

Public Comment Report - CCDF Plan

Last Updated 6/21/21

Connecticut's Proposed CCDF Plan 2022 -2024 Public Comments

The Connecticut Office of Early Childhood (OEC) solicited feedback and input from families, providers, and other stakeholders on the Connecticut 2022-2024 Child Care and Development Fund (CCDF) Plan. OEC provided several channels and opportunities for public feedback:

- Oral testimony collected during public Webinar
- Online submission portal

OEC received a total of 87 comments from 40 sources across the two channels, which have been transcribed and summarized into this report. Verbatim transcripts can be found in the appendix.

The following table represents the total number of comments for each section of the draft CCDF plan.

Section	Total Number of Comments	Percentage
Introduction and How to Approach Plan Development (p.4)	0	0%
Section 1: Define Leadership and Coordination with Relevant Systems and Funding Sources (p.6)	10	11%
Section 2: Promote Family Engagement Through Outreach and Consumer Education (p.28)	6	7%
Section 3: Provide Stable Child Care Financial Assistance to Families (p.48)	4	5%
Section 4: Ensure Equal Access to Child Care for Low-Income Children (p.71)	16	18%
Section 5: Establish Standards and Monitoring Processes to Ensure the Health & Safety of Child Care Settings (p.100)	4	5%
Section 6: Recruit and Retain a Qualified and Effective Child Care Workforce (p.141)	12	14%
Section 7: Support Continuous Quality Improvement (p.158)	29	33%
Section 8: Ensure Grantee Program Integrity and Accountability (p.178)	0	0%
Appendix A: MRS, Alternative Methodology and Narrow Cost Analysis Waiver Request Form (p.188)	0	0%

Other/General comment	6	7%
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Comment Summaries

Introduction and How to Approach Plan Development (p.4)

Section 1 Define Leadership and Coordination with Relevant Systems and Funding Sources (p.6)

- 1.1 Plan for building diverse ECE leadership, mentoring and internships. (1)
- 1.3 Get Input from FCC providers on Plan drafting at least 6 months before plan is due, and improve dissemination of the public comment opportunities to achieve wider participation. (2)
- 1.3 Include a child care health consultant or a CCHC coordinating entity to advise on the Plan. (2)
- 1.4 Partner, coordinate with higher education and Dept. of Education to maximize opportunities and capacity. (5)
- 1.4 Develop instructional video resources highlighting 'exemplary teaching' for new teacher instructional purposes. (1)
- 1.5 Initiate dialogue with local health departments about developing a model to pilot health supports to children enrolled in family child care. (1)
- 1.6 Positive comment on coaching offered during work hours on Zoom, it allowed provider accessibility to reflect on Developmentally Appropriate practices and improved outcomes. (1)
- 1.8 Disappointment with the lack of updates to the Statewide Child Care Disaster Plan in 2021. (1)

Section 2 Promote Family Engagement Through Outreach and Consumer Education (p.28)

- 2.1 Non-serious Violations should be removed after corrections. (1)
- 2.3 Appreciation for improvements made to the OEC website, including translation of essential documents. (1)
- 2.4 Create a parent cabinet to Increase family representation at community and state levels. (1)
- 2.4.3 Use high-quality family child care providers as a resource in developing and implementing outreach strategies to build enrollment among under-served communities. (1)
- 2.4 Partner with MIECHV to develop educational online modules for multilingual individuals for home visitors to meet the OEC's objective to increase provider knowledge. (2)
- 2.4 Request OEC's materials to feature information about family child care as an option and refer parents to family child care providers. (1)
- 2.6.1 Inform parents of the CCHC availability of health, wellness and safety supports'. (1)

Section 3 Provide Stable Child Care Financial Assistance to Families (p.48)

- 3.1.3 , 3.1.5 Request OEC update the income eligibility guidelines for low-income families with the use of ARPA funding. (2)
- 3.3 Reduce suspension, expulsion and address implicit bias within ECE. (1)
- 3.3 Update outdated sliding scale to accommodate low income families. (1)
- 3.3 Address immigration concerns for families reluctant to fill out Care 4 Kids forms. (1)
- 3.3.2 Request adult education using contracted slots to prioritize low- income families who need quality child care. (1)

Section 4 Ensure Equal Access to Child Care for Low-Income Children (p.71)

- 4.1 Request rollback of the entry date of "ber" children so they are not disadvantaged at the start of their school year and low-income families should receive affordable, high quality child care until their child is ready to enter school. (1)
- 4.1.1 Review and redesign the format for the Child Care Certificate over the Plan period and include the anticipated effective date. The listing is complicated for both providers and parents to read and understand.(1)

- 4.1.3 Positive comment on OEC's plan to increase rates for infants and toddlers in center-based settings. Request OEC include an effective date for the new rates. (1)
- 4.1.8 Request for resources to meet current demand for children with hearing problems, hunger, or dental pain to be referred to a CCMHC. (1)
- 4.1 Request OEC to make grants and contracts available to high-quality family child care homes to create a stable source of income for these providers. (1)
- 4.1 Appreciation of OEC for recognizing that family child care is an important part of the solution to Connecticut's shortage of high-quality care and taking steps to meet the needs of this sector. (1)
- 4.1 Invite family child care stakeholders and educators to collaborate with OEC to develop strategies to increase the supply and quality of family child care and include English and Spanish outreach. (3)
- 4.1 Expand high-quality infant-toddler care with the use of contracts for non-traditional hour care. (3)
- 4.2 Request the OEC include the anticipated date for the new market rate survey and narrow cost analysis in the description. (1)
- 4.2 Positive comment on OEC's decision to request a one-year waiver from collecting new rate information, as pandemic-era rates will skew the data. (1)
- 4.2 Urge OEC to measure differences in the cost of quality of early childhood care using data-driven arguments about the need for additional investments in child care measures. (1)
- 4.2 Urge that Connecticut move away from market-based rates that don't produce quality data to support adequate payment rates and adopt a cost of quality model for determining child care subsidy rates. (7)
- 4.3 Urge OEC to address licensed centers receiving the lowest percentage of cost rates. (1)
- 4.3 Collaborate with CT Gov to prioritize a permanent ARPA 20% Quality Bonus to center-based providers holding national accreditation. (1)
- 4.5 Request the OEC will follow the 7% recommendation after ARPA funds are exhausted. Providing low income families with affordable early child care. (1)

Section 5 Establish Standards and Monitoring Processes to Ensure the Health & Safety of Child Care Settings (p.100)

- 5.3 Collaborate with DPH and RESC Alliance to implement GONAPSACC and resources to support healthy policies. (1)
- 5.3 Include equal access to Thrive workshops for more types of providers. (1)
- 5.3 Program funding should be non denominational. (1)
- 5.5 OEC should work with DESPP to secure participation in the National Fingerprint File (NFF) program. (1)

Section 6 Recruit and Retain a Qualified and Effective Child Care Workforce (p.141)

- 6.1 Invest in video capture of best teaching practices that supports multilingual learners. (1)
- 6.1 FCC compensation continues to lag Center Based Care compensation and barriers such as equity, and access to native language options exist for FCC providers. (2)
- 6.1 Compensation is inadequate to address the current staffing crisis. It should be comparable to CT public school wages to stop the migration of staff out of early care to public schools. (2)
- 6.1 Fund partnership of nursing facility students and Lab School Project with ARP funds to re-engage the SON network. (1)
- 6.1 Survey the family child care providers to get their feedback following onsite inspection visits.(1)
- 6.2 Include focused infant mental health training for the infant and toddler workforce, example program CT-AIMH. (1)
- 6.2.1 Receive training and supervision in native Spanish (not translated). (2)
- 6.2.1 Add a plan for CCHCs, resurrect CT School of Nursing network, invest in building capacity through the CCHC student, professional coordination with a state directory of CCHCs to raise awareness of health, safety and wellness of children. (1)
- 6.3 Continue to build capacity for ECE's to learn about signs of trauma, homelessness and the health supports available to children and families. (1)

Section 7 Support Continuous Quality Improvement (p.158)

- Continue to work with higher ed RESC Alliance to integrate WIDA EarlyYears in professional learning to ensure equity for multi language learners. (1)
- Expand the Pyramid model for more ECE providers to access virtual professional learning. (1)
- 7.1 Need for demonstration videos used in higher ed to support inclusion of Early Years. (1)
- 7.3 The QRIS system of assessment and the accreditation process are overly data driven and overly cumbersome to complete. There is a need for non-accreditation pathways for programs to document their quality. Smaller, private ECE centers cannot afford college credentialed staff to achieve higher ratings.(2)
- Engage FCC experts, providers and support organizations in the development of the AQIS to define quality standards, benchmarks, professional development and accreditation policies. (1)
- 7.3 Tying NAEYC accreditation to ratings presents an administrative and cost burden for smaller private ECEs. (1)
- 7.3.1 Recognize childcare providers that acquire competencies with a CT infant mental health endorsement or the early childhood mental health endorsement. (1)
- 7.4 Train and support nurses to be effective consultants for child care programs. (8)
- 7.4 Create a database to link health consultants and nurse educators with childcare providers. (6)
- Approach supply-building, quality improvement and investments in facilities through an equity lens. (1)
- 7.6 Continue to expand the ECE Video Clip Library for faculty and trainers and include more examples of supporting multilingual learners and supporting children's social and emotional needs. (1)
- 7.8 Conduct a thorough review of existing accreditation standards, it has lost significance as an accurate tool to measure quality. (1)

Section 8 Ensure Grantee Program Integrity and Accountability (p.178)

- No comments for this section

Section: Other/General comment

- Urge that Connecticut move away from market-based rates that don't produce quality data to support adequate payment rates and adopt a cost of quality model for determining child care subsidy rates. (4)
- Request use of contracted slots to prioritize low- income families who need quality child care. (3)
- Provide a streamlined process to obtain program accreditation. (2)
- Define quality standards, benchmarks, and professional development and accreditation policies within early childhood care. (3)
- Appreciation for efforts by the OEC ensuring quality early childcare. (1)
- Request for providers to have the option to opt in to a state healthcare plan. (1)
- Endorse apprenticeship program to get low income individuals involved in early childhood care. (3)
- Use high-quality family child care providers as a resource in developing and implementing outreach strategies to build enrollment among under-served communities. (1)
- Request use of marketing, networking, and IT plan support for providers. (2)
- Create a referral system database to check available providers for parents. (1)
- Invest in educational CEU classes and CCAC registry classes for native language speakers. (1)
- Invest in technology that provides accessibility to native language individuals. (1)

Appendix A: MRS, Alternative Methodology and Narrow Cost Analysis Waiver Request Form (p.188)

- No comments for this section

Appendix: Verbatim Transcripts

Introduction and How to Approach Plan Development (p.4)

No comments for this section

Section 1: Define Leadership and Coordination with Relevant Systems and Funding Sources (p.6)

Online portal submission

Respondent 1171

(1.1) Section 6 New bullet- Equity and Inclusion? Is there a plan to help build diverse ECE leadership. Mentoring Internships etc. RESCS, Higher Ed, CTAEYC.

