progress monitoring, and evaluation strategies to inform decisions about the implementation and effectiveness of individual interventions <input type="checkbox"/> Facilitate and support the family-child/youth, teacher-child/youth, and family-teacher relationship in intervention efforts <input type="checkbox"/> Explain and abide by state and local laws, and agency policies and procedures pertaining to supports and services for children/youth with, or at risk for, disabilities <input type="checkbox"/> Convey the rights of families and children with, or at-risk for, disabilities <input type="checkbox"/> Promote advocacy for young children/youth with disabilities and their families

<p>Level 5 (continued) All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"><input type="checkbox"/> Promote required and recommended practices for transitions of individualized plans between programs<input type="checkbox"/> Utilize funding and referral sources for assistive technology and adaptive equipment<input type="checkbox"/> Analyze, modify, and maintain attitudes and behaviors that influence behavior of individuals with disabilities and other special learning needs and their families<input type="checkbox"/> Be aware of and support publications, organizations, and integrated professional development opportunities that support early childhood and youth development inclusion<input type="checkbox"/> Differentiate roles and functions of families and multiple team members in the development, implementation, and monitoring of individualized plans<input type="checkbox"/> Support and strengthen the knowledge and skills of paraprofessionals, volunteers, and support staff to facilitate inclusion
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Core Knowledge Area 4: Learning Environment and Curriculum

This area describes the extent to which an early care and education and youth development professional needs to understand and utilize strategies that are characteristic of high quality environments, such as consistent scheduling and routines, transitions between activities and settings^{G24}, provision of interesting materials and activities appropriate for various age groups and how to arrange the environment to enhance children's/youth's learning. A professional must know, understand, be familiar with, and be able to implement a variety of developmentally appropriate curriculum models to prepare young children/youth for school

Competency A, Materials and Activities Domain: Demonstrate the ability to create learning environments using materials and activities; general curriculum

Competency B, Personal Care and Routines Domain: Demonstrate the ability to promote personal care routines

Competency C, Physical Development: Demonstrate the ability to promote physical development; physical education

Competency D, Language Development and Literacy: Demonstrate the ability to promote language development and literacy; English and language arts

Competency E, Cognitive Development Domain: Demonstrate the ability to promote cognitive development; mathematics, science and social studies

Competency F, Personal and Social/Emotional Development Domain: Demonstrate the ability to promote personal and social development; social studies

Competency G, Creativity and Arts Domain: Demonstrate the ability to promote creativity and arts; visual arts

Competency H, Positive Interaction and Guidance Domain: Demonstrate the ability to promote positive interactions and guidance

Learning Environment and Curriculum	
Competency A	Materials and Activities Domain: Demonstrate the ability to create learning environment using materials and activities; general curriculum
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Assist in arranging and furnishing materials to allow and encourage appropriate independence <input type="checkbox"/> Obtain and maintain materials and equipment in arranged environments to allow and encourage independence, promote physical development, and encourage appropriate curriculum
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Rotate materials and equipment to encourage curriculum and spontaneous activities <input type="checkbox"/> Describe how materials and experiences are used for play and learning across settings <input type="checkbox"/> Demonstrate knowledge that children/youth learn through interaction with materials, peers, and adults across settings
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Provide well-arranged indoor and outdoor space which meets the developmental needs of all children/youth, including children with special needs <input type="checkbox"/> Organize space into identifiable areas that encourage active involvement, self-initiative, responsibility, and growing sense of autonomy <input type="checkbox"/> Arrange environment to promote physical development, both indoors and outdoors <input type="checkbox"/> Arrange space to encourage appropriate communication <input type="checkbox"/> Organize environment to include large group areas, small group areas, quiet areas, and interest areas <input type="checkbox"/> Organize environment to facilitate positive interactions between children/youth and adults <input type="checkbox"/> Organize and use the outdoor environment and natural settings as an integral part of a children's/youth's active and quiet learning <input type="checkbox"/> Model strategies, techniques, and methods which foster and ensure a physically and psychologically safe environment that promotes children's/youth's development and learning <input type="checkbox"/> Organize environment to include a variety of materials and equipment
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Plan for and use materials that recognize and value diversity as strengths in children/youth and families
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Articulate how arrangement of the environment reflects the philosophy of the program and supports the success of children/youth <input type="checkbox"/> Evaluate, monitor, and implement a program planning and implementation process to support children/youth

Learning Environments and Curriculum	
Competency B Personal Care and Routine Domain: Demonstrate the ability to promote personal care and routines	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Follow established personal care routines for children/youth <input type="checkbox"/> Support implementation of plans to make personal care routines and development of other independent skills^{G14} a positive experience for children/youth <input type="checkbox"/> Recognize the appropriate use of physical positioning and management techniques to support children/youth with physical and health disabilities
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Identify and implement developmentally appropriate nutrition, personal care routines, and self-help strategies for children/youth on an individual basis <input type="checkbox"/> Develop plans to make toileting, feeding, and the development of other independent skills, a positive experience for children/youth <input type="checkbox"/> Tell children/youth what will happen next
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Plan with families to make personal care routines and the development of other independent skills a positive experience for children/youth <input type="checkbox"/> Use appropriate physical positioning and management techniques to support children/youth with physical and health disabilities
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Design appropriate physical positioning and management techniques to support children/youth with physical and health disabilities
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that staff incorporate personal care routine tasks into the program in a relaxed, reassuring and individualized manner based on developmental needs

Learning Environment and Curriculum	
Competency C Physical Development Domain: Demonstrate the ability to promote physical development; physical education	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Support a variety of activities which promote large and small muscle development <input type="checkbox"/> Actively participate in children's/youth's activities <input type="checkbox"/> Interact appropriately⁶¹⁷ with children/youth during physical activities
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Acknowledge and support children's/youth's need to move and be active <input type="checkbox"/> Introduce sensory⁶²² experiences to children/youth <input type="checkbox"/> Use a variety of equipment, activities, and opportunities to promote physical development of children/youth
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Provide space and equipment for formal and informal motor activities that are fun and challenging <input type="checkbox"/> Provide safe and structured experiences for children/youth to move and explore the environment, with special attention to their current developmental levels and developing capacities <input type="checkbox"/> Use music, dance, and movement with children/youth informally and frequently <input type="checkbox"/> Understand and implement frequent opportunities for movement and physical exercise as a way to reduce or prevent many children's/youth's health and behavioral issues
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Include movement as a teaching strategy for a variety of skills and adapt activities for children/youth with special needs <input type="checkbox"/> Plan indoor and outdoor activities for both large and small motor skills <input type="checkbox"/> Work with families to encourage and reinforce family-child activities that involve physical activity and movement, both inside and outside, and in natural settings and parks when possible
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Explain how physical development and other areas of development interrelate <input type="checkbox"/> Understand and articulate concepts of sensory integration <input type="checkbox"/> Use knowledge of kinesthetic learning styles when teaching others

Learning environment and Curriculum	
<p>Competency D Language Development and Literacy: Demonstrate the ability to promote language development and literacy; English and language arts</p> <p>Level 1 All items on Level 1, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Listen and respond to children's/youth's verbal and non-verbal communication <input type="checkbox"/> Encourage children/youth to ask questions and actively listen to their responses <input type="checkbox"/> Talk with children/youth and stimulate conversation among peers <input type="checkbox"/> Follow realistic expectations for children's/youth's understanding and use of speech <input type="checkbox"/> Respond to children's/youth's communication in preferred language⁶²¹ <input type="checkbox"/> Share books with children/youth, re-read favorite stories, and model reading behaviors <input type="checkbox"/> Ask children/youth questions about stories read and told together <input type="checkbox"/> Encourage children/youth to predict what will happen next in a story <input type="checkbox"/> Play word and rhyming games <input type="checkbox"/> Model appropriate handling and selection of books <input type="checkbox"/> Model appropriate and respectful communication
<p>Level 2 All items on Level 1, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Ask children/youth relevant open-ended questions <input type="checkbox"/> Encourage play and act as an adult facilitator or partner in play <input type="checkbox"/> Encourage and support children's/youth's verbal and nonverbal communication with others <input type="checkbox"/> Use conversations to enrich and expand vocabulary <input type="checkbox"/> Provide clear instructions that help children/youth move from simple directions to a more complex sequence of directions <input type="checkbox"/> Encourage understanding of the relationship between spoken and printed words <input type="checkbox"/> Provide opportunities for children/youth to chant familiar rhymes and experiment with word sounds <input type="checkbox"/> Point out the names of things, signs, labels, etc. in learning environments <input type="checkbox"/> Demonstrate recognition of value of reading aloud daily <input type="checkbox"/> Encourage children/youth to engage in print activities and to practice writing <input type="checkbox"/> Provide opportunities for young children to draw and print using markers, crayons, etc. on a variety of surfaces <input type="checkbox"/> Use a variety of music and sing frequently with children/youth <input type="checkbox"/> Share children's/youth's progress and achievements in language development and literacy with families

<p>Level 3 All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Respond to preverbal and Dual Language Learner children's/youth's behaviors with understanding of their possible meanings <input type="checkbox"/> Respond to preverbal and Dual Language Learner children's/youth's attempts at language extending their words without correcting them <input type="checkbox"/> Apply a variety of teaching techniques for working with children/youth <input type="checkbox"/> Use concrete experiences⁶⁴ and interaction to enhance and extend children's/youth's language development and emerging literacy <input type="checkbox"/> Build on children's/youth's interests to introduce new vocabulary and ideas <input type="checkbox"/> Help children/youth learn about appropriate concepts of literacy <input type="checkbox"/> Provide writing materials and models of writing throughout the learning environment <input type="checkbox"/> Encourage and offer simple family-child/youth language and literacy activities
<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Communicate with children/youth and families using preferred language with interpreters when necessary <input type="checkbox"/> Talk about a variety of topics and use language to ask questions, give answers, make statements, share ideas, or use pretend, fantasy, or word play <input type="checkbox"/> Use a variety of songs, books, stories, and games from many cultures <input type="checkbox"/> Facilitate language development by respectfully expanding, extending, and elaborating upon children's/youth's communication attempts <input type="checkbox"/> Recognize and respond to the general warning signs of communication/language delays or disorders for children/youth of various ages, making referrals as needed <input type="checkbox"/> Provide materials such as puppets, flannel board sets, and other props to act out and tell stories <input type="checkbox"/> Provide many types of children's/youth's books, references, pictures, and posters in the environment. <input type="checkbox"/> Immerse children/youth in a print-rich environment including languages represented in the community and facilitate the relationship between spoken and printed words <input type="checkbox"/> Promote literacy-related play activities that encourage children's/youth's attempts at writing and storytelling <input type="checkbox"/> Offer ongoing information to family and community members about simple ways to promote language development and early literacy at home <input type="checkbox"/> Respond to language differences and literacy abilities of families in printed materials sent home with children/youth

<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Analyze and apply current theory and research on communication, language acquisition and early literacy <input type="checkbox"/> Design curriculum consistent with current theories of language use and language acquisition, including Dual Language Learners <input type="checkbox"/> Inform families and others about the importance of adult-child/youth and child/youth interactions in children's/youth's English and preferred language development <input type="checkbox"/> Develop family and community awareness about importance of reading to young children/youth
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Learning Environment and Curriculum	
Competency E Cognitive Development: Demonstrate the ability to promote cognitive development; mathematics, science and social studies	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Encourage the development of cognitive skills by providing concrete experiences <input type="checkbox"/> Engage children/youth in play that encourages curiosity, exploration, and problem solving <input type="checkbox"/> Support planned math, science, and nature exploration in response to children's/youth's emerging interests <input type="checkbox"/> Support opportunities for conversation using everyday words to indicate concepts such as space, location, shape, and size <input type="checkbox"/> Play with children/youth during activities <input type="checkbox"/> Offer, and actively participate in, expressive arts that pertain to jobs people do in family and community <input type="checkbox"/> Be aware of the importance of the adult's role as facilitator and partner
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Provide activities and opportunities that encourage curiosity, exploration, and problem solving appropriate to the developmental level and learning styles of the children/youth <input type="checkbox"/> Guide math, science, and nature exploration in response to children's/youth's emerging interests <input type="checkbox"/> Facilitate children's/youth's exploration of concepts such as space, time, shape, size, and quantity in meaningful ways <input type="checkbox"/> Facilitate activities and opportunities appropriate to children's/youth's development that promote counting and number concepts <input type="checkbox"/> Actively participate in play and activities <input type="checkbox"/> Provide materials and opportunities for children/youth to imitate and engage in pretend and dramatic play <input type="checkbox"/> Discuss the sequence of daily and special family or community events <input type="checkbox"/> Encourage children/youth to describe and appreciate their own characteristics and those of others <input type="checkbox"/> Discuss family and community member roles, jobs and rules

<p>Level 3 All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate awareness that individual cognitive development is related to a child's/youth's earliest experiences <input type="checkbox"/> Integrate cognitive development into all curricular areas <input type="checkbox"/> Support and scaffold⁶²³ learning activities for children/youth so that they can develop thinking skills <input type="checkbox"/> Plan and implement math, science, pretend, and nature exploration activities in response to children's/youth's emerging interests and cognitive development <input type="checkbox"/> Provide opportunities appropriate to the children's/youth's developmental levels that promote exploration of shapes, sizes, space, measurement, and time <input type="checkbox"/> Provide opportunities for children/youth to use simple strategies to solve mathematical problems <input type="checkbox"/> Provide opportunities for children/youth to organize, compare and contrast, pattern, and categorize thoughts, words, objects, and sensory experiences <input type="checkbox"/> Assist children/youth in observing nature and natural phenomena and make predictions about natural events <input type="checkbox"/> Create maps of school, local area, or neighborhood <input type="checkbox"/> Incorporate photos, art, music, clothing, etc. from various cultures into the curriculum <input type="checkbox"/> Acknowledge and discuss differences in family and community member roles, jobs, and rules in various cultures
<p>Level 4 All items on Level 1, 2, 3 plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Describe how cognitive development and other areas of development interrelate <input type="checkbox"/> Plan, implement, evaluate, and modify curriculum to encourage children/youth to construct knowledge <input type="checkbox"/> Encourage children/youth to reflect and build on previous learning to develop and refine thinking skills <input type="checkbox"/> Evaluate the appropriateness and effectiveness of activities and opportunities for promoting exploration of shapes, sizes, space, measurement, and time <input type="checkbox"/> Provide opportunities for children/youth to sort objects into subgroups that vary by one or two attributes <input type="checkbox"/> Provide opportunities for enhancing the ability to observe, see, and perceive and to pay attention to natural phenomenon <input type="checkbox"/> Encourage children/youth to see themselves as part of larger community <input type="checkbox"/> Discuss appropriate use of technology with children/youth and families <input type="checkbox"/> Evaluate the appropriateness and effectiveness of opportunities for children/youth to organize, compare and contrast, pattern, and categorize thoughts, words, objects, and sensory experiences
<p>Level 5 All items on Level 1, 2, 3, 4 plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Articulate, analyze, evaluate, and apply current theory and research on promoting cognitive development

Learning Environment and Curriculum	
Competency F Social/Emotional Domain: Demonstrate the ability to promote personal and social/emotional development; social studies	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Treat children/youth as individuals with their own strengths and needs <input type="checkbox"/> Recognize that periods of stress, separation, and transition may affect children's/youth's personal and social development <input type="checkbox"/> Engage in conversation with children/youth <input type="checkbox"/> Share children's/youth's excitement in discoveries, exploration, and manipulation of items in the environment
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Affirm children's/youth's worth and growing identity as individuals <input type="checkbox"/> Work to ensure consistency of assigned professional⁶⁵ <input type="checkbox"/> Show respectful and matter-of-fact attitude related to personal hygiene of family <input type="checkbox"/> Maintain confidentiality between the program and families <input type="checkbox"/> Help children/youth learn to communicate and successfully solve personal conflicts <input type="checkbox"/> Model recognizing, naming, and expressing feelings <input type="checkbox"/> Model and encourage feelings of empathy and mutual respect among children/youth and adults <input type="checkbox"/> Help children/youth through periods of stress, separation, and transition <input type="checkbox"/> Help children/youth feel valued as members of the group <input type="checkbox"/> Emphasize cooperation in games and activities and provide many opportunities for cooperative play <input type="checkbox"/> Intervene when necessary to help children/youth develop socially <input type="checkbox"/> Demonstrate sensitivity to varying cultural values and expectations about the child as a member of a family and an ethnic or social group. <input type="checkbox"/> Model curiosity and information seeking <input type="checkbox"/> Support children's/youth's sustained efforts at activities and problem solving <input type="checkbox"/> Show support, for, and acceptance of, individual children and their families

<p>Level 3 All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Work to create a community in the program or home setting and encourage children/youth to include others who may be isolated <input type="checkbox"/> Guide children/youth in understanding and expressing their feelings and those of others <input type="checkbox"/> Guide children/youth in asserting themselves in positive ways and helping others <input type="checkbox"/> Help children/youth learn and practice empathy and respect for the feelings and rights of others <input type="checkbox"/> Encourage shy or quiet children/youth to interact with others while respecting their personality style and temperament <input type="checkbox"/> When possible, offer children/youth acceptable choices to promote autonomy and reduce oppositional behavior <input type="checkbox"/> Develop positive relations with families and recognize the child/youth is an integral part and extension of the family
<p>Level 4 All items on Level 1, 2, 3 plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Provide physical environments, schedules, and routines that promote self-control and self-realization <input type="checkbox"/> Design and provide a curriculum that emphasizes and enhances development of social skills, relationships, and friendships <input type="checkbox"/> Guide children/youth through problem solving and conflict resolution interactions <input type="checkbox"/> Create environments that offer an appropriate amount of stimulation and opportunities to choose new, as well as familiar activities <input type="checkbox"/> Provide sufficient time for children/youth to engage in sustained activities <input type="checkbox"/> Provide an environment of psychological safety where children are encouraged to experiment without fear of making mistakes <input type="checkbox"/> Identify atypical personal and social development and initiate appropriate referral strategies <input type="checkbox"/> Work to support and reinforce families for their primary role in children's/youth's personal and social development
<p>Level 5 All items on Level 1, 2, 3, 4 plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Analyze and apply current theory on attachment and promoting social development <input type="checkbox"/> Identify and communicate to others, specific strategies for interacting with children/youth with challenging behaviors <input type="checkbox"/> Communicate to others, the process for developing curriculum that promotes social/emotional development and positive approaches to learning

Learning Environment and Curriculum	
Competency G Creativity and Arts Domain: Demonstrate the ability to promote creativity and arts	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize the process of creating as more important than the end product <input type="checkbox"/> Support opportunities for children/youth to use a variety of media for creative activities <input type="checkbox"/> Recognize cultural differences that may affect children's/youth's ways of expressing themselves creatively
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Encourage and support children/youth to express their creative abilities through a variety of activities including use of open-ended materials such as water, clay, paints, and blocks <input type="checkbox"/> Describe, discuss, and accept the process as well as the product of children's/youth's creative activities and the arts
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that all children/youth have access to opportunities that allow for individual creative expression <input type="checkbox"/> Support development and acceptance of personal preferences by giving children/youth choices and supporting discussions of likes and dislikes <input type="checkbox"/> Show respect for creative expression through appropriate documentation and display of children's/youth's work
Level 4 All items on Level 1, 2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Provide time, materials, and space to explore and experiment with creative expression in multiple media (e.g., problem solving, visual arts, construction, music, movement, drama) <input type="checkbox"/> Expose children/youth to, and help develop their appreciation for, creative and aesthetic experiences in their communities <input type="checkbox"/> Encourage awareness and appreciation of the arts and creative expression from a variety of cultures <input type="checkbox"/> Challenge children/youth to extend their creative thinking and problem solving by asking open-ended questions
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Inform families about the importance of individual creative expression <input type="checkbox"/> Communicate to others, research for developing curriculum that promotes creative expression

Learning Environment and Curriculum	
Competency H Positive Interactions and Guidance: Demonstrate the ability to promote positive interactions and guidance	
<p>Level 1</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Model behavior that communicates the importance of each child/youth <input type="checkbox"/> Recognize children's/youth's sense of security <input type="checkbox"/> Communicate frequently with each child/youth, both verbally and non-verbally (e.g., calm voice, smiles, touch, embraces, at the child's eye level) <input type="checkbox"/> Follow regulations regarding guidance of behavior⁶³ <input type="checkbox"/> Treat all children/youth equitably and fairly <input type="checkbox"/> React consistently to children's/youth's behavior <input type="checkbox"/> Serve as a constant and reliable listener and supporter for each child/youth, even when his/her behavior seems to be challenging
<p>Level 2</p> <p>All items on Level 1, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Encourage feelings of empathy and respect for others <input type="checkbox"/> Identify a variety of child/youth behaviors according to individual development levels <input type="checkbox"/> Use positive guidance techniques and behaviors to help children/youth act responsibly (e.g., consistency, kindness, redirecting, modeling) <input type="checkbox"/> Respond appropriately to a variety of child/youth behaviors, recognizing individual developmental levels <input type="checkbox"/> Provide consistent, clear rules which are explained to children/youth and understood by adults <input type="checkbox"/> Establish supportive relationships with children and implement developmentally appropriate techniques for guidance and group management <input type="checkbox"/> Assist with methods of behavior support and management appropriate for children/youth with special needs <input type="checkbox"/> Identify signs of emotional distress in children/youth and follow procedures
<p>Level 3</p> <p>All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Facilitate children's/youth's sense of security during transition through linkages with, and visitation to, the new setting/staff <input type="checkbox"/> Utilize modeling and various prompting techniques to facilitate children's/youth's interactions with their environment <input type="checkbox"/> Implement, in collaboration with related service personnel, methods of behavior support and management appropriate for children/youth with special needs, including a range of strategies from less directive, less structured methods (e.g., verbal support and modeling) to more directive, more structured methods <input type="checkbox"/> Provide developmentally appropriate interactions and practices to help young children develop intellectual curiosity, solve problems, and make decisions

<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Articulate the importance of relationships to children's/youth's development and learning <input type="checkbox"/> Provide assistance during conflict resolution, problem solving, friendship development, and other social interactions, which are based on the child's/youth's ability to understand
<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that staff respond appropriately to a variety of child/youth behaviors, recognizing individual development <input type="checkbox"/> Articulate the rationale for developmentally appropriate interactions and practices

Core Knowledge Area 5: Developmentally Appropriate Content

This area describes the extent to which an early care and education and youth development professional needs to provide and create materials that demonstrate acceptance of all children's/youth's age, gender, race, language, culture and special needs. A professional must incorporate, to the greatest possible extent, native language and linguistically diverse routines relative to individual children/youth and families

Competency A: Demonstrates knowledge of, and sensitivity towards, cultural/linguistic diversity

Competency B: Demonstrates understanding that children are best understood within the contexts of family, community, culture and society

Developmentally Appropriate Content	
Competency A: Demonstrates knowledge of, and sensitivity towards, cultural/linguistic diversity	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize the role of preferred language and culture in individual child's/youth's development <input type="checkbox"/> Model respect for cultural/linguistic diversity
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Include the role and the importance of preferred language and culture in planning <input type="checkbox"/> know how programs recognize and understand children's/youth's preferred language and culture in order to support the use and development of children's/youth's preferred language
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Foster the development of the whole child by supporting children's/youth's and families' use of preferred language and cultural practices <input type="checkbox"/> Implement curriculum to support cultural/linguistic diversity
Level 4 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Relate the significance of cultural/linguistic influences on the development of children/youth <input type="checkbox"/> Create learning environments that reflect cultural/linguistic influences
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate and revise learning environments to affirm and reflect cultural/linguistic influences <input type="checkbox"/> Assess early childhood and children/youth development programs for their inclusion of cultural/linguistic diversity and make recommendations as needed

Developmentally Appropriate Content	
Competency B	Demonstrates understanding that children are best understood within the contexts of family, community, culture and society
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Recognize the role of family and community contexts in influencing the child's/youth's development and learning
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Explain the significance of family and community contexts in influencing the child's/youth's development and learning <input type="checkbox"/> Recognize the role of cultural and societal contexts in influencing the child's/youth's development and learning
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Foster the development of the child/youth by supporting children's/youth's and families' cultural practices
Level 4 All items on Level 1,2, 3, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Relate the significance of community and cultural influences in child's/youth's development and learning <input type="checkbox"/> Create environments that reflect the influences of the family, community, and society <input type="checkbox"/> Educate families about how they can impact social institutions such as educational programs and governmental entities
Level 5 All items on Level 1, 2, 3, 4, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate and revise learning environments to affirm and reflect cultural and societal influences <input type="checkbox"/> Assess children's/youth's programs for responsiveness to family, community, cultural and societal changes and make recommendations as needed <input type="checkbox"/> Advocate for systems development and changes to support children's/youth's families

Core Knowledge Area 6: Family^{G9} and Community Partnership

This area describes the extent to which an early care and education child/youth development professional must know and understand that the family and community are integral to each child's/youth's optimal learning and development. A professional knowledge and understanding of diverse family structures and influences will enable the support of individual children/youth and families in positive ways. A professional must be able to build respectful and reciprocal relationships with families, as well as know how to provide meaningful family and community involvement. A professional must be aware of community resources and opportunities, and know how to make collaborative connections to benefit children/youth and families.

Competency A: Demonstrate knowledge and understanding of the importance of fostering family and community partnerships which include,

- Understanding of the family's role in child's/youth's development and learning
- Understanding of the importance of communication with families
- Understanding of families' diverse structures, traditions, languages and backgrounds
- Understanding of community resources to support families

Family And Community Partnership	
Competency A: Demonstrate knowledge and understanding importance of fostering family and community partnerships	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Practice confidentiality relative to all aspects of the lives of individual children/youth and their families <input type="checkbox"/> Follow the program's plan for maintaining written and verbal daily communication with families <input type="checkbox"/> Practice positive communication and relationships with families
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate awareness of individual families relative to differences in family strengths, structure, lifestyle, expectations, values, religions, customs, traditions, childrearing practices and language <input type="checkbox"/> Respect the families' role as primary decision-maker for their children/youth <input type="checkbox"/> Practice effective communication with families in the preferred language to share information, report progress, and demonstrate developmentally appropriate techniques, in the preferred language whenever possible in collaboration with appropriate staff <input type="checkbox"/> Assist families and children/youth to become acquainted with the program and the staff on the child's/youth's first day <input type="checkbox"/> Respond empathetically and knowledgeable to families' feelings and concerns regarding the child's/youth's care, guidance, and development, using the preferred language whenever possible <input type="checkbox"/> Incorporate the role of families' cultures, religions, and childrearing practices into the program <input type="checkbox"/> Develop positive learning opportunities for families <input type="checkbox"/> Show awareness of community resources <input type="checkbox"/> Provide relevant information to families regarding community resources <input type="checkbox"/> Collaborate with families to support transition of children/youth
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate respect for individual families relative to differences in family strengths, structure, lifestyle, expectations, values, religions, customs, traditions, childrearing practices, and language <input type="checkbox"/> Assist families in making their own decisions, accessing services, finding their own resources, and becoming independent of professionals <input type="checkbox"/> Plan and implement effective family meetings, considering adult learning principles and the interests and needs of families in the home or center-based program <input type="checkbox"/> Assist families to become active participants on the educational team <input type="checkbox"/> Utilize family goals, traditions, and cultural considerations in planning environments and programming to enrich children's/youth's health and experiences <input type="checkbox"/> Identify the child/youth program's potential impact on the family of a child/youth with special needs

	<ul style="list-style-type: none"> <input type="checkbox"/> Implement and interpret to other adults, the program's policies and procedures related to families, including transition
<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Foster alternative models and methodologies for family support and involvement <input type="checkbox"/> Provide opportunities to families and the community to be members of an advisory body that assists in policy setting and program evaluation <input type="checkbox"/> Demonstrate sufficient knowledge to serve as a culturally responsive resource to families for information regarding child/youth development and childrearing <input type="checkbox"/> Anticipate and negotiate potential conflicts in philosophies and childrearing practices between self, the program, and diverse families <input type="checkbox"/> Actively involve families in the assessment of their child's/youth's development and communicate results in everyday language, using the preferred language whenever possible <input type="checkbox"/> Collaborate with families in providing intervention strategies, including assistive technology, that promote development and learning for children/youth with diverse needs and abilities <input type="checkbox"/> Ensure that child/youth assessment is shaped by family priorities and information needs, as well as by child/youth characteristics and diagnostic concerns <input type="checkbox"/> Ensure the provision of a range of family-oriented services based on each family's identified resources, priorities, and concerns <input type="checkbox"/> Effectively supervise and evaluate support staff in their work with families
<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Apply family systems theory⁶⁺⁰ and knowledge of the dynamics, roles, and relationships within families and communities <input type="checkbox"/> Apply and/or conduct research that addresses families & communities <input type="checkbox"/> Apply research information regarding family systems and stresses, to daily practice with families and children/youth <input type="checkbox"/> Provide leadership through teaching, mentoring, coaching, research, and advocacy for issues across the field of family and community involvement in early childhood development and education and youth development programs

Core Knowledge Area 7: Management and Administration

This area describes the extent to which an early care and education and youth development professional understands the importance of personal interactions and leadership in creating a nurturing environment for children/youth and adults.

Professionals understand that effective leadership across systems in early care and education and youth development is based upon strong caring relationships fostered between, and among all involved. A professional must understand effective management of human and financial resources, and understand and be able to use principles of effective supervision. Professionals must know regulations, policies, and quality standards that apply to the program and how to organize, evaluate, and implement regulations and standards that enable a quality environment.

Competency A: Demonstrate knowledge and skills to manage and administer early care and education and youth development programs, which include:

- Knowledge of pedagogy^{G20}; creating a learning community of children/youth, and adults (including staff) that promotes optimal child/youth development and healthy families
- Knowledge of building organization and systems
- Knowledge of human resources
- Understanding of collaboration
- Knowledge of public policy

Program Management and Administration	
Competency A: Demonstrate knowledge and skills to manage and administer early care and education and youth development programs	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Possess and use basic skills with computers and other technology as appropriate <input type="checkbox"/> Support the program mission and purpose <input type="checkbox"/> Behave as a responsible staff member <input type="checkbox"/> Participate as a team member in the program <input type="checkbox"/> Keep appropriate records <input type="checkbox"/> Comply with program policies and any licensing requirements <input type="checkbox"/> Communicate and work effectively with other staff, volunteers, and administrators as appropriate <input type="checkbox"/> Be able to give, receive, and use constructive feedback
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Organize, plan, and keep records effectively <input type="checkbox"/> Assist in gathering information for program evaluation <input type="checkbox"/> Value and work to strengthen the program's team of staff, administrators, and volunteers as appropriate <input type="checkbox"/> Provide constructive feedback for administrators as appropriate
Level 3 All items on Level 1, 2, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Participate in strategic planning and goal setting for the program <input type="checkbox"/> Conduct both self and performance evaluations as appropriate <input type="checkbox"/> Incorporate program and parent feedback into program evaluation and improvement <input type="checkbox"/> Verbalize the relationship between the program's philosophy and daily practice <input type="checkbox"/> Understand, use, implement, and articulate program policies <input type="checkbox"/> Use a plan for the recruitment, orientation, and supervision staff as appropriate <input type="checkbox"/> Use and implement staff job descriptions and performance review forms and procedures as appropriate

<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Plan and implement parent orientation and parent education programs <input type="checkbox"/> Demonstrate knowledge of valid and appropriate assessment and evaluation practices <input type="checkbox"/> Use a variety of techniques and procedures to evaluate and modify program goals for children/youth and their families <input type="checkbox"/> Develop the program plan <input type="checkbox"/> Provide effective lines of communication among staff and administrators as appropriate <input type="checkbox"/> Conduct and maintain the inventory of supplies, materials, and equipment <input type="checkbox"/> Implement policies and practices of the program <input type="checkbox"/> Supervise student teachers and practicum students, volunteers, and other staff as appropriate <input type="checkbox"/> Encourage and support staff in meeting professional development goals as appropriate <input type="checkbox"/> Articulate developmentally appropriate practices to colleagues, families, and others
<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Develop policies and practices for positive family-staff relationships <input type="checkbox"/> Communicate effectively with board and advisory groups as appropriate <input type="checkbox"/> Communicate effectively with community and media representatives <input type="checkbox"/> Apply knowledge of federal, state, and local legislation, regulations, and professional standards to provide healthy and safe practices for all children/youth and maintain current license and accreditation standards <input type="checkbox"/> Develop and implement program policies and fee structure <input type="checkbox"/> Identify, develop, and implement formative and summative program evaluation strategies and understand their benefits, strengths, and limitations <input type="checkbox"/> Design a plan for the recruitment, orientation, and supervision of staff as appropriate <input type="checkbox"/> Design, write, and implement staff job descriptions and performance review forms and procedures as needed <input type="checkbox"/> Plan and implement staff professional development opportunities when applicable <input type="checkbox"/> Develop clear policies and practices for positive and mutually supportive work environment <input type="checkbox"/> Evaluate assessment practices and remain current on assessment research <input type="checkbox"/> Advocate for developmentally appropriate practices for children's/youth's programs <input type="checkbox"/> Design development of the program budget and maintain, and report on the budget as needed <input type="checkbox"/> Identify and seek additional funding opportunities as needed <input type="checkbox"/> Develop and maintain a program marketing plan as needed <input type="checkbox"/> Possess or seek legal knowledge necessary for effective management as needed <input type="checkbox"/> Demonstrate strong leadership and visionary direction

Core Knowledge Area 8: Professionalism

This area describes the extent to which an early care and education and youth development professional knows and uses ethical guidelines and other professional standards related to his/her practice. A professional must be a continuous collaborative learner who demonstrates and shares knowledge, reflects on, and has a critical perspective of, his/her work, makes informed decisions, and integrates knowledge from a variety of sources. A professional must be a role model and advocate for best educational practices and policies.

Competency A: Demonstrate professional behaviors and practices that adhere to discipline-specific code of ethical conduct, such as NAEYC or that of another pertinent professional organization that guides practices, which include:

- Demonstrate knowledge of federal, state and local regulations
- Demonstrate continuous learning to inform practice
- Demonstrate a personal philosophy of developmentally appropriate early care and education and youth development
- Demonstrate decision-making based on knowledge
- Demonstrate a commitment to advocacy on behalf of children/youth and their families

Professionalism	
Competency A: Demonstrate professional behaviors and practices that adhere to discipline-specific code of ethical conduct, such as NAEYC or that of another pertinent professional organization that guides practices	
Level 1	<ul style="list-style-type: none"> <input type="checkbox"/> Practice working with children/youth and exhibit positive attitude <input type="checkbox"/> Practice good hygiene and professional appearance <input type="checkbox"/> Follow good work habits <input type="checkbox"/> Consult with supervisor or resource person regarding concerns as needed <input type="checkbox"/> Work cooperatively with colleagues <input type="checkbox"/> Manage demands of personal and professional commitments <input type="checkbox"/> Recognize the appropriate code of ethics for professional practice <input type="checkbox"/> Behave ethically, maintaining confidentiality and impartiality <input type="checkbox"/> Show commitment to the program's goals <input type="checkbox"/> Recognize federal, state, and local regulation of programs and services for children/youth <input type="checkbox"/> Seek out knowledge and skills to improve practice
Level 2 All items on Level 1, plus	<ul style="list-style-type: none"> <input type="checkbox"/> Use problem-solving skills as needed <input type="checkbox"/> Interact in a manner reflecting respect for self and others <input type="checkbox"/> Perform routine tasks to maximize the amount of time spent interacting with children/youth <input type="checkbox"/> Meet program expectations for team members <input type="checkbox"/> Promote the value of quality in child/youth programs <input type="checkbox"/> Demonstrate a commitment to practice professional organization code of ethics <input type="checkbox"/> Utilize professional resources <input type="checkbox"/> Take advantage of opportunities to improve competence <input type="checkbox"/> Accept advice and constructive criticism to improve practice <input type="checkbox"/> Participate in one (or more) professional association(s)

<p>Level 3 All items on Level 1, 2, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate child/s/youth's education and care practices that support inclusion and cultural and linguistic diversity <input type="checkbox"/> Reflect on how teaching practices affect children's/youth's behavior <input type="checkbox"/> Plan and implement routine tasks to maximize the amount of time spent interacting with children/youth <input type="checkbox"/> Participate in professional organizations and on-going professional development to enhance knowledge and skills <input type="checkbox"/> Consistently adhere to the appropriate code of ethics for professional practice <input type="checkbox"/> Demonstrate understanding of the child/youth professions <input type="checkbox"/> Use other professions providing related services for children/youth and their families <input type="checkbox"/> Exhibit knowledge of child/youth and family advocacy issues <input type="checkbox"/> Demonstrate knowledge of federal, state, and local regulation of programs and services for children/youth <input type="checkbox"/> Demonstrate awareness of own culture and begin to articulate how cultural heritage influences values, decisions, and behavior <input type="checkbox"/> Seek out professional relationships to enhance professional growth
<p>Level 4 All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Demonstrate critical reflection on own professional and educational practices from community, state, national, and global perspectives <input type="checkbox"/> Articulate and use the appropriate code of ethics for professional practice <input type="checkbox"/> Participate in group problem solving of ethical dilemmas as appropriate <input type="checkbox"/> Articulate personal philosophy regarding child/youth profession based on knowledge of child/youth development and best practices. <input type="checkbox"/> Demonstrate knowledge of basic principles of administration, organization, and operation of children/youth programs including supervision of staff and volunteers <input type="checkbox"/> Use professional resources to continually improve practice <input type="checkbox"/> Actively participate in professional development <input type="checkbox"/> Acknowledge personal values and own cultural biases <input type="checkbox"/> Support others working with children/youth and families

<p>Level 4 (continued) All items on Level 1, 2, 3, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Advocate for excellence in programs and services <input type="checkbox"/> Keep current on research and policy relevant to child/youth development and learning and revise program practices accordingly <input type="checkbox"/> Establish working relationships with other professionals to promote continuity in children's/youth's development and learning <input type="checkbox"/> Understand the impact of public policy upon children, youth, families, and educational programs and advocate for supportive public policies
<p>Level 5 All items on Level 1, 2, 3, 4, plus</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Initiate and mediate group problem solving of ethical dilemmas as applicable <input type="checkbox"/> Recognize causes and symptoms of "burnout" and develop strategies to prevent it <input type="checkbox"/> Understand how historical, philosophical, and social foundations of child/youth development affect current practices and future trends <input type="checkbox"/> Ensure staff development in: child/youth growth and development; health; safety and nutrition; child/youth observation and assessment to meet individual needs; learning environment and curriculum; and family and community partnership <input type="checkbox"/> Recognize variations in adult and child/youth learning styles and apply knowledge to practice <input type="checkbox"/> Provide a work culture that fosters staff initiative to solve problems and resolve conflict <input type="checkbox"/> Evaluate best practices, research and policy in child's/youth's professional development and learning and revise practices as appropriate <input type="checkbox"/> Assess personal values and own cultural biases to make appropriate changes in practices

Glossary

Term	Definition
^{G1} Assessment	The process of observing, recording, and otherwise documenting the work children/youth do and how they do it. It is gathering information from several sources of evidence, organizing the evidence, and finally interpreting the evidence, to inform instruction and monitor child/youth progress.
^{G2} Authentic	A systematic examination of a child's learning and development that occurs within the child's/youth's normal routines over many points in time, usually by the teacher or caregiver of the child.
^{G3} Behavior (guidance of)	A way of teaching that nurtures each child's/youth's potential through consistently positive interactions; classroom management that teaches rather than punishes.
^{G4} Concrete Experiences	The experience children/youth have when they have opportunities to interact with real life objects, familiar and new. Children can learn about themselves when exposed to role models in the program, and visiting people in the community who are like them.
^{G5} Consistency of assigned professional	When children/youth remain together over-time or with an established care giver over time care. This term includes continuity of care for infant-toddler programs.
^{G6} Cultural Factors	A shared, learned, symbolic system of values, beliefs, and attitudes that shape and influence perception and behavior.
^{G7} Curriculum	Curriculum is the organized framework that delineates the following: <ul style="list-style-type: none"> • The content that children are to learn • The processes through which children achieve the identified curricular goals • What teachers do to help children achieve these goals • The context in which teaching and learning occur
^{G8} Environmental Factors	The people, procedures, habits, routines and things that affect the child.
^{G9} Family	The primary social group of people who share common beliefs; the definition of "family" varies across culture and according to social norms.
^{G10} Family System Theory	Hypotheses or sets of general principles, concepts or assumptions used to explain family such as: Family Systems Theory, Family Development Theory, Conflict Theory, Structural Functionalism, Symbolic Interaction, Social Exchange Theory, etc.

Term	Definition
^{G11} Feeding	Child/youth feeding practices are multidimensional and they change rapidly within short age-intervals in the first years of life. Unlike exclusive breastfeeding, which can be summarized in a single indicator, the measurement of feeding practices in children aged 6 months and older involves assessing various dimensions of feeding simultaneously. These dimensions include continued breastfeeding, appropriate timing of introduction of complementary foods, and optimum quantity and quality of food consumed.
^{G12} Health Check	Reported or observed illness or injury affecting the child/youth or family members since the last time of setting attendance. Changes noted include: behavior of the child/youth or in his/her appearance, skin rashes, impetigo, itching or scratching of the skin, itching or scratching of the scalp, or the presence of one or more live crawling lice; a temperature check if the child appears ill, and other signs or symptoms of illness and injury (such as drainage from eyes, vomiting, diarrhea, cuts/lacerations, pain, or feeling ill).
^{G13} Inclusive Philosophy	The practice of including all children/youth regardless of their abilities in regular early childhood care and education programs.
^{G14} Independent Skills	The skills needed to become a self-sufficient person. This is part of normal child/youth development. As children/youth grow, they learn to do more and more tasks.
^{G15} Individual Educational Plan (IEP)	An annually revised program for an exceptional student, detailing present achievement level, goals and strategies. It is drawn up by teachers, parents, specialists and when appropriate, the student
^{G16} Individual Family Service Plan (IFSP)	The written document specified in the Individuals with Disabilities Education Act (IDEA) to guide the implementation of early intervention services for children from birth to age three and their families. It is to be developed through collaborative interchanges between families and the professionals involved in assessment and service delivery.
^{G17} Interact Appropriately	Refers to how professionals interact with children/youth in different settings. Professionals follow - children/youth leads. While professionals may look for opportunities to gently challenge children/youth by introducing a new idea or appropriate vocabulary, they stay within the context of the child's/youth's lead.

Term	Definition
^{G18} Observation and Anecdotal Records	An act or instance of observing, gathering information by noting facts or occurrences and conclusion drawn from observing. A note that describes behavior, complete with verbal responses in a narrative style.
^{G19} Interplay of Genetics	Role of genes, heredity, variation in living humans in learning and development.
^{G20} Pedagogy	The ways teachers promote children's/youth's development and learning and ensure that children/youth experience a learning environment that promotes their development and learning in all areas of curriculum.
^{G21} Preferred Language	Teachers' sensitivity to whatever language preference a families with other native language might prefer the teacher to use to communicate with them or their children.
^{G22} Sensory	Includes any activities that stimulates child's/youth's senses: touch, smell, taste, sight and hearing. It facilitates exploration and naturally encourages children/youth to use a scientific process while they play, create, investigate and explore.
^{G23} Scaffold	A teaching strategy originating from Lev Vygotsky's sociocultural theory. It provides individualized support based on what children/youth can do by themselves and the next learning that they can be helped to achieve with competent assistance.
^{G24} Settings	Refers to any location where any adult is responsible for the direct care and education of a group of children/youth. Included are not only classrooms, but also infant/toddler caregiving, family child care homes, and any other place in other discipline where an adult fulfills a role of teacher or caregiver.
^{G25} Systems	Comprehensive systems of preparation and ongoing development and support for all professionals working with children/youth and on behalf of them.
^{G26} USDA Guidelines for Nutrition	United States Department of agriculture offers a food guide of healthy foods divided into sections to show the recommended intake for each food group for each age.

