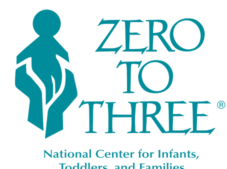
EXPANDING ACCESS TO EARLY HEAD START:

STATE INITIATIVES FOR INFANTS & TODDLERS AT RISK

SEPTEMBER 2012



EXPANDING ACCESS TO EARLY HEAD START:

STATE INITIATIVES FOR INFANTS & TODDLERS AT RISK

BY JAMIE COLVARD, ZERO TO THREE
AND STEPHANIE SCHMIT, CLASP

SEPTEMBER 2012

1 INTRODUCTION
3 METHODOLOGY
5 FINDINGS
11 RECOMMENDATIONS
14 ENDNOTES
18 APPENDIX

ACKNOWLEDGEMENTS

This report would not have been possible without the generous support of the Birth to Five Policy Alliance, Annie E. Casey Foundation, George Gund Foundation, Irving Harris Foundation, The W.K. Kellogg Foundation, The John D. and Catherine T. MacArthur Foundation, A.L. Mailman Family Foundation, and an anonymous donor.

The authors are grateful to the many state leaders who took time out of their busy schedules to share information and lessons learned about their state initiatives. They are also grateful to colleagues Barbara Gebhard, Assistant Director of Public Policy at ZERO TO THREE, and Hannah Matthews, Director of Child Care and Early Education at CLASP, for their input.

Jamie Colvard is a Senior State Policy Analyst at ZERO TO THREE. Stephanie Schmit is a Policy Analyst at CLASP. The findings and conclusions of this report are those of the authors alone, and do not necessarily reflect the opinions of our funders.

© 2012 by the Center for Law and Social Policy and ZERO TO THREE. All rights reserved.

These materials are intended for education and training to help promote a high standard of care by professionals. The findings and recommendations included here are the result of an extended process of review and analysis on the part of the author organizations. The views expressed in these materials represent the opinions of the respective authors. The interview process did not include an exhaustive list of possible participants, and therefore the findings and opinions do not necessarily reflect the opinions of all stakeholders in the selected states or project funders.

The Center for Law and Social Policy and ZERO TO THREE expressly disclaim any liability arising from any inaccuracy or misstatement.

INTRODUCTION

All babies need good health, strong families, and positive early learning experiences to foster their healthy intellectual, social, and emotional development.[1] Unfortunately, far too few young children receive the supports they need to build a strong foundation for future growth. Infants and toddlers living in households under great economic stress are more likely to face challenges that negatively impact their development. Research shows that young children growing up in poverty experience poorer health, higher incidence of developmental delays and learning disabilities, hunger, and more reported cases of abuse and neglect compared to their peers.[2] As a result, they are less likely to be successful in school and productive in the labor force as adults.[3] The recent economic recession significantly increased the number of families struggling, and the number of infants and toddlers at risk for these outcomes. In 2010, 1 in 4 children under age 3 was living in poverty (defined as less than 100 percent of the federal poverty level), and almost half were living in low-income families (less than 200 percent of the federal poverty level).[4] This represents an increase of 15 percent and 8 percent respectively from just five years earlier.[5] Providing supports to vulnerable infants, toddlers, and their families is essential to putting young children on a path toward healthy development.

The federal Early Head Start (EHS) program was created in 1994 to address the comprehensive needs of children under age 3 in low-income families and vulnerable low-income pregnant women. In addition to early learning opportunities, EHS's comprehensive early childhood development programs provide children and families with access to a range of services such as health screenings, referrals and follow-up support, parenting resources, and social services. Research shows that EHS positively impacts children's cognitive, language, and social-emotional development; family self-sufficiency; and parental support of child development.[6]

WHAT IS EARLY HEAD START?

EHS is a federally-funded, community-based program that provides comprehensive child and family development services to low-income children under age 3 and pregnant women. EHS's mission is to support healthy prenatal outcomes and enhance the intellectual, social, and emotional development of infants and toddlers to promote later success in school and life. To be eligible, families must meet the federal poverty guidelines, which include gross annual income of $23,050 per year for a family of four in 2012.

