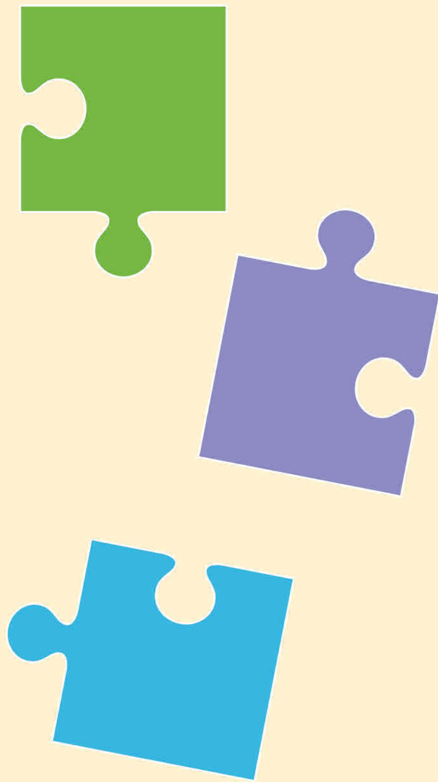

Working Together for Children and Families: Findings from the National Descriptive Study of Early Head Start-Child Care Partnerships

OPRE Report #2019-16
February 2019
Final Report

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Working Together for Children and Families: Findings from the National Descriptive Study of Early Head Start-Child Care Partnerships

FINAL REPORT

OPRE Report 2019-16

February 2019

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OVERVIEW

High quality early learning experiences can promote young children's development and help to reduce achievement gaps between children from low-income families and children from more affluent families. Early care and education programs also promote parents' ability to support their children's learning, and allow parents to work or go to school. However, affordable, high quality, child care for infants and toddlers from low-income families is scarce. One strategy for improving access to high quality care for infants and toddlers is to form partnerships at the point of service delivery to build seamless systems of care and promote quality across settings.

In 2015, the Administration for Children and Families (ACF) awarded 275 Early Head Start (EHS) Expansion and EHS-Child Care (EHS-CC) Partnership grants. Of these, 250 grantees received funding for EHS-CC Partnerships or funding for both EHS-CC Partnerships and EHS Expansion. The EHS-CC Partnership grants support partnerships between EHS grantees and regulated child care centers and family child care homes serving infants and toddlers from low-income families. The partnerships aim to bring together the best of both programs by combining the high quality, comprehensive, relationship-based child development and family services of EHS with the flexibility of child care and its responsiveness to the social, cultural, and work-support needs of families.

To better understand the characteristics of early care and education partnerships, including the EHS-CC Partnerships, the Office of Planning, Research, and Evaluation (OPRE) in ACF commissioned a national descriptive study of EHS-CC Partnerships. Through a contract with Mathematica Policy Research, the national descriptive study provides a rich knowledge base about the characteristics of EHS-CC Partnerships and strategies for implementing partnerships in both center-based child care and family child care homes.

Research Questions

- What are the characteristics of EHS-CC Partnership programs?
- How are EHS-CC Partnership programs developed and maintained?
- What activities do EHS-CC Partnership programs engage in to deliver high-quality services to infants, toddlers, and families?

Purpose

The purpose of this report is to document findings from the national descriptive study of EHS-CC Partnerships. It provides detailed information about the EHS and child care programs participating in EHS-CC Partnerships, as well as the activities they engaged in to develop and maintain partnerships and deliver services to infants, toddlers, and families. This is the first study of EHS-CC Partnerships to include a representative sample of the child care providers engaged in the partnerships. As such, the report has a particular focus on the perspectives of child care partners and how child care centers and family child care homes implemented partnerships. The information and lessons learned can inform ongoing and future activities of partnerships in early care and education programs as well as training and technical assistance efforts.

Key Findings and Highlights

- Most partnership grantees were nonprofit, community-based organizations with experience providing EHS or Head Start services. Some grantees partnered with both centers and family child care providers; few partnered with family child care providers only.
- Many grantees and their child care partners had experience collaborating before the EHS-CC Partnership grant. The most frequently cited factor motivating child care partners to participate in the partnership program was improving the quality of infant and toddler care and education.
- Though grantees and child care partners engaged in many strategies to maintain partnerships, about one-third of grantees had terminated at least one partnership by the time of the survey, which occurred about one year after ACF awarded grants. The most common reason for terminations was issues complying with the Head Start Program Performance Standards (HSPPS) and staff-child ratio and health and safety requirements were the most challenging standards to meet.
- Grantees transferred slightly more than half of EHS-CC Partnership grant funds to child care partners. Partners reported many uses of these funds, including purchasing materials and supplies and providing staff training and professional development. Child care partners also leveraged funds from other sources, including child care subsidies and the Child and Adult Care Food Program.
- Child care partners most often relied on word of mouth to recruit children and families. Most had a waiting list, and about half used a system that prioritized enrollment based on family risk or need.
- Consistent with EHS requirements, partnership programs offered a wide range of comprehensive services to children and families who received care through EHS-CC Partnership grant funds. Many programs also offered at least one service to children and families whose care was not supported by the EHS-CC Partnership grant.
- Partnership programs engaged in a variety of activities for improving the quality of care and ensuring child care partners were meeting the HSPPS. Most child care partners reported receiving from grantees guidance on meeting the HSPPS, support for individualizing services for families, various materials or supplies, quality monitoring activities, staff coaching and/or training, and the opportunity to obtain a Child Development Associate credential.

Methods

The national descriptive study gathered data from three sources:

1. A web-based survey of the 250 2015 EHS Expansion and EHS-CC Partnership grantees that received funding for EHS-CC Partnership or funding for both EHS-CC Partnerships and EHS Expansion. For purposes of this study, among grantees that received funding for both EHS-CC Partnership and EHS Expansion, the study focused on the EHS-CC Partnership component of their grant only. The survey was conducted from January through July 2016; 88 percent of eligible respondents completed the survey.

2. A web-based survey of a sample of 470 child care partners, including child care center directors and family child care providers. The study identified the child care partners using information collected from grantee directors. The survey was conducted from February through November 2016; 82 percent of eligible respondents completed the survey.
3. In-depth data from case studies of 10 partnership programs that varied in their characteristics and approaches to implementation. The case studies, which were conducted in 2017, included in-person and telephone interviews with grantee directors and key partnership staff, child care partner staff, parents, and state and local stakeholders (such as child care administrators and child care resource and referral agency staff).

This report includes results for the 220 grantees and 386 child care partners with completed web-based surveys, as well as data collected as part of the case studies.

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EXECUTIVE SUMMARY

The purpose of this report is to document findings from the national descriptive study of Early Head Start-Child Care (EHS-CC) Partnerships. The national descriptive study was designed to develop a rich knowledge base about EHS-CC Partnerships. The report provides detailed information about the EHS-CC Partnership grantees and child care partners and the activities they engaged in to develop and deliver services to children and families. In particular, as the first study of EHS-CC Partnerships to include a representative sample of the child care providers engaged in the partnerships, this report highlights the perspectives of child care partners and details how partnerships were implemented in child care centers and family child care homes. The information and lessons learned may help to inform ongoing and future activities of partnerships in early care and education programs as well as training and technical assistance efforts.

A. Early care and education partnerships

High quality early learning experiences can promote young children's development and help to reduce achievement gaps between children from low-income families and children from more affluent families (Duncan and Sojourner 2013; Ruhm and Waldfogel 2012). Early care and education programs also promote parents' ability to support their children's learning and allow parents to work or go to school. However, affordable, high quality child care for infants and toddlers from low-income families is scarce. One strategy to meet children's developmental needs and parents' workforce needs is to form partnerships at the point of service delivery to build seamless systems of care and promote quality across settings.

Studies on the features of early care and education partnership programs—including partnerships between Early Head Start (EHS) or Head Start programs and child care providers and between Head Start and public pre-kindergarten programs—have shown that these partnerships may have the potential to support quality care and the delivery of comprehensive services by offering opportunities to increase providers' credentials, enhancing the care environment through the provision of materials and supplies, and ensuring that providers meet high standards (for example, Chaudry et al. 2011 Paulsell et al. 2002; Schilder et al. 2005). However, limited research exists on the characteristics and components of early care and education partnerships serving infants, child care providers' perspectives on the partnerships, and strategies for implementing partnerships in home-based settings (Del Grosso et al. 2014).

1. EHS-CC Partnerships

In 2015, the Administration for Children and Families (ACF) awarded 275 EHS Expansion and EHS-CC Partnership grants. Of these, 250 grantees received funding for either EHS-CC Partnerships only or funding for both EHS-CC Partnerships and EHS Expansion. EHS Expansion grants were awarded to new entities or existing Head Start and EHS grantees to expand the number of center-based slots in traditional EHS programs. EHS-CC Partnership grants, the focus of this report, supported partnerships between grantees, which include both existing and new EHS and Head Start grantees, and regulated child care centers and family child care providers serving infants and toddlers from low-income families (Office of Head Start 2016). The box below contains a glossary of terms used to describe the entities involved in EHS-CC Partnerships.

Glossary

Throughout this report, we use the following terms to describe the entities involved in the EHS-CC Partnerships:

Grantee. An existing or new EHS or Head Start organization that received an EHS-CC Partnership grant award in 2015

Grantee director. A representative from the grantee organization that oversees the implementation of the grant

Delegate agency. An organization to which a grantee has delegated part or all of its responsibility for operation of the EHS-CC Partnership grant (also known as "subrecipient")

Child care partner. Child care center or family child care home that partners with a grantee or delegate agency to provide services to enrolled infants and toddlers

Partnership. The formal relationship between a grantee or delegate agency and a child care center or family child care home to provide program services to enrolled infants and toddlers

Partnership program. A grantee or delegate agency and all of the child care partners that work together to provide services to enrolled families and their infants and toddlers

Partnership slots. Child care partner enrollment spaces reserved for children funded under the EHS-CC Partnership grant

Nonpartnership slots. Child care partner enrollment spaces reserved for children not funded under the EHS-CC Partnership grant

Public entities, including states, and nonprofit or for-profit private entities, including community-based and faith-based organizations, were eligible to apply for the EHS Expansion and EHS-CC Partnership grants. Although these categories of organizations are the same as the categories of organizations eligible to apply for Head Start and EHS grants, applicants did not need to be an existing Head Start or EHS grantee to apply for EHS-CC Partnerships (Office of Head Start 2017). ACF allocated funding to every state based on the number of children younger than 5 years old living in poverty in the state. ACF prioritized applicants proposing to serve children through EHS-CC Partnership slots over those applying for EHS Expansion slots; those serving areas of concentrated poverty, including federally designated Promise Zones; and those who could blend funding by ensuring at least 40 percent of their slots were filled by children with a child care subsidy (Office of Early Childhood Development 2016).

The partnerships aim to bring together the best of both programs. EHS-CC Partnerships combine the high quality, comprehensive, relationship-based child development and family services of EHS with the flexibility of child care and its responsiveness to the social, cultural, and work-support needs of families (Office of Early Childhood Development 2016). EHS-CC Partnership grantees and child care providers work together to provide full-day, full-year early care and education services to enrolled infants and toddlers, as well as services designed to support children's healthy development and parents' role as their child's first teacher. These services include (1) health, developmental, and behavioral screenings; (2) health, safety, and nutritional services; and (3) parent engagement opportunities.

The EHS-CC Partnership grantees and child care partners are required to meet the Head Start Program Performance Standards (HSPPS) for children funded under the grant (see box on next page). In addition, grantees were expected to ensure that at least 25 percent of the EHS-CC Partnership slots are filled by children receiving a child care subsidy funded by the Child Care and Development Fund (CCDF) or another source (such as Temporary Assistance to Needy Families, Social Services Block Grant, or private funding; see box). Finally, child care partners must also meet applicable state and local child care licensing requirements.

About the Child Care and Development Fund (CCDF)

CCDF is a federal and state partnership program authorized under the Child Care and Development Block Grant Act (CCDBG) and administered by states, territories, and tribes with funding and support from ACF's Office of Child Care. In 2018, CCDF was funded at $8.1 billion in federal dollars. States use CCDF to provide financial assistance to low-income families to access child care so that they can work or attend a job training or educational program. A percentage of CCDF funds is set aside for improving child care quality (Office of Child Care 2016). Many states use CCDF funds to make systemic investments, such as developing quality rating and improvement systems (QRISs) and professional development systems.

The passage of the CCDBG Act of 2014 reauthorized the law governing CCDF. The law defines health and safety requirements for child care providers, outlines family-friendly eligibility policies, expands quality improvement efforts, and ensures that parents and the public have transparent information about the child care choices available to them. Under the law, states continue to have flexibility within federal guidelines over key policy levers—including subsidy payment rates, co-payment amounts contributed by the family, income thresholds for determining eligibility, and quality improvement investments (Office of Child Care 2018).

**ACF published a Final Rule to provide clarity to states on how to implement the 2014 CCDBG law. The rule went into effect in November 2016, less than two years after the EHS-CC Partnership grants were awarded and about mid-way through data collection for the study described in this report.*

About the Head Start Program Performance Standards (HSPPS)

The HSPPS define standards and minimum requirements for the entire range of Head Start services. They apply to both Head Start and EHS programs, including EHS-CC Partnerships. They serve as the foundation for Head Start's mission to deliver comprehensive, high quality individualized services supporting the school readiness of children from low-income families. The HSPPS outline requirements in the following areas:

- **Part 1301 Program governance** includes requirements related to governing bodies and policy councils.
- **Part 1302 Program operations** specifies operational requirements for serving young children and their families. Requirements are organized into ten subparts, labeled a–j:
  - (a) Eligibility, recruitment, selection, enrollment, and attendance
  - (b) Program structure, including adult-child ratio and group size requirements
  - (c) Education and child development program services, including requirements for the teaching and learning environment, the use of research-based curriculum and screening and assessment procedures
  - (d) Health program services, including requirements related to children's physical, oral, and mental health and well-being and family support services for health, nutrition, and mental health
  - (e) Family and community engagement program services
  - (f) Additional services for children with disabilities
  - (g) Transition services, including requirements for supporting transitions from EHS
  - (h) Services to enrolled pregnant women
  - (i) Human resources management, including staff qualification and competency requirements and requirements for staff training and professional development
  - (j) Program management and quality improvement
- **Part 1303 Financial and administrative requirements** specifies the financial and administrative requirements of agencies. It also includes requirements related to ensuring the confidentiality of any personally identifiable data, information, and records collected or maintained; prescribes regulations for the operation of delegate agencies; and includes requirements related to facilities and transportation.
- **Part 1304 Federal administrative procedures** includes the procedures the federal government takes to determine whether a grantee needs to compete for continued renewed funding and the results of competition for all grantees, any actions against a grantee, and other transparency-related procedures required by the Head Start Act.
- **Part 1305 Definitions** defines the terms used throughout the HSPPS.

For more information see https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii.

Source: ACF 2018.

**ACF published a Final Rule revising the HSPPS to strengthen and improve the quality of Head Start programs. These revised standards went into effect in November 2016, although some standards had delayed effective dates. This change occurred less than two years after the 2015 EHS-CC Partnership grants were awarded. However, because most grantees were working toward meeting the revised HSPPS during this period, we describe and reference the 2016 HSPPS here and throughout this report.*

B. The study of Early Head Start-Child Care Partnerships

To better understand the characteristics of early care and education partnerships—in particular, the EHS-CC Partnerships—the Office of Planning, Research, and Evaluation (OPRE), housed in ACF in the U.S. Department of Health and Human Services, commissioned a national descriptive study of EHS-CC Partnerships. The national descriptive study was part of a contract with Mathematica Policy Research to develop a rich knowledge base about EHS-CC Partnerships. We collected information about the characteristics of EHS-CC Partnerships and strategies for implementing partnerships with both child care centers and family child care providers to answer seven research questions:

1. What are the characteristics of EHS-CC Partnership programs, partnership grantees, and child care partners?
2. How are EHS-CC Partnerships developed and maintained?
3. What levels of funding are used to support EHS-CC Partnership programs and how are funds allocated?
4. How do EHS-CC Partnership programs recruit and enroll children and families?
5. How do EHS-CC Partnership programs provide comprehensive services to children and families?
6. What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?
7. What are families' experiences with partnership services?

To answer these questions, the project team collected data from the 250 grantees that received funds for EHS-CC Partnerships in 2015. The 2015 EHS Expansion and EHS-CC Partnership grants program provided funding for EHS-CC Partnerships only (supporting children participating in center-based or family child care programs), EHS Expansion only (for expanding enrollment in EHS), or both. Almost two-thirds of the grants were awarded for EHS-CC Partnerships only, another 30 percent were awarded as a mix of EHS-CC Partnership and EHS Expansion grants, and the remaining 6 percent were awarded as EHS Expansion-only grants. This study includes grantees that received funding for EHS-CC Partnerships only and those that received funding for EHS-CC Partnerships and EHS Expansion; it does not include Expansion-only grantees. In addition, for the purposes of this study, among grantees that were awarded funding for both EHS-CC Partnerships and EHS Expansion, we focused only on the EHS-CC Partnerships component of their grant.

The study provides a snapshot of the characteristics and activities of the EHS-CC Partnership grantees and their child care partners during the first year of implementation, approximately 12 to 18 months after receiving an EHS-CC Partnership grant. It is also the first study of EHS-CC Partnerships to include a representative sample of the child care providers engaged in these partnerships. Thus, a key goal of the study was to describe the partnership experience from the child care providers' as well as the grantees' perspectives.

The national descriptive study gathered data through web-based surveys of grantee and delegate agency directors and a sample of child care directors and family child care providers.

The team also collected in-depth data from case studies of 10 partnership programs that varied in their characteristics and approaches to implementation. The Executive Summary highlights the survey results, completed by the 220 grantees and 386 child care partners. The full report provides all survey results and features findings from the case studies, including information about families' experiences with the partnership services. The case studies included in-person and telephone interviews with grantee directors and key staff, child care partner staff, parents, and state and local stakeholders (such as child care administrators and child care resource and referral agency staff). The following sections summarize key findings from the study.

C. What are the characteristics of partnership programs, partnership grantees, and child care partners?

To carry out the EHS-CC Partnership grants, new or existing EHS programs (the grantees) formed relationships with child care centers or family child care homes (the child care partners) serving infants and toddlers from low-income families, including children receiving child care subsidies. A partnership program consists of a grantee and all of the child care partners that work together to provide services to enrolled families and their infants and toddlers. In this section, we describe the characteristics of the partnership programs, the grantees, and the child care partners.

1. Partnership programs

Grantees formed partnerships with existing regulated child care centers, family child care homes, or both. More than half of grantees (59 percent) had partnerships with child care center partners only. Thirty-two percent had both child care center and family child care partners. Only 7 percent of grantees had family child care partners only. Sixty-five percent of grantees had between 1 to 5 child care center partners, and 28 percent of grantees had 1 to 10 family child care partners. About 27,000 EHS-CC Partnership enrollment slots were offered across all child care partners (at the time of the survey in 2016): approximately 23,000 enrollment slots in child care centers and about 4,000 in family child care homes. The median number of enrollment slots across all partnership programs was 80, with a range of 2 to 1,100 slots.

2. Partnership grantees

Slightly more than half (52 percent) of partnership grantees were nonprofit, community-based organizations, community action agencies, or community action partnerships. One-quarter were public agencies, such as schools, tribal governments, or other public entities. Fewer than 10 percent were child care resource and referral agencies, universities, or child care networks. Grantees were located in all 12 Office of Head Start regions.[1] More than half of grantees (53 percent) operated in large urban areas with populations of one million or more, and one-third of grantees were in smaller metropolitan areas. Only 2 percent were in a completely rural area or a region with fewer than 2,500 people.

[1] The Office of Head Start (OHS) has 12 regions, which include tribal (Region XI) and migrant and seasonal (Region XII) programs. The Office of Child Care (OCC) covers the same regions except Regions XI and XII.

Eighty-seven percent of the partnership grantees had experience providing EHS or Head Start services. Sixty-one percent had experience providing both Head Start and EHS services and 26 percent had experience with either Head Start or EHS. The median grantee with EHS or Head Start experience had 15 years providing EHS services and 44 years providing Head Start services. Of those with EHS experience, most (90 percent) offered services through a center-based option and fewer (20 percent) offered services through a family child care option.

Partnership grantee directors had varied years of experience working in early childhood education and in their current position. About half (49 percent) of grantee directors had worked in early childhood education for more than 15 years, one-third had worked for 5 to 15 years, and 19 percent of directors began working in early childhood education within the past 5 years. Almost half (47 percent) were in their current position for more than five years. Nearly all grantee directors (95 percent) had at least a college degree. About half of grantee directors (49 percent) had a degree concentration in early childhood or education.

3. Child care partners

At the time of the survey, partnership grantees had identified almost 1,892 child care partners: 1,084 child care center partners and 808 family child care partners. Partnership slots accounted for about half of partners' infant–toddler enrollment slots. Overall, child care partners had a median number of 8 partnership slots, out of a median licensed enrollment capacity of 16 infant–toddler slots. Child care center partners had a median of 16 partnership slots, out of a median licensed enrollment capacity of 38 infant–toddler slots. Family child care partners had an average of four partnership slots out of a median licensed enrollment capacity of six infant–toddler slots.

Nearly all child care partners (98 percent) offered full-day, full-year care. Child care partners were open a median number of five days per week and 52 weeks per year. Child care partners were open for a median number of 11 hours per day. Nearly all child care partners (96 percent) were open on all weekdays. Overall, 9 percent of child care partners were open on weekends, with a higher percentage of family child care partners than child care center partners operating on weekends. Most partners (81 percent) allowed parents to use varying hours of care each week.

Most child care center directors and family child care managers or owners had early care and education experience and at least some college education. Fifty-one percent of child care center directors and 39 percent of family child care managers or owners had more than 15 years' experience working in early childhood education. Seventy-one percent of child care center directors had completed at least a college degree. Sixty-three percent of family child care managers or owners had completed at least some college, an associate's degree, or higher.

Most child development staff at child care center partners and family child care partners had or were in training for a child development associate (CDA) credential. Ninety-three percent of child development staff at centers caring for children in partnership slots were in training for or had completed a CDA or higher degree. Seventy-nine percent of adults who regularly worked with children at family child care homes were in training for or had completed a CDA or higher degree.

The median salary for early childhood educators was about $24,000 per year. The median salary of child development staff caring for infants and toddlers at child care center partners was about $23,000; the median salary at family child care partners was approximately $27,000. Seventy-seven percent of all child care partners offered benefits such as paid holidays and vacation days in addition to salaries.

Two-thirds of child care partners participated in a quality rating system. Most commonly (for 58 percent of partners), the quality rating was provided at the state or local level, often through a child care quality rating and improvement system (QRIS).

D. How are EHS-CC Partnerships developed and maintained?

In early care and education partnerships, organizations work together to deliver high quality services to children and families. Prior research provides operational lessons about factors that may help facilitate partnerships (Del Grosso et al. 2014). Several of these factors relate to how organizations establish and maintain partnerships. These factors include establishing a common vision and goals in the early planning phases, developing formal partnership agreements between organizations, developing plans for ongoing communication among partners, and building strong relationships and trust among staff at multiple levels of the organizations. In this section, we describe the strategies EHS-CC Partnership grantees and child care partners engaged in to establish and maintain the partnerships.

