



Promoting Continuity of Care in Infant and Toddler Settings

What State, Territory, and Tribal Leaders Can Do



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Very young children develop in the context of their relationships with adults, including their infant/toddler care providers. Neuroscientists have documented the influence of early experiences on development well into childhood and beyond. In fact, these experiences help determine the architecture of the brain, the ability to regulate one's emotions, and how a child's genetic makeup is expressed (National Scientific Council on the Developing Child, 2007). Experts have shown that the first five years—in particular the first three—have the greatest potential for setting a strong foundation for lifelong learning and health. Advances in neuroscience indicate that the earliest years are the most critical for brain development; brain development is cumulative; and future growth and development stem from a child's earliest experiences. Infants form stronger and more secure attachments to adult caregivers who are consistently available to them and able to read their pre-verbal cues and respond sensitively to their needs (Raikes, 1996).

Infants who experience multiple disruptions in their early care are more likely to show aggression and be less outgoing in the preschool years (Howes & Hamilton, 1992). Additionally, repeated “detaching” and “re-attaching” to people who matter is emotionally distressing and can lead to enduring problems. Although the importance of sustained, reliable relationships within the family is well understood, the need for stable and predictable relationships in child care settings is acknowledged less frequently. The disruptive impacts of the abrupt changes related to high caregiver turnover are too often disregarded. (Howes & Ritchie, 2002).

Continuity of care in a group setting refers to assigning a teacher or primary caregiver to an infant or toddler at the time the child is enrolled in the program and continuing that relationship until the child is 3 years old or leaves the program. Access to sensitive, responsive caregiving may be particularly protective for infants and toddlers growing up in families struggling with poverty and life stress. One in five children under age 3 who live in extreme poverty are estimated to face three or more risks to their development (National Center for Children in Poverty, n.d.). Children's relationships with adult caregivers are vital for shaping the brain, early childhood development, and the foundations of school readiness; this is the scientific basis for promoting continuity of care and primary caregiving in infant/toddler settings.

State, territory, and tribal leaders have multiple policy, funding, and regulatory levers they can use to promote continuity of care. **Subsidy policies and procedures, quality improvement efforts, and professional development and workforce initiatives** all play a role in influencing what happens between adults and the infants and toddlers in their care and the families they support. This document provides background information on continuity of care. It offers some examples of potential strategies leaders can use as they consider the best opportunities to promote continuity of care in their state, territory, or Tribe.

Infant/Toddler Community of Practice

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How Does Primary Caregiving Support Continuity of Care?

Continuity of care in a group care setting minimizes the number of caregivers a child interacts with during a day and over time to ensure as much consistency of relationships, environment, language, and culture as possible. This provides a secure anchor for the infant, which in turn enables him or her to explore a wealth of early learning experiences.

Primary caregiving is a critical component to ensuring continuity for infants and toddlers. It requires that one caregiver be matched to an infant or toddler upon entering group care, including center-based, home-based, or family child care settings. The approach enhances the caregivers' ability to work in partnership with families. This includes communicating with parents during drop-off and pick-up, learning about the family's cultural values and child-rearing practices, and sharing insights and information about the child's development (WestEd, 2017). The primary caregiver also works to promote continuous caring relationships for the child through the coordination of care, services, and staffing so that when she or he is not present the child is still cared for within a system of trusted, familiar adults.

Implementing Continuity of Care in Infant and Toddler Settings

Smaller group sizes and adult-child ratios, as well as flexibility in licensing rules regarding grouping by developmental age ranges versus specific chronological age make it possible for early childhood professionals to build stronger relationships with each child in their care. These factors may also contribute to staff retention, a key component to implementing continuity of care at the program level (Reidt-Parker and Chainski, 2015). The longer a young child spends in the care of the same sensitive and skilled professional, the more likely he or she is to form a secure attachment to that person (Raikes, 1993).¹

This continuity is also important for the primary caregiver. The extended time may help the caregiver better understand the needs of the growing child and form trusting relationships with his or her family. These factors also add continuity in caregiving practices across the program setting and home environments.

There are two ways of providing continuity of care: by same-age groupings or by mixed-age groupings.

- With the same-age approach, children stay together with the same caregivers from when they first enter the child care setting until age 3. They move from one age-appropriate environment to another as they achieve more developmental sophistication. If children leave, they are replaced with a child in the same age range. Once the children move on to preschool, a new cohort of infants may start.

