
Children Entering School Ready to Learn Fiscal 2002 Budget Overview

**Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland**

February 2001

**Children Entering School Ready to Learn
Fiscal 2002 Budget Overview**

Operating Budget Data

**Fiscal 2000 through 2002
(\$ in Thousands)**

	<u>FY 00</u> <u>Actual</u>	<u>FY 01</u> <u>Appn.</u>	<u>FY 02</u> <u>Allow.</u>	<u>Change</u>	<u>% Change</u> <u>Prior Year</u>
Improve Quality of Child Care and Early Childhood Experience	\$15,201	\$19,379	\$24,397	\$5,018	25.9%
Increase Access to Early Childhood Experiences	37,011	41,519	45,591	4,072	9.8%
Support Families with Young Children	9,380	16,018	17,364	1,346	8.4%
Increase Access to Health Care and Early Childhood Health Screening	9,999	11,301	10,021	(1,280)	(11.3)%
Total	\$71,590	\$88,217	\$97,374	\$9,156	10.4%
General Fund	\$38,775	\$40,874	\$45,937	\$5,063	12.4%
Special Fund	182	\$7,144	7,182	38	0.5%
Federal Fund	30,889	37,949	41,619	3,669	9.7%
Reimbursable Fund	1,744	2,250	2,636	387	17.2%

Key Points

- **Quality Early Childhood Experiences Require Quality Staffing:** Ensuring quality among program staff is a necessary component of a successful program. Credentialing child care workers and accrediting child care centers and family day care homes is a first step in raising quality.
- **Compensation:** One impediment to attracting and retaining qualified staff is compensation. Currently, child care workers in centers and family day care homes make less than half of what the average teacher in a public school earns. Similarly, salaries of Head Start teachers in some jurisdictions are less than \$20,000 annually. The subcabinet's strategies for improving early childhood education are not sufficient to adequately address the compensation issue.
- **Given Limited Resources, Funds Should Target At-risk Children and Families:** Given the limited resources available for early childhood programs, it is most appropriate to target funds to at-risk children and families rather than provide universal services.

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- **Conflicting Strategies?:** One of the subcabinet’s strategies for improving quality is to credential child care workers and accredit child care programs. A separate strategy proposes expanding pre-school opportunities for three- and four-year-old children. While both approaches are laudable, there is the potential for conflict. If quality child care programs are readily available, then why does the State need to expand pre-school programs when it could spend the same dollars to make child care more affordable? Ideally, it might make sense to use both approaches and wrap the child care around the pre-school. Barring a substantial infusion of funding into early childhood programs, however, the State should probably focus the majority of its resources on one approach or the other.

- **Funds in Allowance Could Be Earmarked to Expand Early Childhood Programs:** The fiscal 2002 allowance contains \$19 million for local school systems to spend to improve outcomes in the third grade. The administration’s proposal focuses the dollars on children in kindergarten through the third grade. Targeting these funds to pre-kindergarten programming for at-risk children appears more cost effective.

- **Early Childhood System Lacks a Single Point of Entry:** Child Care Resource and Referral networks offer parents assistance in identifying appropriate child care options, public schools provide pre-kindergarten and kindergarten programs, schools systems and various other organizations administer Head Start, and community-based family support centers provide services for children ages zero through three and their parents. With the exception of communities with fledgling Judy Centers, there is no single point of entry into the early child care and education systems and no entity at the local level which coordinates the activities of the various publicly funded programs.

Issues

Results-based Budgeting and Evaluation: Evaluation efforts are assessed.

Recommended Actions

	<u>Amount Reduction</u>
1. Adopt narrative encouraging consolidation of Home Visiting Programs.	
2. Adopt narrative directing the transfer of State Head Start funds to the Maryland State Department of Education.	
3. Adopt narrative requesting report on plans to evaluate credentialing and accreditation initiatives.	
4. Add language restricting use of State Head Start funds to specific purposes.	
5. Reduce Temporary Assistance to Needy Families funding for Home Visitation Program.	\$950,000 FF

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6.	Reduce funding for Judy Centers.	500,000	GF
	Total Reductions	\$1,450,000	

Background

For the past four years, the Department of Legislative Services (DLS) has prepared an overview of all State spending on children and family services. This overview was prepared at the request of the budget committees to provide a holistic view of spending on children and family services, something virtually impossible to obtain in the routine oversight of individual agency and unit budgets.

In last year's analysis, DLS aligned its children's budget with the work of the Maryland Partnership for Children, Youth, and Families. The partnership is an advisory body to the Governor on children and family issues. Beginning in 2000, the partnership published its *Maryland's Results for Child Well-Being*. This annual publication, which identifies eight result areas and indicators within each result area, brings into one document a snap-shot of how children are faring in Maryland. Thus, DLS presented its children budget overview around the partnership's result areas.

At the same time, the Joint Committee for Children, Youth, and Families (JCCYF), established by Chapters 362 and 363, Acts of 1999 chose to devote its energy to one of the eight result areas: children entering school ready to learn. The committee has been holding hearings for the past two interims on the issue of school readiness, and at the prompting of the JCCYF, the subcabinet developed a set of four overarching strategies to promote school readiness:

- Improve Quality of Child Care and Early Childhood Experience;
- Increase Access to Early Childhood Experiences;
- Support Families with Young Children; and
- Increase Access to Health Care and Early Childhood Health Screening.

Budget decisions in fiscal 2001 saw some initial steps to implement pieces of these overarching strategies.

Why This Hearing?

A final piece of the work of the JCCYF in the area of school readiness was to place the strategic planning process into the budget arena. Typically budget hearings focus on programs or groups of programs as they are organized administratively, for example, a single department or part of a larger department. They are also typically concerned with the immediate upcoming budget year rather than having a longer-term strategic planning focus.

This hearing focused instead on school readiness outcomes and the four strategies outlined by the subcabinet to positively move indicators around school readiness. It includes an identification of dollars most directly targeted to the achievement of stated results regardless of the specific agency or source of those funds. In this way, the legislature has the opportunity to:

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- Take a holistic, view of those programs, dollars, and policies that the State is utilizing to achieve a common goal. This is done in the context of one meeting rather than being spread across numerous agency budget hearings. Integrating all of the programs related to this result in one analysis provides both a singular focus on the chosen result area and the opportunity to assess how these programs interact with one another (e.g., if and how they are coordinated, if they use similar evaluation methodologies, what populations they serve, program eligibility and so forth);
- Focus not only on what is in the proposed budget but also on long-term strategic questions (five years out) about how to move the State's performance in this result area from where we are to where we want to go. While the Managing for Results (MFR) initiative is an attempt to move the State's budgeting process into a more strategic framework, an agency MFRs rarely move beyond the immediate upcoming fiscal year, nor do they necessarily link to another agency's MFR although moving forward in any given area often will involve a multiplicity of agencies;
- Focus attention on initiatives that have an important impact but which may be normally considered as part of larger programs which dwarf them in size and thus deflect attention; and
- Have all the appropriate parties at the table when discussing this result area.

While this hearing is certainly a positive step forward in terms of focusing on the issue of child readiness, it also needs to be made clear from the outset that the amount of dollars identified as being targeted for school readiness in this analysis does not include all of the dollars that could impact this result area. This is particularly true for the strategies Supporting Families with Young Children and Increasing Access to Health Care and Early Childhood Health Screening.

There are a number of reasons for this:

- While for the purpose of this hearing, an effort has been made to identify spending in a result area, the State budget is developed by program and not by result which leads to technical problems of disaggregation;
- The scope of the strategies being discussed would involve pulling together significant dollar amounts, potentially broadening the scope of the hearing in a way that is both unmanageable and unfocused, thereby defeating the point of such a hearing;
- It was agreed that the school readiness hearing would be the single point of analytical discussion by DLS for those programs that comprise the funding under discussion. Expanding this funding to match the strategy would make DLS's analysis of the rest of the State budget unnecessarily cumbersome as well as expose the executive agencies to multiple budget hearings on the same funding. Similarly, as this analysis moves into a discussion of the overarching strategies, it will become apparent that two of the strategies -- Improving Quality of Child Care and Early Childhood Experience and Increasing Access to Early Childhood Experiences -- are more narrowly focused than the other two strategies -- Supporting Families with Young Children and Increasing Access to Health Care and Early Childhood Health Screening. As it will become clear in our discussion, these broader strategies have a vital role

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to play in school readiness, but a full discussion of those strategies is for the moment beyond the scope of this analysis.

Why School Readiness?

The renewed attention paid to school readiness has in large part been prompted by developments in neurological research and the visualization of how much development actually occurs in the early years. Consider, for example, **Exhibit 1** which illustrates the growth of the network which is our brain. The exhibit illustrates what the network of connections between brain cells (neural synapses) looks like at birth and at age six. By one estimate, brain growth (as measured by the number of newly-formed connections between cells) is at its height between zero and three, with the number of connections being made in the brain increasing twenty-fold during that period. What is important about these connections is that those that get used most will strengthen and last. Those that are not, will ultimately go through a pruning process and eventually disappear.

Exhibit 2 presents a more dramatic image of brain development. Using positron emission tomography (PET) which measures electrical activity based on brain activity and connections, researchers have imaged the brains of two two-year-old infants: one who had enriched and nurturing experiences, the other having less suitable experiences. The relative lack of activity for the child growing up in less than ideal circumstances is visually apparent.

What these visual images reinforce, and indeed bring to life, are tenets of child development which have been discussed for a number of years: the quality of such things as relationships, stimulative experiences, nutritional adequacy, and overall physical well-being in a child's early years have a deep and lasting impact on how brain connections are formed. Experiences made in the context of a warm, supportive, and positive environment tend to strengthen brain connections. Children in environments without positive interactions may experience brain and behavioral development which progresses slowly or even fails to progress in normal ways. Children subject to stress in early age experiences (for example, because of abuse or neglect), in turn have high levels of stress hormones which can weaken the connections made by the brain and result in developmental delays.

These then are the two seemingly paradoxical images of early childhood development: this is a time of tremendous development, but also a time of extreme vulnerability, a time where that development can be stunted. As the National Academy of Sciences concluded in its recent study of the science of early childhood development, it is a time not when an indelible blue-print for adult well-being is formed, but rather a time which "sets either a sturdy or fragile stage for what follows" (*From Neurons to Neighborhoods*).

Exhibit 1

**Comparison of Brain Connections
Birth and Six-years of Age**

Source: Rima Shore, *Rethinking the Brain*

Exhibit 2

Effect of Extreme Deprivation

Source: K. T. Chugani, University of Chicago

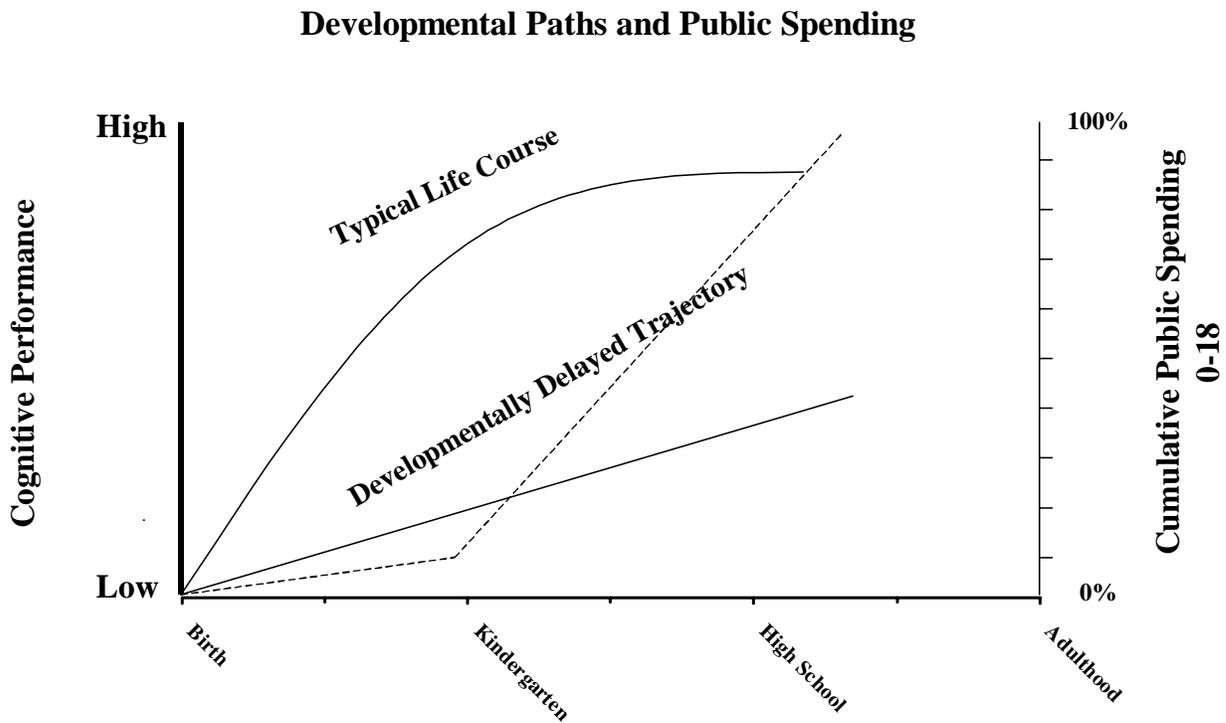
Implications for Policy-making

If the brain research tags the earliest period of childhood as indeed such a critical time in the development of young children, what are the implications for policy-makers? Perhaps more than anything else, if, as suggested by the data presented below, striking disparities in what children know and can do are evident by the time they enter kindergarten, redressing those disparities is critical both for the children and for society as a whole. In other words, children that do not enjoy quality early learning environments need quality prevention and early intervention programs to redress any developmental delays.

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Consider, for example, **Exhibit 3**, which contrasts a typical development path with a developmentally delayed path. Again, Exhibit 3 illustrates what is supported by research, that it is more difficult to reverse negative outcomes the longer the delay before early intervention programming is put in the place. While the new brain research should not lead to the conclusion that effective intervention can only take place in the earliest years, it seems clear that the earlier at-risk children are identified and supported, the more cost-effective intervention should be. Interestingly, superimposed upon that chart, is a broken line derived from an early 1990s RAND study which tracked cumulative public spending on children 18-years and under. As is **evident and not** surprising, public spending tends to grow faster once children enter kindergarten rather than before it.

Exhibit 3



Source: Adapted from Ramcy and Ramcy, *American Psychologist*, 1998; RAND Corporation

The heightened interest and renewed focus on early childhood development stimulated by the new brain research has been matched by research to discover what works in early intervention programs. This research has involved evaluating the impact of such model programs as the Perry Preschool program (based in Ypsilanti, Michigan) and the Abecedarian Project (based in Chapel Hill, North Carolina) as well as larger programs such as Head Start. (A summary of the programming involved in some of these model programs is included as **Appendix 1**). Reviews of these programs offer a range of results in terms of cognitive and emotional development, subsequent educational achievement, as well as longer-term

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economic well-being. While results are by no means uniform, a recent Rand review of these programs concluded that carefully targeted early childhood interventions, can yield measurable benefits in the short-run and some of the benefits persist long after the program has ended.

What Is the Cost of the Bad Outcomes?

When evaluating whether to invest additional dollars in prevention programs, policymakers frequently ask what could be saved by reducing the number of "bad outcomes." Estimating the cost of bad outcomes is extremely speculative as it is difficult to predict what will happen to a person who does not enter school ready to learn. One can not say for sure whether a child who lacks stimulating early childhood experiences will give birth as a teen, require remedial education, and/or enter the juvenile justice system; nor can one guarantee that a child with a rich array of early childhood experiences will do well in school, shun drugs, stay clear of the juvenile justice system, and complete high school.