1. Developing partnerships

Partnership grantees recruited 60 percent of child care partners before or during the grant application process and the rest after grant award. Forty-eight percent of child care partners were recruited during discussions initiated by the grantee, whereas only 14 percent were recruited through discussions initiated by child care partners. Grantees recruited 30 percent of partners through a community planning process and 30 percent as an extension of a prior partnership between the child care center or family child care home and the grantee.

Almost all child care partners (93 percent) reported that improving the quality of infant–toddler care and education motivated them to participate in the EHS-CC Partnerships. Other common factors motivating participation included access to new funding, access to training for staff, and increasing families' access to comprehensive services. Sixty-nine percent of partners cited one or more of these reasons.

At the time of the survey, partnership grantees had a written partnership agreement with 97 percent of child care partners. Grantees developed these agreements in collaboration with partners in multiple ways (e.g., jointly with partners, with some partner input, and/or with input from a committee of partners), although no partner input was solicited in developing agreements for 32 percent of partners. Agreements commonly included roles and responsibilities of partners to comply with the HSPPS, the number of children and families to be served, a statement of each party's rights, and training and professional development to be provided by the grantee, among other topics.

At the time of the survey, 32 percent of grantees had terminated at least one partnership, most commonly because of issues complying with the HSPPS. The reason grantees most commonly cited for terminating partnerships with child care partners was difficulty complying with the HSPPS, followed by differences in philosophy and mission and difficulty meeting staff-child ratio and group size requirements.

2. Maintaining the partnerships

Grantees and child care partners engaged in a variety of activities to support quality relationships. Nearly all grantees (98 percent) held regular meetings with lead child care partner staff, as well as participated in discussions with frontline staff. These activities occurred on a monthly or weekly basis. Most child care partner directors or managers described grantee directors as effective leaders in implementing the EHS-CC Partnerships. In addition, most grantee directors and child care partner directors or managers described their relationships as mutually respectful and focused on similar goals.

E. What levels of funding are used to support EHS-CC Partnership programs and how are funds allocated?

One of the ways in which organizations in early care and education partnerships work together is by leveraging funding and other resources; however, partnership funding arrangements vary. Research has shown that regulatory differences across funding streams and insufficient or uncertain funding can be barriers to forming and sustaining partnerships, whereas funding plans or formal funding agreements specifying allocation can facilitate partnerships (Del Grosso et al. 2014). In this section, we describe total grant funding and allocations for the EHS-CC Partnerships, uses of grant funds, and how grantees and child care partners layered grant funds with other sources of funds.

1. Total grant funding and allocation across grantees and child care partners

The median annual EHS-CC Partnership grant amount was $1.4 million, with a median amount provided to child care partners of $7,875 per partnership slot. Total annual grant amounts ranged from $220,000 to $14.8 million. Partnership grantees also had a median amount provided to child care partners of $8,000 per child care center slot and $7,280 per family child care slot. Almost 70 percent of grantee directors had an average amount of funding per enrollment slot of less than $10,000.

The median partnership grantee transferred 54 percent of EHS-CC Partnership grant funds to child care partners. Seventy-one percent of grantees transferred 40 percent or more of EHS-CC Partnership grant funds to child care partners.

2. Uses of grant funds by child care partners

Child care partners received a median amount of $50,000 per year from the partnership grantee. The median child care center partner received $100,000 per year, and the median family child care partner received $24,000 per year. Seventy-three percent of child care

partners received an average amount of funding per enrollment slot of less than $10,000.[2] For 58 percent of child care partners, the amount of money they received from the grantee varied from month to month. The most common reasons for this variation included differences in receipt of child care subsidies, children's ages, and the number of children enrolled from month to month.

Fifty-nine percent of child care center partners and 20 percent of family child care partners received start-up funding from the grantee at the beginning of the partnership, in addition to funds received as part of the grant. Among those receiving start-up funds, 32 percent of child care center partners received $30,000 or more, compared with 24 percent of family child care partners. Conversely, 73 percent of family child care partners received less than $10,000, whereas only 23 percent of child care center partners received less than $10,000. For both child care center and family child care partners, start-up funds were most commonly used for materials, supplies, furniture, and equipment.

Fifty-six percent of child care center partners and 33 percent of family child care partners received additional funds from the grantee, apart from start-up funds and annual funding for partnership slots. For both child care center and family child care partners, the most common use of additional funds was for staff training and professional development. The next most common use of additional funds was for materials, supplies, furniture, and equipment.

3. Layering grant funds with other sources of funding

The most common sources of funding to offset the cost of care for children in partnership slots other than EHS-CC Partnership grant funds were child care subsidies and Child and Adult Care Food Program (CACFP) funds. Twenty-seven percent of child care partners received child care subsidies paid by state or county governments for at least one child in their care, and 25 percent received CACFP funds to offset the cost of care for children in partnership slots.[3] Overall, however, 34 percent of child care partners received funds from sources other than the grantee to offset the cost of care for children in partnership slots.

The percentage of partnership slots funded by child care subsidies varied substantially. A median of 50 percent of children enrolled in partnership program slots received a child care subsidy, although there was wide variability. Nearly all grantee directors (96 percent) said that at least one enrolled child received a child care subsidy.

Grantees used EHS-CC Partnership funds to offset the loss of child care subsidies. Most EHS-CC Partnership grantees (86 percent) used partnership funds to offset the costs of care for children who lost eligibility for child care subsidies for some period of time. Sixty-nine

[2] The percentage of grantee directors reporting providing less than $10,000 in funding per slot differs from the percentage of partners reporting receiving less than $10,000 per partnership slot. It is possible that grantees provided different amounts to different partners, which could lead to the difference. For example, consider a grantee that had two partners, and gave one partner $15,000 per slot and one partner $8,000 per slot. The grantee therefore gave funding of more than $10,000 per slot on average, though one of its two partners received less than $10,000 per slot.

[3] CACFP is a federally funded program that provides aid to child and adult care institutions and family child care homes to provide nutritious foods (Food and Nutrition Service 2017).

percent of grantees provided payment for the entire time the child was enrolled, and 17 percent provided payment for a limited period after the loss of a subsidy.

F. How do EHS-CC Partnership programs recruit and enroll children and families?

Well-designed and -implemented family recruitment processes assist partnership programs in informing potentially eligible families about the availability of services and encouraging families to apply for these programs (Office of Early Childhood Development 2017). Waiting lists assist programs in filling vacant slots as soon as possible. This section describes how child care partners recruited children and families into partnership slots.

Child care partners engaged in multiple strategies to recruit children and families for partnership slots, but they most often relied on word-of-mouth referrals. Three-quarters of child care partners recruited families through word-of-mouth referrals. Fifty-two percent received referrals from the grantee.

Most child care partners had families on a waiting list and about half used a system to prioritize families for enrollment. Sixty-eight percent of child care partners had a waiting list for infant–toddler slots. Fifty-six percent of child care center partners and 31 percent of family child care partners had a system to prioritize enrollment into partnership slots based on family risks or needs. Having such a system is a requirement of the HSPPS.

G. How do EHS-CC Partnership programs provide comprehensive services to children and families?

In addition to providing early care and education to children, EHS programs offer additional services to promote the health and well-being of children and support families in parenting. These services, which are part of the HSPPS, include the following:

- Connection and access to preventive health care services, such as health care providers and insurance, preventive dental screenings, and tracking of vaccination and medical screening records
- Support for emotional, social, and cognitive development, including screening children to identify developmental delays, mental health concerns, and other conditions that may warrant early intervention, mental health services, or educational interventions
- Family engagement, including parent leadership development, parenting support, and connecting families to needed economic supports and social services

This section describes how the EHS-CC Partnership programs provided comprehensive services to children and families.

Child care partners offered a range of services to children and families, including screenings, referrals, and assessments. Overall, more than 80 percent of child care partners offered developmental assessments and other screenings to children in partnership slots. Nearly 80 percent of partners offered referrals to children, including medical, dental, mental health, and

social service referrals. Sixty-seven percent of partners offered mental health observations or assessments.

Seventy-two percent of child care partners developed Individualized Family Partnership Agreements (IFPAs) with families to identify their parenting and self-sufficiency goals, and 86 percent conducted home visits with families in partnership slots, according to child care partners. Of those partners that developed IFPAs, most (68 percent) said that grantee staff were primarily responsible for working with families to develop IFPAs, compared with only 25 percent reporting that child care partner staff were responsible for providing this service. Of those child care partners that conducted home visits, the percentage reporting that grantee staff were responsible for providing home visits (46 percent) was about the same as the percentage reporting that child care partner staff were responsible for this service (48 percent).

Child care partners also offered a range of other services to parents and caregivers of children in partnership slots. More than two-thirds of child care partners offered mental health or health care screenings, assessments, or referrals for parents and caregivers, and just under two-thirds offered consultation or follow-up to families about findings from screenings or assessments of children.

Many child care partners offered services to children and families in nonpartnership slots. EHS-CC Partnership programs enhanced access to comprehensive services for children whose care was not supported through funds from the EHS-CC Partnership grant (i.e., children in nonpartnership slots). Many child care partners (70 percent) offered at least one service (such as screenings, referrals, or assessments) to children from birth to age 3 who were in nonpartnership slots. Twenty-two percent of child care partners offered IFPAs, and 13 percent offered home visits to families in nonpartnership slots. Almost half of child care partners offered at least one service (such as mental health or health care screenings, assessments, or referrals for parents and caregivers) to families of children in both partnership and nonpartnership slots.

More child care partners offered comprehensive services to children and families at the time of the survey than before the EHS-CC Partnership grant. About one-third to one-half of child care partners offered developmental and other screenings, referrals, mental health observations, and speech or physical therapy to any children before the partnership. At the time of the survey, at least two-thirds of partners offered these services to at least some children in care. Similarly, before the EHS-CC Partnership grant, 31 percent of partners offered IFPAs and 23 percent offered home visits, but after the grant 78 percent offered IFPAs and 88 percent offered home visits.

H. What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?

A key goal of the EHS-CC Partnership grant program is to increase the community supply of high quality early learning environments for infants and toddlers by supporting child care partners in meeting the HSPPS (Office of Early Childhood Development 2017). To accomplish this goal, partnership programs can implement a variety of strategies to enhance the quality of services, including opportunities for staff training, professional development, and enhancements

to learning environments. In this section, we describe the activities the EHS-CC Partnership programs engaged in to improve the quality of child development services.

1. Establishing expectations for meeting the HSPPS

Three-quarters of child care center partners and 65 percent of family child care partners received guidance from the grantee on implementing the HSPPS. Specifically, at least 50 percent of child care center partners and family child care partners received training, written materials, coaching, or classroom observation and feedback from the grantee. Overall, child care centers and family child care providers received similar types of guidance from grantees, with one exception: a significantly higher percentage of child care centers received classroom observation and feedback.

2. Using an early childhood education curriculum, individualizing services, and enhancing learning environments

Most child care partners (86 percent) used an early childhood education curriculum. The most commonly used curriculum was Creative Curriculum, used by 68 percent of partners. Family child care providers were significantly more likely than child care centers to use an agency-created curriculum or a "named" curriculum other than Creative Curriculum. (By named curriculum, we mean a curriculum other than an agency-created curriculum.) Sixty-two percent of child care partners implemented one curriculum; about one-quarter implemented two or more curricula.

Seventy-eight percent of child care partners met regularly with grantees to discuss services for individual children and families. Forty-one percent met once or twice a month, and 27 percent met almost weekly or more frequently. Among child care partners that met with grantees, the most common meeting topics were child assessment results and communication with parents.

Child care partners received a variety of materials and supplies directly from grantees. The materials partners most commonly received were furniture, such as cribs or bookshelves; curriculum materials; toys or materials for pretend play; and books (reported by about 70 percent of partners). At least 50 percent of partners also received screening and assessment materials, and playground or other outdoor equipment, and at least 45 percent received information technology and art supplies.

3. Supporting staff skills and credentials

Most child care partners received professional development opportunities from grantees. Eighty-six percent of child care partners said that grantees provided coaching or one-on-one training, and 84 percent said that grantees provided workshops. Thirty-nine percent of partners reported that grantees provided online training.

Nearly all grantees offered quality monitoring activities to child care partners and used information from these activities to provide staff training. The activity most commonly offered by grantees was classroom observations to assess practice, followed by using checklists on HSPPS compliance and reviewing of program files. Most grantees used information gathered

during quality monitoring activities to provide staff training and to schedule follow-up reviews or observations, develop written implementation plans, or obtain technical assistance.

Through their involvement in the partnership program, child care partners had opportunities to obtain a CDA credential or other degree. Seventy-seven percent of partners said that the grantee offered child care partner staff the opportunity to obtain a CDA credential. Thirty-seven percent of partner staff had the opportunity to obtain a state-awarded credential that met or exceeded CDA requirements, 26 percent had the opportunity to obtain an associate's degree, and 19 percent had the opportunity to earn a bachelor's degree.

I. Directions for future research

This report summarizes findings from the national descriptive study of EHS-CC Partnerships and provides the first national picture of these partnerships. In particular, the study fills an important gap in our knowledge base around the experiences of child care providers engaged in these partnerships. Nonetheless, the report points to several topics worth further exploration:

- Structure and features of the partnership programs that support quality improvement and access to high quality infant/toddler care
- Structure and features of professional development offerings for child development staff and how those offerings support improvements in caregiving practices
- Structure and approaches to the delivery of comprehensive services and how those services meet the needs of families and support family wellbeing
- Funding approaches for partnership programs, including the sources of funding, the allocation of funds across partners, and use of funds to support access and quality
- Short- and long-term outcomes that the partnership programs achieve
- State-level policies and procedures that help facilitate effective early care and education partnerships

I. INTRODUCTION AND METHODS

The purpose of this report is to document findings from the national descriptive study of Early Head Start-Child Care (EHS-CC) Partnerships. The national descriptive study was designed to develop a rich knowledge base about EHS-CC Partnerships. The report provides detailed information about the EHS-CC Partnership grantees and child care partners and the activities they engaged in to develop and deliver services to children and families. In particular, as the first study of EHS-CC Partnerships to include a representative sample of the child care providers engaged in the partnerships, this report highlights the perspectives of child care partners and details how partnerships were implemented in child care centers and family child care homes. The information and lessons learned may a help to inform ongoing and future activities of the partnerships in early care and education programs as well as training and technical assistance efforts.

A. Early care and education partnerships

High quality early learning experiences can promote young children's development and help to reduce achievement gaps between children from low-income families and children from more affluent families (Duncan and Sojourner 2013; Ruhm and Waldfogel 2012). Early care and education programs also promote parents' ability to support their children's learning and allow parents to work or go to school. However, affordable high quality child care for infants and toddlers from low-income families is scarce. One strategy to meet children's developmental needs and parents' workforce needs is to form partnerships at the point of service delivery to build seamless systems of care and promote quality across settings. These partnerships involve two or more organizations working together to provide early care and education services to young children and their families. The organizations may combine funding, resources, materials, and staff to serve additional children; provide comprehensive services; enhance service quality; or provide full-day, full-year early care and education.

Studies have documented the features of early care and education partnership programs, including partnerships between Head Start and Early Head Start (EHS) programs and child care providers and Head Start and public pre-kindergarten programs, and the potential these partnerships hold to support quality care and the delivery of comprehensive services by offering opportunities to increase providers' credentials, providing materials and supplies, and ensuring that providers meet high standards (for example, Chaudry et al. 2011; Paulsell et al. 2002; Schilder et al. 2005).

Early care and education partnerships are formed on the premise that collaborative service delivery mechanisms can have many positive outcomes for the organizations involved (Sowa 2008). Potential or perceived benefits include (1) improving the quality of early care and education services; (2) increasing access to early care and education services; (3) meeting families' child care needs and preferences; (4) increasing staff credentials, knowledge, and access to professional development; (5) improving the quality of services for all children in care (including children in slots not funded by the partnership); (6) sharing expertise and ideas among partners; (7) setting the stage for future collaboration; (8) increasing access to comprehensive services; and (9) reducing the number of transitions in care settings for children (Del Grosso et

al. 2014). However, collaboration alone is not always associated with positive outcomes; instead, the characteristics and quality of the collaborative relationship are important factors in achieving outcomes (Hicks et al. 1999; Sandfort et al. 2001).

Forming and maintaining partnerships can also pose challenges for the organizations involved. Previous studies have identified five barriers to early care and education partnerships (Del Grosso et al. 2014):

1. Low quality of collaboration among partners
2. Regulatory differences across funding streams
3. Discrepancies in standards (Head Start Program Performance Standards [HSPPS], state preschool standards, and child care licensing regulations) across settings
4. Insufficient or uncertain funding
5. Discrepancies in teacher pay and issues with teacher turnover across settings

Although the existing literature provides useful information about the range of activities that are likely to support implementation and the range of potential barriers to partnerships, questions remain about the characteristics and features of partnerships that are essential for improving quality and supporting infant and toddler development and family outcomes. Limited research also exists on the characteristics and components of early care and education partnerships serving infants, child care providers' perspectives on the partnerships, and strategies for implementing partnerships in home-based settings. In the next section, we describe one type of early care and education partnership, EHS-Child Care Partnerships.

B. EHS-CC Partnerships

In 2015, the Administration for Children and Families (ACF) awarded 275 EHS Expansion and EHS-CC Partnership grants. Of these, 250 grantees received funding for EHS-CC Partnerships or funding for both EHS-CC Partnerships and EHS Expansion. EHS Expansion grants were awarded to new entities or existing Head Start and EHS grantees to expand the number of center-based slots in traditional EHS programs. EHS-CC Partnership grants, the focus of this report, supported partnerships between grantees, which include existing EHS and Head Start grantees and entities new to EHS, and regulated child care centers and family child care providers serving infants and toddlers from low-income families (Office of Head Start 2016).

Public entities, including states, and nonprofit or for-profit private entities, including community-based and faith-based organizations, were eligible to apply for the EHS Expansion and EHS-CC Partnership grants. Although these categories of organizations are the same as the categories of organizations eligible to apply for Head Start and EHS grants, applicants did not need to be an existing Head Start or EHS grantee to apply for an EHS-CC Partnership grant (Office of Head Start 2016). ACF allocated funding to every state based on the number of children younger than 5 years old living in poverty in the state. ACF prioritized applicants proposing to serve children through EHS-CC Partnership slots over those applying for EHS Expansion slots; those serving areas of concentrated poverty, including federally designated Promise Zones; and those who could blend funding by ensuring at least 40 percent of their slots were filled by children with a child care subsidy (Office of Early Childhood Development 2016).

The EHS-CC Partnerships aim to bring together the best of both EHS and community-based child care. They combine the high quality comprehensive, relationship-based, child development and family services of EHS with the flexibility of child care and its responsiveness to the social, cultural, and work-support needs of families (Office of Early Childhood Development 2016). EHS-CC Partnership grantees and child care providers work together to provide full-day, full-year early care and education services to enrolled infants and toddlers, as well as services designed to support children's healthy development and parents' role as their child's first teacher. These services include (1) health, developmental, and behavioral screenings; (2) health, safety, and nutritional services; and (3) parent engagement opportunities.

The EHS-CC Partnership grantees and child care partners are required to implement the Head Start Program Performance Standards for children funded under the grant (see box on next page).[4] EHS-CC Partnership grantees were expected to ensure that at least 25 percent of the EHS-CC Partnership slots are filled by children receiving a child care subsidy funded by the Child Care and Development Fund (CCDF) or another source (such as Temporary Assistance to Needy Families, Social Services Block Grant, or private funding; see box). Child care partners must also meet applicable state and local child care licensing requirements.

About the Child Care and Development Fund (CCDF)

CCDF is a federal and state partnership program authorized under the Child Care and Development Block Grant Act (CCDBG) and administered by states, territories, and tribes with funding and support from ACF's Office of Child Care. In 2018, CCDF was funded at $8.1 billion in federal dollars. States use CCDF to provide financial assistance to low-income families to access child care so that they can work or attend a job training or educational program. A percentage of CCDF funds is set aside for improving child care quality (Office of Child Care 2016a). Many states use CCDF funds to make systemic investments, such as developing quality rating and improvement systems (QRISs) and professional development systems.

The passage of the CCDBG Act of 2014 reauthorized the law governing CCDF. The law defines health and safety requirements for child care providers, outlines family-friendly eligibility policies, expands quality improvement efforts, and ensures that parents and the public have transparent information about the child care choices available to them. Under the law, states continue to have flexibility within federal guidelines over key policy levers—including subsidy payment rates, co-payment amounts contributed by the family, income thresholds for determining eligibility, and quality improvement investments (Office of Child Care 2018).

**ACF published a Final Rule to provide clarity to states on how to implement the 2014 CCDBG law. The rule went into effect in November 2016, less than two years after the EHS-CC Partnership grants were awarded and about mid-way through data collection for the study described in this report.*

[4] The study of EHS-CC Partnerships was not intended to monitor whether partnership programs met the HSPPS. We provide an overview of the standards here for context. Furthermore, in each chapter of this report, we include language from specific standards, where relevant, to provide context to the information reported in the chapter.

About the Head Start Program Performance Standards (HSPPS)

The HSPPS define standards and minimum requirements for the entire range of Head Start services. They apply to both Head Start and EHS programs, including EHS-CC Partnerships. They serve as the foundation for Head Start's mission to deliver comprehensive, high quality individualized services supporting the school readiness of children from low-income families. The HSPPS outline requirements in the following areas:

- **Part 1301 Program governance** includes requirements related to governing bodies and policy councils.
- **Part 1302 Program operations** specifies operational requirements for serving young children and their families. Requirements are organized into 10 subparts, labeled a–j:
  - (a) Eligibility, recruitment, selection, enrollment, and attendance
  - (b) Program structure, including adult-child ratio and group size requirements
  - (c) Education and child development program services, including requirements for the teaching and learning environment, the use of research-based curriculum and screening and assessment procedures
  - (d) Health program services, including requirements related to children's physical, oral, and mental health and well-being and family support services for health, nutrition, and mental health
  - (e) Family and community engagement program services
  - (f) Additional services for children with disabilities
  - (g) Transition services, including requirements for supporting transitions from EHS
  - (h) Services to enrolled pregnant women
  - (i) Human resources management, including staff qualification and competency requirements and requirements for staff training and professional development
  - (j) Program management and quality improvement
- **Part 1303 Financial and administrative requirements** specifies the financial and administrative requirements of agencies. It also includes requirements related to ensuring the confidentiality of any personally identifiable data, information, and records collected or maintained; prescribes regulations for the operation of delegate agencies; and includes requirements related to facilities. And transportation.
- **Part 1304 Federal administrative procedures** includes the procedures the federal government takes to determine whether a grantee needs to compete for continued renewed funding and the results of competition for all grantees, any actions against a grantee, and other transparency-related procedures required by the Head Start Act.
- **Part 1305 Definitions** defines the terms used throughout the HSPPS.

For more information see: https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii.

Source: ACF 2018.