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

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- Mixed-age continuity more closely resembles a family child care setting. Infants and toddlers of different ages stay with the same early childhood professionals and children over time, but receive care together in an environment that meets the needs of children of multiple ages (WestEd, 2017).

How Do States, Territories, and Tribes Promote Continuity of Care in Infant and Toddler Settings?

A number of state, territory, and tribal strategies promote continuity of care using policy, funding, and regulatory levers. The Child Care and Development Fund (CCDF) requires state, territorial, and tribal Lead Agencies to design programs that provide uninterrupted service to families. It also requires providers, to the extent allowed under the statute, to support parental education, training, and employment and continuity of care that minimizes disruptions to children's learning and development (45 CFR §98.1(b)(7)). The following section describes opportunities to enhance continuity of care in infant and toddler settings and offers some strategies from various states.

Subsidy Policies and Procedures

Stable access to child care subsidies may make it easier for families with low incomes to maintain continuous access to the same child care provider. Across a group of 32 states in fiscal year 2012, the median length of a subsidy spell for families with infants was nine months, whereas the median spell length was six months for families whose youngest child was age 5 or older (Swenson and Burgess, 2108). Other studies found that some policies and procedures common in state subsidy systems—such as requiring parents to come to the subsidy office during working hours to report changes in family status—have the unintended consequence of making it difficult for eligible families with low incomes to maintain access to subsidies (Adams, Snyder, & Sandfort, 2002a, 2002b; Adams, Snyder, & Banghart, 2008). The Office of Child Care (OCC) now requires states, territories, and Tribes to report on their efforts to promote continuity of care through subsidy policies. They have issued guidance to support Lead Agencies in adopting policies that promote continuity of care services for the benefit of children and families. For example, state, territory, and tribal leaders are required to provide a description and demonstration of eligibility determination and redetermination processes to promote continuity of care for children and stability for families receiving CCDF services, including:

- **Providing a minimum 12-month eligibility and redetermination period regardless of changes in family income (as long as income does not exceed the federal threshold of 85 percent of state median income) or temporary changes in participation in work, training, or education activities.** Redetermination of subsidy eligibility can trigger unnecessary subsidy loss when eligible parents with low incomes face difficulties in meeting state, territory, or tribal-set requirements to maintain subsidy (e.g., when they cannot attend on-site



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meetings, document small income changes, or understand written communications in English) (Adams, Snyder, & Sandfort, 2002a). Several state studies have documented that moving from six- to 12-month eligibility periods is cost neutral and can result in cost savings in terms of the time it takes to process redetermination paperwork (Ewen & Matthews 2010).

- **Offering a graduated phase-out of assistance for families whose income has increased at the time of redetermination;** 29 states currently provide graduated phase-out of assistance.
- **Implementing a policy regarding the process to take parents' irregular fluctuations in earnings into account for initial determination and redetermination;** 35 states currently have a policy in place.
- **Ensuring procedures are in place to not unduly disrupt parents' employment, education, or job training activities in order to comply with the state, territory, and tribal requirements for redetermination of eligibility for assistance.** States, territories, and Tribes must design subsidy systems to anticipate common circumstances experienced by families with low incomes, such as fluctuating employment, education, or income levels, ill health and medical leave, or sick-child or vacation days. Disrupting subsidy receipt every time these changes occur adds to instability of care arrangements.



Quality Improvement Initiatives

Continuity of care, including primary caregiving, is critical to infant and toddler group care quality. Primary care establishes which caregiver is mainly responsible for a child, and continuity of care policies extend the time period from care entry to at least age 3. Ensuring continuity of care, particularly for vulnerable children and families, is essential if we are to deliver on the promise of positive long-term outcomes in future academic and social success linked to high-quality early childhood programming (Reidt-Parker and Chainski, 2015). Early Head Start programs are required to emphasize nurturing and responsive practices, interactions, and environments that foster trust and emotional security. The EHS-CC Partnership grantees must include a requirement in their partnership agreements stating that the continuity of services and relationships must be preserved, and a child should remain in the current care setting and classroom regardless of loss of subsidy. Should a family lose subsidy, EHS-CC Partnership children remain enrolled in the same classroom or setting and EHS-CC Partnership grant funds will be used to cover the **temporary** cost of lost subsidy and the continuation of services (ACF-IM-HS-15-03).