Crosswalk Grids

Grid 1: Crosswalk Other States' Core Competencies to NAEYC Professional Development Preparation Areas and CDA Subject Areas

Grid 1: Core Knowledge Area	NAEYC Competency Description	CDA Competency Description
<p>Child Growth and Development (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)</p>	<p>Standard 1: Promoting child development and learning</p> <p>Use their understanding of young children’s characteristics and needs, and of multiple interacting influences on children’s development and learning, to create environments that are healthy, respectful, supportive and challenging for each child.</p>	<p>Competency Goal II: To advance <u>physical and intellectual competence</u>; provides a variety of equipment and activities to promote physical development of children. Provides activities and opportunities that encourage curiosity, exploration, and problem solving appropriate to the developmental levels and learning styles of children. Actively communicates with children and provides opportunities and support for children to understand, acquire, and use verbal and non-verbal means of communicating thoughts and feelings. Provides opportunities that stimulate children to play with sound, rhythm, language, materials, space, and ideas in individual ways and to express their creative abilities.</p>
<p>Health, Safety and Nutrition (IL, MO, KS, KY, NV, NM, PA, WV)*</p>	<p>Not Specific</p>	<p>Competency Goal I: To establish and maintain a <u>safe, healthy, learning environment</u>; provides safe environment to prevent and reduce injuries, promotes good health and nutrition practices and provides an environment that contributes to the prevention of illness.</p>

Grid 1: Core Knowledge Area	NAEYC Competency Description	CDA Competency Description
<p>Child Observation and Assessment (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)</p>	<p>Standard 3: Observing, documenting, and assessing to support young children and families</p> <p>Know about and understand the goals, benefits, and uses of assessment. They know about and use systematic observations, documentations, and other effective assessment strategies in responsible ways, in partnership with families and other professionals, to support children's development and learning.</p>	<p>Not Specific</p>
<p>Learning Environment and Curriculum (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)</p>	<p>Standard 5: Using content knowledge to build curriculum</p> <p>Use their knowledge of academic disciplines to design, implement and evaluate experiences that promote positive development and learning each day for every young child. They understand the importance of developmental domains and academic disciplines in early childhood curriculum. They know the essential concepts, inquiry tools, and structure of academic areas, including academic subjects, and can identify resources to deepen their understanding. They use their own knowledge and other resources to design, implement, and evaluate meaningful, challenging curriculums that promote comprehensive developmental and learning outcomes for every young child.</p>	<p>Competency Goal 1: To establish and maintain a <u>safe, healthy, learning environment</u>; uses spaces, relationships, materials, and routines as resources for constructing an interesting, secure, and enjoyable environment that encourages play, exploration and learning.</p>

Grid 1: Core Knowledge Area	NAEYC Competency Description	CDA Competency Description
<p>Developmentally Appropriate Content (IL, MO, KS, NV, NM, NY, PA, WV)*</p>	<p>Standard 4: Using developmentally effective approaches to connect with children and families Understand that teaching and learning with young children is a complex enterprise, and details very depending on children's ages, characteristics and the settings within which teaching and learning occur. They understand and use positive relationships and supportive interactions as the foundation for their work with young children and families. They know, understand, and use a wide array of developmentally appropriate approaches, instructional strategies, and tools to connect with children and families and positively influence each child's development and needs.</p>	<p><u>Competency Goal III: To support social/emotional development and to provide positive guidance;</u> provides physical and emotional security for each child and helps each child know, accept, and take pride in himself or herself and develop a sense of independence. Helps each child feel accepted in the group, helps children learn to communicate and get along with others, and encourages feelings of empathy and mutual respect among child and adults. Provides a supportive environment in which children can begin to learn and practice appropriate and acceptable behaviors as individuals within a family.</p>
<p>Family and Community Partnerships (CA, IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)*</p>	<p>Standard 2: Building family and community relationships Know about, understand, and value the importance and complex characteristics of children's families and communities. They use this understanding to create respectful, reciprocal relationships that support and empower families, and to involve all families in their children's development and learning.</p>	<p><u>Competency Goal IV: To establish positive and productive partnerships with families;</u> maintains open, friendly and cooperative relationships with each child's family, encourages their involvement in the program, and supports the child relationships with his or her family.</p>
<p>Program Management and Administration (CA, MO, KS, KY, NV, PA, WV)*</p>	<p>Not Specific</p>	<p><u>Competency Goal V: To ensure a well-run, purposeful program responsive to participant needs;</u> a manager who uses all available resources to ensure effective operation. A competent organizer, planner, record keeper, communicator, and a cooperative worker.</p>

Grid 1: Core Knowledge Area	NAEYC Competency Description	CDA Competency Description
Professionalism (CA, IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)*	Standard 6: Becoming a professional Identify and conduct themselves as members of early childhood profession. They know and use ethical guidelines and other professional standards related to early childhood practices. They are continuous, collaborative learners who demonstrate knowledgeable, reflective, and critical perspectives on their work, making informed decisions that integrate knowledge from a variety of sources. They are informed advocates for sound educational practices and policies.	Competency Goal VI: To maintain a commitment to professionalism; makes decisions based on knowledge of early childhood theories and practices and promotes quality in child care services. Takes advantages of opportunities to improve competence, both for personal and professional growth and for the benefit of children and families.

*Each state names this competency differently

Grid 2: Crosswalk Other States' Core Knowledge and Competencies to CLASP Infant-Toddler Competencies and Indiana Youth Development Credential Standards and Core Competencies

Grid 2: Core Knowledge Area	Infant/Toddler** Competency Description	Indiana Youth Development Credential Competency Description ***
Child Growth and Development (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)	Providers and caregivers need to understand that babies' and toddlers' physical, social-emotional, language and cognitive development are interrelated	<u>Competency: Knowledge of Child/Youth Development</u> ; learns practices, communicates and demonstrates an awareness of child/youth development theory, principles and practices.
Health, Safety and Nutrition (IL, MO, KS, KY, NV, NM, PA, WV)*	Not specific	<u>Competency 7: Assures a Healthy and Safe Environment</u> ; provides a safe environment to prevent and reduce injuries, and promotes good health and nutrition, while providing an environment that contributes to the prevention of illness.
Child Observation and Assessment (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)	Providers and caregivers need to allow each baby to develop at his/her own pace and understand that there are wide range in what one can reasonably expect babies and toddlers to be able to do as they develop. Yet they must also be able to recognize when development doesn't occur within expected ranges and support the development of range.	<u>Competency 2: Observes and records pertinent information about children/youth</u> ; utilizes information from observations and assessment to plan for activities, materials and environment so that individual children/youth needs, interests and abilities are being met.
Learning Environment and Curriculum (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)	Providers and caregivers need to be able to provide babies and toddlers with language rich interactions and environment.	<u>Competency 8: Uses Indoor/Outdoor Environments</u> ; uses spaces, equipment and materials as resources for creating an interesting, secure, enjoyable environment that encourages interaction, exploration, learning and self- management for each child/youth, including those with special needs.

Grid 2: Core Knowledge Area	Infant/Toddler** Competency Description	Indiana Youth Development Credential Competency Description***
<p>Developmentally Appropriate Content (IL, MO, KS, NV, NM, NY, PA, WV)*</p>	<p>Providers and caregivers need to know how to establish warm, responsive, and nurturing relationships with infants and toddlers.</p> <p>Providers and caregivers need to be culturally competent in their care in order to help babies and toddlers understand and develop their sense of identity.</p>	<p><u>Competency 9: Planning for Interpersonal (Social) and Intrapersonal (Self);</u> supports development of peer group cohesion and collaborative participation by promoting group work, cooperative learning and community building. Provides many opportunities for all children/youth, including those with disabling conditions to feel effective, experience success and gain positive recognition from others.</p> <p><u>Competency 3: Individual Differences;</u> recognizes and respects the wide range of abilities, interests and needs of individual participants in a way that increases their self-esteem and their respect to others.</p> <p><u>Competency 4: Guidance skills;</u> handles a students' challenging behavior using age appropriate procedures established by best practice and in line with program policies. Identifies types of challenging behavior in students and responds appropriately and consistently.</p>

Grid 2: Core Knowledge Area	Infant/Toddler** Competency Description	Indiana Youth Development Credential Competency Description***
<p>Family and Community (CA, IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)*</p>	<p>Providers and caregivers must be able to form partnerships with families to better understand the needs of babies and toddlers.</p>	<p>Competency 5: <u>Respect for Diverse Cultures in Communities</u>; incorporates a positive attitude toward differences relating to language, culture, economics, gender roles, religion, family structures, age, and physical/mental capacity.</p> <p>Competency 6: <u>Works with Families</u>; maintains open, friendly and cooperative relationships with each child's/youth's family, encourages their involvement in the program and supports the child's/youth's relationship with his/her family.</p>
<p>Program Management and Administration (CA, MO, KS, KY, NV, PA, WV)*</p>	<p>Not specific</p>	<p>Not specific</p>

Grid 2: Core Knowledge Area	Infant/Toddler** Competency Description	Indiana Youth Development Credential Competency Description***
Professionalism (CA, IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)*	Not specific	<p>Competency 13: <u>Self-Development</u>: <u>Understanding of Self</u>- uses knowledge of self, including personal values and philosophy to evaluate program approaches. Takes Measures to ensure one's own mental and physical health.</p> <p><u>Basic Skills</u>- processes basic communication and computation skills and is able to apply thinking skills to solve problems.</p> <p>Competency 14: <u>Appreciates Children/Youth</u>; demonstrates a belief in the potential and empowerment of all children and youth and enjoys being with youth.</p> <p>Competency 15: <u>Ethical and Responsible Employee</u>; demonstrates professional work habits and conforms practices to information from public policy, agency policies and professional ethics.</p> <p>Competency 16: <u>Professional Development</u>; promotes quality in children/youth services and takes advantage of opportunities to improve competence for personal and professional growth, and for the benefit of children/youth and their families.</p>

* Each state names this competency differently

** Charting Progress for Babies in Child Care: Establish Core Competencies (CLASP)

*** Indiana Youth Development Credential Competencies

Grid 3: Crosswalk Other States' Core Competencies to Infant-Toddler Specialists of Indiana (ITSI) Credential Competencies

Grid 3 Core Knowledge Area	Infant-Toddler Specialists of Indiana (ITSI) Competencies
Child Growth and Development (IL, MO, KS, KY, NV, NJ, NM, NY, PA,, WV)	<p><u>C. 1. Infant-Toddler Development</u></p> <p>Requires both the acquisition of knowledge about child growth and development in all domains and how to apply this knowledge in practice.</p>
Health, Safety and Nutrition (IL, MO, KS, KY, NV, NM, PA, WV)*	<p><u>C. 3. Learning Environments</u></p> <p>Requires an understanding of how to create healthy and safe environments for infants and toddlers. Analyze these environments regularly to support the development, implementation, and maintenance of health and safety policies and procedures. Learn how to apply this understanding in these</p>
Child Observation and Assessment (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)	<p><u>C. 4. Assessment & Evaluation</u></p> <p>Requires learning about the importance of and developing the skills to assess and evaluate both children and learning environments.</p>
Learning Environment and Curriculum (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV)	<p><u>C. 3. Learning Environments</u></p> <p>Requires acquisition of knowledge of physical and relationship factors that impact the care and learning environment.</p>
Developmentally Appropriate Content (IL, MO, KS, NV, NM, NY, PA, WV)*	<p><u>C. 5. Diversity & Inclusion</u></p> <p>Includes understanding special education as it applies to birth to three, as well as social and cultural diversities.</p>
Family and Community (CA, (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV))*	<p><u>C. 2. Relationships</u></p> <p>Requires understanding the nature of and the role of the relationships that support sensitively responsive care, knowledge of attachment, and family centered practices.</p>
Program Management and Administration (CA, MO, KS, KY, NV, PA, WV)*	<p><u>C.6 Professionalism:</u></p> <p>Requires an understanding of ethics of the profession, advocacy and leadership, as well as current issues, trends, and challenges in the field of infant toddler care and education.</p>
Professionalism (CA, (IL, MO, KS, KY, NV, NJ, NM, NY, PA, WV))*	<p><u>C.6 Professionalism:</u></p> <p>Requires an understanding of ethics of the profession, advocacy and leadership, as well as current issues, trends, and challenges in the field of infant toddler care and education.</p>

Grid 4: Crosswalk Indiana Association for Infant and Toddler Mental Health (IAITMH) Endorsement Competencies to Indiana Core Knowledge and Competencies

IAITMH	Core Knowledge Areas
Theoretical Foundations	CK 1: Child/Youth Growth and Development CK 4: Learning Environment and Curriculum
Law, Regulation & Agency Policy	CK: Health, Safety and Nutrition CK 8: Professionalism
Systems Expertise	CK 6: Family and Community Partnership CK 7: Management and Professionalism
Direct Service Skills	CK 2: Health, Safety and Nutrition CK 3: Child/Youth Observation and Assessment CK 5: Learning Environment and Curriculum
Working with Others	CK 6: Family and Community Partnership CK 7: Management and Administration
Communicating	CK 6: Family and Community Partnership
Thinking	CK 8: Professionalism
Reflection	CK 8: Professionalism

Grid 5: Crosswalk Indiana’s Core Knowledge and Competencies to Indiana Common Core Academic Standards and Indiana Foundations to the Indiana Academic Standards for Young Children from Birth to Age 5

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<p><u>Competency A:</u> Demonstrate ability to create learning environments using materials and activities</p>	<p>None</p>	<p>Not Specific</p>
<p><u>Competency B:</u> Demonstrate the ability to use materials and activities to promote personal care and routines</p>	<p>None</p>	<p>Foundations for Personal Care</p>
<p><u>Competency C:</u> Demonstrate ability of using materials and activities to promote physical development; Physical Education</p>	<p>Physical Education:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Movement forms and proficiency in a few movements <input type="checkbox"/> Learning and development of motor (movement) Skills <input type="checkbox"/> Physically active lifestyle <input type="checkbox"/> Health-enhancing level of physical fitness <input type="checkbox"/> Personal and social behavior in physical activity settings <input type="checkbox"/> Respect for differences among people in physical activity settings <input type="checkbox"/> Opportunity for enjoyment, challenge, self-expression, and social interaction 	<p>Foundations for Physical Development/Physical Skills</p>

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<p><u>Competency D:</u> Demonstrate ability of using materials and activities to promote language development and literacy</p>	<p><u>English Language Arts:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Reading Standards: Foundational Skills-Phonological Awareness <input type="checkbox"/> Reading Standards: Foundational Skills- Print Concepts; Phonics and Word recognition <input type="checkbox"/> Reading Standards: Foundational Skills- Information Texts <input type="checkbox"/> Reading Standards: Foundational Skills- Literature: stories, Novels, Drama, and Poetry <input type="checkbox"/> Writing Standards: Language Conventions- printing, punctuation, capitalization; Speaking and Listening- Comprehend and Collaborate 	<p>Foundations for English/Language Arts</p>
<p><u>Competency E:</u> Demonstrate ability of using materials and activities to promote cognitive development; mathematics, science and social studies</p>	<p><u>Mathematics:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Counting, Cardinality, and Operations Base Ten <input type="checkbox"/> Operations and Algebraic Thinking <input type="checkbox"/> Measurement and Data <p><u>Science:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Physical Science <input type="checkbox"/> Earth and Space Science <input type="checkbox"/> Life Science <input type="checkbox"/> Science, Engineering and Technology <p><u>Social Studies:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> History: Past and Present <input type="checkbox"/> Civics and Government: Citizenship <input type="checkbox"/> Geography: Maps and Globes, Human and Physical System, and Seasonal Changes <input type="checkbox"/> Economics: Work, Goods and Services 	<p>Foundations for Mathematics</p> <p>Foundations for Science</p>

Grid 5: Indiana Core Knowledge Area: Learning Environment and Curriculum	Indiana Academic Common Core Standards	Indiana Early Childhood Foundations
<p><u>Competency F:</u> Demonstrate ability of using materials and activities to promote personal and social development; social studies</p>	<p><u>Social Studies:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> History: Past and Present <input type="checkbox"/> Civics and Government: Citizenship <input type="checkbox"/> Geography: Maps and Globes, Human and Physical System, and Seasonal Changes <input type="checkbox"/> Economics: Work 	<p>Foundations for Social Studies</p>
<p><u>Competency G:</u> Demonstrate ability of using materials and activities to promote creativity and arts</p>	<p><u>Visual Arts:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Responding to Arts <input type="checkbox"/> Visual Literacy <input type="checkbox"/> Creating Arts <input type="checkbox"/> Integrated Studies 	<p>Foundations for Fine Art</p>
<p><u>Competency H:</u> Demonstrate ability of using materials and activities to promote positive interactions and guidance</p>	<p>None</p>	<p>Foundations for Social Emotional</p>

Grid 6: Crosswalk Indiana’s Core Knowledge and Competencies to Indiana Early Childhood Administrator Credential

<p>Grid 6: Indiana Early Childhood Program Administrator Credential</p>	<p>Indiana Core Knowledge & Competencies</p>
<p><u>Pedagogical:</u></p> <ul style="list-style-type: none"> 1.1 Implement a curriculum which reflects the most accepted practices in child development. 1.2 Implement state/local regulations and professional standards pertaining to the health, safety, and nutrition of young children. 1.3 Design and plan indoor and outdoor environments that are nurturing, aesthetically pleasing, intellectually stimulating, and safe (physically and psychologically). 1.4 Differentiate and apply knowledge of theoretical perspectives in child development. 1.5 Apply knowledge of the biological, environmental, cultural, and social influences impacting children’s growth and development, prenatal through school age. 1.6 Apply knowledge of the historical roots and philosophical foundations of early care and education. 1.7 Apply knowledge of developmental progression and appropriate expectations in children’s physical, cognitive, language, aesthetic, social, and emotional development. 1.8 Apply knowledge of current research in neuroscience and its application to the field of early care and education. 1.9 Apply knowledge of different curriculum models, standards for high-quality programming, and child assessment practices. 1.10 Develop and implement a program to meet the needs of young children at different ages and developmental levels (infant/toddler, preschool, school age). 1.11 Implement administrative practices that promote the inclusion of children with special needs. 1.12 Apply child observations and assessment data to planning and structuring developmentally appropriate instructional strategies. 1.13 Be a reflective practitioner and apply strategies from a repertoire of techniques to improve the level of personal fulfillment and job satisfaction. 	<p><u>Core Knowledge Area 1: Child/Youth Growth and Development</u></p> <p><u>Core Knowledge Area 2: Health, Safety and Nutrition</u></p> <p><u>Core Knowledge Area 3: Child/Youth Observation and Assessment to meet individual needs</u></p> <p><u>Core Knowledge Area 4: Learning Environment and Curriculum</u></p> <p><u>Core Knowledge Area 5: Developmentally Appropriate Content</u></p>

Indiana Core Knowledge & Competencies	Indiana Core Knowledge & Competencies
<p>Grid 6: Indiana Early Childhood Program Administrator Credential</p> <p>1.14 Reflect on one’s personal professional growth and development, set goals for improvement, and take responsibility for one’s choices and actions.</p> <p>1.15 Model healthful lifestyle choices and provide opportunities for staff and children to learn habits that promote health and well-being.</p> <p>1.16 Apply knowledge of diverse family systems, traditional and nontraditional family structures, parenting styles, and the effect of family dynamics on the development of young children.</p> <p>1.17 Demonstrate awareness and appreciation of different cultural and familial practices and customs.</p> <p>1.18 Evaluate ethical and moral dilemmas based on a professional code of ethics.</p>	<p>Indiana Core Knowledge & Competencies</p>
<p><u>Organization and Systems:</u></p> <p>2.1 Develop a business plan</p> <p>2.2 Evaluate the cost-benefit of different marketing and promotional strategies.</p> <p>2.3 Create systems that utilize the fundamentals of effective marketing, public relations, and community outreach to:</p> <ul style="list-style-type: none"> a. Market a program such as defining the image of the center, maintaining the appearance of the building and program, and development of appropriate marketing materials (advertisements, brochures, promotional campaigns, web-based promotion, and staff incentives). b. Manage the response to parental inquiries including: defining the role of all staff in marketing, handling phone calls and tours, and managing a waiting list. c. Communicate the program’s philosophy and promote a positive public image to parents, business leaders, public officials, and prospective funders. d. Promote linkages with local schools. <p>2.4 Use written communication to effectively express one’s thoughts through the application of the mechanics of writing, including organization of ideas, grammar, punctuation, and spelling in communication with families, the community and the media.</p>	<p><u>Core Knowledge Area 6: Program Management and Administration</u></p> <p><u>Core Knowledge Area 7: Professionalism</u></p>

Indiana Core Knowledge & Competencies	Grid 6: Indiana Early Childhood Program Administrator Credential
	<p>2.5 Utilize oral communication techniques in public speaking, including establishing rapport, preparing the environment, active listening, and voice control in communication with families, the community and the media.</p> <p>2.6 Communicate ideas effectively in multiple formats, using the most current technology.</p> <p>2.7 Implement policies and procedures that help prevent, prepare for, and respond to emergencies and disasters.</p> <p>2.8 Establish procedures to maintain compliance with all applicable codes.</p> <p>2.9 Establish and maintain security practices.</p> <p>2.10 Maintain all equipment in safe, working condition.</p> <p>2.11 Oversee janitorial maintenance of building, grounds, and vehicles.</p> <p>2.12 Describe the legal definition of various early childhood organizational structures and philosophical bases.</p> <p>2.13 Comply with federal, state, and local regulations, including the understanding of rights and responsibilities of licensees.</p> <p>2.14 Develop a program philosophy, including a clear mission, vision statement, and program goals.</p> <p>2.15 Evaluate all program components and use the evaluation data to inform continuous program improvement.</p> <p>2.16 Use strategic planning techniques in program development and assessment.</p> <p>2.17 Apply organizational theory and leadership styles as they relate to early childhood work environments.</p> <p>2.18 Utilize the computer for child care administrative functions including effective use of pertinent software applications.</p> <p>2.19 Communicate with parents and colleagues via electronic mail.</p> <p>2.20 Articulate a vision, clarify and affirm values, and create a culture built on norms of continuous improvement and ethical conduct.</p> <p>2.21 Apply knowledge of NAEYC Early Childhood Program Standards and Accreditation Criteria.</p> <p>2.22 Identify organizational challenges, gather data to generate alternative solutions, and effectively apply analytical skills in their solution.</p> <p>2.23 Apply knowledge of various federal, state, and local revenue sources.</p> <p>2.24 Apply knowledge of bookkeeping methods.</p>

Indiana Core Knowledge & Competencies	Indiana Early Childhood Program Administrator Credential
	<p>2.25 Apply knowledge of budgeting, policies, regulations, grant writing, and fundraising.</p> <p>2.26 Apply knowledge of health and occupational safety rules.</p> <p>2.27 Apply knowledge of potential liability issues.</p> <p>2.28 Use financial tools and concepts including budget, fixed and variable expense, cash flow, deviation analysis, staffing plans and breakeven analysis.</p> <p>2.29 Apply concepts of income projection including pricing strategies, effect of discount policies and full time equivalent enrollment.</p> <p>2.30 Ensure cost-effective purchase of supplies and equipment.</p> <p>2.31 Collect tuition fees in an efficient and tactful manner.</p>
<p><u>Core Knowledge Area 7: Program Management and Administration</u></p>	<p><u>Human Resources:</u></p> <p>3.1 Recruit, select, orient, retain, coach, mentor and motivate staff to high levels of performance.</p> <p>3.2 Develop and manage personnel policies that include payroll, fringe benefits and leave.</p> <p>3.3 Schedule staff consistent with enrollment policies, involve staff in scheduling decisions, and to secure and supervise substitutes.</p> <p>3.4 Provide guidance, supervision, and formal evaluations for each employee.</p> <p>3.5 Apply knowledge of group dynamics, communication styles, and techniques for conflict resolution.</p> <p>3.6 Apply knowledge of different supervisory styles and career counseling strategies to implement an individualized model of staff development.</p> <p>3.7 Plan and facilitate group meetings.</p> <p>3.8 Relate to staff and board members of diverse genders, racial, cultural, and ethnic backgrounds.</p> <p>3.9 Apply skills in consensus building, team development, and problem solving.</p> <p>3.10 Model and teach problem solving techniques to staff.</p> <p>3.11 Apply knowledge of advantages and disadvantages of different legal structures.</p> <p>3.12 Apply knowledge of different codes and regulations as they relate to the delivery of early childhood program services.</p>

Indiana Core Knowledge & Competencies	Grid 6: Indiana Early Childhood Program Administrator Credential
	<p>3.13 Apply knowledge of child custody, child abuse and neglect, inclusion, confidentiality, antidiscrimination, risk management, contract, and labor laws pertaining to program management and child care.</p> <p>3.14 Guide teachers in planning and implementing an emerging, bias-sensitive, integrated curriculum that builds on children’s abilities and interests.</p> <p>3.15 Develop and implement strategies for management that build teamwork and participation of staff; to make effective use of time and other resources; to use short-term problem solving and long-term planning and conflict resolution.</p> <p>3.16 Provide a mechanism to define job roles, the distribution of authority, quality standards and concepts of teamwork and decision making.</p> <p>3.17 Maintain personal stability and confidence, self-awareness, desire for growth and ability to change and ability to establish a professional support system.</p> <p>3.18 Attend relevant, continuous, and appropriate training.</p> <p>3.19 Maintain memberships in professional organizations and child advocacy groups.</p> <p>3.20 Describe and defend one’s own beliefs, values, and philosophical stance.</p> <p>3.21 Discuss adult and career development, personality typologies, dispositions, and learning styles.</p>

Indiana Core Knowledge & Competencies	Indiana Core Knowledge & Competencies
<p>Grid 6: Indiana Early Childhood Program Administrator Credential</p> <p><u>Collaborative:</u></p> <ul style="list-style-type: none"> 4.1 Manage shared space as necessary; effectively negotiate a mutually positive relationship. 4.2 Work with and contribute to Board development and host relationships. 4.3 Facilitate the development of community among staff, parents, and the Board or advisory groups. 4.4 Communicate with parents about their individual child's development, about the program and policy issues and about the business aspects of caring for their child. 4.5 Arrange for or refer to social services or health services appropriate to the needs of families. 4.6 Apply knowledge of community resources to support family wellness. 4.7 Apply knowledge of different professional organizations and resources. 4.8 Implement program practice that support families of diverse cultural, ethnic, and linguistic, and socio-economic backgrounds. 4.9 Support parents as valued partners in the education process. 	<p>Core Knowledge Area 6: Family and Community Partnership</p>
<p><u>Public Policy:</u></p> <ul style="list-style-type: none"> 5.1 Advocate on behalf of young children, their families, and the profession. 5.2 Apply knowledge of the legislative process, social issues, and public policy affecting young children and their families. 	<p>Core Knowledge Area 8: Professionalism</p>

Resources

1. American Public Health Association, National resource Center for Health and Safety in Child Care and Early Education and American Academy of Pediatrics (2011). *Caring for our children: National health and safety performance standards. Guidelines for early care and Education Programs*. Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services. Ann Arbor, MI: Edwards Brothers.
2. Arkansas Early Childhood Professional Development System (2009). Arkansas' Key Content Areas and Core Competencies for Early Childhood Educators. Retrieved from <http://www.arkansas.gov/childcare/newsandevents/Arkansas%20Key%20Content%20Areas%20and%20Core%20Competencies%20Final%20DRAFT%20Version.pdf>
3. Center for the Study of Child Care Employment. (2008) Early Childhood Educator Competencies: A Literature review of Current Best Practices, and a Public Input Process on Next Steps for California.
4. CLASP (2009). Charting Progress for Babies in Child Care: Establish Core Competencies. Retrieved from http://www.clasp.org/admin/site/babies/make_the_case/files/cp_rationale1.pdf
5. Copple, C. & Bredekamp, S. (2009). *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*. NAEYC: D.C.
6. Council for Professional Recognition. (2011). *The Child Development Associate: Assessment System and Competency Standards*. Council for professional recognition: DC.
7. Cost, Quality, and Child Outcomes Study Team (1995). *Cost, quality, and outcomes in child care centers, Executive summary, 2nd ed.* Denver, CO: University of Colorado at Denver, Economics Department.
8. Division of Early Childhood Standards (2009).
9. Educational Developmental Center. (2002). *Early language and literacy classroom observation (ELLCO)*. Baltimore, MD: Paul Brooks Publishing Co.
10. Gestwicki, C. (1997). *The essentials of early education*. Delmar Publishers.
11. Harms, T., Clifford, R., and Cryer, D. (1998). *Early childhood environmental rating scale*. New York: Teachers College Press.
12. Harms, T., Cryer, D., & Clifford, R. (2003). *Infant/Toddler Environment Rating Scale. (Rev. ed.)*. New York: Teachers College Press
13. Indiana Afterschool Network and Indiana After School Taskforce. (2009). *Indiana Afterschool Standards: Advancing Quality Programs*. Retrieved from www.indianaafterschool.org
14. Indiana Department of Education & Family and Social Services Administration (2012). *Foundations to the Indiana Academic Standards for Young Children from Birth to Age*.
15. Kent County Professional Development System Training Consortium (2003). *Michigan's Core Knowledge and Core Competencies for Early Childhood Care and Education Professionals*. Retrieved from http://web.grcc.edu/FreyPDS/pdf_msdocs/CoreKnowledge_0103.pdf
16. Kids NOW. (2004). *Kentucky's early childhood core content*. Retrieved from <http://www.education.ky.gov/NR/rdonlyres/8CD5AF58-330F-42D1-8F9A-9C340E7842E2/0/RevisedCoreContent91504.pdf>

17. Kurz-Riemer, K. (2004). Core Competencies for Early Childhood education and Care Practitioners in Minnesota who work with children birth through age eight and their families. Retrieved from <http://www.health.state.mn.us/divs/cfh/meccs/corecompetencies.pdf>
18. National Association for the Education of Young Children (NAEYC) (2003). *NAEYC accreditation classroom observation book*. Washington, DC: Author.
19. NAEYC. (2009). *NAEYC: Where we stand on standards for programs to prepare early childhood professionals*. Retrieved from <http://www.naeyc.org/files/naeyc/file/positions/programStandards.pdf>
20. NAEYC. (2010). NAEYC standards for initial and advanced early childhood professional preparation: For use by Associate, Baccalaureate and Graduate degree programs. Retrieved from http://www.naeyc.org/ecada/files/ecada/file/Standards/NAEYC%20Initial%20and%20Advanced%20Standards%203_2012.pdf
21. National Association for the Education of Young Children (2009). Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8, Position Statement
22. Retrieved from <http://www.naeyc.org/files/naeyc/file/positions/PSDAP.pdf>
23. NAEYC. (2005). Code of ethical conduct and statement of commitment: A position statement of the National Association for the Education of Young Children. Retrieved from <http://www.naeyc.org/files/naeyc/file/positions/Ethics%20Position%20Statement2011.pdf>
24. NAEYC & NACRRA. (2009). ECE PD Training and TA Glossary.
25. National Training Institute (NTI) for Child Care Health Consultants (2001). *Caring for our children with special needs module*. Chapel Hill, NC: University of North Carolina, School of Public Health, Department of Maternal and Child Health.
26. OPEN Initiative. (2001). *Kansas and Missouri core competencies for early care and education professionals*. Center for Family Policy and Research/University Outreach and Extension. Retrieved from <https://www.openinitiative.org/content/pdfs/CoreCompetencies/EC-CoreCompetencies.pdf>
27. Pianta, R. C., La Paro, K., M., & Hamre, B. K. (2008). Classroom Assessment Scoring System™ (CLASS™). Baltimore, MD: Paul H Brookes Publishing.
28. U. S. Department of Health and Human Services (1998). *Head Start program performance standards and other regulations, Part 1304 and Part 1308*. Washington DC: Administration for Children and Families, Administration on Children, Youth and Families, Head Start Bureau
29. Sandall, S., McLean, M.E., Smith, B.J. (Eds.) (2000). *DEC recommended practices in early intervention/early childhood special education*. Denver, CO: Division for Early Childhood (DEC).
30. Trawick-Smith, J. (2003). *Early childhood development: A multicultural perspective*. Upper Saddle River, NJ: Pearson Education.
31. Family Child Care Accreditation Project (2003). *Quality standards for NAFCC accreditation, 3rd ed.* Wheelock College: The National Association for Family Child Care.
32. U. S. Department of Health and Human Services (2003). *The Head Start path to positive child outcomes: The Head Start child outcomes framework*. Washington DC: Administration for Children and Families, Administration on Children, Youth and Families, Head Start Bureau.
33. Indiana Early Childhood Program Administrator Credential Competencies (2009).
34. Indiana Academic Common Core Standards <http://www.doe.in.gov/achievement/standards>

Indiana Child Care Workforce Study 2005 and 2010 Workforce Education Comparison

The 2005 Indiana Child Care Workforce Study provided a baseline of information about the working conditions of the people in Indiana who care for and educate our youngest children. In 2010, the Indiana Association for the Education of Young Children, Inc., with funding from the Indiana Family and Social Service Administration, Division of Family Resources, Bureau of Child Care coordinated a statewide survey to collect comprehensive data about the child care workforce in Indiana. The 2010 Indiana Child Care Workforce Study provided a follow up study comparing the data collected in 2010 to that collected in 2005.

The data from the workforce surveys provide information about this very important industry and the critical issues that child care professionals face. The 2010 Indiana Child Care Workforce Study provides a comparison to the 2005 Indiana Child Care Workforce Study, which provided decision-makers with the facts to evaluate and plan statewide initiatives to support child care professionals and the children whom they care for and educate daily.

Education of the Indiana Child Care Workforce

Twenty-nine percent directors, 15% of teachers, and 9% of family child care providers have an Associate degree or higher in Early Childhood Education, a significant increase from 2005. Thirty-nine percent of directors, 23% of teachers, and 15% of family child care providers have an Associate's degree or higher in another field, such as Elementary Education or Business.

In 2005, Indiana child care workers reported an interest in achieving higher levels of education, and the reported data indicate an increase in the percent with a Bachelor's Degree or higher in Early Childhood Education or Child Development. In 2010, Indiana child care workers continued to express interest in achieving higher levels of education. As shown in TABLES 1, 2 and 3, many family child care providers, directors, and teachers have completed college courses.

Table 1-Educational Attainment of Licensed Family Child Care Providers

Highest Education Completed***	2005	2010
Bachelor Degree or Higher in ECE/CD*	2%	2%
Bachelor Degree or Higher in Other Field	10%	10%
Associate Degree in ECE/CD*	5%	7%
Associate Degree in Other Field	6%	5%
Other Educational Credits		
Child Development Associate Credential (CDA)	24%	36%
Educational Pursuits		
Currently Taking ECE/CD* Courses	21%	15%

*ECE/CD=Early Childhood Education/Child Development

***Percentages do not total 100% due to multiple responses possible

Table 2-Educational Attainment of Licensed Child Care Center / Unlicensed Registered Ministry Child Care Ministry Directors

Highest Education Completed***	2005	2010
Bachelor Degree or Higher in ECE/CD*	12%	13%
Bachelor Degree or Higher in Other Field	37%	37%
Associate Degree in ECE/CD*	12%	16%
Associate Degree in Other Field	5%	2%
Other Educational Credits		
Child Development Associate Credential (CDA)	22%	17%
Educational Pursuits		
Currently Taking ECE/CD* Courses	17%	15%

*ECE/CD=Early Childhood Education/Child Development
***Percentages do not total 100% due to multiple responses possible

Table 3- Educational Attainment of Teachers in Licensed Child Care Centers/Unlicensed Registered Child Care Ministries

Highest Education Completed***	2005	2010
Bachelor Degree or Higher in ECE/CD*	5%	6%
Bachelor Degree or Higher in Other Field	16%	20%
Associate Degree in ECE/CD*	8%	11%
Associate Degree in Other Field	4%	5%
Other Educational Credits		
Child Development Associate Credential (CDA)	23%	28%
Educational Pursuits		
Currently Taking ECE/CD* Courses	22%	21%

*ECE/CD=Early Childhood Education/Child Development
***Percentages do not total 100% due to multiple responses possible

working in child care in indiana

2010 Indiana Child Care Workforce Study



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For more information about the 2010 Indiana Child Care Workforce Study, please contact the Indiana Association for the Education of Young Children, Inc.

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Introduction

Every day, while they are working or going to school, Indiana families entrust the care and education of over 116,000 children to child care workers in licensed child care centers, unlicensed registered ministries, licensed family child care homes, and Head Start and Early Head Start programs around the state (Source: U.S. Department of Labor, Bureau of Labor Statistics, United States, 2009). In 2007, 65% of the children in Indiana under the age of six lived in families in which all parents present were in the workforce (Source: 2011 KIDS COUNT® Data Book, The Annie E. Casey Foundation). Between 2004 and 2007, there was a 5% increase in the number of children in Indiana under the age of six living in families in which all parents present were in the workforce (Source: 2011 KIDS COUNT® Data Book, The Annie E. Casey Foundation).



The early childhood education industry benefits not only the children who receive care and education, but also the economy of Indiana. The availability of child care is associated with working parents' reduced absenteeism, reduced turnover, and increased productivity at their jobs. Access to early childhood education services also allows greater labor market participation of parents and increases the ability of parents to pursue education. Studies have found significant long-term benefits associated with children's participation in high-quality early childhood education, including improved educational achievement, higher earnings and savings, fewer arrests and incarcerations, and other reductions in public spending.

The 2005 Indiana Child Care Workforce Study provided a baseline of information about the working conditions of the people in Indiana who care for and educate its youngest children. In 2010, the Indiana Association for the Education of Young Children, Inc., with funding from the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care, through the federal American Recovery and Reinvestment Act (ARRA), coordinated a statewide survey to collect comprehensive data about the child care workforce in Indiana. The 2010 Indiana Child Care Workforce Study will provide the first follow-up study comparing the data collected in 2010 to that collected in 2005.

In December of 2010, surveys were emailed and mailed to directors and teachers in licensed child care centers, unlicensed registered ministries, licensed Head Start and Early Head Start facilities, and to licensed family child care programs. Survey response rates were 38% of directors (n=477 director surveys collected), 28% of teachers (n=3,228 teacher surveys collected), and 28% of family child care providers (n=768 family child care provider surveys collected).

The data from the workforce surveys provide information about this very important industry and the critical issues that child care professionals face. This 2010 Indiana Child Care Workforce Study provides a comparison to the 2005 Indiana Child Care Workforce Study, which will better enable decision-makers to evaluate and plan statewide initiatives to support child care professionals and the children whom they care for and educate daily.



Methods

SURVEY INSTRUMENTS

Three written questionnaires were used to collect information from licensed child care center directors, registered child care ministry directors, child care teachers in licensed child care centers and registered child care ministries, and family child care director/owners in licensed family child care homes.

Two of the three questionnaires were used to develop online surveys to gather information from licensed child care center directors, registered child ministry directors, and family child care director/owners in licensed family child care homes with valid email addresses.

SAMPLING PROCEDURES

Licensed and registered child care program information was downloaded on October 29, 2010, and sent to the Indiana Association for the Education of Young Children, Inc. by the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care. One hundred percent of the providers on the list were included in the original sampling of all 92 Indiana counties. Two counties did not have any licensed child care centers or unlicensed registered child care ministries operating at the time of the download. Two counties were without any licensed family child care homes.

SURVEY MAILING AND DATA COLLECTION

Survey packets were mailed to 369 directors, 11,008 teachers, and 1,427 family child care providers across Indiana. Center/ministry packets included a cover letter and director survey (for the directors), as well as cover letters and teacher surveys (for teachers). Family child care home packets included a cover letter and a family child care provider survey. All packets included program incentive tickets that were to be completed and returned with the survey in the business reply envelopes provided for mailing. Surveys were returned to a designated post office box.

The online survey was emailed to those directors and family child care providers having valid email addresses, totaling 962 directors and 1,617 family child care providers. Online survey emails included the cover letter and the direct link to the survey. Additionally, for those directors with a valid email address, a teacher survey packet, which included surveys for teachers, program incentive tickets, and business reply envelopes for mailing, was mailed to the program.

The initial mailing (regular post and email) began the second week of December and was completed by December 17, 2010. After the initial mailing, 1,374 phone calls were made, 2,571 surveys were re-mailed, and 2,747 surveys were re-mailed to sites that had not yet responded to the survey. Directors were asked to remind teachers to return the surveys. The data collection and data entry phase culminated on June 14, 2011.

During the data collection phase, the Indiana Association for the Education of Young Children, Inc. project staff worked with the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care to clarify disconnected phone numbers, incorrect addresses, and program closures.



EXCLUSIONS

The original sample size for each type of survey was adjusted through the data collection phase. Sample size was reduced to 1,265 directors by through identification of facility closures and facilities where no children were enrolled. The family child care provider sample size was reduced to 2,768 due to location closures. The child care center/ministry teacher sample was increased to 11,737 as a result of directors' survey responses about the number of teacher surveys distributed. Phone calls were made to centers/ministries not responding to the survey.

REPORTING DATA

Median numbers have been reported in this document in order to convey the value that separates the highest half from the lowest half of each sample. For purposes of this report, percentages have been rounded, which may cause the variables in tables and figures to equal more or less than 100%.



Attachment D: A Great Early Childhood Education Workforce

Key Findings

- Child care workforce wages are markedly low despite increases since 2005. The median hourly wage reported for directors was \$14.77 per hour, a sixteen percent increase from 2005; \$9.00 per hour for teachers, a thirteen percent increase from 2005; and \$13.32 per hour for family child care home providers, a 49% increase from 2005.
- Fifty-five percent of licensed child care center/unlicensed registered ministry directors reported that their facilities do not help employees pay for health insurance. However, this represents a 5% improvement in the number licensed child care center/unlicensed registered ministries reporting that their facilities help employees pay for health insurance (from 2005). Thirty-seven percent of family child care providers reported having no health insurance. Since 2005, this represents a 12% increase in the number of family child care providers who report being without health insurance.
- Directors, teachers, and family child care providers responding to the survey were predominantly female. Of the 4,473 respondents, 176 were male.
- Fifty-two percent of teachers reported an annual family income below \$30,000; 57% of teachers at that income level reported having children of their own. This is comparable to data collected in the 2005 Indiana Child Care Workforce Study.
- Seventeen percent of directors, 26% of teachers, and 36% of family child care providers reported having a Child Development Associate (CDA) Credential. This represents an increase of 7% (compared to 2005) in the number of directors, teachers, and family child care providers who reported having a Child Development Associate (CDA) Credential. Twenty-nine percent of directors, 15% of teachers, and 10% of family child care providers reported having an Associate's Degree or higher in Early Childhood Education. Since 2005, there has been an 11% increase in the number of directors, teachers, and family child care providers who reported having an Associate's Degree or higher in Early Childhood Education.
- The annual turnover rate for full-time teachers in licensed child care centers/unlicensed registered ministries is 16%, compared to 26% in 2005. Programs offering more professional support benefits have fewer teachers planning to leave their jobs.
- In comparing 2010 to 2005: 11% compared to 13% of directors, 18% compared to 26% of teachers, and 9% compared to 11% of family child care providers reported that they are planning to leave the field within three years. Of those planning to leave (comparing 2010 to 2005): 71% compared to 51% of directors, 90% compared to 77% of teachers, and 82% compared to 43% family child care providers reported that the ability to earn higher wages would factor into the decision to remain in the field.



Survey Participants

The survey participants included licensed and registered types of child care. For clarification purposes, a definition provided by the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care Licensing Regulations and Laws (Indiana Administrative Code) follows:

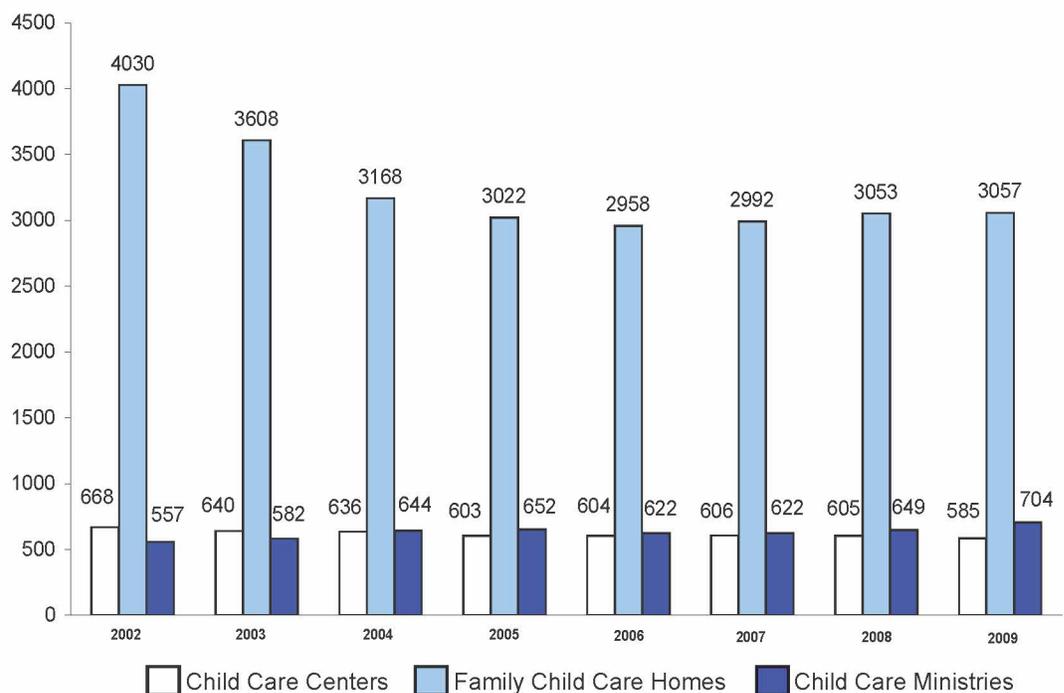
LICENSED CHILD CARE CENTER – a nonresidential building where at least one child receives child care from a provider while unattended by a parent, legal guardian, or custodian for regular compensation for more than four hours but less than 24 hours in each of ten consecutive days per year, excluding intervening Saturdays, Sundays, and holidays.

REGISTERED CHILD CARE MINISTRY – a child care operated by a church or religious ministry that is a religious organization exempt from federal income taxation under Section 501 of the Internal Revenue Code, unlicensed but registered with the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care and the Office of the State Fire Marshal.

LICENSED CHILD CARE HOME – a residential structure in which at least six children (not including the children for whom the provider is a parent, stepparent, guardian, custodian, or other relative) at any time receive child care from a provider while unattended by a parent, legal guardian, or custodian for regular compensation for more than four hours but less than twenty-four hours in each of ten consecutive days per year, excluding intervening Saturdays, Sundays, and holidays.