**ACF published a Final Rule revising the HSPPS to strengthen and improve the quality of Head Start programs. These revised standards went into effect in November 2016, although some standards had delayed effective dates. This change occurred less than two years after the 2015 EHS-CC Partnership grants were awarded. However, because most grantees were working toward the revised HSPPS during this period, we describe and reference the 2016 HSPPS here and throughout this report.*

C. The EHS-CC Partnerships theory of change

Building on the existing literature, the theory of change for EHS-CC Partnerships visually depicts how grantees, child care partners, families, and other early childhood systems could potentially work together in a coordinated manner to provide high quality, comprehensive

services to low-income infants and toddlers and their families (Appendix A; Del Grosso et al. 2014). The theory of change includes four sets of constructs: (1) inputs, (2) activities, (3) short- and long-term outcomes, and (4) organizational and contextual factors.

1. Inputs

Each entity (grantees, child care partners, families, and systems-level stakeholders) invests resources and contributes its experiences, knowledge, and skills to the partnerships.

- **Partnership grantees and child care partners.** For grantees and child care partners, these inputs include organization type, service delivery experience, program size, and other resources and supports from the agency that operates the program. Grantees and child care partners also bring motivation to form partnerships as well as differing levels of readiness to change program activities and procedures to accommodate the needs of new partners and new ways of serving children and families through partnerships. Motivation and readiness to change may be influenced by partners' attitudes toward and experience with collaboration.
- **Families.** Families also play an important role in the partnerships. Families have a range of characteristics, child care needs (including factors related to the hours and flexibility of the schedules offered by child care providers and the proximity of child care to families' homes and work locations), and preferences. Some families might need child care providers that can accommodate older siblings in addition to the child in the partnership slot or providers that can accommodate children's special needs. In addition, some families might seek child care arrangements that foster their home language and culture. Families may also need to meet income and other eligibility requirements for both EHS and child care subsidies.
- **Systems-level stakeholders.** Although they may not be direct participants, other systems at the national, state, and local levels play a crucial role in the partnerships. For example, states establish rules about child care licensing and subsidies. These stakeholders also contribute crucial resources for partnerships, including Head Start grant funds, CCDF funds, and other public and private funds. In addition, they offer supports for quality improvement. Other key stakeholders include community colleges and other institutions of higher education that provide relevant courses and degree programs to prepare infant–toddler service providers to meet requirements for specific credentials.

2. Activities

Many of the activities are conducted jointly by grantees and their child care partners, but families and systems-level stakeholders also play important roles.

- **Partnership grantees and child care partners.** The first crucial step in developing the partnerships is identifying potential partners. The grantees and child care partners then jointly engage in activities to establish the partnerships, recruit and enroll families, deliver services to children and families, and engage in quality improvement and professional development activities.
- **Families.** To participate in partnerships, families enroll in the partnership programs. They also need to communicate their child care needs and preferences to the partnership programs and select a child care arrangement. During their participation in services, families need to

maintain regular and open communication with staff from the partnership programs to facilitate continuity of care and smooth transitions across settings for children.

- **Systems-level stakeholders.** Misalignment of rules for EHS and child care systems can create challenges for partnerships. For example, differences in eligibility requirements and eligibility redetermination schedules between EHS and child care subsidy programs can create gaps in funding and jeopardize continuity of care if families lose eligibility for one source of funding. Systems-level stakeholders, such as subsidy systems, can consider rule accommodations to better align rules across systems. Requirements for staff training and credentials may also differ across the HSPPS, child care regulations, and local or state child care quality rating and improvement systems (QRISs). Community colleges and other institutions of higher education can play an important role in supporting all staff involved in the partnerships to obtain the credentials needed to meet these requirements.

3. Short- and long-term outcomes

Short-term outcomes. The theory of change posits that well-implemented partnerships lead to the following short-term outcomes for partnership programs, families, and systems-level stakeholders:

- **Partnership programs.** Once established, partnerships are able to offer a range of high quality service options to families, with more flexibility to meet their needs for full-day, full-year early care and education and comprehensive services than either partner could on its own. Partnership grantee and child care partner directors, as well as others in leadership roles in the organizations, value and support the partnerships, and grantee and child care partner staff value each other's contributions. In addition, staff demonstrate enhanced competencies to develop mutually respectful and collaborative partnerships, provide effective quality improvement support, and provide developmentally appropriate infant–toddler care. The partnerships also improve the quality of infant–toddler care they offer. In some locations, quality improvement supports might result in added benefits, such as a higher QRIS rating or access to additional training and education. Partnerships also reduce the isolation of infant–toddler service providers and offer them expanded professional support. Financial arrangements of the partnership agreement may strengthen the financial stability of the partners.
- **Families.** Through the partnerships, families gain access to high quality and comprehensive early care and education services that meet their needs. Regular communication among all partners and caregivers can ensure greater continuity of caregiving. With stable child care arrangements, parents are better able to obtain employment or attend school or training. With support from partnership programs, parents can be more involved in their children's early learning.
- **Systems-level stakeholders.** Partnerships provide an opportunity for key players in the various systems that contribute to early care and education services for infants and toddlers to examine misalignment of policies, standards, and regulations and move toward increased alignment. Professional development and quality improvement supports are aligned to help staff involved in the partnership obtain needed training and credentials.

Long-term outcomes. The theory of change posits that, ultimately, the partnerships lead to five long-term outcomes: (1) sustained, mutually respectful, and collaborative partnerships; (2) an increased community supply of high quality infant–toddler care; (3) improved family well-being; (4) improved child well-being and school readiness; and (5) well-aligned infant–toddler policies, regulations, and quality improvement supports at national, state, and local levels.

4. Organizational and contextual factors

Organizational factors. A range of organizational factors can facilitate or pose barriers to establishing and sustaining EHS-CC Partnerships. They include the length of time the grantees and child care partners have been in operation, the degree to which they are established in the communities they serve, and the degree of stability among their staff. The organizational culture and leadership support for the partnerships (among both grantees and child care partners) will influence the amount of support they receive. The extent to which the partnering organizations have shared goals and mutual respect and the quality of their relationships can also influence partnerships. The organizational infrastructure and systems in place to support continuous quality improvement within each organization also influence partnerships. Organizations that already have a culture and the systems in place to support regular self-assessment and the development of improvement plans will be better prepared than those without these resources in place to establish and sustain partnerships.

Contextual factors. Also influencing the partnerships are contextual factors at the national, state, and local levels. National initiatives can influence partnerships and affect the resources available to support them. For example, grantees might perceive partnerships as putting their grants at risk if child care partner settings are reviewed as part of Head Start's federal oversight and accountability systems, such as Federal Monitoring and the Head Start Designation Renewal System. Another important factor at the national level involved the reauthorization of CCDF. Provisions in the 2014 reauthorization established a nationwide baseline for health, safety, and quality standards; ensured that parents have access to adequate information on provider options and available services; and lengthened subsidy eligibility periods to support continuity of care. States and localities have begun to adopt these provisions, which were further specified in the 2016 CCDF Final Rule. At the state level, quality improvement supports through a QRIS or other initiatives may be available. State subsidy policies, such as eligibility and redetermination rules, may affect how partnerships are financed. The supply of infant–toddler child care in the community might influence the number of partnerships that can be formed and the pace of partnership development. The grantees may also need to recruit other types of stakeholders to engage with them in this effort. For example, they may collaborate with a child care resource and referral (CCR&R) agency to recruit unregulated child care providers to become regulated providers.

D. The study of EHS-CC Partnerships

Building on the EHS-CC Partnerships theory of change to better understand the characteristics of early care and education partnerships, the Office of Planning, Research & Evaluation (OPRE), housed in ACF in the U.S. Department of Health and Human Services, commissioned a national descriptive study of EHS-CC Partnerships.

The national descriptive study was part of a contract with Mathematica Policy Research to develop a rich knowledge base about EHS-CC Partnerships. The study documented the characteristics and components of EHS-CC Partnerships, incorporated the perspectives of child care partners, and collected information about strategies for implementing partnerships with both child care centers and family child care providers. The national descriptive study of EHS-CC Partnerships answered seven research questions:

1. What are the characteristics of EHS-CC Partnership programs, partnership grantees, and child care partners?
2. How are EHS-CC Partnerships developed and maintained?
3. What levels of funding are used to support EHS-CC Partnership programs, and how are funds allocated?
4. How do EHS-CC Partnership programs recruit and enroll children and families?
5. How do EHS-CC Partnership programs provide comprehensive services to children and families?
6. What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?
7. What are families' experiences with partnership services?

1. Sample

To answer these questions, the project team collected data from the 250 grantees that received funds for EHS-CC Partnerships in 2015. The 2015 EHS Expansion and EHS-CC Partnership grants program provided funding for EHS-CC Partnerships only (supporting children participating in center-based or family child care programs), EHS Expansion only (for expanding enrollment in EHS), or both. Almost two-thirds of the grants were awarded for EHS-CC Partnerships only, another 30 percent were awarded as a mix of EHS-CC Partnership and EHS Expansion grants, and the remaining 6 percent were awarded as EHS Expansion-only grants. This study includes grantees that received funding for EHS-CC Partnerships only and those that received funding for EHS-CC Partnerships and EHS Expansion; it does not include Expansion-only grantees. In addition, for the purposes of this study, among grantees that were awarded funding for both EHS-CC Partnerships and EHS Expansion, we focused only on the EHS-CC Partnerships component of their grant. The box below contains a glossary of terms used to describe the entities involved in EHS-CC Partnerships.

The EHS-CC Partnership grants supported partnerships between new or existing EHS programs and regulated child care centers and family child care providers serving infants and toddlers from low-income families. Grantees and child care partners provide full-day, full-year child care and comprehensive services to children and families, including (1) health, developmental, and behavioral screenings; (2) health, safety, and nutrition services that meet the HSPPS; and (3) parent engagement opportunities. The objectives of the EHS-CC Partnership grants included the following:

- Offering high quality, full-day and full-year child care services in regulated child care centers and family child care homes

- Meeting the HSPPS
- Layering grant funds with existing resources, such as CCDF and other existing child care funding, ensuring that at least 25 percent of enrolled children receive child care subsidies at the time of enrollment

Glossary

Throughout this report, we use the following terms to describe the entities involved in the EHS-CC Partnerships:

Grantee. Organization that received an EHS-CC Partnership grant award in 2015

Grantee director. A representative from the grantee organization that oversees the implementation of the grant

Delegate agency. An organization to which a grantee has delegated part or all of its responsibility for operation of the EHS-CC Partnership grant (also known as "subrecipient")

Child care partner. Child care center or family child care home that partners with a grantee or delegate agency to provide services to enrolled infants and toddlers

Partnership. The formal relationship between a grantee or delegate agency and a child care center or family child care home to provide program services to enrolled infants and toddlers

Partnership program. A grantee or delegate agency and all of the child care partners that work together to provide services to enrolled families and their infants and toddlers

Partnership slots. Child care partner enrollment spaces reserved for children funded under the EHS-CC Partnership grant

Nonpartnership slots. Child care partner enrollment spaces reserved for children not funded under the EHS-CC Partnership grant

2. Methods

We collected data through web-based surveys of grantee and delegate agency directors and a sample of child care directors and family child care providers. The team also collected in-depth data from case studies of 10 partnership programs that varied in their characteristics and approaches to implementation. This report includes results for the 220 grantees and 386 child care partners with completed surveys, as well as data collected as part of the case studies. The case studies included in-person and telephone interviews with grantee directors and key staff, child care partner staff, parents, and state and local stakeholders (such as child care administrators and CCR&R agency staff). Table I.1 provides a crosswalk of the seven research questions the study was designed to answer with the sample and methods. The box below includes an overview of the data collection and analysis methods; we provide a detailed description of our methods in Appendix B.

Table I.1. Research questions and data collection methods

Research questions	Surveys		Case studies	
	Grantee and Delegate Agency Director Survey	Child Care Partner Survey	Interviews[a]	Focus groups[b]
1. What are the characteristics of EHS-CC Partnership programs, partnership grantees, and child care partners?	X	X		
2. How are EHS-CC Partnerships developed and maintained?	X	X	Partnership director; stakeholders	Child care center directors; child care center teachers; family child care providers
3. What levels of funding are used to support EHS-CC Partnership programs, and how are funds allocated?	X	X	Partnership director	
4. How do EHS-CC Partnership programs recruit and enroll children and families?	X	X	Partnership director; partnership key staff; stakeholders	Child care center directors; child care center teachers; family child care providers
5. How do EHS-CC Partnership programs provide comprehensive services to children and families?	X	X	Partnership director; partnership key staff; stakeholders	Child care center directors; child care center teachers; family child care providers
6. What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?	X	X	Partnership director; partnership key staff; stakeholders	Child care center directors; child care center teachers; family child care providers
7. What are families' experiences with partnership services?				Parents

[a] We conducted semistructured interviews with grantee directors, partnership staff, and state and local stakeholders from each case study site.

[b] As applicable, we convened focus groups with child care center directors, child care center teachers, and family child care providers. We conducted focus groups with parents from each case study site.

Study methods

Web-based surveys

Mathematica Policy Research fielded the web-based survey of grantee and delegate agency directors from January through July 2016. We invited all 250 organizations that received an EHS-CC Partnership grant in 2015 to participate in the survey.* We also invited the 55 delegate agencies affiliated with the grantees to complete the survey so that we could obtain a list of all possible child care partners that were part of a partnership.† Of the 250 grantee directors eligible to complete the survey, 220 completed it, for a response rate of 88 percent.

The survey asked grantee and delegate agency directors to provide the names and contact information for all of their child care partners as well as key characteristics, such as the type of care setting (child care center or family child care home) and the number of enrollment slots funded by the EHS-CC Partnership grant. We randomly sampled child care partners from this list to participate in a separate survey, sampling both child care center and family child care partners. The web-based survey automatically selected a random sample of at least 20 percent of each type of partner, with a minimum of one. This procedure resulted in a random sample of 470 child care partners (302 child care center partners and 168 family child care partners).‡ We sampled separately by partner type to ensure a robust family child care partner sample size because most grantees had only child care center partners.

We fielded the child care partner survey of these randomly selected child care partners from February to November 2016. Of the 470 eligible child care partners, 386 completed the survey (255 child care center partners and 131 family child care partners), for an overall response rate of 82 percent (84 percent for child care center partners and 78 percent for family child care partners).

Even though respondents completed the survey, they might have chosen not to answer particular questions. We report the number of respondents with missing information in the table and figure notes. When information was available from both respondent types (grantees and partners), we chose one as the primary respondent. We chose the respondent with more detailed knowledge of the survey topic or that provided more information on a survey topic. In most cases, grantee and partner responses were similar. We report results from both types of respondents in Appendix C.

We used descriptive statistics such as frequencies, means, and ranges to describe the grantees and their child care partners. We conducted tests for statistically significant differences to support comparisons. We included sampling weights for the child care partner survey, and we included nonresponse weights for both surveys to ensure that responses represent all EHS-CC Partnership grantees and child care partners.

The child care partner survey contained items asking about how partners conducted certain activities before the grant and after becoming part of their EHS-CC Partnerships. We include information on selected items in the chapters and report all results in Appendix C.

** We did not survey grantees that received EHS Expansion-only grants.*

† 80 percent of delegate agencies completed the survey.

‡ The number of randomly selected partners (470) is substantially higher than one-fifth of the total number of partners (1,749) because we required that a minimum of one child care partner of either type be selected regardless of how many partners a grantee had. For example, suppose a grantee had one child care center and one family child care partner. We would have randomly selected both of these partners—that is, 100 percent of the grantee's partners—to participate in the Child Care Partner Survey.

Study methods (continued)

Case studies

Mathematica Policy Research conducted case studies of 10 grantees and their child care partners from February to April 2017. We identified sites for in-depth case studies using data from the grantee and delegate agency director survey. We purposively selected grantees that differed along dimensions prioritized by ACF, including grantee agency auspice, percentage of grant funds transferred to child care partners, experience with Head Start or EHS, child care partner type and number of partners, partnership termination status, and urbanicity of the grantee agency.

During in-person visits, we conducted individual interviews with grantee directors and key staff involved in the management and delivery of the partnerships (including grantee staff, such as EHS directors; family service coordinators; education specialists; health, mental health and disability coordinators; coaches; and, for one grantee, staff from hub organizations that worked directly with child care partners). Focus groups included interviews with child care center directors, child care center teachers, and family child care providers (as applicable); with parents of children enrolled in partnership slots; and by telephone with state and local stakeholders identified by the grantees. Appendix B lists the number of participants for each type of activity.

We used standard qualitative procedures to analyze and summarize information from semistructured interviews and focus groups. Analysis involved organizing, coding, triangulating, and identifying themes. To code the qualitative data for key subtopics and themes, the evaluation team developed a coding scheme based on the research questions. We also used the constructs included in the Consolidated Framework for Implementation Research to systematically code facilitators and barriers to successful implementation (Damschroder et al. 2009). Using the coded data, we compared responses and identified themes across respondents within and across partnership programs.

3. Measures

Table I.2 provides a crosswalk between the data collection instruments and the key constructs each was designed to address. To the extent possible, we drew on questions used in previous studies (see Appendix B, Table B.1).

4. Contextualizing findings with other national surveys of EHS and child care

To contextualize the findings, particularly findings on characteristics of grantees and their child care partners detailed in Chapter II, we reference findings from two national surveys:

- The Early Head Start Family and Child Experiences Survey (Baby FACES) 2009 is a longitudinal descriptive study of EHS that captures family- and child-level information in addition to program-level characteristics. The study included a nationally representative sample of 89 EHS programs.
- The National Survey of Early Care and Education (NSECE) is a set of four integrated, nationally representative surveys conducted in 2012. It included surveys of (1) households with children under age 13, (2) home-based providers of early care and education, (3) center-based providers of early care and education, and (4) the center-based provider workforce.

Both surveys are funded by OPRE.

Table I.2. Data collection instruments and key constructs measured

Instrument	Key constructs
Partnership Grantee and Delegate Agency Director Survey	Characteristics of grantees, basic information about all of a grantee's child care partners, partnership development activities, funding arrangements, quality improvement activities, and services provided to children and families, for a subset of partners, the quality of partnerships
Child Care Partner Survey	Characteristics of child care partners, partnership development activities, funding arrangements, quality improvement activities, services provided to children and families, and the quality of their partnerships with the grantees
Case study interview and focus group topic guides	
Partnership grantee director interview guide	Partner recruitment; development of partnership agreements; quality improvement activities; monitoring compliance with the HSPPS; providing child development services; developing and implementing family partnership agreements; and challenges encountered, lessons learned, and satisfaction with the partnership
Partnership staff interview guide	Coordination of activities among partners; monitoring compliance with the HSPPS; providing technical assistance and training; and challenges encountered, lessons learned, and satisfaction with the partnership
Child care center director focus group guide	Motivations for partnering; roles in and process of partnership development; experiences implementing the partnership in compliance with the HSPPS; experiences collaborating with the grantee agency; and challenges encountered, lessons learned, and satisfaction with the partnership
Child care center teacher focus group guide	Receipt of training and support; experiences with implementing the partnership, working with children and families, and collaborating with grantee and other partner staff; and challenges encountered, lessons learned, and satisfaction with the partnership
Family child care provider focus group guide	Motivations for partnering; receipt of training and support; roles in and process for partnership development; experiences implementing the partnership in compliance with the HSPPS, working with child and families, and collaborating with the grantee and other partners staff; and challenges encountered, lessons learned, and satisfaction with the partnership
Parent focus group guide	Child care needs and preferences, motivation for enrolling in partnership services, process of selecting a child care provider, experiences receiving services through the partnership, and satisfaction with services received
State and local stakeholders interview guide	Availability of quality improvement supports and professional development opportunities in the community, efforts to coordinate supports and opportunities with the partnerships, barriers to partnerships, and efforts to address the barriers at the local and state levels

HSPPS = Head Start Program Performance Standards.

In the remainder of this report, we describe findings for each of the seven research questions. In Chapter II, we describe the characteristics of grantees and their child care partners. In Chapter III, we describe the activities grantees and child care partners engaged in to develop and maintain the partnerships. In Chapter IV, we describe the levels of funds used to support partnerships and the allocation of funds across grantees and partners. In Chapter V, we describe how grantees and child care partners recruited and enrolled children and families in EHS-CC Partnerships. In Chapter VI, we discuss how the grantees and child care partners delivered comprehensive services to children and families. In Chapter VII, we describe the quality improvement activities in which grantees and child care partners engaged. In Chapter VIII, we provide a study and key findings summary, discuss some limitations of the study, and recommend directions for future research. Throughout the report, we draw on family experiences with partnership services to answer the last research question.

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II. CHARACTERISTICS OF EHS-CC PARTNERSHIP PROGRAMS, PARTNERSHIP GRANTEES, AND CHILD CARE PARTNERS

ACF awarded EHS-CC Partnership grants to 250 organizations in 2015.[5] To carry out the partnership grants, the grantee organizations formed relationships with child care partners. Child care partners could be child care centers or family child care homes. A partnership program consists of a grantee and all of the child care partners that work together to provide services to enrolled families and their infants and toddlers.

In this chapter, we use data from the EHS-CC Partnership Grantee and Delegate Agency Director Survey and the Child Care Partner Survey to answer the following research question: *What are the characteristics of EHS-CC Partnership programs, partnership grantees, and child care partners?* We begin by describing the partnership programs and the number of slots funded through partnership grants. We then describe the characteristics of EHS-CC Partnership grantees and grantee directors, such as their agency type, location, and experience. Finally, we describe characteristics of child care partners, covering the size and operating hours of partners as well as staff and manager characteristics.

Key findings: What are the characteristics of EHS-CC Partnership programs, partnership grantees, and child care partners?

- Sixty-one percent of grantees had partnerships with child care centers only, 32 percent had partnerships with child care centers and family child care homes, and 7 percent had partnerships with family child care homes only.
- Partnership slots accounted for about half of child care partners' infant–toddler enrollment capacity, and nearly all (98 percent) child care partners offered full-day, full-year care.
- Grantees were located in all 12 Office of Head Start regions and were most often nonprofit, community-based organizations.
- Most grantees (87 percent) had experience providing EHS or Head Start services, and nearly all administered the EHS-CC Partnership grants directly, rather than working through delegate agencies.
- Fifty-one percent of child care partner directors and 39 percent of family child care managers had 15 or more years' early childhood education experience and at least some college education. Seventy-one percent of child care center partner directors had completed at least a college degree, and 63 percent of family child care managers or owners had completed at least some college.
- Two-thirds of child care partners participated in a quality rating system.

[5] In 2015, ACF awarded 275 EHS-CC Partnership and EHS Expansion grants. This report focuses on the 250 grantees that received EHS-CC Partnership grants. We did not survey grantees that received EHS Expansion-only grants.