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Recent changes to the CCDF regulations include some key requirements that are designed to address continuity of care:

- Small group sizes provide a rich opportunity to support strong adult-child relationships
- A 12-month eligibility period for children enables them to continue care despite small changes in family income
- Redetermination policies do not unduly disrupt a parent's employment
- A 90-day job-search period when a parent loses employment
- Regulation requiring procedures for enrolling vulnerable populations such as children of teen parents and children experiencing homelessness, including training and outreach to promote access to services for families experiencing homelessness
- Establishment of policies that reflect generally accepted payment practices for child care providers, including paying for absence days and timely reimbursement for child care services (Reidt-Parker and Chainski, 2015)

States, territories, and Tribes can support the implementation of continuity of care strategies by raising awareness and understanding of the importance of continuity of care for infants and toddlers. At the local level, state, territory, and tribal leaders can highlight programs that demonstrate continuity of care practices. At a systems level, leaders can review current licensing rules, quality rating and improvement systems (QRIS), and other quality improvement strategies and embed support for the approach. State, territory, and tribal leaders can consider, but are not limited to, the following options (Reidt-Parker and Chainski, 2015):



- **Adopt policies that promote staff retention**, such as bonuses for completion of specified time periods and adequate compensation. **Delaware** found through cost modeling that its reimbursement rates for infant/toddler care were not sufficient to attract early childhood professionals, and made adjustments.



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- **State child care subsidy systems can recognize the true costs associated with operating child care businesses and employing qualified staff.** When child care programs have access to reliable, consistent revenue streams, caregivers are ensured wage stability, which contributes to continuity of care. Low-income and vulnerable families are more likely to have access to quality programs and continuity of care.
- **Develop policies for tiered eligibility,** or a graduated phase-out of assistance for families whose income has increased at the time of redetermination but remains below the federal threshold. States can also align the eligibility period for families simultaneously enrolled in Head Start, Early Head Start, and public pre-K.
- **Adjust policies to be aligned with generally accepted payment practices** in the private market, such as paying based on enrollment versus attendance.
- **Flexibility within licensing regulations** to promote the use of primary caregiving. Provide opportunities for overlapping age groupings of two to three years versus mandating groups by chronological age enabling children to stay with the same teacher for extended periods, and minimizing disruptions to adult-child relationships. For example:
 - **New York's** overhaul to its child care licensing regulations included the allowance to operate continuity-of-care classrooms. It required that the center make every effort to establish and maintain a primary relationship between the teacher and child and their family from birth to 3 years old. In the continuity-of-care model, infants and toddlers and their teachers stay together until all children in the group are 36 months of age. The teacher must develop positive relationships with each child assigned to his or her care, and tend to their physical and emotional needs. The teachers work together with a second group teacher or assistant teacher in the group who maintains this same relationship with another small number of assigned children.
 - **Michigan** has a regulatory section wherein infant/toddler programs are required to implement a primary care system so that each infant and toddler has a primary caregiver. The primary caregiver is responsible for direct care, verbal and physical interactions, primary responses to the child's physical and emotional needs, and continued interaction with the child's parents regarding the child's experiences. Information regarding a child's food, health, and temperament must be shared daily.
 - **Indiana** requires continuity of care for children under 30 months of age.



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- **Ensure that the principles and practices of continuity of care are embedded in the core knowledge and competencies for the early childhood workforce;** Forty-seven states and territories have infant/toddler early learning standards or guidelines; few include principles and practices of continuity of care. Tribes are not required to have early learning standards or guidelines.
- **Use contracts** with centers, family child care networks, counties, or individual providers to build the supply of quality child care and ensure payments are more aligned with practices in the private market.
- **Encourage providers to move toward continuity of care in state and territory licensing or a QRIS;** Thirty-one states and territories have infant/toddler standards within their QRIS. There is limited encouragement of providers to move toward continuity of care. Tribes are not required to participate in QRIS or state licensing.
- **Use quality dollars to pay for training and technical assistance (T/TA) for center directors and early childhood professionals to learn about and implement continuity of care.**
For example, **Indiana** contracts with local child care resource and referral agencies to employ regionally based infant/toddler specialists to provide intensive T/TA and coaching to child care providers statewide. Forty-four states and territories now provide TA through statewide networks of infant/toddler specialists.