While it is challenging to forecast long-term savings at the outset of a program, there is a body of evaluation research which focuses on the cost savings from specific early intervention programs. In a recent book *Investing in Our Children* published by RAND Corporation, the net savings from a home visiting program (Elmira Prenatal/Early Infancy Project) and a pre-school program (High/Scope Perry Preschool Project) are examined. In both longitudinal studies, net savings are noted from the interventions. The four areas where the programs produced savings were:

- **Welfare:** Cash assistance, food stamp, and Medicaid costs were lower for program participants than the control group. In the pre-school study, lifetime welfare savings were calculated for the child. Savings for both the child and the parent were identified in the pre-natal/early infancy program. More than half of the savings for high-risk families in the Elmira study were attributed to reduced welfare payments.
- **Increased Tax Revenues:** The pre-school program measured increased employment and income for program participants through the age of 27 and projected future earnings through age 65. A significant increase in taxable earnings was noted.
- **Lower Criminal Justice Expenditures:** Lifetime criminal activity by program participants in the two studies was projected to be lower than the control groups producing a substantial reduction in law enforcement and incarceration costs. About 40% of the savings in the pre-school program were attributed to lower criminal justice spending.
- **Reduced Spending on Education, Health, and Other Services:** The pre-school program was associated with reduced utilization of special education and less grade repetition while the Elmira evaluation highlighted fewer emergency room visits for children between the ages of 25 months and 50 months. Interestingly, neither study considered increased spending related to children entering publicly supported higher education facilities who would not otherwise have pursued post-secondary education.

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Key conclusions in the RAND study include:

- Based on a comparison of "high-risk" and "low-risk" families in the Elmira study, it appears that little to no savings accrue from intervening on behalf of low-risk families.
- Savings from the interventions accrue over a period of many years while the costs are incurred in the short-term.
- Governmental savings are complemented from societal savings generated by fewer crime victims and more productive citizens.
- Programs like the Elmira and Perry studies may generate savings to the government, but these findings can not be generalized to similar programs.

Cost of Bad Outcomes in Maryland

Most of Maryland's existing or proposed early childhood programs have endured rigorous longitudinal studies examining cost savings. The best proxy for estimating the potential savings for Maryland from investing in new or expanded early childhood intervention programs is the current spending on children who are troubled academically and socially. **Exhibit 4** highlights State spending on programs seeking to counteract bad early childhood outcomes. The list is by no means comprehensive as it excludes spending on welfare programs for teen moms and compensatory education and excludes spending in the adult years resulting from bad outcomes, including prison spending, food stamps, and Medicaid.

So, what does the early learning environment look like in Maryland, and how are children faring in that system?

What System Does Maryland Already Have in Place?

There are about 419,000 children in Maryland under the age of six. Analysis performed by the Annie E. Casey foundation indicates that about 70%, or 293,000, of these children live in a home where their parents are working at least part-time. Data collected by the Census Bureau for 1997 indicates about 16% of children under five will live with families with incomes below the poverty level. Maryland's overall child poverty rate has fallen from 13.4% in 1997 to 8.9% in 1999 which suggests that the number of children under five, who live in poverty, has also fallen.

The support system available to assist Maryland's youngest residents is a patchwork of public and private programs. Some of the public programs like kindergarten and screening of infant hearing are universally available to families, while others including pre-kindergarten and Head Start target low-income, at-risk children and families. More affluent families often must rely on their own resources to access child care and early childhood education programs.

Exhibit 4

**Spending to Counteract "Bad Outcomes"
Fiscal 2002 Allowance
(\$ in Thousands)**

	All Funds	General Funds	Cigarette Restitution Funds
Dropout Prevention (MSDE)	\$9,847	\$0	\$0
Children At-risk (Homelessness/Substance Abuse) (MSDE)	5,428	0	n/a
Special Education (MSDE)	354,910	194,067	n/a
Disruptive Youth (MSDE/Subcabinet Fund)	3,101	1,601	n/a
Department of Juvenile Justice	180,631	162,949	n/a
Governor's Council on Adolescent Pregnancy Grants	1,060	560	n/a
Youth Service Bureaus	2,048	n/a	n/a
Academic Intervention (MSDE)	19,500	n/a	19,500
Improvements to Kindergarten -- Grade 3 (MSDE)	19,000	19,000	n/a
Other (Youth Crisis Hotline, Choice, etc.)	2,718	2,718	n/a
Total	\$598,243	\$380,895	\$19,500

MSDE - Maryland State Department of Education

Source: Maryland State Budget

What Public Programs Serve Young Children?

There are numerous public programs targeting children ages 0 through 5. **Exhibits 5 and 6** provide a summary of the age groups targeted by Maryland's largest public early child care and education programs and support services and parenting programs. Without context, the charts make it appear as though there are no gaps in any of the three services. The charts, however, do not speak to the eligibility criteria for the programs or consider the quality of the services.

Exhibit 5

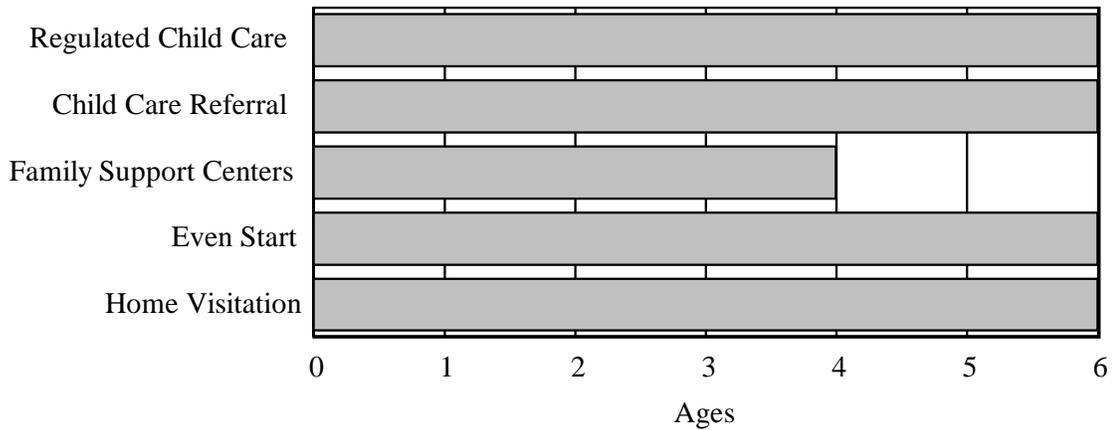
Public Early Childhood and Education



Source: Department of Legislative Services

Exhibit 6

Public Support Services for Families and Parenting Programs



Source: Department of Legislative Services

Do Public Programs Provide Universal Access and Quality Services?

Most of the direct service programs for children ages zero to five which are funded by the State do not offer universal access. Instead, they target low-income families and children with specific risk factors or disabilities. Many of the screening and supportive service programs, in contrast, do serve all Maryland families. **Exhibits 7 and 8** highlight the eligibility criteria for the largest programs targeting young children and indicate the percentage of the eligible population believed to access the program.

Exhibit 7

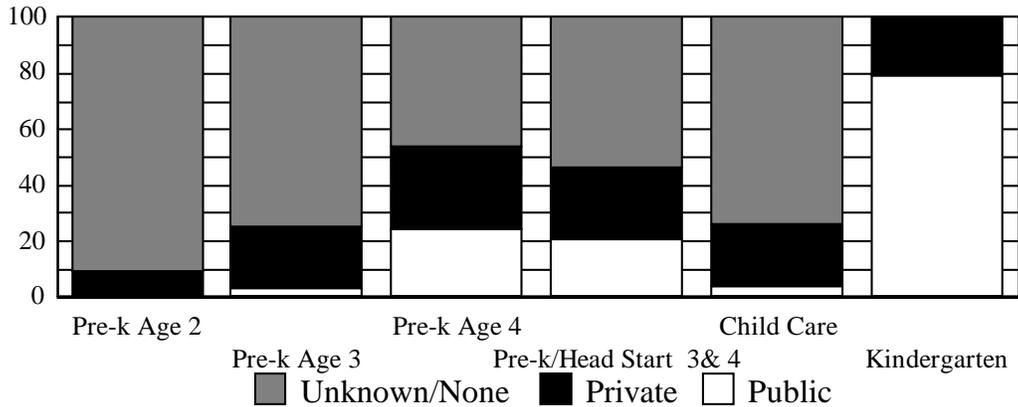
Early Child Care and Education

<u>Program</u>	<u>Eligibility</u>	<u>Program Utilization Rate</u>	<u>% of Total Age Eligible Population Served</u>
Child care Subsidies -- Purchase of Care Program (POC)	Families with incomes up to 45% of the State median income.	16,687 children (35%). There are no waiting lists.	4%
Public Kindergarten	Universal access for five-year-olds.	56,942 (79% of five-year-olds).	79%
Public Pre-school	Four-year old children at-risk of failing in school. Younger children qualify if special education is required.	19,285 children.	27% of all four-year-olds
Head Start	Children ages three and four with incomes below federal poverty level.	9,535 (57% of eligible population).	7% of all children ages three and four
Early Head Start	Children zero to three.	454 children.	0.02% of children under the age of three
Infants and Toddlers	Children zero to three with disabilities.	7,350 children.	3.5% of all children under the age of three.
Judy Centers	Coordinating body which serves all children in area.	New Program.	n/a

Source: Subcabinet for Children, Youth, and Families; Department of Legislative Services

Exhibit 8

Who Pays? Public vs. Private



Notes:

- (1) Numbers are not unduplicated. The same child could be participating in child care, pre-kindergarten, and Head Start.
- (2) Child care utilization by families is estimated based on the utilization patterns of POC children. Currently about 60% of the children receiving a State subsidy are below the age of 6. Based on this data, DLS assumed that 60% of all family day care and child care center slots are utilized by children under age 6 and that the facilities are operating at 85% capacity.
- (3) Child care data represents regulated care with the exception of about 3,300 children with State subsidies for informal care.
- (4) Pre-school data for children age two assumes that all children under age three who are in pre-school are two-year olds. It is possible that some of the children utilizing pre-school are under the age of two.

Sources: Maryland State Department of Education; Office for Children, Youth, and Families; Department of Human Resources; and Department of Health and Mental Hygiene

Early Childhood Care and Education

Maryland’s system of child care and pre-school programming is a true patchwork of public and private programs. Available services include child care centers and family day care homes, Head Start, pre-school, and the Infants and Toddlers Program. In theory, these programs provide parents with a range of options for their young children. For example, low-income parents can choose among subsidized child care, Head Start, and pre-kindergarten for their four-year-old.

Interestingly, none of these programs is fully utilized due to a lack of demand and funding. While there are no waiting lists, subsidized child care reaches only about one-third of the eligible families. A lack of demand results in some pre-kindergarten programs operating below capacity and limited funding constrains participation in Head Start to slightly more than half of the eligible population.

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Until their child turns five and enters kindergarten, families with a healthy child and incomes above 45% of the State median income must use their own resources to purchase out-of-home early childhood experiences. Exhibit 8 demonstrates the extent to which most families seeking early childhood programs for their children must or do rely on their own funds to access services.

A number of observations can be made about the quality of Maryland's early childhood programs and gaps in the availability of services including:

- The majority of children under the age of five appear to be foregoing both pre-school and regulated child care. These children may be cared for by a parent, family member, friend, neighbor, nanny, and/or unregulated child care provider.
- Access to publicly funded pre-kindergarten programs is limited. Only about half of all four-year-olds attend pre-school and public pre-schools serve only 46% of four-year-olds in pre-school. Publicly funded pre-kindergarten for three-year-olds is limited to children with special educational needs.
- Poor families appear to utilize public pre-school and Head Start for services more than other forms of regulated child care. Moderate- and upper-income families seem to rely heavily on the regulated child care system, and to some extent private pre-school programs.
- While there are more than 200,000 regulated child care slots in the State, including Head Start and the Extended Elementary Education Program (EEEP), the State subsidizes only a small percentage of these slots through the POC Program. As a result, most families pay 100% of child care costs out-of-pocket. According to data compiled by the Maryland Committee for Children, the average weekly cost of a child care center in 2000 was \$107.60 for a child ages two to five, and \$168.95 for a child ages zero to two. Family day care costs averaged \$97.40 for a child ages two to five, and \$115.70 for a child ages zero to two.
- There is a shortage of infant child care slots. Data compiled by the Maryland Committee for Children indicates that there are only 12,504 slots for children under the age of two, which means there is roughly one slot for every ten children. In contrast, there is one slot for every four children ages 0 to 11.
- Low-salaries for child care workers and Head Start instructors in some jurisdictions may contribute to the concerns about quality. Data compiled by the Maryland Committee for Children indicates that the salaries of public school teachers are more than double most child care workers.
- Oversight of the current system of early childhood programming focuses on child safety and health but does not offer parents much assurance about the quality of the experiences. Only about 4.5% of child care centers/programs in Maryland are accredited, family day care providers are not currently accredited or credentialed, and the quality of Head Start in Baltimore City has been questioned in a recent Abell Foundation report.

Parenting Programs and Services for Families

Exhibit 9 indicates that most of the services in this area benefit or are at least available to all families with children under the age of six. Child care licensing and resource and referral, for example, assist every family seeking a safe placement for their child. While these services benefit all families, the supply of licensed child care is not sufficient to care for every child ages zero to five. In fact, the roughly 200,000 child care slots (including Head Start and State funded EEEP) are only enough to serve about half of all the children under age six. A snapshot of child care utilization compiled by the Maryland Committee for Children and the Department of Human Resources (DHR) from a sample of centers and day care homes between July and September 2000 indicates that child care centers and family day care providers are operating at roughly 85% of capacity.

Exhibit 9

Support Services for Families and Parenting Programs

<u>Program</u>	<u>Eligibility</u>	<u>Utilization Rate</u>	<u>Percent of All Children</u>
Child Care Licensing and Regulation	Universal Benefits	Programs with more than 200,000 slots are licensed.	Licensed slots equate to about 50% of children ages zero to five, but many of the programs serve children to age 12
Child Care Resource and Referral Network	Universal	44,524 calls received, 15,000 people trained, and 11,000 people receiving technical assistance. About 37,500 of the children are age five or below.	n/a
Family Support Centers	Young mothers with children zero to three	8,500 families or about 4% of families with children ages zero to three.	4% of families
Even Start	Families with children in poverty	155 to 160 families or about 0.3% of eligible families.	0.1% of families
Home Visitation	Eight different State programs serve different at-risk populations	Complete data is not available. 9,430 families were served by seven of the programs, but the largest State-funded program (Healthy Families Maryland) did not report data.	n/a

Source: Subcabinet for Children, Youth, and Families; Department of Legislative Services

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While Family Support Centers are more widely available to the general public, the home visiting and Even Start initiatives are more targeted programs with limited budgets. Even Start and most of the State's home visiting programs address specific problems (literacy, health risks, non-marital births, juveniles delinquents with children, etc.). Most families with children ages zero to five do not require or seek these services. Further discussion concerning the State's home visitation programs is provided in the Issues section of this analysis.