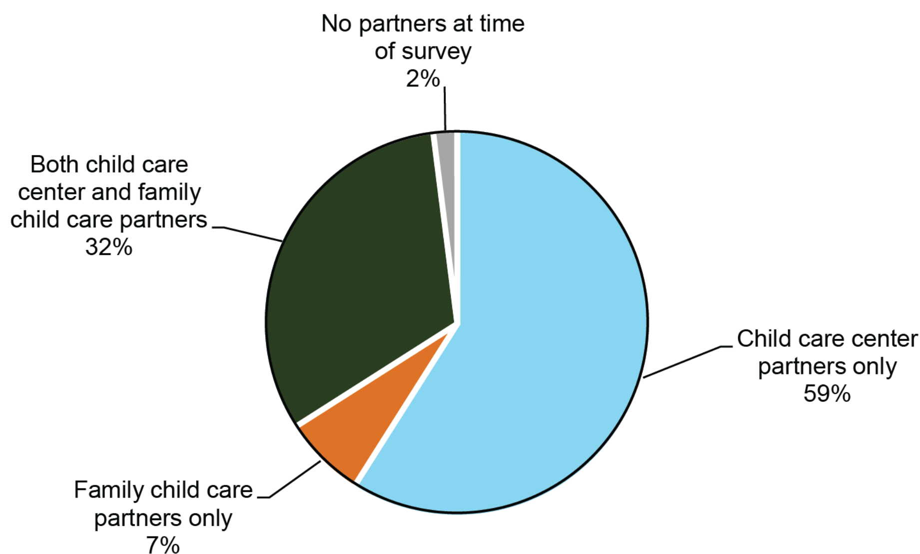
A. Partnership programs

In this section, we report findings from the Grantee and Delegate Agency Director Survey and the Child Care Partner Survey on the characteristics of grantees and their child care partners. In establishing the partnership programs, grantees formed partnerships with existing regulated child care centers, family child care homes, or both. Each grant specified the number of funded enrollment slots for each partnership program.

1. Most grantees had partnerships with child care centers only

Almost all grantees (98 percent) had child care partnerships in place at the time of the survey. Most grantees (59 percent) had partnerships with child care centers only. Almost one-third (32 percent) of grantees had partnerships with centers and family child care homes. Only 7 percent of grantees had family child care partners only (Figure II.1). Sixty-five percent of grantees had partnerships with 1 to 5 child care centers, and 28 percent of grantees had partnerships with 1 to 10 family child care providers. Almost one-quarter (23 percent) of grantee directors planned to recruit more partners at the time the Grantee and Delegate Agency Director Survey was administered (Appendix C, Table C.II.1).

Figure II.1. Most grantees had child care center partners only



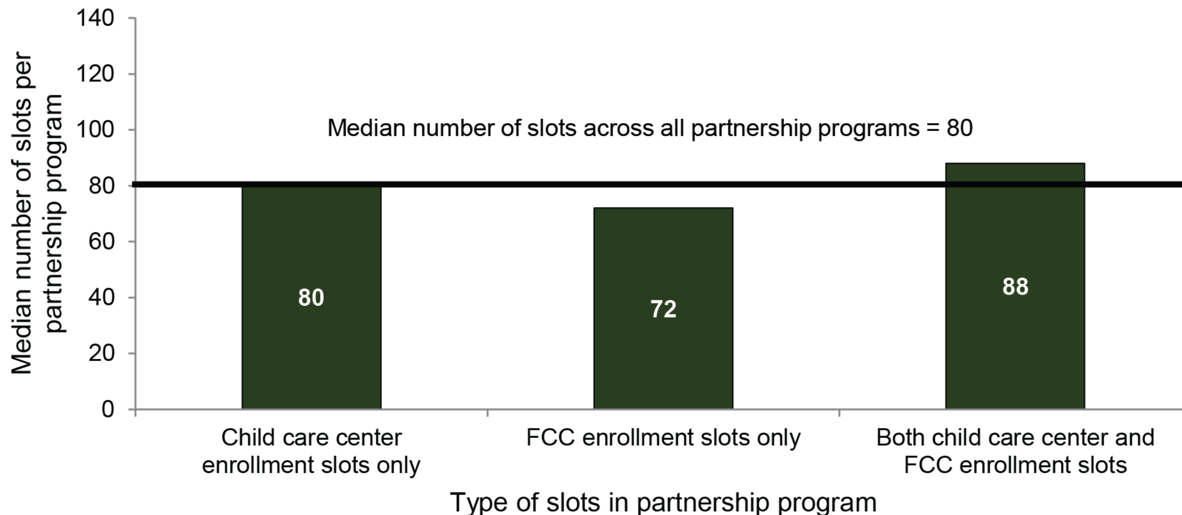
Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220. Information was missing for one grantee. Results are weighted to account for nonresponse.

2. About 27,000 EHS-CC Partnership enrollment slots were offered across all child care partners (at the time of the survey in 2016)

Overall, grantees offered about 23,000 partnership enrollment slots in child care centers and about 4,000 in family child care homes (not shown).[6] These numbers align with the number of children expected to be served through EHS-CC Partnership grants according to the Early Head Start–Child Care Partnerships Year One Report (Office of Early Childhood Development 2016). The median number of slots across all partnership programs was 80, with a range of 2 to 1,100. The median number of slots for partnership programs with child care center enrollment slots only was 80 (range: 2–750); for partnership programs with family child care slots only, the median was 72 slots (range: 17–176); and for partnership programs with both child care center and family child care slots, the median was 88 slots (range: 16–1,100; Figure II.2; Appendix C, Table C.II.2).

Figure II.2. The median number of EHS-CC Partnership slots across all partnership programs was 80



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220. Information was missing for three grantees. Results are weighted to account for nonresponse.

FCC = family child care.

B. Partnership grantees

In this section, we report findings from the Grantee and Delegate Agency Director Survey on EHS-CC Partnership grantee characteristics. States, local governments, public and private nonprofits, and for-profits were eligible to apply for EHS-CC Partnership grants (ACF 2015). In

[6] The national descriptive study asked partnership programs about children and families in partnership slots only. These were slots for enrollment in child care centers and family child care homes, funded with the EHS-CC Partnership grant funds. Slots for enrollment in EHS were funded with EHS Expansion grant funds and not part of this study.

addition, applicants could be existing EHS or Head Start grantees, but they did not need experience delivering EHS or Head Start services.

1. Most partnership grantees were nonprofit, community-based organizations, community action agencies, or community action partnerships

More than half (52 percent) of EHS-CC Partnership grantees were community-based organizations (CBOs), community action agencies (CAAs), or community action partnerships (CAPs); 4 percent were CCR&R agencies; 3 percent were universities; and 2 percent were child care networks. One-quarter were public agencies, such as schools, tribal governments, or other public entities (Table II.1). This distribution of organization types is broadly similar to that of EHS grantees as a whole. Nearly half of all EHS programs are nonprofit organizations, about 30 percent are CAAs, 11 percent are school systems, and 7 percent are government agencies (Mayoral 2013).

Table II.1. Type and auspice of grantee or delegate agency

	Percentage of grantees
Agency type	
Private nonprofit	72%
Public agency	25%
Private for-profit	3%
Agency auspice	
Community-based organization	28%
Community action agency or community action partnership	24%
Government agency	12%
Public or private school system	4%
Child care resource and referral agency	4%
University	3%
Tribal government or tribal consortium	3%
Faith-based organization	2%
Child care network	2%
Health care provider or agency	1%
Hospital	1%
Other	16%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for two to three grantees. Results are weighted to account for nonresponse. “Government agency” includes state or county offices of education, county boards of supervisors, city governments, and other governmental entities. Seven grantees were state or territory grantees that administered partnerships through state agencies such as state departments of education or school systems. Responses in the “Other” category included unspecified nonprofit organizations (17 respondents) and Head Start or EHS programs (6 respondents).

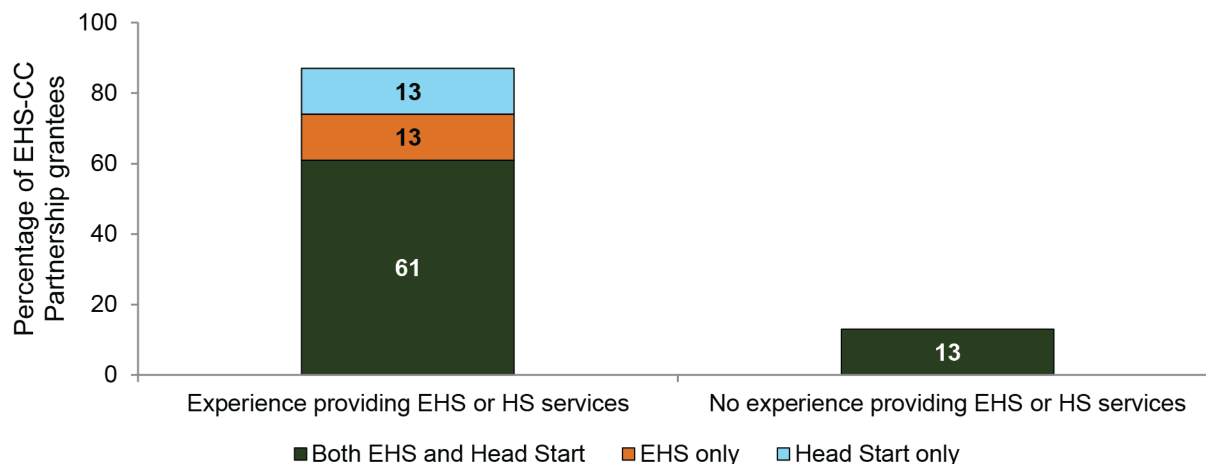
2. Grantees were located in all 12 Office of Head Start regions

Funding for the EHS-CC Partnership and EHS Expansion grants was allocated to every state based on the number of children younger than 5 years old living in poverty in the state (Office of Early Childhood Development 2016). The largest concentrations of grantees were in Regions IV (the Southeast); V (the Great Lakes area); VI (Texas and surrounding states); and IX (California, Arizona, Nevada, Hawaii, and island territories; Appendix C, Table C.II.3).[7] Fifty-three percent of grantees operated in large urban areas with populations of 1 million or more. One-third of grantees were in smaller metropolitan areas, 13 percent were in urban areas with a population of at least 2,500, and 2 percent were in a completely rural area or a region with fewer than 2,500 people (Appendix C, Table C.II.4).

3. Most of the partnership grantees had a great deal of experience providing EHS or Head Start services

Eighty-seven percent of EHS-CC Partnership grantees had experience providing Head Start or EHS services. Specifically, 61 percent had experience providing both Head Start and EHS services, 26 percent had experience with either Head Start or EHS, and 13 percent of grantees had no previous experience with either program (Figure II.3). The median grantee with EHS or Head Start experience had 15 years providing EHS services and 44 years providing Head Start services (Appendix C, Table C.II.5). Thirty-four percent of grantees had 16 or more years of experience providing EHS services, 41 percent had 1 to 15 years of experience, and 26 percent had no experience providing EHS services (Appendix C, Table C.II.6). Of those with EHS experience, most (90 percent) offered services through a center-based option and fewer (20 percent) offered services through a family child care option (Appendix C, Table C.II.5).

Figure II.3. Most EHS-CC Partnership grantees had prior experience providing EHS and Head Start services



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220. Information was missing for two or three grantees. Results are weighted to account for nonresponse.

[7] The Office of Head Start (OHS) has 12 Regions, which includes a tribal (Region XI) and migrant and seasonal (Region XII) programs. The Office of Child Care (OCC) covers the same regions except for Regions XI and XII.

4. Almost all grantees administered the partnership grants directly

Only 7 percent of grantees used delegate agencies. Grantees with delegates had 1 to 19 delegate agencies, with a median of 2. Approximately two-thirds of grantees with a delegate had either 1 or 2 delegates. Three percent of grantees (about half of those with delegates) administered some of their own partnership slots, whereas 4 percent (the other half) administered slots entirely via delegates (Table II.2).

Table II.2. Use of delegate agencies

Grantee characteristic	Percentage of grantees, unless otherwise noted
Has at least one delegate agency	7%
Median number of delegates (range)	2 (1 to 19)
Grantee administers some partnership slots directly (others administered by delegate agency or agencies)	3%
Grantee administers no partnership slots directly (all slots are administered via delegates)	4%
Has no delegate agencies and administers all partnership slots directly	93%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for zero grantees. Results are weighted to account for nonresponse.

5. Partnership grantee directors had varied years of experience working in early childhood education and in their current position

About half (49 percent) of grantee directors had worked in early childhood education for more than 15 years, one-third had worked for 5 to 15 years, and 19 percent of directors began working in early childhood education within the past 5 years. Almost half (47 percent) were in their current position for more than five years. Nearly all grantee directors (95 percent) had at least a college degree. Almost one-third (31 percent) had a bachelor's degree, and 59 percent had a master's degree. Forty-nine percent of grantee directors had a degree concentrated in an early childhood or education field (Table II.3). The experience and education levels of grantee directors are in line with program directors' responses to Baby FACES. According to Baby FACES data, directors and assistant directors had 8 to 11 years of experience at their current programs. In addition, more than 90 percent of program directors had at least a college degree: 32 percent had a bachelor's degree, and 59 percent had a graduate/professional degree or higher (Vogel et al. 2011).

HSPPS: EHS or Head Start director qualifications

A program must ensure an EHS or Head Start director hired after November 7, 2016, has, at a minimum, a baccalaureate degree and experience in supervision of staff, fiscal management, and administration.

– HSPPS Part 1302, Subpart I: Human resources management

Table II.3. Education and experience of partnership grantee directors

	Percentage of grantee directors
Highest degree	
Some college courses, but no degree	2%
Associate's degree (A.A., A.A.S.)	3%
Bachelor's degree (B.A., B.S.)	31%
Master's degree (M.A., M.S.)	59%
Doctoral degree (Ph.D., Ed.D.)	4%
Professional degree after bachelor's degree	1%
Field of highest degree	
Child development or developmental psychology	10%
Early childhood education	29%
Elementary education	8%
Special education	2%
Other	51%
Years of experience in early childhood education	
Fewer than 5	19%
5 to 15	33%
More than 15	49%
Years in current position	
New to position (1 year or less)	31%
2 to 5	22%
More than 5	47%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for one to five grantees. Results are weighted to account for nonresponse.

C. Child care partners

The aim of the EHS-CC Partnership grant was to establish partnerships between grantees and child care centers and family child care providers in the community to serve children from low-income families, including children receiving child care subsidies. At the time of the survey, EHS-CC Partnership grantees and delegate agencies identified a total of 1,892 child care partners: 1,084 child care center partners and 808 family child care partners. Overall, the median number of child care partners was 5, with a range of 0 to 70 partners. The median number of child care center partners was 3, with a range of 0 to 33; and the median number of family child care partners was 0, with a range of 0 to 50 (not shown).[8] In this section, we report findings on child care partner characteristics from the Child Care Partner Survey.

[8] The Grantee and Delegate Agency Director Survey asked grantees to include child care partners that currently had at least one child enrolled in partnership slots when they reported the number of child care partners.

1. Partnership slots accounted for about half of child care partners' infant–toddler enrollment capacity

Overall, child care partners had a median number of 8 partnership slots, out of a median licensed enrollment capacity of 16 slots for infants and toddlers from birth to age 3.[9, 10] Child care center partners had a median number of 16 partnership slots, out of a median licensed enrollment capacity of 38 infant–toddler slots. Family child care partners had a median number of 4 partnership slots, out of a median licensed enrollment capacity of 6 infant–toddler slots (Table II.4; Appendix C, Table C.II.7).

Table II.4. Child care partner enrollment capacity

	Amount (range) or percentage		
Enrollment capacity	All partners	Child care center partners	Family child care partners
Median licensed enrollment capacity across all ages (range)	33 (4–534)	80 (8–534)	12 (4–24)
Median licensed enrollment capacity for children from birth to age 3 (range)	16 (2–224)	38 (8–224)	6 (2–16)
Median number of EHS-CC Partnership slots (range)	8 (0–160)	16 (0–160)	4 (0–12)
Median percentage of licensed enrollment slots for children from birth to age 3 that are EHS-CC Partnership slots[a]	50%	42%	75%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 0 to 4 child care partners and was trimmed for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. The analysis excludes centers with enrollment capacity greater than 1,000 and family child care partners with enrollment capacity greater than 25. The percentage of total licensed enrollment slots for children from birth to age 3 that are EHS-CC Partnership slots is capped at 100 percent.

[a] To obtain this percentage, we first calculated the percentage for each partner separately. We then took the median of the percentages across all relevant partners.

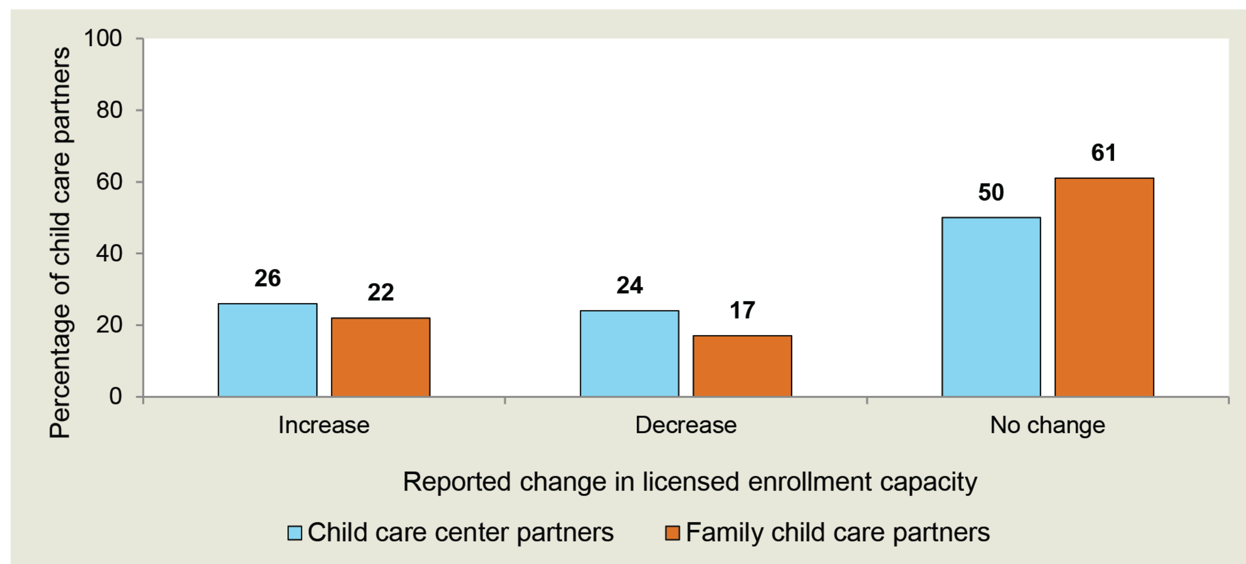
Overall, there is little evidence to suggest that the EHS-CC Partnership grant increased the number of infant–toddler child care slots available in partner centers and family child care homes, though there was substantial variation across child care partners. (Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.) Fifty-four percent of child care partners had no change in licensed

[9] All analyses using data from the partner survey, administered to a randomly selected subset of all partners, are weighted to be representative of all child care partners.

[10] Standards for licensed capacity in a child care center or family child care home are set at the state or local level and reflect the maximum number of children that a center or home can enroll. These standards are distinct from group size and ratio requirements outlined in the HSPPS.

enrollment capacity since before the partnership began. About a quarter of partners (26 percent of child care center partners and 22 percent of family child care partners) had an increase in licensed enrollment capacity, and about 20 percent (24 percent of child care center partners and 17 percent of family child care partners) had a decrease (Figure II.4; Appendix C, Table C.II.8).

Figure II.4. Most child care partners reported no change in licensed enrollment capacity since before the start of the EHS-CC Partnership grants



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 4 child care partners and was trimmed for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. Centers with enrollment capacity greater than 1,000 and family child care providers with enrollment capacity greater than 25 are excluded from this analysis.

2. Nearly all child care partners offered full-day, full-year care

Ninety-eight percent of child care partners offered at least 1,380 annual hours of service. Child care partners were open a median number of five days per week and 52 weeks per year. Child care partners were open for a median number of 11 hours per day. Child care center partners and family child care partners had similar hours and days of operation. Nearly all partners were open on all weekdays (96 percent). Overall, 9 percent of child care partners were open on weekends. A higher percentage of family child care partners than child care center partners operated on weekends: 17 versus 3 percent.[11] In addition, most partners (81 percent) allowed parents to use varying hours of care each week (Table II.5; Appendix C, Table C.II.9).

[11] This difference is statistically significant. Except for this result, throughout Chapter II, we do not conduct statistical tests for differences between child care center and family child care partners because they are not comparable along most dimensions (for example, size).

HSPPS: EHS service duration requirements

Center-based option service duration. By August 1, 2018, a program must provide 1,380 annual hours of planned class operations for all enrolled children. A program that is designed to meet the needs of young parents enrolled in school settings may meet the service duration requirements in paragraph (c)(1)(i) of this section if it operates a center-based program schedule during the school year aligned with its local education agency requirements and provides regular home-based services during the summer break.

Family child care option s*ervice duration*. Whether family child care option services are provided directly or via contractual arrangement, a program must ensure family child care providers operate sufficient hours to meet the child care needs of families and not less than 1,380 hours per year.

− HSPPS Part 1302, Subpart B: Program structure

Some findings from the Child Care Partner Survey about hours of operation differ from findings from the National Survey of Early Care and Education. According to the NSECE, about 30 percent of child care centers offer fewer than 30 hours per week of care (NSECE Project Team 2014), whereas 98 percent of child care center partners in the Child Care Partner Survey offered full-day, full-year care. One reason for this discrepancy may be that, unlike the child care centers in the Child Care Partner Survey, the child care centers in the NSECE did not all have to meet the HSPPS requiring full-day, full-year care.

Other findings about hours of operation, however, are similar across the two surveys. According to the NSECE, home-based providers were more likely than center-based providers to offer nonstandard hours of care (NSECE Project Team 2015a). Results from the Child Care Partner Survey, presented above, show that family child care partners were more likely than child care center partners to operate on weekends.

Table II.5. Child care partner business hours

	Number or percentage		
Business hours	All partners	Child care center partners	Family child care partners
Median hours per day in operation (range)	11.0 (6–23)	12.0 (6–18)	11.0 (6–23)
Median number of days per week in operation (range)	5.0 (3–7)	5.0 (3–7)	5.0 (4–7)
Percentage operating five weekdays	96%	97%	96%
Percentage operating on weekends (Saturday or Sunday)	9%	3%	17%
Median number of weeks per year in operation (range)	52.0 (4–52)	52.0 (5–52)	51.0 (4–52)
Percentage offering full-day, full-year care[a]	98%	98%	97%
Percentage allowing parents to use varying hours of care each week	81%	81%	80%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 4 to 16 child care partners. Results are weighted to account for sampling probability and nonresponse.

[a] Full-day, full-year care is defined as 1,380 annual hours of service.

Lessons learned from the case studies: Parent experiences with partnership program operations

Parents were important stakeholders in the partnership programs that enrolled their children and provided comprehensive services and referrals. During the case studies, parents who participated in focus groups provided important information about how the programs operate.

In some cases, the hours of care offered by child care partners did not meet the parents' needs. Some parents said that they needed care for longer than the child care partners offered, specifically during morning, evening, and weekend hours. However, other parents told us that their provider's schedules met their needs.

3. Child care center partner directors and family child care managers or owners had early care and education experience and at least some college education

Fifty-one percent of child care center directors and 39 percent of family child care managers or owners had more than 15 years' experience working in early childhood education. Almost two-thirds (65 percent) of center directors and 76 percent of family child care managers or owners had worked in their current position for more than five years (Table II.6).

Seventy-one percent of child care center partner directors had completed at least a college degree. Among center directors, 3 percent had only a high school diploma or General Education Development (GED) equivalent. Among family child care managers or owners, 63 percent had completed at least some college, an associate's degree, or higher: 25 percent had completed some college, 21 percent had an associate's degree, and 17 percent had completed a bachelor's degree or higher levels of education. More than one-fifth (22 percent) had only a high school diploma or GED equivalent (Table II.6). The family child care managers or owners we surveyed appear to have similar levels of education as listed, paid providers in the NSECE.[12] The NSECE also reported that 63 percent of listed, paid providers had some college or higher levels of education.