FIGURE 1 shows the number of child care facilities regulated by the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care for State Fiscal Years (SFY) 2002-2009.

FIGURE 1 - Number of Child Care Facilities Regulated by the Division of Family Resources for Fiscal Years 2002-2009



Licensed Child Care Centers and Unlicensed Registered Child Care Ministries

Licensed child care centers and unlicensed registered child care ministries participating in the survey operated under several auspices. Most of the director surveys represented not-for-profit facilities (69%). Programs included not-for-profit centers sponsored by faith communities, private not-for-profit centers sponsored by a community/board, and not-for-profit government-sponsored centers, such as Head Start and Early Head Start programs. For-profit centers included privately-run single centers and corporations/companies that operated multiple centers enrolling hundreds of children (See TABLE 1).

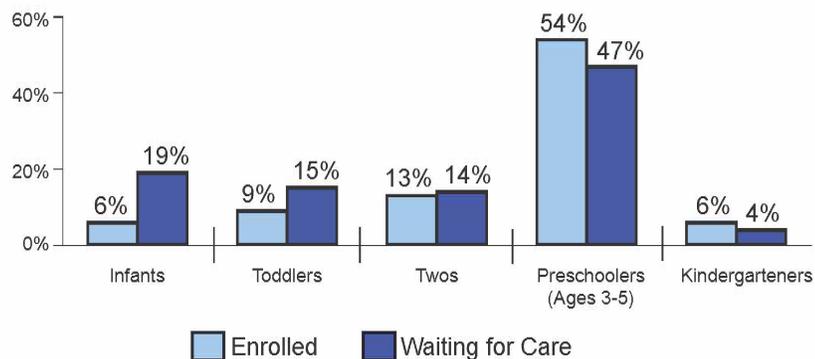
TABLE 1 - Licensed Child Care Center/Unlicensed Registered Child Care Ministry Director Survey
Respondents by Auspice

Center and Ministry Organizational Structure	Percentage of Return
Private for-profit (single center)	14%
Private for-profit (multi-center)	9%
Private not-for-profit (community/board sponsored)	19%
Private not-for-profit (sponsored by faith communities)	35%
Employee sponsored program	2%
Head Start and Early Head Start	15%
Other public programs*	2%

*Public school programs and other public programs

In October 2010, licensed child care centers and unlicensed registered child care ministries enrolled a median of 52 children from birth to age five (not including school-age children) per site and employed a median of six full-time and two part-time teachers. Seventy-five percent of the programs had children on a waiting list for enrollment. Infants and toddlers were 15% of the total number of children enrolled in centers/ministries but represented 34% of the children on a waiting list for care (as compared to 44% in 2005). Preschool children from three to five years of age were 54% of the total number of children enrolled (compared to 60% in 2005) and represented 47% of children waiting for care (compared to 42% in 2005; See FIGURE 2).

FIGURE 2 - Percentage of Children Enrolled in and Waiting for Care in Licensed Child Care Centers/Unlicensed Registered Child Care Ministries in October 2010



FUNDING SOURCES

Licensed child care centers and unlicensed registered ministries rely on a combination of funding sources to cover operating expenses. Fees paid by parents, child care subsidy payments, and reimbursements for food costs through the USDA Child and Adult Care Food Program are the primary sources of income. Weekly child care fees charged by centers ranged from a median of \$157.78 for infant care to a median of \$124.04 for children from three through five years of age. Thirty-one percent of the centers reported the enrollment of at least one child whose family was utilizing child care subsidy assistance (compared to 70% in 2005). Fifty-six percent of the centers/ministries were participating in the USDA Child and Adult Care Food Program to help defray the cost of serving nutritious meals to the children. Since 2005, this represents an 8% increase in centers/ministries utilizing the USDA Child and Adult Care Food Program.

STAFFING

Child care facilities represented a wide variety of positions in the child care field and worked with children of all ages. For purposes of this report, and to compare the responses to the 2005 Indiana Child Care Workforce Study, the term ‘Teachers’ refers to all teacher survey respondents. ‘Lead Teacher’ refers to the self-reported titles of Lead Teacher and Teacher, and ‘Assistant Teacher’ refers to the self-reported title of Assistant Teacher. Respondents held titles of Lead Teacher (44%) compared to (24%) in 2005, Teacher (20%) compared to (36%) in 2005, and Assistant Teacher (25%) compared to (27%) in 2005. Eleven percent described themselves as working in the capacity of “Other Position” as compared to 13% in 2005. Most teachers responding worked with children from birth through five years of age. Six percent worked with school-age children. Seventeen percent worked in more than one classroom. Those who completed a director survey held titles such as Director (80%) compared to (86%) in 2005, Director/Owner (7%) compared to (8%) in 2005, and “Other Positions” (13%) compared to (6%) in 2005.



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EMPLOYMENT BENEFITS

Employment benefits offered by licensed child care centers and unlicensed registered child care ministries in Indiana are shown in TABLE 2. Fifty-five percent of directors reported that their centers/ministries do not help employees pay for health insurance coverage; this is an improvement from 2005 when 60% of the directors reported that their centers/ministries did not help employees pay for health insurance coverage. According to center/ministry directors, 18% of their programs offer free child care to staff compared to 36% in 2005, and 44% offer reduced child care fees compared to 52% in 2005. Twenty-Eight percent of the teaching staff indicated that their children were enrolled in the child care facilities where they work compared to 36% in 2005.



Although teachers work with very young children who are frequently ill, 41% of centers/ministries do not offer a single day of paid sick leave (compared to 41% in 2005). Forty-five percent of the teaching staff reported that they had worked more than 40 hours per week at some point; 56% of those who worked more than 40 hours said that their centers paid them time and a half for the overtime hours worked.

TABLE 2 - **Employment Benefits in Licensed Child Care Centers and Unlicensed Registered Child Care Ministries**
(as reported by directors)

Type of Benefit	Percentage of Centers/Ministries Offering Benefits
Fully Paid Health Insurance	4%
Partially Paid Health Insurance	42%
Free Child Care	18%
Reduced Child Care Fee	44%
Parental Leave	53%
Paid Sick Leave	60%
Paid Vacation	80%
Paid Holidays	85%
Paid Retirement Benefits	34%



Family Child Care Homes

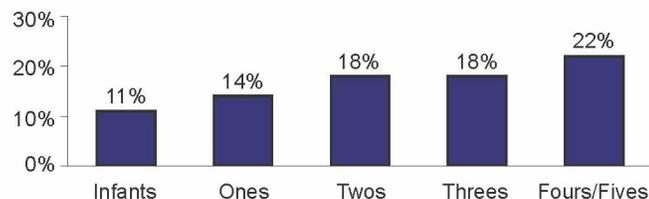
Family child care home providers responding to the survey had been in business for a median of 12 years as compared to 8.5 years in 2005. Providers reported working an average of 40 hours per week as compared to an average of 55 hours per week in 2005. Forty-nine percent reported having help from a paid assistant compared to 42% in 2005. Another 25% reported receiving assistance from a family member compared to 27% in 2005. Special services offered by family child care providers included: evening care 29% compared to 25% in 2005, overnight care 12% compared to 11% in 2005, holiday care 12%, the same as in 2005, and weekend care 14% compared to 12% in 2005. Forty-three percent of the family child care home providers reported caring for children on a drop-in basis. Nearly all homes (97%) required parents to sign a written agreement before enrolling their children. Others (58%) offered fee discounts to families enrolling more than one child; this is a decrease of 7% from 2005. Fifteen percent offered scholarships or sliding-fee scales compared to 9% in 2005. Forty-three percent of providers reported that they sometimes allowed sick children to attend child care.

Thirteen percent of family child care respondents indicated that their family child care home was in the process of becoming accredited through the National Association for Family Child Care (NAFCC). Eleven percent of family child care providers responding had achieved national accreditation through NAFCC compared to 7% in 2005.

As of October 2010, family child care home enrollment ranged from 0 to 85 children from birth to five years of age, with a median of ten young children enrolled in each home. FIGURE 3 shows the percentage of children from birth to five years of age enrolled in family child care homes. Four percent of the enrolled children from birth to five years of age were the providers' own children compared to 3% in 2005.

Weekly child care fees varied by age group. The median weekly fee for full-time infant care was \$109, up from \$90 in 2005. The median full-time fee for three-year olds was \$95, up from \$80 per week in 2005. Median fees from family child care homes were lower than center/ministry fees in every age group.

FIGURE 3 - Percentage of Children Ages Birth to Five Enrolled in Family Child Care Homes in October 2010



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EARNINGS AND EXPENDITURES

Family child care home providers' median gross monthly earnings (based on child care fees, subsidy payments, and USDA Child and Adult Care Food Program reimbursements) for October 2010 were \$4,277.97 compared to \$2,439.68 in 2005. Monthly median expenditures were \$1,292.50 compared to \$930.00. Fifty-two percent of homes reported enrolling children who received child care subsidy as compared to 44% in 2005. Food costs represented about 39% of providers' monthly expenditures as compared to 33% in 2005; 62% of family child care home providers defrayed this expense by participating in the USDA Child and Adult Care Food Program. The median reimbursement that providers reported receiving for October 2010 was \$634.00 as compared to \$445.52 in 2005. Median hourly earnings were \$13.32 as compared to \$8.83 in 2005; this was estimated by dividing net monthly earnings by the number of hours each home is open. This estimate does not include home occupancy costs, such as utilities, home improvements or repairs, cleaning, rent or mortgage. TABLE 3 shows the earnings and expenditures in family child care homes in October 2010.

TABLE 3 - Earnings and Expenditures in Family Child Care Homes for October 2010

Total Monthly Earnings (median)	\$4,277.97
Total Monthly Expenditures (median)	\$1,292.50
Net Monthly Income (median)	\$2,636.75
Hours Worked Per Week (median)	40
Hourly Earnings (median)	\$13.32

BENEFITS

Forty-nine percent of family child care home providers reported having help from a paid assistant; another 25% received assistance from a family member. Forty-three percent of family child care providers charged parents for weeks when they were on vacation and not providing care; 14% said that they never take vacations. Twenty-two percent of providers said that they worked when sick, and 43% charged for days when they were sick and not providing care. Sixty-three percent of family child care home providers have health insurance as compared to 76% in 2005. More than 38% of those with health insurance are covered by a spouse's insurance policy as compared to 53% of those covered in 2005. Only 21% have their own health insurance policy.



Demographic Profile of Indiana's Child Care Workforce

The child care workforce in Indiana is more than 96% female and includes a large proportion of workers who have children of their own (See TABLE 4). A total family income of less than \$30,000 was reported by 11% of directors, 52% of teachers, and 24% of family child care home providers. Of those in the \$30,000 or less annual income bracket, 78% of the directors, 57% of the teachers, and 87% of the family child care providers reported having children of their own. Thirty-seven percent of the directors, 39% of the teachers, and 52% of the family child care home providers with a total family income of less than \$30,000 annually reported themselves as being single parents.

TABLE 4 - Demographic Profile of the Child Care Workforce by Position

	Directors	Teachers	Family Child Care Providers
Median Age	45	33	46
Female	98%	98%	85%
People of Color	26%	21%	36%
Have Children	85%	66%	92%
At Least One Child 0-18	48%	46%	51%
Single Parent of Children 0-18	9%	17%	12%
Annual Family Income Below \$30,000	11%	52%	24%

Education of the Child Care Workforce

“Learning and motivation are dynamic, cumulative processes. Skill begets skill; learning begets learning. Early disadvantage, if left untreated, leads to academic and social difficulties later in life. Early advantages accumulate; just as early disadvantages.”

(Heckman & Masterov 2007, p.447)

Twenty-nine percent directors, 15% of teachers, and 10% of family child care providers have an Associate's Degree or higher in Early Childhood Education, a significant increase from 2005. Thirty-nine percent of directors, 23% of teachers, and 15% of family child care providers have an Associate's Degree or higher in another field, such as Elementary Education or Business.

In 2005, Indiana child care workers reported an interest in achieving higher levels of education, and the reported data indicate an increase in the percent with a Bachelor's Degree or higher in Early Childhood Education or Child Development. In 2010, Indiana child care workers continued to express interest in achieving higher levels of education. As shown in TABLES 5 and 6, many directors, teachers, and family child care providers have completed college courses. Of the survey respondents who were not taking courses, 20% of the directors, 36% of the teachers, and 24% of family child care providers expressed an interest in attending college to earn a degree (See TABLES 5 and 6 for educational attainment data on center/ministry directors, teachers, and family child care providers).



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TABLE 5 - Educational Attainment of Licensed Child Care Center/Unlicensed Registered Ministry Child Care Ministry Directors and Family Child Care Providers

Education	Center/Ministry Directors	Family Child Care Providers
Highest Education Completed***		
Bachelor Degree or Higher in ECE/CD*	13%	2%
Bachelor Degree or Higher in Other Field	37%	10%
Associate Degree in ECE/CD*	16%	7%
Associate Degree in Other Field	2%	5%
High School + Any College Courses	17%	49%
High School + Workshops	5%	12%
High School Diploma or G.E.D.	2%	10%
Some High School	<1%	1%
Other Educational Credits		
Child Development Associate (CDA) Credential	17%	36%
Educational Pursuits		
Currently Taking ECE/CD* Courses	15%	15%
Interested in Attending College to Earn a Degree**	20%	24%

*ECE/CD=Early Childhood Education/Child Development

**Percentages were drawn from the survey respondents not currently taking courses

***Percentages do not total 100% due to multiple responses possible

TABLE 6 - Educational Attainment of Teachers in Licensed Child Care Centers/Unlicensed Registered Child Care Ministries

Education	Teachers	Lead Teachers	Assistant Teachers
Highest Education Completed***			
Bachelor Degree or Higher in ECE/CD*	5%	6%	1%
Bachelor Degree or Higher in Other Field	18%	21%	12%
Associate Degree in ECE/CD*	10%	12%	5%
Associate Degree in Other Field	5%	5%	6%
High School + Any College Courses	38%	36%	46%
High School + Workshops	10%	10%	13%
High School Diploma or G.E.D.	12%	10%	18%
Some High School	1%	1%	2%
Other Educational Credits			
Child Development Associate (CDA) Credential	26%	30%	21%
Educational Pursuits			
Currently Taking ECE/CD* Courses	21%	21%	24%
Interested in Attending College to Earn Degree**	36%	35%	42%

*ECE/CD=Early Childhood Education/Child Development

**Percentages were drawn from the survey respondents not currently taking courses

***Percentages do not total 100% due to multiple responses possible



Earnings of Indiana's Child Care Workforce

The earnings of the child care workforce in Indiana are low (See TABLES 7 and 8). In 2010, median annual earnings for child care teachers in Indiana were \$18,720 as compared to \$16,596 in 2005. According to the Indiana Department of Workforce Development information on industry wages, jobs with salaries comparable to the wages of child care teachers include general merchandise store employees and transit and ground passenger transportation service providers (Source: Indiana Department of Workforce Development, Industry Wages Information, Quarter-1 2011).

Eleven percent of teachers and 9% of family child care providers reported that they worked another paid job in addition to their job in child care. Teachers worked a median of 10 hours in these additional jobs, and family child care providers worked a median of 20 hours in these additional jobs.

TABLE 7 - Self-Reported Earnings of Teachers in Licensed Child Care Centers/Unlicensed Registered Child Care Ministries

	Teachers	Lead Teachers	Assistant Teachers
Highest Hourly Earnings (90th Percentile)	\$13.00	\$13.33	\$11.00
Median Hourly Earnings (50th Percentile)	\$ 9.00	\$ 9.45	\$ 8.25
Lowest Hourly Earnings (10th Percentile)	\$ 7.30	\$ 7.50	\$ 7.25

The mean hourly wage for child care workers in 2009 was \$9.88. In 2009, the mean hourly wage for preschool teachers was \$16.61 an hour, \$34.24 an hour for kindergarten teachers, and \$37.02 an hour for elementary teachers (Source: U.S. Department of Labor, Bureau of Labor Statistics, National Compensation Survey: Occupational Earnings in the United States, 2009).

Child care center/ministry directors' median self-reported wage barely competes with the \$31,149.00 annual starting salary of an Indiana public school teacher (Source: National Education Association, 2010). Median annual earnings for center/ministry directors was \$30,721.60. Forty-nine percent of center/ministry directors reported working more than 40 hours a week.

TABLE 8 - Earnings of Licensed Child Care Center/Unlicensed Registered Child Care Ministry Directors and Family Child Care Providers

	Center/Ministry Directors	Family Child Care Providers
Highest Hourly Earnings (90th Percentile)	\$22.00	\$31.17
Median Hourly Earnings (50th Percentile)	\$14.77	\$13.32
Lowest Hourly Earnings (10th Percentile)	\$10.00	\$ 2.00



Attachment D: A Great Early Childhood Education Workforce

FIGURE 4 shows the median hourly wages earned by center/ministry directors and family child care providers at four levels of educational attainment.

FIGURE 4 - Median Hourly Wage of Licensed Child Care Center/Unlicensed Registered Child Care Ministry Directors and Family Child Care Providers by Educational Attainment

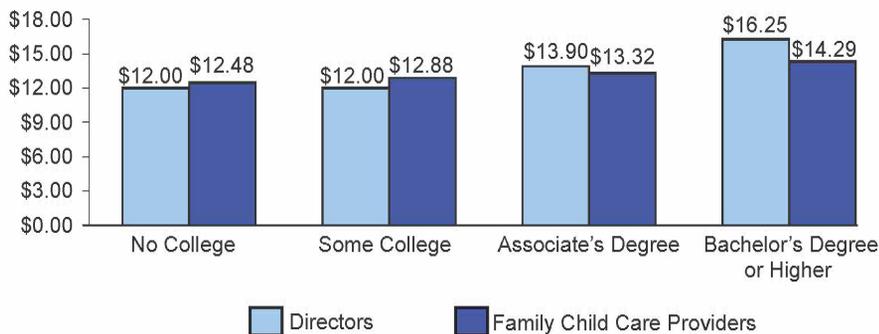


TABLE 9 shows the growth potential in earnings for teachers within licensed child care centers and unlicensed registered child care ministries that have achieved accreditation. Accrediting bodies included are the National Association for the Education of Young Children (NAEYC), the National Early Childhood Program Accreditation (NECPA), the Association of Christian Schools International (ACSI), the National Afterschool Association (NAA), and the Council on Accreditation (COA). Twenty-three percent of center/ministry respondents indicated that their program was in the process of becoming nationally accredited.



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TABLE 9 - Pay Rates of Lead Teachers and Assistant Teachers (reported by directors) in Licensed Child Care Centers, Unlicensed Registered Child Care Ministries, and Accredited Licensed Child Care Centers and Unlicensed Registered Child Care Ministries

	Median Starting Wage	Median Highest Wage
Lead Teachers		
Registered Child Care Ministries	\$ 8.00	\$ 9.65
Licensed Child Care Centers	\$ 9.00	\$11.45
Accredited Licensed Child Care Centers and Registered Child Care Ministries	\$10.00	\$12.00
Assistant Teachers		
Registered Child Care Ministries	\$ 7.50	\$ 8.50
Licensed Child Care Centers	\$ 7.99	\$ 9.00
Accredited Licensed Child Care Centers and Registered Child Care Ministries	\$ 8.00	\$ 9.50

Pay rates for teaching staff, including the typical starting wages and the typical highest wages paid to lead teachers and assistant teachers, were reported by center/ministry directors. Unlike self-reported earnings, these data highlight wage ranges within the child care centers and child care ministries. The lowest median starting wage reported for a lead teacher in an unaccredited program was \$8.00 per hour as compared to \$7.00 in 2005; the median starting wage reported for a lead teacher in an accredited program was \$10.00 per hour as compared to \$7.50 in 2005. The median highest wage reported for a lead teacher in an unaccredited program was \$9.65 per hour as compared to \$8.50 in 2005; the median highest wage reported for a lead teacher in an accredited site was \$12.00 per hour as compared to \$10.00 in 2005. This pattern of increase was also found among assistant teacher wages. The difference between the starting wage and the highest wage provides insight into the possibilities for growth in earnings.

Professional Support for the Child Care Workforce

T.E.A.C.H. EARLY CHILDHOOD® INDIANA PROJECT

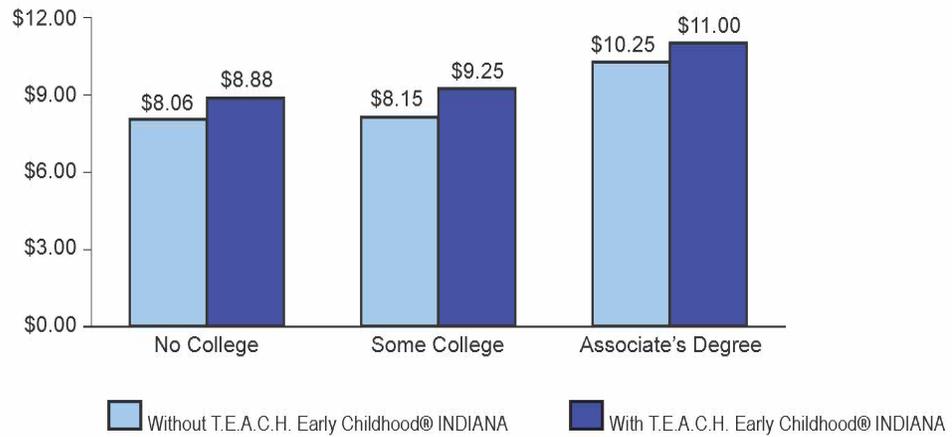
Sixty-eight percent of center/ministry directors reported that at least one staff member had received a T.E.A.C.H. Early Childhood® INDIANA scholarship at some point since the Project's implementation in 1999. Twenty-nine percent of teachers and 39% of family child care providers reported having received a T.E.A.C.H. Early Childhood® INDIANA scholarship. Only 2% of center/ministry directors, 8% of teachers, and 4% of family child care providers reported having never heard of the T.E.A.C.H. Early Childhood® INDIANA Project.



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FIGURE 5 compares the median hourly wage of teachers who have not received a T.E.A.C.H. Early Childhood® INDIANA scholarship with those who have received said scholarship. T.E.A.C.H. Early Childhood® INDIANA scholarships are available for eligible applicants who are pursuing a Child Development Associate (CDA) Credential, a Child Development Associate (CDA) Assessment, or a Child Development Associate (CDA) Renewal, or an Associate or Bachelor’s Degree in Early Childhood Education or Child Development.

FIGURE 5 - Median Hourly Wages by Educational Attainment of Teachers with and without a T.E.A.C.H. Early Childhood® INDIANA Scholarship



OTHER PROFESSIONAL SUPPORTS

There are many ways that licensed child care centers and unlicensed registered child care ministries can support the professional development of teachers. The workforce survey asked about seven types of professional development support: paid breaks, paid time off for training, paid planning or preparation time, paid education and training expenses, orientation programs, written job descriptions, and written personnel policies (See TABLE 10). Over 99% of centers/ministries offered at least one of these types of benefits as compared to 55% in 2005.

TABLE 10 - Professional Support Benefits for Teachers in Licensed Child Care Centers and Unlicensed Registered Child Care Ministries

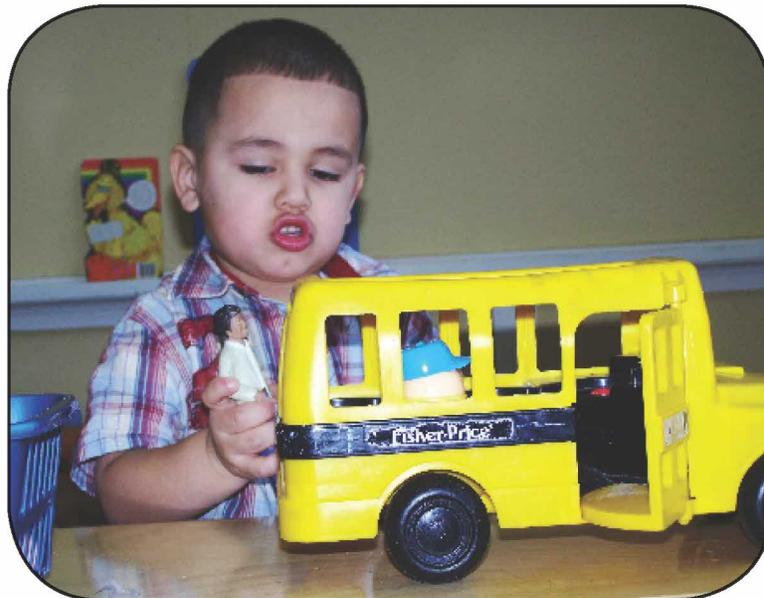
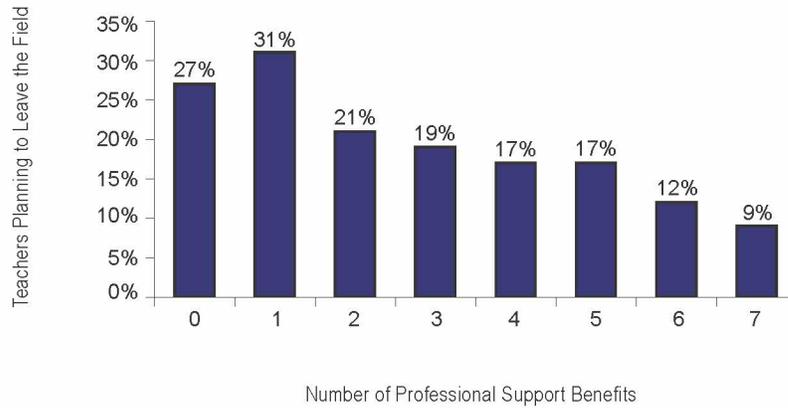
	Percentage of Centers/Ministries Offering Benefits
Paid Breaks	47%
Paid Time Off for Training	59%
Paid Planning/Preparation Time	71%
Paid Education/Training	71%
Orientation	79%
Written Job Description	79%
Written Personnel Policies	80%



Attachment D: A Great Early Childhood Education Workforce

Providing these types of professional support benefits may be a means for centers/ministries to reduce teacher turnover. Whereas, 18% of teachers statewide said that they would leave the child care field within three years compared to 26% in 2005, only 9% of the teachers in centers/ministries offering seven of the benefits listed in TABLE 10 said the same (See FIGURE 6). Although it is not clear whether these professional supports alone lower turnover, there is a definite pattern established with increased benefits.

FIGURE 6 - Teachers Planning to Leave the Child Care Field within Three Years by Number of Professional Support Benefits Received



Paths to QUALITY™ - Indiana's Quality Rating and Improvement System

Indiana is one of many states that has implemented a voluntary quality rating and improvement system designed to help parents find high-quality care for their children. In Indiana this system is “Paths to QUALITY™.” Paths to QUALITY™ was implemented statewide beginning in 2008 with the enrollment of licensed centers and licensed homes, and of unlicensed registered ministries meeting the voluntary certification system. In state fiscal year (SFY) 2008, there were 1,436 child care facilities, with a total capacity to serve 58,986 children, enrolled in Paths to QUALITY™. By state fiscal year (SFY) 2010, there were 1,867 child care facilities, with a capacity of 69,264 children, enrolled. As of April 2011, 2,001 child care facilities, with the capacity to serve 73,887 children, were enrolled (Source: Indiana Family and Social Service Administration, Division of Family Resources, Bureau of Child Care, 2011).

Paths to QUALITY™ Levels:

- Level 1: Basic health and safety needs of children
- Level 2: Environment supports children's learning
- Level 3: Planned curriculum that aligns with Indiana Early Learning Guidelines
- Level 4: National accreditation

The 2010 Indiana Child Care Workforce Study survey included questions for directors, teachers, and family child care home providers about program enrollment and status in Paths to QUALITY™. Sixty-three percent of the directors from licensed child care centers and unlicensed registered child care ministries responded that their program is currently enrolled in Paths to QUALITY™. Seventy percent of the teachers working in licensed child care centers and unlicensed child care ministries reported that their program is currently enrolled in Paths to QUALITY™. Sixty-seven percent of the family child care home providers reported that their program is currently enrolled in Paths to QUALITY™.

Ninety-four percent of the directors in licensed child care centers and unlicensed registered ministries and 91% of the family child care home providers reported that the Paths to QUALITY™ Media Toolkit was helpful in marketing their child care facility. Ninety-five percent of the directors in licensed child care centers and unlicensed child care ministries and 93% of the family child care home providers reported that the on-site mentoring/quality advising and technical assistance was helpful in increasing the quality of care and education provided to children.

Eighteen percent of the teachers responding to the survey reported that their program was a Level 1 in Paths to QUALITY™; 17% of teachers reported their program was at a Level 2 in Paths to QUALITY™; 24% of teachers reported their program was at a Level 3 in Paths to QUALITY™; 32% of teachers reported their program was at a Level 4 in Paths to QUALITY™. Nine percent of teachers responding said that they didn't know the Paths to QUALITY™ level of their respective program. Sixty-five percent of the teachers in licensed child care centers and unlicensed registered child care ministries reported that they have noticed positive changes at the center because of their enrollment in Paths to QUALITY™. Fifty-eight percent of the teachers in licensed child care centers and unlicensed registered child care ministries reported that they share what's happening with Paths to QUALITY™ with the children's parents.



Experience and Turnover of Indiana's Child Care Workforce

Young children need consistent, experienced, well-educated child care teachers with whom they can form close attachments. The national turnover rate for child care workers is between 25% and 40% annually (Source: Center for the Child Care Workforce, 2010). Indiana has a combination of child care professionals who have remained with their current programs for several years and those who have either just entered the field or started in a new child care program (See TABLE 11). The median number of years that center/ministry directors have worked in the field is 15 as compared to 12 years in 2005. The median years that directors have worked in their present position is 5 years as compared to 4 years in 2005. The range included directors who have worked in their position less than a year and directors who have worked in their position for over 45 years. Among family child care providers, the median length of time in the business is 12 years as compared to 8.5 years in 2005. The range included family child care providers who have worked as a family child care provider for less than a year and providers who have been a family child care provider for over 45 years.

TABLE 11 - Child Care Workforce Median Years of Experience

Lead Teachers	
Median Years in Current Center	3
Median Years in Child Care Field	8
Assistant Teachers	
Median Years in Current Center	2
Median Years in Child Care Field	5
Directors	
Median Years in Current Center	5
Median Years in Child Care Field	15
Family Child Care Providers	
Median Years as Family Child Care Provider	12



The survey included two measures of turnover: (1) the percentage of lead teachers and assistants who left their centers/ministries during the previous year, and (2) the percentage of directors, teachers, and family child care providers who are planning to leave the child care field within the next three years (see TABLE 12). A proportion of all full-time teachers (16%) left their centers in the previous twelve months compared to 26% in 2005. Of the centers responding, 17% had no full-time staff turnover during the previous year, while 3% of the centers/ministries had turnover at or above 100% of current full-time staff.

TABLE 12 - Child Care Workforce Turnover

Full Time Teacher Turnover	16%
Part-Time Teacher Turnover	20%
Teachers Planning to Leave the Field within 3 Years	18%
Lead Teachers Planning to Leave the Field within 3 Years	17%
Assistant Teachers Planning to Leave the Field within 3 Years	25%
Directors Planning to Leave the Field within 3 Years	11%
Family Child Care Providers Planning to Leave within 3 Years	9%



Potential Turnover

Eleven percent of directors, 18% of teachers, and 9% of family child care providers reported that they planned to leave the field within three years. This is a significant decrease from the 2005 report for all positions. Of those planning to leave the field, 71% percent of directors, 90% of teachers, and 82% of family child care providers commonly indicated that higher earnings would encourage them to stay. Different motivators among the groups stemmed from the unique roles and responsibilities of each group, though all three were generally interested in additional support for the work they do, such as the ability to have more time off (family child care providers) and better employment benefits (directors and teachers). Of those planning to leave the field, some directors (45%), teachers (20%), and family child care providers (30%) reported that they were leaving for reasons not likely influenced by the receipt of additional supports. Eighty-nine percent of directors, 82% of teachers, and 91% of family child care providers reported that they would be working in the child care field in three years.

Final Comments

Children from birth through five years of age are estimated to comprise 8.3% of the total Hoosier population. In 2009, there were an estimated 534,603 children from birth through five years of age in the state of Indiana. Not only does the Early Childhood Education industry benefit from the number of children who receive formal care, but so does the economy of Indiana. Every day while they are working or going to school, Indiana's families entrust the care and education of their young children to child care directors, teachers, and family child care providers. The availability of child care is associated with working parents' reduced absenteeism, reduced turnover, and increased productivity at their jobs. Access to early childhood education also allows greater labor market participation of parents and increases the ability of parents to pursue education.

The 2010 Indiana Child Care Workforce Study provides comprehensive data on various issues facing the child care workforce.



Glossary

ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL (ACSI): A worldwide accrediting organization uniquely dedicated to delivering the message of Christ dedicated to school improvement to assist schools in changing for the better in an orderly and systematic way through accreditation.

CHILD CARE SERVICES ASSOCIATION (CCSA): Located in Chapel Hill, North Carolina, CCSA is a non-profit, United Way agency committed to ensuring the affordability, accessibility and quality of child care. Through research, services and advocacy, CCSA works to improve child care systems across the United States. CCSA has developed several innovative and effective quality improvement initiatives, including the T.E.A.C.H. Early Childhood® Project, Child Care WAGES® Project, and numerous other child care quality improvement projects.

CHILD DEVELOPMENT ASSOCIATE CREDENTIAL (CDA): The CDA is a national competency-based certification for individual child care providers awarded through the national Council for Professional Recognition. The credentialing program focuses on the skills of early care and education professionals and is designed to provide performance-based training and assessment of preschool teachers, home visitors, and family child care providers.

COUNCIL ON ACCREDITATION (COA): An international organization partnering with human service organizations to improve service delivery outcomes by developing, applying, and promoting best practice standards for programs serving all ages. Accreditation for Early Child Care and Development Services and for After School Programs provided.

HEAD START AND EARLY HEAD START: Head Start and Early Head Start are federally funded comprehensive child development programs. Focusing on children from age three to kindergarten entry and their families, Head Start has the overall goal of increasing the school readiness of young children in low-income families. Early Head Start serves pregnant women, infants and toddlers up to age three. All programs provide early childhood educational, social, medical, dental, nutritional and mental health services to the enrolled children and are based on comprehensive child development services, parent involvement and community partnerships.

NATIONAL AFTERSCHOOL ASSOCIATION (NAA): An accrediting organization of after school professionals dedicated to the development, education and care of children and youth during their out-of-school hours.

NATIONAL ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN (NAEYC): Founded in 1926, NAEYC is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age eight. In 1985 NAEYC developed a national voluntary accreditation system to set professional standards for early childhood programs and to help families identify high-quality programs. The accreditation system is administered by the NAEYC office in Washington, D.C.



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NATIONAL ASSOCIATION FOR FAMILY CHILD CARE (NAFCC): A non-profit organization dedicated to promoting quality child care by strengthening the profession of family child care.

NATIONAL EARLY CHILDHOOD PROGRAM ACCREDITATION (NECPA): An international accrediting organization dedicated to raising early care and education program's quality bar, bringing tangible benefits and experiences to the lives of the children and families they serve.

T.E.A.C.H. EARLY CHILDHOOD® INDIANA PROJECT: T.E.A.C.H. Early Childhood® stands for Teacher Education and Compensation Helps Early Childhood, an umbrella for a variety of different scholarship programs. The T.E.A.C.H. Early Childhood® INDIANA project provides scholarships for teachers, directors, and family child care providers who are working in legally exempt or regulated early childhood programs. Each scholarship is made up of four components and includes an educational scholarship, completion of formal education, compensation upon completion of the education, and a commitment by the scholarship recipient to remain at the site or in the field for a specified period of time. All T.E.A.C.H. scholarships link continuing education with increased compensation and require that recipient and their sponsoring child care programs share in the cost. Project funding comes from the Indiana Family and Social Services Administration, Division of Family Resources, Bureau of Child Care through the federal Child Care and Development Block grant.

USDA CHILD AND ADULT CARE FOOD PROGRAM (CACFP): CACFP is a federal program that provides healthy meals and snacks to children and adults receiving day care. The facilities that receive reimbursement for their meal costs include child care centers, family child care homes, after school care program, homeless shelters, and adult day care services.



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Appendix A

2010 Indiana Early Childhood Workforce Study - Survey Response Final Report

#	County	Population	Director Sample %	Director Sample Original	Director Sample Current	Director Surveys Received	Director Response Rate	Teacher Sample Original	Teacher Sample Current	Teacher Surveys Received	Teacher Response Rate	Home Sample %	Home Sample Original	Home Sample Current	Home Surveys Received	Home Response Rate
1	Adams	Rural	100%	8	8	5	63%	48	70	36	51%	100%	7	6	4	67%
2	Allen	Urban	100%	72	69	33	48%	683	734	264	36%	100%	204	178	59	33%
3	Bartholomew	Urban	100%	13	13	9	69%	142	148	49	33%	100%	31	28	8	29%
4	Benton	Rural	100%	2	2	1	50%	12	5	3	60%	100%	8	7	4	57%
5	Blackford	Rural	100%	2	2	1	50%	3	6	4	67%	100%	9	9	1	11%
6	Boone	Urban	100%	13	13	5	38%	135	155	37	24%	100%	20	20	8	40%
7	Brown	Rural	100%	2	2	0	0%	3	3	0	0%	100%	4	4	3	75%
8	Carroll	Rural	100%	4	4	3	75%	16	11	4	36%	100%	1	1	1	100%
9	Cass	Rural	100%	6	6	1	17%	54	54	9	17%	100%	8	7	3	43%
10	Clark	Urban	100%	23	23	8	35%	214	203	32	16%	100%	36	31	7	23%
11	Clay	Rural	100%	5	5	2	40%	23	32	3	9%	100%	10	9	1	11%
12	Clinton	Rural	100%	7	6	4	67%	51	51	10	20%	100%	7	6	2	33%
13	Crawford	Rural	100%	2	2	0	0%	2	2	2	100%	100%	6	5	0	0%
14	Daviess	Rural	100%	6	6	2	33%	50	53	18	34%	100%	22	20	8	40%
15	Dearborn	Rural	100%	9	7	2	29%	91	55	28	51%	100%	7	5	1	20%
16	Decatur	Rural	100%	4	4	2	50%	27	30	18	60%	100%	9	7	3	43%
17	Dekalb	Rural	100%	8	8	5	63%	36	58	30	52%	100%	13	12	7	58%
18	Delaware	Urban	100%	21	19	8	42%	205	197	102	52%	100%	31	29	12	41%
19	Dubois	Rural	100%	5	5	3	60%	36	57	26	46%	100%	28	26	8	31%
20	Elkhart	Rural	100%	30	30	8	27%	240	249	64	26%	100%	46	44	9	20%
21	Fayette	Rural	100%	3	3	0	0%	17	17	4	24%	100%	10	7	4	57%
22	Floyd	Urban	100%	23	22	9	41%	178	185	48	26%	100%	73	67	24	36%
23	Fountain	Rural	100%	1	1	1	100%	4	8	6	75%	100%	5	4	1	25%
24	Franklin	Rural	100%	0	0	0	0%	0	0	0	0%	100%	13	13	7	54%
25	Fulton	Rural	100%	4	4	4	100%	18	20	15	75%	100%	13	13	7	54%
26	Gibson	Rural	100%	6	6	4	67%	43	48	13	27%	100%	27	23	5	22%
27	Grant	Urban	100%	7	6	4	67%	53	57	12	21%	100%	20	18	7	39%
28	Greene	Rural	100%	3	3	1	33%	11	19	8	42%	100%	29	27	6	22%
29	Hamilton	Urban	100%	55	52	22	42%	760	766	143	19%	100%	64	57	17	30%
30	Hancock	Urban	100%	12	12	6	50%	72	77	18	23%	100%	37	29	5	17%
31	Harrison	Rural	100%	4	4	1	25%	27	33	6	18%	100%	29	26	4	15%
32	Hendricks	Urban	100%	30	29	15	52%	327	352	88	25%	100%	51	48	20	42%
33	Henry	Rural	100%	6	6	2	33%	38	28	13	46%	100%	22	18	6	33%
34	Howard	Urban	100%	25	24	6	25%	188	216	36	17%	100%	24	20	7	35%
35	Huntington	Rural	100%	10	10	5	50%	63	78	25	32%	100%	17	13	4	31%
36	Jackson	Rural	100%	6	6	4	67%	21	47	4	9%	100%	29	27	8	30%
37	Jasper	Rural	100%	2	2	0	0%	16	16	4	25%	100%	5	5	2	40%
38	Jay	Rural	100%	1	1	0	0%	7	7	0	0%	100%	12	11	4	36%
39	Jefferson	Rural	100%	5	5	3	60%	22	45	8	18%	100%	28	24	10	42%
40	Jennings	Rural	100%	2	2	1	50%	9	15	2	13%	100%	14	10	2	20%
41	Johnson	Urban	100%	25	25	7	28%	270	294	47	16%	100%	29	26	12	46%
42	Knox	Urban	100%	11	11	2	18%	82	113	36	32%	100%	29	25	7	28%
43	Kosciusko	Rural	100%	16	16	6	38%	91	102	25	25%	100%	22	20	5	25%
44	LaGrange	Rural	100%	4	4	2	50%	25	23	16	70%	100%	6	6	1	17%
45	Lake	Urban	100%	101	94	23	24%	804	819	224	27%	100%	267	241	41	17%
46	LaPorte	Rural	100%	10	10	4	40%	57	72	17	24%	100%	73	68	18	26%
47	Lawrence	Rural	100%	6	6	2	33%	44	41	9	22%	100%	31	31	8	26%

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2010 Indiana Early Childhood Workforce Study - Survey Response Final Report

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48	Madison	Urban	100%	18	17	6	35%	145	152	60	39%	100%	54	51	11	22%
49	Marion	Urban	100%	311	290	79	27%	2763	2755	627	23%	100%	487	447	96	21%
50	Marshall	Rural	100%	7	7	0	0%	38	38	0	0%	100%	21	20	8	40%
51	Martin	Rural	100%	1	1	1	100%	7	5	5	100%	100%	8	7	1	14%
52	Miami	Rural	100%	9	9	4	44%	53	55	12	22%	100%	5	5	1	20%
53	Monroe	Urban	100%	30	30	15	50%	221	296	78	26%	100%	64	61	15	25%
54	Montgomery	Rural	100%	8	7	1	14%	43	40	6	15%	100%	11	11	2	18%
55	Morgan	Urban	100%	15	15	4	27%	151	141	8	6%	100%	15	11	6	55%
56	Newton	Rural	100%	0	0	0	0%	0	0	0	0%	100%	2	2	0	0%
57	Noble	Rural	100%	7	6	3	50%	47	39	21	54%	100%	8	8	3	38%
58	Ohio	Rural	100%	2	2	2	100%	7	9	6	67%	100%	1	1	0	0%
59	Orange	Rural	100%	1	1	0	0%	7	7	0	0%	100%	18	16	8	50%
60	Owen	Rural	100%	2	2	2	100%	11	8	4	50%	100%	9	8	1	13%
61	Parke	Rural	100%	3	3	3	0%	13	14	5	36%	100%	11	11	3	27%
62	Perry	Rural	100%	3	3	1	33%	13	13	4	31%	100%	9	9	5	56%
63	Pike	Rural	100%	3	3	1	33%	11	11	3	27%	100%	10	10	3	30%
64	Porter	Urban	100%	26	24	7	29%	181	204	53	26%	100%	25	24	8	33%
65	Posey	Rural	100%	4	4	3	75%	29	32	15	47%	100%	8	8	1	13%
66	Pulaski	Rural	100%	2	2	1	50%	8	11	6	55%	100%	6	6	4	67%
67	Putnam	Rural	100%	7	7	4	57%	39	39	7	18%	100%	14	14	10	71%
68	Randolph	Rural	100%	3	3	1	33%	17	22	8	36%	100%	5	4	2	50%
69	Ripley	Rural	100%	7	6	3	50%	49	49	21	43%	100%	15	15	4	27%
70	Rush	Rural	100%	1	1	0	0%	4	4	0	0%	100%	9	9	2	22%
71	Saint Joseph	Urban	100%	58	56	23	41%	439	475	146	31%	100%	143	124	25	20%
72	Scott	Rural	100%	3	3	1	33%	20	27	3	11%	100%	8	8	2	25%
73	Shelby	Urban	100%	4	4	0	0%	31	31	17	55%	100%	15	15	9	60%
74	Spencer	Rural	100%	5	5	3	60%	26	23	12	52%	100%	13	12	2	17%
75	Starke	Rural	100%	2	2	0	0%	8	8	0	0%	100%	2	1	0	0%
76	Steuben	Rural	100%	6	6	4	67%	48	74	5	7%	100%	13	10	6	60%
77	Sullivan	Rural	100%	1	1	0	0%	5	5	0	0%	100%	20	18	2	11%
78	Switzerland	Rural	100%	2	2	0	0%	8	8	0	0%	100%	4	4	2	50%
79	Tippecanoe	Urban	100%	43	42	18	43%	341	435	193	44%	100%	66	56	17	30%
80	Tipton	Rural	100%	3	2	1	50%	17	16	9	56%	100%	0	0	0	0%
81	Union	Rural	100%	1	1	1	100%	7	7	6	86%	100%	1	1	1	100%
82	Vanderburgh	Urban	100%	41	38	21	55%	415	498	186	37%	100%	131	119	38	32%
83	Vermillion	Rural	100%	2	1	1	100%	9	6	4	67%	100%	9	7	4	57%
84	Vigo	Urban	100%	17	15	5	33%	133	151	33	22%	100%	167	157	28	18%
85	Wabash	Rural	100%	8	8	4	50%	48	57	12	21%	100%	9	8	4	50%
86	Warren	Rural	100%	1	1	0	0%	9	9	0	0%	100%	0	0	0	0%
87	Warrick	Rural	100%	8	8	2	25%	49	52	13	25%	100%	53	51	12	24%
88	Washington	Rural	100%	2	1	0	0%	14	8	2	25%	100%	27	27	11	41%
89	Wayne	Urban	100%	20	16	9	56%	111	95	12	13%	100%	30	30	4	13%
90	Wells	Rural	100%	5	4	1	25%	33	46	28	61%	100%	10	10	4	40%
91	White	Rural	100%	3	3	2	67%	15	25	7	28%	100%	15	15	8	53%
92	Whitley	Rural	100%	6	5	4	80%	47	66	25	38%	100%	7	6	4	67%
	TOTAL		100%	1331	1265	477	38%	11008	11737	3228	28%	100%	3044	2768	768	28%

Attachment D: A Great Early Childhood Education Workforce

Appendix B

Data Summary by Auspice and Position

Child Care Facilities	State Total n=477	For-Profit Centers n=119	Not-for-Profit Faith-Based Centers n=174	Not-for-Profit Centers n=175
Median Center Preschool (0-5) Enrollment	52	65	42	53
Accredited Centers	87	25	5	54
Turnover Rate of Full-Time Teachers	16.0%	18.0%	14.0%	17.0%
Median Starting Teacher Wage	\$8.50	\$8.00	\$7.75	\$8.50
Median Highest Teacher Wage	\$10.50	\$9.75	\$9.00	\$10.50
Fully Paid Health Insurance	4.0%	< 1.0%	2.0%	6.0%
Annual Vacation Days: 10 or More	46.0%	42.0%	36.0%	59.0%
Monthly Sick Leave: 1 Day or More	24.0%	20.0%	10.0%	39.0%
Job Protected Parental Leave	53.0%	52.0%	36.0%	70.0%
Retirement Contributions	34.0%	28.0%	11.0%	61.0%
Paid Education/Training Expenses	71.0%	76.0%	57.0%	84.0%
Paid Time Off for Training	59.0%	58.0%	48.0%	73.0%
Provide Orientation	79.0%	84.0%	68.0%	87.0%
Reduced Cost Child Care	44.0%	60.0%	43.0%	34.0%
Free Child Care	18.0%	17.0%	29.0%	10.0%

Directors	State Total n=477	For-Profit Centers n=119	Not-for-Profit Faith-Based Centers n=174	Not-for-Profit Centers n=175
Median Hourly Wage	\$14.77	\$15.62	\$13.50	\$16.91
Median Number of Years in Center	5.0	4.5	5.3	4.7
Median Number of Years in Child Care Field	15.0	13.0	13.5	16.0
Associate's Degree or Higher in ECE	29.0%	35.0%	24.0%	43.0%

Teachers	State Total n=3,228	For-Profit Centers n= 1,150	Not-for-Profit Faith-Based Centers n= 986	Not-for-Profit Centers n= 1,082
Median Hourly Wage	\$9.00	\$9.00	\$8.34	\$9.98
No Health Insurance	31.0%	32.0%	33.0%	28.0%
Median Number of Years in Center	4.6	3.9	4.8	4.4
Median Number of Years in Child Care Field	9.6	14.0	6.0	8.0
Associate's Degree or Higher in ECE	15.0%	10.0%	8.0%	27.0%

Indiana's Family Child Care Home Summary Data

Family Child Care Providers	State Total n=768
Accredited Family Child Care Homes	87
Median Hourly Wage	\$13.32
Median Number of Years as a Family Child Care Provider	12.0
Associate's Degree or Higher in ECE	10.0%



INDIANA ASSOCIATION FOR THE



EDUCATION OF YOUNG CHILDREN, INC.