Health Programs

A child's health has a significant impact on her/his development and school readiness. The State provides a wide array of services to ensure access to quality care. As depicted in **Exhibit 10**, health services available to children ages zero to five and their parents include:

- Access to comprehensive health insurance through Medicaid and the Maryland Children's Health Program (MCHP). Currently, pregnant women and children qualify for coverage with incomes at or below 200% of the federal poverty level. Beginning July 1, 2001, MCHP will be expanded to children with incomes up to 300% of the poverty level and pregnant women with incomes to 250% of poverty.
- Various screenings and immunizations are available through local health departments.
- Substance abuse treatment is available for Medicaid and non-Medicaid clients. However, the treatment systems capacity is not sufficient to meet demand.
- Mental health services are available to all children enrolled in Medicaid and MCHP. Services are also available to low-income families who do not qualify for Medicaid through the State's Specialty Mental Health System.
- Dental care is provided for children through Medicaid/MCHP. However, only 17% of the eligible population utilizes dental services. Low dental rates and a shortage of providers in certain parts of the State are cited as reasons for the appalling utilization rates. Further access problems relate to a lack of dental coverage in many private insurance plans.

The existing programs provide low-income families with access to primary and preventive care through Medicaid/MCHP and local health departments. There are, however, a number of areas where further improvement is needed including:

- **Birth Outcomes:** While Maryland's infant mortality rate dropped in 1999, it remains among the poorest in the nation. The percent of low-birth weight babies rose to 9.1% in 1999 which was Maryland's highest rate in the 1990s and far exceeds the national average of 7.6%. The African American percentage of 13.7% is particularly disturbing and exceeds the national average of 13.1%.
- **Immunizations:** Only about four of every five children have all the necessary immunizations at age two.

Exhibit 10

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Health Programs

<u>Program</u>	<u>Eligibility</u>	<u>Utilization Rate for Eligible Children</u>	<u>Percent of All Children</u>
Medicaid/MCHP	Children with family incomes to 300% of poverty level (200% of poverty until 7/1/01).	132,00 children are covered. Estimates range from 80% to 100% of eligible population is insured.	31%
Infant Screenings	Universal hearing screenings are required.	Screening of at least 85% of newborns is expected in fiscal 2002.	85%
Substance Abuse Treatment	All Medicaid/MCHP recipients and women in seven pilot counties who give birth to drug-exposed infants are eligible for treatment. Any adult can seek treatment through programs funded with State grants. Chapter 551, Acts of 2000 expands services to parents with children in foster care or at-risk of foster care entry.	Data is incomplete. Utilization by Medicaid population has dropped since implementation of Health Choice. Utilization of pilot program has also been lower than anticipated.	n/a
Mental Health	Available to all Medicaid/MCHP enrollees. Additional services offered through specialty mental health system.	Data is incomplete.	At least 31% are funded with public dollars. Private insurance covers additional families.
Oral Health	Medicaid/MCHP provide coverage to children.	Utilization rate by children enrolled in Medicaid is less than 20% .	At least 31% are eligible for public programs. Private insurance covers some other families.
Immunizations	Universal.	81% of two-year-olds receive necessary immunizations. 99% of school-aged children are immunized.	81%

Source: Department of Legislative Services; Department of Health and Mental Hygiene; United States Census Bureau; and Maryland Results for Child Well-being, 2001

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- ***Lead Paint Screening:*** Presently less than a quarter of Maryland's children receive the required blood lead tests at age one and two.
- ***Dental Access and Utilization:*** The Department of Health and Mental Hygiene (DHMH) anticipates significant improvement in fiscal 2002 with 40% utilization of dental care projected for Medicaid/MCHP.
- ***Access to Substance Abuse Treatment:*** There is reportedly a shortage of residential slots for mothers and their young children.
- ***Comprehensive Health Insurance:*** Data compiled by the federal government's Current Population Survey indicates that between 20% and 30% of all Maryland children with family incomes below 200% of poverty were uninsured between 1996 and 1999. This data pre-dates MCHP implementation. No credible data on the uninsured is available for the period after MCHP implementation.

How Is Maryland Doing?

"Mediocre," responded State Superintendent of Education, Dr. Nancy Grasmick when asked by the JCCYF in June 2000 about Maryland's performance in preparing children for school.

Until the release of the Work Sampling System Kindergarten Checklist a few days ago, there was almost no data available to properly evaluate whether Maryland children are entering school ready to learn. Frequently used proxies included performance by third and fifth graders participating in the Maryland School Performance Assessment Program (MSPAP), second grade scores on the Comprehensive Test of Basic Skills (CTBS), participation rates for Head Start, enrollment in a public or private pre-school programs, and utilization of the Infants and Toddlers Program. Other indicators cited by the Subcabinet for Children, Youth, and Families include such things as poverty rates, immunization rates, births to adolescents, and low-birth weight babies.

Existing Measures of Limited Utility

None of the proxies is a good measure of children entering school ready to learn. The proxies can be grouped into three categories, each with its own advantages and disadvantages:

- ***Indirect Predictors:*** Indicators such as immunization rates, low-birth weight babies, and especially poverty may be linked in one way or another to school success, but are of limited utility as a variety of other factors (early childhood experiences, parental education, etc.) will also impact a child's school readiness.
- ***Direct Predictors:*** Participation rates for pre-school, Head Start, and the Infants and Toddler's Program are more directly related to school preparation, but in the final analysis they are really process indicators. Participation in these programs is only meaningful if the programs provide quality

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experiences. Moreover, failure to participate in such programs can be more than overcome by parental influences and/or quality child care experiences.

- **Lagging Indicators:** MSPAP and CTBS scores are the most meaningful measures as they are outcome oriented. However, the lag between school entry and the time these tests are taken makes it difficult to determine if the result should be attributed to the child's preparation for school or the school experience itself. Analysis of this information will be more valuable once data are available on the readiness of children when they enter school. For example with school readiness data available, policy makers will be better able to assess which pre-school programs have the most lasting impact on school performance and which intervention programs produce favorable results for children who entered school trailing their peers.

Kindergarten Assessment

The Work Sampling System Kindergarten Checklist (WSS) was initiated statewide in the fall of 2000. The information collected represents the skills and abilities of kindergarten students as assessed by their teachers in the first few weeks of the school year. To complete each assessment, the teacher rates the child in a number of categories. For reporting purposes, the results from 28 readiness indicators are summarized within seven domains representing:

- social and personal;
- language and literacy;
- mathematical thinking;
- scientific thinking;
- social studies;
- arts; and
- physical development.

MSDE will collect this information on an annual basis allowing stakeholders to evaluate whether Maryland is successful in improving school readiness over time. The data will also allow teachers, schools, and school systems to develop plans for improving services to young children and should allow for more targeting of resources to the specific weaknesses of students in each school/school system.

To allay fears that teachers or schools would inflate the scores of their students out of concern that the results would be used to make judgements about the school, MSDE is using a representative sample of children from each county in reporting the results. The sample size reflects one-third of the students taking the test in most counties. Exceptions are eight jurisdictions which required a transition year and did not assess every child. Five large jurisdictions (Anne Arundel County, Baltimore City, Baltimore

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County, Frederick County, and Prince George's County) limited the assessment to a random sample of students representing one-third of all kindergarten enrollees. Three other counties (Queen Anne's, Harford, and Howard) limited the assessment to students in specific schools. Thus, the sample for these three counties is not representative and should not be used as a baseline against which to compare future results.

The results for the first year of the assessment are presented in **Exhibit 11**. The data from this initial effort will serve as a baseline against which to measure future performance. With only one year of data, it is difficult to draw conclusions about how children are doing as there is no standard for the percentage of children who it is reasonable to expect will be ready in each domain.

Exhibit 11

Work Sampling System - Statewide Trends*

<u>Domain</u>	<u>Full Readiness</u>	<u>Approaching Readiness</u>	<u>Developing Readiness</u>
Social and Personal	48%	42%	10%
Language and Literacy	35%	48%	17%
Mathematical Thinking	35%	51%	14%
Scientific Thinking	21%	60%	20%
Social Studies	34%	57%	9%
The Arts	43%	51%	6%
Physical Development	51%	44%	5%
Composite Score	40%	50%	10%

*For reporting purposes, children are assessed as fully ready (demonstrate most skills necessary to succeed in kindergarten), approaching readiness (skills and abilities may require targeted support), or developing readiness (considerable support is required to be successful in kindergarten). To determine within which of the three categories to place a child, a rank from one to three with three being the highest was given for each of four readiness indicators within a domain.

Note: Numbers may not add to total due to rounding.

Source: Maryland State Department of Education

Using the results from the first year of the assessment as a baseline is also problematic as this is the first time many kindergarten teachers have performed such assessments. Despite the training which MSDE provided to about 1,300 teachers and detailed instructions for completing the assessment, there will likely be significant variations among teachers. As teachers become more comfortable with the assessment instrument, there may be more standard results across classrooms. Until then, it will be difficult to determine whether variations in the results from year-to-year reflect changes in the preparation of students or changes in the way the assessment is performed.

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A number of points can be made about Exhibit 11:

- Overall composite scores indicate mediocre performance with 40% of children deemed ready, 50% identified as requiring some supports to succeed in kindergarten, and 10% requiring considerable support to succeed in kindergarten.
- Students were especially unprepared in terms of scientific thinking with only 21% assessed as ready and 20% needing considerable assistance.
- Assessments of physical development and social/personal skills were the most favorable with about half of the children identified as ready.
- While information was collected by ethnicity, gender, and early childhood experience (Head Start, EEEP, family day care, etc.), most of the data were incomplete at the time of writing due to a variety of coding problems including teachers selecting more than one form of prior care or leaving this section blank.

Jurisdictional data are presented in **Exhibit 12**. A number of points can be made about the variation among localities including:

- Wide variations are evident across the State. Talbot County has the highest percentage of students deemed school ready at 76% while Baltimore City and has the lowest percentage at 16%.
- Dorchester County reports a wide variation in school readiness with 55% of students assessed as school ready (fourth highest in the State) and 18% assessed as developing readiness (the highest in the State).
- Counties with high levels of pre-school enrollment tended to have a high percentage of their students assessed as achieving a level of readiness. However, this pattern was not observed universally.
 - Kent County, which has the largest percentage of children ages two to four enrolled in public pre-school, has the third highest percentage of children assessed fully proficient and had only 4% of its students assessed as developing readiness (the lowest in the State).
 - There are four counties in the State where more than one-third of children ages two to four attended pre-school (public or private) in the 1999-2000 school year (Baltimore, Howard, Montgomery, and Talbot). Two of the four counties (Howard and Talbot) ranked first and second in the percentage of students assessed as fully ready. Less impressive results were demonstrated by the Baltimore County (21%) and Montgomery County (47%) where less than half of the students were assessed ready to learn.
- Not surprisingly, there appears to be a link between low child poverty rates and school readiness. High poverty rates, however, do not always seem to predict low levels of school readiness.

Exhibit 12

Composite Scores by Jurisdiction

<u>County</u>	<u>Full</u>	<u>Approaching</u>	<u>Developing</u>
Allegany	50%	46%	4%
Anne Arundel	45%	48%	8%
Baltimore City	16%	77%	6%
Baltimore	21%	68%	11%
Calvert	43%	47%	10%
Caroline	26%	58%	16%
Carroll	53%	44%	3%
Cecil	38%	43%	18%
Charles	32%	59%	9%
Dorchester	55%	27%	18%
Frederick	47%	45%	8%
Garrett	49%	43%	9%
Harford	n/a	n/a	n/a
Howard	59%	36%	5%
Kent	58%	38%	4%
Montgomery	47%	46%	8%
Prince George's	31%	52%	17%
Queen Anne's	n/a	n/a	n/a
St. Mary's	36%	55%	10%
Somerset	19%	65%	17%
Talbot	76%	18%	6%
Washington	55%	35%	10%
Wicomico	53%	42%	5%
Worcester	31%	56%	13%

Note: Numbers may not add to total due to rounding.

Source: Maryland State Department of Education

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- The percent of students assessed fully ready exceeded the State average in every county in the State with a child poverty rate below 10%.
- The six jurisdictions with the highest child poverty rates in the State, showed mixed results on the assessment. Somerset County and Baltimore City have the highest child poverty rates in the State and the fewest students fully ready. Dorchester, Allegany, and Garrett counties, in contrast, ranked fourth, eighth, and ninth respectively in terms of students assessed as fully ready despite experiencing very high rates of child poverty.
- Some counties with low third grade MSPAP scores actually reported that most students enter school ready to learn. However, there was generally a correlation between MSPAP scores and school readiness.
 - Talbot County's third grade MSPAP scores are among the worst in the State yet 76% of children entering kindergarten in the fall of 2000 were assessed fully ready.
 - Dorchester County's experience is similar to that in Talbot with 39% of third graders scoring at the satisfactory level on MSPAP, but 55% of kindergarten students assessed as fully ready.
 - Most children in Baltimore City, Somerset County, and Prince George's County do not appear to enter school ready to learn. These localities are also the three poorest performing jurisdictions in terms of MSPAP scores.
 - The counties with the highest third grade MSPAP scores (Kent and Howard) ranked second and third in terms of students fully ready for school.

CTBS and MSPAP Scores Also Mixed

Trends in lagging indicators (**Exhibit 13**), like the findings of the kindergarten assessment, demonstrate mediocre overall performance. MSPAP scores for third and fifth graders are poor with less than 50% of students scoring at the satisfactory level and only minimal improvement in recent years. The percentile rank of Maryland students on the CTBS, however, has risen and now exceeds 50%.

The WSS results combined with the MSPAP and CTBS scores suggest that many Maryland school children enter school without the proper preparation and exhibit mediocre performance during their first few years of school. The explanation for these results may be found in national studies on kindergarten readiness as well as proxy indicators for Maryland.

Exhibit 13

**Trends in Education Indicators
Fiscal 1996 through 2000**

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>
MSPAP Scores					
Third Grade Composite Index	38%	40%	43%	42%	43%
Fifth Grade Composite Index	43%	43%	46%	45%	47%
Second Grade CTBS (National Percentile Rank)					
Reading		45		46	55
Language		39		40	55
Mathematics		53		43	53
Language Mechanics		45		54	60
Mathematics Computation		49		49	68

Source: Maryland State Department of Education

National Research Links Success in Kindergarten to Specific Characteristics

A February 2000 report from the National Center for Education Statistics identifies the family characteristics which seem to correlate with success in kindergarten. Findings include:

- Children's performance in reading, mathematics, and general knowledge increases with the level of their mothers' education. Kindergartners whose mothers have more education are more likely to score in the highest quartile in reading, mathematics, and general knowledge than all other children.
- Kindergartners from two-parent families are more likely to score in the highest quartile in reading, mathematics, and general knowledge than children from single-mother families. This is a significant issue in Maryland as about 70% of the children born each year in Baltimore City are borne to a single mother and almost 30% of children in Maryland live in a single-parent household.
- Students who are welfare recipients, members of single parent families, or the child of a mother without a high school diploma have more difficulty forming social attachments than other children.
- Children who received public assistance were less likely to exhibit excellent general health than other children.

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- The likelihood of a parent reading to a child every day and participating in other activities which should positively impact a child's development rose with the mother's educational level. Family type and receipt of public assistance were also linked to reading to the child on a regular basis.
- Almost 80% of children entering kindergarten received care from a non-family member on a regular basis. About half of the children in kindergarten receive care from a non-family member before or after school.

Creating quality early childhood experiences: (1) targeting disadvantaged families, (2) encouraging parental involvement; and (3) reducing high school drop-out and adolescent pregnancy rates appear to be the most promising solutions to the differential in outcomes highlighted in the study.

