

Promoting Continuity of Care in Infant/Toddler Settings: What Can State/Territory Leaders Do?

Infant/Toddler Community of Practice

Jointly funded by ACF's Office of Child Care and Office of Head Start
Convened by the National Center on Child Care Professional Development Systems and Workforce Initiatives (PDW Center)



Very young children develop in the context of their relationships with adults, including their infant/toddler (IT) care providers. Neuroscientists have documented the influence of early experiences on development well into childhood and beyond. In fact, these experiences help determine the architecture of the brain, the ability to regulate one's emotions, and how a child's genetic makeup is expressed (National Scientific Council on the Developing Child, 2007). Babies form stronger and more secure attachments to adult caregivers who are consistently available to them and are able to read their preverbal cues and respond sensitively to their needs (Raikes, 1996). Research has shown that babies who experience multiple disruptions in their early care are more likely to show aggression and be less outgoing in the preschool years (Howes & Hamilton, 1992). Access to sensitive, responsive caregiving may be particularly protective for infants and toddlers growing up in families struggling with poverty and life stress; one in five children under age 3 who live in extreme poverty are estimated to face three or more risks to their development (National Center for Children in Poverty, n.d.). Children's relationships with adult caregivers are vital for shaping the brain, early childhood development, and the foundations of school readiness (see, e.g., Early Head Start National Resource Center, 2012); this is the scientific basis for promoting continuity of care and primary caregiving in IT settings.

State/Territory leaders have multiple policy, funding, and regulatory levers they can use to promote continuity of care. **Subsidy policies and procedures, quality improvement efforts, and professional development (PD) and workforce initiatives** all play a role in influencing what happens between adults and the babies and toddlers in their care. This document provides background information on continuity of care and examples of potential strategies that leaders can use as they consider the best opportunities to promote continuity of care in their State/Territory.

How Does Primary Caregiving Support Continuity of Care?

Continuity of care in a group care setting minimizes the number of caregivers a child interacts with during a day and over time to ensure as much consistency of relationships, environment, language, and culture as possible in order to strengthen relationships and the child's early learning experiences. Primary caregiving, a critical component to ensuring continuity for infants and toddlers, requires that one caregiver be matched to a baby or toddler upon entering group care (including center, Early Head Start, or family home settings). This single caregiver has the primary responsibility for establishing and maintaining a relationship with the child and his or her family. As a result, a primary caregiver forms a close bond with the infant or toddler and the family and is primarily responsible for that child's care in the group. The primary caregiver also works to promote continuous caring relationships for the child through the coordination of care, services, and staffing so that when she is not present the child is still cared for within a system of trusted, familiar adults. Low numbers of children to each adult in the group and smaller group sizes make it easier to offer primary caregiving (Lally & Tsao, 2004).

Implementing Continuity of Care in IT Settings

When children are in safe, nurturing, and high-quality settings, maintaining the primary caregiving relationship until the child is at least 3 years old is an important effort to support continuity for the child and family (Lally & Tsao, 2004). The longer a young child spends in the care of the same sensitive and

skilled caregiver, the more likely he or she is to form a secure attachment to that person (Raikes, 1993).¹ This continuity is also important for the primary caregiver. The extended time may help the caregiver better understand the needs of the growing child and form trusting relationships with his/her family that also add continuity in caregiving practices across the program setting and home environments. Continuity of care over these early years can be implemented in a number of ways, including:

- **Keeping a group of similar age children with the same teacher(s) over time.** If children leave, they are replaced with a child in the same age range. Once the children move on to preschool, a new cohort of infants may start.
- **Maintaining a mixed age group with the same teacher(s).** Children who leave may be replaced by a child of any age, as long as the staff-to-child ratio and group size are determined by the youngest child in care (Chainski, 2010). This model is similar to how a family child care home operates but can be implemented in centers.

How Do States/Territories Promote Continuity of Care in IT Settings?

A number of State/Territory strategies promote continuity of care using policy, funding, and regulatory levers. The following section describes opportunities to enhance continuity of care in IT settings and offers example strategies from various States.

Subsidy Policies and Procedures

Stable access to child care subsidies may make it easier for families with low incomes to maintain continuous access to the same child care provider. Research on subsidy receipt data in five States found that the median duration of receipt was just three to seven months (Collins, Kreader, & Georges, 2002). Other studies found that some policies and procedures common in State subsidy systems—such as one requiring parents to come to the subsidy office during working hours to report changes in family status—have the unintended consequence of making it difficult for eligible families with low incomes to maintain access to subsidies (Adams, Snyder, & Sandfort, 2002a, 2002b; Adams, Snyder, & Banghart, 2008). The Office of Child Care (OCC), which now requires States/Territories to report on their efforts to promote continuity of care through subsidy policies in section 2.2.6. of the Child Care and Development Fund Biennial Plan, has issued guidance to encourage Lead Agencies to adopt policies that promote continuity of care services for the benefit of children and families (U.S. Department of Health and Human Services, 2011). For example, State/Territory leaders have the option to:

- **Extend the period of subsidy eligibility to 12 months.** Redetermination of subsidy eligibility can trigger unnecessary subsidy loss when eligible parents with low incomes face difficulties in meeting State/Territory-set requirements to maintain subsidy—for example, when they cannot attend onsite meetings, document small income changes, or understand written communications in English (Adams, Snyder, & Sandfort, 2002a). At least 22 States have extended the maximum subsidy duration to 12 months. Some apply this policy system wide, others only to those who are enrolled simultaneously in an early childhood program with different eligibility requirements, such as Early Head Start, Head Start, or State prekindergarten programs. Several State studies have documented

¹ Raikes found that the longer infants and toddlers were with the same provider, the more likely they were to form a secure attachment to that provider; 91% of infants and toddlers who had been with their provider for more than one year had a secure attachment relationship. In comparison, 67% of infants and toddlers who had been with their caregiver for 9–12 months had secure attachments, and 50% of infants and toddlers who had been with their caregiver for 5–8 months had secure attachments.

that moving from 6- to 12-month eligibility periods is cost neutral and can result in cost savings in terms of the time it takes to process redetermination paperwork (see, e.g., Tarnai, 2011, for Washington State’s study of a pilot program extending 12-month eligibility for children also enrolled in Early Head Start, Head Start, or prekindergarten; also Ewen & Matthews 2010).

- **Make job search an allowable activity to qualify for subsidy.** Families with low incomes are experiencing upheaval and job insecurity in the current economy. States/Territories can allow working parents some time to look for a new job without disrupting their children’s subsidized care. In 2011, OCC reported that two-thirds of States now include “job search” in their definition of “working” (U.S. Department of Health and Human Services, 2011).
- **Be flexible when eligible families face changes in their situation.** States can design subsidy systems to anticipate common circumstances experienced by families with low incomes, such as fluctuating employment, education, or income levels, ill health and medical leave, or sick-child or vacation days. Disrupting subsidy receipt every time these changes occur adds to instability of care arrangements. In their FY2012-13 CCDF Plans, 16 States and Territories indicated that they had two-tiered income eligibility with a higher exit point than entry point. For example, New Jersey established two-tiered income eligibility with a higher exit point than entry point to cover temporary changes in family’s circumstances. Additionally, New York allows continuous income eligibility for up to two years for families as long as their child is dually enrolled in child care and a Head Start collaboration program or a State prekindergarten.

Quality Improvement Initiatives

Continuity of care, including primary caregiving, is critical to IT group care quality. Primary care establishes which caregiver is mainly responsible for a child, and continuity of care policies extend the time period from care entry to at least age 3. Early Head Start programs are required to ensure “the development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time” and develop an environment of “trust and emotional security so that each child can explore the environment according to his or her developmental level” (Head Start, 2009a). States/Territories can support the implementation of continuity of care strategies by raising awareness and understanding of the importance of continuity of care for infants and toddlers. At the local level, State and Territory leaders can highlight programs that demonstrate continuity of care practices. At a systems level, leaders can review current licensing rules, quality rating and improvement systems (QRIS), and other quality improvement strategies and embed support for the approach. State/Territory leaders can consider, but are not limited to, the following options:

- **Encourage providers to move toward continuity of care in State/Territory licensing or a QRIS.** National analysis on States requiring continuity of care is not currently available, although Indiana provides an example of how licensing may be used to encourage providers to move toward the approach. For example, Section 51 of the Indiana child care center licensing rules, adopted in 2003, defines continuity of care and requires child care centers to make a “reasonable effort” to achieve it for infants and toddlers up to 30 months of age (State of Indiana Administrative Code, 2005).
- **Use quality dollars to pay for technical assistance (TA) for center directors and teachers to learn about and implement continuity of care.** To successfully change program design and practice, it is important to provide adequate support and TA to directors and teachers. In Indiana the regulation change was accompanied by support for a network of IT specialists housed in the child care resource

and referral networks in the State. An [evaluation](#) by researchers at Purdue University found that IT classrooms participating in TA provided by the [4C of Southern Indiana](#), one of the State’s resource and referral agencies, increased their ratings on interactions and relationship quality using the observation-based Program Assessment Rating Scale (PARS) from the “adequate” range to the “good” range during a six-month period (Elicker & Ruprecht, 2007).