Comprehensive services provided by EHS include:

- Access for children to medical, mental health, and early intervention services
- Early learning services that support the full range of child development from infancy through preschool age
- Parent support and linkages to needed services
- Prenatal health care and support

All EHS programs must comply with federal Head Start Program Performance Standards, which were adapted to address the needs of infants and toddlers and pregnant women when EHS was created. EHS grantees tailor services to communities' needs by choosing from several program options, including center-based programs, home-based programs where services are delivered in the family's home from a qualified home visitor and through group activities, family child care programs, combination programs that include center- and home-based services, and locally-designed programs created by the grantee and approved by the federal government.[8]

Despite the program's proven ability to lessen the negative effects of poverty, consistently low levels of federal funding and increasing child poverty have kept the program's capacity low. Even the $1.1 billion increase in federal funding from the 2009 American Recovery and Reinvestment Act (ARRA)–which increased the total number of children and pregnant women served from 93,287 in 2009 to 133,971 in 2010–failed to significantly change the percentage of those eligible who were served because poverty also increased over the same period. Despite the fact that the ARRA-funded slots became part of the base funding formula for EHS in FY2012, less than 4 percent of eligible children are served at 2012 federal funding levels.[7]

Using innovative funding, policies, and partnerships, states can expand the critically important EHS program and better meet the needs of more low-income children and pregnant women living in their state. In 2008, ZERO TO THREE and CLASP released *Building on the Promise: State Initiatives to Expand Access to Early Head Start for Young Children and their Families*,[9] which outlined the diverse ways states expanded upon or enhanced EHS services for infants, toddlers, and their families. At that time, the researchers found 20 states with some efforts to expand or enhance EHS services at the state level.[10] This report provides updated information on how states are supplementing EHS four years later.

METHODOLOGY

Utilizing the findings from *Building on the Promise*, CLASP and ZERO TO THREE gathered updated information from every state. CLASP and ZERO TO THREE sent a preliminary e-mail survey to Head Start Collaboration Directors in all states and the District of Columbia to assess whether they had existing or planned initiatives to expand or enhance EHS services. Twenty-three states responded that they did. [11] The authors followed up with these states through e-mails and phone conversations to gather all necessary and relevant information. CLASP and ZERO TO THREE found that states are continuing to utilize the four approaches to building on EHS outlined in *Building on the Promise*:

- Extend the day/year of existing EHS services
- Expand the capacity of EHS programs to increase the number of children and pregnant women served
- Provide resources and assistance to child care providers to help them deliver services meeting EHS standards
- Support partnerships between EHS and center-based and family child care providers to improve the quality of child care

Though the approaches remain the same, some states are implementing them in new ways. The most significant change is a result of the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, which provides states the opportunity to further invest in EHS by utilizing MIECHV grant funds to support EHS programs utilizing the home-based program option.

THE MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM

The federal MIECHV program was authorized by the Patient Protection and Affordable Care Act in 2010. It provides $1.5 billion over five years to states and territories to improve the health and development outcomes of at-risk children through evidence-based home visiting programs.[12] The majority of funding is used to implement program models with demonstrated evidence of effectiveness, including the EHS home-based program option. Remaining funds can be used to implement and evaluate "promising approaches." MIECHV provides states the opportunity for system building and collaboration at the state and community levels.

FINDINGS

In the four years since *Building on the Promise* was written, states have faced significant budget shortfalls, requiring many to make difficult funding decisions. State EHS initiatives have not been immune to cuts. Several states that had initiatives in 2008 no longer have them in the same form in 2012. Six initiatives ended completely, and many more now operate with less funding or fewer options than previously.

Despite difficult economic times, 23 states have at least one initiative that builds on the federally-funded EHS program. A chart detailing the states using each of the four approaches is included in the appendix.

- Nine states have initiatives that **extend the day or year of existing services** by making additional funding available or implementing policies to ease the process of layering federal EHS funding with other funding sources. This approach is often used to allow programs to extend their operating hours to meet the needs of working parents (the majority of center-based programs operate five days per week for six or more hours per day without state funding).[13]
- Nineteen states have initiatives that **expand the capacity of EHS programs to increase the number of children and pregnant women served** by allocating state funds specifically for this purpose, allowing supplemental funding to be used for EHS, or selecting the EHS home-based program option as one of the models to implement under the MIECHV program.
- Two states **provide resources and assistance to child care providers** to help them deliver services meeting EHS standards by providing both funding and technical assistance directly to child care providers.
- Six states **support partnerships between EHS and center-based and/or family child care providers** to improve the quality of care by leveraging EHS expertise and resources, delivering EHS services in child care settings, or establishing policies that facilitate partnership.