Grants for Enhanced Assessment Instruments

Kindergarten Entry Assessment Competition

Project Narrative

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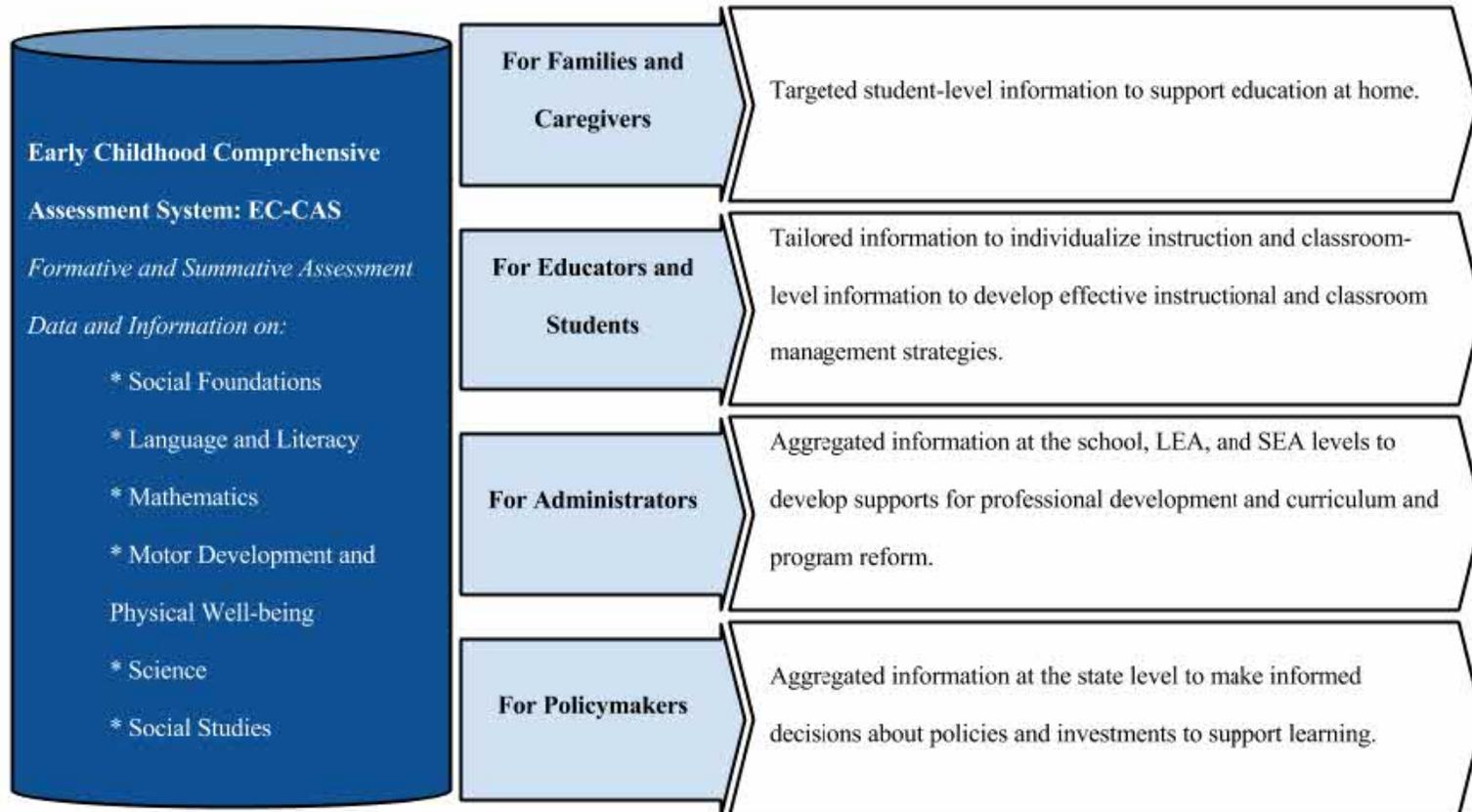
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Project Overview

The Consortium¹ has a compelling vision for enhancing a multi-state, state-of-the-art assessment system composed of a kindergarten entry assessment (KEA) and aligned formative assessments. This enhanced system—supported by expanded use of technology and targeted professional development—provides valid and reliable information on each child’s learning and development across the essential domains of school readiness, which will lead to better instruction, more informed decision-making, and reductions in achievement gaps over time. The Consortium recognizes that achieving this vision will be challenging, requiring high levels of commitment, technical expertise, collaboration across member States and partners, and strong management skills, systems, and supports.

Building on a highly successful existing effort already underway between Maryland and Ohio, the proposed system greatly expands the use of technology for more authentic and compelling items and tasks; efficiency of administration, scoring, and reporting; and increased student motivation. The end result will be a more reliable and valid system that provides timely, actionable data to identify individual student and program strengths and weaknesses, drive instruction, support curricular reform, and inform all stakeholders in the system about the effectiveness of preschool and kindergarten programs. The figure on page 3 shows the information that the assessment system provides for all end users.

¹ “The Consortium” refers to an alliance of States—including Connecticut, Indiana, Maryland, Massachusetts, Michigan, Nevada, and Ohio, with Maryland serving as the fiscal agent—and three prominent educational research and development organizations: WestEd (Assessment & Standards Development Services [ASDS] and Center for Child & Family Studies programs), the Johns Hopkins University Center for Technology in Education (JHU CTE), and the University of Connecticut’s Measurement, Evaluation, and Assessment Program.



Background Information on the Development of EC-CAS 1.0—On December 16, 2011, Maryland and Ohio were each awarded Race to the Top Early Learning Challenge (RTT-ELC) Grants for four years. These grants support an innovative partnership to revise and enhance Maryland’s and Ohio’s kindergarten entry assessments and develop preschool and kindergarten formative assessments for children ages 36 to 72 months. These partnership efforts will culminate in a new Early Childhood Comprehensive Assessment System (EC-CAS), including a KEA and formative assessments, supported by a statewide technology infrastructure, and a professional-development system. In the context of this proposal, the existing EC-CAS and KEA will be referred to as version 1.0; the proposed enhanced EC-CAS and KEA will be referred to as version 2.0. The development of the EC-CAS 1.0, conducted under a Memorandum of Understanding (MOU) with Maryland serving as the fiscal agent, is currently in its second year, and KEA 1.0 is slated for field testing in November 2013, with statewide implementation in both Maryland and Ohio in the 2014–15 school year.

A number of partners are playing a vital role in executing Maryland and Ohio’s shared vision for improving kindergarten readiness and early childhood assessments. These partners include the Johns Hopkins University Center for Technology in Education (JHU CTE), WestEd (including the agency’s Assessment & Standards Development Services program and the Center for Child & Family Studies), State advisory councils in each Consortium State, and a national Technical Advisory Committee (TAC), facilitated by the Council of Chief State School Officers (CCSSO), advising both States.

Early Childhood Comprehensive Assessment System 1.0 (EC-CAS 1.0)—Maryland and Ohio are committed to developing the EC-CAS for all children from preschool through kindergarten, and to a statewide implementation of the system in 2014–15. The assessment components of the EC-CAS are:

- aligned to both States’ guidelines or standards for young children from birth through kindergarten;
- designed to assess children in seven developmental domains, including Social Foundations (approaches toward learning, executive functioning, and social and emotional development),

Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, Social Studies, and (in Maryland only) The Arts;

- linked to State longitudinal data systems, to allow for consistent and meaningful reporting at the student, class, school, district, and state levels;
- designed to be maximally accessible to young children with a wide range of background experiences and developmental needs;
- systematically developed and field tested within a framework grounded in theory, research, and best practice, to ensure its validity and reliability; and
- reviewed by a national TAC composed of developmental psychologists, early childhood content and assessment experts from fields including child psychology and measurement, and experts on young, diverse student populations (e.g., English language learners and students with disabilities).

The EC-CAS includes a kindergarten entry assessment (targeted at children aged 66 months) and (for children aged 36 through 72 months) formative assessments. Combined, these two assessment components provide key stakeholders—families/caregivers, educators, administrators, and policymakers—with a balanced view of students’ learning needs and provide actionable information to help tailor instruction and interventions.

Kindergarten Entry Assessment 1.0 (KEA 1.0)—KEA 1.0 is the cornerstone of the assessment system. The KEA blueprint includes assessment standards within each domain of learning or development; alignment with early learning and development standards, including the States’ kindergarten standards; and three types of assessment approaches, measuring essential skills and knowledge of incoming kindergarteners in age-appropriate, reliable, and valid formats. Once KEA 1.0 is fully operational in 2014–15, the data will be used to inform early-childhood education and care stakeholders, guide decision-making about professional-development needs, and assist teachers in data-driven instructional decision-making to meet each student’s individual needs.

Formative Assessments—Formative tools are being developed to monitor children’s progress on a continuum of typical development along critical learning progressions, which define the knowledge and skills that are typically developed over time for children ages 36 months through 72 months. These formative assessments will equip families, caregivers, and teachers to track individual children’s learning trajectories; individualize learning opportunities and plan for interventions; engage in real-time curriculum planning; and ensure that children are on a path to kindergarten readiness and beyond.

Response to Selection Criteria

(a) Theory of Action

(1) The Consortium is committed to the enhancement of EC-CAS 1.0 in order to provide a meaningful, comprehensive early childhood assessment system that provides meaningful results to a range of stakeholders. Within this system, the purpose of the KEA is to provide information to stakeholders at the local, regional, and state levels about how well prepared children are for kindergarten. This will be accomplished in two ways:

- Use of KEA information at the individual student level—Families, caregivers, and kindergarten teachers will learn about each student’s skills, learning, and developmental needs, so that they can identify strengths and weaknesses for each student, resulting in individualized plans to inform instruction and any necessary interventions.
- Use of KEA information at student group and subgroup levels—School, local district, and State leaders will learn about students’ levels of preparedness and readiness for kindergarten (i.e., school), which will enable programmatic decision-making at the school, district, and state levels. Score information by domain, and overall readiness, will be summarized by demographic characteristics, in order to pinpoint where there are achievement gaps upon kindergarten entry, how children’s prior education and care experiences impacted readiness, and where to target

resources to better support identified at-risk children through academic, health, and behavioral supports and interventions. By making aggregated assessment reports available in the online reporting system (ORS) at the student, classroom, school, and district levels, and facilitating the integration of the KEA results into longitudinal data systems at the state level, the KEA can inform these policy, research, and educational decisions.

The purposes of the KEA are complemented by the purposes of the formative assessments:

- to monitor children’s progress along a continuum of typical child development across six domains of learning (seven if assessing The Arts), as facilitated by 28 learning progressions (32 if assessing The Arts), from 36 to 72 months; and
- to determine if a child with an Individualized Education Program (IEP) or Individualized Family Support Plan (IFSP) has demonstrated improved (1) social-emotional skills; (2) acquisition of knowledge and skills; and (3) use of appropriate adaptive behaviors to meet his or her needs.

The relationship between the formative assessments and KEA 2.0 is illustrated in the following chart.

Both the formative assessments and KEA 2.0 are based on six domains of learning and development (seven if assessing The Arts). The formative assessments are based on the learning progressions within the age range of 36 to 72 months, and KEA 2.0 serves as the summative “snapshot” of kindergarten (i.e., school) readiness at roughly 66 months. The chart further illustrates how the KEA is part of a larger early-childhood assessment system, from preschool through kindergarten, the components of which serve as key milestones within States’ preschool-through-grade 12 statewide assessment systems. KEA 2.0 will allow for expectations to be aligned and student progress to be tracked from the end of the EC-CAS, at 72 months, through grade 3—when students begin taking either the PARCC or Smarter Balanced assessments or others equally aligned to rigorous college/career readiness standards—and beyond.

Early Childhood Comprehensive Assessment System

Domains	36 mo.	42 mo.	48 mo.	54 mo.	60 mo.	66 mo.	72 mo.	Grade 3
Social Foundations	Formative Assessments <i>Development represents a continuum of changing behaviors</i>					KEA <i>Summative “snapshot” of readiness</i>	Formative Assessments	
Language and Literacy								College and
Mathematics								Career
Motor Development and Physical Well-being								Readiness
Science								
Social Studies								
The Arts (MD only)								

(2) The KEA and the formative assessments are part of an overall educational system that includes early learning and development standards, curricular resources and instructional practices, professional development, and instructional interventions and policy improvements, all designed to enhance the school-readiness skills of entering kindergarten students and ensure that students are on a learning trajectory to graduate from high school ready for college and careers. Each of these components of the system is considered in the following sections.

Early Learning and Development Standards—Critical to the establishment of the Consortium is commonality of the States’ early learning and development standards. Although all participating States have adopted rigorous college and career readiness standards, each State has also individually developed early learning and development standards that vary from those of other Consortium States. Close alignment among them can be found in the Language and Literacy and Mathematics domains, but the other areas vary in scope, content, and expression. Maryland and Ohio faced this issue when they

embarked on developing EC-CAS 1.0 as part of their RTT-ELC Grant. Agreement was reached when the nexus of the problem was defined not as identical standards but as common standards, in terms of scope and content, for the most critical learning progressions. As a consequence, the Common Language Standards (CLS) were developed to define the specific content that was to form the basis of the KEA and the formative assessments. The CLS are aligned to the individual State standards and provide common definitions for the scope and content to be assessed. This approach led to agreement on standards for Maryland and Ohio that are substantially identical; the Consortium is confident that a similar approach will assure that the standards across all Consortium States meet the same expectation of commonality.

The following table provides an overview of the domains, strands, and learning progressions included in EC-CAS 1.0, as expressed in the CLS². States that joined the Consortium reviewed the CLS to determine whether their State's early learning and development standards are compatible with the CLS and reflect a meaningful sampling of the State's standards for kindergarten entry.

Domains, Strands, and Learning Progressions Included in EC-CAS 1.0

Domain	Strands	Learning Progressions
Social Foundations	Social Emotional Approaches to Learning and Executive Functioning	Awareness and Expression of Emotion Relationship with Adults Conflict Resolution Self-Control Persistence

² The learning progressions for the Arts domain are currently in development. For EC-CAS 1.0, Maryland opted to assess this domain, and Ohio did not; the other States in the Consortium have yet to make a decision about the assessment of this domain. All other domains reflect learning progressions that are aligned with the early learning standards of the Consortium States.

Domain	Strands	Learning Progressions
		Working Memory Problem Solving Initiative Cooperation with Peers
Language and Literacy	Reading Speaking and Listening Writing Language	Story/Text Comprehension Phonological Awareness Phonics and Letter Recognition Communication Emergent Writing Grammar Vocabulary
Mathematics	Counting and Cardinality Operations and Algebraic Thinking Measurement and Data Geometry	Number Sense Number Operations Classification Measurement Shapes
Motor Development and Physical Well-being	Physical Education Health	Coordination—Large Motor Coordination—Small Motor Safety and Injury Prevention Personal Care Tasks
Science	Skills and Processes/Life Science	Inquiry and Observation
Social Studies	Government History	Responsible Behavior Events in the Context of Time

Domain	Strands	Learning Progressions
The Arts (MD only)	Music Visual Arts Theater Dance	Music Visual Arts Theater Dance

Curricular Resources and Instructional Practices—Preschool and kindergarten teachers need the tools to implement curriculum and instructional practices based on early learning and development standards. Maryland and Ohio have established processes—including adding requirements to the States’ tiered quality rating and improvement systems—by which published preschool curricula and instructional practices must be aligned with each State’s early learning and developments standards. Such practices will be reviewed by all States in the Consortium to ensure that the available instructional resources are known and utilized.

Professional Development for Teachers—Recognizing the critical role of effective professional development to support real reform, the proposed assessment system calls for professional development for educators in three key areas: pre-administration, administration of the assessment with fidelity, and post-administration analysis and use of assessment data.

The professional-development sessions will be provided to educators using a variety of methods, including face-to-face, online, communities of practice, and discussion groups. A system of regional professional-development providers, situated within and funded by each State, will facilitate the training and supports needed for educators. In addition, each State will tie the KEA and the importance of using assessment information into other professional development that focuses on standards and learning supports. As the technology applications are expanded with the development of EC-CAS 2.0, professional-development opportunities will be expanded to include support for systematic progress

monitoring, enhanced accommodations through the use of technology, and tailored professional development based on specific State needs and identified needs from the implementation of EC-CAS 1.0.

(3) Instructional Interventions and Policy Improvements—The educational system, with its elements of standards, curriculum, professional development, instruction, and assessment, strengthens support for teachers as they prepare young children for the important transition into a new learning environment. It is critical that such a system remains responsive to each individual learner. Without formative assessments and the KEA, the responsiveness of teachers is impaired, and a systemic approach to addressing learning difficulties or specific learning styles is not possible. A KEA embedded in formative assessments, progress monitoring, and individualized instruction allows opportunities for teachers to improve each student’s foundational skills and eradicate school readiness gaps among students. The KEA results provide information on groups and subgroups of children, identify early opportunity gaps before children come to school, and strengthen accountability among early-childhood education providers and curriculum and program developers. In addition, by incorporating the formative assessments and the KEA into their broader preschool–through–grade 12 assessment and longitudinal data systems, States are able to understand relationships between kindergarten readiness and assessment results in grade 3 and beyond, in order to inform overall college and career readiness.

(d) Research and Evaluation

(1) The proposed technology-enhanced assessment system is highly innovative, creating challenges for both users and researchers. This section describes a series of analyses and studies designed to inform each phase of development and to ensure that both the KEA and aligned formative components of the assessment system are valid, reliable, and able to meet their ambitious goals and claims and reflect the recommendations of the National Research Council. Consequential validity studies will also be included, to determine whether the assessments are being implemented as designed and whether the theory of action is being realized, including whether the intended effects on individuals and institutions are being achieved.

The *Joint Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 1999) function as the predominant basis for the evaluation of educational assessment programs by the measurement community. The Standards “provide criteria for the evaluation of tests, testing practices, and the effects of test use” (p. 2) by addressing issues related to test construction and documentation, test fairness, and applications of testing across disciplines. Further, the U.S. Department of Education’s Peer Review Guidance for Evaluating Evidence of Final Assessments under Title I of the Elementary and Secondary Education Act (1999) specifically recommends that States use the Standards to document the technical quality of large-scale assessments. In the Standards, validity is defined as the “degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of tests” (p. 9). The interrelationships among the interpretations and proposed uses of test scores and the sources of validity evidence define the validity argument for an assessment. The evaluation of scores from multiple sources of evidence forms the foundation of what is referred to as the unitary conceptualization of validity (Kane, 2006); this perspective will form the foundation for the validation of KEA 2.0.

Evidence Based on Test Content—The foundation of EC-CAS 1.0 is the CLS, which are based on the Maryland and Ohio standards for preschool and kindergarten. These standards address Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, Social Studies, and (currently in Maryland only) The Arts. Each charter State in the Consortium has committed to adopting, no later than the 2016–17 academic year, essential skills and knowledge that are based on each State’s standards and that align with the CLS.

Test construction is at the heart of instrument validation. Alignment and accessibility will be the major considerations in the selection of content for KEA 2.0. Educators of students with disabilities and English language learners will play an active role in item development and review in both the pilot and field-test phases. All items will undergo a bias (fairness) review to address cultural stereotyping, item-irrelevant characteristics that may render student groups at an advantage or disadvantage, sensitive topics,

and offensive language. The development, training, and review processes, including those involving State committees, are outlined in the following sections *(h)* and *(i)*.

Validity evidence based on test content will include:

- alignment reports from charter Consortium States, to demonstrate the consistency between individual State standards and the KEA 2.0 blueprint (Consortium standards);
- alignment reports that demonstrate alignment with kindergarten and grade 1 standards (where applicable);
- review and revision of the test specifications by the Consortium TAC;
- review of item writer and editor training protocols; and
- an empirical survey of a representative sample of preschool and kindergarten teachers in each State, to demonstrate the depth of instruction on and relative importance of the Consortium standards. Samples will be constructed to represent diversity in student populations, geography, and program types.

Evidence Based on Internal Structure—All evidence based on internal structure will be drawn from the 2015 KEA 2.0 field test. The design of KEA 2.0 will incorporate multiple measures, including guided recorded observation, performance tasks, developmental rubrics, and selected-response items.

Statistical analyses of the selected-response items will include the following:

- the proportion of students selecting each option for each item;
- analyses based on the total raw score of the set of items and the proportions of upper, middle, and lower percentages of students selecting each option;
- the difficulty of each item (*p*-value and delta);
- the discrimination of each item (biserial and point-biserial);
- IRT difficulty and discrimination indices;
- discrimination indices for each option for each item;
- differential item functioning (DIF); and

- internal consistency estimates of reliability for the set of items.

Statistical analyses for the performance tasks and observational data will include:

- the proportion of students at each score point;
- based on the total raw score of the set of items, the proportion of upper, middle, and lower scores by score point; and
- measures of central tendency for the total score for each set of items.

Standard internal-consistency measures of reliability will be conducted on the selected-response items at the subscore and total-score levels. Generalizability theory will be used to quantify the proportion of variance in scores on the performance tasks that is attributable to the measurement procedures (to be defined further during the instrument development process). Reliability estimates will be reported at the State level and the Consortium level.

Reliability will also be addressed through the subgroup-level analysis of KEA 2.0 data. Descriptive data for the individual items and raw scores will be presented by student demographic subgroup as additional evidence of test fairness. Reliability evidence will also include bias and sensitivity review of the test content and assessment, as well as DIF analyses. Dimensionality of the set of items will be evaluated using factor analysis and structural equation modeling. It is expected that field-test items will maintain the structure of domains of early learning and development that was used to design KEA 2.0.

Interrater reliability is an important consideration for the KEA. Reliability is a key component of the online professional development offered to teachers. See section (e) for details on the professional development and training that all administrators and scorers will receive.

Evidence Based on Response Processes—Evidence based on response processes is particularly relevant to the development of KEA 2.0. First, a key component of KEA 2.0 is direct response data from kindergarten students online at the start of the kindergarten year. Detailed evidence that these young students are capable of critically analyzing prompts and selecting appropriate responses is critical to the validity of the KEA. Evidence based on response processes can contribute to questions about differences

in scores among subgroups of students. Cognitive labs will be set up in order to explore students' thought processes when completing the items. The cognitive labs are particularly critical for ensuring that the selected-response items are accessible to a wide range of students at various levels of development, as well as to students with disabilities and English language learners. Item accessibility includes comprehension of the item stem, as well as the ability to store the item stem in the working memory, search the memory store for information relevant to the item stem, and review the response options. Methodologies and results for these studies will be reviewed with the KEA 2.0 TAC, and items will be revised accordingly.

Rubric-based observations and performance tasks are also at the foundation of the KEA and the larger assessment system. It is critical to the success of the program to understand whether rubrics and rating scales are applied to student performances, skills, and behaviors as intended. Evidence based on response processes can serve as reliability evidence. In the pilot phase of development, questionnaires and cognitive labs will be used to explore the fit between the skill being measured and the performance or observation rating elicited from the student or teacher. All teachers who participate in the KEA 2.0 pilot will be asked to complete a survey to evaluate the accessibility of the items and the feasibility of the administration. A similar survey was administered to teachers during KEA 1.0 development.

External Validity: Evidence Based on Relationships to Other Variables—Validity evidence should include the relationships between the assessment instrument (i.e., the KEA and the formative assessments) and other variables and outcomes. Such evidence considers the relationship of the test to measures of the skill or behavior that it is intended to predict, similar measures of the same construct or different constructs, or studies of group differences as they apply to the proposed test interpretations. These other measures may be administered at the same time as KEA 2.0 (concurrent validity) or may be used to predict later performance (predictive validity). Though this development project will end at the census administration of the instrument across seven States in 2016, the following studies are recommended to States for incorporation into a longer-term sustainability plan for KEA 2.0:

- correlation between a student's raw score on the KEA and measures of progress on the EC-CAS formative assessments;
- correlation between scores on the KEA and other multidimensional (e.g., Teaching Strategies GOLD, the Early Development Instrument, Mullen Scales of Early Learning) and unidimensional (e.g., DIBELS, DIBELS Math, PPVT-4, Ages and Stages Questionnaire) measures of learning and development designed for young children;
- for Maryland and Ohio, school-level correlations between KEA 1.0 and KEA 2.0;
- student-level quantitative analyses of the association between scores on KEA 2.0 in 2016 and scores on grade 3 PARCC/Smarter Balanced assessments (as the cohorts advance to grade 3);
- examination of distribution of KEA scores by English language learner status, identification for special education services, and/or kindergarten retention; and
- examination of distribution of KEA scores by demographic variables, school/district resources, disability categories, and communication abilities.

(2) External Validity: Evidence Based on Test Consequences—The proposed plan to determine whether the assessments are being implemented as designed focuses on the role that the KEA and the formative assessments play in the larger context of improved outcomes for students and schools. Evidence based on testing consequences concerns examination of whether the intended benefits of the testing program are being realized in the educational system and the extent to which unintended negative consequences are minimized. Although the collection of evidence based on test consequences is critical to the success of the overall EC-CAS, as well as to the validation of the use of KEA 2.0 data, it falls outside the scope of this grant. However, the assessment system can be used to collect baseline data against which future outcomes can be compared.

Collection of validity evidence based on test consequences will begin immediately following the census administration in October 2016. This evidence will include:

- continued administration of the empirical survey of the depth of instruction on and relative importance of the standards to a representative sample of preschool teachers in each State;
- teacher/administrator surveys and focus groups focused on data use;
- surveys and focus groups for families, focused on the assessment purpose and data use;
- continued cognitive labs with English language learners and students with disabilities; and
- longitudinal analyses of KEA scores to show growth over time, by subgroup and in the aggregate.

(e) Professional Capacity and Outreach

(1) In EC-CAS 1.0, a train-the-trainer model is being used in order to support large-scale training efforts. Prior to training teachers, State-approved trainers complete a two-module, face-to-face training on delivering EC-CAS training to local practitioners in both online and face-to-face formats, including the required training for how to administer the assessment. These State-approved trainers must have specific prerequisite skills and knowledge, including knowledge of assessment of young children and strategies for teaching adult learners, in order to participate in the train-the-trainer training session. Online professional learning modules and resources are offered to these trainers to build their capacities. In addition, the State-approved trainers must successfully complete the EC-CAS administration training and pass the reliability qualifications. As part of their responsibilities, the State-approved trainers also provide immediate, post-training support to teachers and providers. Trainers use an online learning community for communications and resource exchange. Webinars are also used to communicate with teachers and administrators about the assessments prior to the summative assessment window.

In focus groups conducted early on in EC-CAS 1.0, teachers and State trainers communicated the need for ongoing support beyond their formal training experiences. JHU CTE worked within the different State structures to identify potential local resources who can provide this support. Technical assistance providers, local resources who provide timely, direct, and ongoing coaching and support to practitioners, were identified to serve as a point of contact for questions related to assessment implementation, data

analysis, and instructional planning. These providers maintain frequent contact with practitioners, to support fidelity of implementation of the assessment and improved instructional practice.

Technical assistance providers, along with the colleagues they will coach, also complete training on administering the assessment and must fulfill the same reliability qualifications. Prior to assessment training, they are also provided with training in coaching methods that align to the International Coaching Federation's Professional Coaching Core Competencies (1998).

The Consortium plans to implement a similar comprehensive approach to professional development for EC-CAS 2.0. This approach will provide face-to-face and online training for various audiences and will also include ongoing coaching and support by local resources through a communities-of-practice model. The enhanced professional-development approach will expand the current approach and will provide an individualized collection of learning experiences in multiple formats, including ongoing, tiered support for professionals with varying levels of experience in child assessment and across different educational settings. The range of professional-development activities will be designed to develop skills in collecting, interpreting, and using data among school and program leaders, teachers, and families, and to support the development of research-based tools and resources that address emerging needs.

Following best-practice guidelines from the National Research Council (2008), planned professional development activities will be organized around three stages of assessment, as described below:

- Pre-administration—Professional development related to pre-administration will focus on ensuring that users understand the purpose of the various assessment tools, are thoroughly knowledgeable about issues related to data security and integrity, and know how to communicate effectively with families and other stakeholders about the purposes and results of the assessments.
- Administration of assessments—Professional development related to administration of the assessments will increase understanding of the processes and procedures for each type of assessment instrument, afford opportunities for hands-on use of assessment tools and associated resources, promote understanding of accommodations and adaptations for various at-risk

populations, build the skills needed to interpret and score children’s responses to multiple item types, introduce participants to the data collection and reporting system, and offer opportunities for hands-on use of the system.

- Post-administration analysis and use of data—A third set of professional-development offerings will focus on the post-administration analysis and use of data. These materials will focus on increasing teachers’ understanding of assessment scores, communicating assessment results to families and caregivers, utilizing data to make instructional decisions and tailoring instruction, and providing additional information on data quality and integrity.

Validation by Simulation—The Consortium believes it is imperative that teachers, as assessors, be properly trained to score assessment items with reliability. Training for administration of the assessment will include assessment administration protocols, guidelines for supports for children with disabilities and English language learners, and practice with scoring procedures. Upon completion of the assessment administration training, all teachers and providers will be required to qualify for scoring through the successful completion of a simulation. The simulation, accessed through the web, will provide hands-on experience and practice in administering assessments and analyzing data for instructional improvement. The simulation will be used to enhance the interrater agreement as the basis for the assessor certification process.

Online Learning Community—KEA 2.0 will use an electronic learning community, a password-protected, user-friendly online environment that supports collaboration, content delivery, and file sharing for teachers and administrators throughout the assessment process. The community site will be customizable to include separate communities for different audiences or space to share information and resources across audiences. In addition, it will include a repository of state-developed and state-vetted resources (e.g., web-based learning modules and tutorials) for improving professional skills and practices, and a forum for sharing knowledge, insights, and observations. Examples of resources and online

activities include recommended readings, focus-group discussions, and sharing of annotated examples of best practices and exercises to help educators develop expertise within the context of local practice.

Personalization of PD Content Based on Teacher and Student Needs—With this enhanced professional-development approach, teachers will receive personalized professional development to meet their learning needs (as identified by self-evaluation as well as through the tracking of their students' assessment data). Each teacher will have a unique profile, which may include their type of program, setting (e.g., rural, suburban, urban), and/or class size. In addition to completing the core professional-development training required by the State, teachers will be provided with specific recommendations for professional development based on factors such as needs for retraining, supporting special populations (e.g., students with disabilities and English language learners), and domain-specific teaching strategies to target specific student needs. Strands of professional-development offerings, which include formal professional credits for teacher recertification purposes, will be extended to all States participating in the Consortium.

Enhanced Scalability—EC-CAS 2.0 will include advanced verification of professional-development completion and tracking features for teacher certification. This will accommodate a significant increase in the number of teachers using the system and will improve the efficiency of documentation of completion of online professional development. These enhanced features will also allow for better tracking of module completion and data collection based on program characteristics or other data points, as prioritized by the participating States.

Instructional Resources Based on Student Data—The Consortium realizes the importance of finding the right level of instruction and support to ensure that every student can progress. The current supports embedded within EC-CAS 1.0 will be expanded to include a bank of evidence-based activities and intervention strategies that support the current developmental learning progressions and provide linkages to local school curricula that are aligned to each State's standards. These activities and strategies will assist teachers in planning tailored instruction to meet the developmental needs of individual students and

groups of students, based on the assessment data. Teachers will be able to interact with instructional planning features to help apply Universal Design principles and identify activities that can be easily, seamlessly integrated into a teacher's typical day.

Additionally, a process for examining student assessment data will be integrated into the online professional-development system. JHU CTE's approach to data-informed decision-making, TAP-IT, will be utilized to guide novice and experienced educators through a structured examination of data and inquiry to improve student outcomes and professional practice. Special educators and administrators working with kindergarten students will also play a key role in interpreting student data and supporting teachers to make instructional decisions. To assist in this role, administrators—particularly those who do not have an early-childhood educational background—will be provided with their own professional-development resources.

Learning Community Connections and Collaboration—Recent survey and focus-group data collected from participating teachers in EC-CAS 1.0 indicated frequent usage of, high comfort level with, and overall interest in social-media tools such as Facebook or Pinterest, with significantly less interest in the more traditional online course format. Opportunities for teachers and administrators to share resources and collaborate to develop a shared knowledge base will be incorporated into EC-CAS 2.0 through an engaging professional learning community that integrates features of popular social-media tools. The enhanced learning community will incorporate features of social-networking services, in order for individuals to easily post, collect, and organize resources and ideas as well as to “follow” individuals and topics. The resources will be tagged and then recommended to individuals based on their personal profiles and their interests or needs. This community will harness the creativity of teachers by encouraging them to collaborate on the creation of professional resources, activities, and games, with the goal of supporting children's development along the continuum. Communication tools such as threaded discussions, commenting features, and blog posts will allow community members, experts, and State agency

representatives to provide feedback on the resources and share their own adaptations. Individuals will be able to start or join groups to solve problems and collaborate at the local or state level.

Additionally, families will be able to access this community, which will provide them with expert advice, resources, and opportunities to promote learning and development at home. Families also will have the opportunity to provide input into specific areas of priority identified by the States and local communities. These enhancements to the professional-development system will allow for better, more efficient scalability to reach larger groups of teachers, administrators, and families, with increased flexibility to create personalized learning opportunities, higher levels of engagement in the learning community, and appropriate supports and interventions that are linked directly to student data.

(2) In EC-CAS 1.0, Maryland and Ohio work closely with their partners and key stakeholder groups to communicate clearly and consistently with community members, families, and policymakers, as well as with teachers, caregivers, and service providers. Communication currently takes place through a variety of means, including:

- the establishment of a governance structure that includes communication with state advisory committees, ad-hoc work groups, and a national TAC;
- presentations at state meetings for local stakeholders, including early-childhood special educators;
- presentations and communications with district and regional groups of administrators and teachers;
- communications, via email, in-person presentations, and webinars, with district and regional early-childhood supervisors, staff, and professional-development providers;
- communications, via email and presentations/meetings, with local technical-assistance centers and governmental agencies/officials; and
- communications, via reports and presentations, to the States' early-childhood advisory councils and business-community representatives.

For EC-CAS 2.0, this approach will be expanded to all States in the Consortium. It will be important for all stakeholders to remain informed throughout development, testing, and rollout of all aspects of the system. This will ensure that the purpose of each system component; the content standards it is intended to measure; how it was developed; to whom, when, and how it will be administered; who will score responses or rate performances; and how results will be interpreted, reported, and used are accurately articulated to constituents. Planned short- and long-term research agendas will also be communicated to stakeholders, in order to keep them apprised of system integrity and plans to monitor test-based consequences, both immediately and over time.

A publicly accessible web presence will inform and educate stakeholders at all levels with regard to the theoretical framework, educational goals, specific methodologies, implementation practices, technology usage, and data analytics that comprise the assessment system. Video demonstrations, sample assessment items, and a “frequently asked questions” page will be employed to generate awareness of and support for the program.

In addition, communication with State stakeholders will take various other forms, including presentations, formal reports, research briefs, and fact sheets, that will be available in hard copy and online. JHU CTE will work with the Consortium to ensure that each State has a communications strategy on the importance and value of the new assessment system. The goal of this collaboration will be to provide ongoing opportunities for learning about the system and how to use the information it yields to ensure that all children enter school with equal opportunity to learn, grow, and thrive. The reporting system will provide both standard, paper-based reports and more technologically advanced, web-based data-analysis tools.

All States participating in the Consortium will be committed to transparency regarding all development and implementation plans, the purposes of each system component, and the intended outcomes of the system. Each State will implement an outreach and communications plan for informing and updating the public and key stakeholder groups. The system will include timely reporting of

assessment results and dissemination of resource materials, such as templates for presentations, brochures, pamphlets, information letters, newsletters, and notices about opportunities to support activities related to the system.

Other new resources that will be created for stakeholders include:

- Kindergarten readiness tool—An engaging and interactive online resource to educate families of young children about what kindergarten readiness means, with information specific to families of children entering kindergarten.
- What the data tell us—Content targeting legislators and policymakers, explaining assessment for young children and how to interpret results in the context of appropriate assessment practice.
- Virtual town-hall forums—Themed online webinar sessions to inform stakeholders about the assessment system, with creative ways to engage participants to gather support and input.
- Virtual performance assessment (VPA) demos—One or more demos for teachers and families to “play with” interactive activities that children will use in the assessment.

These processes and expanded resources will assist in communicating with the variety of stakeholders and Consortium members.

(f) Technology Approach

(1) Technology Approach for EC-CAS 1.0—Currently, in EC-CAS 1.0, the technology available for the KEA includes an online reporting system (ORS), teacher dashboards and customized professional development, and a virtual performance assessment (VPA).

The ORS provides secure access for teachers to enter student performance data and teacher observational data. Accessible via desktop computer, laptop, or tablet, the ORS allows for data import and export, including the transfer of data to longitudinal data systems. User dashboards and reports support state-, district-, school-, classroom, and student-level data reporting and analysis. Customizable views and reports can be created for families, teachers, and administrators at the school, district, or state levels.

Types of reportable data include:

- Assessment completion—the percentage of assessment items completed by individual students or by a whole class;
- Readiness performance—student performance on the KEA by domain at the individual student, class, district, or state levels, to inform broad readiness monitoring; and
- Formative item performance—student performance on the formative items, to inform instructional decision-making.

In addition, the ORS allows student artifacts to be uploaded and linked to a longitudinal profile for monitoring student performance over time. Nightly data transfers ensure that teachers and administrators at all levels are able to access real-time data as needed.

Teacher dashboards and customized professional development provide contextualized resources to support instruction and the use of best practices in the classroom. Data from the ORS generate information and recommendations for instructional groupings, as well as targeted instruction based on individual child and class performance. Suggested instructional activities are available for teachers to incorporate in daily lesson planning. Simulation software familiarizes teachers with assessment protocols and use of professional-development resources. The easily accessible system enables educators to monitor progress, make informed decisions, and promote continuous improvement in children’s knowledge and skills.

The VPA uses technology to provide child-friendly and engaging interaction with the assessment environment. Two assessment types are currently available:

- point-and-touch items that involve single-touch/click selection; and
- interactive activities for children to engage in and receive instructional feedback on during formative assessments.

The design of the VPA is age-appropriate and utilizes a guided system of navigation that guarantees that targeted skills are probed sufficiently. Regardless of a child’s performance, the virtual environment encourages, engages, and motivates children to interact with each activity.

Technology Approach for EC-CAS 2.0—Technology will be incorporated in a variety of ways in EC-CAS 2.0 to support the development of assessment items, the delivery of the assessment, the collection of scoring data, and the analysis and reporting of the assessment results. An overview of the application of technology by category of user follows.

- **Children**—Students will have access to direct-performance items, as appropriate for the assessment domain, to be completed using child-friendly technology for use on tablets or PCs. They will log in by selecting their name or picture (with support, as needed), and will then have access to the interactive formative items assigned by the teacher. The interactive items will be designed to be engaging and fun for children. The resulting scores will feed into a child’s profile without the need for the teacher to manually enter them. The direct-assessment items will be supported with audio and visual cues and accommodations where appropriate.
- **Teachers/assessors**—Teachers will access the system on a computer or tablet through secure, encrypted authentication. Upon entry, teachers will be presented with a dashboard that includes a listing of their students (by class) and the assessment completion status of each child and of the class as a whole. Teachers will be able to use mobile technology to document observational and performance-rubric data while observing their students’ actions and/or interactions. Score information obtained through these observations will be automatically fed into the ORS. Other functions of the system include the abilities to browse assessment items, access embedded professional-development resources, enter scoring data directly into the system, assign assessments for a student to complete, and upload a sample of work to a student’s profile. In addition, teachers will have access to a variety of score reports at the student and class levels, which will inform instructional strategies tailored to students’ needs.
- **Administrators (school, district, and state)**—Administrators will have access (based on their positions and data and reporting needs) to dashboards that support data-driven decision-making and reporting requirements. Reports will be available at the classroom, building, school, district,

regional, and state levels as designated by each State. The system will make data available to external systems as well, facilitating the capacity for longitudinal analysis across multiple relevant data systems. External stakeholders, such as early-childhood advisory councils, business leaders, legislators, and other key policymakers and decision-makers, will also have access to aggregated reports.

All of the proposed technology components described in this section will substantially benefit from existing systems and intellectual capital created under the current RTT-ELC Grant. The data and feedback from KEA 1.0 will provide the basis for significant enhancements and expanded functionality of these systems. Building upon existing systems will exponentially improve the efficiency of new development, because much of the analysis and conceptual development has already been carried out and documented. Additional funding and resources will be directly applied toward the construction of KEA 2.0, which will include numerous system enhancements, as described in the following sections.

Longitudinal Analysis—Dashboard capacity will be expanded to allow direct integration with other relevant data systems, providing enhanced support for longitudinal tracking, student progress monitoring, and student intervention monitoring at the state, local, school, and classroom levels.

Expansion of Interactive Assessments—KEA 2.0 will expand the capacity of the system to provide direct student assessment using child-friendly, touchscreen technologies. The amount of engaging, interactive content will be increased and improved upon, based on the feedback and results from KEA 1.0 testing and implementation. The system also will allow for auto-leveling of assessment difficulty based on student performance.

Charting Student Progress Over Time—The next generation of the KEA system will embed the JHU CTE Student Compass Tool. This tool will allow teachers to monitor children’s progress relative to defined performance indicators based on the KEA learning progressions; review interventions; and select the most appropriate intervention for addressing the identified need of the student.