Directors and managers or owners who had completed some type of postsecondary credential most commonly had a credential in early childhood education. Specifically, among those who had completed some higher education, 46 percent of center directors and 38 percent of family child care managers or owners had a degree or credential in early childhood education (Table II.6).

[12] Listed home-based providers, according to the NSECE, are "providers who appear on state or national lists of early care and education services, such as licensed, regulated, license-exempt, and registered home-based providers" (NSECE Project Team 2016).

Table II.6. Education and experience of child care center directors and family child care managers or owners

	Percentage	
	Child care center directors	Family child care managers or owners
Highest degree		
High school diploma or GED certificate	3%	22%
Some technical/vocational school, but no diploma	1%	3%
Technical/vocational diploma	0%	3%
Some college courses, but no degree	10%	25%
Associate's degree (A.A., A.A.S.)	16%	21%
Bachelor's degree (B.A., B.S.)	30%	12%
Master's degree (M.A., M.S.)	31%	4%
Doctoral degree (Ph.D., Ed.D.)	3%	0%
Professional degree after bachelor's degree	3%	1%
Other	4%	8%
Field of highest degree		
Child development or developmental psychology	13%	27%
Early childhood education	46%	38%
Elementary education	6%	9%
Special education	3%	0%
Other	32%	26%
Years of experience in early childhood education		
Fewer than 5	15%	13%
5 to 15	34%	48%
More than 15	51%	39%
Years in current position		
New to position (1 year or less)	11%	5%
2 to 5	24%	19%
More than 5	65%	76%
Sample size	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 3 to 20 child care partners. Results are weighted to account for sampling probability and nonresponse.

GED = General Educational Development.

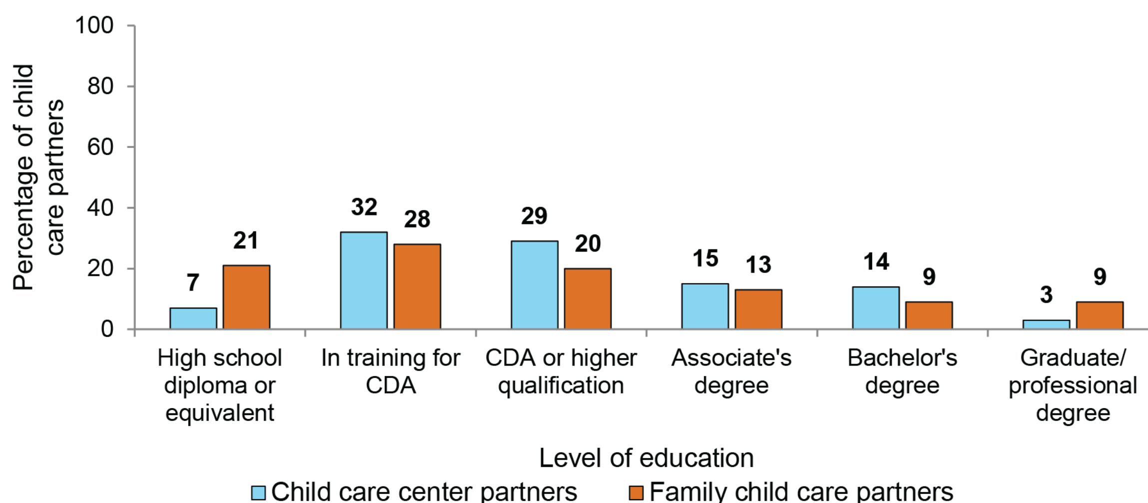
4. Most child development staff at child care centers and family child care providers had or were in training for a child development associate (CDA) credential

Ninety-three percent of child development staff at centers caring for children in partnership slots were in training for or had completed a CDA or higher degree. Among such staff, 14 percent had a bachelor's degree and 3 percent had a graduate degree. Seventy-nine percent of adults who regularly worked with children at family child care homes were in training for or had

completed a CDA or higher degree. Nine percent of family child care providers had a bachelor's degree, and 9 percent had a graduate degree (Figure II.5; Appendix C, Table C.II.13).

These findings differ from program director reports of staff education levels from Baby FACES: a higher percentage of EHS teachers in Baby FACES had associate's or bachelor's degrees, but a slightly lower percentage had CDAs. Baby FACES examined a nationally representative sample of EHS programs and found that, according to program directors, 60 percent of EHS teachers had an associate's degree or higher level of education (Vogel et al. 2011), compared with 32 percent of EHS-CC Partnership child care center staff. Conversely, 29 percent of EHS-CC Partnership child care center staff had a CDA (or other qualification that met or exceeded CDA requirements), compared with 23 percent of EHS teachers in Baby FACES (Vogel et al. 2011).[13]

Figure II.5. Nearly all child care partner staff had completed or were in training for a CDA or higher qualification



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for seven child care partners. Results are weighted to account for sampling probability and nonresponse.

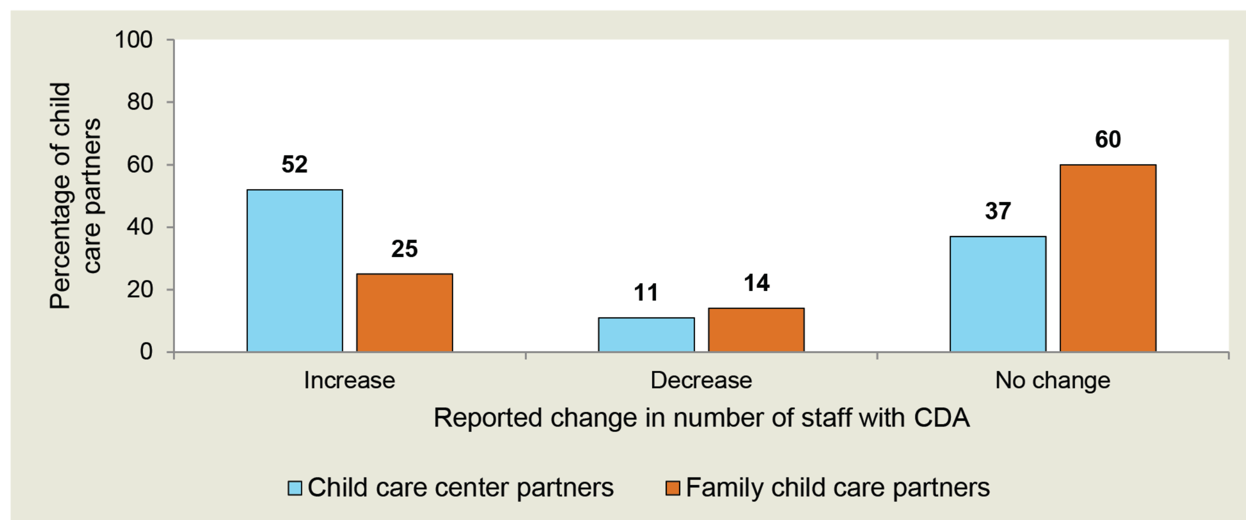
CDA = child development associate.

Fifty-two percent of child care center partners and 25 percent of family child care partners (41 percent of all partners) said the number of child care partner staff with a CDA increased since before the partnership began. Among child care partners reporting an increase, the median increase in the number of staff with a CDA was two staff members. Almost half (47 percent) of child care partners said they had no change in the number of staff with a CDA, and only 12 percent said they had a decrease (Figure II.6; Appendix C, Table C.II.14). Because these findings are based on answers to retrospective questions administered about one year after receiving the

[13] These findings are from a representative sample of EHS programs in 2009. EHS enrollment has expanded from approximately 80,000 slots in the 2008 to 2009 program year to almost 150,000 slots in the 2015 to 2016 program year (Child Trends 2015; Office of Head Start 2018).

grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant. In addition, based on the survey responses, it is difficult to determine whether changes are a result of existing staff obtaining new credentials, hiring new staff, or turnover. Exploratory analyses of Child Care Partner Survey Data showed that child care centers where staff had left were nearly twice as likely to report an increase in the number of staff with a CDA as centers where staff did not leave (not shown; this information is not available for family child care providers)—but this evidence is not conclusive.

Figure II.6. Nearly all child care partners reported an increase or no change in the number of staff with a CDA credential



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 13 child care partners. Results are weighted to account for sampling probability and nonresponse.

CDA = child development associate.

5. The median salary for early childhood educators was $23,900 per year

The median salary of child development staff caring for infants and toddlers at child care center partners was $22,880; the median salary at family child care partners was $27,300 (Table II.7). These findings are similar to NSECE findings that center-based teachers and caregivers serving children birth through three years earned $20,800 per year (NSECE Project Team 2013) and that listed home-based providers had an annual income from early care and education of $29,377 (NSECE Project Team 2016).[14]

[14] The NSECE reported an average hourly wage for center-based teachers and caregivers serving children from birth through three years of $10.40 (NSECE Project Team 2013). We converted the hourly wage to a yearly salary as follows: $10.40 * 40 hours per week * 50 weeks per year.

Table II.7. Child care partner staff salaries and benefits

	Amount (range) or percentage		
	All partners	Child care center partners	Family child care partners
Salary			
Median annual salary of child care development staff or family child care provider (range)	$23,900 ($14,400–$60,000)	$22,880 ($14,843–$51,200)	$27,300 ($14,400–$60,000)
Distribution of annual salary of child care development staff or family child care provider			
25th percentile	$19,500	$19,528	$19,200
75th percentile	$29,000	$26,000	$42,000
Benefits (percentage of partners offering benefit)			
Paid holidays	62%	76%	43%
Vacation days	57%	78%	26%
Sick days	44%	61%	19%
Health benefits	28%	46%	2%
Retirement benefits	24%	41%	0%
Reduced tuition rates for continuing education	22%	34%	5%
Other	7%	11%	2%
Offers no benefits	23%	10%	41%
Sample size	**386**	**255**	**131**

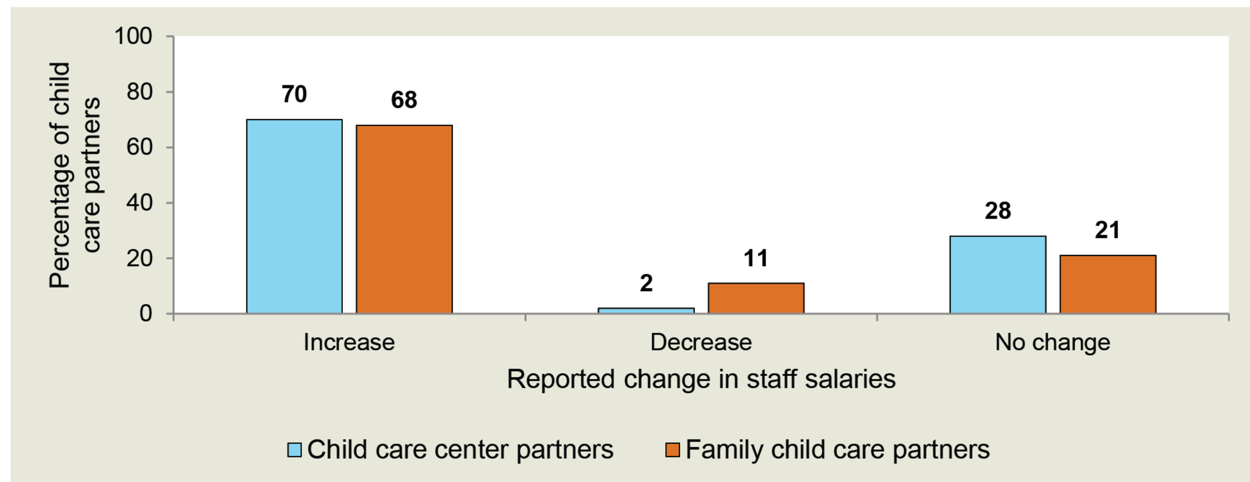
Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 to 53 child care partners and was trimmed for 32 child care partners. Results are weighted to account for sampling probability and nonresponse. For average annual salaries, we report amounts only within the 5th and 95th percentiles.

Most child care partners (69 percent) had an increase in child care partner staff salaries since before the partnership began. About one-quarter (26 percent) said they had no change, and only 5 percent said they saw a decrease. The increase in the median annual salary was $3,900 ($2,880 for child care center partners and $5,300 for family child care partners; Appendix C, Table C.II.15; Figure II.7).[15]

[15] As noted previously in the report, we cannot know from these data what would have happened had the child care partner not participated in the EHS-CC Partnership program, so we cannot attribute any changes to the EHS-CC Partnership grant.

Figure II.7. Most child care partners reported an increase in staff salaries



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 70 child care partners and was trimmed for 52 child care partners. Results are weighted to account for sampling probability and nonresponse. For average annual salaries, we report amounts only within the 5th and 95th percentiles.

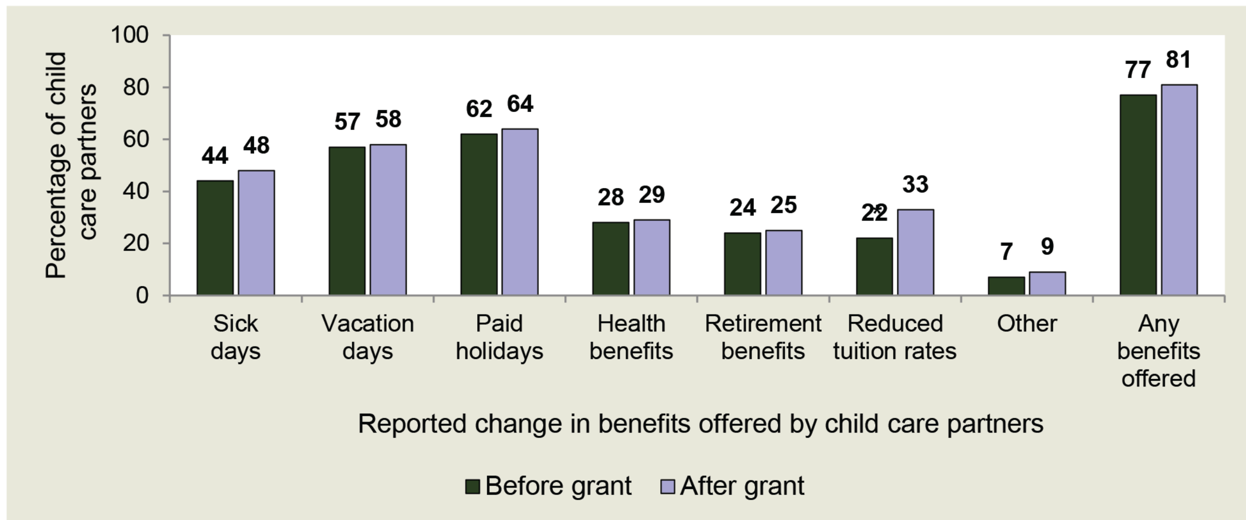
Seventy-seven percent of partners offered benefits in addition to salaries. The most common benefits offered were paid holidays (offered by 62 percent of partners) and vacation days (offered by 57 percent of partners). Other benefits included sick days (offered by 44 percent of partners), health benefits (28 percent), and retirement benefits (24 percent). Almost all centers (90 percent) offered some type of benefits. This finding is consistent with findings from Baby FACES, where more than 80 percent of EHS teachers said they received paid sick leave, paid holidays, paid vacations, retirement/pension plans, life insurance, or health insurance (Vogel et al. 2011).[16]

Fifty-nine percent of family child care homes offered some type of benefits. Fewer than 10 percent of family child care homes offered health benefits, retirement benefits, or reduced tuition rates for continuing education; at least 30 percent of child care centers offered each of these types of benefits (Table II.7).

Child care partners said they had no change in the benefits they offered to staff since before the partnership began, with one exception: before the EHS-CC Partnerships, 22 percent of partners offered reduced tuition rates. At the time of the survey, 33 percent of child care partners offered this benefit (Figure II.8; Appendix C, Table C.II.16).

[16] Baby FACES surveyed EHS teachers directly; findings from the study of EHS-CC Partnerships on child care staff benefits come from responses to the Child Care Partner Survey by child care partner directors or managers.

Figure II.8. A significantly higher percentage of child care partners reported offering reduced tuition rates than before the EHS-CC Partnership grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 10 or 11 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

6. Two-thirds of child care partners participated in a quality rating system

Two-thirds (67 percent) of all partners had an overall quality rating. Most commonly, the quality rating was provided at the state or local level, often through a QRIS.[17] About one-eighth (13 percent) of partners were accredited by either the National Association for the Education of Young Children (NAEYC) or the National Association for Family Child Care (NAFCC; Table II.8).

HSPPS: Participation in QRIS*

Quality Rating and Improvement Systems. A program, with the exception of American Indian and Alaska Native programs, must participate in its state or local Quality Rating and Improvement System (QRIS) if: (1) its state or local QRIS accepts Head Start monitoring data to document quality indicators included in the state's tiered system; (2) participation would not impact a program's ability to comply with the Head Start Program Performance Standards; and, (3) the program has not provided the Office of Head Start with a compelling reason not to comply with this requirement.

− HSPPS Part 1302, Subpart E: Family and community engagement program services

**This standard was included in the revised HSSPS that went into effect in November 2016; however, this standard had a delayed effective date of September 2019.*

[17] We did not collect data on the specific ratings child care partners received, only on whether they participated in a quality rating system.

Table II.8. Child care partners' participation in quality rating systems

	Percentage		
Overall quality ratings	**All child care partners**	**Child care center partners**	**Family child care partners**
Has an overall quality rating	67%	70%	64%
Agency or group that provides overall quality ratings			
State or local quality rating	58%	64%	49%
NAEYC/NAFCC	13%	12%	15%
Other	8%	7%	9%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 14 to 23 child care partners. Percentages do not sum to 100 because respondents selected all agencies or groups that applied. Results are weighted to account for sampling probability and nonresponse.

NAEYC = National Association for the Education of Young Children; NAFCC = National Association for Family Child Care.

III. ESTABLISHING AND MAINTAINING PARTNERSHIPS

In early care and education partnerships, organizations work together to deliver high quality services to children and families. Prior research provides operational lessons about factors that may help facilitate partnerships (Del Grosso et al. 2014). Several of these factors relate to how the organizations establish and maintain the partnerships, including establishing a common vision and goals in the early planning phases, developing formal partnership agreements between organizations, developing plans for ongoing communication among partners, and building strong relationships and trust among staff at multiple levels of the organizations.

In this chapter, we use data from the EHS-CC Partnership Grantee and Delegate Agency Director Survey and the Child Care Partner Survey to answer the following research question: *How are EHS-CC Partnerships developed and maintained?* We describe how partnerships were formed, including child care partners' motivations for partnering, based on data from the grantee and the child care partner surveys. Using data from the grantee survey, we then describe the types of communication and activities grantees and partners engaged in to maintain the partnerships. Next, we examine the number of grantees that terminated partnerships and the reasons for those terminations. Throughout the chapter, we draw on lessons learned about establishing and maintaining partnerships from case studies of 10 partnership programs.

Key findings: How are EHS-CC Partnerships developed and maintained?

- Grantees recruited 60 percent of child care partners before or during the EHS-CC Partnership grant application process.
- Almost half (46 percent) of grantees and child care partners had experience collaborating before the EHS-CC Partnership.
- Child care partners cited a range of factors that motivated them to participate in the partnership program; almost all (93 percent) said that improving the quality of infant–toddler care and education was a motivating factor.
- Grantees had written partnership agreements in place with nearly all child care partners (97 percent) by the time of the survey.
- Thirty-two percent of grantees terminated at least one partnership by the time of the survey. They reported a range of reasons for terminations; the most common reason, reported by 44 percent of grantees, was related to difficulties complying with the HSPPS.

A. Developing partnerships

Partnership grantees used a variety of methods to identify and recruit child care partners. Both grantees and child care partners brought a variety of experiences and attitudes to partnerships that are often influenced by prior experiences with collaboration. To form the partnerships, grantees and child care partners developed written agreements. In some cases, grantees terminated partnerships when the terms of the agreements could not be met. In this section, we report findings from the Grantee and Delegate Agency Director Survey and the Child Care Partner Survey on activities undertaken to develop partnerships. We discuss the timing of child care partner recruitment, how grantees recruited child care partners, the motivations of

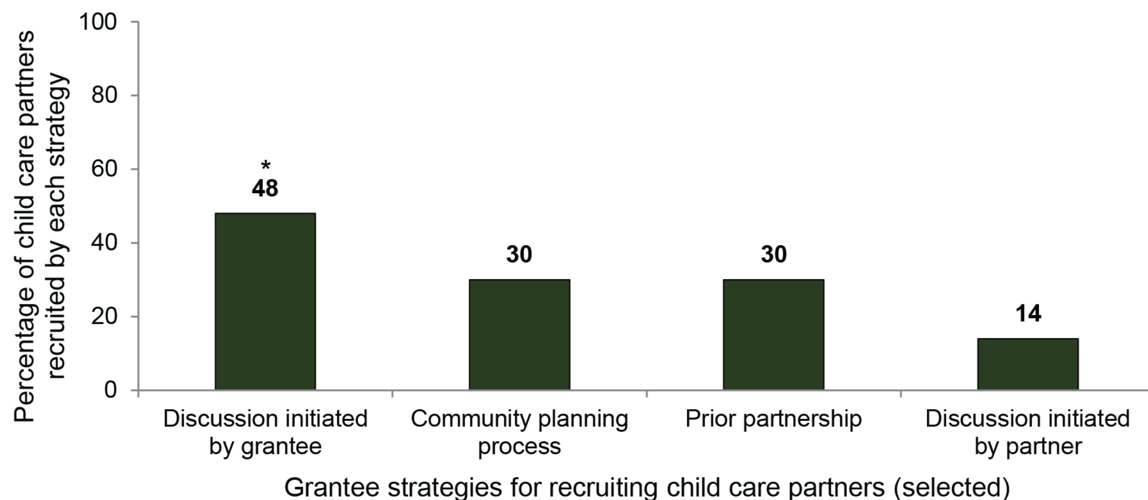
child care partners to participate in partnership programs, the existence of written partnership agreements, and the frequency of partnership termination.

1. Grantees recruited 60 percent of child care partners before or during the grant application process and the rest after grant award

Recruitment timing differed by type of partner. Grantees recruited most child care center partners (73 percent) during the application process; they recruited most family child care partners (59 percent) after award (Appendix C, Table C.III.1).

Almost half (48 percent) of child care partners were recruited during discussions initiated by the grantee, whereas only 14 percent were recruited through discussions initiated by child care partners. Grantees recruited 30 percent of partners through a community planning process and 30 percent as an extension of a prior partnership between the child care center or family child care home and the grantee. Grantees also conducted quality observations and consulted with CCR&R agencies to recruit child care partners. Grantees less commonly consulted with QRIS administrators or local planning councils or had a competitive request for proposals process. Child care centers were more likely to be recruited either by discussions initiated by the grantee or the child care partner than were family child care homes. Family child care providers were more likely to be recruited by consultation with a CCR&R agency than were child care centers (Figure III.1; Appendix C, Table C.III.1).