Why Are Maryland Children Not Entering School Ready to Learn? -- Trends in Proxy Indicators

Despite recent improvements in the trends for many of the proxy indicators depicted in **Exhibit 14**, many children still face significant barriers to school readiness which considered in the context of national studies help to explain the poor school preparation identified by the WSS:

- 19% of children do not have the proper immunizations at age two;
- 9% of all births are low-birth weight infants;
- 16% of children are born to families in poverty;
- 43 of every 1,000 children are born to a teen mother;
- 40% of the eligible children are not enrolled in Head Start; and
- less than one in three children between the ages of two and four participate in pre-school.

The good news is that many of the indicators are moving in a favorable direction. Child poverty rates, abuse/neglect rates, and births to adolescents have all dropped since 1996. The decline in the poverty rates and to some extent the rate of abuse/neglect is attributed to the strong economy, the advent of the Maryland's refundable earned income tax credit, and the success of welfare reform. These trends may well turn upward in the next year as the cash assistance rolls are no longer shrinking and the economy is showing signs of slowing down. The reduction in the births to adolescents is consistent with national trends and is expected to continue over the next few years.

Exhibit 14

**Trends in Other Indicators
Fiscal 1996 through 2000**

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>
Immunization Rates	80%	82%	79%	81%	
Child Poverty ⁽¹⁾	16.3%	15.2%	12.2%	8.9%	
Births to Adolescents (Per 1,000 Women Ages 15 to 19)	46.0	43.9	42.8	42.5	
Abuse/Neglect (Indicated and Unsubstantial Per 1,000)	13.2	13.3	12.3	12.6	12.1
Low Birth Weight Infants	8.6%	8.8%	8.7%	9.1%	
% of Two- to Four-year-olds Enrolled in Pre- school	27%	28%	28%	29%	29%
High School Drop Out Rates	4.6%	4.7%	4.1%	4.2%	3.9%
% of Children Tested Who Have an Elevated Blood Lead Level ⁽²⁾	16.5%	11.6%	8.6%	n/a	

⁽¹⁾Three-year average of data drawn from Current Population Survey.

⁽²⁾Calendar year.

Source: Department of Legislative Services

Proposed Budget

As shown in **Exhibit 15**, the dollars identified with this school readiness analysis in the fiscal 2002 allowance increase by \$9.2 million, or 10.4%, over fiscal 2001. Major changes within each of the identified strategies are also identified in the exhibit. To the extent that they impact the ability of the State to implement its strategies to improve school readiness, these changes will be discussed below.

Two general points can be made about the change from fiscal 2001 to 2002. Both involve funding sources:

- There is no change in the extent of Cigarette Restitution Fund (CRF) dollars supporting fiscal 2002 programming. \$7 million in CRF dollars continues to support the Judy Centers as well as school readiness and accreditation programming. The additional \$5 million provided for Judy Center expansion and additional accreditation support in fiscal 2002 is all general funds and accounts for virtually all of the general fund expansion associated with this group of programs.

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- Two of the initiatives -- the Office of Credentialing and the expansion of home visiting programs -- are funded through federal Temporary Assistance for Needy Families (TANF) funds. It should be noted that DLS has expressed concern that the level of spending with TANF dollars throughout the budget is unsustainable.

Exhibit 15

**Children Entering School Ready To Learn
Fiscal 2000 to 2002
(\$ in Thousands)**

	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>\$ Change</u>	<u>%</u>
	<u>Actual</u>	<u>Appn.</u>	<u>Allow.</u>	<u>FY 01-02</u>	<u>Change</u>
					<u>FY 01-02</u>
Improve Quality of Child Care and Early Childhood Experience	\$15,201	\$19,379	\$24,397	\$5,018	25.9%
Child Care Regional Operations	9,028	9,192	9,337		
Child Care Resource Center Network	4,462	4,462	5,262		
MSDE Quality Initiative (Maryland Model for School Readiness (MMSR); Accreditation etc.)		3,000	4,000		
Office of Credentialing	0	0	2,323		
Other	1,711	2,725	3,475		
Increase Access to Early Childhood Experiences	\$37,011	\$41,519	\$45,591	\$4,072	9.8%
EEEP	19,263	19,263	19,263		
Infants and Toddlers Program	6,977	6,960	7,058		
Preschool Special Education	6,319	6,742	6,319		
Judy Centers	0	4,000	8,000		
Head Start	2,500	3,000	3,000		
Other	1,952	1,554	1,952		
Support Families with Young Children	\$9,380	\$16,018	\$17,364	\$1,346	8.4%
Family Support Centers	5,896	6,550	6,550		
Home Visiting (Local Management Boards)	0	5,000	5,950		
Other	3,484	4,468	4,864		
Increase Access to Health Care and Early Childhood Health Screening	\$9,999	\$11,301	\$10,021	(\$1,280)	(11.3%)
Hereditary Disorders	1,440	4,280	4,123		
Immunizations	3,452	4,077	3,367		
Children's Medical Services	4,305	2,154	1,720		
Other	801	789	810		

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Total	\$71,590	\$88,217	\$97,374	\$9,156	10.4%
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Where it Goes:

Improve Quality of Child Care and Early Childhood Experience

Office of Credentialing	2,323
Expansion of support for voluntary program accreditation	1,000
Contract increase for the Child Care Resource Center Network to allow for increased data collection and making referrals to parents seeking after-school programs	800
Child Care Administration personnel costs	472

Increase Access to Early Childhood Experiences

Judy Center expansion	4,000
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Support Families with Young Children

Home visiting expansion	950
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Increase Access to Health Care and Early Childhood Health Screening

Reduction in federal immunization funding	(710)
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Other	321
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Note: Numbers may not sum to total due to rounding.

Source: Department of Legislative Services

Improve Quality of Child Care and Early Childhood Experiences

Exhibit 16 demonstrates the goals and objectives supporting the strategy to improve quality of child care and early childhood experiences.

Exhibit 16

Quality of Child Care and Early Childhood Experiences

<u>Goal</u>	<u>Objectives</u>	<u>Funding Estimate</u>
Promote voluntary national or State accreditation of programs (MSDE).	By fiscal 2005, 30% of all early care and education programs have received national or State accreditation.	Fiscal 2002 -- \$1.8 million Fiscal 2003 through 2005 -- \$3.4 million per year
In fiscal 2002, initiate a credentialing program to support the professional development of child care providers and the accreditation of family child care homes and centers (DHR).	By fiscal 2002: <ul style="list-style-type: none"> • provide financial assistance to 2,695 child care providers to access approved, quality training; • provide training to 350 experienced child care professionals to mentor less experienced child care providers seeking accreditation; • provide cash rewards to 3,000 child care providers for achieving advanced levels of education and experience; and • provide financial assistance to 180 child care facilities pursuing accreditation. 	Fiscal 2002: \$750,000 Fiscal 2002: \$105,000 Fiscal 2002: \$735,000 Fiscal 2002: \$163,500
Encourage adequate compensation for early care and education providers.	Develop a tiered reimbursement system in fiscal 2002.	Fiscal 2002: \$1.9 million
Contract with agencies having specific expertise to offer ongoing training in a variety of settings and subjects.	No specific objectives. But, the Child Care Administration has almost 30 contracts with organizations that have specific expertise in child care and child development. CCA also has a contract with the Maryland Committee for Children to operate the Training Clearinghouse.	Fiscal 2002: \$1.9 million (does not include contract for Maryland Child Care Resource and Referral Network)
Establish effective models of professional preparation and development, coordinated by institutions of higher education.	Establish six pilot sites that would replicate the Professional Development Schools (PDS).	Fiscal 2002: \$0

CCA - Child Care Administration

Source: Subcabinet for Children, Youth and Families

Provider Credentialing and Program Accreditation

Two major initiatives designed to support this strategy are underway: provider credentialing and program accreditation. These two initiatives provide a systematic way to assure quality care for young children by ensuring child care providers have acquired a recognized level of early childhood education and training. Currently, only 4.5% of programs in Maryland are accredited (90 child care centers); no family child care providers are accredited. According to data collected by the National Association for the Education of Young Children (NAEYC), Maryland ranked 37th among the 50 states in 2000 for the number of accredited child care programs.

Beginning July 1, 2001, child care providers can participate in the Maryland Child Care Credential system. Under this system, family day care and center care staff will obtain a “core body of knowledge” in early childhood education through college course work and training. **Appendix 3** describes in more detail the core body of knowledge. Currently, staff must meet continued training requirements that are measured in clock hours and are not tied to specific skills or coursework. This system will ensure a systematic, quality level of child care. It will also encourage professionalism and career advancement by rewarding further education and experience with higher credential attainment. Participation is completely voluntary. **Exhibit 17** shows the four levels of credential attainment and the two advanced levels for providers with a college degree.

The Maryland Child Care Credential system will be run out of the newly created Office of Credentialing, in DHR’s Child Care Administration. Among its responsibilities, the office will have a tracking system to monitor provider accomplishments and assist providers in determining the appropriate level of course work or experience needed to attain a higher credential level. In addition, the office will administer a mentor training program for experienced providers so that they can assist inexperienced providers seeking accreditation. Moreover, the office will administer a public awareness campaign to educate providers and parents about the new system.

Building upon DHR’s credentialing system, MSDE will administer the State accreditation of center care and Head Start programs. This initiative will encourage child care programs to seek State or national recognition for their ability to provide quality educational care to young children. In addition, the accreditation process will assist parents in their search and selection of child care programs. Accreditation status, as well as higher credential levels, can serve as a signal to parents that the programs will provide an educational environment for children.

MSDE’s accreditation project for child care providers is an extension of its current program that provides free State validation of pre-kindergarten and kindergarten programs. The department has already prepared its “*Standards for Implementing Quality Early Childhood Education Programs*” tool to help programs through the accreditation process, which involves a self-appraisal and validation by State selected validators. MSDE will provide technical and financial assistance to providers to help offset the cost of supplies and materials. DHR’s Office of Credentialing will also help defer the cost of achieving national accreditation through grants to center and family day care providers.

Exhibit 17

Maryland Child Care Credential

Level One - Entry		Career Lattice	
		Position(s) Qualified For	Additional Requirement(s)
Child Care Administration Requirements		Family Child Care Provider Aide Assistant Group Leader	None None None
Level Two			
45 clock hours core of knowledge training	12 clock hours annual training	Family Child Care Provider Assistant Group Leader Group Leader	None None 400 hours of experience or college
1 Professional Activity Unit			
Level Three			
90 clock hours core of knowledge training	18 clock hours annual training	Family Child Care Provider Senior Staff Preschool Center Director School Age Center Director	None 1 yr of experience or college 1-2 yrs experience, college course work 400-800 hours of experience
2 Professional Activity Units			
1 year of experience or 1 year of college			
Level Four			
135 hours core of knowledge training	24 clock hours continuing training per year	Family Child Care Provider Senior Staff-Infant Option Preschool Center Director Preschool Center Director/Infant School Age Center Director	None 1 yr of experience or college 1-2 yrs experience, college course work 1-2 yrs experience, college course work 400-800 hours of experience
3 Professional Activity Units			
2 years of experience			
Advanced Level A-One			
Associates Degree with a minimum of 15 semester hours of approved core of knowledge coursework		24 clock hours annual training	
4 Professional Activity Units			
2 or more years of experience			
Advanced Level A-Two			
Bachelor's, Master's, or Doctorate Degree in early childhood education or elementary education (*Any degree must include coursework that meets the requirements of the 90 hour course for preschool and/or school- age)		24 clock hours annual training	
5 Professional Activity Units			
2 or more years of experience			

Source: Department of Human Resources

Financial Incentives To Encourage Credentialing and Accreditation

Tiered Reimbursement

A number of financial incentives will be provided by DHR and MSDE to encourage participation in the voluntary credentialing and accreditation process. One of the largest financial assistance tools is the tiered reimbursement system. As providers meet the requisites for higher levels of credential, providers receive a higher rate of reimbursement for each child in their care using POC. **Appendix 4** demonstrates the relationship between the credential levels and reimbursement. Approximately \$1.9 million of the fiscal 2002 POC appropriation will be used toward the tiered reimbursement system.

Exhibit 18 shows the differential rates that providers will receive based on their level of credential. As a provider moves up the credential ladder and attains accreditation status at level 4, the provider will receive a higher reimbursement rate for each child served by the POC program.

Exhibit 18

Summary of Tiered Reimbursement Cost Differential by Levels and Type of Care

Reimbursement Levels	Center Care Infant	Family Care Infant	Center Care (2 Years to 13 Years of Age)	Family Child Care (2 Years to 13 Years of Age)
1*	0.0%	0.0%	0.0%	0.0%
2	21.6%	10.7%	9.5%	10.3%
3	36.7%	21.5%	19.0%	20.7%
4	43.8%	29.2%	25.7%	27.9%

Notes: The differential at each level is based on the age of the child and whether care is provided in a child care center or a family care home. The percentage differential payment, which is applied to a child's subsidy rate, is modeled on Oklahoma's tiered reimbursement system.

*There is no cost differential offered at the first level, which is equivalent to meeting child care licensing standards.

Source: Department of Human Resources

Exhibit 19 demonstrates an example of what a provider may receive, given different credential levels and type of care provided.

Exhibit 19

**Tiered Reimbursement -- Hypothetical Examples of
Monthly POC Care Quality Differentials
Fiscal 2002**

Family of Three in Baltimore City: \$17,000 Annual Income	Level 1 State Subsidy*	Level 2 Differential	Level 3 Differential	Level 4 Differential
Preschool Child in a Child Care Center, First Child	\$315	\$30	\$60	\$81
Child Under Two in a Family Child Care Home	331	35	71	97

Notes: *Based on current rates.

On average, providers qualified to receive tiered reimbursement will receive a monthly differential payment of \$55.00/child above the child's POC rate (overall average, statewide).

Source: Department of Human Resources

Financial Assistance Grants

In addition to the tiered reimbursement system, DHR will provide financial assistance grants to encourage providers to achieve higher levels of credentialing. In fiscal 2002 the Office of Credentialing will provide approximately \$750,000 in training vouchers to an estimated 2,695 providers to take college course work, to attend workshops, or to attend conferences. Also, the Office will provide \$735,000 in bonus grants to an estimated 4,200 providers when they attain higher levels of credentialing. Awards will be \$200, \$300, and \$500 for achieving credential levels two, three, and four respectively.

Both DHR and MSDE will provide assistance for providers seeking accreditation. MSDE will fund enhancement grants to private providers to help offset the cost of applications for accreditation and development of child care programs in order to achieve accreditation status. Funding will also offer professional and staff development activities leading to increased competency and credential attainment. Accreditation support has already begun in MSDE. In fiscal 2001 MSDE issued 22 enhancement grants, which will help 86 separate providers achieve accreditation.

Exhibit 20 shows new funds in the fiscal 2002 budget associated with the strategy to improve the quality of child care and early childhood experiences.

Exhibit 20

**Improving Quality of Child Care and Early Childhood Experiences
Fiscal 2002 Budget**

<u>Program</u>	<u>Fiscal 2002 Funding Level</u>
Credentialing	
Office of Credentialing*	
New Personnel (7) and Overhead	\$277,938
Mentoring System*	105,000
Public Awareness Campaign*	250,000
Credential Tracking System*	350,000
Financial Incentives	
Training Vouchers*	750,000
Provider Bonus*	735,000
Tiered Reimbursement*	1,900,000
Accreditation	
National Accreditation Support* -- DHR	163,500
Enhancement Grants -- MSDE	1,500,000
Total	\$6,031,438

*100% Federal Funds

Source: Department of Human Resources; Maryland State Department of Education

The strategy to improve childhood experiences appears to have a long-term focus. Should providers participate in the credentialing and accreditation systems, the State can anticipate the level of care being provided to improve. Moreover, the strategy seeks to enhance the support provided to early childcare programs and providers. This will infuse a sense of professionalism among early child care providers and programs. However, four major issues regarding this strategy arise:

- Are the financial incentives high enough to encourage accreditation and credentialing?
- Is there a seamless system of accreditation?
- Does the strategy target those most in need of quality care?
- Do the financial incentives provide adequate compensation to providers?