Online portal submission

Respondent 1376

(1.3) KinderCare Education is pleased to see the Office of Early Childhood (OEC) considered using social media to post the draft CCDF Plan and public hearing announcement. Unfortunately, we were unable to find this information on the Department's YouTube, Facebook or Twitter page and suggest OEC remove this description or provide dates for the uploaded video and/or post(s). We recommend the Department consider stronger protocols for disseminating information about CCDF to ensure it reaches the widest audience possible.

Online portal submission

Respondent 1382

(1.3) Suggest including a child care health consultant or a CCHC coordinating entity, such as School of Nursing, a stakeholder and partner to advise on the Plan, especially considering COVID. May be valuable partner for both health and safety of children and staff but also for community college and higher education partnerships in creating additional CCHC capacity.

Online portal submission

Respondent 1386

(1.3) All Our Kin greatly appreciates OEC's efforts to solicit public comments about the draft CCDF Plan, including a presentation at the Early Childhood Cabinet meeting and distribution of a five-page summary. At the same time, we are mindful of systemic barriers to meaningful participation in this process by family child care providers. Given family child care providers' keen interest in OEC's future directions, we suggest that OEC partner with a limited number of FCC providers at least six months before the next plan is due. This group would advise OEC on content, strategies to inform FCC providers about the purpose of the plan, the best format and the timeline for releasing the draft and for eliciting meaningful public comment from a larger group of FCC providers.

Online portal submission

Respondent 1255

(1.4) The Lab School Investment project is an intriguing plan for the OEC to partner with higher education providers and maximize opportunities for professional learning and professional preparation. In addition to the proposed ideas, the project could also invest in capturing best teaching practices within lab schools on video so that exemplary teaching can be shared with current and future teachers and providers throughout the Connecticut, now and in the future. This could help develop needed video resources on supporting multilingual

learners and other topics. It would also ensure that current and future providers would have access to visual examples of high quality teaching in settings that serve children from diverse backgrounds, regardless of the region they live in and the population served by their regional lab school.

Online portal submission

Respondent 1382

(1.4) 1.4.1.a.iv. Suggest including plan for engaging CCHCs to support care for infants and toddlers and children with special 'healthcare' needs and how supports of a CCHC, like the supports of a CCMHC, will be ongoing and ties to some intentional system and methodology of support, as with Pyramid for CCMCs. 1.4.1.a.vi. Might help to include CCHCs in coordination with public health 1.4.1.a. vii. Perhaps coordinate with workforce development for parents becoming health professionals, e.g., CCHCs, with higher education including community colleges 1.4.1.a.viii. Coordinate with SDE on health and safety and Schools of Nursing re: school nurses. In years past there was a strong alliance among SONs on both field placements of nursing students in ECE and assistance with ongoing TTA. Higher education can provide broader partnership than limiting it to teacher/caregivers and directors and expanding to health professionals as it was through Healthy Child Care CT in the past.

Online portal submission

Respondent 1386

(1.4) We are encouraged by recent collaboration with workforce development agencies. In addition to securing state approval for CCDF funds to support parents enrolled in education and training programs, we hope OEC will work closely with workforce development agencies to more closely align supply and demand for 24-hour care. Three additional areas that are ripe for future collaboration with the State Department of Education include: • Planning to support the participation of accredited family child care programs in state pre-k (School Readiness) programs (development of requirements that pertain to physical space, instructional models, professional development, assessment and reporting that apply to family child care and build on its strengths.) • Effective transition from infant-toddler care based in family child care homes to school-based pre-k (continuity of care, alignment of standards and policies, operational challenges) • Effective transition from preschool/pre-k based in family child care homes to kindergarten. (continuity of care, alignment of standards and policies, operational challenges) We recommend that this collaboration reach beyond Department of Education staff to involve local superintendents, whose school communities would benefit from better understanding of family child care and relationships with family child care providers themselves. Through its collaboration with the state's higher education institutions, we encourage OEC to develop lab schools for family child care . These will ensure that students receive exposure to FCC as an existing teaching and career option. They will also ensure that all students have meaningful options for practicums and encourage a stronger feedback loop between ECE offerings in higher education and teaching practices. All Our Kin recognizes that OEC does not control provider payments from the Department of Children and Families (DCF). At the same time, we encourage the Lamont Administration to improve the timeliness of payments to child care providers. Slow payment and cumbersome payment processes are making it unfeasible for family child care providers to care for children in the foster care system and contribute to a decline in the number of child care options for children who are in need of stability. There is a critical need for collaboration between OEC and family child care educators on issues that extend beyond the scope of the agency's important contractual relationship with the union. While fully supportive of this relationship, All Our Kin and the providers we work with are eager to partner with OEC on such issues as how family child care providers participate in local School Readiness Councils, the design and ongoing evaluation of Connecticut's family child care networks, professional development, quality improvement, and equitable strategies to increase the supply of child care. Collaboration must occur across a number of platforms and venues, including strengthening the family child care

presence in the Early Childhood Cabinet, establishing a Family Child Care Advisory Council that meets regularly, and creating family child care working groups to assist OEC in developing new initiatives.

Online portal submission

Respondent 1386

(1.5) All Our Kin, its providers and the families they serve through the EHS-CCP are deeply appreciative of OEC's support of this valuable program. Family child care serves some of Connecticut's lowest-income families. State and local pandemic relief offer opportunities to help local health departments recognize that child care providers often provide frontline preventative health care and referrals. While they serve populations that are similar in many respects to Head Start, family child care programs are not funded to provide itinerant health care or health consultation. We encourage OEC to initiate dialogue with local health departments about developing a model to pilot health supports to children enrolled in family child care. This type of collaboration can increase the equity of health outcomes among our youngest children. All Our Kin deeply appreciates OEC's commitment to Mental Health Consultation. We are especially grateful that federal child care relief has been used to provide consultation for children and educators during the pandemic.

Online portal submission

Respondent 1171

(1.6) 6 Standards Curriculum and Assessment coaching- through the RESC Alliance was offered to community ECE providers. The Coaching virtual format (Zoom) during work hours allowed provider accessibility to reflect on Developmentally Appropriate Practices and improved outcomes for young children.

Online portal submission

Respondent 1376

(1.8) We are disappointed the state did not find the COVID-19 pandemic sufficient enough to update Connecticut's Statewide Child Care Disaster Plan. New procedures and practices such as conducting virtual licensing inspections and cross-referencing childcare rules with the Department of Public Health and the Office of the Governor are not addressed in the current Plan. We suggest OEC include a statement intending to update the Statewide Child Care Disaster Plan in 2021.

Section 2: Promote Family Engagement Through Outreach and Consumer Education (p.28)

Online portal submission

Respondent 1375

(2.1) Section 2 2.1 211 keeping violation that have been corrected for 5years is way to long .. *Non-serious Violations should be removed after corrections(they give us 15 days) . Serious issues or what may be considered: eg.un corrected violations, (they usually re inspect) or no proof you have scheduled a med class, capacity issue, any thing serious..Stay on for a max.1year. daycare. Corrected violations for 5years could effect the survival of our family home child care centers. No access to household info...16 year old present at home of inspection. Eg. Parents or public having info we would not share if we did not intend to take that family in our home. This is family child home care and this impedes the safety of our own families. Deeply Concerned Provider, Jeannine Lewis
Licensed provider of 18 years Lead Union organizer seiu/csea

Online portal submission

Respondent 1386

(2.3) All Our Kin deeply appreciates the improvements that have been made to OEC's web site over the past year, including more frequent translation of essential documents. The site is clear, well-organized and well-maintained. Most of the information on the site itself is laid out in a way that can be followed by adults at various literacy levels.

Online portal submission

Respondent 1171

(2.4) 2 New Bullet- Parent Cabinet- launch to increase family voice and representation at the state level and across and local communities. Increase representation of family in leadership positions and engagement at the Local ECE Councils building a ECE Collective.

Online portal submission

Respondent 1255

(2.4) Comment #1: As noted in 2.4.3, the OEC invested in the development of a series of videos to support implementation of the CT ELDS, along with guidance for using the videos for training, higher education, and coaching purposes. (<https://www.easterncct.edu/center-for-early-childhood-education/ct-early-learning-and-development-standards/index.html>) Use of these videos has grown over time - and increased dramatically during the pandemic. For example, daily average views of the 13 videos in the "Mathematics and Early Mathematical Discovery in the CT ELDS" increased by 294% during the pandemic. Daily average views of videos in the "Fostering Essential Dispositions" series increased by 95% during the pandemic. Given the ongoing reliance on videos that illustrate best teaching practices - as well as teachers and providers reflecting on their own practices - it makes sense to invest in the development of educational videos in other needed areas, such as supporting multilingual learners in early childhood classrooms. Comment #2: As noted in 2.4.4., the OEC used MIECHV support to invest in the development of robust and video-rich online modules for home visitors on topics such as infant and early childhood mental health, trauma-informed care, physical activity, nutrition, the importance of play, and safe sleep practices (in English and Spanish). These modules could be adapted to be targeted to home day care providers and/or infant, toddler, and preschool teachers to meet the OEC's objective to increase provider knowledge in healthy eating, physical activity, and other areas. There is a particular need for resources to support children's social and emotional development needs – the OEC-funded video "Understanding Challenging Behavior" has been viewed more than 160,000 times.