Figure III.1. Grantees initiated partnership discussions more often than child care partners in the recruitment process



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

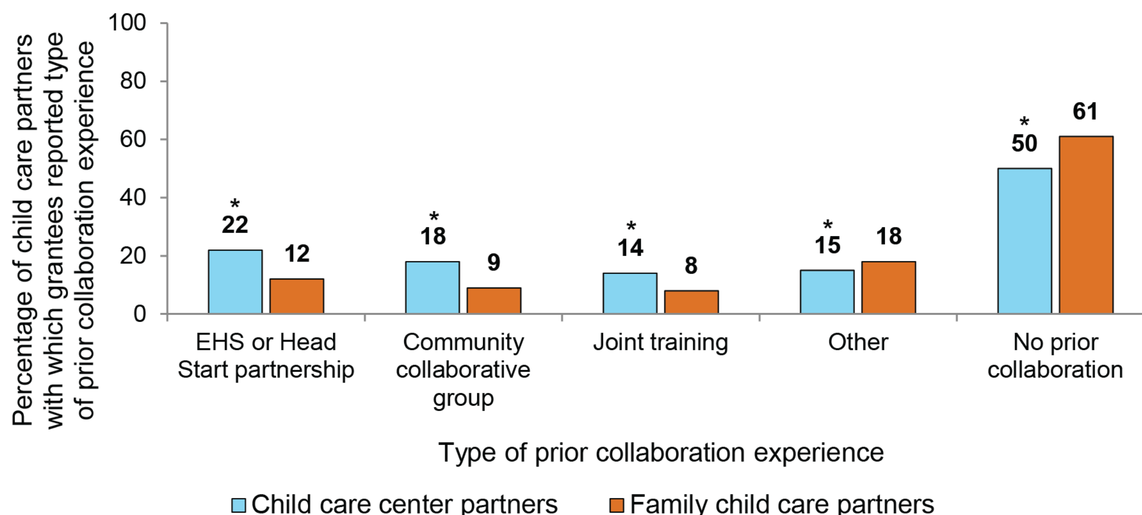
Note: *N* = 470. Items in this figure are based on grantee and delegate agency director survey responses about a randomly selected sample of child care partners. Information was missing for two grantees. Percentages do not sum to 100 because respondents selected all strategies that applied. Results are weighted to account for grantee nonresponse and partner sampling probability. This is a subset of the possible responses. For the full set of responses, see Appendix C, Table C.III.1.

* The percentage of child care partners recruited during discussions initiated by the grantee is significantly larger than the percentage recruited by any other strategy.

2. Almost half (46 percent) of grantees and child care partners had experience collaborating before the partnership program

Grantees had prior collaboration experience with 50 percent of child care center partners and 39 percent of family child care partners. Prior collaboration experience took several forms. Grantees had a previous partnership to serve EHS or Head Start children and families with 18 percent of child care partners (22 percent of child care center partners and 12 percent of family child care partners). They collaborated with 14 percent of partners (19 percent of child care center partners and 9 percent of family child care partners) as part of a community collaborative group and with 11 percent (14 percent of child care center partners and 8 percent of family child care partners) as part of a joint training event (Figure III.2; Appendix C, Table C.III.3).

Figure III.2. Nearly half of grantees and child care partners had prior collaboration experience



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 1,749. Items in this figure are based on grantee and delegate agency director responses about all of their child care partners. Information was missing in grantee responses for about 158 of their partners. Results are weighted to account for nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Recruiting child care partners

Many grantees struggled to find enough child care partners, either because the grantees were unable to find suitable partners or because potential partners were unwilling to participate. Several of the grantees considered child care provider quality when recruiting partners. They looked for providers with QRIS ratings, talked with local licensing agencies about the quality of providers, and conducted visits to providers to informally observe quality. Although grantees thought this process was worthwhile, a few had difficulty finding enough potential partners that met their quality standards. One grantee, for example, eliminated many potential child care partners because, based on the grantee staff's initial assessments, it seemed unlikely that the partners would meet the HSPPS in the area of health and safety. When grantees identified potential child care partners, they struggled to get those partners to agree to participate in the EHS-CC Partnership. Some child care providers were reluctant to commit to the higher quality expectations, including the lower staff-child ratios or having people in their homes for monitoring visits.

To recruit partners, many grantees used existing or past relationships they had with child care providers. Consistent with findings from the survey, grantees described partnering with child care providers in the past, serving with them on community boards, or participating with them in other local groups. Some family child care providers were former employees of the grantee agency and were encouraged to become a provider by the grantee agency so that they could join the partnership. Others participated in family child care networks with which the grantee had an existing relationship. Grantees also commonly worked with CCR&R agencies and local and state licensing agencies to obtain lists of potential partners.

Grantees also described in-person, one-on-one meetings with child care providers as a useful strategy to recruit partners. During these meetings, grantee staff described to child care providers the opportunities and expectations of the partnerships, addressed providers' concerns, and discussed the providers' capacity to meet the requirements. Center directors from one program, for example, had many conversations with grantee staff to review the grant opportunity and decide whether it matched the missions of their organizations and whether they had the capacity to take it on. According to the child care partner directors, this upfront investment narrowed the field of available partners, ensuring that only partners seriously considering forming a partnership moved forward. The center directors from another partnership program said that one-on-one conversations with the grantee director about plans for the partnership sold them on participating. Other grantee directors said the same was true for their child care partners; when they saw the potential benefits that would accompany the additional work, they became interested in participating.

3. Child care partners cited a range of factors that motivated them to participate in the EHS-CC Partnership

Child care partners listed many factors that motivated them to participate in the EHS-CC Partnership. Almost all (93 percent) said that improving the quality of infant–toddler care and education was a motivating factor. Other common factors motivating child care partner participation included gaining access to new funding, improving access to training for staff, and increasing families' access to comprehensive services, all cited by at least two-thirds of partners. Child care center partners were more likely than family child care partners to report the following motivations: gaining access to new funding and other resources, improving access to training for staff, increasing families' access to comprehensive services, improving staff credentialing, and improving staff compensation. A significantly higher percentage of family child care partners than child care center partners said that better meeting families' child care needs was a motivation for participating in the grant program (Table III.1).

Lessons learned from the case studies: Factors motivating grantees to participate in the EHS-CC Partnership

Grantee directors described the factors that motivated their organizations to apply for an EHS-CC Partnership grant. The primary factors they described included the following:

- **Support quality and comprehensive child care for infants and toddlers.** Grantees described viewing the EHS-CC Partnerships as an opportunity to extend the EHS model, including the HSPPS, to child care settings. One grantee that formed partnerships with family child care providers knew that many of the families it served in its Head Start program used these providers, so the director saw the partnerships as an opportunity to help support these providers in offering quality care and comprehensive services. Another grantee had existing funding to support a family child care network and viewed the partnership grant as an opportunity to enhance the quality of the support available to providers through the network.
- **Meet the child care needs of families.** Grantees viewed the EHS-CC Partnership grant as an opportunity to meet the child care needs of families in their community. One grantee cited findings from their community assessment that indicated that families were struggling to keep consistent child care arrangements, especially when they experienced a job loss. The grant provided an opportunity to help families access and maintain the child care arrangements.
- **Expand services to reach more families,** including expanding services to new geographic areas and new target populations. One grantee described viewing the EHS-CC Partnership grant as an opportunity to expand services to meet the needs of families seeking EHS services (the grantee maintained a waitlist for its existing EHS programs). Another grantee said the grant allowed it to serve families in rural communities that did not have access to EHS services. Two grantees described the grant as an opportunity to reach infants and toddlers with teenage parents by partnering with child care centers in high schools.

Table III.1. Factors motivating child care partners to participate in EHS-CC Partnership

Factors	Percentage		
	All partners	Child care center partners	Family child care partners
Improve the quality of infant and toddler care and education	93%	93%	92%
Gain access to new funding and other resources	72%	80%*	61%*
Improve access to training for staff	70%	76%*	61%*
Increase families' access to comprehensive services	69%	75%*	61%*
Increase continuity of care for children	66%	68%	65%
Improve curriculum	66%	64%	70%
Use resources more efficiently	63%	64%	62%
Improve staff credentialing	58%	66%*	48%*
Improve staff compensation	57%	62%*	49%*
Better meet families' child care needs	56%	47%*	67%*
Link to other early care and education resources in the community	55%	54%	57%
Increase families' access to full-day, full-year care	49%	48%	50%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for three child care partners. Results are weighted to account for sampling probability and nonresponse.

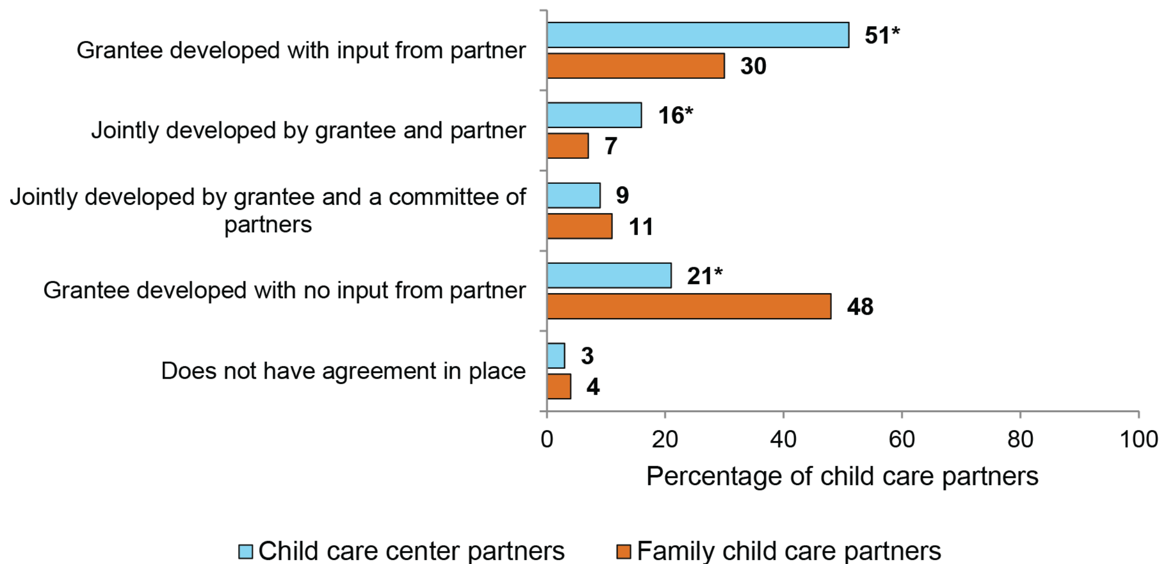
* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

4. At the time of the survey, grantees had a written partnership agreement in place with 97 percent of child care partners[18]

Grantees were significantly more likely to develop partnership agreements with input from child care center partners than from family child care partners. Grantees developed these agreements jointly with 10 percent of partners (16 percent of child care center partners and 7 percent of family child care partners), with some partner input for 42 percent of partners (51 percent of child care center partners and 30 percent of family child care partners), with input from a committee of child care partners for 10 percent of partners (9 percent of child care center partners and 11 percent of family child care partners), and no partner input for 32 percent of partners (21 percent of child care center partners and 48 percent of family child care partners; Figure III.3; Appendix C, Table C.III.5).

[18] The Grantee and Delegate Agency Director Survey took place approximately one year after EHS-CC Partnership grants were awarded.

Figure III.3. Grantees were more likely to develop partnership agreements with input from child care center partners than from family child care partners



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 470. Items in this figure are based on grantee and delegate agency director responses about a randomly selected sample of child care partners. Information was missing for 0 to 12 grantees. Results are weighted to account for grantee nonresponse and partner sampling probability.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Grantee directors also described the components of partnership agreements. More than 90 percent said that their agreements specified the roles and responsibilities of partners to comply with the HSPPS, the number of children and families to be served, a statement of each party's rights under the agreement, and training and professional development to be provided by the grantee. At least three-quarters included information about the amount and purpose of funds to be provided; goals, materials, and supplies to be provided; and actions planned to meet the goals. Least commonly listed (by 42 percent of grantees) was information about enhancements to child care partner staff salaries (Table III.2).

Lessons learned from the case studies: Developing partnership agreements and buy-in among partners

Involving child care partners in the process of developing partnership agreements facilitated buy-in among partners. Child care partners that grantees involved in the process of developing the agreements, as well as partners that perceived the grantee as willing to adjust the agreement to address their concerns, said they were satisfied with the process. Child care partners from a few programs reported that the grantee staff listened to their concerns and ideas, which in turn increased their buy-in. Grantee staff from these programs also asserted high levels of buy-in from partners and little pushback or areas of disagreement with partners.

Table III.2. Components of partnership agreements

Partnership agreement component	Percentage of grantees reporting component
Specific roles and responsibilities of partners to comply with HSPPS	95%
The number of children and families to be served in the partnership	94%
A statement of each party's rights, including the right to terminate the agreement	94%
T/TA to be provided or arranged by the partnership grantee to child care partners	92%
Amount and purpose of the funds to be provided	89%
A statement of the partnership's goals	85%
Materials and supplies to be provided by the partnership grantee to child care partners	79%
Actions partners will take to meet the goals specified in the agreement	79%
Information about procedures for recruitment and enrollment	74%
Eligibility criteria for partnership slots	72%
The number of children to be served in the partnerships that receive child care subsidies	69%
Start-up and ongoing procedures for filling partnership slots	63%
Enhancements to child care partner staff salaries	42%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for one grantee. Percentages do not sum to 100 because respondents could select multiple response categories. Results are weighted to account for nonresponse.

HSPPS = Head Start Program Performance Standards; T/TA = training and technical assistance.

5. At the time of the survey, 32 percent of grantees had terminated at least one partnership, most commonly because of issues complying with the HSPPS

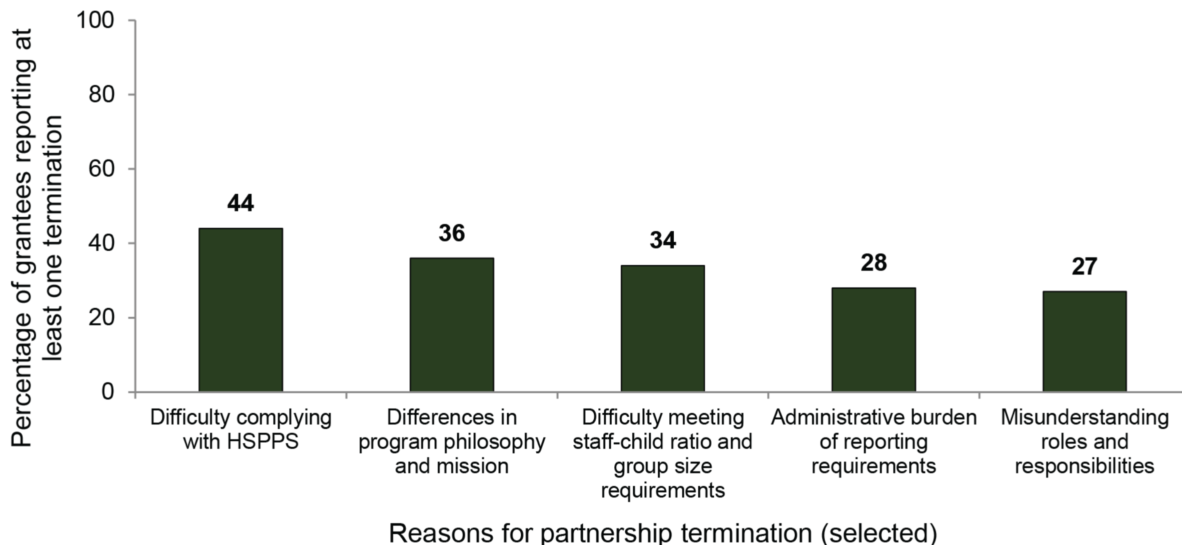
Specifically, at the time of the survey, which occurred approximately one year after grants were awarded, 22 percent of grantees had terminated a partnership with a child care center and 14 percent with a family child care provider (Appendix C, Table C.III.8).[19] The most common reason grantees terminated partnerships was difficulty complying with the HSPPS (44 percent), followed by differences in philosophy and mission (36 percent), and difficulty meeting staff-child ratio and group size requirements (34 percent; Figure III.4). Other reasons, reported by between 20 and 30 percent of grantees, included administrative burden of reporting requirements, misunderstanding of roles and responsibilities, and perceived inadequacy of funding. Fewer than 15 percent of grantees terminated partnership because of difficulty meeting teacher credential requirements, too many vacant slots, or perceived lack of respect among partners (Appendix C, Table C.III.8).

[19] The percentages for child care center partners and family child care partners sum to more than 32 percent because a grantee could have terminated a partnership with both a child care center and a family child care provider.

Lessons learned from the case studies: Partnership terminations

Grantees that experienced turnover said it made it difficult to meet enrollment targets. Partnership terminations were a challenge because they reduced the number of filled enrollment slots for the grantee, especially when families chose to remain with the terminated child care partner. Grantees described terminations that they and the child care partners initiated. Consistent with findings from the survey, most terminations involved difficulty complying with the HSPPS. For example, one family child care provider was unable to put a fence in her backyard, and another was unable to adequately supervise the children because of the layout of her home. Grantees also described child care partners that terminated partnerships because they did not view the partnership as financially viable. Some partnerships did not work out because of circumstances unrelated to the partnership. For example, two partners from one program had health issues that prevented them from continuing as family child care providers.

Figure III.4. Grantees reported several reasons for partnership terminations



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220. Percentages are expressed as the share of the 70 grantees that report terminating partnerships. Information was missing for one grantee. Results are weighted to account for nonresponse. This is a subset of the possible responses. For the full set of responses, see Appendix C, Table C.III.8.

HSPPS = Head Start Program Performance Standards.

B. Maintaining the partnerships

Grantees and child care partners engaged in a range of activities to support implementation of the partnerships. These activities included regular meetings between lead staff from both entities and ongoing reviews of the partnership agreements. Using data from the Grantee and Delegate Agency Director Survey and the Child Care Partner Survey, this section describes grantee and partner assessments of grantee directors' effectiveness in supporting partnership implementation and their perceptions of the partnerships as mutually respectful and beneficial.

1. Grantees and child care partners engaged in a variety of activities to support quality relationships

Nearly all grantees (98 percent) held regular meetings with lead staff. Common activities also included participating in discussions with frontline staff and reviewing the partnership agreement (reported by 73 percent of grantees or more; Table III.3).

Grantees and child care partners engaged in these activities regularly. Many grantees held regular meetings with lead staff and participated in monthly or weekly discussions with frontline staff. More than one-third (37 percent) of grantees had a process in place to review partnership agreements with child care partners annually, and 43 percent reviewed their agreements "as needed" (Table III.4).

Table III.3. Processes to support quality relationships with child care partners

	Percentage			
Process to support quality relationships	**All grantees**	**Grantees with center partners only**	**Grantees with FCC partners only**	**Grantees with both center and FCC partners**
Hold regular meetings with lead staff	98%	98%	100%	97%
Participate in discussions with frontline staff	84%	82%	86%	87%
Conduct staff surveys	28%	26%	39%	30%
Review the partnership agreement	73%	70%	68%	81%
Other	19%	17%	22%	22%
Has no processes in place	1%	1%	0%	1%
Sample size	**220**	**133**	**14**	**67**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 1 to 11 grantees. Percentages do not sum to 100 because respondents selected all activities that applied. Results are weighted to account for nonresponse. Common "other" responses included regular meetings/communications (not specifically with lead staff), trainings/professional development, and on-site visits.

FCC = family child care.

Table III.4. Frequency of engaging in processes to support quality relationships with child care partners

	Of grantees reporting activity, percentage reporting frequency						
Type of activity	Annually	Twice a year	Quarterly	Monthly	Weekly or multiple times per month	As needed	Other
Hold regular meetings with lead staff	0%	0%	14%	42%	11%	30%	2%
Participate in discussions with frontline staff	1%	0%	4%	14%	28%	49%	4%
Conduct staff surveys	49%	14%	10%	2%	2%	24%	0%
Review the partnership agreement	37%	8%	7%	1%	0%	43%	3%
Other	0%	3%	6%	18%	37%	29%	8%
Sample size	**220**						

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for zero to two grantees. Results are weighted to account for nonresponse.

2. Most child care partners described grantee directors as effective leaders in implementing the EHS-CC Partnerships

The roles and responsibilities of the grantee directors included administering the EHS-CC Partnership grant; overseeing operations; and, for some directors, engaging directly with child care partners to implement the partnerships. Given their role, we asked both grantee directors and child care partners to rate the grantee director according to four descriptions of implementation leadership: proactive, knowledgeable, supportive, and perseverant. Proactive leaders develop a plan, establish clear standards for implementing the partnerships, and remove implementation obstacles (Aarons et al. 2014). Knowledgeable leaders can answer questions from staff and partners about the partnership. Supportive leaders recognize and appreciate child care partner staff efforts toward successful implementation, and they support staff efforts to learn more about the partnerships and to deliver services through partnerships. Perseverant leaders carry on through the challenges of implementing the partnerships and openly and effectively address problems that arise. Both grantee directors and child care partners rated the grantee director highly on these four descriptions of implementation leadership. Grantee directors rated themselves more highly than did child care partners in two dimensions: supportive leadership and perseverant leadership (Table III.5; Appendix C, Table C.III.8).

In one program, child care partners were involved in creating the partnership from the ground up. The grantee staff created buy-in and support from partners by engaging them early and often. The child care partners helped draft the grant application and described themselves as equal partners since the start of the grant. The grantee staff and center directors were in constant communication and made joint decisions to meet quality benchmarks. Every other week, the child care partners met as a group with the grantee staff; they also stayed in touch through emails and telephone calls. Grantee staff were also in centers weekly providing coaching and connecting with families. Both grantee staff and child care partner directors attributed their partnership's success, in part, to this level of collaboration.

Source: Case study interviews, 2017

Table III.5. Perceptions of partnership grantee director's leadership

	Average score (1 = not at all; 5 = to a very great extent)	
Leadership domain	Grantee directors (self assessment)	Child care partner directors or managers (partner assessment)
Proactive leadership	3.9	4.0
Knowledgeable leadership	4.2	4.2
Supportive leadership	4.5*	4.2*
Perseverant leadership	4.5*	4.3*
Sample size	**220**	**386**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey; EHS-CC Partnership Child Care Partner Survey.