Financial Incentives -- Are They Enough to Encourage Credentialing and Accreditation?

Tiered reimbursement will help make high-quality programs more accessible to families with low incomes. Also, programs that participate in tiered reimbursement can indirectly improve quality of care for children in the program that do not receive subsidies. The key issue, as experts have found, is whether the differential rates are high enough to encourage voluntary accreditation or credentialing? Moreover, how far reaching are the positive impacts of the tiered reimbursement system throughout all types of child care providers and families of different income levels?

Tiered reimbursement systems have been developed throughout the nation as a tool to encourage providers to become credentialed or accredited. At least 18 states have tiered reimbursement programs linked to accreditation with varying differential rates, as shown in **Exhibit 21**. However, recent research on the impact of these financial incentive systems show that a 15% rate differential is the threshold at which providers seek out accreditation.

Maryland's tiered system will be based on Oklahoma's and provides differential rates based on credential level and type of care provided. For the most part, CCA's planned differential rates are 15% or more. However, family care for infants up through 13-years of age and center care for two- through 13-years of age are less than the 15% differential rate. Comparing research to Maryland's tiered reimbursement system, it would appear the differential rates are enough to encourage providers to seek higher credential levels and accreditation status.

Is There a Seamless System of Accreditation Support between DHR and MSDE?

As noted above, both DHR and MSDE will provide accreditation support for child care providers. Both have worked into their system a set of grants to help center-based and family child care providers achieve accreditation status. Also, MSDE has developed a State accreditation process free of charge for center-based child care and Head Start programs. However, family child care providers are not eligible for the free State accreditation process.

Because Maryland will not have an accreditation system for family child care providers, those family child care providers seeking accreditation (and higher tiered reimbursement rates) will have to obtain national accreditation. Currently, there is one nationally recognized family day care accreditation organization -- the National Association for Family Child Care (NAFCC). For family day care providers, this will be the only avenue to become accredited. As a result, while center care providers have the option to become State accredited for free through MSDE, family day care providers will have to pay an application fee. The total cost of becoming accredited by the NAFCC is \$495.

Exhibit 21

States with Tiered Reimbursement

<u>State</u>	<u>Date of Adoption</u>	<u>Differential Reimbursement Rate</u>
Arizona	July 1999	10%
Florida	July 1998	20%
Hawaii	November 1999	7%
Kentucky	October 1997	10% - 15% *
Louisiana	February 1993	10%
Minnesota	July 1984	10%
Mississippi	October 1997	10%
Missouri	September 1999	20%
Nebraska	January 1998	20%
New Jersey	January 1998	5%
New Mexico	July 1997	12% - 17% *
Ohio	October 1997	5%
Oklahoma	February 1998	10% - 42% (9% - 47% in 2000)
South Carolina	April 1992	26% - 28% *
Texas	September 1999	5% ***
Utah	January 1999	10%
Vermont	July 1994	15%
Wisconsin	March 1997	10%

*These states have varying rate increases depending on age of children and location of centers. The rates here refer only to centers providing full-time care.

**Oklahoma has a three-star system: one star refers to the base rate; two stars are awarded to an accredited facility or meets state quality standards; and three stars are awarded to a facility that is accredited and meets state quality standards.

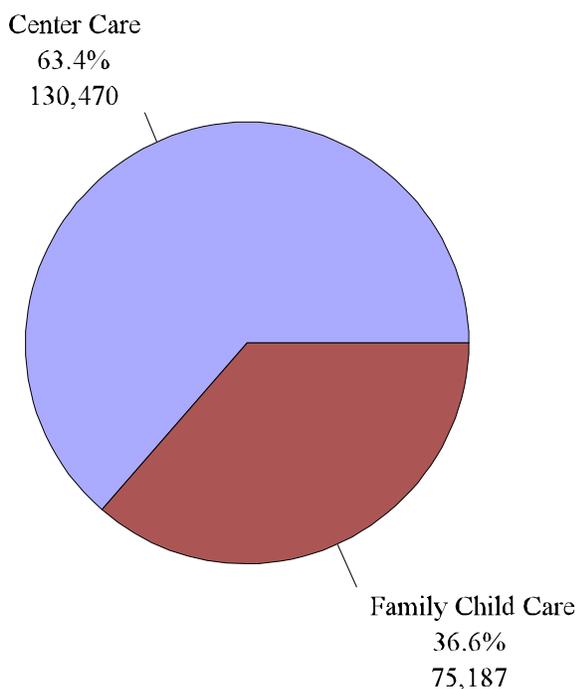
*** The Texas reimbursement rate differential is set at the discretion of regional Workforce Commissions. Five percent is the minimum required rate increase.

Source: *Differential Reimbursement and Child Care Accreditation*, Dr. William T. Gormley, Jr., Working Paper, Georgetown University, Public Policy Institute, August 11, 2000

Exhibit 22 shows the breakdown of regulated care capacity by type. Over a third of the regulated child care slots are in family child care. Because family child care providers generally have limited resources, if the financial incentives are not great enough, they may be less likely to become accredited. This could potentially set up a bifurcated system where children in center-based care are in higher quality care than those in family day care.

Exhibit 22

Regulated Child Care Capacity in Maryland (Regulated Slots as of September 2000)



Source: Department of Human Resources, Child Care Administration

The subcabinet should address how their accreditation support will create a seamless system across types of care. In addition, the agencies should discuss to what extent their financial grants will help family day care providers achieve national accreditation status. Given the backlog the national child care center accrediting bodies have been facing, particularly the NAEYC, the subcabinet should address whether NAFCC is capable of handling a large influx of family child care accreditation applications.

Does Strategy Target Those Most in Need?

Similar to the concern that there will be a difference of quality among types of early childhood programs, there is concern that there will be variations of quality among programs that serve families of different income levels. In particular, programs that traditionally serve low-income families may not receive adequate support or incentives to provide quality care.

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As part of its Early Childhood Accreditation Project, MSDE has set a goal that by fiscal 2005, 30% of early care and education programs will be nationally or State accredited. DHR expects that in fiscal 2002, 8% of children in the POC program will be served by providers who have achieved credential level 2; in fiscal 2003 and 2004 this number will grow to 15%. But, in fiscal 2003 and 2004, only 1% and 3% of POC children will be served by providers with a fourth level credential. Level 4 is the level at which providers have achieved accreditation status. Thus, while MSDE estimates that 30% of all early childhood programs will be accredited by 2005, DHR estimates that only 3% of children in POC will be served by accredited providers.

This raises the issue of how broadly MSDE and DHR are thinking in their strategy to improve early childhood experiences. While MSDE and DHR want to improve the quality of care in all programs, estimates demonstrate that those families that need quality care the most -- the low-income families -- will not benefit as greatly compared to programs serving middle to high income families. Will this establish a system where those programs that become accredited serve middle and high income families, while a very limited number serve low-income families?

Is Tiered Reimbursement Enough?

According to child care experts and national organizations, public policies aimed at improving the quality of child care and early childhood experiences must take a holistic approach. Accreditation and credentialing are only pieces of the puzzle that create a comprehensive quality early childhood system. A major component that cannot be ignored is adequate child care provider compensation and benefits. Training child care providers to become professional early childhood educators through credentialing and accreditation will have little impact on the quality of care if providers can be paid higher salaries elsewhere.

Research has shown that turnover rates are high in the child care profession and for the most part are attributed to low compensation and little or no benefits. As shown in **Exhibit 23**, in Maryland, child care providers earn less than half the annual salary of public school teachers; child care center aides earn just above the minimum wage. A combination of high turnover rates and low compensation has a significant impact on the quality of care provided. Children become attached to providers at young ages; when there is high turnover, children have difficulties adjusting to their environment. Moreover, high turnover results in inconsistent levels of training and gaps in experience among providers.

In its reports to the JCCYF, the subcabinet recognized that an investment in child care credentialing and accreditation should be accompanied by adequate provider compensation. To address this issue, the subcabinet recognized the tiered reimbursement system as the objective to achieve the goal of adequate compensation for providers. Yet, the tiered reimbursement system would help raise compensation rates for only a limited number of child care providers or programs. As noted already, tiered reimbursement is tied to children in the POC program. Providers serving POC recipients represent only a portion of all providers and programs. Moreover, tiered reimbursement may only offset the cost of becoming credentialed or accredited. The financial incentive may not be enough to also bring salaries up to the same level as public school teachers. Although the tiered reimbursement system is a step in the right direction, it is only one of several steps that must be taken to address the issue of adequate compensation.

Exhibit 23

**Salaries of Child Care Workers and Public School Teachers
1999-2000**

	<u>Salary</u>
Public School Teacher (1998-1999)	\$42,545 (avg.) 27,605 (starting salary)
Nonpublic School Teacher Average	35,524
Family Child Care Provider	18,503
Child Care Center Director	26,571
Center Senior Staff/Teacher	16,957
Center Aide	11,688

Source: Department of Legislative Services and Maryland Committee for Children

The subcabinet should address what is the role of public policy in providing adequate compensation to child care providers. Also, the subcabinet should address whether the financial incentives will be enough to sustain quality care providers in the profession once they become credentialed or attain accreditation status.

Increase Access to Early Childhood Experiences

Exhibit 24 details the Subcabinet's strategy for increasing access to early childhood experiences. The strategy raises a number of interesting issues:

- Should the State be developing targeted or universal access programs?
- What makes for a successful early childhood program?
- Can successful model programs be replicated on a large-scale?
- What does all this say of our efforts in this area to date and the proposals made in the strategy?

Exhibit 24

Strategy -- Increase Access to Early Childhood Experiences

<u>Goal</u>	<u>Objective</u>	<u>Funding Estimate</u>
Establish voluntary pre-kindergarten for all four-year-olds, statewide, regardless of income.	By fiscal 2005, all four-year-old children in Maryland will have access to quality pre-kindergarten programs.	If implemented over four years (fiscal 2002 to 2005), this would require up to an additional \$23 million per year. No specific funding is provided in the allowance.
Work towards full day programs in kindergarten, and wrap around services for three- and four-year-olds to create full day programs.	By fiscal 2005, 40% of the targeted population would have high quality, comprehensive, publicly funded, full-day early care and education services and family support services.	If implemented over four years (fiscal 2002 to 2005), this would require an additional \$11 million per year, and would build on existing Judy Centers. The fiscal 2002 allowance increases Judy Center funding by \$4 million. There is another \$19 million in the education budget which could be used for at least part of this purpose.
Expand services for at-risk three-year-olds.	By fiscal 2005, all at-risk three-year-olds (based on free and reduced price meal eligibility) would have access to high quality early education programs.	If implemented over four years (fiscal 2002 to 2005), this would require an additional \$11.5 million per year. There is no funding in the fiscal 2002 allowance for this purpose.

Source: Subcabinet for Children, Youth, and Families

Should the State Be Developing Targeted or Universal Access Early Childhood Programs?

The strategy outlined by the subcabinet contains both universal access to early childhood programs (voluntary pre-kindergarten for all four-year-olds, regardless of income), as well as more targeted wrap-around programming and programming for at-risk three-year-olds. The issue of targeted versus universal early childhood programming raises numerous points of debate:

- Developing a universal access pre-kindergarten program for four-year-olds, for example, would offer a large subsidy for many middle income as well as lower income families. Exhibit 9 noted that almost

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80% of all kindergarten students are in publicly funded programs. However, what is known about pre-kindergarten programs suggests that more children are served in private than public programs.

- Given the fact that the benefits of a universal access pre-kindergarten for four-year-olds offers a benefit to a greater slice of families, developing public support for such a program versus more targeted programming could be easier.
- The extent of existing private involvement in pre-kindergarten programming for four-year-olds raises questions about how the State would best develop a system which takes advantage of, rather than supplanting, the existing programming. According to MSDE, other states such as New York offer a model for this allowing local school systems to subcontract for accredited services.
- The impact of early intervention has often been found to be disproportionately larger for more disadvantaged children, which provides a rationale for targeting such programs to these children. Similarly, more disadvantaged children suffer disproportionately from exposure to low quality care.
- Targeting remains an imprecise concept and there are a number of different ways of identifying at-risk children. For example, existing State pre-kindergarten programming has different eligibility criteria: EEEP eligibility is determined locally in accordance with State guidelines, guidelines which make children who have limited English proficiency, are homeless, or prior enrollment in Head Start or Even Start automatically eligible and then gives priority to children with a variety of health or other family conditions. Judy Centers are not limited to at-risk communities although preference is given for centers operating in Title I schools and Hot Spot communities. Head Start eligibility (predominantly federally funded) is limited to children from families with incomes below the federal poverty limit (FPL). The subcabinet strategy identifies developing programming for at-risk three-year-olds based on free and reduced price meal availability (free meals are for children from families below 130% FPL, reduced meals 185% FPL).

Interestingly, a number of researchers agree that targeting resources, especially in the context of limited budgets, is the best strategy. Yet, they argue, targeting should not be only on the basis of income, but should also take into consideration should factors as the risk of abuse and neglect, lack of maternal education, and limited English-proficiency.

What Makes for a Successful Early Childhood Program?

As noted earlier, much recent effort has gone into evaluating early childhood programs to discover what works. Key program design questions include: whether programs should concentrate on both the child and the parents or just the child; at what point intervention is best, infancy or closer to pre-kindergarten; what interventions should be included; what service intensity should be offered; what service quality criteria should be established (staff to child ratios, training qualifications, resources, and so forth).

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Interestingly, the RAND study *Investing in Our Children*, concluded that we really do not know why successful programs work, but there appear to be some common components which are suggestive of successful programs including: more intensive interventions (all-day, year-round); quality trained providers; and quality interactions through, for example, small group size.

Can Successful Model Programs Be Replicated on a Large-scale?

While there is research evidence for the long-term benefits of early childhood intervention programs, much of this research is based on small-scale model programs. Thus, it is legitimate to ask whether these programs can be replicated on a larger scale. Questions about "scaling-up" revolve around:

- Funding adequacy -- for example, many of the model programs spend two to three times per child what Head Start spends.
- Staff quality -- one of the more common components of the model programs is qualified staff, typically remunerated at a level equivalent to surrounding public school systems thereby facilitating staffing quality and consistency. These staff may also have an additional motivation to show that the program "works."
- Program consistency across multiple sites.
- How far to scale up, which goes back to the targeting issues noted above.

Most research on large-scale early childhood public programs such as Head Start, point to some positive gains from the program, but they are neither as deep or as lasting as the model programs. This reflects funding differentials and resulting differences in teacher quality. However, the same research also notes that Head Start enrollees do better than children in more traditional child care settings. But this may speak as much to the lower quality of childhood experiences in those settings.

What Does All This Say of Our Efforts in This Area to Date and the Proposals Made in the Strategy?

Our review of the research, the State's existing programs, and the proposals made in the strategy lead to the following conclusions and recommendations:

- ***Targeting Resources, Especially in the Context of Limited Budgets, Appears to Be the Optimum Strategy for the State:*** However, targeting should not be only on the basis of income, but should also take into consideration such factors as the risk of abuse and neglect, lack of maternal education, and limited English-proficiency. In this regard, program eligibility for EEEP, for example, appears to be appropriately focused on the children who can take the most advantage of this kind of programming. In contrast, eligibility for Judy Centers appears insufficiently focused.