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- **Reduce staff-child ratios and group size in infant and toddler settings through licensing.** Nationally recognized standards for program quality can be included in state and territory requirements for licensing or higher levels of a QRIS. For example, Head Start Program Performance Standards (HSPPS) for the family child care option specify:
 - For one family child care provider, the maximum group size is six children, and no more than two of the six may be under 2 years of age
 - When there is a provider and an assistant, the maximum group size is 12 children with no more than four of the 12 under 2 years of age
 - One family child care provider may care for up to four infants and toddlers, with no more than two of the four children under the age of 18 months (45 CFR §1302.23(b)).
- **Use QRIS to encourage smaller groups and better staff-child ratios.** States and territories can encourage better group sizes and ratios at higher levels of the QRIS. This can help to minimize the impact of lost income that results from serving fewer children.

Professional Development and Workforce Initiatives

The success of continuity of care hinges in part on the capacities of early childhood staff and directors to establish individualized, consistent, responsive, and nurturing relationships with children and to positively engage and support their families. State, territory, and tribal leaders have the opportunity to strengthen capacities through professional development and workforce initiatives. Leaders can consider the following options:

- **Include primary caregiving and continuity of care skills in core knowledge and competencies (CKCs) and professional development for infant/toddler professionals and directors.** Deliver professional development to assist infant/toddler staff in developing trusting, sensitive primary-care relationships. State, territory, and tribal leaders can also provide access to education and support for directors to implement new staffing and planning models and offer support to early childhood professionals in implementing continuity of care. For example: Current professionals who are comfortable working with infants may need training and mentoring to be responsive to those same children as they become toddlers with more advanced physical, emotional, and language skills and capacities. **Georgia** implemented the Talk With Me Baby Initiative, a cross-sector professional development for health, nutrition, and early educators to support improved knowledge and skills in professional and family stimulation of infant/toddler language development through a partnership of the state, higher education, and health and education departments, among others.
- **Include continuity of care in professional development as a strategy to increase family engagement.** Strong family engagement in early childhood

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systems and programs is central—not supplemental—to promoting children’s healthy intellectual, physical, social, and emotional development; preparing children for school; and supporting academic achievement in elementary school and beyond. Research indicates that families’ involvement in children’s learning and development impacts lifelong health, developmental, and academic outcomes. Settings that practice continuity of care can support early childhood professionals in developing positive parent relationships that increase family engagement.

- **Integrate continuity of care and primary caregiving into the state or territory QRIS.** The levels of a QRIS can gradually introduce center directors and staff to training, support, and implementation of continuity of care. States and territories can require that providers use tiered payment for higher QRIS levels specifically to support continuity of care strategies.
- **Target infant/toddler professionals and directors for increased compensation or bonuses to decrease turnover and support continuity of care.** Beginning in 2017, **Delaware** established the Child Care WAGES® Project to provide education-based salary supplements to under-paid teachers, directors, administrators and family child care providers, working with children birth through 5. The Infrastructure Fund provides capital and technology funding to programs to assist them in their ongoing quality improvement efforts through Delaware Stars, the state's QRIS. These efforts are augmented by a statewide strategy for supporting programs in the areas of developmental screening and child formative assessment through Stars. Programs electing to work on these areas receive free professional development and training on the instruments, specialized TA to address implementation, and use of online databases to capture the results. Making infant/toddler care more financially rewarding could also help reduce turnover.



Conclusion

Continuity of care, including primary caregiving, is critical to enhancing secure, responsive relationships in infant/toddler settings. Early childhood professionals have more time to build relationships with children and their families, resulting in enhanced early care experiences and better supports for the bond between parents and children. These early connections fuel important neurological processes that help infants and toddlers explore and learn to regulate their emotions, forming the roots of school readiness. State, territory, and tribal leaders have many options through subsidy, quality, and professional development and workforce systems to support continuity of care based on their assessment of the best opportunities to do so in their state, territory or Tribe. See the reference list following the Continuity of Care Assessment Tool for more resources.