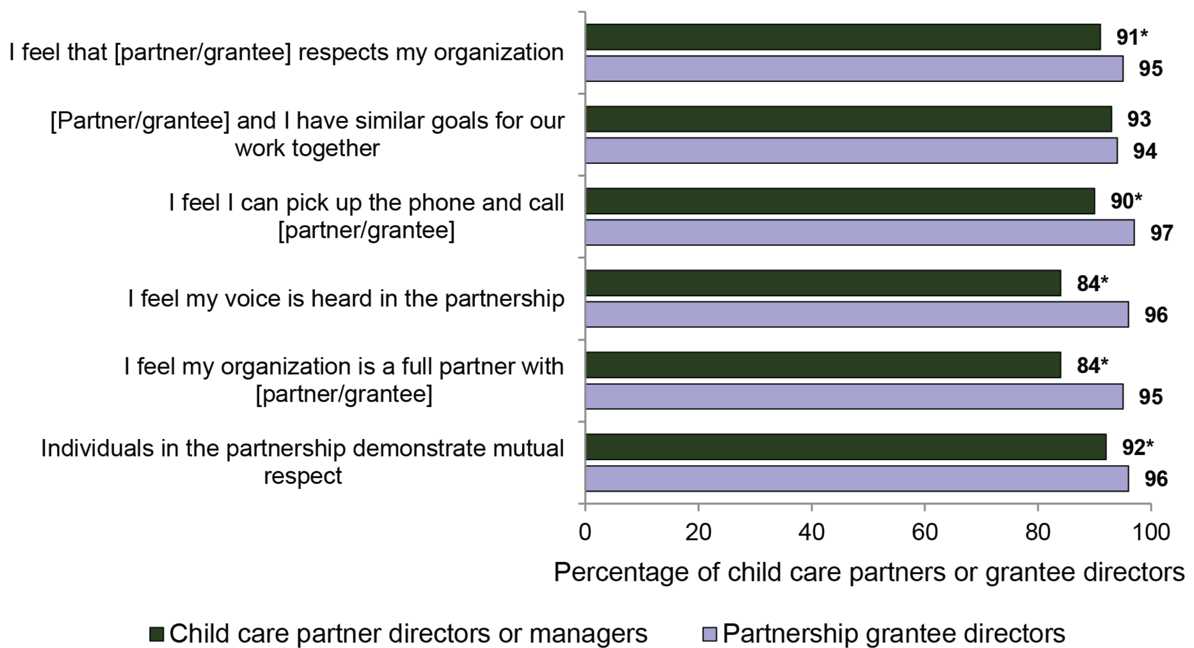
Note: Information was missing for four grantees. Information was missing for 33 to 35 child care partners. Scores for each domain of leadership take the mean score across three items. Domains of leadership were adapted from Aarons et al. (2014). Grantee results are weighted to account for nonresponse. Partner results are weighted to account for sampling probability and nonresponse.

* Average scores differ significantly between grantee director and child care partner director or manager reports at the 0.05 level, two-tailed test.

3. Most grantee directors and child care center directors or family child care managers described their relationships as mutually respectful and focused on similar goals

More than 90 percent of grantee directors agreed or somewhat agreed with statements about mutual respect between the grantee and their child care partners such as "I feel like I can pick up the phone and call [partner]," "Individuals in the partnership demonstrate mutual respect," "I feel my voice is heard in the partnership," and "I feel my organization is a full partner with [partner]." For all but two of these statements, more than 90 percent of child care center directors and family child care managers or owners agreed or somewhat agreed with statements about mutual respect between the child care partner and the grantee. However, a lower percentage of child care center directors and family child care managers or owners agreed or somewhat agreed with statements describing grantee directors as full and equal partners (Figure III.5; Appendix C, Table C.III.10).

Figure III.5. Relationships between grantees and child care partners were mutually respectful



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 470 grantees; *N* = 386 partners. Partnership grantee director items are based on grantee and delegate agency director responses about a randomly selected sample of child care partners. Information was missing for 1 to 11 grantees. Information was missing for 19 to 30 partners. Bars indicate the percentage of respondents who agree or somewhat agree with each of the listed statements, excluding those who answered not sure. Statements listed are presented from the point of view of the grantee and were adapted for the partner survey. Results are weighted to account for sampling probability and nonresponse.

* Average percentage agreement differs significantly between grantee director and child care partner director or manager reports at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Finding effective ways to communicate and maintain partnerships

Grantee staff reported difficulty communicating effectively with child care partners. Grantee staff said it was difficult to find a balance between providing enough information to partners to keep them engaged and informed and not overwhelming them with too much information or causing them to feel micromanaged. Finding this balance was particularly difficult for a program that used a central hub* to provide training and technical assistance to the child care partners because partners received information from both the hub and the grantee. Grantee staff from another program said that they often overlooked their family child care partners when communicating important information to their EHS centers. The grantee staff attributed this oversight to two issues: (1) the family child care partners were a small part of the overall Head Start program run by the grantee organization and (2) the grantee did not consistently meet with the family child care partners. At another program, grantee staff turnover disrupted sharing information with partners despite regular meetings.

*What is a hub?

A hub is a third-party organization that grantees work with to support the implementation of the EHS-CC Partnership grant. Hubs may provide child care partners with technical assistance and provide comprehensive services to families enrolled in partnership slots. For example, the hub may employ family service workers and health, disability, and nutrition consultants as well as support and monitor certain administrative procedures, including ensuring that there is appropriate documentation of compliance with HSPPS.

Regularly scheduled meetings, communication protocols, and frequent informal communication helped grantees and child care partners overcome communication challenges. Regularly scheduled meetings between grantees and partners enabled everyone to be on the same page, according to grantee and partner staff from a few programs. One program, for example, had quarterly staff meetings that child care partner directors attended. These meetings provided the grantee an opportunity to share more complete information on the HSPPS and to make sure everyone had a consistent understanding of the information. Other grantees held regular meetings with child care partner directors; in one program, these meetings were monthly, and in another, they were biweekly. In response to challenges communicating with partners in a program that used a hub to support implementation, staff from the hub and grantee created a communication protocol to determine the best way to share information with the partners. Another program described developing new protocols to ensure partners received necessary communications. Child care partners appreciated when grantee staff were accessible and responsive to informal and unplanned communications. In more than half of the partnership programs, child care partners said they could call or email grantee staff at any time and get a response. Partners said these informal communications were how they addressed challenges and maintained a positive relationship with the grantee staff. Teachers from several programs also had a direct line of communication with grantee support staff that they found helpful when they had questions about implementing the HSPPS.

Partnerships ran more smoothly when the grantee made program decisions in collaboration with child care partners, rather than unilaterally. Child care partners that described the grantee as engaging them as equal partners said they could voice their concerns and work through challenges together as a team with the grantee. For example, one grantee included its child care partners in the annual self-assessment process. The partners met as a group with the grantee director to talk about what was working well and what could be working better. The grantee committed to making improvements based on the partners' ideas.

Setting clear and realistic expectations about partnership program requirements and benefits facilitated more positive relationships between grantees and child care partners. Grantee directors and child care partner directors agreed that focusing only on the benefits of joining the program led to unrealistic expectations among the child care partners. One grantee described the start-up period for the project as too quick and said the grantee did not invest enough time in ensuring that all partners and grantee staff started with the same understanding of the requirements. The grantee director from another program reported that learning to clearly communicate the vision of the project to child care partners was challenging but important. The director had to figure out how to effectively explain the details and mechanics of how the program would work to the child care partners; being clear and direct helped facilitate relationships with the partners and achieve her vision for the partnerships.

IV. FUNDING FOR PARTNERSHIP PROGRAMS

EHS-CC Partnerships offer opportunities for partnership grantees and child care partners to leverage multiple funding sources to serve infants and toddlers from families with low incomes. By leveraging funding from multiple sources, partnership programs can enhance the existing budgets that include funds from CCDF and other sources to support quality improvement efforts, including professional development for child care partner staff, and provide comprehensive child care and development services for infants and toddlers. The Funding Opportunity Announcement (FOA) for the EHS-CC Partnership, encouraged grantees to leverage multiple funding streams and required partnership grantees to ensure that at least 25 percent of the total number of partnership slots were funded with a child care subsidy (Office of Head Start 2016). Despite this opportunity, prior research has documented that regulatory differences across funding streams and insufficient or uncertain funding can be barriers to forming and sustaining partnerships, whereas funding plans or formal funding agreements specifying allocation may facilitate early care and education partnerships (Del Grosso et al. 2014).

In this chapter, we use data from the EHS-CC Partnership Grantee and Delegate Agency Director Survey and the Child Care Partner Survey to answer the following research question: *What levels of funding are used to support EHS-CC Partnership programs, and how are funds allocated across grantees and their child care partners?* We begin by describing total grant funding amounts and allocations, based primarily on reports from grantee directors. We then describe the uses of grant funds, based primarily on reports from child care partners. Next, we describe how child care partners layer grant funds with other sources of funds. Throughout the chapter, we discuss challenges and lessons learned from case studies of 10 partnership programs.

Key findings: What are the characteristics of EHS-CC Partnership programs?

- The median annual EHS-CC Partnership grant amount was $1.4 million, with a median amount provided to child care partners of $7,875 per partnership slot.
- On average, grantees transferred 54 percent of EHS-CC Partnership grant funds to child care partners.*
- Child care partners received regular funding, start-up funds, and additional funds from the grantee.
- According to child care partners, the most common use of start-up funds was for materials, supplies, furniture, and equipment (37 percent of all partners used funds for these purposes).
- More than one-quarter (27 percent) of child care partners received child care subsidies paid by state or county governments, and 25 percent received CACFP funds to offset the cost of care for children in partnership slots.

**The amount of funds transferred to child care partners does not differ substantially between grantees with EHS-CC Partnership-only slots and grantees with a mix of EHS-CC Partnership and Expansion slots.*

A. Total grant funding and allocation across EHS-CC Partnership grantees and child care partners

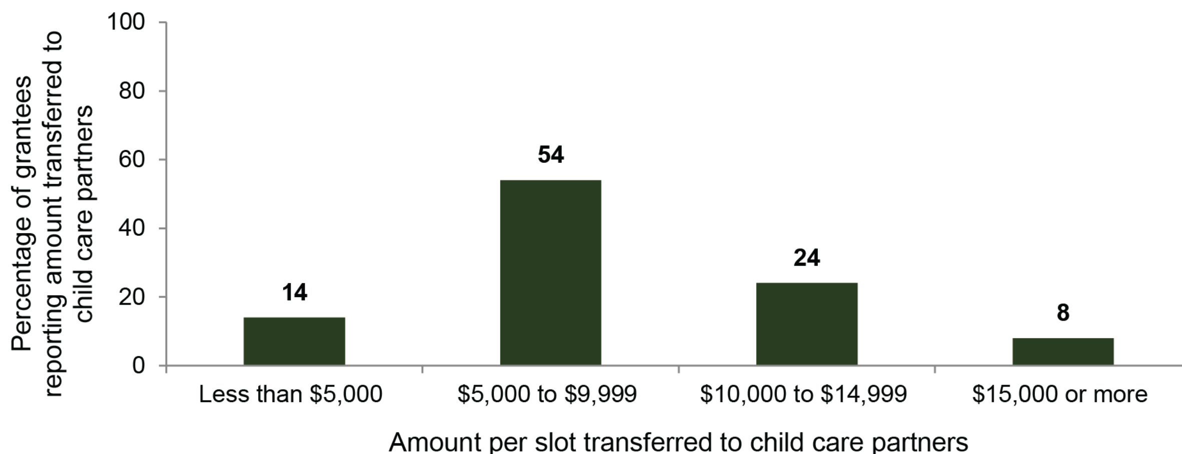
In 2015, ACF began awarding annual EHS-CC Partnership grants that could be renewed for up to five years. Grantees were also eligible for one-time grants for start-up funds (Office of Head Start 2016). Examples of start-up activities included facility renovations, purchase of

classroom supplies, and background checks for staff. The percentage of funds grantees allocated to partners varied based on the number of slots per partner, the availability of CCDF or other funds, the roles of grantee and partner staff in serving children and families and providing training and technical assistance to staff, and the costs of needed enhancements to the care environments. In this section, we use data from the Grantee and Delegate Agency Director Survey and funding information provided by the Office of Head Start to report on total grant funding and allocation across grantees and child care partners.

1. The median annual EHS-CC Partnership grant amount was $1.4 million,[20] with a median amount provided to child care partners of $7,875 per partnership slot

Total annual partnership grant amounts ranged from $220,000 to $14.8 million.[21] Partnership grantees provided a median amount to child care partners of $8,000 per child care center slot and $7,280 per family child care slot (Appendix C, Table C.IV.1). Sixty-eight percent of grantee directors paid child care partners an average amount of funding per partnership slot of less than $10,000 (Figure IV.1; Appendix C, Table C.IV.1).[22]

Figure IV.1. Most grantees transferred $5,000–$9,999 per slot to child care partners



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220 grantees. Information was missing for 28 grantees and was trimmed to remove outliers for 18 grantees. For funding amount variables, we report amounts only within the 5th and 95th percentiles (see Appendix B). Results are weighted to account for nonresponse.

[20] Funding information provided by the Office of Head Start.

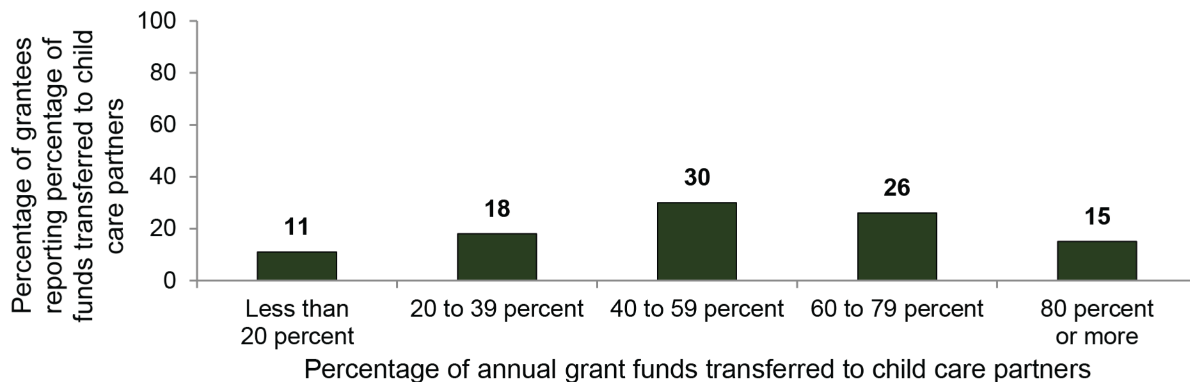
[21] Funding information provided by the Office of Head Start.

[22] The amount of funds transferred to child care partners does not differ substantially between EHS-CC Partnership-only and EHS Expansion grantees.

2. The median partnership grantee transferred 54 percent of EHS-CC Partnership grant funds to child care partners

Most grantees (71 percent) transferred 40 percent or more of EHS-CC Partnership grant funds to child care partners. Among grantees, 15 percent transferred at least 80 percent of EHS-CC Partnership grant funds to child care partners. Only 11 percent transferred less than 20 percent of EHS-CC Partnership funds to child care partners (Figure IV.2; Appendix C, Table C.IV.1).[23]

Figure IV.2. Most grantees transferred at least 40 percent of funds to child care partners



Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: *N* = 220. Information was missing for 24 grantees and was trimmed to remove outliers for 13 grantees. For funding amount variables, we report amounts only within the 5th and 95th percentiles (see Appendix B). Results are weighted to account for nonresponse.

B. Uses of grant funds by child care partners

In this section, we use data from the Child Care Partner Survey to report on the annual, start-up, and additional funds that child care partners received from grantees and how they used these funds.

1. Child care partners received regular funding, start-up funds, and additional funds from the grantee

Regular funds. Child care partners received a median amount of $50,000 per year from the grantee. The median child care center partner received $100,000 per year, and the median family child care partner received $24,000 per year. Seventy-three percent of child care partners received an average amount of funding per enrollment slot of less than $10,000 (Appendix C, Table C.IV.2).[24]

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[23] The amount of funds transferred to child care partners did not differ substantially between grantess with EHS-CC Partnership-only slots and grantees with a mix of EHS-CC Partnership and EHS Expansion slots.

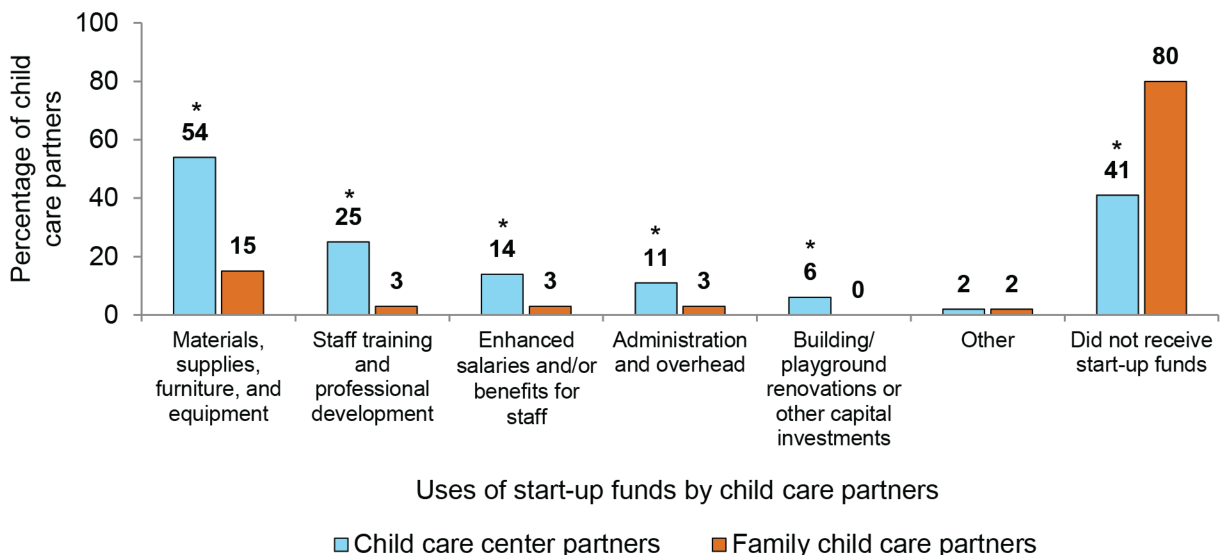
[24] The percentage of EHS-CC Partnership grantee directors reporting providing less than $10,000 in funding per slot differs from the percentage of partners reporting receiving less than $10,000 per partnership slot. It is possible that grantees provided different amounts to different partners, which could lead to the difference. For example, consider a grantee that had two partners and gave one partner $15,000 per slot and one partner $8,000 per slot. The grantee therefore gave funding of more than $10,000 per slot on average, though one of its two partners received less than $10,000 per slot.

Fifty-eight percent of child care partners received varying amounts of money from the EHS-CC Partnership grantee each month. Child care partners also listed the reasons they received varying amounts of money from the grantee each month. The most common reasons included variation in receipt of child care subsidies, children's ages, and the number of children enrolled from month to month (Appendix C, Table C.IV.2).

Start-up funds. Fifty-nine percent of child care center partners and 20 percent of family child care partners received start-up funding from the EHS-CC Partnership grantee at the beginning of the partnership grant program. Among those receiving start-up funds, 34 percent of child care center partners received $30,000 or more, compared with 24 percent of family child care partners. Conversely, 73 percent of family child care partners received less than $10,000, whereas only 23 percent of child care center partners received less than $10,000 (Appendix C, Table C.IV.3).

For both child care center and family child care partners, the most common use of start-up funds was for materials, supplies, furniture, and equipment (37 percent of all partners used funds for these purposes: 54 percent of child care center partners and 15 percent of family child care partners). One-quarter of child care center partners used start-up funds for staff training and professional development; only 3 percent of family child care partners used start-up funds for this purpose (Figure IV.3; Appendix C, Table C.IV.3).

Figure IV.3. Child care partners reported many uses of start-up funds



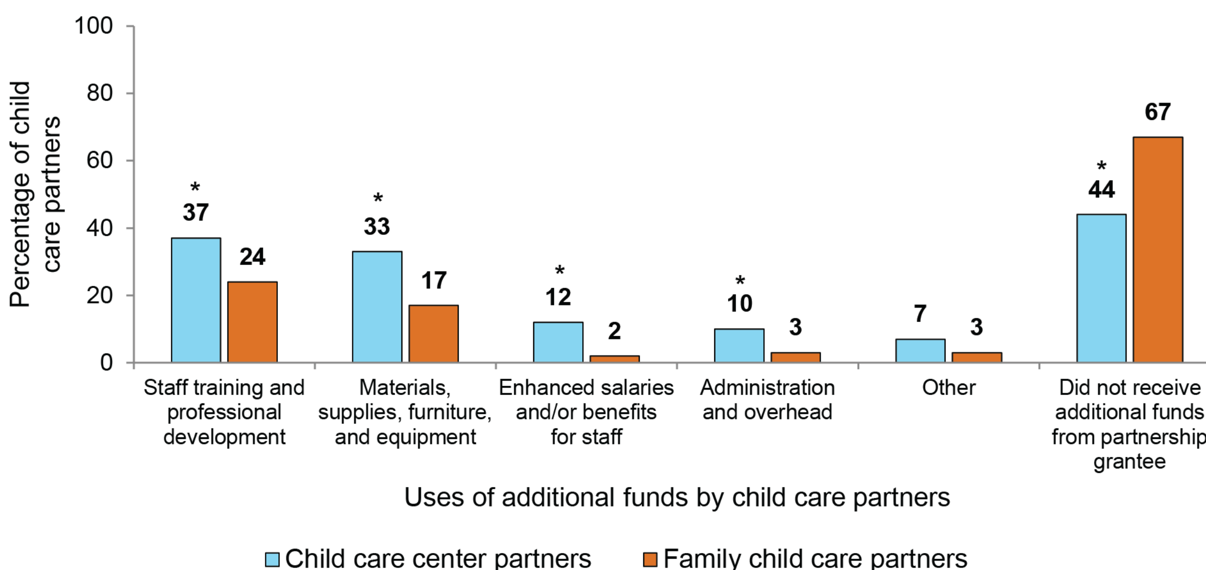
Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 10 to 13 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Additional funds. More than half (56 percent) of child care center partners and 33 percent of family child care partners received additional funds from the EHS-CC Partnership grantee, apart from start-up funds and annual funding received for partnership slots (Figure IV.4; Appendix C, Table C.IV.4). Twenty-two percent of child care partners received both start-up and additional funds (not shown). For both child care center and family child care partners, the most common use of additional funds was for staff training and professional development (31 percent of all partners used funds for this purpose: 37 percent of child care center partners and 24 percent of family child care partners). The next most common use of additional funds was for materials, supplies, furniture, and equipment; 26 percent of all partners used additional funds for these purposes (33 percent of child care center partners and 17 percent of family child care partners; Figure IV.4; Appendix C, Table C.IV.4).

Figure IV.4. Child care partners used additional funds received from the partnership grantee in many ways



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 36 child care partners. Results are weighted to account for sampling probability and nonresponse. Additional funds refer to funds received from the grantee apart from start-up funds and annual funding received for partnership slots.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

2. Some child care partners received funds from the grantee to pay for vacant enrollment slots to mitigate possible reduction in revenue

Twenty-seven percent of child care partners received funds to pay for vacant enrollment slots (please see the box on the next page for context from the case studies on this finding). A large percentage (83 percent) of child care partners that received funds to pay for vacant enrollment slots received full payment (Table IV.1).

Table IV.1. Payment for unfilled slots

	Percentage of partners		
	All partners	Child care center partners	Family child care partners
Timing of payment for unfilled slots from partnership grantee			
Payment provided until slot is filled	16%	22%*	8%*
Payment provided for limited period of time	11%	12%	11%
No payment provided for unfilled slots	73%	66%*	82%*
Of those reporting payment for unfilled slots, amount of payment			
Full payment	83%	85%	78%
Partial payment	7%	5%	13%
Other	10%	10%	9%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 3 to 28 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Mitigating possible reductions in revenue for child care partners

Several child care partners attributed participation in the partnerships to reduced revenue because they served fewer children to meet the staff-child ratios defined in the HSPPS or they had vacant slots for older children. Although both child care center and family child care partners cited reduced revenue as a barrier, it was especially an issue for family child care partners. These providers explained that under the HSPPS, they can care for only two children younger than age 2, a more restrictive requirement than the staff-child ratios specified in their state licensing rules. Family child care partners from a few programs stated that lower demand for preschool-age slots added to their financial pressures. They said that most families looking for family child care in their areas had infants, so although they had waiting lists for infant and toddler slots, they had vacant slots for older children that they could not fill.