Digital Portfolios—While KEA 1.0 includes the ability to attach digital artifacts (e.g., sample work, audio or video clips, teacher notes) to a student’s profile, KEA 2.0 will provide additional capacity that transforms this basic function into a digital portfolio that can be added to over time and accessed by families and the student’s future teachers. An expanded portfolio will support the concept of multiple measures and provide an additional means to assess students’ progress over time.

Enhanced Accessibility Features and Accommodations—KEA 2.0 will use the results of KEA 1.0 testing and implementation, teacher surveys, classroom observations, and recommendations from expert consultants to expand and improve upon the embedded accessibility features and accommodations of KEA 1.0. The enhanced system will continue adherence to Universal Design principles, and will utilize child-friendly technologies and strategies that are based on research and proven best practices for the instructional use of technology with young children.

Scaling Professional Development—KEA 2.0 will enhance the scalability of the professional development (online learning modules and embedded support) provided in KEA 1.0. Based on the results of student assessments, teachers will be presented with targeted online professional development and embedded supports, including interventions and activities that could be implemented in the classroom and promote individualized instruction.

Cloud Hosting and Scalability—Technology systems developed to support KEA 2.0 will require enhancements to an already robust cloud-hosting environment. The increase in the number of users across the Consortium States will require that additional resources be allocated to the cloud-based server environment, to improve scalability and load balancing. The States will benefit from the efficiency of the multi-state system architecture designed to support both Maryland and Ohio users in KEA 1.0, and will also benefit from cost efficiencies as a result of multiple States sharing in the ongoing cost of the system. KEA 2.0 will include sufficiently increased bandwidth, server capacity, and security controls to ensure that each collaborating State experiences strong application performance. Robust technical protocols, to ensure the security of student data, will also be revised and improved.

In order to promote cost-effective adoption by schools, cross-platform technical development strategies will be enhanced, and adherence to an open-licensed interoperability standard that is industry-recognized and approved by the U.S. Department of Education will be implemented. The Question and Test Interoperability (QTI) and Accessible Portable Item Profile (APIP) standards are examples of protocols that will be used to maximize interoperability. QTI and APIP incorporate key elements of established specifications to create an integrated system for an accessible and interoperable item-file format. The technology being developed under this grant is being built to achieve the expectations for interoperability to facilitate the transfer of information within and across states. Interoperable design will support (a) test-test content portability; (b) transfer of assessments from one technology platform to another; (c) consistent assessment delivery across the Consortium; (d) consistent application of accessibility features, including the universal design of items; and (e) construction of assessment databases that allow for long-term analysis and digital report dissemination across multiple platforms.

(2) Potential Factors Limiting Adoption—Both Maryland and Ohio include rural areas and regions of poverty, with schools and community-based early-childhood centers that possess limited technology capacity. During the conceptual development of KEA 1.0, this fact necessitated strategies to limit barriers to adoption as much as possible. At a minimum, participating schools will need a computer with Internet access in order to input assessment results into the system for reporting and analysis. However, the KEA can also be administered using printed materials and without the use of technology. For the foreseeable future, this approach will continue to be employed. To the extent possible, all technology components developed will also be supported across multiple computer platforms, browser versions, and touchscreen devices, to maximize the number of students who have access to the virtual performance assessments.

(g) Project Management

The Consortium recognizes that achieving its vision for this project will be challenging. Enhancing the EC-CAS, and the KEA in particular, will require high levels of commitment, technical expertise, collaboration, and, of most relevance for this section, strong management skills, systems, and supports.

Three major management components will provide for a timely delivery of EC-CAS 2.0 with strong safeguards of accountability: (1) the Consortium Executive Committee; (2) a Project Management Partner (PMP) to support the work of the Consortium; and (3) collaboration with national expert institutions to provide support and ongoing services beyond the grant period.

The Consortium States are committed to fully and equitably participating in the oversight and decision-making process regarding the scope of work and the implementation of EC-CAS 2.0. This collaboration is based on formal agreements (MOUs) among the States and is being implemented through the formation of an Executive Committee consisting of leadership representation from each State. The Consortium will establish a stringent communication protocol, including monthly leadership calls, semiannual planning meetings, and ongoing work groups. The project will be supported by individuals who will serve as leads in each State and as the facilitators for stakeholder input within each State. Within the Consortium, the Maryland State Department of Education (MSDE) will serve as the lead applicant and the fiscal and procurement agent.

WestEd's Assessment & Standards Development Services (ASDS) program will serve as the PMP for the Consortium, and will provide overall project management on its behalf. The PMP will be responsible for drafting the scope of work and detailed planning of activities and tasks with specified milestones and deliverables, and will work closely with MSDE, as the fiscal agent, to ensure that the project implementation stays within budget.

As partnering organizations to the Consortium, JHU CTE (assisting with technology and professional development) and the University of Connecticut's Measurement, Evaluation, and Assessment program (assisting with research) will formally work closely with the PMP. In addition, CCSSO will facilitate an annual meeting of the TAC, consisting of 12 national experts in child development and assessment.

Together, the Consortium and partnering organizations will ensure that the five project-management qualifications for this grant are met efficiently and effectively.

(1) A critical first step in supporting the Consortium's assessment development and implementation will be to develop a work plan that includes the high-level requirements for meeting major goals. This work plan will define the start-up processes, associated outcomes, and ongoing tasks that will ensure successful completion of each milestone task, as specified in the Scope of Work. An initial draft of the high-level project plan is included in Appendix A on page 65.

WestEd will be prepared to work immediately with the Consortium to develop detailed schedules for all system components. The final project plan, including detailed information about project milestones, will be developed and submitted to Consortium leadership for approval prior to the commencement of project activities, and no later than December 1, 2013. The final project plan will encompass the overall scope and schedule of the assessment system development. Any proposed changes to the project plan will be provided to the Executive Committee for approval. The project plan will be the prime source document that specifies the primary tasks, services, activities, schedule, and requirements for the contract. As such, it will be available to all partners, to ensure a common understanding of the project's scope, schedule, and context. To support this effort, Smartsheet.com, an online project planning and collaboration tool, will be used to assign and manage tasks, staffing, and other resources in order to ensure that all timelines are met. Staff can be strategically reassigned as needed to meet specific needs. Smartsheet.com has proven effective in helping WestEd manage other highly complex projects.

The PMP will plan, monitor, and report on the Consortium work as necessary to ensure successful development and implementation of the proposed work (e.g., the KEA, including technology and professional-development supports). This will help ensure that tasks are clearly communicated, roles and responsibilities are understood, schedules are followed, deadlines are met, potential risks are evaluated and managed proactively, and all work is completed within allocated budgets.

As PMP, WestEd will build on its existing processes and tools to effectively implement and maintain the project schedule/timeline; manage and support all Consortium meetings through collaboration on agenda development; document meeting discussions and decisions, and identify action items for follow-

up; and work to ensure effectiveness and efficiency in all system processes through continual review and improvement. The PMP will also apply proven strategies to oversee and facilitate work around critical design issues, coordinating the involvement of the TAC and other advisory councils at key junctures.

Throughout the duration of the contract, the PMP will monitor Consortium activities and track progress toward completion of key deliverables (on time and within budget); adapt plans to meet emerging project needs as activities unfold; ensure that roles and responsibilities are understood and that outcomes meet expectations; promote sustainability of the initiative through responsible planning, ongoing documentation, careful monitoring, and proven communication practices; and identify, manage, and mitigate risks.

(2) Identification, Management, and Mitigation of Risk—Successful project management requires a careful balance of time, resources, and quality. Further, understanding how system components interact during development and implementation will allow the PMP to anticipate potential risks and plan for contingencies. The primary risk management strategy will be to create comprehensive work plans as soon as possible, to ensure that sufficient time and resources are allocated to complete the KEA. Additionally, as part of the project schedule development process, the PMP will work with Consortium States to identify implementation barriers, risks, and possible solutions or mitigation strategies. The key to the success of a project of this complexity will be contingency planning from the outset. Three major levels of risk will be used to categorize and develop mitigation strategies:

- Program-level risk: Any potential issue identified that could jeopardize the overall success of the project. An example of this may be loss of funding to the level anticipated, or exit of several member States from the Consortium. Additionally, systemic risks, associated with a diverse and geographically distributed membership, that could result in delays in decision-making or miscommunications would qualify as program-level risks.
- Component-level risk: Any potential issue identified that could jeopardize the development or implementation of one of the Consortium's core assessment components. Risks at this level that

go without mitigation could potentially have an impact on other aspects of the project, given the high degree of interdependency in the various deliverables. It is especially important for the PMP and the Executive Committee to establish response plans for each risk considered to have a probability and impact on other aspects of the project that might extend beyond the component level.

- Deliverable-level risk: These risks would be managed within the project teams.

Response plans and mitigation strategies will be captured for risks at each of these levels.

Additionally, risks may be classified according to the various types of potential impact or domain: financial, schedule, technical, legal, quality, etc.

The Executive Committee, the MSDE grant manager, and the lead staff will work with the Consortium States to capture, identify, and classify the various risks that each of these bodies can anticipate, and will, with support from the PMP, establish appropriate mitigation strategies and response plans. Risks are potential issues; should a risk materialize without adequate containment of its impact, it will become an issue for escalation through processes established in the project management activities of the Consortium.

Monthly project management reports, including stoplight-status reports, will be shared with the MSDE grant manager and the Executive Committee. The stoplight-status reports will provide a high-level progress indicator for each core assessment component—indicating, for each assessment component, whether it is considered “green” (on schedule, with no anticipated risks), “yellow” (on schedule, with medium risk of moving off schedule), or “red” (off schedule, or on schedule with high risk of moving off schedule). Any variances from the anticipated schedule (i.e., yellow or red indicators) will be reported along with strategies for course correction, the estimated likelihood that corrective action will be effective, and possible mitigation strategies if course correction fails. As part of the project master plan development process, WestEd will work with the Executive Committee to identify implementation barriers, risks, and possible solutions or mitigation strategies.

Compliance Monitoring and Communication—MSDE, on behalf of the Consortium, will serve as the lead agency in ensuring compliance with federal statutes and limitations. It will consult regularly with the grant’s U.S. Department of Education program officer on the progress of the project and any anticipated changes that require amendments to the scope of work and project budgets.

Governance Support—The primary governing mechanism of the Consortium will be the Executive Committee. The Executive Committee will be composed of one representative from each charter State in the Consortium. In addition to representing a charter State, each Executive Committee member must meet the following criteria:

- must have prior experience in either the design or the implementation of curriculum, standards, and/or assessment systems at the policy or implementation level; and
- must have a willingness to serve as the liaison to the full Consortium membership.

The responsibilities of the Executive Committee will be to:

- determine the broad picture of what the assessment system will look like;
- identify issues to be presented to the charter and/or advisory States;
- oversee the expenditure of funds in collaboration with MSDE;
- operationalize the plan to transition from the proposal governance to implementation governance; and
- evaluate and recommend successful contract proposals for approval by MSDE.

Decision-Making—Consensus will be a goal of all decisions. Major decisions that do not reach consensus must be passed with a 2/3 majority vote. Each charter State will have one vote. The Executive Committee will meet monthly throughout the grant period. Most meetings will be virtual; however, twice each year, the committee will meet in person. For efficiency and cost savings, these face-to-face meetings will be linked, if possible, to other events—e.g., conferences, TAC meetings—that Executive Committee members are likely to attend. The PMP, in consultation with the Executive Committee chair and the MSDE grant manager, will prepare agendas and supporting documents for each meeting, make webinar or

facility/travel arrangements, document all decisions, and prepare and disseminate draft and approved minutes.

(3) The Consortium is fully confident that the submitted budget is adequate for the development and validation of the KEA, as well as for the development of the technology necessary to administer the assessment and report its results. The Consortium also fully believes that the submitted budget will allow for the development of a state-of-the-art set of supports, including professional-development modules designed to assist teachers to prepare students to take the assessment; administer and score the various components; and interpret reports and use information to inform instruction. This confidence is bolstered by WestEd's very recent experience with the development of KEA 1.0 and other, similar assessment development projects at the state and local levels.

The budget associated with each activity leverages the previous work on KEA 1.0, and focuses on project deliverables (e.g., item/task development, score reports, professional development), with management costs linked directly to these activities for the enhancement of KEA 2.0. Most Consortium management and assessment development meetings will be virtual. Because many of the costs related to this work are fixed (i.e., independent of the number of States in the Consortium) and others increase based on the number of States in the Consortium, the Consortium's ability to attract seven States (intermediate level for this grant competition) creates a perfect balance between efficiency and complexity.

(4) Commitment and sustainability planning by member States are essential to the success of the Consortium's efforts. Per the signed MOUs, each State that is a member of the Consortium agrees to do the following:

- adopt and fully implement, statewide, the common KEA no later than December 31, 2017;
- adopt a set of essential skills and knowledge that are based on early learning and development standards, and that are substantially identical across all Consortium States, no later than the 2016–17 school year;
- adhere to the Consortium governance as outlined in the MOU;

- agree to support the decisions of the Consortium;
- agree to follow agreed-upon timelines; and
- be willing to participate in the decision-making process and, if a charter State, final decisions.

While costs will differ, to a degree, from State to State, due to State-specific factors and factors related to agreements with potential implementation vendors, WestEd estimates that the per-pupil cost to administer, score, and report KEA 2.0 is about \$4 per student. This estimate is based on current experience administering similar assessments and Maryland's and Ohio's experience in pilot testing KEA 1.0. It also involves a comparison to cost estimates of the much more complex PARCC and Smarter Balanced assessment systems. The KEA estimate is based on the following assumptions:

- The grant will bear the cost of item and task development, and of the administration, data collection, and scoring technology applications;
- Scoring will be performed onsite by the assessment administrator or designee;
- Professional development and training to administer the assessment will be virtual; and
- All reports will be electronic (no printing required).

The cost of technology to administer the assessment is not included in this estimate. WestEd assumes that local education agencies and service providers will be investing in technology as part of their instructional responsibilities and their readiness for PARCC and Smarter Balanced, and that this technology will be available for the KEA. For those agencies and service providers that do not have access to sufficient technology, a paper version of the KEA will be provided, with costs assumed by the agency or service provider. Also not included in this estimate are costs related to hosting the professional-development materials, technology-supported items, and the ORS. These costs will also differ from State to State, depending on the number of students enrolled in kindergarten in the State and other system-readiness issues.

(5) The team proposed to manage this grant is knowledgeable, experienced, and familiar with collaborating on a project of this size and scope. For the past several years, the core team has successfully

built KEA 1.0 and its associated products and services. The Leadership Team currently utilized in EC-CAS 1.0—composed of member representatives from MSDE, the Ohio Department of Education, the Ohio Department of Job and Family Services, the Ohio Governor’s Office, JHU CTE, and WestEd; State advisory councils; a 12-member TAC; and ad hoc committees and work groups from each State—will be expanded to include members from charter States in the Consortium, to be named the Executive Committee. Each State will also establish a State advisory council, composed of stakeholders similar to those currently in Maryland and Ohio. This group will continue its work and will include additional talent to meet the specifications for this grant.

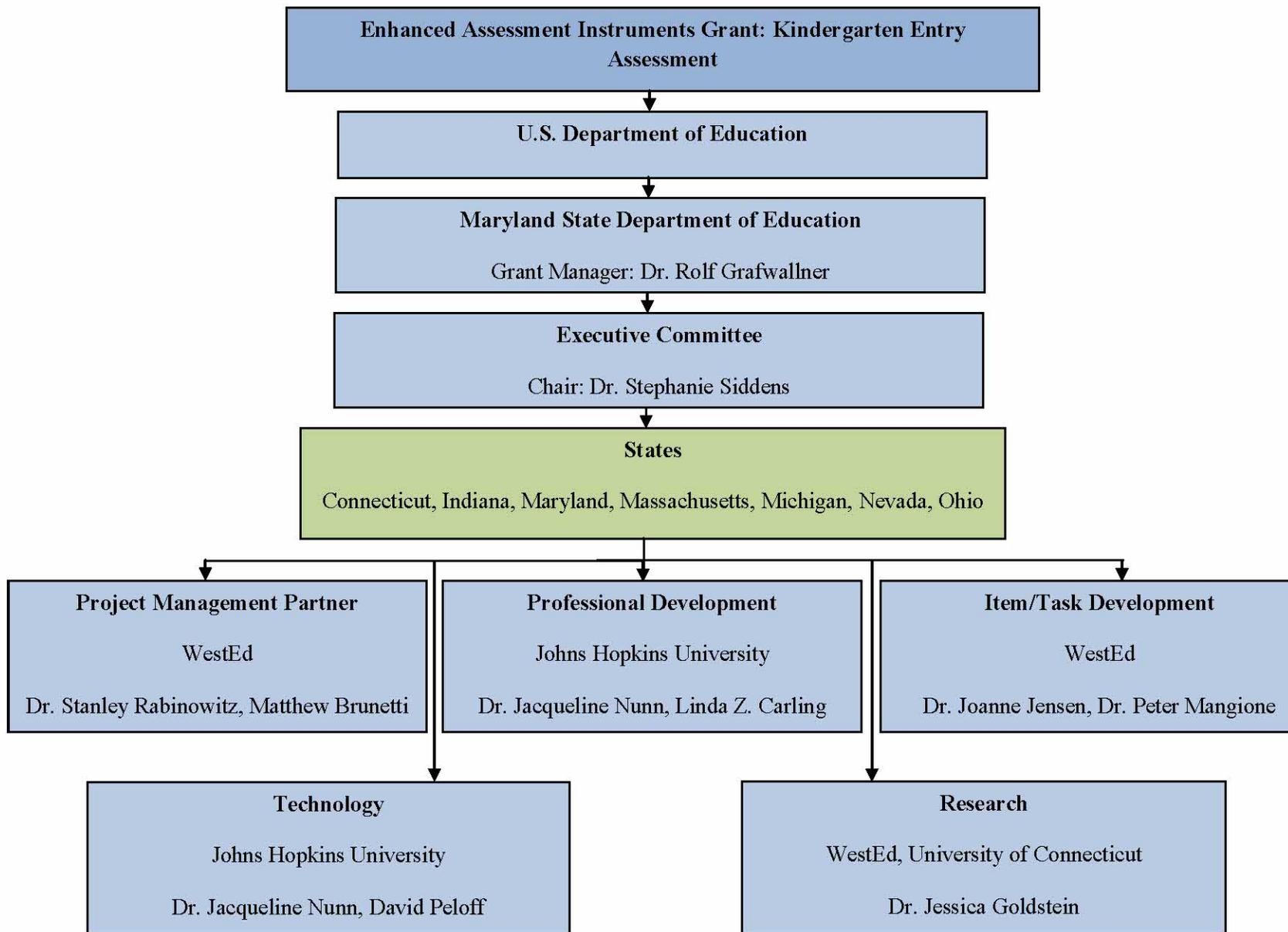
WestEd’s current role as a partner in Maryland and Ohio’s RTT-ELC assessment development process brings a critical, intimate, and advantageous quality to its proposed role as PMP for the development of EC-CAS 2.0. More broadly, WestEd has demonstrated high-quality management support as the PMP of the more complex Smarter Balanced Assessment Consortium. For EC-CAS 2.0, WestEd will work within the Consortium governance structure to establish protocols that meet baseline expectations; plan for translating project scope into action; describe inputs and outputs; establish standards for performance; apply lessons learned; use information formatively to improve internal processes; and document action items and resolutions on a deliverable-by-deliverable basis.

The Consortium and its partnering organizations understand the importance of alignment and coordination among all system features and are committed to utilizing best practices in project management to meet the objectives of the proposed project across the following principles of project management:

- Time—As PMP, WestEd will assume responsibility for setting and monitoring the sequence of events and duration for each activity; tracking, reviewing, regulating, and monitoring the schedule for each deliverable; planning controls and monitoring deviations from deadlines; and updating and documenting changes to the project schedule and communicating implications of these changes to the Consortium’s Executive Committee.

- Cost—The PMP will work with MSDE, the grant manager and fiscal agent, and the Consortium’s Executive Committee to estimate costs, create budgets, control costs so that all work stays within budgets, create plans for overseeing accounting systems, and share forecasts.
- Quality—Using its management experience, the PMP will assess and analyze risk; communicate quality assurances to stakeholders; use effective quality-management methodologies; identify, control, and monitor risk and articulate risk responses, strategies for mitigating risk, and contingency plans; keep all stakeholders updated on project status; and conduct cost-benefit analyses.
- Resources—The PMP will work with the Consortium to plan, document, and implement steps that capitalize on existing and emerging strengths and to develop strategies for sustaining the project beyond the grant period.
- Communication—The PMP will foster effective communication within and across levels, ensuring that the most important information is shared using the most appropriate medium or approach; distributing information to appropriate audiences; managing expectations; monitoring the effectiveness of communication and technology-support systems; working with the Consortium to develop guidelines for communicating with internal and external stakeholders; and implementing mechanisms for reporting on performance outcomes.

The organization chart included on page 40 illustrates the proposed management structure for EC-CAS 2.0. Please refer to Part 6 of this grant application to review staff qualifications in the submitted résumés.



Consortium State Capacity and Commitment—While the proposed KEA and aligned formative assessments will build off of the extensive progress made by Maryland and Ohio on KEA 1.0 in their joint RTT-ELC Grant, all of the States in the Consortium have made significant progress in developing and implementing early-childhood programs, including assessments, that are consistent with the goals and priorities of this grant offering. The most relevant of these accomplishments among the states that did not participate in KEA 1.0 are described in the following sections.

Connecticut—The Kindergarten Entrance Inventory (KEI) was developed in response to Connecticut Public Act 05-245, which required the Commissioner of Education to “develop and implement a statewide developmentally appropriate kindergarten assessment tool that measures a child’s level of preparedness for kindergarten” by October 2007. The stated purpose of the KEI is to “provide a statewide snapshot of the skills students demonstrate, based on teachers’ observations, at the beginning of the kindergarten year.” The content of the KEI was selected to represent the most important skills that students need to demonstrate at the beginning of kindergarten, based on the Connecticut Preschool Curriculum Framework and the State Curriculum Standards for language arts and mathematics that were in use at that time. A group of preschool and kindergarten teachers, representing urban and suburban districts, special education, and English language learners, reviewed the indicators and provided the Connecticut State Department of Education (CSDE) with their recommendations on the appropriateness of the indicators. A revised version of the KEI was introduced in the fall of 2007 and has been used statewide since that time. CSDE partnered with researchers at the University of Connecticut to validate the use of the KEI. Research supporting its use addressed two broad themes: the relationship of the KEI to other measures of academic achievement and the structure of the indicators used to define each domain. In addition to the KEI, the Connecticut Preschool Assessment Framework was developed in 2003, based upon the early learning standards included in the Connecticut Preschool Curriculum Framework.

Indiana—The Indiana Standards Tool for Assessment Reporting—Kindergarten Readiness (ISTAR-KR) was launched in 2009. This assessment tool is currently available to all early-learning programs as an

assessment for children from two months of age through kindergarten entry. Although kindergarten programs are not required to use the ISTAR-KR, many began to implement its use in the 2012–13 school year, with more planned to employ it in 2013–14. This assessment does not provide longitudinal data for participating children, but the potential benefit of those data is recognized. Indiana also understands the advantages of gathering this information to inform instruction in kindergarten and to show student growth from the beginning of the year to the end of the school year; therefore, it desires a tool that can provide valid comparisons across all school districts within the state.

Massachusetts—Under its RTT-ELC Grant, the Massachusetts Department of Early Education and Care (EEC) is required to design and implement a kindergarten entry assessment initiative. The federal requirements for this initiative include measurement, within the first six weeks of the kindergarten year, of kindergarten children’s skills and competencies in language/literacy, mathematics, social-emotional development, and physical development. EEC has partnered with the Massachusetts Department of Elementary and Secondary Education (ESE) on this effort. The resulting initiative, known as the Massachusetts Kindergarten Entry Assessment (MKEA), has been designed as a formative assessment initiative in kindergarten. The expectation is that districts implement the Work Sampling System or Teaching Strategies GOLD formative assessment tool. Both assessments will help educators measure the targeted developmental domains in order to guide kindergarten teachers in designing instruction for individual children through the use of data. These two assessments are also being examined for alignment to the Massachusetts standards for English language arts/literacy and mathematics. EEC and ESE jointly developed a four-year roll-out plan for the MKEA that includes the participation of all 306 Massachusetts school districts with a kindergarten enrollment. In addition, the agencies are working together to ensure that the early elementary assessment work of PARCC informs and is informed by the MKEA work in Massachusetts.

Michigan—Michigan is in the beginning stages of implementing a statewide kindergarten entry assessment. It recently selected the Teaching Strategies GOLD online assessment for a 2013 fall pilot,

following a review plan that included stakeholder involvement in showcase demonstrations of existing assessments by other states and vendors, issuance of a Request for Proposals, and a thorough review of each proposal received. The state is currently planning to pilot the assessment in 200–300 schools this fall, during the first 45 days of school. To prepare for the fall pilot study, focus groups around experienced and new users of the KEA are being conducted to inform communications and training. In late July, 30 trainers are being trained; during the last three weeks of August, these trainers will then train the 600–900 teachers participating in the pilot. When the pilot study is complete, the state will use the information gathered to customize the assessment for a 2014 fall field test with a significantly larger group of schools and students. Statewide implementation (optional by school) is planned for fall 2015.

Nevada—The Silver State KIDS project is a statewide effort to build a comprehensive early-childhood education system that supports the ability of all children in Nevada to enter kindergarten ready to learn. The Nevada Early Childhood Advisory Council (NECAC), managed by Nevada’s Head Start Collaboration and Early Childhood Systems (HSC&ECS) Office in collaboration with the Nevada Department of Education (NDE), is leading this effort, which has identified two major components of system change as priorities for implementation. Adoption of a common Kindergarten Inventory of Development Statewide (Silver State KIDS), which measures each child’s developmental status upon entering kindergarten across five domains of learning, and development of a coordinated data system that aligns pre-kindergarten data to K–12 data (and beyond) will improve understanding about which early-childhood education policies, strategies, services, and supports are the most likely to improve school readiness. This will facilitate expansion and replication of effective and proven early-childhood education practices throughout Nevada.

In the recent legislative session, the Governor’s budget included \$4 million as a part of the P-16 Council to further support the work of NECAC and work toward a common statewide kindergarten assessment and the development of an early childhood database system. Nevada is currently making some significant investments to help support these efforts. Recently, the Governor and the state legislature have

supported additional investments for full-day kindergarten as well as further support for English language learners, pre-kindergarten, and K–4 education.

(h) Kindergarten Entry Assessment Design

(1) The EC-CAS includes the KEA and formative assessments for children ages 36 months through 72 months. Both the current version of the KEA and the proposed enhanced KEA are being developed based on the CLS, which align to both Maryland and Ohio early learning and development standards extending from birth through kindergarten entry, including the States' kindergarten standards. Each of the CLS is defined by essential skills and knowledge (ESKs), currently common to Maryland and Ohio, which specify the depth and breadth of the standard. The ESKs also form the basis of the learning progressions that provide the foundation for the formative assessments. Each of the 28 (32 including The Arts) standards is aligned to a learning progression. The standards combine to form strands, and the strands combine to form domains.

The KEA and formative assessments will focus on six developmental domains: Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, and Social Studies. Presently, Maryland is the only State to be assessing The Arts. KEA 2.0, within the context of each State's existing early childhood comprehensive assessment system, will include a combination of selected-response, performance tasks, and rubric-based observational instruments, reflecting a multiple-measures approach to the assessments. Because of the limited attention span of students at the ages assessed, and in recognition of the need to assess all students within the first eight weeks of the school year, the KEA is focusing on a select number of ESKs for each standard that are seen as particularly critical and readily assessable or observable by teachers early in the school year. In contrast, the formative assessments will reflect the full range of skills and knowledge that define the learning progressions and will be designed for children from 36 months to 72 months. The formative assessments will include selected-response items, performance tasks, and observational instruments tied to each of the learning progressions.

(2) Inherent in the design process is the explicit definition of the content to be assessed. The CLS serve as the key document in the definition process. As such, all item and task development activities will be keyed to the ESKs that define the standards. To ensure consistent interpretation of the ESKs, item specifications have been developed by WestEd staff to provide operational definitions for specific knowledge and behaviors. The item specifications provide an overview of the item structures and formats and the nature of the content that is best assessed by each item type. As the items for KEA 1.0 were developed, the training of item and task development staff focused on the centrality of the ESKs in the development process and the specification of the content to be assessed. The alignment of all items, tasks, and observational rubrics to the ESKs will continue to be emphasized in future training. Throughout the assessment content development and review process, the content editors will evaluate alignment and will introduce edits, as needed, to ensure alignment.

Following the internal review of all assessments by WestEd staff, the assessments will be submitted to the States for their review, in which alignment will be one of the key considerations. The State-level reviews will be combined with the results of formal content reviews, involving representatives from all States in the Consortium. Additional edits will be made as required to meet the alignment expectations of the States. The final, edited assessments will be submitted to the States for their final review and signoff. This iterative review and signoff procedure has proven to be effective in achieving aligned items and tasks throughout WestEd's previous assessment development experience.

(3) Assessment data will be made available and transmitted, on a defined schedule, to State data systems. Data security will be enforced, end to end, during transmission via an industry-standard security method. All data will be keyed with identifiers and other metadata to allow for merging, disaggregation, reporting, and longitudinal analysis. Data will be formatted in a manner that is most agreeable and compliant with States' systems and needs, but conformity to Common Education Data Standards will be encouraged in order to foster interoperability and consistent understanding among systems and stakeholders.

(4) (i) In order to assist teachers in using the assessment data to guide instruction throughout the school year, professional development activities will support teachers in linking assessment and instruction. Four key steps for linking assessment and instruction are: (1) administering the KEA to all children in all domains; (2) interpreting assessment findings and identifying children's needs by identifying (a) which children already have all of the important age-expected skills or indicators, (b) which children might be at risk or missing a component of one or more expected skills or indicators, and (c) which children may not yet have an expected skill or indicator due to missing critical foundational and/or prerequisite behaviors; (3) aligning intentional instruction with identified needs of groups and of individual children; and (4) monitoring progress, at designated intervals, and revising instruction, as needed, to maximize effectiveness (Grisham-Brown & Pretti-Frontczak, 2011). In order to support this process, the JHU CTE Student Compass Tool will be embedded into the ORS; this will allow teachers to easily view their students' assessment results, group students by need areas, review and select interventions and strategies, and continue to monitor students' progress toward defined performance indicators.

(ii) Teacher professional-development and support needs will be identified via several media. Teachers will be trained, practice, and qualify for scoring via an online simulation tool that functions as a validation of a teacher's qualifications to administer and score the assessment with reliability. They will be directed to additional supports as needed, based upon their performance on the interrater reliability feature of the simulation tool. Self-evaluation measures are employed via discussion-board reporting. Throughout training on and implementation of the assessments, teachers will use the online community to identify additional professional-development and support needs. Peer-to-peer feedback and input from community moderators will be provided.

(iii) The ORS will be designed to provide information at the student (for use by both teachers and families), classroom, school, and state levels. At the school level, students can be placed on the learning progressions (if the formative assessments are used), and overall readiness and domain readiness scores

can be reported, based on the KEA. Classroom- and school-level reports can be used to identify persistent, widespread overall problem areas, as well as achievement gaps across student populations. The reporting scale of both the formative assessments and the KEA will allow the progress of individual students to be tracked within and across school years and allow cohorts to be tracked across years.

In order to support school-level teams in making effective educational decisions using the KEA data, a series of online professional learning modules will be made available. This professional-development series will feature TAP-IT, which is a systematic process for data-informed decision making, developed by JHU CTE faculty. TAP-IT was specifically designed to help educational teams use data to improve results for students, including those with special needs. Currently, this process is being effectively used by MSDE to support data-informed decision-making at the state, district, and school levels in order to narrow achievement gaps of students with special needs. In the TAP-IT process, a team analyzes (i.e., taps into) student and teacher data to plan an intervention for a student, implements the intervention, and then tracks its impact.

(iv) States will receive aggregate district and State reports that will allow policymakers to identify areas where students are entering school with high degrees of readiness and areas where students are entering at risk of chronic and persistent failure. Reports by subgroup (e.g., English language learners, students with disabilities) will help determine if there are systematic differences among student populations and/or if there are pockets of risk within otherwise high-performing areas.

(v) JHU CTE's expertise includes the development of data reports that have been carefully designed and piloted (via survey and focus groups) to meet the needs of parents and families. Families will be able to use graphics to determine the degree to which their children are meeting the expectations for school readiness overall and for each assessed domain. The family reports also will include targeted support activities to improve learning. Consistent with State statutes and regulations across the Consortium, reports will be made available in a variety of languages other than English.

(5) The KEA includes three basic item types—three-option selected response, performance tasks, and observational rubrics. The academic domains of Mathematics and Language and Literacy are assessed through selected-response items and performance tasks in which students are asked to demonstrate their knowledge through answering questions or performing tasks that reflect academic and real-world applications. The Science domain includes a combination of selected-response items and observational rubrics, whereas Social Studies is assessed solely through observational rubrics. The domains of Social Foundations and Motor Development and Physical Well-being are also assessed solely through observational rubrics. Suggested structured activities will be provided to teachers, to support them in evaluating student performance if the assessed behaviors have not been observed in the course of student activity. Across the six domains common to all States, a total of 15 selected-response items, 18 performance tasks, and 29 rubric-based observations combine to produce the total score on the KEA. (The methods for assessing The Arts are still under development.)

(6) In KEA 1.0, options exist to administer the assessment via paper and pencil or via computer presentation of the selected-response items and performance tasks. Teachers directly observe student performance on the items and tasks, and record student answers to selected-response items, which are then scored automatically by the ORS. Up to ten items are interactive. For performance tasks, test administrators are required to observe and score student responses and enter the scores within the ORS.

In KEA 2.0, students will be able to interact directly with the assessment platform to indicate and record their responses to selected-response items, and to perform many of the tasks by employing a variety of system capabilities, including, for example, drag-and-drop features. Student responses requiring the evaluation and scoring of a verbal student response will continue to be scored by teachers, as the ability to capture and automatically score students' verbal responses remains an emerging technology to be explored for this project. However, accommodations for English language learners, such as directions given in languages other than English to improve accessibility, will be a feature of KEA 2.0.

(7) In KEA 1.0, teachers are required to record student responses to some selected-response items because only ten of the items are interactive. In KEA 2.0, the ORS will provide for the capture of student responses to all of the selected-response items and will automatically score them in real time. Because of the variety of response modes required for the performance tasks, including verbal responses, KEA 2.0 will still require teachers to score student responses to the performance tasks and to directly enter those scores into the ORS. This scoring will be done in real time as part of the task administration.

For the observational rubrics, teachers will directly enter their observations into the ORS, either in real time or at intervals convenient for the teachers.

(8) It will be critical for the Consortium to develop procedures for standard setting that are collaborative and transparent to all States. WestEd will lead the standard-setting activities, along with Dr. Jessica Goldstein of the University of Connecticut, and will vet all steps in the process with the national TAC. The key activities for standard setting include selection of the standard-setting method (e.g., bookmark, body of work), determination of the number of performance levels, development of the performance level descriptors, approval of the preliminary performance level descriptors by the Consortium, recruitment of participants, preparation of materials for the standard-setting session, training of staff facilitators, implementation of the standard-setting method, finalization of the performance level descriptors, and, finally, approval of the performance level descriptors and the corresponding cut points on the performance continuum. One key decision that Consortium States must make is whether to set standards on the field-test data or to wait until the first live administration. While the latter is typically preferable because of the quality of resultant data, waiting for the live administration will push standard setting beyond the timeframe of this grant.

While all of the aforementioned standard-setting steps are critical to the development of valid, reliable, and fair performance standards for students, the engagement of representatives from each of the States is especially critical for ensuring broad-based, informed decisions about the levels of performance expected of students. Each State must provide representative key stakeholders to the standard-setting

panel. These key stakeholders should, at a minimum, include family members/parents, early-childhood/preschool educators, kindergarten teachers, early-childhood/development experts, and specialists on students with disabilities and English language learners. The recommended steps for the recruitment of panelists include identifying key stakeholder groups and desired panelist groups; determining the qualifications of panelists for each panelist type; asking stakeholder groups to nominate prospective panelists; and selecting from among the qualified nominees to satisfy the desired distribution. Establishing these explicit qualifications and recruitment strategies will produce the intended distribution and qualifications of the standard-setting panelists and enable evaluation of how well these intentions were realized. This will provide valuable evidence of defensibility of the standards that will result from the process (Hambleton, 2001).

(9) The following table summarizes the specific contents of proposed reports for specific audiences, as well as benefits and/or uses of the reports for each audience.

Audience	Reports	Benefits/Uses
Principals and Administrators	<ul style="list-style-type: none"> • Summary school-level performance reports by domain • Summary performance reports by students' age and/or birth date • Summary performance reports by gender, race/ethnicity, English language learner and/or disability status, and other demographic characteristics • Quarterly or biannual facility-/school-level formative assessment reports • Quarterly or biannual teacher-/co- 	<ul style="list-style-type: none"> • Informs principals of professional-development needs for teachers and co-teachers • Informs principals of strengths and possible weaknesses in programs • Informs principals of intervention needs for students • Supports routine data analysis of student and teacher performance

Audience	Reports	Benefits/Uses
	<p>teacher-level formative assessment reports</p> <ul style="list-style-type: none"> • Quarterly or biannual formative assessment reports by domain • Status reports providing pre-kindergarten schools and centers information on the preparedness of their students for entry into kindergarten 	
Teachers	<ul style="list-style-type: none"> • Summary performance reports on current classes • Summary performance reports on current classes by domain • Summary performance reports on individual students • Quarterly formative assessment reports on current classes • Quarterly formative assessment reports on current classes by domain • Quarterly formative assessment reports on individual students • Reports analyzing how close classes are to projected targets, based on the first summative assessment 	<ul style="list-style-type: none"> • Promotes evidence-based instructional decisions for classes and individual students • Generates ongoing performance data for timely refinement and adjustment of instructional strategies • Promotes personalization of instruction • Informs teachers of any gaps in the curriculum • Informs teachers of needed professional development for improving performance

Audience	Reports	Benefits/Uses
Families	<ul style="list-style-type: none"> • Summary performance reports for children by domain • Quarterly formative assessment reports for children by domain • Quarterly reports analyzing how close children are to reaching end-of-year targets 	<ul style="list-style-type: none"> • Creates transparency between the facility/school and the family • Encourages a collaborative approach to student learning • Supports the personalization of instructional delivery and needed interventions • Informs future supports needed to help students reach targeted goals (e.g., grouping, homework, tutoring)

(10) The States within the Consortium, whether aligned with Smarter Balanced or PARCC, will be implementing assessments for grades 3–8 and high school that provide information about students’ ongoing performance against standards for college and career readiness, as measured by assessments aligned to the States’ K–12 standards. As an assessment for readiness for kindergarten entry, the KEA now provides one of the “bookends” for entering and exiting K–12 education, tied to the expectations expressed through the States’ K–12 standards. Including the KEA within a State’s student assessment system will enable identification of students at risk of failure or falling behind as they enter the K–12 educational system (or earlier, for those students who are enrolled in child-care or preschool programs that administer the formative assessments).

(i) Kindergarten Entry Assessment Development Plan

(1)(i) WestEd proposes implementing an Evidence-Centered Design (ECD) approach to the KEA item and task development. Our approach is modeled on the best practices in assessment design introduced by Mislevy, Steinberg, and Almond (2003), and it has been adapted by WestEd, over the past

decade, to support traditional item development practices as well as the design and development of innovative item types implementing technology-enhanced features. ECD reflects an integrated approach to constructing educational assessments in terms of evidentiary arguments that can be used to improve the validity of items and tests.

ECD builds on the vision of Samuel Messick (1994): “the nature of the construct being assessed should guide the selection or construction of relevant tasks, as well as the rational development of construct-based scoring criteria and rubrics.” ECD is a systematic approach to the design of assessments that focuses on the evidence (student performance and products) of proficiencies as the basis for constructing assessment tasks. It provides a way to reason about assessment design and a way to reason about learner performance. Collecting the right information from assessments that help to make accurate inferences about students’ competencies is critical because these inferences will inform policy and instructional decisions that promote learning.

The use of ECD will also be critical in WestEd’s ability to design assessments that support valid and reliable decisions for all students. To strengthen that evidentiary argument, particularly for students with disabilities or students who are English language learners, it is important that the assessment design consider not only the constructs that are targeted for measurement, but also constructs that are not targeted for measurement (e.g., sight, hearing, or certain aspects of the English language) and that could interfere with measurement of the targeted constructs (Hansen & Mislevy, 2008; Mislevy & Haertel, 2006). Assessment designs that are valid across populations will specify accessibility features that minimize or eliminate the impact of these non-targeted constructs through the use of Universal Design principles. ECD provides a framework that makes the underlying evidentiary argument more explicit—thereby supporting sharing and communication among assessment designers, test delivery platform developers, and psychometricians, who can work together to minimize the influences of non-targeted constructs—and supports an examination of the validity of inferences. ECD considers the targeted

constructs, the observations collected, and the context in which those observations occur (Hansen & Mislevy, 2008; Zhang et al., 2009).

At its core, ECD requires assessment developers to perform five important steps in the development of an assessment instrument. As described by Mislevy, Almond, and Lukas (2003), these steps include:

1. Domain analysis: Defining the content and subcontent areas to be included in the assessment.
2. Domain modeling: A high-level description of the components of the assessment that provide evidence to support inferences.
3. Conceptual assessment validity framework: Clear articulation of the construct(s) that are targeted within the domain, articulation of unintended constructs that may cause construct-irrelevant variance, and specifications for tasks that provide a context in which evidence about the targeted knowledge or skill is collected without construct-irrelevant variance.
4. Item and task development: Development of items and tasks that are based on the specifications developed during the third step and that are used to form the assessment instrument(s) used to collect observations that serve as the evidence from which inferences will be made.
5. Evidence collection: Description of the conditions and procedures through which assessment instruments are delivered, and design for reporting results that enables valid inferences about the knowledge, skills, and abilities targeted within the defined domain.

WestEd has recently supported the Smarter Balanced Assessment Consortium as it developed its item specifications through the application of ECD principles, and will draw on this experience as the development of the KEA is expanded.

(ii) The development model enacted by the Consortium places significant value on the involvement of stakeholders and content and development experts. The track record of inclusiveness established by Maryland and Ohio will continue as the work is expanded. The Consortium States will continue to provide significant leadership and guidance, through the Executive Committee, as the assessment system

is developed, to ensure that the developed assessment system meets their needs and will support their educators and families in improving the learning of all children.

The assessment development process will involve state-identified ad hoc and standing committees for content review of the learning progressions and all assessment materials. The content-review committees will combine early-childhood and kindergarten teachers, early-childhood measurement experts, and consultants. In addition, the States will convene a common, cross-state bias and sensitivity review committee that will include both early-childhood experts and educators who work with English language learners and students with disabilities. The States will also actively engage families and representatives from their early-childhood advisory councils, and will establish a State advisory committee to review the assessment development process. These actions will provide a means to engage all key stakeholders in the review process prior to field-test and operational implementation.

As the lead for content development, WestEd recognizes the importance of building bridges among developmental, content, assessment, and psychometric experts. Consequently, WestEd has assembled a team that combines these areas of expertise. WestEd's CCFS program is a leader in promoting high-quality, research-based, early child-care and educational services. Its work informs national, State, and local child and family policies. CCFS staff have developed the learning progressions and continue to serve as early-childhood expert advisors to the project, reflecting the latest research in the field. WestEd's ASDS program leads the assessment development activities. As a research and development organization, WestEd will work collaboratively with the University of Connecticut to design and implement the necessary psychometric analyses and research activities to ensure that the developed assessment system meets criteria for reliability and validity.

JHU CTE complements the team by providing its expertise in emerging technologies and professional development. JHU CTE is recognized for its application development, which capitalizes on emerging technologies to support classroom management, reporting, and data-driven decision-making. Its knowledge of delivery systems will support the goal of developing a user-friendly platform for student

use with the assistive technology needed to meet the needs of English language learners and students with disabilities. The technology infrastructure will also support administration, recording, scoring, and reporting functions and will provide for the importing and exporting of data to State longitudinal and early-learning data systems. JHU CTE is also known for its high-quality professional development, and it will provide both training and support for the use of the assessment system, as well as instructional implications based on student and classroom results.

Finally, CCSSO is facilitating the work of the national TAC, which provides critical review and advice on early childhood learning, assessment, and technology.

(2) A primary goal of the project work is to develop, through the use of ECD and Universal Design principles, assessments that are as universally accessible to students as possible, but there will be students who, due to disabilities, developmental delays, and/or limited English language proficiency, will require accommodations. JHU CTE will lead expert work groups, including practitioners from each Consortium State, convened specifically to address accommodations policies for these students. Using the accommodations policies and assessment design features of PARCC and Smarter Balanced as models, the work groups will ensure that the assessment system includes universal accessibility features that remain true to the purpose and vision of the assessment, and that, from the time of its inception, individualized supports and accommodations for children with special learning needs are considered. Members of the work groups will draft and review policies regarding, but not limited to, participation requirements, the application of accessibility features to assessment administration, and the provision of accommodations. These policies will be grounded in research on best practices for assessing young children, with an emphasis on assessing special populations. The work groups will also assist in designing content for professional development, to disseminate to teachers and other IEP team members in schools. The policies and professional development will be piloted and field tested during the applicable phases of assessment development. Data will be gathered during each phase in order to evaluate appropriateness,

usability, and feasibility. Once the policies and professional development protocols are finalized, the partnering States will adopt them.