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- ***First Judy Center Grants Awarded:*** The fiscal 2001 budget includes \$4 million to establish Judy Centers, defined in Chapter 680, Acts of 2000 as a site where comprehensive early child care and education services are provided to young children and their families for the purpose of promoting school readiness. Collaboration with participating agencies and programs is considered an integral part of the centers. MSDE's request for proposals for Judy Centers indicated that the centers must be school-based or school-linked. In addition, the centers are required to include linkages with public pre-kindergarten, kindergarten, preschool special education, the Maryland Infants and Toddlers Program, and before and after early childhood education services provided through child care providers.

After a competitive procurement process, MSDE awarded Judy Center grants to 13 counties in December 2000. The grants, which total \$8 million (\$4 million from fiscal 2001 budget and \$4 million from fiscal 2002 allowance), will cover the 18-month period from January 2001 to June 2002. All of the programs are required to include an evaluation component. A short summary of each grant proposal is provided in **Appendix 2**. A few observations can be made about the first Judy Center awards:

- Most of the grant proposals focus on coordinating the delivery of early childhood services, the provision of case management services, and access to health screenings.
- Most grantees will use a portion of the funding to ensure full-day, full-year pre-k and/or kindergarten is available through the center.
- While State law does not require that Judy Centers target at-risk neighborhoods, MSDE awarded an extra point in the procurement process to proposals linked to Title I schools. The majority of the grants were awarded to centers operating in Title I schools or Hot Spot communities. Targeting Judy Centers dollars to disadvantaged children appears appropriate since evaluations of early childhood programs in other states indicate targeting is a more cost effective approach than universal coverage. **To enhance the effectiveness of the Judy Centers, DLS recommends that MSDE increase the importance of targeting disadvantaged students in determining the location of any additional Judy Centers.**
- A major component of the Montgomery County proposal appears to be accreditation of providers in the area. One of the requirements for Judy Center applications was on-going efforts to obtain accreditation. Thus, it is unclear why the State is providing a Judy Center grant which will be used to pursue accreditation. MSDE is already funding a separate program providing assistance to early education facilities seeking accreditation.

MSDE should brief the committees on the quality of the applications and whether it is advisable to expand to another set of Judy Centers without first evaluating the impact of the first round of awards on school readiness.

- ***Quality Early Childhood Experiences Requires Quality Staffing:*** Ensuring quality among program staff appears to be a necessary component of a successful program. Ensuring quality is certainly a component of the programs being implemented by the State. For example, the State has its initiative

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to encourage accreditation among early childhood programs (family day care, center care, as well as other pre-kindergarten programs). The Judy centers have a requirement that services are to be provided by accredited programs.

- ***State Funding of Head Start:*** The State's involvement in Head Start programs since fiscal 2000 has also tried to encourage quality programming by requiring State funds to be used consistent with the Maryland Model for School Readiness (MMSR). MMSR is a program to foster school readiness through intensive staff training and concurrent classroom implementation of best early learning practices. While State funding of Head Start is small relative to the federal dollars, the subcabinet has argued that the presence of State dollars coupled with the requirement to use these dollars on programs consistent with MMSR will result in better quality programming.

While that may be the case, the Abell Foundation released a report in June 2000 (*The Untapped Potential of Baltimore City Public Preschools*) highly critical of Baltimore City's Head Start program, the program which receives almost half of the State funding for Head Start. The most striking criticisms were:

- Head Start teacher average salaries were 50% of the average salary for a teacher in the public school system, which speaks to quality of the learning environment; and
- Despite the State's attempt to link Head Start funds to MMSR, the quality of the State's pre-school standards and its clear focus on school readiness did not mesh with Head Start's treatment of the same skills.

While linking State Head Start support to MMSR is one way to infuse additional quality into the Head Start program, DLS recommends that a more direct and effective approach would be to allow State Head Start funds to be used only to supplement the salary and benefits of Head Start teachers to a level of at least 90% of the salary and benefits of an equivalent public preschool teacher in the jurisdiction in which the Head Start program is located and that those Head Start teachers must meet the equivalent qualifications for a public preschool teacher. An exception is made for programs that already meet this criteria which can use the State funds to expand and enhance existing programming. **Further, DLS recommends that the State funding for Head Start funds should be awarded on a competitive basis rather than allocated according to the federal formula.** Most new funds in this area are awarded based on the quality of responses to award announcements and we see no rationale for excluding State Head Start funds from this competitive requirement.

- ***Consolidate Oversight of Early Childhood Programs:*** The April 2000 *Joint Chairmen's Report* (JCR) asked the subcabinet to examine the feasibility of undertaking program consolidation in a variety of areas that seem to be served by multiple State programs. The reasoning behind this request was that while programs often target different populations, they appeared comparable enough to justify coordination through a single administrative entity and in some instances integration into a single initiative. The subcabinet produced its response to this request in November.

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In considering the consolidation of the State's early childhood programs, the subcabinet's bottom line finding is that programmatic differences and federal funding requirements would make it difficult to consolidate oversight of the programs. **Despite the concerns about funding streams and programmatic differences, DLS finds that there could be some efficiencies from shifting oversight and State funding for Head Start from the Office for Children, Youth, and Families (OCYF) to MSDE.** EEEP, Infant's and Toddler's, and the Judy Centers are already housed within MSDE, while the Head Start is overseen by OCYF. Shifting oversight of Head Start to MSDE appears logical since:

- MSDE is already overseeing most of the State's other early childhood education programs.
- Head Start has been criticized at the State and national level for lacking an adequate focus on education.
- Head Start and EEEP target the same age group and provide some of the same services.
- State Head Start funds are currently allocated to programs which implement MSDE's Maryland Model for School Readiness and MSDE will be accrediting Head Start centers. Additional linkages between MSDE curriculum and evaluation efforts would appear beneficial. For example, it would be extremely useful to be able to track the success of children who participate in Head Start as they move through the public education system and to require Head Start programs to utilize the work sampling system. With oversight for both the public school systems and the State's Head Start funding, MSDE may be in a better position than OCYF to encourage collaboration.
- **Utilization of EEEP:** EEEP is the State's largest investment in pre-kindergarten programming. However, it does not operate at full capacity (see **Exhibit 25**). Part of the reason for this has to do with the fact that some jurisdictions request waivers to reduce enrollment per session (i.e., class size) from 20 to 18. Further, these figures represent enrollment in September of each year and any jurisdiction with low enrollment numbers is required to actively recruit to fill slots. However, as has been mentioned by the State Superintendent to the JCCYF, part of the problem is linking EEEP slots with wrap-around child-care services. Part of the mission of the Judy Centers is to provide this linkage between programs. Given the paucity of State resources in the pre-kindergarten arena, none of these EEEP slots should be unfilled.

It is also interesting to note that while enrollment in EEEP in most jurisdictions has increased, or at worst held steady in recent years, enrollment in Baltimore City fell by 13% from school year beginning September 1999 to September 2001.

Exhibit 25

Maryland's Extended Elementary Education Program
Enrollment and Capacity
School Years 1998-99 to 2000-01

<u>School Year</u>	<u>Capacity</u>	<u>Enrollment</u>	<u>Enrollment</u>
1998-99	10,760	9,847	91.5
1999-00	11,000	10,150	92.3
2000-01	10,940	10,299	94.1

Source: Maryland State Department of Education

- ***There Is an Inextricable Link Between Quality "Child Care" and Quality "Early Education" in Providing the Intensity of Early Childhood Experience That Needs to Be Provided:*** Looking at what we know of the system of care we currently have for preschoolers, most of the care (even for three- and four-year-olds) takes place in settings not associated with schools (public or private). Child care centers and family day care settings continue to provide the bulk of this care, and the quality of those settings is complimentary to school-based settings. That complimentary nature is recognized in the accreditation work being undertaken by the State, although as noted above, it needs to go further to better encompass family day care.

This complimentary nature also needs to be recognized as priorities for funding decisions are made. Without substantial investments, investments that at this point appear unlikely, it is questionable whether the State will be able to fund all of the early childhood strategies or even substantial pieces of those strategies. Certainly, if having more accredited child care centers results in the early learning experience the State wants for four-year-olds for example, then why invest in other forms of public programming for those four-year-olds. Minimizing duplication of efforts is key given the available funding.

- ***How to Get to Scale:*** National experts look at what Maryland is doing and think we have the components of an excellent system in place. The trick is how to get up-to-scale. We have noted earlier, that "scale" has a variety of definitions depending on where resources should be targeted. But even looking at the more targeted pieces of the strategy of increasing access to early childhood experiences shows the gulf between the dollars available and the dollars required.

However, the General Assembly has been given a choice of spending \$19 million to implement methods to "improve and enhance the readiness and academic performance of children in kindergarten through third grade." This language is somewhat ambiguous in that it could be argued that this includes spending on children before kindergarten in order to improve their readiness and academic performance in kindergarten through third grade. The Governor has noted that school systems can use the funding for any efforts as long as the efforts help children improve third grade achievement standards. Again, that does not necessarily preclude pre-kindergarten programming.

Given that earlier intervention programming appears to yield the biggest results, the General Assembly might wish to consider restricting the \$19 million for use only for pre-kindergarten programming targeted at at-risk children. Local flexibility is retained over precise programming, but options could include expanding Head Start funding, funding the at-risk three-year-old program proposed in the subcabinet's strategy, developing innovative programming such as linking local school systems to be partners with child care centers and offering "drop-in" teaching from a qualified early childhood teacher, and expanding EEEP services.

Support Families with Young Children

Exhibit 26 details the subcabinet's strategy for supporting families with young children.

The strategy is more broadly-focused than the first two strategies discussed, but certainly contains elements addressing risk factors associated with school readiness. The most obvious is poverty. Poor children experience a form of "double jeopardy" in this regard in that children born in poverty are both likely to be exposed to risk factors for development and are more likely to be adversely affected by that risk factor. The various income, housing, and other direct family support programs listed here are in some way just examples of the various State efforts to reduce poverty. Indeed, one of the most encouraging trends in recent years has been in the State's child poverty rate, now the lowest in the nation.

Points that can be made about this strategy include:

- The importance of income support is particularly relevant given the system of early childhood care currently available in the State. As noted above, much of this care is received through private providers and without public subsidy. According to the Maryland Committee for Children, for those persons with child care expenses, child care costs are often the principal household expense.
- What we know of the child care system indicates that many children do not receive care in a formal setting. The role of family support centers and home visiting programs for example, in offering support services for parents outside of formal settings is likely to be of great importance.
- Part of this strategy is also the need to make people aware of the importance of quality care and education. Maryland is one of a number of states that received a National Governors Association grant to develop a strategy to promote public awareness and build political will for early childhood education and care. However, as noted above, creating public awareness about the importance of early care and education also leads to questions of what kind of programming develops from that campaign: universal programming which likely receives more widespread public support or targeted programming which may have a greater relative public benefit.
- A number of the pieces of the strategy do not contain specific objectives: improving access to mental health and substance abuse services for parents of young children (although there is funding to support substance abuse treatment for parents of children in danger of being placed in foster care); encouraging family-friendly business practices; and providing educational opportunities and job skills training.

Exhibit 26

Strategy -- Support Families with Young Children

<u>Goal</u>	<u>Objective</u>	<u>Funding Estimate</u>
Use every route at our disposal to reach out to parents and families so that the importance of quality care and education are understood and practiced.	Include parent involvement components in all efforts to improve the quality of child care and early childhood experience, and increase access to early childhood experiences.	No funds provided in the fiscal 2002 allowance for a public awareness campaign. Subcabinet working through an NGA grant to develop a public awareness campaign.
Utilize home visiting to provide in-home intervention for expectant parents and new parents.	Targeted population adopted by local funding recipient.	Fiscal 2002 allowance funding for the various home visiting programs is \$9 million, including an almost \$1 million increase for home visiting in the Subcabinet Fund.
Improve access for parents of young children to needed mental health and substance abuse services and coordinate behavioral healthcare provided to adults and children within families.	Utilization or treatment by mothers of drug-exposed infants and TCA recipients is expected to improve.	The fiscal 2002 allowance includes \$4 million to implement Chapter 551, Acts of 2000 which offers substance abuse treatment to parents of children in danger of being placed in foster care.
Encourage family-friendly business practices with employer and child care options.		DHR implementing a final report of Maryland Child Care Business Partnership of \$500,000 in fiscal 2001 and 2002.
Provide appropriate educational opportunities and job skills training for working low-income families.		
Explore expansion of the Maryland child and dependent care tax credit.	Expand the credit from 25 to 50% of the federal credit, make the credit refundable, increase coverage to 17-years-old.	Note: Chapter 520, Acts of 2000 raised the credit to 32.5% of the federal credit. Increasing to 50% and making refundable would cost an estimated \$12. 8 million in the first year.
Enhance earned income credit (EIC).	Increase percentage of the federal EIC upon which the refundable portion of the State credit is based to 50%.	First year cost estimated at \$163 million.
Increase rental assistance, home ownership assistance, and the supply of affordable housing for low-income working families with at-risk children.	Develop State low-income tax credit.	
Develop a strategy of intensive support for selected communities coordinated at the State and local level.	Implement child well-being neighborhoods initiative.	

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Source: Subcabinet for Children, Youth, and Families; Department of Legislative Services

- Consolidate Funding of Home Visiting Programs. Again, in response to the April 2000 JCR on the feasibility of undertaking program consolidation in a variety of areas, the subcabinet identified eight different home visitation programs with which the State is involved (see **Exhibit 27**). The programs are administered by five different State agencies. Most of the programs receive little to no direct State funding with the fiscal 2002 allowance containing only \$9 million for the eight programs, of which \$3.5 million supports the Healthy Families Maryland program funded through the Subcabinet Fund. Despite the plethora of programs, there are distinct differences in the goals of most of the initiatives.

Exhibit 27

Home Visiting Programs Included in Consolidation Study (\$ in Millions)

<u>Programs Included in Review</u>	<u>Funding in Allowance</u>
Healthy Families Maryland (OCYF)	\$3.5
Funding for LMBs (OCYF)	2.5
Juvenile Justice Advisory Council (JJAC) -- Home Visitation Grants (Office of Crime Control and Prevention)	0.0
Responsible Choices (DHR)	0.9
Family Support Centers -- In-home Prevention Program (DHR)	0.3
Healthy Start (DHMH)	0.0 *
Baltimore City Maternal and Infant Nursing Program (DHMH)	0.0 *
Home Instruction for Pre-School Youngsters Program (HIPPY), (MSDE)	0.0 *
Even Start (MSDE)	1.8

*No direct State funding. Local health departments use State and local grants to support Healthy Start and the Baltimore City Maternal Infant Nursing Program while HIPPY is funded through local school systems.

Source: Subcabinet for Children, Youth, and Families

Outcome and evaluation material is limited making it difficult to determine if one program is more effective than the others. DLS questions the wisdom of creating and expanding so many home visiting programs without ever formally evaluating the effectiveness of the existing programs.

Local responsibility is equally dispersed with the local schools systems (HIPPY and Even Start), local management boards (LMBs) (Healthy Families Maryland), local health departments (Healthy Start), and State funded community-based organizations (Family Support Centers, JJAC Grants, and Responsible Choices) all operating programs. Operation of many of the programs is limited to a handful of jurisdictions. Two of programs are active only in Baltimore City. In the cases of Healthy

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Start, HIPPY, and the Maternal and Infant Nursing Program, the programs are funded because local entities have elected to spend funds available from the State on home visitation.