Despite difficult economic times, 23 states have at least one initiative that builds on the federally-funded EHS program.

Conversations with states revealed five primary findings within and across the four approaches. These findings are detailed on the following pages.

INITIATIVES TO EXTEND THE DAY OF EHS SERVICES ARE FUNDED THROUGH A VARIETY OF SOURCES AND POLICY STRATEGIES

States use a variety of sources to fund initiatives that extend the day or year, including tobacco settlement funds, state general revenue, Child Care and Development Block Grant (CCDBG), and private foundation funds. Many of these initiatives have been around for several years. In Maine, for example, $1.3 million in tobacco settlement dollars are used to support the Fund for a Healthy Maine, which provides funds to existing Head Start and EHS programs to expand to full day, full year services and increase the number of children served.

Some states are pursuing policies to ease the layering of funds to extend the day or improve quality in child care settings. Three states—Illinois, Montana, and New Hampshire—do not allocate additional dollars to the program, but instead have created policies to make it easier for federal EHS grantees to access state-administered child care subsidy dollars. The Illinois Child Care Collaboration Program promotes collaboration between child care and other early care and education providers, including EHS, by creating policies to ease layering of funds to extend the day or year of existing services. While no funding is provided through the initiative, participating programs may take advantage of several child care rule exceptions that make it easier to access child care subsidy dollars to extend the day or year of EHS services, including: annual redetermination of family eligibility; a 90-day job loss grace period; and indefinite eligibility for families whose Temporary Assistance for Needy Families (TANF) Responsibility and Service Plan specifies the child's or family's participation in the collaboration. In FY 2012, 1,731 children were served through Illinois' initiative.

INCREASING EHS FUNDING IN A DIFFICULT ECONOMIC TIME: Minnesota State Supplemental Funding Initiative

Despite hardships in Minnesota and across the country, the state investment in EHS increased from $4.5 million in 2008 to $6.2 million in 2011. This was part of an overall increase to $20.1 million in state supplemental funding for Head Start. These state general revenue funds are used to increase the capacity of existing EHS programs to serve additional children and pregnant women. In 2012, 568 children birth to age 3 and 324 expectant mothers were served through the state initiative–an increase of 361 children and expectant mothers since 2008.

STATE POLICIES EASE PARTNERSHIP: New Hampshire Memorandum of Agreement

In August 2011, the New Hampshire Division for Children, Youth and Families (DCYF) signed a memorandum of agreement (MOA) with the Head Start Directors Association to better promote Head Start/EHS and child care wrap-around services for children receiving child care subsidies. The original process, which was established in 2001, was expanded to enable licensed child care providers to bill the DCYF Child Development Bureau directly for the non-Head Start/EHS part of the day. Compensation is based on the number of hours a child attends Head Start/EHS and child care combined for the week, and may include full time subsidy payment to a child care provider. EHS programs and child care providers interested in participating must sign a MOA that outlines how billing requirements will be met and describes how other areas of collaboration will occur, such as joint staff training or shared transportation. Since the new policy went into effect, six partnership MOAs have been submitted. Two of New Hampshire's five grantees offer their own child care wrap-around services for which no agreement is necessary.

SEVERAL STATES ARE UTILIZING MIECHV FUNDING TO EXPAND EHS SERVICES

MIECHV funding has provided states with a new opportunity to expand the capacity of EHS programs and increase the number of children and pregnant women served. Fifteen states are implementing the EHS home-based program option with MIECHV funding.[14] For example, Michigan gave its at-risk communities receiving MIECHV funds the choice of four evidence-based models to employ. Three of the seven communities chose to utilize the EHS home-based program option by expanding existing EHS programs. In Idaho, the EHS home-based program option was one of three evidence-based models selected. All four of the MIECHV at-risk communities currently funded are expanding existing EHS programs, one of which is a migrant/seasonal grantee that will begin providing home-based services in addition to the center-based program already offered. Some of the states that are not implementing EHS as a MIECHV model at this time reported that they are exploring doing so in the future.

Whether EHS was selected as a funded model or not, the majority of states reported that EHS representatives were involved in planning for the MIECHV grant and broader home visiting system work. For example, in New York, several state agencies, advocacy organizations, and service providers (including EHS) have worked together for many years to build a system of home visiting services to meet the needs of vulnerable families.