(3) Accurate and consistent scoring of the assessment items and ratings of observational behaviors is a necessity for a reliable and valid assessment system. Methods to achieve accurate and consistent scoring will be incorporated into the development of the items and tasks themselves, the rubrics, scored exemplars, and training.

ECD will be instrumental in supporting the development of the items and tasks. The conceptual assessment validity framework, a key component of ECD, involves articulation of the construct(s) to be assessed and specifications for items and tasks that provide a context in which evidence about the targeted knowledge and skill can be collected. By clearly specifying the construct and contexts to be assessed, the development process is purposefully guided to consider appropriate evidence of student performance, including the relative ease of evidence collection and the reliability of observing and rating student performance.

As previously described, the KEA and formative assessments will include selected-response items that have a single correct answer and will be machine scored. The performance tasks will require training of teachers. This training will be available online and will allow individuals to work at their own pace through the materials and repeat sessions, as needed. The performance tasks will have well-defined rubrics that clearly differentiate student performance by score point. The observational rubrics will be further supplemented with anchor papers that exemplify each of the score points. In addition, training sets will provide further support for the application of the rubrics to student work. The training materials will also include student work that does not clearly align to the anchors, to support teachers in scoring the full range of student work. Before teachers are allowed to score operational student work, they must demonstrate their ability to accurately score student work by achieving a level of accuracy (to be determined) in which adjacent, but not discrepant, scores will be allowed. The industry standard is a minimum of 80% exact agreement, but this standard will be vetted with the TAC before implementation.

Observational rubrics will also require teacher training, as they will be based on a 0–2 scale for the KEA and a 0–3 scale for the formative assessments. The decision to move toward a 0–2 scale for the KEA observational instruments was based on results of the KEA 1.0 pilot study, in which teachers were asked to compare the use of the checklists (employing a 0–2 scale) with the use of observational rubrics based on a 0–3 scale. Whereas teachers preferred the ease of use of the checklists, they preferred the rubric language, which defined the student behavior to be observed at each score point, for reasons of consistency of ratings. Given the need to administer the KEA to all students within the initial eight weeks of instruction, WestEd recommends the use of the rubric-based score descriptions with an abbreviated scale, to maximize efficiency and reliability. The formative assessments will continue to use the 0–3 scale in order to allow for finer distinctions in student performance and thus provide more diagnostic information to support instructional decisions.

Training for teachers on the use of the observational rubrics will be delivered online through the use of videos of students. Just as with the scorer training for the performance tasks, anchor, training, and qualifying videos will be available for each rubric. Administrators must achieve the desired level of accuracy in rating of student behavior in order to rate students during the operational administration of the KEA and the formative assessments.

During the field test, a within-school moderation system, in which a fellow teacher or school administrator will observe students' performance and/or behavior to determine interrater reliability for the performance tasks and observational rubrics, will be employed. The results of these analyses will help to identify potential scorer training issues and allow revision to the scoring materials in advance of their operational use. The ongoing process for moderation and monitoring of scorer behavior is a key component of the research agenda.

(4) The underlying goal of the ORS is to provide the relevant stakeholders with reliable, valid information that can be used to inform student-, classroom-, school-, program-, and state-level decisions. Given the stakes associated with these decisions, it is critical that the reliability of the information

provided be appropriate for its use. For example, while individual student scores on the ESKs assessed on the KEA may be seen as valuable, the limits of testing time do not allow for sufficient test items for each assessed ESK to support this level of reporting. However, due to the number of students tested within the classroom, it may be possible to report these data at the classroom level, subject to the data meeting a minimum reliability threshold. Consequently, student-level reports for the KEA will focus on reporting at the domain and total score levels. KEA reporting at the ESK, learning progression, and strand levels will be subject to psychometric review.

However, the project team believes that the formative assessment results must be reported by individual learning progression, because these assessment items and tasks are designed to inform individual instructional decisions for students. Each formative assessment task will provide evidence to support the placement of a student along a learning progression, and as such, the scores for individual students must be made available to classroom teachers. Having the capability to capture a “snapshot” of the status of an individual classroom is also valuable for informing classroom instruction. These data can be reported at the school level, across classrooms. The reporting of the formative data will be limited to the classroom and school levels.

Strategies for developing the reporting system will leverage innovative technology-driven solutions to generate and disseminate customized reports that deliver information to key stakeholders. Report dissemination efforts using information technologies can have greater reach, adoption, implementation, and maintenance, and, therefore, greater public impact; however, these efforts have to be designed with careful consideration of the populations and educational environments involved. The interactive reporting mechanisms will use user-centered designs to address the needs, limitations, and desired system functions of educators, administrators, and families/caregivers. As such, it will be essential to clearly identify the demographics and related system functions of each user group. The Consortium will administer surveys to key stakeholders, which will help to finalize a list of desired and necessary system features for each specific group of users.

Score reports resulting from the KEA will build on the Consortium's experience with delivering meaningful, uniform score reports customized to the needs of the various stakeholders at different levels. All levels of reporting will focus on providing a context for interpreting the assessment results; however, these contexts will differ by key stakeholder needs. To this end, the Consortium will explore how to most effectively develop: (a) reports for families, which present interactive assessment results to help families and caregivers understand the specific strengths and weaknesses of their children's knowledge, skills, and abilities; (b) reports for educators, which provide detailed information that can be interactively displayed according to domain and overall score, question type, and performance level; (c) reports for administrators, which provide aggregate information that helps to build instructional and professional development strategies for early-childhood education; and (d) state-level reports, which can inform policy decisions about the adequacy of educational programs and centers to prepare students for entry into kindergarten.

Central to each of these reporting levels will be users' ability to engage and interact with the assessment data. All key stakeholders will be provided with narrative and graphical components within the reports, which will provide context for interpreting the reports. For example, families/caregivers will be presented with a narrative describing early childhood development, which can help to explain why certain skills are essential for learning and describe key practices that families can implement at home to support their children's learning. Similarly, educators will receive interactive graphical reports at the student and classroom levels, which will enable them to explore specific concepts or learning progressions and examine how both individual students and whole classes are performing.

(5) Given the ambitious nature of the Consortium's goals for the development of the EC-CAS, it is critical to establish processes for quality control throughout the item/task development process. The proposed management structure places both the day-to-day management of the Consortium and the development process with WestEd as PMP and lead item developer. Given WestEd's combined roles of management and development, it will maintain constant and clear communication about the ongoing

status of all development. As outlined in the management plan in section (g), WestEd's success in serving as the PMP for Smarter Balanced has prepared it to work within the unique demands placed on the activities of a consortium committed to the development of an assessment system. WestEd has established processes and procedures to document all phases of the development process and methods to evaluate progress in meeting the goals of each phase on a regular and ongoing basis.

Effective management of processes will be critical in maintaining quality control, but ensuring that the development processes themselves are sound is equally important. WestEd's knowledge of and experience with test development practices, combined with the critical research and evaluation provided by the University of Connecticut, will ensure fidelity to established standards for the development of a fair, reliable, and valid assessment system. Key steps that have been built into the process include cognitive interviews to determine students' strategies for responding to items and tasks, pilot testing of items among representative samples of students from all Consortium States, revision and refinement of items based on the results of cognitive interviews and pilot tests, item and bias review committees composed primarily of early-childhood educators, field testing all items before operational use, implementation of accommodations strategies with purposeful inclusion of students with disabilities or developmental delays and English language learners in the field test, and training of all teachers for the administration and scoring of the assessments. All assessment reports will be evaluated for their potential use, anticipating both intended and unintended consequences. Care will be given to providing documentation to ensure the appropriate interpretation and use of all reports. Quality-control procedures will be established to ensure the accuracy of all reports before distribution.

Finally, WestEd will ensure involvement of Consortium State leads and the TAC in the review of all proposed procedures, to ensure that these procedures reflect the quality and technical standards expected of the States and the research and assessment communities.

Description of Absolute Priorities

Priority 1 (Collaboration)—With the goal of developing a comprehensive assessment system, the Consortium comprises seven States (Connecticut, Indiana, Maryland, Massachusetts, Michigan, Nevada, and Ohio) and three prominent educational research and development organizations: WestEd’s Assessment & Standards Development Services and Center for Child & Family Studies, the Johns Hopkins Center for Technology in Education (JHU CTE), and the University of Connecticut’s Measurement, Evaluation, and Assessment Program. Additionally, the Council of Chief State School Officers has committed resources and supports for the Technical Advisory Committee. These organizations will assist the Consortium in its efforts to build a reliable, valid, and high-quality assessment system that is based on current research and best practices. WestEd will serve as the Project Management Partner and lead assessment developer. In these roles, WestEd will use its extensive experience and expertise in assessment development and management to ensure that the assessment items and tools reliably measure and align to children’s learning and development across the essential domains of school readiness. The Consortium’s collaboration with JHU CTE will ensure that the assessment system incorporates technology wherever possible, including support for administration, scoring, and reporting of the assessment instruments. In addition, JHU CTE will provide professional-development support to the Consortium, including face-to-face and online training, technical assistance, coaching, and providing instructional resources through learning communities and collaborations. The University of Connecticut, in conjunction with WestEd, will provide the Consortium with research and evaluation assistance to ensure that evidence-based practices are employed.

Priority 2 (Multiple Measures)—The Consortium’s assessment system will measure the full range of early learning and development standards across all essential domains of school readiness. The assessment system will utilize several assessment methods, including selected-response items, performance tasks, and observational rubrics, aligned to learning progressions that encompass children’s performance across the spectrum of development. All components of the assessment system will

incorporate the principles of Universal Design that seek to eliminate aspects of items and tasks that increase the presence of construct-irrelevant factors that preclude access for English language learners and children with disabilities or developmental delays.

Priority 3 (*Charting Student Progress*)—In order to chart student progress over time, the Consortium will utilize technology in the administration of the assessment instruments and the collection and reporting of data. This will allow all stakeholders (e.g., administrators, teachers, families) to track children’s progress from preschool through kindergarten, and in subsequent years. The assessment items will be aligned to learning progressions that span the developmental spectrum and that provide teachers, early-learning providers, and families with the capacity to offer individualized instruction and support. Furthermore, the KEA will result in a comprehensive score across the learning progressions for each child, which can then be incorporated into States’ longitudinal data systems.

Priority 4 (*Comprehensive Academic Assessment Instruments*)—The Consortium recognizes the value of a system of summative and formative assessments that are organized around a common set of early learning and development standards that measure the entire range of skills across the essential domains of school readiness. The KEA summative assessment will utilize multiple item types, including, but not limited to, selected-response items, performance tasks, and observational rubrics; technology will be used to deliver and/or enhance the assessment. The learning progressions support aligned formative tools leading up to the KEA and then extending the available information through the end of kindergarten. This range of balanced, aligned instrumentation will identify students’ strengths and weaknesses, identify instructional intervention strategies, and track student progress over time and across cohorts.

Priority 5 (*KEA*)—The Consortium proposes to enhance KEA 1.0, currently in development by Maryland and Ohio, and build KEA 2.0 to adhere to all of the requirements set forth in this grant competition. KEA 2.0 will provide the Consortium States with valid, reliable, and fair information on children’s readiness for school across the essential domains of school readiness, including Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being,

Science, Social Studies, and The Arts. Further, KEA 2.0 will utilize multiple methods of assessment, including selected-response items, performance tasks, and observational rubrics, that are consistent with nationally recognized technical standards, research, and best practices, and will employ the principles of Universal Design in order to assess all children upon entry to kindergarten. The summative results, consisting, at a minimum, of domain-level scores and comprehensive scores, from KEA 2.0 will then provide all stakeholders, including families, with appropriate information to help guide individualized instruction and inform program and policy decisions to help improve student achievement.

KEA 2.0 will be administered by trained teachers and assessors in the first eight weeks of school and will utilize technology in the administration of assessment items and in the collection and reporting of data. The online reporting system will be able to export data for use in a State's assessment or longitudinal data systems, and will be able to create reports for teachers, administrators, early-childhood providers, and families, in order to reflect a child's learning and development against set levels of performance. The KEA will not be used to prevent entry into kindergarten or for any purpose for which it has not been validated.

Description of Competitive Preference Priority

The state education agencies from Connecticut, Massachusetts, Indiana, Michigan, Nevada, and Ohio join the Maryland State Department of Education in its application for this grant. Each of these states has signed a Memorandum of Understanding (MOU) that describes the vision and principles of the Consortium; the roles and responsibilities of the Consortium and its member States; and the governance structure and activities of the States in the Consortium. The MOUs are included within this application.

Appendix A – High-Level Project Plan for EC-CAS 2.0

Budget Year	Activity	Timeline	Responsible Party
Phase I (2013–2014)	Consortium Kickoff Meeting	Nov	CS, WE, CTE
	Development Specifications	Nov – Jan	EC, WE, CTE
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
	Initial Item and Technology Development	Feb – Mar	WE and CTE
	Human Subjects Committee Protocol	Mar – Apr	WE
	Student Cognitive and Teacher Interviews	Apr	WE and CTE
	Item and Technology Development (cont.)	Apr – Jun	WE and CTE
	Pilot Test Recruitment and Preparation	May – Aug	CS
	Bias/Content Review of Items	Jun	WE
Phase II (2014–2015)	Pilot Test Administration	Sep – Oct	CS, WE, CTE
	Analyze Data from Pilot Test	Nov – Dec	WE, CTE, UConn
	Technical Report (Pilot Summary)	Jan – Feb	WE, CTE, UConn
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
	Revise Development Specifications	Jan – Mar	WE and CTE
	Item Development for Field Test	Mar – Jun	WE
	Field Test Recruitment	May – Jun	CS
	Bias and Content Review of Items	Jul	WE
	Field Test Preparation	Jul – Aug	WE and CTE
Phase III (2015–2016)	Field Test Administration	Sep – Oct	CS, WE, CTE
	Analyze Data from Field Test	Nov – Dec	WE, CTE, UConn
	Field Test Report (item statistics)	Jan – Feb	WE, CTE, UConn
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
Post Award (2016–2017)	KEA Census Administration	Sep – Oct	CS, WE, CTE
	Census Report	Nov – Dec	WE, CTE, UConn
Virtual Executive Committee Meetings (Monthly); In-person Meetings two times per year (TBA)			
CS = Consortium States; CTE = JHU Center for Technology in Education;			
EC = Executive Committee; WE = WestEd			

Memorandum of Understanding
Maryland State Department of Education
Enhanced Assessment Instruments Grants Program—Enhanced Assessment
Instruments—Kindergarten Entry Assessment Competition
CFDA Number: 84.368

This Memorandum of Understanding (“MOU”) is entered as of July 3, 2013, by and between the **Maryland State Department of Education** (the “Consortium”) and the **State of Indiana**, which has elected to participate in the Consortium as (check one)

A **Charter State** (description in section e),

OR

An **Advisory State** (description in section e),

pursuant to the Early Learning Collaborative Efforts Among States for the Enhanced Assessment Program for the Kindergarten Entry Assessment Competition Grant Application, henceforth referred to as the “Program,” as published in the Federal Register on May 23, 2013 (78 FR 31344-31365).

Background

Beginning in May 2012, Ohio Department of Education (ODE) and Maryland State Department of Education (MSDE) entered into a formal collaboration after each was awarded the Race to the Top Early Learning Challenge Grant (RTT-ELC) in December 2011. In response to the solicitation for proposals regarding the RTT-ELC, ODE and MSDE formally collaborated to develop the Early Childhood- Comprehensive Assessment System (EC-CAS). MSDE and ODE agreed to be accountable for the following activities from May 2012 to December 31, 2015 throughout the term of the RTT-ELC grant:

- Establish the governance and management infrastructure for the EC-CAS project,
- Developing and implementing a management plan which includes the recruitment of staff, fiscal and legal management procedures, and ongoing planning toward the accomplishment of the project goals;
- Develop a Kindergarten Entry Assessment (KEA) and formative assessments (36-72 months) to be fully implemented in both states by 2014-15;
- Develop and implement professional development for the administration and use of the assessment;

- Develop and deploy technology infrastructure for the EC-CAS project; and
- Implement stakeholder communication to measure the impact of the KEA and formative assessment on the efficacy of learning.
- Establishing a Technical Advisory Council with national experts, coordinated by the Council of Chief State School Officers. The 12-member Council will jointly be selected by Ohio and Maryland and will provide technical expert advice to the Collaboration.
- Establishing and engaging state advisory committees, one in Ohio and one in Maryland as subcommittees to the Maryland and Ohio Early Childhood Advisory Councils;
- Disseminating information jointly about the development and implementation of the EC-CAS project to national audiences.

The aforementioned activities, referred to as EC-CAS Version 1.0, will form the basis of the EAG proposal. The proposed plan, submitted by MSDE on behalf of the following states [list of states], describes the enhancement of the existing Version 1.0. Work activities related to EC-CAS Version 1.0, to be completed by December 2015, will be governed only by the two founding states.

Any state that joined ODE and MSDE as a Charter State under the proposed EAG plan, may enter into a separate agreement with ODE and MSDE to implement EC-CAS Version 1.0. The costs of the implementation will be borne by the state.

The purpose of this MOU is to

- (a) Describe the Consortium vision and principles,
- (b) Detail the responsibilities of States in the Consortium,
- (c) Detail the responsibilities of the Consortium,
- (d) Describe the management of Consortium funds,
- (e) Describe the governance structure and activities of States in the Consortium,
- (f) Describe State entrance, exit, and status change, and
- (g) Bind each State in the Consortium to every statement and assurance made in the application through the following signature blocks:
 - (i)(A) Charter State Assurance
 - OR**
 - (i)(B) Advisory State Assurance

(a) Consortium Vision and Principles

The Consortium's priorities for a next generation early childhood Comprehensive Assessment System for preschool and kindergarten programs are rooted in a concern for the valid, reliable, and fair assessment of learning and development across the essential domains of school readiness. These priorities are also rooted in a belief that assessment must support ongoing improvements in instruction and learning, and must be useful for all members of the educational enterprise: students, families, teachers, school administrators, early learning providers, members of the public, and policymakers.

The Consortium intends to build a system of assessment, particularly a Kindergarten Entry Assessment (KEA), based upon the essential domains of school readiness with the intent that a summative assessment of a child's learning and development at kindergarten entry is provided for all students across this Consortium of States. The Consortium recognizes the need for a system of summative and formative assessments that are organized around early learning and development standards that measure the full range of skills across the essential domains of school readiness. These assessments shall support high-quality learning, have the capacity to guide individualized instruction, can be reported to and understood by all stakeholders, and provide information that can be incorporated into a state's early learning data system. The efforts of the Consortium will be organized to accomplish these goals.

The Kindergarten Entry Assessment developed by the Consortium will include the following key elements and principles:

1. The KEA that will be grounded in a set of early learning and development standards.
2. The KEA will measure the full range of the early learning and development standards across all essential domains of school readiness, including a set of levels of performance that encompass what a child knows and is able to do for each level.
3. The KEA will use multiple methods, including selected-response, performance-task, and observational items, to measure performance and development across the essential domains of school readiness, with each making a significant contribution to the overall comprehensive kindergarten readiness score.
4. Technology will be used to collect data and in the process of administering the assessment. Technology applications will be designed to maximize interoperability across user platforms.

5. All components of the system will incorporate principles of Universal Design that seek to remove construct-irrelevant aspects of tasks that could increase barriers for dual language learners and children with disabilities or developmental delays.

(b) Responsibilities of States in the Consortium

Each State that is a member of the Consortium in 2013–2017 agrees to the following:

- Adopt and fully implement statewide the common Kindergarten Entry Assessment no later than December 31, 2017,
- Adopt a set of essential skills and knowledge that are based on early learning and development standards that are substantially identical across all States no later than the 2016–2017 school year,
- Adhere to the governance as outlined in this document,
- Agree to support the decisions of the Consortium,
- Agree to follow agreed-upon timelines,
- Be willing to participate in the decision-making process and, if a Charter State, final decision.

(c) Responsibilities of the Consortium

The Consortium will provide the following by the 2016-17 school year:

1. A comprehensively designed assessment system that includes a strategic use of a variety of item types to assess all the essential domains of school readiness with each domain making a significant contribution to the overall comprehensive score.
2. An assessment system that incorporates a required Kindergarten Entry Assessment with optional formative components which provides accurate assessment of all children (as defined in the Federal notice) including children with disabilities or developmental delays and dual language learners.
3. Psychometrically sound scaling and equating procedures based on multiple methods of assessment that provide reliable, valid, and fair scores for children and groups that can be used to evaluate school readiness; guide individualized instruction; and better understand the effectiveness and professional development needs of teachers, principals, and early learning providers.
4. An assessment system that is designed to incorporate technology in the collection of data and process of assessing that is cost-effective to administer, maintain, and enhance.

5. A Kindergarten Entry Assessment that can be a component of a State's student assessment system, include the State's comprehensive early learning assessment system, and provide data that can be incorporated into a State's longitudinal data system.

(d) Management of Consortium Funds

All financial activities will be governed by the laws and rules of the State of Maryland, acting in the role of Lead Procurement State/Lead State. Additionally, Maryland is prepared to follow the guidelines for grant management and will be legally responsible for the use of grant funds and for ensuring that the project is carried out by the Consortium in accordance with Federal requirements.

(e) Governance Structure and Activities of States in the Consortium

Total State Membership

The Total State Membership of the Consortium includes Charter and Advisory States, with Maryland serving in the role of Lead Procurement State/Lead State on behalf of the Consortium.

A **Charter State** is a State that:

- Has fully committed to this Consortium only and met the qualifications specified in this document,
- Is a member of only one Consortium receiving a grant in the Program,
- Has an active role in policy decision-making for the Consortium,
- Provides a representative to serve on the Executive Committee,
- Participates in the final decision-making of the following:
 - Changes in Governance and other official documents,
 - Specific Design elements, and
 - Other issues that may arise.

An **Advisory State** is a State that:

- Has not fully committed to any Consortium but supports the work of this Consortium,
- Participates in all Consortium activities but does not have a vote unless the Executive Committee deems it beneficial to gather input on decisions or chooses to have the Total Membership vote on an issue,
- May contribute to policy, logistical, and implementation discussions that are necessary to fully operationalize the Kindergarten Entry Assessment.

Executive Committee

The Executive Committee is comprised of one representative from each Charter State in the Consortium. Committee members may be a chief or his/her designee. Executive Committee Members must meet the following criteria:

- Be from a Charter State,
- Have prior experience in either the design or implementation of curriculum, standards, and/or assessment systems at the policy or implementation level, and
- Must have willingness to serve as the liaison to the Total State Membership.

Executive Committee Responsibilities

- Determine the broad picture of what the assessment system will look like,
- Determine the issues to be presented to the Charter and/or Advisory States,
- Oversee the expenditure of funds in collaboration with the Lead Procurement State/Lead State (Maryland),
- Operationalize the plan to transition from the proposal governance to implementation governance, and
- Evaluate and recommend successful contract proposals for approval by the Lead Procurement State/Lead State (Maryland).

Decision-making

Consensus will be the goal of all decisions. Major decisions that do not reach consensus must be passed with a 2/3 majority vote. Each Charter State will have one vote.

(f) State Entrance, Exit, and Status Change

This MOU shall become effective as of the date first written above upon signature by both the Consortium and the Lead Procurement State/Lead State (Maryland) and remain in force until the conclusion of the Program, unless terminated earlier in writing by the Consortium as set forth below.

Entrance into Consortium

Entrance into the Consortium is assured when:

- The level of membership is declared and signature is secured on the MOU from the Chief State School Officer;
- The signed MOU is submitted to the Consortium;
- The Charter and Advisory States agree to and adhere to the requirements of the governance;
- The Chief State School Officer has reviewed its applicable procurement rules and provided assurance that it may participate in and make procurements through the Consortium; and
- The State agrees to support all decisions made prior to the State joining the Consortium.

After receipt of the grant award, any request for entrance into the Consortium must be approved by the Executive Committee. A State may begin participating in the decision-making process after receipt of the MOU.

Exit from Consortium

Any State may leave the Consortium without cause, but must comply with the following exit process:

- A State requesting an exit from the Consortium must submit in writing their request and reasons for the exit request,
- The written explanation must include the statutory or policy reasons for the exit,
- The written request must be submitted to the Executive Committee with the same signatures as required for the MOU, and
- The Executive Committee will act upon the request within a week of the request.

Changing Roles in the Consortium

A State desiring to change from an Advisory State to a Charter State or from a Charter State to an Advisory State may do so under the following conditions:

- A State requesting a role change in the Consortium must submit in writing their request and reasons for the request,
- The written request must be submitted to the Executive Committee with the same signatures as required for the MOU, and
- The Executive Committee will act upon the request within a week of the request and submit to the USED for approval.

(g) Bind each State in the Consortium to every statement and assurance made in the application through the following signature blocks

<p>(h)(i)(A) CHARTER STATE SIGNATURE BLOCK for the Enhanced Assessment Program Kindergarten Entry Assessment Grant Application Assurances</p> <p><i>(Required from all "Charter States" in the Consortium.)</i></p> <p>As a <u>Charter State</u> in the Consortium, I have read and understand the roles and responsibilities of Charter States, and agree to be bound by the statements and assurances made in the application.</p>	
<p>State Name:</p>	
<p>Chief State School Officer (Printed Name):</p>	<p>Telephone:</p>
<p>Signature of the Chief State School Officer:</p>	<p>Date:</p>

(h)(i)(B) ADVISORY STATE SIGNATURE BLOCK for the Enhanced Assessment Program
Kindergarten Entry Assessment Grant Application Assurances

(Required from all "Advisory States" in the Consortium.)

As an Advisory State in the Consortium, I have read and understand the roles and responsibilities of Advisory States, and agree to be bound by the statements and assurances made in the application.

I further certify that as an Advisory State I am fully committed to the application and will support its implementation.

State Name:

State of Indiana, Indiana Department of Education

Chief State School Officer (Printed Name):

(b)(6)

Telephone:

(b)(6)

Signature of the Chief State School Officer:

(b)(6)

Date:

July 3, 2013

Project Plan Export Report

2012 - Indiana - SEA

PR Award #: R372A120027

Project Plan Version: Version (8/29/2013 9:39:14 AM)

Effective Date: 8/29/2013

Code	Project and Task Name	Status	Start Date	End Date	Description	Deliverable	Milestone	Comments
1	Conduct feasibility study	Operational	5/1/2012	3/1/2013		No	No	
1.1	Identify principal investigator (selected by the Indiana Education Roundtable)	Operational	12/1/2012	1/30/2013		No	No	
1.2	Identify stakeholders for stakeholder interviews	Operational	12/2/2012	1/30/2013		No	No	
1.3	Principal investigators selected by the Indiana Education Roundtable conduct Stakeholder Interviews	Operational	6/1/2012	3/1/2013		No	No	
1.4	Principal investigators selected by the Indiana Education Roundtable produce final report	Operational	10/2/2012	3/1/2013		No	No	
2	Develop Data Governance Structures	In Progress	1/1/2013	6/30/2014		No	No	
2.1	Recruit governing council members	Operational	2/1/2013	4/30/2013		No	No	
2.2	Develop governing council charter	Operational	4/30/2013	6/30/2014		No	No	
2.2.1	Develop process for recruiting additional agencies to contribute data	Operational	5/30/2013	6/30/2014		No	No	
2.2.2	Adopt Governing Council Charter	Operational	5/31/2013	6/30/2013		No	No	
2.3	Create sustainability plan	Not Started	4/30/2013	4/30/2014		No	No	
2.3.1	Adopt sustainability plan	Not Started	4/30/2013	4/30/2014		No	No	
2.4	Develop governance model and policies	Operational	2/1/2013	6/30/2013		No	No	
2.5	Adopt Governance model and policies	Operational	5/31/2013	6/30/2013		No	No	
2.6	Develop MOU's	Operational	1/1/2013	5/31/2013		No	No	
2.6.1	For K12	Operational	3/1/2013	5/31/2013		No	No	
2.6.2	For Post Secondary	Operational	3/1/2013	5/31/2013		No	No	
2.6.3	For Workforce Development	Operational	3/1/2013	5/31/2013		No	No	
2.7	Develop Data Sharing Agreements	In Progress	5/1/2013	12/31/2013		No	No	
2.7.1	For K12	In Progress	5/31/2013	12/31/2013		No	No	
2.7.2	For Higher Ed Institutions	Operational	5/1/2013	5/31/2013		No	No	
3	Develop Strategic Plan	In Progress	7/12/2012	1/30/2015		No	No	
3.1	Develop Stakeholder plan	In Progress	6/30/2013	12/31/2013		No	No	
3.1.1	Develop survey to solicit stakeholder feedback to be used for prioritization	Operational	6/30/2013	8/23/2013		No	No	
3.2	Develop Vision for Research Agenda	In Progress	7/12/2012	9/30/2013		No	No	
3.2.1	Adopt Research Agenda	Not Started	7/31/2013	9/30/2013		No	No	
3.3	Rebrand existing IWIS system	Not Started	7/1/2013	1/30/2015		No	No	

Project Plan Export Report

2012 - Indiana - SEA

PR Award #: R372A120027

Project Plan Version: Version (8/29/2013 9:39:14 AM)

Effective Date: 8/29/2013

Code	Project and Task Name	Status	Start Date	End Date	Description	Deliverable	Milestone	Comments
3.3.1	Governing Council adopts rebranding solution	Not Started	12/31/2013	1/30/2015		No	No	
3.4	Develop strategy to incorporate additional agencies	Not Started	12/31/2014	1/30/2015		No	No	
3.4.1	Develop strategic data release plan	Not Started	12/31/2014	1/30/2015		No	No	
4	Define data management and controls	In Progress	7/1/2012	12/31/2013		No	No	
4.1	Develop data dictionary and mapping table using list of Master Data Elements that exist across all agencies	In Progress	7/1/2012	11/29/2013		No	No	
4.2	Review physical location, maintenance governance, and platform	Not Started	1/1/2013	12/31/2013		No	No	
4.3	Conduct gap analysis to identify data elements needed for program objectives not currently collected	In Progress	1/1/2013	11/29/2013		No	No	
4.4	Create process for bringing new data elements into the system	In Progress	1/1/2013	11/29/2013		No	No	
4.5	IT Staff from each agency will develop security measures and implementation plan and Governing Council will sign off	Not Started	1/1/2013	11/29/2013		No	No	
4.5.1	K12	Not Started	3/1/2013	11/29/2013		No	No	
4.5.2	Post sec	Not Started	3/1/2013	11/29/2013		No	No	
4.5.3	Workforce	Not Started	3/1/2013	11/29/2013		No	No	
4.6	Implement data quality and audit plan	Not Started	1/1/2013	12/31/2013		No	No	
4.6.1	Develop data quality and audit plan	Not Started	1/1/2013	12/31/2013		No	No	
4.6.2	Test data quality and audit plan	Not Started	1/1/2013	12/13/2013		No	No	
4.6.3	Fully rollout data quality and audit plan	Not Started	1/1/2013	12/31/2013		No	No	
4.7	Develop Researcher Approval Process	Not Started	6/30/2013	12/31/2013		No	No	
5	Review and Expand Existing P20 W Data System	Not Started	4/1/2013	12/31/2014		No	No	
5.1	Define and validate requirements based on use cases	Not Started	4/1/2013	12/31/2014		No	No	
5.1.1	Mock up reports from use cases	Not Started	4/1/2013	12/31/2014		No	No	
5.1.2	Obtain feedback based on mockups	Not Started	4/1/2013	12/31/2014		No	No	
5.1.3	Finalize reports from use cases	Not Started	4/1/2013	12/31/2014		No	No	
5.1.4	Review logical system design and data modeling standards	Not Started	7/1/2013	12/31/2014		No	No	
5.1.5	Finalize reports from use cases	Not Started	4/1/2013	12/31/2014		No	No	

Project Plan Export Report

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Effective Date: 8/29/2013

Code	Project and Task Name	Status	Start Date	End Date	Description	Deliverable	Milestone	Comments
5.2	Develop logical system design and data modeling standards	Not Started	7/1/2013	3/31/2014		No	No	
5.2.1	Review physical system design	Not Started	10/1/2013	3/31/2014		No	No	
5.2.2	Formalize data transfer process between agencies	Not Started	10/1/2013	3/31/2014		No	No	
5.3	Identify and define datasets for publication	Not Started	10/1/2013	3/31/2014		No	No	
5.3.1	Aggregate data sets	Not Started	10/1/2013	3/31/2014		No	No	
5.3.2	Identifiable data sets	Not Started	10/1/2013	3/31/2014		No	No	
5.3.3	De-identified data sets	Not Started	10/1/2013	3/31/2014		No	No	
5.4	Map primary questions to data elements	Not Started	10/1/2013	3/31/2014		No	No	
5.5	Define business rules for IWIS system	Not Started	10/1/2013	3/31/2014		No	No	
5.6	Document business rules for IIS system	Not Started	10/1/2013	3/31/2014		No	No	
6	Develop User Interface and Reports and Implement User Support	Not Started	10/1/2014	6/30/2015		No	No	
6.1	Develop pre-defined reports	Not Started	10/1/2014	12/31/2014		No	No	
6.2	Develop data query interface	Not Started	10/1/2014	12/31/2014		No	No	
6.2.1	Build data query interface	Not Started	10/1/2014	12/31/2014		No	No	
6.2.2	Test data query interface	Not Started	10/1/2014	12/31/2014		No	No	
6.2.3	Incorporate feedback	Not Started	10/1/2014	12/31/2014		No	No	
6.3	Design professional development plan	Not Started	10/1/2014	12/31/2014		No	No	
6.3.1	Professional development for using reports and query system	Not Started	10/1/2014	12/31/2014		No	No	
6.3.2	Professional development for understanding the data	Not Started	10/1/2014	12/31/2014		No	No	
6.3.3	Professional development for data analysis/interpreting results	Not Started	10/1/2014	12/31/2014		No	No	
6.4	Implement professional development plan	Not Started	4/1/2015	6/30/2015		No	No	
6.4.1	Professional development for using reports and query system	Not Started	4/1/2015	6/30/2015		No	No	
6.4.2	Professional development for understanding the data	Not Started	4/1/2015	6/30/2015		No	No	
6.4.3	Professional development for data analysis/interpreting results	Not Started	4/1/2015	6/30/2015		No	No	

Grants for Enhanced Assessment Instruments

Kindergarten Entry Assessment Competition

Project Narrative

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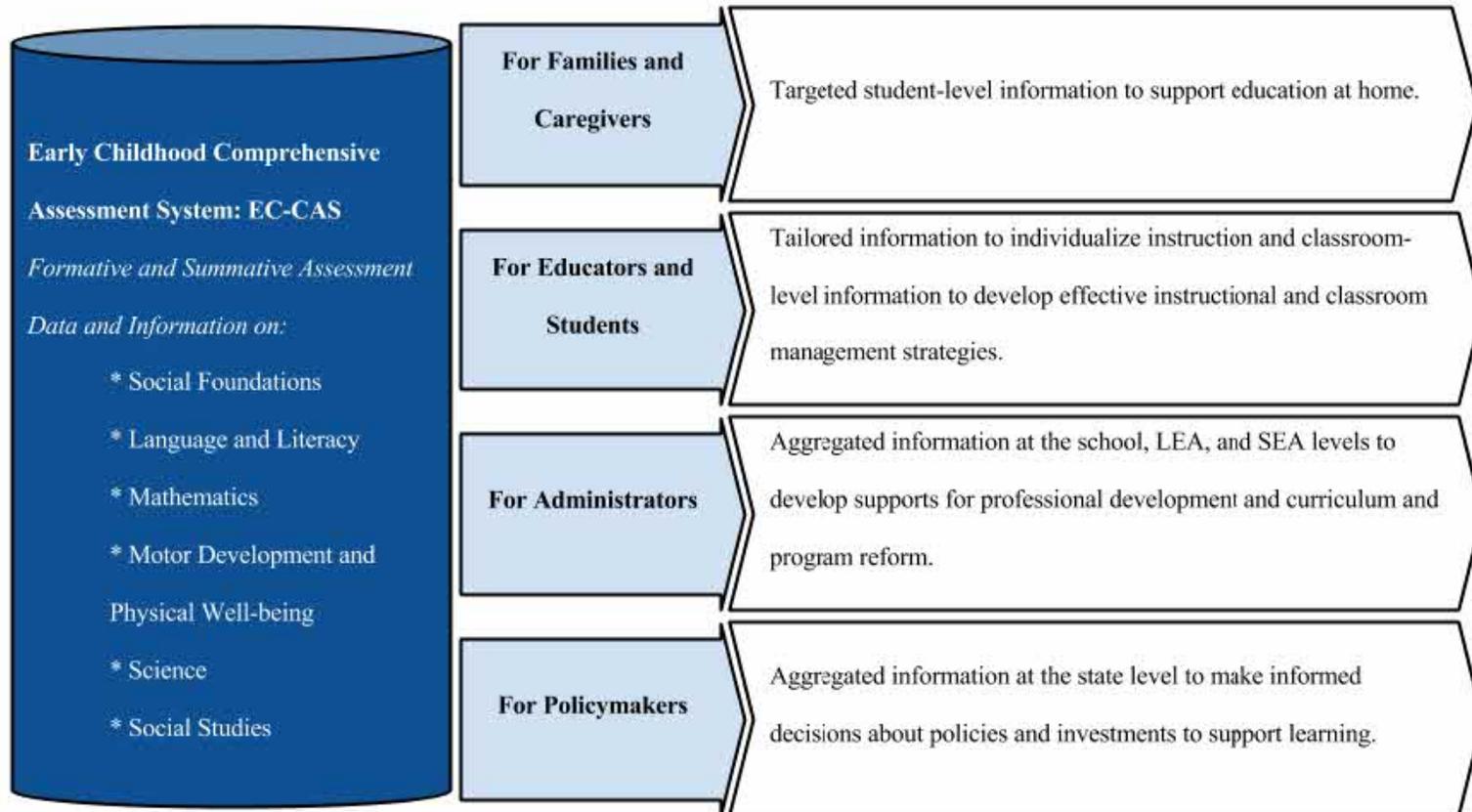
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Project Overview

The Consortium¹ has a compelling vision for enhancing a multi-state, state-of-the-art assessment system composed of a kindergarten entry assessment (KEA) and aligned formative assessments. This enhanced system—supported by expanded use of technology and targeted professional development—provides valid and reliable information on each child’s learning and development across the essential domains of school readiness, which will lead to better instruction, more informed decision-making, and reductions in achievement gaps over time. The Consortium recognizes that achieving this vision will be challenging, requiring high levels of commitment, technical expertise, collaboration across member States and partners, and strong management skills, systems, and supports.

Building on a highly successful existing effort already underway between Maryland and Ohio, the proposed system greatly expands the use of technology for more authentic and compelling items and tasks; efficiency of administration, scoring, and reporting; and increased student motivation. The end result will be a more reliable and valid system that provides timely, actionable data to identify individual student and program strengths and weaknesses, drive instruction, support curricular reform, and inform all stakeholders in the system about the effectiveness of preschool and kindergarten programs. The figure on page 3 shows the information that the assessment system provides for all end users.

¹ “The Consortium” refers to an alliance of States—including Connecticut, Indiana, Maryland, Massachusetts, Michigan, Nevada, and Ohio, with Maryland serving as the fiscal agent—and three prominent educational research and development organizations: WestEd (Assessment & Standards Development Services [ASDS] and Center for Child & Family Studies programs), the Johns Hopkins University Center for Technology in Education (JHU CTE), and the University of Connecticut’s Measurement, Evaluation, and Assessment Program.



Background Information on the Development of EC-CAS 1.0—On December 16, 2011, Maryland and Ohio were each awarded Race to the Top Early Learning Challenge (RTT-ELC) Grants for four years. These grants support an innovative partnership to revise and enhance Maryland’s and Ohio’s kindergarten entry assessments and develop preschool and kindergarten formative assessments for children ages 36 to 72 months. These partnership efforts will culminate in a new Early Childhood Comprehensive Assessment System (EC-CAS), including a KEA and formative assessments, supported by a statewide technology infrastructure, and a professional-development system. In the context of this proposal, the existing EC-CAS and KEA will be referred to as version 1.0; the proposed enhanced EC-CAS and KEA will be referred to as version 2.0. The development of the EC-CAS 1.0, conducted under a Memorandum of Understanding (MOU) with Maryland serving as the fiscal agent, is currently in its second year, and KEA 1.0 is slated for field testing in November 2013, with statewide implementation in both Maryland and Ohio in the 2014–15 school year.

A number of partners are playing a vital role in executing Maryland and Ohio’s shared vision for improving kindergarten readiness and early childhood assessments. These partners include the Johns Hopkins University Center for Technology in Education (JHU CTE), WestEd (including the agency’s Assessment & Standards Development Services program and the Center for Child & Family Studies), State advisory councils in each Consortium State, and a national Technical Advisory Committee (TAC), facilitated by the Council of Chief State School Officers (CCSSO), advising both States.

Early Childhood Comprehensive Assessment System 1.0 (EC-CAS 1.0)—Maryland and Ohio are committed to developing the EC-CAS for all children from preschool through kindergarten, and to a statewide implementation of the system in 2014–15. The assessment components of the EC-CAS are:

- aligned to both States’ guidelines or standards for young children from birth through kindergarten;
- designed to assess children in seven developmental domains, including Social Foundations (approaches toward learning, executive functioning, and social and emotional development),

Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, Social Studies, and (in Maryland only) The Arts;

- linked to State longitudinal data systems, to allow for consistent and meaningful reporting at the student, class, school, district, and state levels;
- designed to be maximally accessible to young children with a wide range of background experiences and developmental needs;
- systematically developed and field tested within a framework grounded in theory, research, and best practice, to ensure its validity and reliability; and
- reviewed by a national TAC composed of developmental psychologists, early childhood content and assessment experts from fields including child psychology and measurement, and experts on young, diverse student populations (e.g., English language learners and students with disabilities).

The EC-CAS includes a kindergarten entry assessment (targeted at children aged 66 months) and (for children aged 36 through 72 months) formative assessments. Combined, these two assessment components provide key stakeholders—families/caregivers, educators, administrators, and policymakers—with a balanced view of students’ learning needs and provide actionable information to help tailor instruction and interventions.

Kindergarten Entry Assessment 1.0 (KEA 1.0)—KEA 1.0 is the cornerstone of the assessment system. The KEA blueprint includes assessment standards within each domain of learning or development; alignment with early learning and development standards, including the States’ kindergarten standards; and three types of assessment approaches, measuring essential skills and knowledge of incoming kindergarteners in age-appropriate, reliable, and valid formats. Once KEA 1.0 is fully operational in 2014–15, the data will be used to inform early-childhood education and care stakeholders, guide decision-making about professional-development needs, and assist teachers in data-driven instructional decision-making to meet each student’s individual needs.

Formative Assessments—Formative tools are being developed to monitor children’s progress on a continuum of typical development along critical learning progressions, which define the knowledge and skills that are typically developed over time for children ages 36 months through 72 months. These formative assessments will equip families, caregivers, and teachers to track individual children’s learning trajectories; individualize learning opportunities and plan for interventions; engage in real-time curriculum planning; and ensure that children are on a path to kindergarten readiness and beyond.

Response to Selection Criteria

(a) Theory of Action

(1) The Consortium is committed to the enhancement of EC-CAS 1.0 in order to provide a meaningful, comprehensive early childhood assessment system that provides meaningful results to a range of stakeholders. Within this system, the purpose of the KEA is to provide information to stakeholders at the local, regional, and state levels about how well prepared children are for kindergarten.

This will be accomplished in two ways:

- Use of KEA information at the individual student level—Families, caregivers, and kindergarten teachers will learn about each student’s skills, learning, and developmental needs, so that they can identify strengths and weaknesses for each student, resulting in individualized plans to inform instruction and any necessary interventions.
- Use of KEA information at student group and subgroup levels—School, local district, and State leaders will learn about students’ levels of preparedness and readiness for kindergarten (i.e., school), which will enable programmatic decision-making at the school, district, and state levels. Score information by domain, and overall readiness, will be summarized by demographic characteristics, in order to pinpoint where there are achievement gaps upon kindergarten entry, how children’s prior education and care experiences impacted readiness, and where to target

resources to better support identified at-risk children through academic, health, and behavioral supports and interventions. By making aggregated assessment reports available in the online reporting system (ORS) at the student, classroom, school, and district levels, and facilitating the integration of the KEA results into longitudinal data systems at the state level, the KEA can inform these policy, research, and educational decisions.

The purposes of the KEA are complemented by the purposes of the formative assessments:

- to monitor children’s progress along a continuum of typical child development across six domains of learning (seven if assessing The Arts), as facilitated by 28 learning progressions (32 if assessing The Arts), from 36 to 72 months; and
- to determine if a child with an Individualized Education Program (IEP) or Individualized Family Support Plan (IFSP) has demonstrated improved (1) social-emotional skills; (2) acquisition of knowledge and skills; and (3) use of appropriate adaptive behaviors to meet his or her needs.