While recognizing the need to improve coordination, the subcabinet rejected the possibility of consolidating the programs due to differences in program goals and complex funding streams. As depicted in **Exhibit 28**, the subcabinet instead recommended the creation of a coordinating body and a variety of other changes which should improve collaboration, reduce the number of home visits one family receives, and provide a single point of entry. A number of points can be made about the subcabinet's recommendations:

- Local control over funding for three of the programs makes it difficult for the State to consolidate the full range of home visiting programs. Even if the State directly funded all of the programs, determining which initiatives to eliminate would be difficult due to the lack of outcome data.
- Consolidated grant applications and development of a single point of entry should improve service delivery and efficiency in the short-term. In the long-term, development of a unified assessment tool and cross-training should reduce the overlap in services.
- Evaluating the various programs and service delivery models, as recommended by the subcabinet, is critical so that the State can determine which programs should be expanded and which should be abolished.
- There do not appear to be significant obstacles to the State pooling funds for Healthy Families Maryland, Responsible Choices, and Family Support Centers (in-home intervention) and providing these dollars to LMBs in the form of a home visitation block grant.
- Coordination of services at the local level could be improved by hiring case managers who would assess a families needs and coordinate the delivery of the necessary home visiting services.
- The allowance includes funding to expand home visiting programs through the LMBs.
- The subcabinet's plan to develop an oversight body is prudent. Minimal savings would be realized at the State level from consolidating oversight of the home visiting programs as the State incurs limited administrative costs. However, improved coordination among the existing programs is necessary.

DLS recommends that beginning in fiscal 2003 the subcabinet allocate as much of the State funding for home visitation programs as possible to the LMBs as a block grant. As a condition of receiving the funds, LMBs should be required to evaluate the programs, establish a single point of entry at the local level, and demonstrate that they will coordinate services with local and federally funded initiatives.

Exhibit 28

Consolidation of Home Visiting Programs

<u>Advantages of Consolidation</u>	<u>Issues/Obstacles</u>	<u>Recommendations</u>	<u>Implementation Status</u>
Collapsing of administrative costs into one dedicated office.	In most cases, the funding entity (e.g. federal government) mandates or identifies the State agency in which funds and program administration must reside.	<ul style="list-style-type: none"> • Create a home visiting oversight body. 	<ul style="list-style-type: none"> • Not yet established.
Coordination and/or consolidation of training and technical assistance functions.		<ul style="list-style-type: none"> • Develop a consolidated grant application. 	<ul style="list-style-type: none"> • Complete.
Consolidation and uniformity of grant making process.		<ul style="list-style-type: none"> • Centralize training and initiate cross-training of staff. 	<ul style="list-style-type: none"> • Not yet.
Creation of a single-point of entry at the local level which would allow families to be assessed using a universal assessment tool and referred to the appropriate home visiting model.		<ul style="list-style-type: none"> • Develop common evaluation tools. • Explore development of a "universal" family assessment tool. • Create a single point of entry by establishing a hotline. • Minimize total number of visits a family receives. 	<ul style="list-style-type: none"> • Not yet. • Not yet. • Not yet.

Source: Subcabinet for Children, Youth, and Families

Increase Access to Health Care and Early Childhood Screening

The strategies proposed by the subcabinet are highlighted in **Exhibit 29**. A number of comments can be made about the strategies and the funding including:

- There is no clear prioritization. The strategies are essentially a laundry list of all the on-going health programs targeting children ages zero through five. While all the strategies are important and will impact school readiness, identification and full funding of the highest priorities may make the most sense.
- Expansion of MCHP appears to be the highest priority which is appropriate since access to comprehensive care should make it easier to address a number of the other strategies (immunizations, lead paint screening, improved birth outcomes, substance abuse treatment, etc.).
- With a few exceptions (immunizations, MCHP, dental care, and the infant hearing screening), measurable goals are not identifiable in the strategic plan.
- Improvements in dental utilization appear unlikely without a more significant public education and outreach campaign.
- The strategies for improving birth outcomes are vague and do not appear to be funded. To make progress in this area, the State will need a focused plan which draws upon successes in other states. Expansion of MCHP to additional pregnant women should help produce favorable birth outcomes.
- Funding targeted specifically to expanding residential treatment options for women and their young children is needed. **DHMH should comment on the degree to which the additional treatment dollars in the allowance will target this population.**

Exhibit 29

Increase Access to Health Care and Early Childhood Health Screening

<u>Goals</u>	<u>Strategies</u>	<u>Funding</u>
Expand access through MCHP	Extend coverage to children with family incomes at or below 300% of the poverty level and pregnant women with incomes at or below 250% of poverty.	\$28 million is included in the fiscal 2002 allowance to extend coverage to 14,700 children and about 1,000 pregnant women. The fiscal note on the legislation expanding the program indicated that about 35,000 children are eligible for the program. If fully utilized, the program will eventually require an additional \$25 million to \$30 million (\$8 million to \$10 million in general funds).
Improve Birth Outcomes	Enhance outreach efforts to pregnant women and educate teachers about identifying conditions that might go unnoticed.	Additional staff requested in fiscal 2002 allowance to perform fetal and infant mortality case reviews.
Increase Immunization Levels	Develop statewide immunization registry to ensure children receive necessary vaccines.	No funding for expansion of services is included in the allowance.
Expand Substance Abuse Prevention and Treatment Services	Expand outreach, tracking, and clinic hours.	
	Implement integration of child welfare and substance abuse services.	\$4 million is included in allowance to expand treatment for parents with children at-risk of or in an out-of-home placement. The fiscal note on the legislation indicated that as much as \$16 million per year might be required.
	Improve substance abuse screening process for welfare recipients.	
	Continue to improve pilot program for drug-exposed infants.	\$2.2 million is included in the allowance to fund 75 addiction specialists in local departments of social services who will screen welfare recipients and support the integration of the child welfare and substance abuse services. Another \$6.1 million may be required to hire case managers to fully implement the two programs.
	Add capacity at programs serving pregnant, post partum women and their neonates, pre-schoolers, and other children young than age ten.	
		Funding is included in the allowance to expand substance abuse treatment services to all populations.
Expand Mental Health Services	Provide funding for school-based mental health promotion and treatment.	The allowance contains \$2 million for this purpose.

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<u>Goals</u>	<u>Strategies</u>	<u>Funding</u>
Reduce Lead Exposure/Poisoning	Increase blood lead testing, facilitate reporting by private labs, and perform abatement.	The allowance contains \$5 million for the second year of a three-year effort targeting Baltimore City. The allowance contains an additional \$357,000 to expand efforts in the counties. The funds will support new positions in the Laboratories Administration and case-management grants to local health departments.
Expand Access to Oral Health	<p>Monitor progress in improving Medicaid dental utilization rates.</p> <p>Continue to support dental loan assistance repayment program if dentist agrees to serve at least 20% Medicaid patients.</p> <p>Train WIC staff so they can educate public.</p>	<p>If Medicaid utilization rates do not improve, additional funding may be required to improve outreach and dental rates.</p> <p>No additional dollars are included in the allowance.</p>
Screen and Provide Services to Deaf Infants	Establish a hearing aid loaner bank so parents of infants can obtain a hearing aid in a timely manner as first six months of life are of critical importance to development of language.	No funds are included in the budget for the loaner bank. Costs are not likely to exceed \$1 million to \$2 million.
Improve Nutritional Status	Enhance outreach efforts and increase the number of dietitians and nutritionists at the local level.	No funding is included in the allowance to expand these programs. Costs of such an expansion should be minimal.
Child Abuse and Neglect	Develop community-based approach to addressing health needs of children and families. Public information, provider education, referral and treatment protocols, and case management are examples of services which could be coordinated in the community.	No cost estimate is attached to this proposal and no funding appears to be included in the allowance to expand efforts in this area.

Source: Department of Health and Mental Hygiene; Subcabinet for Children, Youth, and Families, and Maryland State Budget.

Overarching Conclusions on Strategies

- **Quality Early Childhood Experiences Require Quality Staffing:** Ensuring quality among program staff is a necessary component of a successful program. Credentialing child care workers and accrediting child care centers and family day care homes is a first step in raising quality.

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- **Compensation:** One impediment to attracting and retaining qualified staff is compensation. Currently, child care workers in centers and family day care homes make less than half of what the average teacher in a public school earns. Similarly, Head Start teachers in some jurisdictions make less than \$20,000 annually. The subcabinet's strategies for improving early childhood education are not sufficient to adequately address the compensation issue.
- **Given Limited Resources, Funds Should Target At-risk Children and Families:** Given the limited resources available for early childhood programs, it is most appropriate to target funds to at-risk children and families rather than provide universal services.
- **Conflicting Strategies?:** One of the subcabinet's strategies for improving quality is to credential child care workers and accredit child care programs. A separate strategy proposes expanding pre-school opportunities for three- and four-year-old children. While both approaches are laudable, there is the potential for conflict. If quality child care programs are readily available, then why does the State need to expand pre-school programs when it could spend the same dollars to make child care more affordable? Ideally, it might make sense to use both approaches and wrap the child care around the pre-school. Barring a substantial infusion of funding into early childhood programs, however, the State should probably focus the majority of its resources on one approach or the other.
- **Funds in Allowance Could Be Earmarked to Expand Early Childhood Programs:** The fiscal 2002 allowance contains \$19 million to for local school systems to spend to improve outcomes in the third grade. The administration's proposal focuses the dollars on children in kindergarten through the third grade. Targeting these funds to pre-kindergarten programming for at-risk children appears more cost effective.
- **Early Childhood System Lacks a Single Point of Entry:** Child Care Resource and Referral networks offer parents assistance in identifying appropriate child care options; public schools provide pre-kindergarten and kindergarten programs; schools systems and various other organizations administer Head Start; and community-based family support centers provide services for children ages zero through three and their parents. With the exception of communities with fledgling Judy Centers, there is no single point of entry into the early child care and education systems and no entity at the local level which coordinates the activities of the various publicly funded programs.

Issues

1. Results-based Budgeting and Evaluations

The purpose of this type of results-based budget presentation is to move beyond budget numbers in order to examine outcomes, and to see how the State is going to move those outcomes in a positive direction beyond the immediate upcoming year. This emphasis on out-year results is something seldom found in the State's MFR initiative which typically only relates the proposed budget to outcomes in that proposed budget year. Thinking beyond the immediate upcoming year has the advantage of both reducing the temptation to focus all efforts on the short term as well as acknowledging that it can often take multi-year commitments to fundamentally move outcomes in some areas.

This long-term, strategic focus is a long-way from line-item budgeting. It puts an increased emphasis on our understanding of how well a program is contributing to the achievement of the desired outcomes. This goes beyond the need for programs to develop appropriate outcome measures (although that is a necessary first step).

One of the most interesting conclusions of the RAND review of early childhood programs was not that there was insufficient evidence to say these programs did not result in measurable improvements for program participants. On the contrary, as noted above, these programs did have quantifiable benefits. What was unknown was exactly why these programs did work. This places even greater emphasis on the need for rigorous program evaluation. Similarly, the National Academy of Sciences review of the science of early childhood development noted the importance of paying much more attention to program implementation and to ensuring high quality evaluation of early childhood interventions.

The Current Status of Program Evaluations -- Children Entering School Ready To Learn

DLS asked the executive agencies to supply us with outcome measures and the most recent evaluation for each of the programs that form part of this analysis. Although it should be noted that a number of the programs included within this analysis are relatively new and have yet to undergo evaluation, based on a review of the information submitted, a number of conclusions can be drawn:

- while most programs did try and link to MFR goals and objects, few of the programs submitted evaluations.
- The State's largest investment in early childhood programming, EEEP, has not had a substantial evaluation since 1991.
- More often than not, where programs have independent evaluations they are federally-funded programs which require a specific evaluation component.
- Two programs (DHR's Access and Visitation program which offers a venue for families to mediate and effectively resolve issues which prevent noncustodial parent and child visitation, and Young

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Fathers/Responsible Fathers program which offers services to low-income young, unwed, or expectant fathers to increase capacity to provide emotionally and financially for their children), both noted that they chose to spend all of their funding on services rather than evaluations because of the need for services. Even if this is the case, how can we know if programs are effectively meeting that need unless we choose to evaluate them?

- Interestingly, MSDE, in the development of the Judy Centers for example, specifically requires an evaluation and allows the grant recipient to request that up to 5% of the grant funds be used on that evaluation. While this means reduced service delivery, it can facilitate best and effective practices. This is a difficult choice to make: spending funds on research and evaluation versus providing services. However, this kind of investment is vital to our understanding of what works and what does not.
- For the Judy Centers MSDE has outlined a set of statewide outcome measures, outcome measures which utilize the WSS. For example:
 - by June 2001, all Judy Centers will establish baseline WSS information;
 - by June 2002, 50% of the children served will achieve proficiency in all WSS domains;
 - by June 2003, 60% of the children served will achieve proficiency in all WSS domains;
 - by June 2004, 70% of the children served will achieve proficiency in all WSS domains; and
 - by June 2005, 75% of the children served will achieve proficiency in all WSS domains.

These outcome measures raise two questions. First, DLS supposes that MSDE will adjust these outcomes once they actually have the WSS data available. These targets may be overly optimistic or insufficiently challenging depending on the data. Second, while the Judy Centers utilizes these standard set of statewide outcome measures, no such uniformity exists for EEEP. The current goals, objectives, and milestones established by local school systems are both uneven in terms of the quality of the outcomes chosen and what they aim to achieve. The introduction of the WSS throughout school systems should mean that MSDE develops uniform measures. **DLS recommends that MSDE develop a standard set of outcome measures for the EEEP program.**

- If the Judy Centers are indeed the focal point for collaborative service delivery that the State wants them to be, it is reasonable to ask if outcome measures for more of the programming that is supposed to be offered through the Judy Centers should not also reference the WSS in their outcomes.
- Similarly, while Head Start grantees are subject to separate federal evaluation, a link to the WSS would be beneficial to understanding how effective those programs are in getting those children ready to perform in schools.
- Clearly, the State needs to be able to track children individually from their earliest childhood contact with early learning experiences through entry into the public school system and through the earliest

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grades in order to track the long-term impacts of early childhood experiences. While this kind of longitudinal tracking is difficult, it is the best way to know with some degree of certainty that we are investing in is producing adequate results.

- As noted above, the establishment of credentialing and the concomitant offering of incentives through cash bonuses and tiered reimbursement is an important part of the State's overall strategy to improve the quality of child care and early childhood experiences. A program evaluation component is built into the provider credentialing and accreditation system. Providers will be able to use State grants to conduct evaluations of their own programs. However, there does not appear to be any funding for an evaluation of the overall credentialing effort and whether the credentialing system and other incentives are addressing provider compensation and retention issues.

To sum up, if evaluations are so important to our understanding of program effectiveness, how is the State doing in this area? Like our children's school readiness, the answer is "mediocre."

Recommended Actions

Amount Reduction

1. Adopt the following narrative:

Home Visitation Programs: The committees find that the State supports eight different home visitation programs. The current service delivery system lacks a single point of entry, results in multiple programs serving the same family, and fails to encourage collaboration. To encourage more efficient delivery of home visitation services, the subcabinet should allocate as much of the State funding for home visitation programs as possible to the Local Management Boards (LMBs) as a block grant in fiscal 2003. As a condition of receiving the funds, LMBs should be required to evaluate the programs, establish a single point of entry at the local level, and demonstrate that they will coordinate services with other local and federally funded home visitation programs.