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Infant and Toddler Continuity of Care Assessment Tool

Continuity of care means that children and a primary caregiver remain together, often for the first three years of the child's life. This provides the extended time and intimacy infants and toddlers need to develop secure attachments and strong positive relationships, which in turn significantly contributes to children's long-range social and emotional development and self-confidence (Sroufe, Egeland, Carlson & Collins, 2005). The approach also enhances the professional caregiver's ability to work in partnership with families, learning about the family's cultural values and child-rearing practices, and sharing insights and information about the child's development.

State, territory, and tribal leaders have multiple policy, funding, and regulatory strategies they can use to promote continuity of care. Subsidy policies and procedures, quality improvement efforts, and professional development and workforce initiatives all play a role in influencing what happens between adults and the infants and toddlers in their care, as well as the families they support. Leaders can use this assessment tool to examine current practices. It includes a continuum of practices that support strong attachments among families, staff, and children. This can help leaders consider how to best promote continuity of care in their state, territory or Tribe.



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| Strategies to Promote Continuity | Yes | No | In Progress | Comments |
|---|-----|----|-------------|----------|
| SUBSIDY POLICIES | | | | |
| Subsidy eligibility and redetermination is extended to a period of 12 months for all families regardless of changes in family income (as long as income does not exceed the federal threshold of 85 percent of state median income) or temporary changes in participation in work, training, or education activities. | | | | |
| Subsidy policies provide for tiered eligibility or a graduated phase-out of assistance for families whose income has increased at redetermination time but remains below the federal threshold. | | | | |
| Income eligibility for both initial determination and redetermination is based on an average of salary or wages over a year's time to allow for irregular fluctuations in earnings. | | | | |
| Parents' employment, education, or job training activities cannot be disrupted in order to comply with state or territory requirements for redetermination of eligibility for assistance. | | | | |
| Subsidy eligibility is continued for at least 90 days following the loss of a job or onset of a parent's disability. | | | | |
| Job search is an allowable activity to qualify for or retain subsidy. | | | | |
| Providers and parents with limited English proficiency (LEP) have improved accessibility to the subsidy system through translated information, regulations, and applications; hiring of bilingual staff; use of qualified interpreters; and recertification notification in the family's language. | | | | |
| Programs have procedures for enrolling vulnerable populations including children of teen parents and children experiencing homelessness and provide training and outreach to promote access to services for families experiencing homelessness. | | | | |
| Family copayments are based on family size and income and not calculated per child. Copayments do not exceed seven percent of adjusted family income. | | | | |



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| Strategies to Promote Continuity | Yes | No | In Progress | Comments |
|--|-----|----|-------------|----------|
| Lead Agencies can enhance the supply of high-quality care for infants and toddlers by coordinating activities from the set aside funding, (e.g., quality improvement dollars) to use resources most effectively. | | | | |
| Subsidy policies include providing stable payment and effective payment practices recognizing the costs associated with operating child care businesses and employing qualified staff. | | | | |
| Subsidy policies include payment levels reflecting at least the 75th percentile of the current market rate for infant/toddler care. | | | | |
| Providers are paid on an enrollment basis with an attendance policy that supports continuity of care. | | | | |
| Providers are reimbursed during emergency closures. | | | | |
| Providers are reimbursed for sick days and a limited number of vacation days. | | | | |
| Providers are permitted to layer various funding sources for the same child to meet the cost of providing consistent, high-quality, full-day/full-year care in one facility, with each funding source paying for different aspects of services to avoid duplicate payment for same services. | | | | |
| States or territories contract with centers, family child care networks, counties, or individual providers to build the supply of quality child care and ensure payments are more aligned with practices in the provider market. | | | | |
| The state or territory contracts with quality infant and toddler providers for slots allocated for subsidy-eligible families. | | | | |
| The subsidy program promotes transitioning children from lower to higher quality care in a way that minimizes disruption. | | | | |
| Policies allow flexible wrap-around care with quality care as the core program. | | | | |
| Subsidy policies eliminate child support cooperation provisions for families applying for subsidy. | | | | |