The relationship between the formative assessments and KEA 2.0 is illustrated in the following chart.

Both the formative assessments and KEA 2.0 are based on six domains of learning and development (seven if assessing The Arts). The formative assessments are based on the learning progressions within the age range of 36 to 72 months, and KEA 2.0 serves as the summative “snapshot” of kindergarten (i.e., school) readiness at roughly 66 months. The chart further illustrates how the KEA is part of a larger early-childhood assessment system, from preschool through kindergarten, the components of which serve as key milestones within States’ preschool-through-grade 12 statewide assessment systems. KEA 2.0 will allow for expectations to be aligned and student progress to be tracked from the end of the EC-CAS, at 72 months, through grade 3—when students begin taking either the PARCC or Smarter Balanced assessments or others equally aligned to rigorous college/career readiness standards—and beyond.

Early Childhood Comprehensive Assessment System

Domains	36 mo.	42 mo.	48 mo.	54 mo.	60 mo.	66 mo.	72 mo.	Grade 3
Social Foundations	Formative Assessments <i>Development represents a continuum of changing behaviors</i>					KEA <i>Summative “snapshot” of readiness</i>	Formative Assessments	
Language and Literacy								College and
Mathematics								Career
Motor Development and Physical Well-being								Readiness
Science								
Social Studies								
The Arts (MD only)								

(2) The KEA and the formative assessments are part of an overall educational system that includes early learning and development standards, curricular resources and instructional practices, professional development, and instructional interventions and policy improvements, all designed to enhance the school-readiness skills of entering kindergarten students and ensure that students are on a learning trajectory to graduate from high school ready for college and careers. Each of these components of the system is considered in the following sections.

Early Learning and Development Standards—Critical to the establishment of the Consortium is commonality of the States’ early learning and development standards. Although all participating States have adopted rigorous college and career readiness standards, each State has also individually developed early learning and development standards that vary from those of other Consortium States. Close alignment among them can be found in the Language and Literacy and Mathematics domains, but the other areas vary in scope, content, and expression. Maryland and Ohio faced this issue when they

embarked on developing EC-CAS 1.0 as part of their RTT-ELC Grant. Agreement was reached when the nexus of the problem was defined not as identical standards but as common standards, in terms of scope and content, for the most critical learning progressions. As a consequence, the Common Language Standards (CLS) were developed to define the specific content that was to form the basis of the KEA and the formative assessments. The CLS are aligned to the individual State standards and provide common definitions for the scope and content to be assessed. This approach led to agreement on standards for Maryland and Ohio that are substantially identical; the Consortium is confident that a similar approach will assure that the standards across all Consortium States meet the same expectation of commonality.

The following table provides an overview of the domains, strands, and learning progressions included in EC-CAS 1.0, as expressed in the CLS². States that joined the Consortium reviewed the CLS to determine whether their State's early learning and development standards are compatible with the CLS and reflect a meaningful sampling of the State's standards for kindergarten entry.

Domains, Strands, and Learning Progressions Included in EC-CAS 1.0

Domain	Strands	Learning Progressions
Social Foundations	Social Emotional Approaches to Learning and Executive Functioning	Awareness and Expression of Emotion Relationship with Adults Conflict Resolution Self-Control Persistence

² The learning progressions for the Arts domain are currently in development. For EC-CAS 1.0, Maryland opted to assess this domain, and Ohio did not; the other States in the Consortium have yet to make a decision about the assessment of this domain. All other domains reflect learning progressions that are aligned with the early learning standards of the Consortium States.

Domain	Strands	Learning Progressions
		Working Memory Problem Solving Initiative Cooperation with Peers
Language and Literacy	Reading Speaking and Listening Writing Language	Story/Text Comprehension Phonological Awareness Phonics and Letter Recognition Communication Emergent Writing Grammar Vocabulary
Mathematics	Counting and Cardinality Operations and Algebraic Thinking Measurement and Data Geometry	Number Sense Number Operations Classification Measurement Shapes
Motor Development and Physical Well-being	Physical Education Health	Coordination—Large Motor Coordination—Small Motor Safety and Injury Prevention Personal Care Tasks
Science	Skills and Processes/Life Science	Inquiry and Observation
Social Studies	Government History	Responsible Behavior Events in the Context of Time

Domain	Strands	Learning Progressions
The Arts (MD only)	Music Visual Arts Theater Dance	Music Visual Arts Theater Dance

Curricular Resources and Instructional Practices—Preschool and kindergarten teachers need the tools to implement curriculum and instructional practices based on early learning and development standards. Maryland and Ohio have established processes—including adding requirements to the States’ tiered quality rating and improvement systems—by which published preschool curricula and instructional practices must be aligned with each State’s early learning and developments standards. Such practices will be reviewed by all States in the Consortium to ensure that the available instructional resources are known and utilized.

Professional Development for Teachers—Recognizing the critical role of effective professional development to support real reform, the proposed assessment system calls for professional development for educators in three key areas: pre-administration, administration of the assessment with fidelity, and post-administration analysis and use of assessment data.

The professional-development sessions will be provided to educators using a variety of methods, including face-to-face, online, communities of practice, and discussion groups. A system of regional professional-development providers, situated within and funded by each State, will facilitate the training and supports needed for educators. In addition, each State will tie the KEA and the importance of using assessment information into other professional development that focuses on standards and learning supports. As the technology applications are expanded with the development of EC-CAS 2.0, professional-development opportunities will be expanded to include support for systematic progress

monitoring, enhanced accommodations through the use of technology, and tailored professional development based on specific State needs and identified needs from the implementation of EC-CAS 1.0.

(3) Instructional Interventions and Policy Improvements—The educational system, with its elements of standards, curriculum, professional development, instruction, and assessment, strengthens support for teachers as they prepare young children for the important transition into a new learning environment. It is critical that such a system remains responsive to each individual learner. Without formative assessments and the KEA, the responsiveness of teachers is impaired, and a systemic approach to addressing learning difficulties or specific learning styles is not possible. A KEA embedded in formative assessments, progress monitoring, and individualized instruction allows opportunities for teachers to improve each student’s foundational skills and eradicate school readiness gaps among students. The KEA results provide information on groups and subgroups of children, identify early opportunity gaps before children come to school, and strengthen accountability among early-childhood education providers and curriculum and program developers. In addition, by incorporating the formative assessments and the KEA into their broader preschool–through–grade 12 assessment and longitudinal data systems, States are able to understand relationships between kindergarten readiness and assessment results in grade 3 and beyond, in order to inform overall college and career readiness.

(d) Research and Evaluation

(1) The proposed technology-enhanced assessment system is highly innovative, creating challenges for both users and researchers. This section describes a series of analyses and studies designed to inform each phase of development and to ensure that both the KEA and aligned formative components of the assessment system are valid, reliable, and able to meet their ambitious goals and claims and reflect the recommendations of the National Research Council. Consequential validity studies will also be included, to determine whether the assessments are being implemented as designed and whether the theory of action is being realized, including whether the intended effects on individuals and institutions are being achieved.

The *Joint Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 1999) function as the predominant basis for the evaluation of educational assessment programs by the measurement community. The Standards “provide criteria for the evaluation of tests, testing practices, and the effects of test use” (p. 2) by addressing issues related to test construction and documentation, test fairness, and applications of testing across disciplines. Further, the U.S. Department of Education’s Peer Review Guidance for Evaluating Evidence of Final Assessments under Title I of the Elementary and Secondary Education Act (1999) specifically recommends that States use the Standards to document the technical quality of large-scale assessments. In the Standards, validity is defined as the “degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of tests” (p. 9). The interrelationships among the interpretations and proposed uses of test scores and the sources of validity evidence define the validity argument for an assessment. The evaluation of scores from multiple sources of evidence forms the foundation of what is referred to as the unitary conceptualization of validity (Kane, 2006); this perspective will form the foundation for the validation of KEA 2.0.

Evidence Based on Test Content—The foundation of EC-CAS 1.0 is the CLS, which are based on the Maryland and Ohio standards for preschool and kindergarten. These standards address Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, Social Studies, and (currently in Maryland only) The Arts. Each charter State in the Consortium has committed to adopting, no later than the 2016–17 academic year, essential skills and knowledge that are based on each State’s standards and that align with the CLS.

Test construction is at the heart of instrument validation. Alignment and accessibility will be the major considerations in the selection of content for KEA 2.0. Educators of students with disabilities and English language learners will play an active role in item development and review in both the pilot and field-test phases. All items will undergo a bias (fairness) review to address cultural stereotyping, item-irrelevant characteristics that may render student groups at an advantage or disadvantage, sensitive topics,

and offensive language. The development, training, and review processes, including those involving State committees, are outlined in the following sections *(h)* and *(i)*.

Validity evidence based on test content will include:

- alignment reports from charter Consortium States, to demonstrate the consistency between individual State standards and the KEA 2.0 blueprint (Consortium standards);
- alignment reports that demonstrate alignment with kindergarten and grade 1 standards (where applicable);
- review and revision of the test specifications by the Consortium TAC;
- review of item writer and editor training protocols; and
- an empirical survey of a representative sample of preschool and kindergarten teachers in each State, to demonstrate the depth of instruction on and relative importance of the Consortium standards. Samples will be constructed to represent diversity in student populations, geography, and program types.

Evidence Based on Internal Structure—All evidence based on internal structure will be drawn from the 2015 KEA 2.0 field test. The design of KEA 2.0 will incorporate multiple measures, including guided recorded observation, performance tasks, developmental rubrics, and selected-response items.

Statistical analyses of the selected-response items will include the following:

- the proportion of students selecting each option for each item;
- analyses based on the total raw score of the set of items and the proportions of upper, middle, and lower percentages of students selecting each option;
- the difficulty of each item (*p*-value and delta);
- the discrimination of each item (biserial and point-biserial);
- IRT difficulty and discrimination indices;
- discrimination indices for each option for each item;
- differential item functioning (DIF); and

- internal consistency estimates of reliability for the set of items.

Statistical analyses for the performance tasks and observational data will include:

- the proportion of students at each score point;
- based on the total raw score of the set of items, the proportion of upper, middle, and lower scores by score point; and
- measures of central tendency for the total score for each set of items.

Standard internal-consistency measures of reliability will be conducted on the selected-response items at the subscore and total-score levels. Generalizability theory will be used to quantify the proportion of variance in scores on the performance tasks that is attributable to the measurement procedures (to be defined further during the instrument development process). Reliability estimates will be reported at the State level and the Consortium level.

Reliability will also be addressed through the subgroup-level analysis of KEA 2.0 data. Descriptive data for the individual items and raw scores will be presented by student demographic subgroup as additional evidence of test fairness. Reliability evidence will also include bias and sensitivity review of the test content and assessment, as well as DIF analyses. Dimensionality of the set of items will be evaluated using factor analysis and structural equation modeling. It is expected that field-test items will maintain the structure of domains of early learning and development that was used to design KEA 2.0.

Interrater reliability is an important consideration for the KEA. Reliability is a key component of the online professional development offered to teachers. See section (e) for details on the professional development and training that all administrators and scorers will receive.

Evidence Based on Response Processes—Evidence based on response processes is particularly relevant to the development of KEA 2.0. First, a key component of KEA 2.0 is direct response data from kindergarten students online at the start of the kindergarten year. Detailed evidence that these young students are capable of critically analyzing prompts and selecting appropriate responses is critical to the validity of the KEA. Evidence based on response processes can contribute to questions about differences

in scores among subgroups of students. Cognitive labs will be set up in order to explore students' thought processes when completing the items. The cognitive labs are particularly critical for ensuring that the selected-response items are accessible to a wide range of students at various levels of development, as well as to students with disabilities and English language learners. Item accessibility includes comprehension of the item stem, as well as the ability to store the item stem in the working memory, search the memory store for information relevant to the item stem, and review the response options. Methodologies and results for these studies will be reviewed with the KEA 2.0 TAC, and items will be revised accordingly.

Rubric-based observations and performance tasks are also at the foundation of the KEA and the larger assessment system. It is critical to the success of the program to understand whether rubrics and rating scales are applied to student performances, skills, and behaviors as intended. Evidence based on response processes can serve as reliability evidence. In the pilot phase of development, questionnaires and cognitive labs will be used to explore the fit between the skill being measured and the performance or observation rating elicited from the student or teacher. All teachers who participate in the KEA 2.0 pilot will be asked to complete a survey to evaluate the accessibility of the items and the feasibility of the administration. A similar survey was administered to teachers during KEA 1.0 development.

External Validity: Evidence Based on Relationships to Other Variables—Validity evidence should include the relationships between the assessment instrument (i.e., the KEA and the formative assessments) and other variables and outcomes. Such evidence considers the relationship of the test to measures of the skill or behavior that it is intended to predict, similar measures of the same construct or different constructs, or studies of group differences as they apply to the proposed test interpretations. These other measures may be administered at the same time as KEA 2.0 (concurrent validity) or may be used to predict later performance (predictive validity). Though this development project will end at the census administration of the instrument across seven States in 2016, the following studies are recommended to States for incorporation into a longer-term sustainability plan for KEA 2.0:

- correlation between a student's raw score on the KEA and measures of progress on the EC-CAS formative assessments;
- correlation between scores on the KEA and other multidimensional (e.g., Teaching Strategies GOLD, the Early Development Instrument, Mullen Scales of Early Learning) and unidimensional (e.g., DIBELS, DIBELS Math, PPVT-4, Ages and Stages Questionnaire) measures of learning and development designed for young children;
- for Maryland and Ohio, school-level correlations between KEA 1.0 and KEA 2.0;
- student-level quantitative analyses of the association between scores on KEA 2.0 in 2016 and scores on grade 3 PARCC/Smarter Balanced assessments (as the cohorts advance to grade 3);
- examination of distribution of KEA scores by English language learner status, identification for special education services, and/or kindergarten retention; and
- examination of distribution of KEA scores by demographic variables, school/district resources, disability categories, and communication abilities.

(2) External Validity: Evidence Based on Test Consequences—The proposed plan to determine whether the assessments are being implemented as designed focuses on the role that the KEA and the formative assessments play in the larger context of improved outcomes for students and schools. Evidence based on testing consequences concerns examination of whether the intended benefits of the testing program are being realized in the educational system and the extent to which unintended negative consequences are minimized. Although the collection of evidence based on test consequences is critical to the success of the overall EC-CAS, as well as to the validation of the use of KEA 2.0 data, it falls outside the scope of this grant. However, the assessment system can be used to collect baseline data against which future outcomes can be compared.

Collection of validity evidence based on test consequences will begin immediately following the census administration in October 2016. This evidence will include:

- continued administration of the empirical survey of the depth of instruction on and relative importance of the standards to a representative sample of preschool teachers in each State;
- teacher/administrator surveys and focus groups focused on data use;
- surveys and focus groups for families, focused on the assessment purpose and data use;
- continued cognitive labs with English language learners and students with disabilities; and
- longitudinal analyses of KEA scores to show growth over time, by subgroup and in the aggregate.

(e) Professional Capacity and Outreach

(1) In EC-CAS 1.0, a train-the-trainer model is being used in order to support large-scale training efforts. Prior to training teachers, State-approved trainers complete a two-module, face-to-face training on delivering EC-CAS training to local practitioners in both online and face-to-face formats, including the required training for how to administer the assessment. These State-approved trainers must have specific prerequisite skills and knowledge, including knowledge of assessment of young children and strategies for teaching adult learners, in order to participate in the train-the-trainer training session. Online professional learning modules and resources are offered to these trainers to build their capacities. In addition, the State-approved trainers must successfully complete the EC-CAS administration training and pass the reliability qualifications. As part of their responsibilities, the State-approved trainers also provide immediate, post-training support to teachers and providers. Trainers use an online learning community for communications and resource exchange. Webinars are also used to communicate with teachers and administrators about the assessments prior to the summative assessment window.

In focus groups conducted early on in EC-CAS 1.0, teachers and State trainers communicated the need for ongoing support beyond their formal training experiences. JHU CTE worked within the different State structures to identify potential local resources who can provide this support. Technical assistance providers, local resources who provide timely, direct, and ongoing coaching and support to practitioners, were identified to serve as a point of contact for questions related to assessment implementation, data

analysis, and instructional planning. These providers maintain frequent contact with practitioners, to support fidelity of implementation of the assessment and improved instructional practice.

Technical assistance providers, along with the colleagues they will coach, also complete training on administering the assessment and must fulfill the same reliability qualifications. Prior to assessment training, they are also provided with training in coaching methods that align to the International Coaching Federation's Professional Coaching Core Competencies (1998).

The Consortium plans to implement a similar comprehensive approach to professional development for EC-CAS 2.0. This approach will provide face-to-face and online training for various audiences and will also include ongoing coaching and support by local resources through a communities-of-practice model. The enhanced professional-development approach will expand the current approach and will provide an individualized collection of learning experiences in multiple formats, including ongoing, tiered support for professionals with varying levels of experience in child assessment and across different educational settings. The range of professional-development activities will be designed to develop skills in collecting, interpreting, and using data among school and program leaders, teachers, and families, and to support the development of research-based tools and resources that address emerging needs.

Following best-practice guidelines from the National Research Council (2008), planned professional development activities will be organized around three stages of assessment, as described below:

- Pre-administration—Professional development related to pre-administration will focus on ensuring that users understand the purpose of the various assessment tools, are thoroughly knowledgeable about issues related to data security and integrity, and know how to communicate effectively with families and other stakeholders about the purposes and results of the assessments.
- Administration of assessments—Professional development related to administration of the assessments will increase understanding of the processes and procedures for each type of assessment instrument, afford opportunities for hands-on use of assessment tools and associated resources, promote understanding of accommodations and adaptations for various at-risk

populations, build the skills needed to interpret and score children’s responses to multiple item types, introduce participants to the data collection and reporting system, and offer opportunities for hands-on use of the system.

- Post-administration analysis and use of data—A third set of professional-development offerings will focus on the post-administration analysis and use of data. These materials will focus on increasing teachers’ understanding of assessment scores, communicating assessment results to families and caregivers, utilizing data to make instructional decisions and tailoring instruction, and providing additional information on data quality and integrity.

Validation by Simulation—The Consortium believes it is imperative that teachers, as assessors, be properly trained to score assessment items with reliability. Training for administration of the assessment will include assessment administration protocols, guidelines for supports for children with disabilities and English language learners, and practice with scoring procedures. Upon completion of the assessment administration training, all teachers and providers will be required to qualify for scoring through the successful completion of a simulation. The simulation, accessed through the web, will provide hands-on experience and practice in administering assessments and analyzing data for instructional improvement. The simulation will be used to enhance the interrater agreement as the basis for the assessor certification process.

Online Learning Community—KEA 2.0 will use an electronic learning community, a password-protected, user-friendly online environment that supports collaboration, content delivery, and file sharing for teachers and administrators throughout the assessment process. The community site will be customizable to include separate communities for different audiences or space to share information and resources across audiences. In addition, it will include a repository of state-developed and state-vetted resources (e.g., web-based learning modules and tutorials) for improving professional skills and practices, and a forum for sharing knowledge, insights, and observations. Examples of resources and online

activities include recommended readings, focus-group discussions, and sharing of annotated examples of best practices and exercises to help educators develop expertise within the context of local practice.

Personalization of PD Content Based on Teacher and Student Needs—With this enhanced professional-development approach, teachers will receive personalized professional development to meet their learning needs (as identified by self-evaluation as well as through the tracking of their students' assessment data). Each teacher will have a unique profile, which may include their type of program, setting (e.g., rural, suburban, urban), and/or class size. In addition to completing the core professional-development training required by the State, teachers will be provided with specific recommendations for professional development based on factors such as needs for retraining, supporting special populations (e.g., students with disabilities and English language learners), and domain-specific teaching strategies to target specific student needs. Strands of professional-development offerings, which include formal professional credits for teacher recertification purposes, will be extended to all States participating in the Consortium.

Enhanced Scalability—EC-CAS 2.0 will include advanced verification of professional-development completion and tracking features for teacher certification. This will accommodate a significant increase in the number of teachers using the system and will improve the efficiency of documentation of completion of online professional development. These enhanced features will also allow for better tracking of module completion and data collection based on program characteristics or other data points, as prioritized by the participating States.

Instructional Resources Based on Student Data—The Consortium realizes the importance of finding the right level of instruction and support to ensure that every student can progress. The current supports embedded within EC-CAS 1.0 will be expanded to include a bank of evidence-based activities and intervention strategies that support the current developmental learning progressions and provide linkages to local school curricula that are aligned to each State's standards. These activities and strategies will assist teachers in planning tailored instruction to meet the developmental needs of individual students and

groups of students, based on the assessment data. Teachers will be able to interact with instructional planning features to help apply Universal Design principles and identify activities that can be easily, seamlessly integrated into a teacher's typical day.

Additionally, a process for examining student assessment data will be integrated into the online professional-development system. JHU CTE's approach to data-informed decision-making, TAP-IT, will be utilized to guide novice and experienced educators through a structured examination of data and inquiry to improve student outcomes and professional practice. Special educators and administrators working with kindergarten students will also play a key role in interpreting student data and supporting teachers to make instructional decisions. To assist in this role, administrators—particularly those who do not have an early-childhood educational background—will be provided with their own professional-development resources.

Learning Community Connections and Collaboration—Recent survey and focus-group data collected from participating teachers in EC-CAS 1.0 indicated frequent usage of, high comfort level with, and overall interest in social-media tools such as Facebook or Pinterest, with significantly less interest in the more traditional online course format. Opportunities for teachers and administrators to share resources and collaborate to develop a shared knowledge base will be incorporated into EC-CAS 2.0 through an engaging professional learning community that integrates features of popular social-media tools. The enhanced learning community will incorporate features of social-networking services, in order for individuals to easily post, collect, and organize resources and ideas as well as to “follow” individuals and topics. The resources will be tagged and then recommended to individuals based on their personal profiles and their interests or needs. This community will harness the creativity of teachers by encouraging them to collaborate on the creation of professional resources, activities, and games, with the goal of supporting children's development along the continuum. Communication tools such as threaded discussions, commenting features, and blog posts will allow community members, experts, and State agency

representatives to provide feedback on the resources and share their own adaptations. Individuals will be able to start or join groups to solve problems and collaborate at the local or state level.

Additionally, families will be able to access this community, which will provide them with expert advice, resources, and opportunities to promote learning and development at home. Families also will have the opportunity to provide input into specific areas of priority identified by the States and local communities. These enhancements to the professional-development system will allow for better, more efficient scalability to reach larger groups of teachers, administrators, and families, with increased flexibility to create personalized learning opportunities, higher levels of engagement in the learning community, and appropriate supports and interventions that are linked directly to student data.

(2) In EC-CAS 1.0, Maryland and Ohio work closely with their partners and key stakeholder groups to communicate clearly and consistently with community members, families, and policymakers, as well as with teachers, caregivers, and service providers. Communication currently takes place through a variety of means, including:

- the establishment of a governance structure that includes communication with state advisory committees, ad-hoc work groups, and a national TAC;
- presentations at state meetings for local stakeholders, including early-childhood special educators;
- presentations and communications with district and regional groups of administrators and teachers;
- communications, via email, in-person presentations, and webinars, with district and regional early-childhood supervisors, staff, and professional-development providers;
- communications, via email and presentations/meetings, with local technical-assistance centers and governmental agencies/officials; and
- communications, via reports and presentations, to the States' early-childhood advisory councils and business-community representatives.

For EC-CAS 2.0, this approach will be expanded to all States in the Consortium. It will be important for all stakeholders to remain informed throughout development, testing, and rollout of all aspects of the system. This will ensure that the purpose of each system component; the content standards it is intended to measure; how it was developed; to whom, when, and how it will be administered; who will score responses or rate performances; and how results will be interpreted, reported, and used are accurately articulated to constituents. Planned short- and long-term research agendas will also be communicated to stakeholders, in order to keep them apprised of system integrity and plans to monitor test-based consequences, both immediately and over time.

A publicly accessible web presence will inform and educate stakeholders at all levels with regard to the theoretical framework, educational goals, specific methodologies, implementation practices, technology usage, and data analytics that comprise the assessment system. Video demonstrations, sample assessment items, and a “frequently asked questions” page will be employed to generate awareness of and support for the program.

In addition, communication with State stakeholders will take various other forms, including presentations, formal reports, research briefs, and fact sheets, that will be available in hard copy and online. JHU CTE will work with the Consortium to ensure that each State has a communications strategy on the importance and value of the new assessment system. The goal of this collaboration will be to provide ongoing opportunities for learning about the system and how to use the information it yields to ensure that all children enter school with equal opportunity to learn, grow, and thrive. The reporting system will provide both standard, paper-based reports and more technologically advanced, web-based data-analysis tools.

All States participating in the Consortium will be committed to transparency regarding all development and implementation plans, the purposes of each system component, and the intended outcomes of the system. Each State will implement an outreach and communications plan for informing and updating the public and key stakeholder groups. The system will include timely reporting of

assessment results and dissemination of resource materials, such as templates for presentations, brochures, pamphlets, information letters, newsletters, and notices about opportunities to support activities related to the system.

Other new resources that will be created for stakeholders include:

- Kindergarten readiness tool—An engaging and interactive online resource to educate families of young children about what kindergarten readiness means, with information specific to families of children entering kindergarten.
- What the data tell us—Content targeting legislators and policymakers, explaining assessment for young children and how to interpret results in the context of appropriate assessment practice.
- Virtual town-hall forums—Themed online webinar sessions to inform stakeholders about the assessment system, with creative ways to engage participants to gather support and input.
- Virtual performance assessment (VPA) demos—One or more demos for teachers and families to “play with” interactive activities that children will use in the assessment.

These processes and expanded resources will assist in communicating with the variety of stakeholders and Consortium members.

(f) Technology Approach

(1) Technology Approach for EC-CAS 1.0—Currently, in EC-CAS 1.0, the technology available for the KEA includes an online reporting system (ORS), teacher dashboards and customized professional development, and a virtual performance assessment (VPA).

The ORS provides secure access for teachers to enter student performance data and teacher observational data. Accessible via desktop computer, laptop, or tablet, the ORS allows for data import and export, including the transfer of data to longitudinal data systems. User dashboards and reports support state-, district-, school-, classroom, and student-level data reporting and analysis. Customizable views and reports can be created for families, teachers, and administrators at the school, district, or state levels.

Types of reportable data include:

- Assessment completion—the percentage of assessment items completed by individual students or by a whole class;
- Readiness performance—student performance on the KEA by domain at the individual student, class, district, or state levels, to inform broad readiness monitoring; and
- Formative item performance—student performance on the formative items, to inform instructional decision-making.

In addition, the ORS allows student artifacts to be uploaded and linked to a longitudinal profile for monitoring student performance over time. Nightly data transfers ensure that teachers and administrators at all levels are able to access real-time data as needed.

Teacher dashboards and customized professional development provide contextualized resources to support instruction and the use of best practices in the classroom. Data from the ORS generate information and recommendations for instructional groupings, as well as targeted instruction based on individual child and class performance. Suggested instructional activities are available for teachers to incorporate in daily lesson planning. Simulation software familiarizes teachers with assessment protocols and use of professional-development resources. The easily accessible system enables educators to monitor progress, make informed decisions, and promote continuous improvement in children’s knowledge and skills.

The VPA uses technology to provide child-friendly and engaging interaction with the assessment environment. Two assessment types are currently available:

- point-and-touch items that involve single-touch/click selection; and
- interactive activities for children to engage in and receive instructional feedback on during formative assessments.

The design of the VPA is age-appropriate and utilizes a guided system of navigation that guarantees that targeted skills are probed sufficiently. Regardless of a child’s performance, the virtual environment encourages, engages, and motivates children to interact with each activity.

Technology Approach for EC-CAS 2.0—Technology will be incorporated in a variety of ways in EC-CAS 2.0 to support the development of assessment items, the delivery of the assessment, the collection of scoring data, and the analysis and reporting of the assessment results. An overview of the application of technology by category of user follows.

- Children—Students will have access to direct-performance items, as appropriate for the assessment domain, to be completed using child-friendly technology for use on tablets or PCs. They will log in by selecting their name or picture (with support, as needed), and will then have access to the interactive formative items assigned by the teacher. The interactive items will be designed to be engaging and fun for children. The resulting scores will feed into a child’s profile without the need for the teacher to manually enter them. The direct-assessment items will be supported with audio and visual cues and accommodations where appropriate.
- Teachers/assessors—Teachers will access the system on a computer or tablet through secure, encrypted authentication. Upon entry, teachers will be presented with a dashboard that includes a listing of their students (by class) and the assessment completion status of each child and of the class as a whole. Teachers will be able to use mobile technology to document observational and performance-rubric data while observing their students’ actions and/or interactions. Score information obtained through these observations will be automatically fed into the ORS. Other functions of the system include the abilities to browse assessment items, access embedded professional-development resources, enter scoring data directly into the system, assign assessments for a student to complete, and upload a sample of work to a student’s profile. In addition, teachers will have access to a variety of score reports at the student and class levels, which will inform instructional strategies tailored to students’ needs.
- Administrators (school, district, and state)—Administrators will have access (based on their positions and data and reporting needs) to dashboards that support data-driven decision-making and reporting requirements. Reports will be available at the classroom, building, school, district,

regional, and state levels as designated by each State. The system will make data available to external systems as well, facilitating the capacity for longitudinal analysis across multiple relevant data systems. External stakeholders, such as early-childhood advisory councils, business leaders, legislators, and other key policymakers and decision-makers, will also have access to aggregated reports.

All of the proposed technology components described in this section will substantially benefit from existing systems and intellectual capital created under the current RTT-ELC Grant. The data and feedback from KEA 1.0 will provide the basis for significant enhancements and expanded functionality of these systems. Building upon existing systems will exponentially improve the efficiency of new development, because much of the analysis and conceptual development has already been carried out and documented. Additional funding and resources will be directly applied toward the construction of KEA 2.0, which will include numerous system enhancements, as described in the following sections.

Longitudinal Analysis—Dashboard capacity will be expanded to allow direct integration with other relevant data systems, providing enhanced support for longitudinal tracking, student progress monitoring, and student intervention monitoring at the state, local, school, and classroom levels.

Expansion of Interactive Assessments—KEA 2.0 will expand the capacity of the system to provide direct student assessment using child-friendly, touchscreen technologies. The amount of engaging, interactive content will be increased and improved upon, based on the feedback and results from KEA 1.0 testing and implementation. The system also will allow for auto-leveling of assessment difficulty based on student performance.

Charting Student Progress Over Time—The next generation of the KEA system will embed the JHU CTE Student Compass Tool. This tool will allow teachers to monitor children’s progress relative to defined performance indicators based on the KEA learning progressions; review interventions; and select the most appropriate intervention for addressing the identified need of the student.

Digital Portfolios—While KEA 1.0 includes the ability to attach digital artifacts (e.g., sample work, audio or video clips, teacher notes) to a student’s profile, KEA 2.0 will provide additional capacity that transforms this basic function into a digital portfolio that can be added to over time and accessed by families and the student’s future teachers. An expanded portfolio will support the concept of multiple measures and provide an additional means to assess students’ progress over time.

Enhanced Accessibility Features and Accommodations—KEA 2.0 will use the results of KEA 1.0 testing and implementation, teacher surveys, classroom observations, and recommendations from expert consultants to expand and improve upon the embedded accessibility features and accommodations of KEA 1.0. The enhanced system will continue adherence to Universal Design principles, and will utilize child-friendly technologies and strategies that are based on research and proven best practices for the instructional use of technology with young children.

Scaling Professional Development—KEA 2.0 will enhance the scalability of the professional development (online learning modules and embedded support) provided in KEA 1.0. Based on the results of student assessments, teachers will be presented with targeted online professional development and embedded supports, including interventions and activities that could be implemented in the classroom and promote individualized instruction.

Cloud Hosting and Scalability—Technology systems developed to support KEA 2.0 will require enhancements to an already robust cloud-hosting environment. The increase in the number of users across the Consortium States will require that additional resources be allocated to the cloud-based server environment, to improve scalability and load balancing. The States will benefit from the efficiency of the multi-state system architecture designed to support both Maryland and Ohio users in KEA 1.0, and will also benefit from cost efficiencies as a result of multiple States sharing in the ongoing cost of the system. KEA 2.0 will include sufficiently increased bandwidth, server capacity, and security controls to ensure that each collaborating State experiences strong application performance. Robust technical protocols, to ensure the security of student data, will also be revised and improved.

In order to promote cost-effective adoption by schools, cross-platform technical development strategies will be enhanced, and adherence to an open-licensed interoperability standard that is industry-recognized and approved by the U.S. Department of Education will be implemented. The Question and Test Interoperability (QTI) and Accessible Portable Item Profile (APIP) standards are examples of protocols that will be used to maximize interoperability. QTI and APIP incorporate key elements of established specifications to create an integrated system for an accessible and interoperable item-file format. The technology being developed under this grant is being built to achieve the expectations for interoperability to facilitate the transfer of information within and across states. Interoperable design will support (a) test-test content portability; (b) transfer of assessments from one technology platform to another; (c) consistent assessment delivery across the Consortium; (d) consistent application of accessibility features, including the universal design of items; and (e) construction of assessment databases that allow for long-term analysis and digital report dissemination across multiple platforms.

(2) Potential Factors Limiting Adoption—Both Maryland and Ohio include rural areas and regions of poverty, with schools and community-based early-childhood centers that possess limited technology capacity. During the conceptual development of KEA 1.0, this fact necessitated strategies to limit barriers to adoption as much as possible. At a minimum, participating schools will need a computer with Internet access in order to input assessment results into the system for reporting and analysis. However, the KEA can also be administered using printed materials and without the use of technology. For the foreseeable future, this approach will continue to be employed. To the extent possible, all technology components developed will also be supported across multiple computer platforms, browser versions, and touchscreen devices, to maximize the number of students who have access to the virtual performance assessments.

(g) Project Management

The Consortium recognizes that achieving its vision for this project will be challenging. Enhancing the EC-CAS, and the KEA in particular, will require high levels of commitment, technical expertise, collaboration, and, of most relevance for this section, strong management skills, systems, and supports.

Three major management components will provide for a timely delivery of EC-CAS 2.0 with strong safeguards of accountability: (1) the Consortium Executive Committee; (2) a Project Management Partner (PMP) to support the work of the Consortium; and (3) collaboration with national expert institutions to provide support and ongoing services beyond the grant period.

The Consortium States are committed to fully and equitably participating in the oversight and decision-making process regarding the scope of work and the implementation of EC-CAS 2.0. This collaboration is based on formal agreements (MOUs) among the States and is being implemented through the formation of an Executive Committee consisting of leadership representation from each State. The Consortium will establish a stringent communication protocol, including monthly leadership calls, semiannual planning meetings, and ongoing work groups. The project will be supported by individuals who will serve as leads in each State and as the facilitators for stakeholder input within each State. Within the Consortium, the Maryland State Department of Education (MSDE) will serve as the lead applicant and the fiscal and procurement agent.

WestEd's Assessment & Standards Development Services (ASDS) program will serve as the PMP for the Consortium, and will provide overall project management on its behalf. The PMP will be responsible for drafting the scope of work and detailed planning of activities and tasks with specified milestones and deliverables, and will work closely with MSDE, as the fiscal agent, to ensure that the project implementation stays within budget.

As partnering organizations to the Consortium, JHU CTE (assisting with technology and professional development) and the University of Connecticut's Measurement, Evaluation, and Assessment program (assisting with research) will formally work closely with the PMP. In addition, CCSSO will facilitate an annual meeting of the TAC, consisting of 12 national experts in child development and assessment.

Together, the Consortium and partnering organizations will ensure that the five project-management qualifications for this grant are met efficiently and effectively.

(1) A critical first step in supporting the Consortium's assessment development and implementation will be to develop a work plan that includes the high-level requirements for meeting major goals. This work plan will define the start-up processes, associated outcomes, and ongoing tasks that will ensure successful completion of each milestone task, as specified in the Scope of Work. An initial draft of the high-level project plan is included in Appendix A on page 65.

WestEd will be prepared to work immediately with the Consortium to develop detailed schedules for all system components. The final project plan, including detailed information about project milestones, will be developed and submitted to Consortium leadership for approval prior to the commencement of project activities, and no later than December 1, 2013. The final project plan will encompass the overall scope and schedule of the assessment system development. Any proposed changes to the project plan will be provided to the Executive Committee for approval. The project plan will be the prime source document that specifies the primary tasks, services, activities, schedule, and requirements for the contract. As such, it will be available to all partners, to ensure a common understanding of the project's scope, schedule, and context. To support this effort, Smartsheet.com, an online project planning and collaboration tool, will be used to assign and manage tasks, staffing, and other resources in order to ensure that all timelines are met. Staff can be strategically reassigned as needed to meet specific needs. Smartsheet.com has proven effective in helping WestEd manage other highly complex projects.

The PMP will plan, monitor, and report on the Consortium work as necessary to ensure successful development and implementation of the proposed work (e.g., the KEA, including technology and professional-development supports). This will help ensure that tasks are clearly communicated, roles and responsibilities are understood, schedules are followed, deadlines are met, potential risks are evaluated and managed proactively, and all work is completed within allocated budgets.

As PMP, WestEd will build on its existing processes and tools to effectively implement and maintain the project schedule/timeline; manage and support all Consortium meetings through collaboration on agenda development; document meeting discussions and decisions, and identify action items for follow-

up; and work to ensure effectiveness and efficiency in all system processes through continual review and improvement. The PMP will also apply proven strategies to oversee and facilitate work around critical design issues, coordinating the involvement of the TAC and other advisory councils at key junctures.

Throughout the duration of the contract, the PMP will monitor Consortium activities and track progress toward completion of key deliverables (on time and within budget); adapt plans to meet emerging project needs as activities unfold; ensure that roles and responsibilities are understood and that outcomes meet expectations; promote sustainability of the initiative through responsible planning, ongoing documentation, careful monitoring, and proven communication practices; and identify, manage, and mitigate risks.

(2) Identification, Management, and Mitigation of Risk—Successful project management requires a careful balance of time, resources, and quality. Further, understanding how system components interact during development and implementation will allow the PMP to anticipate potential risks and plan for contingencies. The primary risk management strategy will be to create comprehensive work plans as soon as possible, to ensure that sufficient time and resources are allocated to complete the KEA. Additionally, as part of the project schedule development process, the PMP will work with Consortium States to identify implementation barriers, risks, and possible solutions or mitigation strategies. The key to the success of a project of this complexity will be contingency planning from the outset. Three major levels of risk will be used to categorize and develop mitigation strategies:

- Program-level risk: Any potential issue identified that could jeopardize the overall success of the project. An example of this may be loss of funding to the level anticipated, or exit of several member States from the Consortium. Additionally, systemic risks, associated with a diverse and geographically distributed membership, that could result in delays in decision-making or miscommunications would qualify as program-level risks.
- Component-level risk: Any potential issue identified that could jeopardize the development or implementation of one of the Consortium's core assessment components. Risks at this level that

go without mitigation could potentially have an impact on other aspects of the project, given the high degree of interdependency in the various deliverables. It is especially important for the PMP and the Executive Committee to establish response plans for each risk considered to have a probability and impact on other aspects of the project that might extend beyond the component level.

- Deliverable-level risk: These risks would be managed within the project teams.

Response plans and mitigation strategies will be captured for risks at each of these levels.

Additionally, risks may be classified according to the various types of potential impact or domain: financial, schedule, technical, legal, quality, etc.

The Executive Committee, the MSDE grant manager, and the lead staff will work with the Consortium States to capture, identify, and classify the various risks that each of these bodies can anticipate, and will, with support from the PMP, establish appropriate mitigation strategies and response plans. Risks are potential issues; should a risk materialize without adequate containment of its impact, it will become an issue for escalation through processes established in the project management activities of the Consortium.

Monthly project management reports, including stoplight-status reports, will be shared with the MSDE grant manager and the Executive Committee. The stoplight-status reports will provide a high-level progress indicator for each core assessment component—indicating, for each assessment component, whether it is considered “green” (on schedule, with no anticipated risks), “yellow” (on schedule, with medium risk of moving off schedule), or “red” (off schedule, or on schedule with high risk of moving off schedule). Any variances from the anticipated schedule (i.e., yellow or red indicators) will be reported along with strategies for course correction, the estimated likelihood that corrective action will be effective, and possible mitigation strategies if course correction fails. As part of the project master plan development process, WestEd will work with the Executive Committee to identify implementation barriers, risks, and possible solutions or mitigation strategies.

Compliance Monitoring and Communication—MSDE, on behalf of the Consortium, will serve as the lead agency in ensuring compliance with federal statutes and limitations. It will consult regularly with the grant’s U.S. Department of Education program officer on the progress of the project and any anticipated changes that require amendments to the scope of work and project budgets.

Governance Support—The primary governing mechanism of the Consortium will be the Executive Committee. The Executive Committee will be composed of one representative from each charter State in the Consortium. In addition to representing a charter State, each Executive Committee member must meet the following criteria:

- must have prior experience in either the design or the implementation of curriculum, standards, and/or assessment systems at the policy or implementation level; and
- must have a willingness to serve as the liaison to the full Consortium membership.

The responsibilities of the Executive Committee will be to:

- determine the broad picture of what the assessment system will look like;
- identify issues to be presented to the charter and/or advisory States;
- oversee the expenditure of funds in collaboration with MSDE;
- operationalize the plan to transition from the proposal governance to implementation governance; and
- evaluate and recommend successful contract proposals for approval by MSDE.

Decision-Making—Consensus will be a goal of all decisions. Major decisions that do not reach consensus must be passed with a 2/3 majority vote. Each charter State will have one vote. The Executive Committee will meet monthly throughout the grant period. Most meetings will be virtual; however, twice each year, the committee will meet in person. For efficiency and cost savings, these face-to-face meetings will be linked, if possible, to other events—e.g., conferences, TAC meetings—that Executive Committee members are likely to attend. The PMP, in consultation with the Executive Committee chair and the MSDE grant manager, will prepare agendas and supporting documents for each meeting, make webinar or

facility/travel arrangements, document all decisions, and prepare and disseminate draft and approved minutes.

(3) The Consortium is fully confident that the submitted budget is adequate for the development and validation of the KEA, as well as for the development of the technology necessary to administer the assessment and report its results. The Consortium also fully believes that the submitted budget will allow for the development of a state-of-the-art set of supports, including professional-development modules designed to assist teachers to prepare students to take the assessment; administer and score the various components; and interpret reports and use information to inform instruction. This confidence is bolstered by WestEd's very recent experience with the development of KEA 1.0 and other, similar assessment development projects at the state and local levels.

The budget associated with each activity leverages the previous work on KEA 1.0, and focuses on project deliverables (e.g., item/task development, score reports, professional development), with management costs linked directly to these activities for the enhancement of KEA 2.0. Most Consortium management and assessment development meetings will be virtual. Because many of the costs related to this work are fixed (i.e., independent of the number of States in the Consortium) and others increase based on the number of States in the Consortium, the Consortium's ability to attract seven States (intermediate level for this grant competition) creates a perfect balance between efficiency and complexity.

(4) Commitment and sustainability planning by member States are essential to the success of the Consortium's efforts. Per the signed MOUs, each State that is a member of the Consortium agrees to do the following:

- adopt and fully implement, statewide, the common KEA no later than December 31, 2017;
- adopt a set of essential skills and knowledge that are based on early learning and development standards, and that are substantially identical across all Consortium States, no later than the 2016–17 school year;
- adhere to the Consortium governance as outlined in the MOU;

- agree to support the decisions of the Consortium;
- agree to follow agreed-upon timelines; and
- be willing to participate in the decision-making process and, if a charter State, final decisions.

While costs will differ, to a degree, from State to State, due to State-specific factors and factors related to agreements with potential implementation vendors, WestEd estimates that the per-pupil cost to administer, score, and report KEA 2.0 is about \$4 per student. This estimate is based on current experience administering similar assessments and Maryland's and Ohio's experience in pilot testing KEA 1.0. It also involves a comparison to cost estimates of the much more complex PARCC and Smarter Balanced assessment systems. The KEA estimate is based on the following assumptions:

- The grant will bear the cost of item and task development, and of the administration, data collection, and scoring technology applications;
- Scoring will be performed onsite by the assessment administrator or designee;
- Professional development and training to administer the assessment will be virtual; and
- All reports will be electronic (no printing required).

The cost of technology to administer the assessment is not included in this estimate. WestEd assumes that local education agencies and service providers will be investing in technology as part of their instructional responsibilities and their readiness for PARCC and Smarter Balanced, and that this technology will be available for the KEA. For those agencies and service providers that do not have access to sufficient technology, a paper version of the KEA will be provided, with costs assumed by the agency or service provider. Also not included in this estimate are costs related to hosting the professional-development materials, technology-supported items, and the ORS. These costs will also differ from State to State, depending on the number of students enrolled in kindergarten in the State and other system-readiness issues.

(5) The team proposed to manage this grant is knowledgeable, experienced, and familiar with collaborating on a project of this size and scope. For the past several years, the core team has successfully

built KEA 1.0 and its associated products and services. The Leadership Team currently utilized in EC-CAS 1.0—composed of member representatives from MSDE, the Ohio Department of Education, the Ohio Department of Job and Family Services, the Ohio Governor’s Office, JHU CTE, and WestEd; State advisory councils; a 12-member TAC; and ad hoc committees and work groups from each State—will be expanded to include members from charter States in the Consortium, to be named the Executive Committee. Each State will also establish a State advisory council, composed of stakeholders similar to those currently in Maryland and Ohio. This group will continue its work and will include additional talent to meet the specifications for this grant.