- **Promote the use of primary caregiving in State/Territory licensing.** Primary caregiving is a key component of continuity of care. It is assumed to be a feature of family child care, but center-based directors and teachers need to be intentional to build those one-on-one relationships with infants and toddlers and their families. At least 23 States have center licensing regulations requiring that a consistent primary caregiver be assigned to each child in that age group (National Association for Regulatory Administration & National Child Care Information Center, 2010).
- **Reduce staff-child ratios and group size in group IT settings through licensing.** Nationally recognized standards for program quality can be included in state/territory requirements for licensing or higher levels of a QRIS. Ten States set staff-child ratios at the National Association for the Education of Young Children (NAEYC)-recommended levels of 1:4 at 9, 12, and 18 months and 1:6 at 27 months. Five states follow NAEYC recommendations for maximum group size of eight children at 9, 12, and 18 months of age, and twelve children at 27 months of age (NACCRRRA, 2011). Head Start Program Performance Standards require a 1:4 ratio for Early Head Start infant and toddlers, birth to age 3, and 1:8 group size unless there are more stringent State, Tribal, or local regulations. There are nationally recognized quality program standards for family child care homes as well. For example, Head Start Program Performance Standards for the family child care option specify that for one family child care provider, the maximum group size is six children, and no more than two of the six may be under 2 years of age. When there is a provider and an assistant, the maximum group size is 12 children with no more than 4 of the 12 under 2 years of age. Head Start standards also allow one family child care provider to care for up to four infants and toddlers, with no more than two of the four children under the age of 18 months (Head Start, 2009b).
- **Use QRIS to encourage smaller groups and better staff-child ratios.** States/Territories can encourage better group sizes and ratios at higher levels of the QRIS. For example, Virginia’s QRIS system calls for a 1:3 ratio and maximum group size of six for infants at the higher star levels 4 and 5, as compared to 1:4 and group size of eight for the lower levels. When financial incentives are attached to higher levels of group size, such as in Maine where Step 4 providers receive a 10% increase in subsidy reimbursements, this can help to minimize the impact of lost income that results from serving fewer children.

PD and Workforce Initiatives

The success of continuity of care hinges in part on the capacities of individual teachers and directors to establish consistent, responsive, and nurturing relationships with children and positively engage and support their families. State/Territory leaders have the opportunity to strengthen capacities through professional development (PD) and workforce initiatives. Leaders can consider the following options:

- **Include primary caregiving and continuity of care skills in core knowledge and competencies (CKCs) and PD for IT teachers and directors.** The PDW Center analyzed State CKC documents in March 2012 and found that 14 States mention continuity of care in their CKCs. Of those 14, six States specifically reference infants and toddlers when addressing continuity of care. In addition to providing PD to assist IT staff in developing trusting, sensitive primary-care relationships, State/Territory leaders can provide access to education and support for directors to implement new

staffing and planning models and offer support to teachers to implement continuity of care. For example, current teachers who are comfortable working with infants may need training and mentoring to be responsive to those same children as they become toddlers with more advanced physical, emotional, and language skills and capacities.

- **Include continuity of care in PD as a strategy to increase family engagement.** Strong parent-teacher communications are associated with more sensitive teacher-child interaction (Owen, Ware, & Barefoot, 2002). Settings that practice continuity of care can support teachers in developing positive parent relationships that increase family engagement.
- **Integrate continuity of care and primary caregiving into the State/Territory QRIS.** The levels of a QRIS can gradually introduce center directors and staff to training, support, and implementation of continuity of care. States/Territories can require that providers use tiered payment for higher QRIS levels specifically to support continuity of care strategies.
- **Target IT teachers and directors for increased compensation or bonuses to decrease turnover and support continuity of care.** An estimated 30% of the early care and education workforce changes jobs in a year (Whitebook & Sakai, 2003), which is detrimental to young children's developing sense of attachment. Making IT care more financially rewarding could help reduce turnover.

Conclusion

Continuity of care, including primary caregiving, is critical to enhancing relationships in infant and toddler settings. Teachers have more time to build relationships with children and their families, resulting in enhanced early care experiences and better supports for the bond between parents and children. These early connections fuel important neurological processes that help infants and toddlers explore and learn to regulate their emotions, forming the roots of school readiness. State/Territory leaders have many options through subsidy, quality, and PD and workforce systems to support continuity of care based on their assessment of the best opportunities to do so in their State/Territory. See the box below for more resources.

Related Resources

Office of Child Care (OCC)

OCC Information Memorandum CCDF-ACF-IM-2011-06: *Policies and practices that promote continuity of child care services and enhance subsidy systems.*

<http://www.acf.hhs.gov/programs/occ/law/guidance/current/im2011-06/im2011-06.htm>

Office of Head Start (OHS)

Early Head Start National Resource Center. (2004). *Tip sheet #21: Continuity of care in EHS group settings.*

<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/early-learning/caregiving/EHStipsheet-21.pdf>

Early Head Start National Resource Center. (2010) *Tip sheet #25: How do we support services for infants and toddlers in a birth-to-five program?* [http://eclkc.ohs.acf.hhs.gov/hslc/tta-](http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/Management%20and%20Administration/Planning/Program%20Planning/TIP%20SHEET%2025.pdf)

[system/operations/Management%20and%20Administration/Planning/Program%20Planning/TIP%20SHEET%2025.pdf](http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/Management%20and%20Administration/Planning/Program%20Planning/TIP%20SHEET%2025.pdf)

National Center on Parent, Family, and Community Engagement. (2011). *The Head Start parent, family, and community engagement framework: Promoting family engagement and school readiness, from prenatal to age 8.* <http://eclkc.ohs.acf.hhs.gov/hslc/standards/IMs/2011/pfce-framework.pdf>

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