SEVERAL STATES HAVE SUPPLEMENTAL FUNDING INITIATIVES THAT ARE OPEN TO HEAD START AND EHS GRANTEES

In addition to the 15 states expanding EHS services using MIECHV funds, 11 states allocate state funds (such as state general revenue and tobacco settlement revenues), other federal funding (such as TANF), or private funds to increase the number of children and pregnant women receiving EHS services.

The majority of these states have supplemental funding initiatives in which both existing Head Start and EHS grantees are eligible to participate. The Oklahoma Pilot Early Childhood Program combines public and private money to expand access to high-quality early care and education for children birth through age 3. In addition to Head Start and EHS grantees, child care centers, school districts, and community agencies are eligible to apply as long as they meet federal Head Start Performance Standards.

Oregon and Kansas direct funds specifically to EHS. In Oregon, all federally funded EHS programs, including Tribal EHS programs, are provided state funding to increase the number of children served. The legislature first allocated state funds to EHS in 2010. Kansas has had a state EHS program for much longer. Beginning in 1998, the state offered a combination of state general revenue, tobacco settlement funds, and federal CCDBG quality set-aside funding to EHS sites. In FY2011, 1,163 children birth to age 4 and expectant mothers were served through the state program.

A FEW STATES CONTINUE TO PROVIDE RESOURCES TO CHILD CARE PROVIDERS

Illinois and Oklahoma build on EHS by providing resources to help child care providers meet EHS standards. In Illinois, grants are offered to center- and home-based programs to provide slots for children birth to 3 years and to work toward aligning with state and federal performance standards. These grants are funded through the infant/toddler set-aside in the state general revenue Early Childhood Block Grant. In Illinois, the Early Childhood Block Grant is funded through the Illinois State Board of Education and supports prevention initiatives for at-risk children from birth to age 3 and their families, as well as voluntary preschool for children ages 3 and 4. In Oklahoma, the initiative is funded using state general revenue and private foundation funding. Participating child

NEW STATE FUNDING IN A TIME OF BUDGET CUTS: Oregon EHS

During a special session called in February 2010, the Oregon State Legislature allocated $1 million in state general revenue to EHS for the first time. The decision to expand EHS was made in the midst of discussions over how to fill a $185 million hole in the state budget, demonstrating legislators' commitment to early childhood education. State EHS funding was added to all federally funded EHS programs, including Tribal EHS programs, to expand the number of children they could serve. In the first year, state funding made it possible for 59 children to join the 1,700 already being served by EHS in Oregon. Difficult budget times continued in 2012, but the legislature preserved the 59 slots by allocating $1,504,002 per biennium.

care programs receive funding, training, and technical assistance to meet EHS standards. Programs also receive training in Teaching Strategies GOLD, an online assessment, program planning, National Association for the Education of Young Children (NAEYC) standards, the Infant and Toddler Environmental Rating Scale (ITERS), the Early Childhood Environmental Rating Scale (ECERS), the Program for Infant/Toddler Care (PITC), and a reporting system for early childhood programs.

STATES CONTINUE TO ENCOURAGE EHS-CHILD CARE PARTNERSHIPS

States support partnerships between EHS programs and child care providers to improve the quality of care young children receive. To do this, states are primarily using two strategies: establishing policies that lessen the burden of partnership, as discussed in the first finding, and providing funding to EHS programs that partner with child care providers so EHS services are delivered in child care settings. For example, five EHS programs currently have sub-grants with the Nebraska Department of Health & Human Services for $30,000 each to establish partnerships with center- or home-based child care providers. In addition to providing their child care partners with training and mentoring, the EHS programs have discretion to use part of their grant funds for child care provider incentives such as books, equipment, and hiring of substitutes so full-time child care staff can have time off to attend training. In Kansas, EHS programs receiving state funds are required to collaborate with child care centers and licensed family child care providers to provide EHS services, ensuring that enrolled pregnant women and children receive services meeting the federal Head Start Performance Standards in either setting. Child care partners are offered supports such as technical assistance, grants, and comprehensive services for the families they serve in order to help the providers meet the standards and raise the quality of care all children in their programs receive.

SERVING CHILDREN IN CHILD CARE SETTINGS: Maryland EHS Partnership

Since 2000, Maryland has provided supplemental funds to EHS programs to extend the day or year for EHS children through partnerships with child care centers. The initiative provides an average of four additional hours of care a day for children enrolled in the partnership in their child care setting. Because this initiative extends the day for children already receiving EHS services, no additional children are served. However, through the partnership, eligible children in child care partner settings may be able to receive EHS services even if they are not directly enrolled, although this is left to the discretion of the local programs. In 2012, $213,274 of state general revenue funds supported the initiative.