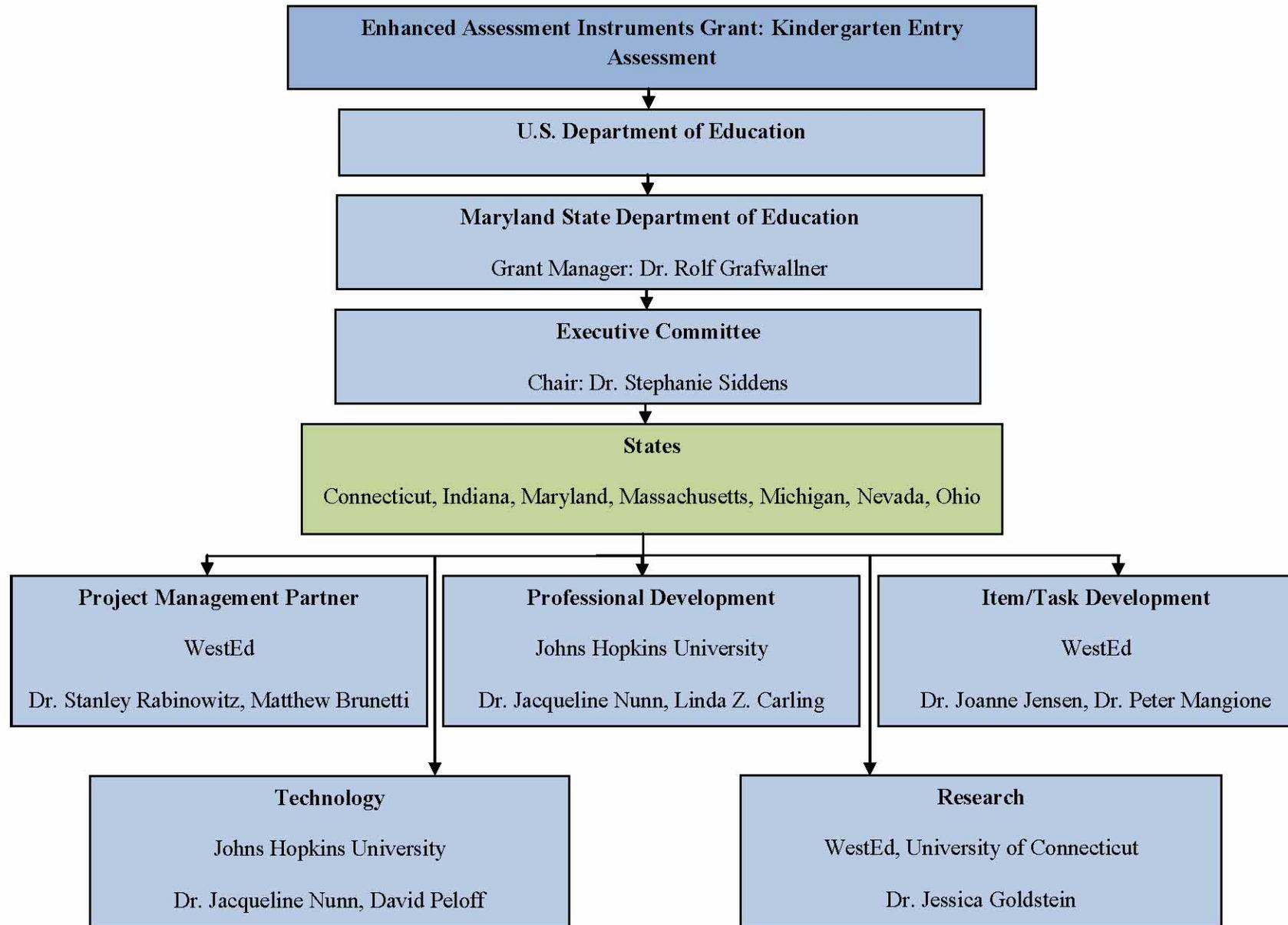
WestEd’s current role as a partner in Maryland and Ohio’s RTT-ELC assessment development process brings a critical, intimate, and advantageous quality to its proposed role as PMP for the development of EC-CAS 2.0. More broadly, WestEd has demonstrated high-quality management support as the PMP of the more complex Smarter Balanced Assessment Consortium. For EC-CAS 2.0, WestEd will work within the Consortium governance structure to establish protocols that meet baseline expectations; plan for translating project scope into action; describe inputs and outputs; establish standards for performance; apply lessons learned; use information formatively to improve internal processes; and document action items and resolutions on a deliverable-by-deliverable basis.

The Consortium and its partnering organizations understand the importance of alignment and coordination among all system features and are committed to utilizing best practices in project management to meet the objectives of the proposed project across the following principles of project management:

- Time—As PMP, WestEd will assume responsibility for setting and monitoring the sequence of events and duration for each activity; tracking, reviewing, regulating, and monitoring the schedule for each deliverable; planning controls and monitoring deviations from deadlines; and updating and documenting changes to the project schedule and communicating implications of these changes to the Consortium’s Executive Committee.

- Cost—The PMP will work with MSDE, the grant manager and fiscal agent, and the Consortium’s Executive Committee to estimate costs, create budgets, control costs so that all work stays within budgets, create plans for overseeing accounting systems, and share forecasts.
- Quality—Using its management experience, the PMP will assess and analyze risk; communicate quality assurances to stakeholders; use effective quality-management methodologies; identify, control, and monitor risk and articulate risk responses, strategies for mitigating risk, and contingency plans; keep all stakeholders updated on project status; and conduct cost-benefit analyses.
- Resources—The PMP will work with the Consortium to plan, document, and implement steps that capitalize on existing and emerging strengths and to develop strategies for sustaining the project beyond the grant period.
- Communication—The PMP will foster effective communication within and across levels, ensuring that the most important information is shared using the most appropriate medium or approach; distributing information to appropriate audiences; managing expectations; monitoring the effectiveness of communication and technology-support systems; working with the Consortium to develop guidelines for communicating with internal and external stakeholders; and implementing mechanisms for reporting on performance outcomes.

The organization chart included on page 40 illustrates the proposed management structure for EC-CAS 2.0. Please refer to Part 6 of this grant application to review staff qualifications in the submitted résumés.



Consortium State Capacity and Commitment—While the proposed KEA and aligned formative assessments will build off of the extensive progress made by Maryland and Ohio on KEA 1.0 in their joint RTT-ELC Grant, all of the States in the Consortium have made significant progress in developing and implementing early-childhood programs, including assessments, that are consistent with the goals and priorities of this grant offering. The most relevant of these accomplishments among the states that did not participate in KEA 1.0 are described in the following sections.

Connecticut—The Kindergarten Entrance Inventory (KEI) was developed in response to Connecticut Public Act 05-245, which required the Commissioner of Education to “develop and implement a statewide developmentally appropriate kindergarten assessment tool that measures a child’s level of preparedness for kindergarten” by October 2007. The stated purpose of the KEI is to “provide a statewide snapshot of the skills students demonstrate, based on teachers’ observations, at the beginning of the kindergarten year.” The content of the KEI was selected to represent the most important skills that students need to demonstrate at the beginning of kindergarten, based on the Connecticut Preschool Curriculum Framework and the State Curriculum Standards for language arts and mathematics that were in use at that time. A group of preschool and kindergarten teachers, representing urban and suburban districts, special education, and English language learners, reviewed the indicators and provided the Connecticut State Department of Education (CSDE) with their recommendations on the appropriateness of the indicators. A revised version of the KEI was introduced in the fall of 2007 and has been used statewide since that time. CSDE partnered with researchers at the University of Connecticut to validate the use of the KEI. Research supporting its use addressed two broad themes: the relationship of the KEI to other measures of academic achievement and the structure of the indicators used to define each domain. In addition to the KEI, the Connecticut Preschool Assessment Framework was developed in 2003, based upon the early learning standards included in the Connecticut Preschool Curriculum Framework.

Indiana—The Indiana Standards Tool for Assessment Reporting—Kindergarten Readiness (ISTAR-KR) was launched in 2009. This assessment tool is currently available to all early-learning programs as an

assessment for children from two months of age through kindergarten entry. Although kindergarten programs are not required to use the ISTAR-KR, many began to implement its use in the 2012–13 school year, with more planned to employ it in 2013–14. This assessment does not provide longitudinal data for participating children, but the potential benefit of those data is recognized. Indiana also understands the advantages of gathering this information to inform instruction in kindergarten and to show student growth from the beginning of the year to the end of the school year; therefore, it desires a tool that can provide valid comparisons across all school districts within the state.

Massachusetts—Under its RTT-ELC Grant, the Massachusetts Department of Early Education and Care (EEC) is required to design and implement a kindergarten entry assessment initiative. The federal requirements for this initiative include measurement, within the first six weeks of the kindergarten year, of kindergarten children’s skills and competencies in language/literacy, mathematics, social-emotional development, and physical development. EEC has partnered with the Massachusetts Department of Elementary and Secondary Education (ESE) on this effort. The resulting initiative, known as the Massachusetts Kindergarten Entry Assessment (MKEA), has been designed as a formative assessment initiative in kindergarten. The expectation is that districts implement the Work Sampling System or Teaching Strategies GOLD formative assessment tool. Both assessments will help educators measure the targeted developmental domains in order to guide kindergarten teachers in designing instruction for individual children through the use of data. These two assessments are also being examined for alignment to the Massachusetts standards for English language arts/literacy and mathematics. EEC and ESE jointly developed a four-year roll-out plan for the MKEA that includes the participation of all 306 Massachusetts school districts with a kindergarten enrollment. In addition, the agencies are working together to ensure that the early elementary assessment work of PARCC informs and is informed by the MKEA work in Massachusetts.

Michigan—Michigan is in the beginning stages of implementing a statewide kindergarten entry assessment. It recently selected the Teaching Strategies GOLD online assessment for a 2013 fall pilot,

following a review plan that included stakeholder involvement in showcase demonstrations of existing assessments by other states and vendors, issuance of a Request for Proposals, and a thorough review of each proposal received. The state is currently planning to pilot the assessment in 200–300 schools this fall, during the first 45 days of school. To prepare for the fall pilot study, focus groups around experienced and new users of the KEA are being conducted to inform communications and training. In late July, 30 trainers are being trained; during the last three weeks of August, these trainers will then train the 600–900 teachers participating in the pilot. When the pilot study is complete, the state will use the information gathered to customize the assessment for a 2014 fall field test with a significantly larger group of schools and students. Statewide implementation (optional by school) is planned for fall 2015.

Nevada—The Silver State KIDS project is a statewide effort to build a comprehensive early-childhood education system that supports the ability of all children in Nevada to enter kindergarten ready to learn. The Nevada Early Childhood Advisory Council (NECAC), managed by Nevada’s Head Start Collaboration and Early Childhood Systems (HSC&ECS) Office in collaboration with the Nevada Department of Education (NDE), is leading this effort, which has identified two major components of system change as priorities for implementation. Adoption of a common Kindergarten Inventory of Development Statewide (Silver State KIDS), which measures each child’s developmental status upon entering kindergarten across five domains of learning, and development of a coordinated data system that aligns pre-kindergarten data to K–12 data (and beyond) will improve understanding about which early-childhood education policies, strategies, services, and supports are the most likely to improve school readiness. This will facilitate expansion and replication of effective and proven early-childhood education practices throughout Nevada.

In the recent legislative session, the Governor’s budget included \$4 million as a part of the P-16 Council to further support the work of NECAC and work toward a common statewide kindergarten assessment and the development of an early childhood database system. Nevada is currently making some significant investments to help support these efforts. Recently, the Governor and the state legislature have

supported additional investments for full-day kindergarten as well as further support for English language learners, pre-kindergarten, and K–4 education.

(b) Kindergarten Entry Assessment Design

(1) The EC-CAS includes the KEA and formative assessments for children ages 36 months through 72 months. Both the current version of the KEA and the proposed enhanced KEA are being developed based on the CLS, which align to both Maryland and Ohio early learning and development standards extending from birth through kindergarten entry, including the States' kindergarten standards. Each of the CLS is defined by essential skills and knowledge (ESKs), currently common to Maryland and Ohio, which specify the depth and breadth of the standard. The ESKs also form the basis of the learning progressions that provide the foundation for the formative assessments. Each of the 28 (32 including The Arts) standards is aligned to a learning progression. The standards combine to form strands, and the strands combine to form domains.

The KEA and formative assessments will focus on six developmental domains: Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being, Science, and Social Studies. Presently, Maryland is the only State to be assessing The Arts. KEA 2.0, within the context of each State's existing early childhood comprehensive assessment system, will include a combination of selected-response, performance tasks, and rubric-based observational instruments, reflecting a multiple-measures approach to the assessments. Because of the limited attention span of students at the ages assessed, and in recognition of the need to assess all students within the first eight weeks of the school year, the KEA is focusing on a select number of ESKs for each standard that are seen as particularly critical and readily assessable or observable by teachers early in the school year. In contrast, the formative assessments will reflect the full range of skills and knowledge that define the learning progressions and will be designed for children from 36 months to 72 months. The formative assessments will include selected-response items, performance tasks, and observational instruments tied to each of the learning progressions.

(2) Inherent in the design process is the explicit definition of the content to be assessed. The CLS serve as the key document in the definition process. As such, all item and task development activities will be keyed to the ESKs that define the standards. To ensure consistent interpretation of the ESKs, item specifications have been developed by WestEd staff to provide operational definitions for specific knowledge and behaviors. The item specifications provide an overview of the item structures and formats and the nature of the content that is best assessed by each item type. As the items for KEA 1.0 were developed, the training of item and task development staff focused on the centrality of the ESKs in the development process and the specification of the content to be assessed. The alignment of all items, tasks, and observational rubrics to the ESKs will continue to be emphasized in future training. Throughout the assessment content development and review process, the content editors will evaluate alignment and will introduce edits, as needed, to ensure alignment.

Following the internal review of all assessments by WestEd staff, the assessments will be submitted to the States for their review, in which alignment will be one of the key considerations. The State-level reviews will be combined with the results of formal content reviews, involving representatives from all States in the Consortium. Additional edits will be made as required to meet the alignment expectations of the States. The final, edited assessments will be submitted to the States for their final review and signoff. This iterative review and signoff procedure has proven to be effective in achieving aligned items and tasks throughout WestEd's previous assessment development experience.

(3) Assessment data will be made available and transmitted, on a defined schedule, to State data systems. Data security will be enforced, end to end, during transmission via an industry-standard security method. All data will be keyed with identifiers and other metadata to allow for merging, disaggregation, reporting, and longitudinal analysis. Data will be formatted in a manner that is most agreeable and compliant with States' systems and needs, but conformity to Common Education Data Standards will be encouraged in order to foster interoperability and consistent understanding among systems and stakeholders.

(4) (i) In order to assist teachers in using the assessment data to guide instruction throughout the school year, professional development activities will support teachers in linking assessment and instruction. Four key steps for linking assessment and instruction are: (1) administering the KEA to all children in all domains; (2) interpreting assessment findings and identifying children's needs by identifying (a) which children already have all of the important age-expected skills or indicators, (b) which children might be at risk or missing a component of one or more expected skills or indicators, and (c) which children may not yet have an expected skill or indicator due to missing critical foundational and/or prerequisite behaviors; (3) aligning intentional instruction with identified needs of groups and of individual children; and (4) monitoring progress, at designated intervals, and revising instruction, as needed, to maximize effectiveness (Grisham-Brown & Pretti-Frontczak, 2011). In order to support this process, the JHU CTE Student Compass Tool will be embedded into the ORS; this will allow teachers to easily view their students' assessment results, group students by need areas, review and select interventions and strategies, and continue to monitor students' progress toward defined performance indicators.

(ii) Teacher professional-development and support needs will be identified via several media. Teachers will be trained, practice, and qualify for scoring via an online simulation tool that functions as a validation of a teacher's qualifications to administer and score the assessment with reliability. They will be directed to additional supports as needed, based upon their performance on the interrater reliability feature of the simulation tool. Self-evaluation measures are employed via discussion-board reporting. Throughout training on and implementation of the assessments, teachers will use the online community to identify additional professional-development and support needs. Peer-to-peer feedback and input from community moderators will be provided.

(iii) The ORS will be designed to provide information at the student (for use by both teachers and families), classroom, school, and state levels. At the school level, students can be placed on the learning progressions (if the formative assessments are used), and overall readiness and domain readiness scores

can be reported, based on the KEA. Classroom- and school-level reports can be used to identify persistent, widespread overall problem areas, as well as achievement gaps across student populations. The reporting scale of both the formative assessments and the KEA will allow the progress of individual students to be tracked within and across school years and allow cohorts to be tracked across years.

In order to support school-level teams in making effective educational decisions using the KEA data, a series of online professional learning modules will be made available. This professional-development series will feature TAP-IT, which is a systematic process for data-informed decision making, developed by JHU CTE faculty. TAP-IT was specifically designed to help educational teams use data to improve results for students, including those with special needs. Currently, this process is being effectively used by MSDE to support data-informed decision-making at the state, district, and school levels in order to narrow achievement gaps of students with special needs. In the TAP-IT process, a team analyzes (i.e., taps into) student and teacher data to plan an intervention for a student, implements the intervention, and then tracks its impact.

(iv) States will receive aggregate district and State reports that will allow policymakers to identify areas where students are entering school with high degrees of readiness and areas where students are entering at risk of chronic and persistent failure. Reports by subgroup (e.g., English language learners, students with disabilities) will help determine if there are systematic differences among student populations and/or if there are pockets of risk within otherwise high-performing areas.

(v) JHU CTE's expertise includes the development of data reports that have been carefully designed and piloted (via survey and focus groups) to meet the needs of parents and families. Families will be able to use graphics to determine the degree to which their children are meeting the expectations for school readiness overall and for each assessed domain. The family reports also will include targeted support activities to improve learning. Consistent with State statutes and regulations across the Consortium, reports will be made available in a variety of languages other than English.

(5) The KEA includes three basic item types—three-option selected response, performance tasks, and observational rubrics. The academic domains of Mathematics and Language and Literacy are assessed through selected-response items and performance tasks in which students are asked to demonstrate their knowledge through answering questions or performing tasks that reflect academic and real-world applications. The Science domain includes a combination of selected-response items and observational rubrics, whereas Social Studies is assessed solely through observational rubrics. The domains of Social Foundations and Motor Development and Physical Well-being are also assessed solely through observational rubrics. Suggested structured activities will be provided to teachers, to support them in evaluating student performance if the assessed behaviors have not been observed in the course of student activity. Across the six domains common to all States, a total of 15 selected-response items, 18 performance tasks, and 29 rubric-based observations combine to produce the total score on the KEA. (The methods for assessing The Arts are still under development.)

(6) In KEA 1.0, options exist to administer the assessment via paper and pencil or via computer presentation of the selected-response items and performance tasks. Teachers directly observe student performance on the items and tasks, and record student answers to selected-response items, which are then scored automatically by the ORS. Up to ten items are interactive. For performance tasks, test administrators are required to observe and score student responses and enter the scores within the ORS.

In KEA 2.0, students will be able to interact directly with the assessment platform to indicate and record their responses to selected-response items, and to perform many of the tasks by employing a variety of system capabilities, including, for example, drag-and-drop features. Student responses requiring the evaluation and scoring of a verbal student response will continue to be scored by teachers, as the ability to capture and automatically score students' verbal responses remains an emerging technology to be explored for this project. However, accommodations for English language learners, such as directions given in languages other than English to improve accessibility, will be a feature of KEA 2.0.

(7) In KEA 1.0, teachers are required to record student responses to some selected-response items because only ten of the items are interactive. In KEA 2.0, the ORS will provide for the capture of student responses to all of the selected-response items and will automatically score them in real time. Because of the variety of response modes required for the performance tasks, including verbal responses, KEA 2.0 will still require teachers to score student responses to the performance tasks and to directly enter those scores into the ORS. This scoring will be done in real time as part of the task administration.

For the observational rubrics, teachers will directly enter their observations into the ORS, either in real time or at intervals convenient for the teachers.

(8) It will be critical for the Consortium to develop procedures for standard setting that are collaborative and transparent to all States. WestEd will lead the standard-setting activities, along with Dr. Jessica Goldstein of the University of Connecticut, and will vet all steps in the process with the national TAC. The key activities for standard setting include selection of the standard-setting method (e.g., bookmark, body of work), determination of the number of performance levels, development of the performance level descriptors, approval of the preliminary performance level descriptors by the Consortium, recruitment of participants, preparation of materials for the standard-setting session, training of staff facilitators, implementation of the standard-setting method, finalization of the performance level descriptors, and, finally, approval of the performance level descriptors and the corresponding cut points on the performance continuum. One key decision that Consortium States must make is whether to set standards on the field-test data or to wait until the first live administration. While the latter is typically preferable because of the quality of resultant data, waiting for the live administration will push standard setting beyond the timeframe of this grant.

While all of the aforementioned standard-setting steps are critical to the development of valid, reliable, and fair performance standards for students, the engagement of representatives from each of the States is especially critical for ensuring broad-based, informed decisions about the levels of performance expected of students. Each State must provide representative key stakeholders to the standard-setting

panel. These key stakeholders should, at a minimum, include family members/parents, early-childhood/preschool educators, kindergarten teachers, early-childhood/development experts, and specialists on students with disabilities and English language learners. The recommended steps for the recruitment of panelists include identifying key stakeholder groups and desired panelist groups; determining the qualifications of panelists for each panelist type; asking stakeholder groups to nominate prospective panelists; and selecting from among the qualified nominees to satisfy the desired distribution. Establishing these explicit qualifications and recruitment strategies will produce the intended distribution and qualifications of the standard-setting panelists and enable evaluation of how well these intentions were realized. This will provide valuable evidence of defensibility of the standards that will result from the process (Hambleton, 2001).

(9) The following table summarizes the specific contents of proposed reports for specific audiences, as well as benefits and/or uses of the reports for each audience.

Audience	Reports	Benefits/Uses
Principals and Administrators	<ul style="list-style-type: none"> • Summary school-level performance reports by domain • Summary performance reports by students' age and/or birth date • Summary performance reports by gender, race/ethnicity, English language learner and/or disability status, and other demographic characteristics • Quarterly or biannual facility-/school-level formative assessment reports • Quarterly or biannual teacher-/co- 	<ul style="list-style-type: none"> • Informs principals of professional-development needs for teachers and co-teachers • Informs principals of strengths and possible weaknesses in programs • Informs principals of intervention needs for students • Supports routine data analysis of student and teacher performance

Audience	Reports	Benefits/Uses
	<p>teacher-level formative assessment reports</p> <ul style="list-style-type: none"> • Quarterly or biannual formative assessment reports by domain • Status reports providing pre-kindergarten schools and centers information on the preparedness of their students for entry into kindergarten 	
Teachers	<ul style="list-style-type: none"> • Summary performance reports on current classes • Summary performance reports on current classes by domain • Summary performance reports on individual students • Quarterly formative assessment reports on current classes • Quarterly formative assessment reports on current classes by domain • Quarterly formative assessment reports on individual students • Reports analyzing how close classes are to projected targets, based on the first summative assessment 	<ul style="list-style-type: none"> • Promotes evidence-based instructional decisions for classes and individual students • Generates ongoing performance data for timely refinement and adjustment of instructional strategies • Promotes personalization of instruction • Informs teachers of any gaps in the curriculum • Informs teachers of needed professional development for improving performance

Audience	Reports	Benefits/Uses
Families	<ul style="list-style-type: none"> • Summary performance reports for children by domain • Quarterly formative assessment reports for children by domain • Quarterly reports analyzing how close children are to reaching end-of-year targets 	<ul style="list-style-type: none"> • Creates transparency between the facility/school and the family • Encourages a collaborative approach to student learning • Supports the personalization of instructional delivery and needed interventions • Informs future supports needed to help students reach targeted goals (e.g., grouping, homework, tutoring)

(10) The States within the Consortium, whether aligned with Smarter Balanced or PARCC, will be implementing assessments for grades 3–8 and high school that provide information about students’ ongoing performance against standards for college and career readiness, as measured by assessments aligned to the States’ K–12 standards. As an assessment for readiness for kindergarten entry, the KEA now provides one of the “bookends” for entering and exiting K–12 education, tied to the expectations expressed through the States’ K–12 standards. Including the KEA within a State’s student assessment system will enable identification of students at risk of failure or falling behind as they enter the K–12 educational system (or earlier, for those students who are enrolled in child-care or preschool programs that administer the formative assessments).

(i) Kindergarten Entry Assessment Development Plan

(1)(i) WestEd proposes implementing an Evidence-Centered Design (ECD) approach to the KEA item and task development. Our approach is modeled on the best practices in assessment design introduced by Mislevy, Steinberg, and Almond (2003), and it has been adapted by WestEd, over the past

decade, to support traditional item development practices as well as the design and development of innovative item types implementing technology-enhanced features. ECD reflects an integrated approach to constructing educational assessments in terms of evidentiary arguments that can be used to improve the validity of items and tests.

ECD builds on the vision of Samuel Messick (1994): “the nature of the construct being assessed should guide the selection or construction of relevant tasks, as well as the rational development of construct-based scoring criteria and rubrics.” ECD is a systematic approach to the design of assessments that focuses on the evidence (student performance and products) of proficiencies as the basis for constructing assessment tasks. It provides a way to reason about assessment design and a way to reason about learner performance. Collecting the right information from assessments that help to make accurate inferences about students’ competencies is critical because these inferences will inform policy and instructional decisions that promote learning.

The use of ECD will also be critical in WestEd’s ability to design assessments that support valid and reliable decisions for all students. To strengthen that evidentiary argument, particularly for students with disabilities or students who are English language learners, it is important that the assessment design consider not only the constructs that are targeted for measurement, but also constructs that are not targeted for measurement (e.g., sight, hearing, or certain aspects of the English language) and that could interfere with measurement of the targeted constructs (Hansen & Mislevy, 2008; Mislevy & Haertel, 2006). Assessment designs that are valid across populations will specify accessibility features that minimize or eliminate the impact of these non-targeted constructs through the use of Universal Design principles. ECD provides a framework that makes the underlying evidentiary argument more explicit—thereby supporting sharing and communication among assessment designers, test delivery platform developers, and psychometricians, who can work together to minimize the influences of non-targeted constructs—and supports an examination of the validity of inferences. ECD considers the targeted

constructs, the observations collected, and the context in which those observations occur (Hansen & Mislevy, 2008; Zhang et al., 2009).

At its core, ECD requires assessment developers to perform five important steps in the development of an assessment instrument. As described by Mislevy, Almond, and Lukas (2003), these steps include:

1. Domain analysis: Defining the content and subcontent areas to be included in the assessment.
2. Domain modeling: A high-level description of the components of the assessment that provide evidence to support inferences.
3. Conceptual assessment validity framework: Clear articulation of the construct(s) that are targeted within the domain, articulation of unintended constructs that may cause construct-irrelevant variance, and specifications for tasks that provide a context in which evidence about the targeted knowledge or skill is collected without construct-irrelevant variance.
4. Item and task development: Development of items and tasks that are based on the specifications developed during the third step and that are used to form the assessment instrument(s) used to collect observations that serve as the evidence from which inferences will be made.
5. Evidence collection: Description of the conditions and procedures through which assessment instruments are delivered, and design for reporting results that enables valid inferences about the knowledge, skills, and abilities targeted within the defined domain.

WestEd has recently supported the Smarter Balanced Assessment Consortium as it developed its item specifications through the application of ECD principles, and will draw on this experience as the development of the KEA is expanded.

(ii) The development model enacted by the Consortium places significant value on the involvement of stakeholders and content and development experts. The track record of inclusiveness established by Maryland and Ohio will continue as the work is expanded. The Consortium States will continue to provide significant leadership and guidance, through the Executive Committee, as the assessment system

is developed, to ensure that the developed assessment system meets their needs and will support their educators and families in improving the learning of all children.

The assessment development process will involve state-identified ad hoc and standing committees for content review of the learning progressions and all assessment materials. The content-review committees will combine early-childhood and kindergarten teachers, early-childhood measurement experts, and consultants. In addition, the States will convene a common, cross-state bias and sensitivity review committee that will include both early-childhood experts and educators who work with English language learners and students with disabilities. The States will also actively engage families and representatives from their early-childhood advisory councils, and will establish a State advisory committee to review the assessment development process. These actions will provide a means to engage all key stakeholders in the review process prior to field-test and operational implementation.

As the lead for content development, WestEd recognizes the importance of building bridges among developmental, content, assessment, and psychometric experts. Consequently, WestEd has assembled a team that combines these areas of expertise. WestEd's CCFS program is a leader in promoting high-quality, research-based, early child-care and educational services. Its work informs national, State, and local child and family policies. CCFS staff have developed the learning progressions and continue to serve as early-childhood expert advisors to the project, reflecting the latest research in the field. WestEd's ASDS program leads the assessment development activities. As a research and development organization, WestEd will work collaboratively with the University of Connecticut to design and implement the necessary psychometric analyses and research activities to ensure that the developed assessment system meets criteria for reliability and validity.

JHU CTE complements the team by providing its expertise in emerging technologies and professional development. JHU CTE is recognized for its application development, which capitalizes on emerging technologies to support classroom management, reporting, and data-driven decision-making. Its knowledge of delivery systems will support the goal of developing a user-friendly platform for student

use with the assistive technology needed to meet the needs of English language learners and students with disabilities. The technology infrastructure will also support administration, recording, scoring, and reporting functions and will provide for the importing and exporting of data to State longitudinal and early-learning data systems. JHU CTE is also known for its high-quality professional development, and it will provide both training and support for the use of the assessment system, as well as instructional implications based on student and classroom results.

Finally, CCSSO is facilitating the work of the national TAC, which provides critical review and advice on early childhood learning, assessment, and technology.

(2) A primary goal of the project work is to develop, through the use of ECD and Universal Design principles, assessments that are as universally accessible to students as possible, but there will be students who, due to disabilities, developmental delays, and/or limited English language proficiency, will require accommodations. JHU CTE will lead expert work groups, including practitioners from each Consortium State, convened specifically to address accommodations policies for these students. Using the accommodations policies and assessment design features of PARCC and Smarter Balanced as models, the work groups will ensure that the assessment system includes universal accessibility features that remain true to the purpose and vision of the assessment, and that, from the time of its inception, individualized supports and accommodations for children with special learning needs are considered. Members of the work groups will draft and review policies regarding, but not limited to, participation requirements, the application of accessibility features to assessment administration, and the provision of accommodations. These policies will be grounded in research on best practices for assessing young children, with an emphasis on assessing special populations. The work groups will also assist in designing content for professional development, to disseminate to teachers and other IEP team members in schools. The policies and professional development will be piloted and field tested during the applicable phases of assessment development. Data will be gathered during each phase in order to evaluate appropriateness,

usability, and feasibility. Once the policies and professional development protocols are finalized, the partnering States will adopt them.

(3) Accurate and consistent scoring of the assessment items and ratings of observational behaviors is a necessity for a reliable and valid assessment system. Methods to achieve accurate and consistent scoring will be incorporated into the development of the items and tasks themselves, the rubrics, scored exemplars, and training.

ECD will be instrumental in supporting the development of the items and tasks. The conceptual assessment validity framework, a key component of ECD, involves articulation of the construct(s) to be assessed and specifications for items and tasks that provide a context in which evidence about the targeted knowledge and skill can be collected. By clearly specifying the construct and contexts to be assessed, the development process is purposefully guided to consider appropriate evidence of student performance, including the relative ease of evidence collection and the reliability of observing and rating student performance.

As previously described, the KEA and formative assessments will include selected-response items that have a single correct answer and will be machine scored. The performance tasks will require training of teachers. This training will be available online and will allow individuals to work at their own pace through the materials and repeat sessions, as needed. The performance tasks will have well-defined rubrics that clearly differentiate student performance by score point. The observational rubrics will be further supplemented with anchor papers that exemplify each of the score points. In addition, training sets will provide further support for the application of the rubrics to student work. The training materials will also include student work that does not clearly align to the anchors, to support teachers in scoring the full range of student work. Before teachers are allowed to score operational student work, they must demonstrate their ability to accurately score student work by achieving a level of accuracy (to be determined) in which adjacent, but not discrepant, scores will be allowed. The industry standard is a minimum of 80% exact agreement, but this standard will be vetted with the TAC before implementation.

Observational rubrics will also require teacher training, as they will be based on a 0–2 scale for the KEA and a 0–3 scale for the formative assessments. The decision to move toward a 0–2 scale for the KEA observational instruments was based on results of the KEA 1.0 pilot study, in which teachers were asked to compare the use of the checklists (employing a 0–2 scale) with the use of observational rubrics based on a 0–3 scale. Whereas teachers preferred the ease of use of the checklists, they preferred the rubric language, which defined the student behavior to be observed at each score point, for reasons of consistency of ratings. Given the need to administer the KEA to all students within the initial eight weeks of instruction, WestEd recommends the use of the rubric-based score descriptions with an abbreviated scale, to maximize efficiency and reliability. The formative assessments will continue to use the 0–3 scale in order to allow for finer distinctions in student performance and thus provide more diagnostic information to support instructional decisions.

Training for teachers on the use of the observational rubrics will be delivered online through the use of videos of students. Just as with the scorer training for the performance tasks, anchor, training, and qualifying videos will be available for each rubric. Administrators must achieve the desired level of accuracy in rating of student behavior in order to rate students during the operational administration of the KEA and the formative assessments.

During the field test, a within-school moderation system, in which a fellow teacher or school administrator will observe students' performance and/or behavior to determine interrater reliability for the performance tasks and observational rubrics, will be employed. The results of these analyses will help to identify potential scorer training issues and allow revision to the scoring materials in advance of their operational use. The ongoing process for moderation and monitoring of scorer behavior is a key component of the research agenda.

(4) The underlying goal of the ORS is to provide the relevant stakeholders with reliable, valid information that can be used to inform student-, classroom-, school-, program-, and state-level decisions. Given the stakes associated with these decisions, it is critical that the reliability of the information

provided be appropriate for its use. For example, while individual student scores on the ESKs assessed on the KEA may be seen as valuable, the limits of testing time do not allow for sufficient test items for each assessed ESK to support this level of reporting. However, due to the number of students tested within the classroom, it may be possible to report these data at the classroom level, subject to the data meeting a minimum reliability threshold. Consequently, student-level reports for the KEA will focus on reporting at the domain and total score levels. KEA reporting at the ESK, learning progression, and strand levels will be subject to psychometric review.

However, the project team believes that the formative assessment results must be reported by individual learning progression, because these assessment items and tasks are designed to inform individual instructional decisions for students. Each formative assessment task will provide evidence to support the placement of a student along a learning progression, and as such, the scores for individual students must be made available to classroom teachers. Having the capability to capture a “snapshot” of the status of an individual classroom is also valuable for informing classroom instruction. These data can be reported at the school level, across classrooms. The reporting of the formative data will be limited to the classroom and school levels.

Strategies for developing the reporting system will leverage innovative technology-driven solutions to generate and disseminate customized reports that deliver information to key stakeholders. Report dissemination efforts using information technologies can have greater reach, adoption, implementation, and maintenance, and, therefore, greater public impact; however, these efforts have to be designed with careful consideration of the populations and educational environments involved. The interactive reporting mechanisms will use user-centered designs to address the needs, limitations, and desired system functions of educators, administrators, and families/caregivers. As such, it will be essential to clearly identify the demographics and related system functions of each user group. The Consortium will administer surveys to key stakeholders, which will help to finalize a list of desired and necessary system features for each specific group of users.

Score reports resulting from the KEA will build on the Consortium's experience with delivering meaningful, uniform score reports customized to the needs of the various stakeholders at different levels. All levels of reporting will focus on providing a context for interpreting the assessment results; however, these contexts will differ by key stakeholder needs. To this end, the Consortium will explore how to most effectively develop: (a) reports for families, which present interactive assessment results to help families and caregivers understand the specific strengths and weaknesses of their children's knowledge, skills, and abilities; (b) reports for educators, which provide detailed information that can be interactively displayed according to domain and overall score, question type, and performance level; (c) reports for administrators, which provide aggregate information that helps to build instructional and professional development strategies for early-childhood education; and (d) state-level reports, which can inform policy decisions about the adequacy of educational programs and centers to prepare students for entry into kindergarten.

Central to each of these reporting levels will be users' ability to engage and interact with the assessment data. All key stakeholders will be provided with narrative and graphical components within the reports, which will provide context for interpreting the reports. For example, families/caregivers will be presented with a narrative describing early childhood development, which can help to explain why certain skills are essential for learning and describe key practices that families can implement at home to support their children's learning. Similarly, educators will receive interactive graphical reports at the student and classroom levels, which will enable them to explore specific concepts or learning progressions and examine how both individual students and whole classes are performing.

(5) Given the ambitious nature of the Consortium's goals for the development of the EC-CAS, it is critical to establish processes for quality control throughout the item/task development process. The proposed management structure places both the day-to-day management of the Consortium and the development process with WestEd as PMP and lead item developer. Given WestEd's combined roles of management and development, it will maintain constant and clear communication about the ongoing

status of all development. As outlined in the management plan in section (g), WestEd's success in serving as the PMP for Smarter Balanced has prepared it to work within the unique demands placed on the activities of a consortium committed to the development of an assessment system. WestEd has established processes and procedures to document all phases of the development process and methods to evaluate progress in meeting the goals of each phase on a regular and ongoing basis.

Effective management of processes will be critical in maintaining quality control, but ensuring that the development processes themselves are sound is equally important. WestEd's knowledge of and experience with test development practices, combined with the critical research and evaluation provided by the University of Connecticut, will ensure fidelity to established standards for the development of a fair, reliable, and valid assessment system. Key steps that have been built into the process include cognitive interviews to determine students' strategies for responding to items and tasks, pilot testing of items among representative samples of students from all Consortium States, revision and refinement of items based on the results of cognitive interviews and pilot tests, item and bias review committees composed primarily of early-childhood educators, field testing all items before operational use, implementation of accommodations strategies with purposeful inclusion of students with disabilities or developmental delays and English language learners in the field test, and training of all teachers for the administration and scoring of the assessments. All assessment reports will be evaluated for their potential use, anticipating both intended and unintended consequences. Care will be given to providing documentation to ensure the appropriate interpretation and use of all reports. Quality-control procedures will be established to ensure the accuracy of all reports before distribution.

Finally, WestEd will ensure involvement of Consortium State leads and the TAC in the review of all proposed procedures, to ensure that these procedures reflect the quality and technical standards expected of the States and the research and assessment communities.

Description of Absolute Priorities

Priority 1 (Collaboration)—With the goal of developing a comprehensive assessment system, the Consortium comprises seven States (Connecticut, Indiana, Maryland, Massachusetts, Michigan, Nevada, and Ohio) and three prominent educational research and development organizations: WestEd’s Assessment & Standards Development Services and Center for Child & Family Studies, the Johns Hopkins Center for Technology in Education (JHU CTE), and the University of Connecticut’s Measurement, Evaluation, and Assessment Program. Additionally, the Council of Chief State School Officers has committed resources and supports for the Technical Advisory Committee. These organizations will assist the Consortium in its efforts to build a reliable, valid, and high-quality assessment system that is based on current research and best practices. WestEd will serve as the Project Management Partner and lead assessment developer. In these roles, WestEd will use its extensive experience and expertise in assessment development and management to ensure that the assessment items and tools reliably measure and align to children’s learning and development across the essential domains of school readiness. The Consortium’s collaboration with JHU CTE will ensure that the assessment system incorporates technology wherever possible, including support for administration, scoring, and reporting of the assessment instruments. In addition, JHU CTE will provide professional-development support to the Consortium, including face-to-face and online training, technical assistance, coaching, and providing instructional resources through learning communities and collaborations. The University of Connecticut, in conjunction with WestEd, will provide the Consortium with research and evaluation assistance to ensure that evidence-based practices are employed.

Priority 2 (Multiple Measures)—The Consortium’s assessment system will measure the full range of early learning and development standards across all essential domains of school readiness. The assessment system will utilize several assessment methods, including selected-response items, performance tasks, and observational rubrics, aligned to learning progressions that encompass children’s performance across the spectrum of development. All components of the assessment system will

incorporate the principles of Universal Design that seek to eliminate aspects of items and tasks that increase the presence of construct-irrelevant factors that preclude access for English language learners and children with disabilities or developmental delays.

Priority 3 (*Charting Student Progress*)—In order to chart student progress over time, the Consortium will utilize technology in the administration of the assessment instruments and the collection and reporting of data. This will allow all stakeholders (e.g., administrators, teachers, families) to track children’s progress from preschool through kindergarten, and in subsequent years. The assessment items will be aligned to learning progressions that span the developmental spectrum and that provide teachers, early-learning providers, and families with the capacity to offer individualized instruction and support. Furthermore, the KEA will result in a comprehensive score across the learning progressions for each child, which can then be incorporated into States’ longitudinal data systems.

Priority 4 (*Comprehensive Academic Assessment Instruments*)—The Consortium recognizes the value of a system of summative and formative assessments that are organized around a common set of early learning and development standards that measure the entire range of skills across the essential domains of school readiness. The KEA summative assessment will utilize multiple item types, including, but not limited to, selected-response items, performance tasks, and observational rubrics; technology will be used to deliver and/or enhance the assessment. The learning progressions support aligned formative tools leading up to the KEA and then extending the available information through the end of kindergarten. This range of balanced, aligned instrumentation will identify students’ strengths and weaknesses, identify instructional intervention strategies, and track student progress over time and across cohorts.

Priority 5 (*KEA*)—The Consortium proposes to enhance KEA 1.0, currently in development by Maryland and Ohio, and build KEA 2.0 to adhere to all of the requirements set forth in this grant competition. KEA 2.0 will provide the Consortium States with valid, reliable, and fair information on children’s readiness for school across the essential domains of school readiness, including Social Foundations, Language and Literacy, Mathematics, Motor Development and Physical Well-being,

Science, Social Studies, and The Arts. Further, KEA 2.0 will utilize multiple methods of assessment, including selected-response items, performance tasks, and observational rubrics, that are consistent with nationally recognized technical standards, research, and best practices, and will employ the principles of Universal Design in order to assess all children upon entry to kindergarten. The summative results, consisting, at a minimum, of domain-level scores and comprehensive scores, from KEA 2.0 will then provide all stakeholders, including families, with appropriate information to help guide individualized instruction and inform program and policy decisions to help improve student achievement.

KEA 2.0 will be administered by trained teachers and assessors in the first eight weeks of school and will utilize technology in the administration of assessment items and in the collection and reporting of data. The online reporting system will be able to export data for use in a State's assessment or longitudinal data systems, and will be able to create reports for teachers, administrators, early-childhood providers, and families, in order to reflect a child's learning and development against set levels of performance. The KEA will not be used to prevent entry into kindergarten or for any purpose for which it has not been validated.

Description of Competitive Preference Priority

The state education agencies from Connecticut, Massachusetts, Indiana, Michigan, Nevada, and Ohio join the Maryland State Department of Education in its application for this grant. Each of these states has signed a Memorandum of Understanding (MOU) that describes the vision and principles of the Consortium; the roles and responsibilities of the Consortium and its member States; and the governance structure and activities of the States in the Consortium. The MOUs are included within this application.

Appendix A – High-Level Project Plan for EC-CAS 2.0

Budget Year	Activity	Timeline	Responsible Party
Phase I (2013–2014)	Consortium Kickoff Meeting	Nov	CS, WE, CTE
	Development Specifications	Nov – Jan	EC, WE, CTE
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
	Initial Item and Technology Development	Feb – Mar	WE and CTE
	Human Subjects Committee Protocol	Mar – Apr	WE
	Student Cognitive and Teacher Interviews	Apr	WE and CTE
	Item and Technology Development (cont.)	Apr – Jun	WE and CTE
	Pilot Test Recruitment and Preparation	May – Aug	CS
	Bias/Content Review of Items	Jun	WE
Phase II (2014–2015)	Pilot Test Administration	Sep – Oct	CS, WE, CTE
	Analyze Data from Pilot Test	Nov – Dec	WE, CTE, UConn
	Technical Report (Pilot Summary)	Jan – Feb	WE, CTE, UConn
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
	Revise Development Specifications	Jan – Mar	WE and CTE
	Item Development for Field Test	Mar – Jun	WE
	Field Test Recruitment	May – Jun	CS
	Bias and Content Review of Items	Jul	WE
	Field Test Preparation	Jul – Aug	WE and CTE
Phase III (2015–2016)	Field Test Administration	Sep – Oct	CS, WE, CTE
	Analyze Data from Field Test	Nov – Dec	WE, CTE, UConn
	Field Test Report (item statistics)	Jan – Feb	WE, CTE, UConn
	Technical Advisory Committee Meeting	Feb	EC, CCSO, WE, CTE
Post Award (2016–2017)	KEA Census Administration	Sep – Oct	CS, WE, CTE
	Census Report	Nov – Dec	WE, CTE, UConn
Virtual Executive Committee Meetings (Monthly); In-person Meetings two times per year (TBA)			
CS = Consortium States; CTE = JHU Center for Technology in Education;			
EC = Executive Committee; WE = WestEd			