Online portal submission

Respondent 1386

(2.4) We are excited to learn about OEC's efforts with the O'Donnell Company to reach English Language Learner families, homeless families, families in deep poverty and those with new infants. Family child care providers serve disproportionately large numbers of families in three out of four categories. Many poses special expertise in working with English Language Learners/Dual Language Learners, families in deep poverty, and families with infants. We hope OEC will view high-quality family child care providers as a resource in developing and implementing outreach strategies that tap informal, community networks to build enrollment among these groups. We also hope OEC's materials will feature information about family child care as an option, and will refer parents to family child care providers through this important initiative.

Online portal submission

Respondent 1382

(2.6) 2.6.1. Inform parents of the availability of the CCHC to the program to ensure health and safety and access to health and wellness supports

Section 3: Provide Stable Child Care Financial Assistance to Families (p.48)

Online portal submission

Respondent 1376

(3.1) 3.1.3: KinderCare Education strongly recommends OEC include a description to work with the Legislature over the Plan implementation period to update the income eligibility guidelines. With annual state minimum wage increases, fewer and fewer hardworking families that need childcare find themselves eligible for childcare subsidy. These families are neither wealthy nor have they yet secured themselves a position in the middle class. 3.1.5: KinderCare Education supports the increase in income eligibility with the use of the American Rescue Plan Act (ARPA) funding. We urge OEC to indicate in the description an intent and/or priority to make a permanent change in eligibility. Serving at-risk children through the Care 4 Kids program for a limited time disrupts what we know is best for children's development: continuity of care. It can also cause financial hardship for parents who are relying on the CCDF program to return to work, especially with the "exit" income set at less than 85% of state median income (SMI).

Online portal submission

Respondent 1171

(3.3) New Bullet- Working to reduce suspension and expulsion and address implicit bias in ECE. Continue to support districts engaged in Pyramid cohorts to review policies and collect data examining behavior incident reports and implementation of pyramid practices to support all young children to be successful.

Online portal submission

Respondent 1314

(3.3) School readiness and cdc programs are required to serve minimally 60% low income children and should receive a flat monthly payment based on these numbers. Too many families we serve are reluctant to fill out care 4 kids forms due to immigration status . Also many families are paying a low parent share due to an outdated sliding fee scale and therefore see no reason to apply for care 4 kids. The process is onerous and often paperwork is returned, and families do not follow through, leaving the provider with large unpaid balances.

Online portal submission

Respondent 1392

(3.3) 3.3.2 Prioritization of Children: Some of the most vulnerable children are those whose mother does not have a high school diploma. Approx. 8-9% of children in CT are born to a mom who does not have a high school diploma. There is much evidence pointing to the level of a mother's educational attainment corresponding to child outcomes, and future earning levels. These are forgotten families and should be a priority for CCDBG funding. This can be done through adult education using contracted slots, prioritizing those parents who need quality child care but also need supporting services to be successful. With federal funding coming to many school districts, it is the perfect time to collaborate with SDE and adult education , and begin to tackle this problem

Section 4: Ensure Equal Access to Child Care for Low-Income Children (p.71)

Online portal submission

Respondent 1270

(4.1) Parental Choice is a false choice right now for parents of "ber" babies in CT. Families are encouraged to send their children to preschool at the early age of 2 yrs 8 mo and then on to K at 4. There should be a roll back of the entry date for K so children are not being disadvantaged at the start of their school year by being developmentally younger than most other children. Additionally, parents should be provided affordable and high quality child care until their child is ready to enter school. It provides an uneven playing field for children from families with low incomes when they are pushed to enter early because public school is free while families with greater means are "holding" their children for another year. The "ber" babies are once again disadvantaged when they exit high school at just 17.

Online portal submission

Respondent 1376

(4.1) 4.1.1: We recommend OEC include a statement to review and redesign the format of the Child Care Certificate over the Plan period. The Lead Agency certifies (13) the family fee is listed in both weekly and monthly amounts and (15)(16) the reimbursement rate is listed in both weekly and monthly amounts. OEC lists another "family fee" amount (17) and a total payment amount (18) that does not include additional charges the family may be responsible to pay. This listing is complicated for both providers and parents to read and understand. We suggest OEC convene a focus group of parents and childcare providers participating in CCDF to create a more user-friendly form. 4.1.3: KinderCare Education strongly supports OEC's plan to increase rates for infants and toddlers in center-based settings. We suggest OEC include an anticipated effective date for the new rates.

Online portal submission

Respondent 1382

(4.1) 4.1.8.b.ix and 4.1.8.c.ix and 4.1.8.e.ix Spell out the role of CCHCs and, again, like done for CCMHCs, how these supports will be ongoing and tied to some intentional system and methodology of support, as with Pyramid for CCMHCs. Considering COVID this seems obvious. Also, as learned in years past, children with hearing problems, hunger, or dental pain may appear disruptive and be referred to a CCMHC. The partnership structure of Schools of Nursing – who are very interested in this supportive role for the field – and existing health consultation content for training developed by Dr. Angela Crowley would be of value for infants and toddlers, children with special needs and family child care networks. Let's resurrect those resources to meet current demand.

Online portal submission

Respondent 1386

(4.1) We are eager to review state data on provider participation in Care4Kids. Anecdotally, we observe that while OEC works with a full range of providers to offer subsidized care through Care4Kids, sub-minimum wage reimbursement rates for family child care providers create de-facto barriers to parent choice. Many family child care providers can no longer afford low Care4Kids payments. Others who accept Care4Kids are forced to charge higher parent co-payments to make ends meet, creating de-facto barriers to parent choice. All Our Kin strongly encourages OEC to make Care4Kids grants and contracts available to high-quality family child care homes to create a more stable and predictable source of income for these providers. We urge OEC to expand high-quality infant-toddler care and non-traditional hours care through the use of grants and contracts, rate increases and grants for supplies and equipment. For example, many family child care programs incur additional expenses to equip facilities for overnight care. Grants can play an important role in mitigating these. In addition, we urge OEC to support these programs through collective marketing and promotion. All Our Kin commends OEC for recognizing that family child care is an important part of the solution to Connecticut's shortage of high-quality care and taking steps to meet

the needs of this sector. We appreciate the tremendous amount of work OEC has completed within a short period of time to expand its family child care networks. At the same time, we hope the vision for these networks will explicitly include family child care quality that builds on licensing standards. Further, we hope that family child care stakeholders, with educators at the center, will be invited to collaborate with OEC to develop strategies to increase both the supply and quality of family child care. As with any new undertaking, we also expect that stakeholder feedback will be continuously solicited, shared with the networks and incorporated into Connecticut's family child care network model as it evolves. Despite our inquiries about OEC's vision for the networks, AQIS and related initiatives, it has been difficult to ascertain whether OEC's vision for family child care includes quality, and if so, how this will be supported. Family child care quality is not well developed in this draft plan, and though several sections discuss NAEYC accreditation, they do not address family child care accreditation through NAFCC. We are not aware that family child care providers, support organizations, researchers or others with FCC expertise have been consulted about the AQIS, professional development and accreditation support. In delaying the development of a vision for family child care quality, OEC risks exacerbating existing inequities between center-based and family child care providers, and between the children they care for. In addition to the absence of information about family child care quality, we are concerned about the business assumptions that inform the model for networks described in this section. The statement that "As OEC works with providers to make infant and toddler care more affordable, the expectation is that providers will pass on the cost savings to families, thereby increasing both access and affordability of care" overlooks the fact that family child care providers must earn adequate incomes before they pass savings on to families. Before the pandemic family child care providers earned average incomes below the minimum wage. It is well known that the number of family child care providers in Connecticut and nationwide had declined for years before the pandemic, with providers citing poor compensation among their primary reasons for closing. Family child care networks are not the solution to Connecticut's affordability crisis. Higher rates and expanded family eligibility are the only solutions to this crisis.

Online portal submission

Respondent 1389

(4.1) The most glaring omission in this plan is that the OEC continues with the 1990's approach of using its CCDF funds solely to fund individual certificates. Connecticut should make use of contracts rather than continue to rely entirely on portable certificates. Contracts could: Help entice providers to invest in new infant and toddler care capacity (the dire shortage of which is noted in the plan) Support wages of Early Educators who achieve credentials Support specialized programs for high risk groups like mothers without a high school diploma by connecting (ideally co-locating) infant toddler care in an adult education program, and Enable the long promised braiding and blending of funding by the office of early childhood in order to deliver one unified, per classroom, funding stream to early care and education programs that would be adequate to pay teachers commensurate with their education and experience. This report from the Urban Institute is a very good resource to see some of the many ways contract can be used to address problems in the early care system <https://www.urban.org/sites/default/files/publication/104344/using-contracts-to-support-the-child-care-workforce.pdf>

Online portal submission

Respondent 1392

(4.1) 4.1.6 The use of contracted slots to impact low income communities, is a means to increase equity and opportunity for the most vulnerable of families. Contracted slots can provide quality programming in child care deserts, can increase the availability of infant toddler care in targeted areas across the state, and target high risk populations, such as those that need basic skills and/or high school equivalency to reach family economic stability,

providing child care and also the type of support services that lead to successful program completion. Contracted slots are used effectively in other states to increase equitable access to quality early care, and they should be utilized in CT.

Online portal submission

Respondent 1376

(4.2) We suggest OEC include the anticipated date for the new market rate survey and narrow cost analysis in the description. We support OEC's decision to postpone the narrow cost analysis to allow time for the childcare market to normalize. We urge OEC to recognize the costs of full recovery from COVID-19 will take much longer than the state can wait to determine the market rate of childcare and to ensure a timely narrow cost analysis. Any free market assumption must include long-term financial data on the impact of COVID-19.