FUNDING MECHANISMS FOR STATE EHS INITIATIVES

STATE	STATE REVENUE SOURCES			PRIVATE SOURCES	FEDERAL FUNDING SOURCES				
	GENERAL REVENUE	TOBACCO SETTLEMENT	GAMING REVENUE	PRIVATE FOUNDATION	CHILD CARE SUBSIDY (CCDBG)	INFANT TODDLER EARMARK (CCDBG)	QUALITY SET-ASIDE (CCDBG)	TANF	MIECHV
CONNECTICUT									X
DISTRICT OF COLUMBIA					X				
GEORGIA									X
IDAHO								X	X
ILLINOIS	X				X[i]				X
IOWA									X
KANSAS		X					X		X
MAINE	X	X							
MARYLAND	X								
MASSACHUSETTS	X								X
MICHIGAN									X
MINNESOTA	X								
MISSOURI			X		X				X
MONTANA					X[i]				
NEBRASKA						X			
NEVADA					X				X
NEW HAMPSHIRE					X[i]				
NEW JERSEY									X
OKLAHOMA	X			X					
OREGON	X				X				X
PENNSYLVANIA									X
SOUTH CAROLINA									X
WISCONSIN	X								X

i. Illinois, Montana and New Hampshire have policies to make it easier for federal EHS grantees to access state administered child care subsidy dollars; they do not allocate additional separate funds to build on the federal program.

RECOMMENDATIONS

State investments in EHS provide comprehensive services to infants and toddlers and their families well beyond the scope of the federal investment. These state investments help serve additional children, provide care to children for longer amounts of time during the day, extend the year of services, and support providers in creating stronger, higher quality programs. Given the positive outcomes of EHS for young children and their families, and the great need for services, state policymakers should look to examples in this paper as opportunities to develop or further expand EHS initiatives.

Conversations with state leaders and information gathered for this brief revealed five recommendations that can help states interested in expanding or further investing in EHS.

Leverage federal funding streams to further state investment in EHS and increase the availability of comprehensive services to more children and families.

Many states reported the use of federal funding streams and, in some cases multiple federal funding sources, to further their state investment in EHS. Two examples of funding streams that have been historically available to support EHS on the state level include CCDBG and TANF. More recent sources of federal funding that can be used with EHS include MIECHV and Race to the Top Early Learning Challenge grants. Because of their flexibility and states' decision-making authority, states should consider utilizing these funding streams to support EHS at the state level.

Provide sufficient state funding to the EHS initiative and participating providers to ensure stable resources in communities.

States understand the value of well-implemented EHS programs and know that supporting or expanding EHS services on the state level is one way to ensure comprehensive services reach the children who are most in need. Providing funding levels that are sufficient enough to support quality comprehensive services to children in need is important to ensuring strong programs in communities. State representatives noted that, in tough economic times, carefully considering and selecting available funding sources, in addition to allocating state resources, can help to ensure the sustainability of funding for programs and staff.

Use EHS initiatives to partner with and enhance the quality of child care for infants and toddlers in the state.

States said that encouraging EHS-child care partnerships is an effective way to leverage state and federal investments both in EHS and child care. They also noted that partnerships can improve the quality and continuity of care for infants and toddlers.

Cultivate champions for EHS and the needs of vulnerable infants and toddlers, inside and outside of state government.

Several states reported that it would not have been possible to initiate or maintain their EHS initiatives without the support of committed champions for EHS. In difficult economic times especially, states said that it is important to have a diverse group of people–including business leaders, policymakers, parents, providers, state agency staff, and other early childhood advocates–bring attention to the needs of very young children.

Integrate EHS into the broader early childhood system so that more infants and toddlers receive high quality services.

Whether they currently have state EHS initiatives or not, states said it is essential that EHS is connected to other early childhood services such as child care and home visiting. They also noted that early childhood system efforts around professional development, quality improvement, and data systems are more effective when EHS is at the table.

CONCLUSION

EHS plays a critical role in the continuum of high quality early childhood services by supporting the most vulnerable young children's healthy development. Unfortunately, far too few families who could benefit from EHS' comprehensive services receive them. With difficult economic circumstances across the country and increased need, it is imperative that states further invest in their youngest children.