2. Adopt the following narrative:

State Head Start Funds: The committees find that State funding for Head Start should be transferred from the Office of Children, Youth, and Families (OCYF) to the Maryland State Department of Education (MSDE) to improve oversight of Head Start and integration of the State's early childhood programs. The Extended Elementary Education Program, Infant's and Toddler's Program, and the Judy Centers are already housed within MSDE while Head Start is overseen by OCYF. Shifting oversight of Head Start to MSDE will:

- consolidate oversight of the State's early childhood education programs; and
- enhance opportunities to link MSDE's curriculum and evaluation efforts to Head Start. For example, it would be helpful to track the success of children who participate in Head Start as they move through the public education system and to require Head Start programs to utilize the work sampling system. With oversight for both the public school systems and the State's Head Start funding, MSDE may be in a better position than OCYF to encourage collaboration.

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3. Add the following narrative:

Report on Credentialing and Accreditation: The fiscal 2002 budget includes funds to begin credentialing child care providers and accrediting early childhood programs (child care centers, Head Start, etc.) and family day care homes. While supportive of the initiatives, the committees are concerned that there is no proposal to evaluate the impact of credentialing and accreditation on the quality of early childhood programs. The Subcabinet for Children, Youth, and Families should submit a proposed evaluation plan to the committees by October 1, 2001. By January 15, 2002, the subcabinet should report to the committees on the number of providers who have been credentialed at levels two through four, the number of newly accredited providers, and the number of children in the Purchase of Care program who are served by a provider receiving an enhanced rate through the tiered reimbursement system.

Information Request	Author	Due Date
Plan for evaluating accreditation and credentialing initiatives	Subcabinet	October 1, 2001
Status report on accreditation and credentialing	Subcabinet	January 15, 2002

4. Add the following language:

. provided that State funds for Head Start may be used only by programs which use the funding to supplement the salary and benefits of Head Start teachers to a level of at least 90% of the salary and benefits of an equivalent public preschool teacher in the jurisdiction in which the Head Start program is located and that those Head Start teachers must meet the equivalent qualifications for a public preschool teacher. Programs which already meet or exceed these salary and benefit standards for their teachers may receive funding to expand and enhance existing programming. Further provided that State funding for Head Start shall be distributed on competitive basis.

Explanation: Research on early childhood programming establishes teacher quality and stability as one of the common components of an effective program. At the same time, a recent report on the Baltimore City Head Start program, noted the low salaries of Head Start teachers relative to their counterparts in the public school system. In an effort to promote teacher quality, the language limits State funding to those programs which will use those funds to supplement teacher salaries and benefits to a certain level compared to their public pre-school counterpart. The language also requires

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those teachers to have the comparable qualifications. An exception is made for programs already meeting those standards. They can continue to apply for funding to expand and enhance existing services. Finally, the language requires the funding to be awarded on a competitive rather than a formula basis.

- | | |
|---|--------------------|
| 5. Reduce funding for home visiting expansion. The fiscal 2002 allowance includes a \$950,000 expansion in home visiting programs funded through the Subcabinet Fund. The expansion is funded with Temporary Assistance for Needy Families dollars which are oversubscribed in the fiscal 2002 allowance. | \$950,000 FF |
| 6. Reduce funding for Judy Centers. Not all of the fiscal 2001 Judy Center awards support proposals of the same quality. In fact, one proposal appears to spend part of the grant on achieving accreditation for providers -- something which the State already provides grants for and which is a prerequisite for seeking a Judy Center grant. The uneven quality of the grantees proposals raises questions about the types of proposals which will be submitted in fiscal 2002. The reduction still allows for a \$3.5 million increase in funding for the Judy Centers and indicates the need for the subcabinet to work with local jurisdictions to ensure high quality applications rather than being a reflection on the potential worth of Judy Centers. | \$500,000 GF |
| Total Reductions | \$1,450,000 |

Summary of Abecedarian Project, Project CARE, and Infant Health and Development Program^a for Preschool Treatment and Control Conditions

Preschool Treatment

Nutritional Supplements

Family Support Social Services

Pediatric Care and Referral

Early Childhood Education at a Center

Six-weeks to five-years of age^a

Good teacher/child ratio and a year round

Program that met or exceeded NAEYC Standards

Developmentally appropriate practices

Hours of operation: 7:30 a.m. to 5:30 p.m.

Partners for Learning curriculum plus other documental approaches with an emphasis on language development

Daily transportation

Control Treatment

Nutritional Supplements

Family Support Social Services

Pediatric Care and Referral

^aThe Infant Health and Development Program was modified: (1) to operate from hospital discharge to three-years of age; and (2) to use home visits plus early childhood education in a child development center from one- to three-years of age. Nutritional supplements were omitted due to lack of need.

Judy Center Grantees

<u>County</u>	<u>Funding</u>	<u>Program</u>	<u>Target Population</u>
Allegany	\$646,667	Expand existing early childhood programs with goal of: (1) improving parenting skills; (2) providing affordable high quality early childhood programming; and (3) providing quality health services.	Children birth to age five.
Baltimore City	\$646,667	Focus on child development, family development, and staff development through collaboration with community partners. Funds will support case managers, program director, professional development activities, expanded mental health services, new before and after school programs, resources and classes for parents, and home visiting.	
Calvert	\$646,667	Provide full-day, full-year comprehensive school program of services in collaboration with community partners. Support services include adult education, family support, home visiting, and case management.	Children ages three to five and their families.
Caroline	\$646,667	Establish school-based and school-linked center. Strategies include full-day/full-year services including before- and after-school care, HIPPIY program for three-year-olds, family literacy services, and full-year pre-k and kindergarten.	192 children birth to age five.
Charles	\$646,667	Establish an early child care and education center at an elementary school. Objectives include providing the center's children with ready access to quality physical and mental health services and appropriate early childhood programs; educating parents to serve as their child's first teacher; and assisting families in becoming economically self-sufficient. The center will partner with a variety of community programs and offer home visiting services.	160 children ages zero to five.
Dorchester	\$646,667	Plan to expand and enhance existing early childhood education and support services through an integrated network of school-based and school-linked services. A project case manager will assist families in identification and coordination of interagency services. Services will include parent-focused education and training, Head Start, comprehensive primary health care, and home visiting.	Not specified.

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Appendix 2 (Cont.)

<u>County</u>	<u>Funding</u>	<u>Program</u>	<u>Target Population</u>
Frederick	\$646,667	School-based center will provide educational interventions and quality child care for children, training and support for adults, and coordinate the work of all agencies and organizations serving these children and their families. Programmatic expansions include extended day kindergarten, a new extended day pre-kindergarten program, Even Start, and a home-based parent/child program.	Children birth to five-years of age.
Kent	\$646,667	Ultimate goal is a "single point of entry" where the educational, health, and resiliency needs of children and their families are addressed. Full-day, full-year kindergarten program to be developed followed by similar pre-k services. Home intervention program will target hard to reach families.	
Montgomery County	\$240,000	Expand and enhance existing children's center child care program and Head Start by adding staff, providing staff training, and pursuing center accreditation.	
Prince George's	\$646,667	Provide staff to direct, coordinate, and assess activities at existing Judy Center, offer staff training, and expand services.	Children from birth to age five.
Queen Anne's	\$646,667	Strategies include: family centered case management, parent support groups, screening and early identification, and child care enrichment services. Family Support Center, Head Start, Even Start, and Infant and Toddlers Program will be co-located at the center.	Children ages three to five from low-income, single-parent families.
St. Mary's	\$646,667	Provide pre-school experience for three-year-old children to allow for intervention and preparation to enter school. In addition, the enrollment area for EEEP will be expanded and extended day programs will be offered. Judy center staff will provide case management services.	200 children from birth to age five and their families.
Washington	\$646,667	Family-centered, centralized services will be offered at two sites (school-based site and school-linked site). Case manager will be hired and children at-risk will receive services through a prevention/intervention worker. Pre-school at the school will be expanded to full-year. School-based health services will be expanded and job training will be offered for parents.	At least 50 children zero to five will be served.

**Maryland Child Care Credential
Core of Knowledge for Child Care Professionals**

The Core of Knowledge is an integrated body of knowledge consisting of concepts, philosophies, theories, and practices, which constitute professional expertise. A core of knowledge is best learned through a systematic process, which enables learners to explore and examine basic concepts and theories at increasing levels of intellectual competence, while also expanding the range of information and ideas that further their proficiency as practitioners.

Child Development

- Child growth and development theories, methods of research and effects on child care and education
- Domains (social, emotional, physical, cognitive and aesthetic) and stages of development
- Links between development and learning
- Methods of observing child behavior and progress
- Documentation of growth and learning
- Theories of guidance and discipline
- Positive child guidance strategies that promote pro-social behavior
- Research in early brain development
- Character development as it relates to behavior and management
- Supervision practices appropriate for the age and level of development

Curriculum

- Significance of play and emergent curriculum in learning and development
- Developmentally appropriate practices that focuses on children's needs and interests, and consider culturally valued content and home experiences
- Learning experiences that help children develop emerging intellectual curiosity, problem solving and decision making skills, and critical thinking
- Integration of learning experiences with curriculum theories and current research
- Design, implementation and evaluation of child care and education programs
- Use of informal and formal assessments to plan activities, individualize programs, and improve program quality

- Planning and implementation of appropriate environments for children which facilitate development in all domains
- Design of new environments or modification of existing ones that nurture and educate children and meet state regulatory requirements
- Appropriate equipment and materials for outdoor and indoor learning spaces
- Using appropriate supervision practices for all children's activities

Health, Safety and Nutrition

- Health issues and nutrition for children
- Implementation of safety management practices
- Knowledge of major issues affecting the health and safety of children in care
- Health record keeping and policy considerations
- Abuse, neglect and injurious treatment
- Practices and procedures for sanitation
- Illness prevention

Professionalism

- Historical and philosophical foundations of early care and education
- Diversity of child care programs
- Current issues, trends, research and opportunities in the field
- Self-awareness and assessment
- Personal philosophical perspective as a basis for making professional decisions
- Ethics and professional behavior
- Mentorship
- Collaborative process
- Advocacy for children and child care programs
- Awareness of professional organizations, licensing and credentialing processes, education and community resources
- Facility and daily operations

- Financial planning and management
- Staff and program development, supervision, and evaluation
- Leadership, team building, and conflict resolution
- Knowledge of child care policies, licensing regulations, legal and advocacy issues
- Determination of community child care needs, marketing, public relations
- The value of developing policies

Community

- Supportive and effective communication skills
- Dynamics, roles and relationships among children, families, and child care professionals
- Community resources that support children and families
- Sociology of children and families
- Parent participation in child care and education programs
- Recognition of diversity in society
- Benefits and process of collaborations

Special Needs

- Developmentally appropriate practices for children with varying developmental, emotional, cognitive, language and/or physical needs
- Understanding the special needs of all children
- Effective partnerships with parents, families, and other professionals
- Inclusionary practices
- Design of accessible learning environments
- Theoretical and legal foundations for special programs

Source: Department of Human Resources

Guidelines for Tiered Reimbursement and Overall Program Evaluation

Accreditation Status ¹	Level One		Level Two		Level Three		Level Four	
	No Criteria	Meet licensing requirements. Start MSDE or nationally recognized accreditation self-study.	Meet licensing requirements. Complete MSDE or nationally recognized accreditation self-study.	Meet licensing requirements. Complete MSDE or nationally recognized accreditation self-study.	Meet licensing requirements. Be fully accredited			
Required Training²	Licensing requirements for position	The staff person in charge of each group of children holds a Level Two Maryland Child Care Credential.	The staff person in charge of each group of children holds a Level Three Maryland Child Care Credential.	The staff person in charge of each group of children holds a Level Four Maryland Child Care Credential.	The staff person in charge of each group of children holds a Level Four Maryland Child Care Credential. R e q u i r e m e n t o f Accrediting Body or a minimum of: 24 clock hrs every year			
To Maintain Level - Continued Training								
Family Child Care Provider	12 clock hrs every two years	12 clock hrs every year	18 clock hrs every year	24 clock hrs every year	24 clock hrs every year			
Child Care Center Director	6 clock hrs every year	12 clock hrs every year	18 clock hrs every year	24 clock hrs every year	24 clock hrs every year			
Senior Staff/Group Leader	3 clock hrs every year	12 clock hrs every year	18 clock hrs every year	24 clock hrs every year	24 clock hrs every year			
Assistant Group Leader/Aide	No requirement	6 clock hrs every year	9 clock hrs every year	12 clock hrs every year	12 clock hrs every year			
Learning Environment	Licensing Requirements	Licensing requirements plus 15 minutes of reading with children per day	Same as Level Two	Same as Level Two	Same as Level Two			
Staff Compensation	No criteria	Incremental salary scale based on training and experience, staff evaluations	Same as Level Two	Same as Level Two	Same as Level Two and benefits package			
Parent Involvement³	No criteria	Parents are involved in at least two ways	Parents are involved in at least four ways	Parents are involved in at least six ways	Parents are involved in at least six ways			

Guidelines for Tiered Reimbursement and Overall Program Evaluation

Program Evaluation	<u>Level One</u>	<u>Level Two</u>	<u>Level Three</u>	<u>Level Four</u>
No criteria	After first year, ITTERS, ECERS, SACERS, or FDCCRS ⁴ rating scale assessment and staff evaluation. Facility has no regulatory violations that jeopardize the health, safety, or well being of children.	ITTERS, ECERS, SACERS, or FDCCRS rating scale assessment, staff evaluation, and parent surveys and program goals set. Facility has no regulatory violations that jeopardize the health, safety, or well being of children.	Same as Level Three. Goals evaluated and revised yearly. Facility has no regulatory violations that jeopardize the health, safety, or well being of children.	

¹Accreditation self-study and accreditation must be from an approved accreditation organization and include a validation visit.

²Directors, senior staff and group leaders must meet these criteria. Staffing must indicate greater than 60% credentialed staff. Those not possessing a credential must have a training plan in place with time frames for achieving the credential.

³Methods of parent involvement include -- parent bulletin boards, open door policy, parent handbook, parent/staff conferences, classroom helpers, newsletters, workshops, programs, field trips, preparing materials at home, support of the program operating, suggestion box, or other methods identified by faculty.

⁴ITTERS = Infant/Toddler Environment Rating Scale, ECERS = Early Childhood Environment Rating Scale, SACERS = School-Age Care Environment Rating Scale, FDCCRS = Family Day Care Rating Scale

Maryland Child Care Credential Accepted Professional Activities

Professional Activity Units are earned for the following:

<u>Units</u>	<u>Activity</u>
1	<ul style="list-style-type: none">• Membership in national child education organization• Membership in State child education organization• Membership in local child education organization• Board member, officer, or committee member in local organization• Presenter of in-service training or workshop for staff or support group
2	<ul style="list-style-type: none">• Board member, officer, or committee member in State, regional, or national organization• Member of task force or advisory group on ECE, School-age or child/family issues• Resource and referral volunteer• Author or contributor of material to newsletter distributed locally or statewide• Successful completion of three semester credits college coursework (limit --- two units per year)
3	<ul style="list-style-type: none">• Presenter at local, State, or national conference• Instructor of infant/toddler, early childhood, school-age training• Author or contributor of material for early childhood, school-age, or related publication distributed nationally• Editor of local, State, or regional newsletter• Developer of early childhood, school-age or infant-toddler curriculum for use by other trainers• Child Development Associate Advisor or Rep• State/National Accreditation observer, validator, or verifier• Mentor to more than one facility• Performed ECERS, ITERS, SACERS, or FDCRS• Supervisor of student teachers, mentor/teacher, or mentor/trainer