Online portal submission

Respondent 1386

(4.2) Inadequate payment rates are the biggest threat to our child care system today. They hasten the decline of child care supply and quality. This is especially true for family child care providers, who care for a disproportionate share of low-income children whose parents face the biggest constraints on their ability to pay. Family child care providers often absorb the difference between the cost of care and parents' ability to pay (with or without subsidy). This results in chronically depressed wages for family child care educators and high attrition from the field. All Our Kin fully supports OEC's decision to request a one-year waiver from collecting new rate information, as pandemic-era rates will skew the data. At the same time, we urge OEC to reconsider its plans to use a new market rate survey (MRS) as the basis of rate setting. In a market that has never worked properly, market rates create a fiction for elected officials and taxpayers. As long as this fiction is upheld, neither group has to grapple with the need for additional funding to support our child care system. Moreover, the MRS depends on accurate data input from providers. Unfortunately, many family child care providers do not have the information they need to complete the survey accurately. A cost estimation model provides a workaround by relying on input from a smaller number of providers with more accurate data. Finally, the MRS was not developed to measure differences in the cost of quality. Without this information, states may allocate token amounts to reward providers for quality, rather than paying them for the full cost of running high-quality programs. We at All Our Kin believe that elected officials will respond to data-driven arguments about the need for additional investments in child care. But first, they need to see the data. With two decades of experience supporting stable family child care business practices and a national TA portfolio, All Our Kin would be happy to share our insights with OEC about family child care costs and business models as the agency consults with stakeholders in preparation for its next data collection effort prior to setting rates. Before initiating data collection about rates, we strongly advise OEC to engage in intensive outreach to providers in English and Spanish, to explain why cost data is being collected and how it will be used, and to engage trusted community partners to offer technical assistance to family child care providers so they can provide the most accurate data. Sensitivity to digital literacy, user-optimization for cell phones, and broadband access will be critical in developing data collection tools.

Online portal submission

Respondent 1389

(4.2) We fully understand and support the decision not to try and do a market survey during the covid pandemic or while the industry is rebalancing after the pandemic disruption, however the pandemic magnified all of the existing problems making them easier to see. The most obvious of those problems is low pay for the staff taking care of children. The market rate will always be lowest in poor communities where parents are least able to afford

quality care. As long as the child care subsidy system sets its payment rates based on the market, it perpetuates this problem of low wages. The CT Early Childhood Alliance firmly believes that Connecticut needs to move away from market-based rates and adopt a cost of quality model for determining child care subsidy rates. These briefs by Louise Stoney help to explain: https://www.oppex.org/s/OppEx_2020_RateSetting_IssueBrf-e7wl.pdf
https://static1.squarespace.com/static/5f4d7a7ef6c82325c5ec80c0/t/60255563541377587d3b4205/1615582714707/OppEx_2020_InfantToddler_Brief_Stoney.pdf And this infographic is very good
https://www.oppex.org/s/OppEx_2020_MarketPrices_Infographic.pdf

Online portal submission

Respondent 1392

(4.2) 4.2 Market Rate Study Due to the impact of Covid, it is understandable that a waiver be requested for the required market rate study. Even if it were to be completed, a market prices do not reflect the cost of care, shortchanging the providers, and leaving early care businesses vulnerable. Instead, CT could ask to use an 'alternative rate-setting strategy to determine the actual cost of care, rather than a regions market rate. An actual cost of care analysis would provide the information needed to address, and hopefully mitigate the crisis facing the industry. This type of study is worthwhile to complete and especially important so that our state officials and the general public can begin to understand the issues facing early care and education.

Online portal submission

Respondent 1314

(4.3) Licensed centers receive the lowest percentage of cost rates. This needs to be addressed.

Online portal submission

Respondent 1376

(4.3) KinderCare Education strongly recommends OEC include an interest in working with the Legislature and Governor to prioritize making permanent the ARPA 20% Quality Bonus to center-based providers holding national accreditation. National accreditation standards encourage providers to build upon licensing regulations to improve the health and safety of our most vulnerable children. Meeting increased program standards can be a heavy weight on providers, but tiered rate reimbursements assist in offsetting the cost of quality.

Online portal submission

Respondent 1386

(4.3) Inadequate payment rates are the biggest threat to our child care system today. They hasten the decline of child care supply and quality. This is especially true for family child care providers, who care for a disproportionate share of low-income children whose parents face the biggest constraints on their ability to pay. Family child care providers often absorb the difference between the cost of care and parents' ability to pay (with or without subsidy). This results in chronically depressed wages for family child care educators and high attrition from the field. We are not convinced that a Market Rate Survey -- based on a market that does not function as markets are supposed to -- will produce data to support adequate payment rates. We also note the importance of a rate structure that pay for the full cost of quality differentials in care.

Online portal submission

Respondent 1389

(4.3) Care4kids rates for preschool age children are too low at the 25th percentile. This leaves families who prefer a faith based program or live outside of communities where they can access the one of the state subsidized School

Readiness preschools or Child Development Centers with few options. Most private preschools charge more than the Care4kids rate and this leaves parents paying their Care4kids parent fee plus the difference. A child care center operator choosing between two children, one who will use a Care4kids certificate and the other private pay will frequently select the private pay student knowing that if they chose the Care4Kids child, there are additional costs to comply with Health and Safety training requirements that are above and beyond licensing regulations, they will be asking the Care4kids family to pay more than the sliding fee scale indicates they can really afford, and the provider will have to wait a month for Care4kids to pay them rather than be paid weekly.

Online portal submission

Respondent 1386

(4.4) See comments in Section 1 about the urgent need to improve payment practices for children funded through DCF.

Online portal submission

Respondent 1386

(4.5) Connecticut's high cost of living makes it especially difficult for low-income families to pay more than the recommended 7% of their income for child care, especially when they have several children. We hope OEC will follow the 7% recommendation after ARPA funds are exhausted. We also urge the state to take other opportunities to make child care affordable for working families, including raising the income eligibility limit to 85% of SMI, limiting required copayments to 7% of income for all children in the family combined, and establishing a graduated phase-out for subsidy as families approach the income eligibility limit.

Section 5: Establish Standards and Monitoring Processes to Ensure the Health & Safety of Child Care Settings
(p.100)

Online portal submission

Respondent 1171

(5.3) Section 5 New Bullet Continue to collaborate with DPH and RESC Alliance to implement GONAPSACC – virtual coaching and resources to support implementation of healthy policies and practices to support health outcomes for all young children.

Online portal submission

Respondent 1322

(5.3) Thrive workshops need to be available to more types of providers. Most are for family childcare providers yet centers have larger numbers of staff who need training and the cost is prohibitive. The plan should include equal access to all types of providers for any trainings.

Online portal submission

Respondent 1322

(5.4) I am questioning whether the oec should use federal funding to pay programs that are religious based. Programs must be non denominational for most funding, except care 4 kids. Why is that not a requirement for these funds?

Online portal submission

Respondent 1376

(5.5) We recommend OEC work with the Connecticut Department of Emergency Services and Public Protection (DESPP) over the Plan period to secure participation in the National Fingerprint File (NFF) program. Nearly 100,000 people move into the state of Connecticut annually. One of the biggest advantages of becoming an NFF state is the reduction of duplicative record maintenance for interstate background checks. We suggest the Lead Agency include an interest in promoting NFF participation.

Section 6: Recruit and Retain a Qualified and Effective Child Care Workforce (p.141)

Online portal submission

Respondent 1255

(6.1) The Lab School Investment project is an intriguing plan to maximize opportunities for professional learning and professional preparation. In addition to the proposed plan to offer robust practicum experiences and provide professional development to the local community, the project could also invest in capturing best teaching practices within lab schools on video so that exemplary teaching can be shared with current and future teachers and providers throughout the Connecticut, now and in the future. Video examples could be added to the ECE Video Clip Library for Faculty and Trainers, and educational videos could be created from footage with targeted guidance on supporting multilingual learners and other needed topics. This would also ensure that current and future providers would have access to visual examples of high quality teaching in settings that serve children from diverse backgrounds.

Online portal submission

Respondent 1382

(6.1) 6.1.b.ii. Suggest including nursing faculty and students in higher education partnership and Lab School Investment Project funded with ARP funds. This can be a way to re-engage the SON network, provide CCHC content in the Lab School project, and support students to pursue CCHC careers.

Online portal submission

Respondent 1384

(6.1) We as providers need to have a chance to have our inspections used as a point of reflection in how inspectors are monitoring family child care providers. OEC cannot know what issues the inspectors are having or creating at childcare sites during our business hours without proper surveying through our experiences after each visit.

Online portal submission

Respondent 1386

(6.1) All Our Kin appreciates the progress OEC is making in developing a compensation structure and career pathways for early childhood educators. We note that the agency's efforts to develop these for family child care educators lag significantly far behind those for center-based educators. We hope OEC will set ambitious goals to address FCC compensation, career pathways and professional development over the next three years. Delaying these initiatives in relation to family child care will worsen existing educational and income inequities between center-based and family child care educators.

Online portal submission

Respondent 1389

(6.1) Nothing written in Section 6 of the plan addresses the primary problem that providers have in recruiting or retaining a qualified and effective child care workforce. To paraphrase the line made famous by James Carville, "It's

wages, stupid!” This is not to imply that anyone at OEC is stupid. All of the responses to the questions posed by the federal government are adequate. However they are not sufficient to address the current crisis in staffing. Across the state accredited programs have empty classrooms and waiting lists of children who can not be served because providers can not find staff with the appropriate credentials. The minimum wage has risen from \$9.15 in 2015 to \$13 (by August 1st 2021) and will go to \$15 within the next two years. It is that mandated increase in the minimum wage that is driving almost all wage growth in Connecticut’s child care industry. Teachers who were making \$16 per hour in 2015 are still earning less than \$17 now. Wage compression is real and it is demoralizing. We have pressured staff to earn degrees and have no money to give them a raise in recognition of their greater worth to the program. Parents are already paying more than they can afford and staff are left subsidizing the care with low wages.