State policymakers interested in putting at-risk infants and toddlers on a path toward success in school and in life should utilize the approaches presented in this paper to expand and enhance EHS. As demonstrated by the experiences of states currently implementing EHS initiatives, states can take the lead in intensifying efforts to make this proven program available to many more infants and toddlers.

ENDNOTES

1 National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack Shonkoff and Deborah A. Phillips, eds. Washington, DC: National Academy Press, 2000.

2 Jeanne Brooks-Gunn and Greg J. Duncan, *The Effects of Poverty on Children*, 1997, www.princeton.edu/futureofchildren/publications/docs/07_02_03.pdf.

3 Center on the Developing Child, *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. Center on the Developing Child, Harvard University, 2007, www.developingchild.harvard.edu/.

4 Sophia Addy and Vanessa Wright, *Basic Facts about Low-income Children: Birth to Three*, 2010, 2012, www.nccp.org/publications/pub_1056.html.

5 Ibid.

6 U.S. Department of Health and Human Services, Administration for Children and Families, "Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start." Washington, DC: U.S. Department of Health and Human Services, 2002.

7 2010 is the most recent year of Census Bureau data available. Note that 120,433 is the exact number of children under 3 served by Early Head Start in Fiscal Year 2010. U.S. Department of Health and Human Services, Administration for Children and Families, Early Childhood Learning and Knowledge Center, *Head Start Program Information Report for the 2010-2011 Program Year, Early Head Start Programs Only*. U.S. Department of Health and Human Services. Note that 3,248,000 children under 3 in the U.S. live below the federal poverty level. U.S. Census Bureau, "Table POV 34: Single Year of Age – Poverty Status: 2010. In *Current Population Survey, 2011 Annual Social and Economic Supplement*. U.S. Census Bureau, 2010, www.census.gov.

8 See *Early Head Start Programs, Families, Staff in 2010,* 2011, www.clasp.org/admin/site/publications/files/EHS-PIR-2010-Fact-Sheet.pdf.

9 *Building on the Promise* was written as an update to the original publication, *Beacon of Hope*. Both of these publications outline state initiatives to expand access to Early Head Start for young children and their families.

10 The 20 states that had initiatives in 2008 were California, District of Columbia, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, Oklahoma, Oregon, Vermont, and Wisconsin.

11 CLASP and ZERO TO THREE were unable to reach Alaska. Information is valid as of June, 2012.

12 For more information on the home visiting models identified as "evidence-based" for the MIECHV program, visit the Home Visiting Evidence of Effectiveness website at www.homvee.acf.hhs.gov.

13 CLASP analysis of 2010 PIR data.

14 For a list of states implementing the EHS-home based option through the MIECHV program, see the Appendix.

APPENDIX

Initiatives that extend the day or year of existing services by making additional funding available or implementing policies to ease the process of blending federal EHS with other funding sources.

STATE	APPROACH	YEAR STARTED	FUNDING MECHANISM
DISTRICT OF COLUMBIA	Extend the day/year of EHS services	1998	CCDBG subsidy funds
ILLINOIS	Extend the day/year of existing EHS services (through policies to ease blending funds)	1998	Not applicable, state initiative does not make specific funding available beyond federal EHS allocation
MAINE	Extend the day/year of EHS services	2001	State tobacco settlement funds
MARYLAND	Extend the day/year of EHS services	2005	State general revenue
MONTANA	Extend the day/year of EHS services (through policies to ease blending funds)	2000	Not applicable, state initiative does not make specific funding available beyond federal EHS allocation
NEVADA	Extend the day/year of existing EHS services	2002	CCDBG subsidy funds
NEW HAMPSHIRE	Extend the day/year of EHS services (through policies to ease blending funds)	2001 (initiated); 2011 (modified)	State initiative enables blending of Head Start and Child Care Subsidy funds to support extended day services for children in part-day EHS
OKLAHOMA	Extend the day/year of existing EHS services	2006	State general revenue and private foundation funds
OREGON	Extend the day/year of existing EHS services	1991	CCDBG subsidy funding

Initiatives that expand the capacity of EHS programs to increase the number of children and pregnant women served by allocating state funds specifically for this purpose, allowing supplemental funding to be used for EHS, or selecting EHS home-based option as one of the models to implement under the MIECHV program.