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| Strategies to Promote Continuity | Yes | No | In Progress | Comments |
|--|-----|----|-------------|----------|
| The subsidy program aligns its eligibility processes with Head Start, Early Head Start, and preschool programs. | | | | |
| LICENSING REGULATIONS | | | | |
| There is movement toward meeting best practice standards outlined in Caring for Our Children (CFOC) Basics for staff-child ratios in infant/toddler settings. | | | | |
| Smaller group sizes are required to support stronger adult-child relationships. | | | | |
| An Early Head Start class that serves children under 36 months old must have two teachers with no more than eight children, or three teachers with no more than nine preschool children. | | | | |
| One family child care provider cares for up to four infants and toddlers, with no more than two of the four children under the age of 18 months. | | | | |
| A primary caregiving system is required in center-based infant/toddler settings. | | | | |
| Enrollment policies and procedures are required to allow for gradual transition into care to establish a relationship between a primary caregiver and an infant, toddler, and his or her family. | | | | |
| Procedures are in place for enrolling vulnerable populations, including children of teen parents and children experiencing homelessness, and provide training and outreach to promote access to services for families experiencing homelessness. | | | | |
| Transition plans promote attachment between child, caregiver, and family. | | | | |
| Licensing regulations allow flexibility for a mixed-age grouping with the same teacher and do not mandate groups by chronological age to support program design for continuity of care and primary caregiving. | | | | |
| State, territory, or tribal policies reflect generally accepted payment practices for child care providers, including paying based on enrollment versus attendance. | | | | |



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| Strategies to Promote Continuity | Yes | No | In Progress | Comments |
|--|-----|----|-------------|----------|
| State, territory, or tribal policies are adopted to promote early childhood professional retention, such as bonuses for completion of specified time periods. | | | | |
| QUALITY RATING AND IMPROVEMENT SYSTEMS (QRIS) | | | | |
| Licensed programs are required to participate in QRIS to receive subsidies. | | | | |
| Smaller group sizes and lower staff-child ratios are embedded in QRIS standards. | | | | |
| Infant and toddler rates award bonuses for differential rates of quality. | | | | |
| Programs enrolled in QRIS provide documentation of primary caregiving assignments. | | | | |
| Infant/toddler coursework and credentials are embedded in QRIS standards. | | | | |
| Observational tools are used in QRIS for the assignment of ratings and as a method for supporting programs' continuous quality improvement (CQI). Commonly used observational tools are supported by a research base with established protocols for tool administration. | | | | |
| Programs enrolled in QRIS have policies and procedures that promote secure attachment through primary caregiving and continuity of care practices. | | | | |
| QRIS standards include documentation by programs serving infants and toddlers of their plan to ensure continuity of care and primary caregiving. | | | | |
| State or territory QRIS policies recognize the true costs associated with operating a child care business and employing qualified staff. | | | | |
| State QRIS provides financial incentives in provider payment systems, such as tiered CCDF subsidy payments or bonuses for higher levels of quality. | | | | |
| PROFESSIONAL DEVELOPMENT | | | | |
| Policies that promote early childhood professional retention are adopted by the state, territory, or Tribe, such as bonuses for completion of specified time periods. | | | | |

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| Strategies to Promote Continuity | Yes | No | In Progress | Comments |
|---|-----|----|-------------|----------|
| Continuity of care skills are included in core knowledge and competencies (CKCs) and professional development for the infant/toddler workforce, including program directors. | | | | |
| Continuity of care is included in professional development as a strategy to increase family engagement. | | | | |
| Infant/toddler workforce is targeted for increased compensation or bonuses to decrease turnover and support continuity of care. | | | | |
| Home visiting training includes information on the importance of continuity of care for families transitioning children to out-of-home care. | | | | |
| State, territory, and tribal quality improvement funds are used to pay for TA for center directors and early childhood professionals to learn about and implement continuity of care. | | | | |
| Training for the infant/toddler workforce includes learning about and implementing continuity of care, including strategies for managing multi-age groups in all caregiving settings. | | | | |
| Coursework specific to caring for infants and toddlers is included in associate, bachelors, and masters degree early childhood teacher preparation programs. | | | | |
| When coursework does not adequately address infants and toddlers, revised coursework or credentials are established to provide specific knowledge and skills related to caring for infants and toddlers. | | | | |
| In-service professional development is available for caregivers to develop knowledge and skills for caring for children across the birth to 3 continuum. | | | | |
| Continuity of care is included in professional development as a strategy to enhance the authentic assessment of infants and toddlers. | | | | |
| Training for the infant/toddler workforce includes learning about the importance of implementing relationship-based care for infants and toddlers that is respectful of and sensitive to cultural, linguistic, and ability diversity. | | | | |



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