Online portal submission

Respondent 1392

(6.1) 6.1.1 Career Pathways: There is a lot of important technical assistance and training for programs offered. Additionally, good connections and plans for working with the colleges are included. However, apprenticeship opportunities are missing and should be included in the career ladder. This will give more equitable access to many potential educators who cannot complete a Bachelor’s degree due to barriers such as work requirements, family responsibilities and the cost associated with college and student teaching. Apprenticeship towards earning a bachelor’s degree programs, (online evening classes using work environment as a learning lab and/or for student teaching) could be one way to give greater opportunity to many existing and potential early educators. This is an equity issue and could attract a more diverse population of early educators, especially those that experience barriers to moving up the career ladder. The higher education opportunities being considered and implemented are great but are only workable if students can make a good living in early care and education, and have the potential to earn as much as similarly qualified public school teachers. Otherwise the migration from early care to public schools will continue. For short term relief, a wage supplement plan can be implemented, a tax credit for early educators can be recommended, etc., but long term strategies should be planned for. Early educator wages and compensation is the biggest obstacle to recruitment and retaining a qualified and effective staff. This is already affecting programs; directors are reporting difficulties in opening classrooms and hiring and retaining qualified staff. The CCDF plan should reflect this problem and include real steps to address the issue. This is critical to keep the early care system viable. There is not time to wait for the legislature to address this problem. They look to the Office of Early Childhood for their cues. Compensation schedule needs to be based on the credentials and expertise of teaching staff. It should be the basis of an actual cost of care study, not a market a market rate study, which only reflects what parents will pay, not the actual cost based on fairly compensated staff. The scale should be comparable to CT public school wages, accounting for full year employment, rather than a school year calendar. Benefits must be addressed.

Online portal submission

Respondent 1264

(6.2) June 8, 2021 To whom it may concern: I write as a Board member of the CT Association for Infant Mental Health (CT-AIMH) and a CT representative on the Board of Directors for the Alliance for the Advancement of Infant Mental Health (AAIMH). CT-AIMH was a founding member of the AAIMH in 2016 that now includes 32 states and two countries. The focus of both Associations is the workforce for infants and young children and their families. That workforce, particularly for infants and toddlers, is often under represented, under included and under valued for its very critical work. It is during the infant and toddler period that brain development is vital for future success. It is during this period that early and responsive relationships from all caregivers must be available to our youngest

children. These early relationships are the foundation for brain development. Child care providers need to be assured that training for their critical work is available. COVID 19 has exacerbated and complicated the opportunities for infants and toddlers to experience those warm, responsive and consistent relationships and has impacted the wellbeing of child care providers as well. Thus, the trainings for these important providers must have a focus on what they do AND how they are, their wellbeing. For these reasons my testimony today is to urge the CCDF to include focused infant mental health training for the infant and toddler workforce. CT-AIMH has a successful history of providing that training to the child care community, starting with work initially supported by OEC since 2014 and currently supported through OEC/PDG. The child care providers have positively responded to the training that has a strong workforce support component. These child care providers have a heavy responsibility to be responsive and consistent caregivers for infants and toddlers. Their jobs are what determine the trajectory of the lives of very young children. They deserve dedicated support and the latest information regarding the social and emotional development of the very young. Equally important to the content training is the opportunity to have time for reflection, to share the very difficult work and its effect on them personally in a safe environment. We call this time reflective supervision which is offered by CT-AIMH to OEC for child care providers and home visitors in our state. Our child care providers need continued reflective supervision opportunities. There should also be opportunities for self-growth, such as the Mindful Mondays now offered by CT-AIMH and supported by OEC. It is vitally important that these training and reflective opportunities be continued and recognized in the CCDF plan for CT. For many of our child care providers to take advantage of training and reflection requires that the training be provided in their native language. CT-AIMH child care provider curriculum has been presented by CT-AIMH in Spanish by Spanish speaking trainers, not translators. The Spanish training began prior to COVID and has continued with participants eagerly learning the Zoom technology. CT-AIMH proposes a more intentional focus throughout the CCDF Draft Plan on diversity, equity, inclusion and access (DEIA). This is a goal of CT-AIMH as well. CT-AIMH believes that the early childhood workforce must be equipped with the knowledge and tools to promote the dignity of all people, including the infants and young children they support, allowing them to experience a sense of belonging that enables them to grow and develop. Fortunately, the infant mental health competencies covered through the CT-AIMH trainings are cross walked with some of the models described in the CCDF plan: e.g. Pyramid Model and CT's own Core Knowledge Competencies. IMH Competencies® emphasize the child's early relationships and their impact. The Pyramid Model places a focus on the child's behaviors that may be of concern. The beauty of the CT-AIMH competencies is that they lead to Endorsement in Infant or Early Childhood Mental Health®: the Endorsement® offered by all 34 members of the AAIMH. This Endorsement is a way of recognizing and honoring child care providers for their competency acquisition. This Competency and Endorsement process would be an appropriate indicator of progress and quality. In summary CT-AIMH urges OEC to state intentionally its commitment to diversity, equity, inclusion and access and to include in its CCDF application continued opportunities for infant and toddler child care providers to:

1. Receive training in infant and early childhood mental health with a focus on brain development, early relationships, emotional health, DEIA, and trauma impact. (pg 145. 6.2.1)
2. Receive reflective supervision/consultation from qualified infant mental health professionals. Pg 145. 6.2.1)
3. Receive training and supervision in Spanish (not translated) whenever called for. (pg 145. 6.2.3)
4. Be recognized for acquiring Competencies by receiving the CT Infant Mental Health Endorsement® or the Early Childhood Mental Health Endorsement®. (pg 162. 7.3.1)

Thank you for the opportunity to comment. CT-AIMH also supports the public comments from the Alliance for Early Childhood. Sincerely, Margaret Holmberg Margaret C. Holmberg, PhD., IMH-E® Margaret.holmberg@att.net 860-908-3473 CT-AIMH c/o Yale Child Study Center Attn. Linda Isakson 230 S. Frontage Road, New Haven, CT 06520 www.ct-aimh.org

Online portal submission
Respondent 1382

(6.2) 6.2.1. There is a plan for including CCMHCs so perhaps add a plan for CCHCs, such as take advantage of the framework laid out years ago and still promoted by Dr. Angela Crowley, resurrecting the CT School of Nursing network, investing in building CCHC capacity through both CCHC student and ongoing CCHC professional coordination and support, e.g., state directory of CCHCs, and raise the health, safety and wellness of children, staff, child care programs and communities, especially now with COVID concerns and the funding to support it. We seem to be able to establish a vision for CCMHCs but the same is not reflected in the Plan for CCHCs.

Webinar comment

Margaret Holmberg - Connecticut Association for Infant Mental Health

(6.2) Connecticut AIM urges OEC to state intentionally its commitment to diversity, equity, inclusion, and access, and to include in its CDD- CCDF application continued opportunities for infant and toddler childcare providers to receive training in infant and early childhood mental health with a focus on brain development, early relationships, emotional health, DEIA, and trauma impact, and this is found on page 145, 6.2.1.

Webinar comment

Margaret Holmberg - Connecticut Association for Infant Mental Health

(6.2) It is vitally important that these training and reflective opportunities be continued and recognized in the CCDF plan for Connecticut.

For many of our childcare providers to take advantage of training and reflection requires that the training be provided in their native language.

Online portal submission

Respondent 1171

(6.3) Section 6 Third Bullet Working with and the RESC Alliance- Continue to build capacity about Trauma and Homelessness CHDI and the RESC Alliance. The LEARN at Lunch Series provided opportunities for ECE professionals to learn about signs of Trauma and Human Service agencies available to provide support for young children and families – ECCP, UCFS Immigrant advocacy groups, homeless shelters etc.

Online portal submission

Respondent 1386

(6.3) As OEC moves to address compensation and career pathways in relation to the FCC workforce, it will be essential to do this through an equity lens. It will also be important to consider unique attributes of the FCC business and service delivery model (including the fact that most FCC educators are self-employed small business people who work, on average, more than 55 hours per week) and barriers to educational access that require unique professional development approaches from OEC. (All Our Kin is supportive of Connecticut's fledgling Registered Apprenticeship for family child care educators as one promising approach for FCC educators.) We urge OEC to consult with family child care educators and support organizations to develop a more comprehensive approach to structuring compensation and career pathways for family child care. OEC will need a range of family child care expertise on its advisory committees and working groups to generate creative and practical solutions to these challenges. In parallel fashion, family child care educators, support organizations and researchers should also be tapped to review course content for the CDA, Associate's, Bachelor's degrees and credentials to ensure they are relevant to the needs of family child care educators at every level. If the Early Childhood Cabinet does not currently include family child care expertise, it should incorporate this expertise and draw on it to develop Connecticut's CKC framework. The Early Childhood Higher Education Consortium and technical assistance providers who support family child care providers should also possess demonstrated expertise in family child care. All Our Kin can help

identify individuals to serve in these roles as needed. While developing higher education options for family child care is important, OEC must recognize that no one-size fits all. Family child care providers come to their work with varied levels of previous education access and experiences. Higher education options must be accompanied by options to grant competency-based credit, combined with evidence-based coaching models, community-building and other services that are provided by FCC networks. Given the growing number of Spanish-speaking residents of Connecticut, OEC appreciates that many OEC materials are now available in translation. We encourage the agency to expand training and the availability of CDA courses in Spanish. While there are many benefits to delivering professional development on line, we hope OEC will also address gaps in digital literacy, user-optimization, and broadband access, which are prevalent among FCC educators.

Section 7: Support Continuous Quality Improvement (p.158)

Online portal submission

Respondent 1009

(7.1) In addition to collaborating with Eastern on videos used in training and higher ed, there is a need for training videos that can be used in higher ed to support Inclusion in the Early Years. This could be an especially important resource for the ECE programs in the community colleges as they move to improve attention to inclusion in their coursework. Demonstration videos would be helpful.