STATE	APPROACH	YEAR STARTED	FUNDING MECHANISM
CONNECTICUT	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
GEORGIA	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
IDAHO	Expand the capacity of EHS programs (by allowing state supplemental funds to be used for EHS)	1999	TANF
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
ILLINOIS	Expand the capacity of EHS programs	2007	State general revenue: birth to three set aside from state early childhood block grant
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
IOWA	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
KANSAS	Expand the capacity of existing EHS programs	1998	Tobacco settlement and CCDBG quality set-aside
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
MAINE	Expand the capacity of existing EHS programs (by allowing state supplemental funds to be used for EHS)	1990s	State general revenue and tobacco settlement funds
MARYLAND	Expand the capacity of existing EHS programs (by allowing EHS eligible working parents to access EHS programs)	2000	State general revenue
MASSACHUSETTS	Expand the capacity of existing EHS programs (by allowing state supplemental funds to be used for EHS)	2006	State general revenue
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds

STATE	APPROACH	YEAR STARTED	FUNDING MECHANISM
MICHIGAN	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
MINNESOTA	Expand the capacity of existing EHS programs (by allowing state supplemental funds to be used for EHS)	1997	State general revenue
MISSOURI	Expand the capacity of existing EHS programs (by providing funding for EHS to partner with child care providers)	1998	State gaming revenue, CCDBG subsidy funds
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
NEVADA	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
NEW JERSEY	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
OKLAHOMA	Expand the capacity of existing EHS programs (by allowing state supplemental funds to be used for EHS)	2006	State general revenue and private foundation funds
OREGON	Expand the capacity of existing EHS programs (by including a line item in the budget for EHS)	2010	State general revenue
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
PENNSYLVANIA	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
SOUTH CAROLINA	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds
WISCONSIN	Expand capacity of existing EHS programs (by allowing state supplemental funds to be used for EHS)	1992	State general revenue
	Expand the capacity of EHS programs (by selecting the EHS home-based program option as one of the models to implement under the MIECHV program)	2012*	MIECHV funds

*Although funds for MIECHV planning were distributed to states before 2012, programs did not begin providing services to families until 2012

Initiatives that provide resources and assistance to child care providers to help them deliver services meeting EHS standards by providing both funding and technical assistance directly to child care providers.

STATE	APPROACH	YEAR STARTED	FUNDING MECHANISM
OKLAHOMA	Provide resources to child care to attain EHS standards	2006	State general revenue and private foundation funds
ILLINOIS	Provide resources to child care to attain EHS standards	2007	State general revenue: birth to three set aside from state early childhood block grant

Initiatives that support partnerships between EHS and center-based or family child care providers to improve the quality of care by using partnerships to leverage EHS expertise and resources, facilitating partnerships so that EHS services are delivered in child settings, and establishing policies that lessen the burden of partnership.

STATE	APPROACH	YEAR STARTED	FUNDING MECHANISM
ILLINOIS	Support EHS-child care partnerships to deliver EHS	2007	State general revenue: birth to three set aside from state early childhood block grant
KANSAS	Support EHS-child care partnerships to deliver EHS and improve quality of care (by encouraging state EHS grantees to partner with child care providers to deliver EHS services)	1998	Tobacco settlement and CCDBG quality set-aside
MARYLAND	Support EHS-child care partnerships to improve the quality of care (by allowing state supplemental funding to be used by EHS to facilitate partnerships with child care providers)	2000	State general revenue
MISSOURI	Support EHS-child care partnerships to deliver EHS and improve the quality of care	1998	State gaming revenue, CCDBG subsidy funds
NEBRASKA	Support EHS-child care partnerships to improve the quality of care (by facilitating formal partnerships between EHS and center- or home-based child care providers)	1999	CCDBG infant and toddler earmark
NEW HAMPSHIRE	Support EHS-child care partnerships to deliver EHS and improve the quality of care (through policies to ease blending funds)	2001 (initiated); 2011 (modified)	State initiative enables blending of Head Start and Child Care Subsidy funds to support extended day services for children in part-day EHS.

CLASP develops and advocates for policies at the federal, state, and local levels that improve the lives of low-income people, focusing on policies that strengthen families and create pathways to education and work.

ZERO TO THREE is a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.

WWW.CLASP.ORG
1200 18th Street NW
Suite 200
Washington, DC 20036
TEL: 202.906.8000

WWW.ZEROTOTHREE.ORG
1255 23rd Street NW
Suite 350
Washington, DC 20037
TEL: 202.638.1144