Online portal submission

Respondent 1171

(7.1) Section 7 New bullet- Work with Higher Ed and the RESC Alliance to continue to integrate the WIDA Early Years in professional learning experiences to ensure ECE professionals address equity and multi language learners from an asset based approach integrating Promising Practices into their classrooms to improve outcomes for all children. Bullet 6 Expand the Pyramid Model for more community ECE providers to access virtual professional learning opportunities to prevent challenging behavior and develop positive relationships with all children and teach social emotional skills. New Bullet Build Capacity of ECE professionals to support young children's literacy skills. Higher Ed, RESC Alliance

Online portal submission

Respondent 1142

(7.3) The QRIS system creates an overly data-driven approach to assessing ECE programs, much the same way the accreditation process itself requires such a process of teachers, administrators, families, and children. Imposing a requirement for NAEYC accreditation on every center as proof of quality is, of course, the easiest way for a bureaucracy to "grade" centers for public consumption. It fails to take into account differences in focus and approach and limits the ability to provide high-quality alternatives for families. ECE programs are not, and should not, be cookie-cutters. Non-accreditation pathways need to be available for programs to document their quality level without penalty in rating. A portfolio approach may create an added burden on the state to assess these programs, but it would allow for high-quality alternative programs to meet the varying needs and desires of Connecticut families. I would expect that this non-traditional assessment process would be stringent enough that few centers would choose it over accreditation, so that its benefits would outweigh any incremental burden on the workload of OEC staff. While it may arguably be reasonable to assign the highest rating only to accredited programs, non-accredited programs that meet high quality standards should have the opportunity to at least receive a higher rating than programs that are basic child-minding centers at level 1. Under the proposed system an unaccredited program that hires only degreed staff with salaries and benefits encouraging low turnover,

incorporates a highly educated and experienced education consultant into everyday operations as a staff developer, and provides a well-rounded developmentally-appropriate experience for children's growth and development will be unable to ever move beyond level 1. The accreditation process itself, along with subsequent reviews, diverts tremendous resources in time and energy away from the actual planning and delivery of early care and education services. Rather than focusing on cataloging and assessing endless minutiae, some programs opt to devote all resources to support teachers in providing non-data-driven child-inspired creative opportunities for children to play, explore, and grow. Rather than trying to prepare children for what comes next, i.e. the rigors of modern kindergarten, allowance should be made for well-designed experiences that focus on engaging and scaffolding young children where they are now. Room must be made for holistic play-based programs that value pro-social relationship-building, self-regulation, positive community interaction, encouragement of natural curiosity, development of critical thinking and ability to engage in self-directed inquiry and exploration. Good teachers can facilitate joyful growth without excessive documentation and assessment. Good teachers know their children, can recognize individual strengths and challenges, and provide appropriate growth opportunities to support those needs. Good teachers appreciate the opportunity to bring all they have to their children without the burden of unnecessary bureaucracy. Indeed, this is—or should be—one of the great values of early childhood education. There is plenty of time for data-driven benchmarks, assessments, and technology once children graduate into the public school system. But this is (sadly) the purview of the school experience for older children. Young children and their dedicated teachers should have the option to eschew all of that in favor of experiencing and enhancing the opportunities for the joy of exploring the world that is the very hallmark of a happy childhood. These children most often arrive in kindergarten uniquely prepared to learn, and contribute to the learning of others, and are frequently counted as the role-models and leaders as they move forward. While accreditation creates a convenient “short-hand” for assigning a level of quality, it is imperative that other avenues exist to document quality in the early childhood classroom. I cannot advocate strongly enough to include a “portfolio of demonstrated quality factors,” as well as “substantial progress toward accreditation” in the QRIS assessment tiers.

Online portal submission

Respondent 1201

(7.3) I recommend that the OEC support a program to train and support nurses to be effective consultants for child care programs. My work as a pediatrician has included medical and developmental consultation for many programs in New Haven for several decades. These programs included federally funded Head Start, several non-profit programs for children from infancy through preschool, and many with children with special needs. It is clear that the directors and teachers need the input of competent nurse consultants to insure high quality health and safety practices for the children. Since 1990 I have seen the benefit to the children and families when there are well-trained nurses to work in these child care programs. Training for nurses does not include the many complicated aspects of working with child care programs, which are different from working in a hospital or out-patient health care setting. The nurses need to learn about the new role as a health consultant. This should be done through an organized curriculum administered by nurse educators who understand the varied aspects of how to address the needs of the child care setting. Funds should be allocated to implement such training. Currently there is no widely available program to train nurse consultants, and there is a grave shortage of people who are competent to fill these much-needed positions. J. Deborah Ferholt, M.D., Fellow American Academy of Pediatrics, Clinical Professor of Pediatrics Yale School of Medicine, Attending Physician Yale New Haven Hospital.

Online portal submission

Respondent 1224

(7.3) I am concerned that forcing programs to become NAEYC accredited in order to obtain a higher rating will put increased and added pressure on already small and struggling programs such as my own. NAEYC programs require a larger amount of credentialed staff and the program is labor intensive and expensive. At this time, the minimum wage increases are already causing concern for small programs with staffing. Additionally, staffing is already difficult for small ECE programs (even prior to the pandemic), nevermind the added need to find college credentialed staff at a much higher rate. Every private center will need to raise their rates expediently to meet this criteria or suffer a poor rating. This will domino effect on centers and the working class. While I value many of the aspects of NAEYC and incorporate them into my program, I feel that there are other ways (including other accreditations that) that can increase our centers value (i.e. rating). We have already lost many programs due to the pandemic and this may cause small private centers to consider closing as well. Thank you for your consideration.

Online portal submission

Respondent 1386

(7.3) It is difficult to ascertain whether OEC's vision for family child care includes quality, and if so, how this will be supported. Family child care quality is not well developed in this draft plan. We are not aware that family child care providers, support organizations, researchers or others with specific expertise in FCC quality have been consulted about quality standards, benchmarks, professional development or accreditation support. In delaying the development of a vision for family child care quality, OEC risks unintentionally worsening educational and income inequity between center-based and family child care providers, and between the children they care for. The risk of failing to engage FCC experts in the development of the AQIS is that OEC will move forward without the support of the providers and families it needs for this effort to succeed.

Webinar comment

Margaret Holmberg - Connecticut Association for Infant Mental Health

(7.3) And finally, of, for the childcare providers to be recognized for acquiring competencies by receiving the Connecticut infant mental health endorsement, or the early childhood mental health endorsement, and this is on page 162, 7.3.1

Webinar comment

Suzanne Miller - Carrot Patch Early Learning Centers in Hamden and Clinton

(7.3) Imposing a requirement for NIAC accreditation on every center as proof of quality is the easiest way for a bureaucracy to grade centers for public consumption, but it fails to take into account differences in focus and approach, and limits the ability to provide high quality alternatives for families.

A portfolio approach may create an added burden on the state to assess programs, but it would allow for high quality alternative programs to meet varying needs and desires of Connecticut families. While it may be reasonable to assign the highest quality only to accredited programs for the purpose of awarding state funding, non-accredited programs should have the opportunity to receive a higher rating than programs that might offer a very basic child-minding model as defined as "Level One". Most importantly, using the proposed system for the purpose of informing families of the quality of care they can expect based solely on accreditation or progress toward accreditation does a great disservice to everyone involved. At the very least, parents should have an opportunity to consider and assess for themselves a variety of options without the state having discounted non-accredited programs as necessarily offering a lower quality program.

Online portal submission

Respondent 1082

(7.4) It would be ideal if we had a health consultant system that includes training and mentoring of health consultants as well as a database that allows providers to find qualified and prepared health consultants. As I understand, multiple studies in CT and other states have confirmed the critical role that prepared nurse consultants play in promoting the health of all children, including preschool children, in early care and education. Weekly nursing consultation visits are associated with inclusion of children with special health care needs and medication administration safety. Family child care providers as well as center-based providers benefit from health consultation.

Online portal submission

Respondent 1095

(7.4) In order to improve the quality of child care programs and services for infants & toddlers, I am advocating for a health consultant system. Within this system, there would be training and mentoring of health consultants as well as a database to assist providers in identifying qualified and well-prepared consultants. As demonstrated in the literature, prepared nurse consultants have a positive impact on promoting health of all children, including infants and toddlers. Further, nurse consultants can specifically address children with special health care needs along with medication administration. The State of CT has demonstrated success with the training of health care consultants for more than a decade but now discontinued. We want to work towards a system built through consortium within schools of nursing in CT to provide a long term solution for the training of health consultants. Furthermore, child care providers should be provided with funds to support the regulatory mandate for health consultant visits.

Online portal submission

Respondent 1112

(7.4) A health consultant system that includes training and mentoring of health consultants as well as a database that allows providers to find qualified and prepared health consultants is needed.

Online portal submission

Respondent 1137

(7.4) This section should include a health consultant system that includes training and mentoring of health consultants as well as support of a database that allows providers to find qualified and prepared health consultants. Multiple studies in CT and other states have confirmed the critical role that prepared nurse consultants play in promoting the health of all children, including preschool children, in early care and education. Weekly nursing consultation visits are associated with inclusion of children with special health care needs and medication administration safety. Family child care providers as well as center-based providers benefit from health consultation.

Online portal submission

Respondent 1193

(7.4) Angela Crowley, PhD, APRN, PNP-BC, FAAN (angela.crowley@yale.edu) I am commenting on the CT CCDF Draft Plan, Section 7.4: Improving supplies and quality of child care programs and services for infants and toddlers. K. Coordinating with health consultants. My first recommendation is that OEC/ the draft plan recognizes the integral role that child care health consultants (CCHC) play in improving the quality of care not only for infants and toddler but for all children including preschoolers who are enrolled in a program. Although weekly visits are only mandated for centers that enroll infants and toddlers, directors have confirmed that health consultants who visit

weekly positively influence the health, safety and inclusion of preschool children enrolled in those programs. Therefore, the CCDF plan should include the vital role of CCHCs in quality care for all children. Based on USDHHS, Maternal Child Health Bureau, Caring for Our Children, 4th ed (AAP, APHA, NRC) the national health and safety standard for child care health consultant and research that I and other colleagues have published, I recommend that the CT CCDF plan support the development of a CCHC system which would include training and mentoring of CCHCs and nursing faculty and a database to link health consultants and nurse educators with center-based and family child care providers to support child care providers in providing quality care. Since the vast majority of CCHCs are nurses in CT and nationally, this could best be accomplished through a consortium of CT Schools of Nursing. In a 2015 national survey, my colleagues and I learned that many schools of nursing were utilizing child care and Head Start programs for clinical experiences. However, the faculty were not aware of Caring for Our Children, the standard for health consultants, and national efforts to prepare CCHCs. Faculty in CT Schools of Nursing have expressed great interest in participating in a consortium to prepare CCHCs. In 2014-2015, several CT Schools of Nursing served as pilot sites for the CT Medication Administration in Early Care and Education curriculum. Developing a consortium of Schools of Nursing to prepare and mentor CCHCs would ensure excellent preparation of CCHCs, long term engagement and would serve as a national model for other states. National surveys reveal that parents' primary concern is that child care is healthy and safe. Children who are not healthy and safe cannot thrive and learn. More than 18% of children have special health care needs and many require medications and care plans. Health consultants play a critical role in supporting the inclusion of children with special health care needs. While nurses have the educational background to provide health resources and support to child care providers and families, their education does not include an understanding of early care and education and the role of the CCHC. Nurses who are not prepared as CCHCs are far less effective. Between 2002-2013, through a federal grant and a national training model, CT and other states trained nurses to serve as CCHCs. When funding ended, so did the training. Since that time the availability of prepared health consultants has significantly diminished. In the late 1960's when CT child care regulations were developed, nursing, medical and early care and education leaders informed the decision to require nurse health consultant visits. At that time, public health nurses provided this service at no charge to child care providers. Currently, most providers pay for this service. Other states, such as NC and IA, have less stringent regulations but have developed systems of CCHC with federal and state funding. Long term many providers need financial assistance. In the short term, creating a system of preparing and mentoring health consultants would ensure that health consultants can provide the essential support and resources needed to promote quality and healthy and safe care. Please contact me with any questions. Thank you. References: American Academy of Pediatrics, American Public Health Association & National Resource Center for Health and Safety in Child Care: National health and safety performance standards. Guidelines for out-of-home child care programs, 4th ed. 2019. Washington, DC. American Public Health Association. Crowley, A. A. & Rosenthal, M. S. 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Macary, S. & Crowley, A. IMPACT: Promoting children's health in early care and education settings by supporting health consultation. Farmington, CT: Child Health and Development Institute of Connecticut. February 2017.

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Online portal submission

Respondent 1201

(7.4) it is very to support the efforts to support a pediatrician tra

Online portal submission

Respondent 1238

(7.4) I think that the CT CCDF plan support the development of a CCHC system which would include training and mentoring of CCHCs and nursing faculty and a database to link health consultants and nurse educators with center-based and family child care providers to support child care providers in providing quality care.

Online portal submission

Respondent 1300

(7.4) I am writing to advocate for a health consultant system in Connecticut's early childhood programs that includes training and mentoring of health consultants as well as a database that allows providers to find qualified and prepared health consultants. As Director of Yale's Calvin Hill Day Care Center for 40 years (I am now Director-Emerita) I know first hand the crucial role a well trained and supervised health care consultant can play in ensuring the health and safety of children in full day early childhood care and education programs, the ability of teachers to work with all children, but specifically those with special health care needs, and the confidence of families who entrust their children to our care. The critical role that prepared nurse consultants play through weekly nursing consultation visits is associated with inclusion of children with special health care needs and medication administration safety. Family child care providers as well as center-based providers benefit from health consultation. Calvin Hill was extremely fortunate to have been supported by the Healthy Child Care CT team that created and delivered health consultant training. Sadly, that model, which was invaluable, was discontinued several years ago. I recommend that we reinstate a robust consultant training model that can help to ensure a supply of highly trained nurse consultants for Connecticut's early childhood programs. I advocate for a system that can be created through a consortium of CT schools of nursing, which would offer high quality preparation and a reliable long term system. In addition, child care providers should be given funds to support the unfunded regulatory mandate for health consultant visits. As health and safety and training regulations have intensified and changed (even before this pandemic) — with NAEYC Accreditation and CT licensing requirements— the availability of such a professional, expert nursing team with direct oversight, supervision and collaboration will be crucial. In addition, centers are enrolling children with increasingly complex health challenges, all of which require significant medically informed support, and as a result, the centers are now able to enroll children who might previously have been excluded. Teachers are also able to administer the medication which is more and more required for these complex health issues. Now, more than ever, early childhood programs require informed, professional health care consultation in order to respond to the many uncertainties, changes and new policies and practices that this pandemic requires. We need such a consultation system in order to keep Connecticut's children and the programs they attend are healthy and safe. Carla M. Horwitz, M.S.; Dip.Ed.; Ed.D. Lecturer, Yale Child Study Center, Psychology and Education Studies Director Emerita, Calvin Hill Day Care Center & Kindergarten

Online portal submission

Respondent 1304

(7.4) As a Pediatric Nurse Practitioner, child health care consultant, and educator, I have seen firsthand the challenges that exist in our current system in CT in the provision of a stable and high quality supply of health care consultants for CT child care providers. This lack of systematic, comprehensive training for consultants as well as an organized means for providers to access such consultants, represent a disservice to children in childcare in CT. I support the development of a CCHC system which would address training and mentoring of CCHCs through CT schools of nursing - a system that currently exists but is underutilized. In addition, I support the development of a database to link health consultants and nurse educators with center-based and family child care providers.

Maryanne Davidson, DNSc, APRN, CPNP Dean, St. Vincent's College Sacred Heart University

Online portal submission

Respondent 1314

(7.4) School readiness and cdc programs that are already licensed and accredited by naeyc should be used to promote accessibility to low income families. CT should be expanding funding for infants and toddlers through these high quality programs. Often the families have a sibling in the subsidized preschool, but need to take their infant to another setting due to cost.

Online portal submission

Respondent 1333

(7.4) I am advocating for a health consultant system that includes training and mentoring of health consultants as well as a database that allows providers to find qualified and prepared health consultants. Multiple studies in CT and other states have confirmed the critical role that prepared nurse consultants play in promoting the health of all children, including preschool children, in early care and education. Weekly nursing consultation visits are associated with inclusion of children with special health care needs and medication administration safety. Family child care providers as well as center-based providers benefit from health consultation. - Kerry Milner RN, DNSc

Online portal submission

Respondent 1353

(7.4) Based on USDHHS, Maternal Child Health Bureau, Caring for Our Children, 4th ed (AAP, APHA, NRC) the national health and safety standard for child care health consultant and research that I and other colleagues have published, I recommend that the CT CCDF plan support the development of a CCHC system which would include training and mentoring of CCHCs and nursing faculty and a database to link health consultants and nurse educators with center-based and family child care providers to support child care providers in providing quality care. Since the vast majority of CCHCs are nurses in CT and nationally, this could best be accomplished through a consortium of CT Schools of Nursing

Online portal submission

Respondent 1357

(7.4) Based on USDHHS Maternal Child Health Bureau, Caring for Our Children, 4th edition I recommend that the CT CCDF plan support the development of a CCHC system which would include comprehensive thought-full, training, mentoring and ongoing support of Child Care Health Consultants (CCHC) and nurse educators in concert with the center-based and family child care providers to provide quality care to the children and families in early care and education. Another important element would be a state-wide database to link CCHCs, nursing faculty and family and child care providers to quality care, services and health information. Since the vast majority of CCHCs are nurses in CT and nationally, this could best be accomplished through a consortium of CT Schools of Nursing.

Additionally funding should support the link of trained CCHCs to provide early, comprehensive home based services so the infants can be assessed and monitored in their natural home environment and linked to early services and ECE programs that meet the unique needs of each child.

Online portal submission

Respondent 1373

(7.4) I am a recently retired nurse consultant and I worked with child care centers and family child care programs for over 25 years. Health consultants are an integral part of the health and safety component. Some children have special needs that may require medication or care plans. Health consultants work with the staff and family to support inclusion of the child in the program through development of a care plan and special training of the staff. Nurses need additional preparation and training to be an effective health care consultant. They need training in the role of the CCHC and in the areas that are unique to child care. There also needs to be a system in place to standardize the policies to strive for best practice. There are national standards but many programs and nurses are not aware of them. The plan to have a consortium of Schools of Nursing to provide training and mentoring is a good model. This past year we have all be part of a highly unusual pandemic which has directly impacted child care programs and their consultants. If a comprehensive training and mentoring program had been in place, this would have provided the framework for making sure children in the child care programs were kept safe. Sara Feudo MS BSN

Online portal submission

Respondent 1386

(7.4) Family child care providers provide the bulk of Connecticut's infant-toddler care. Please see comments about family child care networks in section 1.4 and about quality improvement in section 7.3. In addition, as All Our Kin looks toward a future in which increased federal support may be available to expand the supply of infant-toddler care and improve child care facilities, we urge OEC to approach supply-building, quality improvement and investments in facilities through an equity lens.

Online portal submission

Respondent 1396

(7.4) We as providers need to have a chance to have our inspections used as a point of reflection in how inspectors are monitoring family child care providers. OEC cannot know what issues the inspectors are having or creating at childcare sites during our business hours without proper surveying (offer an actual survey) post inspection offering opinion and real concerns of inspection. Who would be more informed of actual inspection experience other than us providers and inspectors.

Online portal submission

Respondent 1398

(7.4) Alison Moriarty Daley, PhD, APRN, PPCNP-BC, FAAN Director and Associate Professor Yale School of Nursing Pediatric Nurse Practitioner Specialty and Pediatric Nurse Practitioner YHH Career School-Based Health Center I am commenting on the CT CCDF Draft Plan, Section 7.4: Improving supplies and quality of child care programs and services for infants and toddlers. K. Coordinating with health consultants. As a Pediatric Nurse Practitioner and mother, I attest professionally and personally to the important role of high-quality child care/preschool for children and families to live and thrive. Nurse Consultants have a significant role in insuring and improving the quality of health care services within child care/preschool programs. Nurses are uniquely qualified to provide consultation on the holistic needs of children and families to child care agencies to assist in maintaining and

improving the health and safety of infants and children while attending childcare and preschool programs. Currently, there is a need for the expansion and improvement of the infrastructure required to meet the standards recommended for child care/ preschool programs. This is best achieved through the establishment of a Consortium of Schools of Nursing to train and mentor nurse consultants to assist programs in providing evidence-based quality care to all children across the state. A consortium will add to the equity of child care/preschool consultations, across the state, by trained nurses and allow a coordinated and comprehensive approach.

Webinar comment

Angela Crawley - Professor Emerita at Yale University School of Nursing and a pediatric nurse practitioner.

(7.4) My first recommendation is to recognize that child care health consultants not only improve the quality of childcare and services for infants and toddlers, but for preschool children as well.

I recommend that the Connecticut CCDF plan include the development of a health consultation system, which would include training and mentoring of health consultants and nurse educators, and a database to link health consultants and nurse educators with childcare providers.

Conclusion, research confirms and national standards support the essential role of a trained child care health consultant to ensure healthy and safe care. I urge the office of early childhood to include this recommendation, that is, the development of a health consultation system through a consortium of Connecticut schools of nursing in the CCDF plan.

Online portal submission

Respondent 1255

(7.6) As noted in sections 2.4.3. and 7.6.1, the OEC invested in the development of a searchable, online ECE Video Clip Library for Faculty and Trainers, which show snapshots of child development or exemplary teaching strategies that can be used in multiple ways within professional learning contexts. (<https://www.easternct.edu/center-for-early-childhood-education/for-faculty-and-trainers/ece-video-clip-library.html>) It makes sense to continue to expand the resources in this library, particularly to include more examples of supporting multilingual learners and supporting children's social and emotional needs. Use of the library skyrocketed during the pandemic - average daily views increased by 2,939% during the period between 3/16/20 and 6/10/21. Data shows that heavy viewing aligned with the academic calendar, showing the need for higher education to use video to demonstrate specific child development concepts and teaching strategies. The Lab School Investment Project would provide an opportunity to collect new video examples of best practices in teaching from lab schools throughout Connecticut and add them to the library.

Online portal submission

Respondent 1264

(7.8) Please see the comments from CT-AIMH for section 6.

Online portal submission

Respondent 1357

(7.8) There should be a thorough review of existing accreditation standards as there seemed to be a gap in services during the pandemic. Pre-pandemic it seemed that all Programs that submitted portfolios were approved including poor performers so it lost its significance as an accurate tool to measure quality. It would be nice to remove the financial incentives to get programs accredited without keeping up with original intents and standards of practice.

Section 8: Ensure Grantee Program Integrity and Accountability (p.178)

No comments for this section

Appendix A: MRS, Alternative Methodology and Narrow Cost Analysis Waiver Request Form (p.188)

No comments for this section

Other/General comment

Webinar comment

Merrill Gay - Executive Director of the Connecticut Early Childhood Alliance

This plan makes some strides to improve things for parents, by paying the parent fees through September, increasing the income threshold to 60% of state median income, and the pending legislation would extend that parent fee holiday through December and allow for the first time parents to use care for kids so that they can access job training or attend adult ed or post-secondary education.

I want to point out what I'm frequently reminded by many of our childcare provider members, is that increasing payment levels from the 25th percentile of market to the 50th percentile of market, in many cases results in no additional money in the providers pocket, and that's because providers are already charging more than 50th percentile, and charging parents the difference between what care for kids is paying and what their tuition is.

The experience for childcare providers all along is that they hear something, it sounds great, and then it takes a long time and a lot of them are really pretty desperate now. What is not in this plan is a move towards paying based on the cost of quality, as opposed to the cost of a depressed market.

The other thing is the tool in the toolbox that is not selected in this plan is the potential use of contracted slots. We have always used a certificate based subsidy system and that is all about parent choice, but it means that we're not intentionally using the tool in the toolbox to address shortage areas that, you know, we could contract infant-toddler sites.

I'm sure you could also be creative with the staff family childcare networks to promote new programs opening if you were able to contract slots to providers in areas where parents weren't able to pay the full price.

Webinar comment (translated from Spanish)

Maria Amato - Green World Family Childcare Home

My comment would be to have some form of professional streamline, three months training program, 140 hours a month training program, however it could be framed in which incentivizes and allows us to continue keeping up our accreditation at a reasonable time so that we can actually build up those 90 credits.

The use of QuickBooks is not very ideal for our situation, QuickBooks being more, the way I see it, being really well tailored to a business that handles intake of money every day, say a restaurant for instance, while our cases specifically family care centers we're having maybe a max of six children full-time plus an additional three before and after school.

But my comments in regards to just the way we manage our finances, is that, I believe we should have some sort of financial management system or the way we do our taxes that's maybe more specifically tailored to our family care centers that are, that manage these small capacities of six children or are a little more, a little less, as opposed to a system that's very more tailored to larger childcare centers. And that is all.

Webinar comment

Liz Fraser - Policy director at the Connecticut Association for Human Services

Having an apprenticeship program would really help to get more folks involved in early childhood who have that desire. It would open up the field to many more people who can't go to college for whatever reason, they need to work, they have children at home, they just don't have the time.

I would hope that maybe we consider apprenticeships also. Apprenticeships with credits towards a bachelor's degree.

We're not going to get teachers and keep teachers unless we have the wages that can support them. Maybe a wage supplement program that can be used.

When we're looking at market survey and cost, versus cost of quality, if a market survey is necessary to define, but again, I will reiterate what Merrill said, we really need to know what the actual cost of a quality program is, and we need to use that as our guideline. If we keep using a market rate, we are going to be shortchanging our centers, shortchanging the ability for those centers to pay their staff as well.

Targeted outreach, to see if you can, we can get more people that are not applying for that to apply for Care for Kids. That might also help providers.

I think contracted slots are also important. They're particularly important, because it's an equity issue. You can really target areas of need. You can target adult ed programs. You can target certain programs where you know that many hard-to-serve families because they have so many challenges and need so much support are there. And if you can use those contracted slots, it's much easier to develop programs that support those families.

Webinar comment (translated from Spanish)

Rosa Boden - 6 years experience in childcare

What does the OEC do to guarantee quality in childcare? To further follow up with that: what does the OEC either do, plan to do, or intend to do in regards to lessen the amount of childcare that is done or provided by those that are unlicensed? Particularly family providers, or those who just care in a family setting.

As far as I understand, there's only four of us accredited with the organization. And my comment is just making it more streamlined. More accessible to be re-accredited, re-certified. Whatever it may be.

Webinar comment (translated from Spanish)

Yasmin Iglesias

I'd just like to take this moment to say thank you for the efforts for all the work you've been putting towards ensuring a better quality of childcare in, you know, work. I'm a believer that we're in the process of making better human beings. Raising better young men and women and all the efforts are compiling together. It's all in the same fight we're all fighting. The same battle we're all doing. So, I just once again- thank you for your efforts, thank you for your work, and that'll be all.

Webinar comment

Ava Bermuda Zimmerman - Childcare director for CSCA, local 2001s of Service Employees International Union

We would like to see additional resources for the provider community to survive in the workforce, in healthcare expansion opportunities, apprenticeship compensation, a robust marketing plan, solidifying the expansion to parents and quality subsidies, and also, networking and IT support for providers.

It would be great to see an expansion where providers have an opportunity to opt in to state healthcare plans similar to Knee-Hip programs, where maybe state partnership or the co-link plan, providers can opt in, into that.

We'd like to see also incorporated into the Plan, where there's a section of competencies and quality improvement systems. The addition of apprenticeships, so apprenticeships could encompass the whole early ed community, and allow providers to access additional compensation.

Marketing plan and IT plans for providers. Right now, the system with 2 1 1, and the reference system for parents. A referral system for parents to tap in and know who is available. It, the system, is not as robust as other technologies that exist. The example I will use is Care.com

For example, SEIU has created software called software, where providers can log in, create a profile, make sure that the parent can connect with them seamlessly, and this is just for licensed providers who are authorized by the state of Connecticut and come from that state list to make sure that they can provide care, and that way it's easily connected through an app. So, we'd love to see further conversations about how IT systems can help market, grow the provider community and stabilize the private provider community.

We'd also like to see opportunities, uh, for native language speakers to have educational CEU classes, additional CCAC registry classes that are provided with easier access. I know as a union, we have contract negotiations that take this into consideration, and we have professional development committee and teams that have these conversations, but why not also include this into the CCDF plan, making sure that that reflective supervision that other, organizations made mention in today's call and in their plans for CCDF comments. Also, encompasses that technology, that language enrichment, that educational enrichment that includes translators, that includes, native language conversations, and doesn't exclude people from the process of learning, and the process of bettering, bettering themselves through education.

Lastly: when we're talking about the cost of quality not being adequately funded, and the new federal mon- money that has come down the pipeline, and we understand all the conversation that the CCF, CCDF plan has taken to take this in consideration, the changing times.

Rather than creating a CCDF plan that's just centralizing on the three years of survival, why not take those three years a little further and re-imagine "What does the next 20 years of childcare look like in the state of Connecticut? How can we create a bridge between the home-based providers, the center-care providers, and all these programs that are popping up, and opportunities that are popping up with pre-K by stabilizing the network in the community of early ed in a universal childcare system, and seeing how that re-imagining can rework, while still providing amazing care for parents that means education value, stabilizing the workforce with compensation and not unfunded mandates, and ensuring that all communities, pre-K, home-based, center-care, private care, non-profit care still survive for the next 20, 30, 40 years?"