Child care partners were more satisfied with funding arrangements when EHS-CC Partnership grantees took steps to examine the actual costs for the child care partners and accounted for those costs when determining funding arrangements. The grantee director and the child care partners from one program took steps up front to make sure it made fiscal sense for their organizations to participate in the grant. They met to discuss financial arrangements before they even won the grant. The grantee examined the cost to provide child care in its market and continually reviewed market rates for child care to make sure the grant made fiscal sense for the partners. The child care partners expressed satisfaction with the funding arrangements and attributed it to their involvement in the process from the beginning and to the grantee's careful monitoring of the financial situation. Another grantee explained that when it developed the partnership agreements with child care partners, it also developed budgets based on each child care center's operating costs. A third grantee requested that each child care partner provide a budget detailing its requirements to provide care that met the HSPPS. Of the four child care center partners, three gave the grantee comparable budgets that aligned with the grantee's expectations. The fourth partner submitted a higher-than-expected budget but worked with the grantee to align it with the other partners' submissions.

C. Layering grant funds with other sources of funding

As described in the introduction to this chapter, ACF encouraged partnership programs to use a layered funding model, integrating EHS-CC Partnership grant funds and other resources, including CCDF child care subsidies, to support full-day and full-year comprehensive services for children and families in partnership slots (Office of Head Start 2016). In this section, we report findings from the Grantee and Delegate Agency Director Survey and the Child Care Partner Survey on layering EHS-CC Partnership grant funds with funds from other sources.

1. The most common sources of funding to offset the cost of care for children in partnership slots other than EHS-CC Partnership grant funds were child care subsidies and Child and Adult Care Food Program funds

More than one-quarter (27 percent) of child care partners received subsidies paid by state or county governments, and 25 percent received CACFP funds to offset the cost of care for children in partnership slots (Appendix C, Table C.IV.6).[25] Overall, however, 34 percent of child care partners received funds from sources other than the EHS-CC Partnership grantee to offset the cost of care for children in partnership slots. Almost half (46 percent) of child care center partners and only 20 percent of family child care partners received funds from other sources to offset the cost of care for children in partnership slots (Figure IV.5; Appendix C, Table C.IV.6).

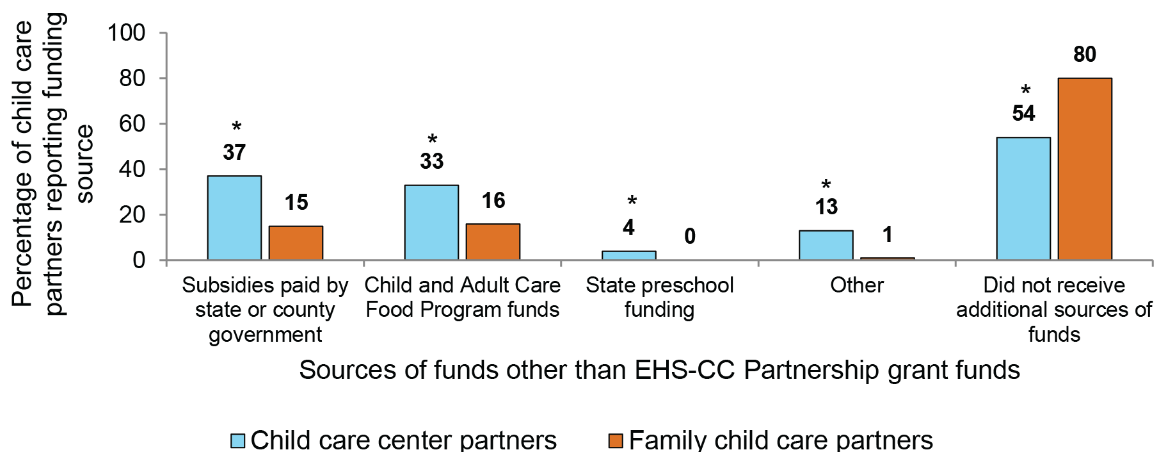
HSPPS: Payment sources for meal services

Payment sources. A program must use funds from U.S. Department of Agriculture (USDA) Food, Nutrition, and Consumer Services child nutrition programs as the primary source of payment for meal services. EHS and Head Start funds may be used to cover those allowable costs not covered by the USDA.

−HSPPS Part 1302, Subpart D: Health program services

[25] CACFP is a federally funded program that provides aid to child and adult care institutions and family child care homes to provide nutritious foods (Food and Nutrition Service 2017).

Figure IV.5. Child care partners received funds from sources other than the EHS-CC Partnership grant to offset the cost of care for children in partnership slots



Child care center partners Family child care partners

Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 1 to 20 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Easing the burden of applying for eligibility for child care subsidies for families and child care partners

Establishing eligibility for both CCDF subsidies and EHS was burdensome to parents and providers. Partnership grantee directors described the amount of paperwork involved in applying for both child care subsidies and EHS as a barrier for some families. In addition, a few directors said that because families already had access to child care through the EHS-CC Partnerships, they were less motivated to apply for subsidies. A state-level stakeholder from a different program noted that family child care providers could serve as a barrier to getting families to apply for subsidies. Because the family child care providers were already being paid through the EHS-CC Partnership grant, they were less motivated to work with families to apply for subsidies. The stakeholder explained that if children received subsidies, it would mean more paperwork for the provider in addition to the paperwork required for the EHS-CC Partnership. In addition, providers must wait for payment through child care subsidies because they submit invoices to the state and then receive reimbursement.

To reduce the burden and address barriers for families and child care partners, partnership grantees streamlined the application process, assigned grantee or child care partner staff to assist families with child care subsidy applications, or partnered with contracted child care centers. One grantee, a state agency, streamlined the application process by creating a single form that covered the requirements for both EHS and child care subsidies. Another grantee worked with the state to allow families to apply for subsidies at their child care center rather than at local subsidy offices. At a few programs, staff helped families complete and submit the applications for child care subsidies. These staff were also tasked with helping families complete redetermination paperwork to help families maintain eligibility for subsidies. Another grantee partnered with child care centers that had contracts with the local child care subsidy administrator to offer subsidized care, thus guaranteeing a predetermined number of subsidized slots.

2. The percentage of partnership slots funded by child care subsidies varied substantially

EHS-CC Partnership grantees were required to recruit and enroll, at a minimum, 25 percent of funded enrollment with child care subsidies or the percentage of children with child care subsidies proposed in their approved grant application (which may be more than 25 percent; ACF 2015).

> Grantee staff from one program work with families regularly to ensure that they enroll for CCDF child care subsidies and meet all requirements for redetermination processes. In addition, the state moved to yearly redetermination for CCDF, which the grantee director described as making it easier for families to maintain eligibility for subsidies.
>
> *Source: Case study interviews, 2017*

The median percentage of children enrolled in partnership program slots who received a child care subsidy was 50 percent, although there was wide variability ranging from 0 to 100 percent (Appendix C, Table C.IV.7).[26] Nearly all grantee directors (96 percent) reported that at least one enrolled child received a child care subsidy (not shown).

[26] As previously stated, 27 percent of child care partners received subsidies paid by state or county governments. This finding is not comparable to the finding that the median percentage of children enrolled in partnership slots who received a child care subsidy was 50 percent because the latter was reported by grantees responding across all of their child care partners.

Lessons learned from the case studies: Addressing state and local policies that inhibited the use of the layered funding model

Stakeholders, partnership grantee staff, and child care partner staff from half of the partnership programs described state or local policies that made it difficult to layer funding. State policies in three states limited eligibility for full-day child care subsidies when children were dually enrolled in other early care and education programs. In another state, families had to work full-time during the hours that care was provided to be eligible for subsidies. Many families, however, worked nontraditional hours, including hours when child care partners were not open. One state froze the waiting list for families applying for child care subsidies because of a lack of funds, which meant families not already receiving a subsidy could not qualify. In another state that administered subsidies locally, a county policy requiring all families to pay a co-payment, as well as timelines for recertification of subsidies, created barriers to layering funds.

Changes to state and local policies made it easier for partnership programs to layer funds. Partnership grantee directors and state-level stakeholders from many programs described changes to state policy to accommodate the partnerships and make accessing subsidies for families enrolled in the partnership programs easier.

- Two states waived co-payment requirements for families enrolled in partnership programs, thus resolving the misalignment between the EHS standards that do not allow copayments and state CCDF policies that required copayments.
- One state established a priority category for CCDF subsidies for families enrolled in partnerships, thus allowing more of these families to qualify for subsidies. Another state created a category for partnership families that made it easier for subsidy administrators to identify these families so that they could receive waivers for subsidy recertification and co-payments.
- The Head Start collaboration director from a state that administers subsidies locally set up a template to make it easier for grantees to apply for county waivers for subsidy recertification and copayments for families.
- A state changed the subsidy requirements for postsecondary schooling (for example, dental, medical, and other post-graduate study), so if an institution considers a student full-time, the state subsidy office will consider the parent a full-time student and eligible for child care subsidies.

Modifications to state policy came about through collaboration between state and local stakeholders, including CCDF administrators and Head Start collaboration directors, and partnership grantees. One grantee described meeting monthly with state officials involved in early care and education (including representatives from CCDF, child care licensing, and the state department of education) to address barriers to layered funding for partnership programs. The group also looked for opportunities to establish contracts or grants with child care partners to make subsidized child care more easily accessible to families who need full-day, full-year care.*

One state-level stakeholder noted that having the right people at the table for these discussions is key. When the stakeholder first started meeting with the state about issues related to layering funding, all of the key stakeholders were not involved, and the environment was not conducive to understanding everyone's perspective and developing a solution. A Head Start collaboration director from the same state described a role for federal staff from the OCC and OHS in helping to facilitate these state-level discussions. She recommended that federal staff provide EHS-CC Partnership grantees guidance and tools that they can use to facilitate conversations with state administrators about how to address policy barriers to the partnership programs.

** Under CCDF, states can award grants and contracts to child care providers to provide financial incentives to offer care for special populations, require higher quality standards, and guarantee the availability of certain numbers of slots for low-income children eligible for CCDF financial assistance. Grants and contracts can provide financial stability for child care providers by paying in regular installments, paying based on maintenance of enrollment, or paying prospectively rather than on a reimbursement basis (OCC 2015a).*

3. Grantees used EHS-CC Partnership funds to offset the loss of child care subsidies

Most grantees (86 percent) used partnership funds to offset the costs of care for children who lost eligibility for child care subsidies for some period of time. More than two-thirds (69 percent) of grantees provided payment for the entire time the child was enrolled, and 17 percent provided payment for a limited period after the loss of a subsidy (Table IV.2).

To address issues related to budgeting and paying for care when families lost eligibility for subsidies, one grantee paid providers a variable amount depending on subsidy receipt when the grant first started. However, the grantee later changed its policy to pay providers a fixed amount per partnership slot rather than a varying amount. The grantee made this change to incentivize providers to help families apply for child care subsidies. Otherwise, child care partners were less motivated to help families obtain subsidies and meet the administrative requirements for subsidies.

Source: Case study interviews, 2017

Table IV.2. Use of partnership funds to offset loss of child care subsidies

Use of partnership funds	Percentage of grantees
Partnership funds used to offset loss of child care subsidy for	
The entire time the child is enrolled	69%
A limited time	17%
Agency does not use partnership funds to offset loss of child care subsidy	13%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for seven grantees. Results are weighted to account for nonresponse. Percentages do not sum to 100 due to rounding.

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V. RECRUITING AND ENROLLING FAMILIES

In accordance with the HSPPS, recruiting and enrolling families includes (but is not limited to) establishing (1) recruitment processes that inform all potentially eligible families about the availability of services and encourage them to apply for the program; (2) criteria for prioritizing infants, toddlers, and their families for services; and (3) waiting lists that rank children according to the program's selection criteria (ACF 2018). The specific activities and strategies that programs may implement to recruit and enroll eligible families are often complex and varied. Collaborations within and across partnering organizations can be a key factor in supporting the recruitment and enrollment of children and families living in poverty and/or with multiple needs into early care and education programs (Fowler et al. 2013). However, limited research exists about how EHS-CC Partnership grantees, child care partners, and other partnering entities such as community agencies and CCR&R agencies may work together to develop and implement strategies to recruit and enroll infants, toddlers, and their families.

In this chapter, we use data from the EHS-CC Partnership Grantee and Delegate Agency Director Survey, the Child Care Partner Survey, and case studies of 10 partnership programs to answer the following research question: *How do EHS-CC Partnership programs recruit and enroll children and families?*[27]

Key findings: How do EHS-CC Partnership programs recruit and enroll children and families?

- Three-quarters of child care partners relied on word-of-mouth referrals to recruit children and families. Fifty-two percent received referrals from the grantee.
- Sixty-eight percent of child care partners had a waiting list for infant and toddler slots, and 32 percent had a waiting list for both partnership and nonpartnership infant and toddler slots. Almost half (46 percent) of child care partners had a formal rating or scoring system in place to prioritize enrollment into partnership slots based on family risks or needs.
- Child care partners considered a range of factors in prioritizing families; the most common factors included whether the family was experiencing homelessness (70 percent), whether the child had special needs (63 percent), parent or guardian employment status (62 percent), and teen mother status (62 percent).

[27] For this study, we collected information about the strategies partnership programs used to recruit and enroll families in partnership slots delivered in child care partner settings (we did not collect information about recruitment and enrollment in EHS Expansion slots).

HSPPS: Family eligibility for EHS

Age requirements. For EHS, except when the child is transitioning to Head Start, a child must be an infant or a toddler younger than three years old.

Eligibility requirements. A pregnant woman or a child is eligible if: (a) the family's income is equal to or below the poverty line; (2) the family is eligible for or, in the absence of child care, would be potentially eligible for public assistance, including TANF child-only payments; (3) the child is homeless (as defined in part 1305 of the HSPPS); or, (4) the child is in foster care. If the family does not meet an eligibility criterion [under paragraph (c)(1) of this section], a program may enroll a child who would benefit from services, provided that these participants only make up to 10 percent of a program's enrollment.

Eligibility duration. If a child is determined eligible under this section and is participating in a Head Start program, he or she will remain eligible through the end of the succeeding program year except that the Head Start program may choose not to enroll a child when there are compelling reasons for the child not to remain in Head Start, such as when there is a change in the child's family income and there is a child with a greater need for Head Start services.

−HSPPS Part 1302, Subpart A: Eligibility, recruitment, selection, enrollment, and attendance

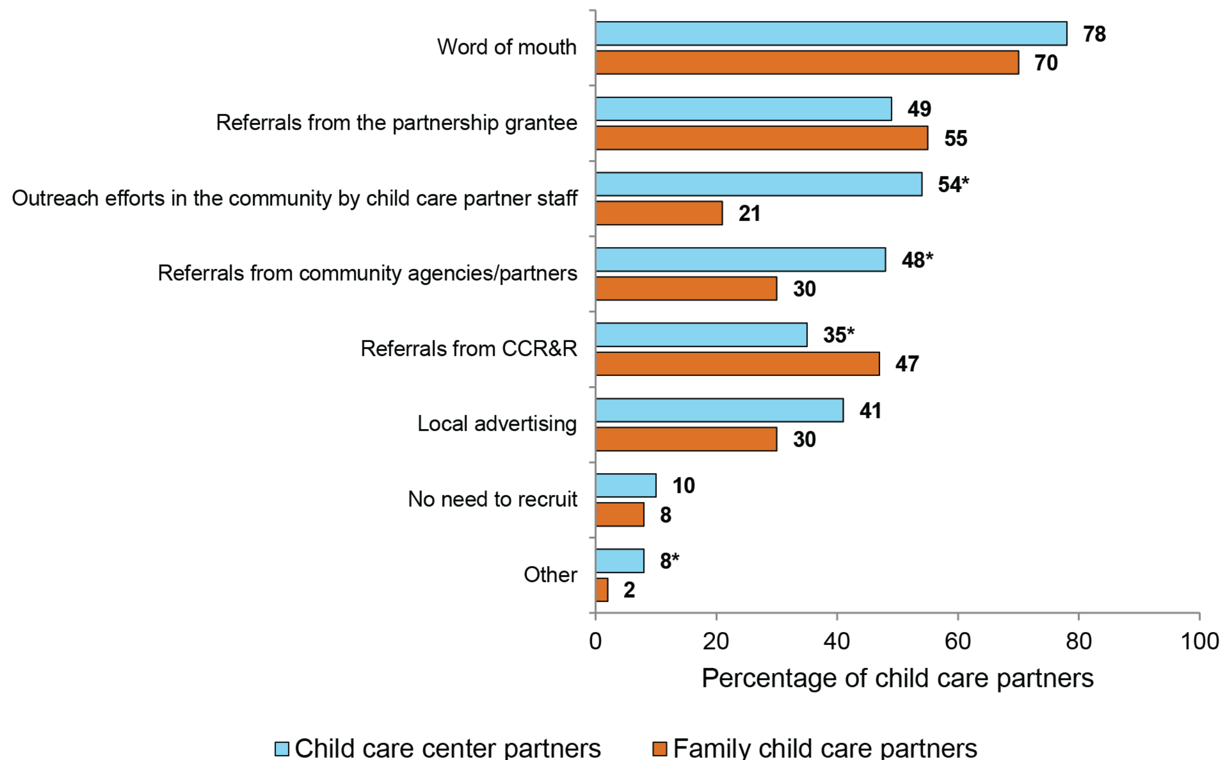
A. Recruiting and enrolling children and families into partnership slots

In this section, we describe the strategies implemented by the EHS-CC Partnership programs to recruit, select, and enroll infants, toddlers, and their families in services.

1. To recruit children and families for partnership slots, child care partners most often relied on word-of-mouth referrals

Child care partners engaged in multiple recruiting strategies, with the average partner using three recruitment strategies. Three-quarters of child care partners recruited families through word-of-mouth referrals. More than half (52 percent) received referrals from the grantee. Recruitment strategies varied by child care partner type. Child care center partners were more likely than family child care partners to receive referrals from other community agencies or partners, and they were more likely to report conducting community outreach to recruit families. Family child care partners were more likely to receive referrals from CCR&R agencies (Figure V.1; Appendix C, Table C.V.1).

Figure V.1. Child care partners used different strategies to recruit families for partnership slots



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for seven child care partners. Results are weighted to account for sampling probability and nonresponse. Responses in “other” category included college campuses and schools (three respondents), online advertising (three respondents), teen parenting programs (two respondents), and Department of Social Services (two respondents).

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

CCR&R = child care resource and referral.

2. Most child care partners had families on a waiting list, and about half used a system to prioritize families for enrollment

Sixty-eight percent of child care partners had a waiting list for infant and toddler slots, and 32 percent had a waiting list for both partnership and nonpartnership infant and toddler slots.[28] More child care center partners than family child care partners had waiting lists: 82 percent of centers had waiting lists, compared with 51 percent of family child care homes (Table V.1). A higher percentage of child care partners had a waiting list for infant and toddler slots at the time of the survey than before the partnership began (Figure V.2; Appendix C, Table C.V.4). (As mentioned previously, because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would

[28] As defined in Chapter I, nonpartnership slots refer to child care partner enrollment spaces reserved for children not funded under the EHS-CC Partnership grant.

have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.)

Table V.1. Waiting list for enrollment of infants and toddlers by child care partners

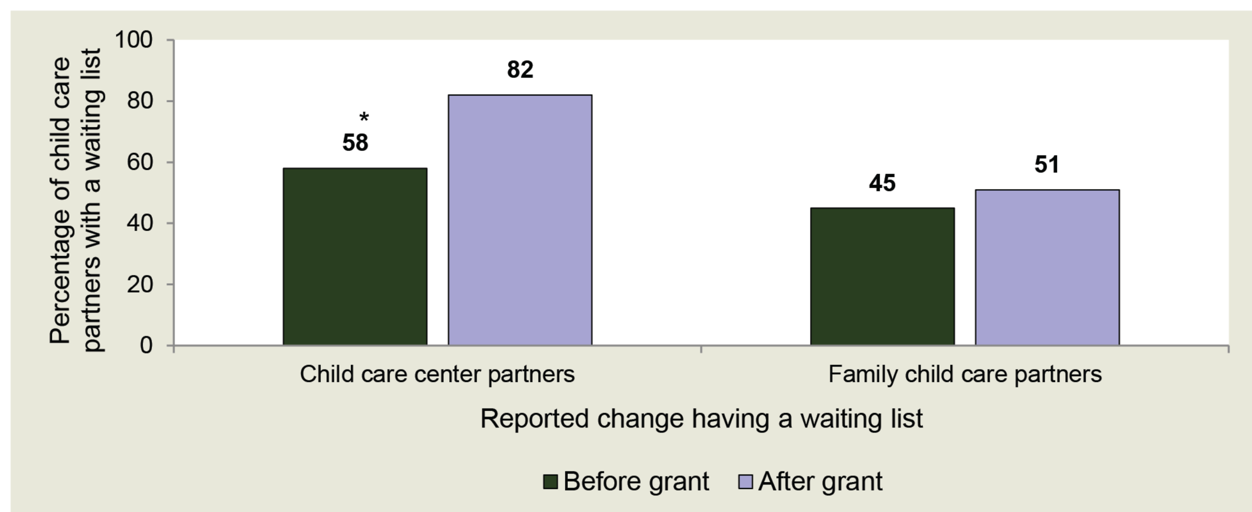
Status of waiting list for infant and toddler slots	Percentage		
	All child care partners	Child care center partners	Family child care partners
Has a waiting list currently	68%	82%*	51%*
Has a waiting list currently for both partnership and nonpartnership infant and toddler slots	32%	39%*	23%*
Has a waiting list currently for infant and toddler slots but not partnership slots	19%	20%	17%
Has a waiting list currently for partnership slots only	17%	22%*	11%*
Does not currently have a waiting list	32%	18%*	49%*
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Figure V.2. A higher percentage of child care centers had a waiting list after the grant than before the grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 10 or 11 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Recruiting and enrolling families

Some partnership programs had challenges filling the target number of partnership slots. Programs that were unable to meet their enrollment goals attributed this challenge primarily to issues they faced recruiting child care partners. Staff from programs partnering with both centers and family child care homes said it was harder for them to fill family child care slots than center slots. Partnership grantee staff at one program explained that families in their area prefer child care centers.

Rather than recruiting new families and enrolling them in child care partners, programs recruited families already enrolled at child care partners to fill partnership slots. Parents from three programs confirmed that they often learned about the program from their existing child care provider either when they enrolled or after the child care partner joined the partnership. The Head Start name was also a helpful recruiting tool to enroll new families, according to teachers at one program.

More than half (56 percent) of child care center partners and 31 percent of family child care partners had a formal rating or scoring system in place to prioritize enrollment into partnership slots based on family risks or needs, which is a requirement of the HSPPS. Child care partners considered a range of factors in prioritizing families; the most common factors included whether the family was experiencing homelessness (70 percent), whether the child had special needs (63 percent), parent or guardian employment status (62 percent), and teen mother status (62 percent; Table V.2). A higher percentage of child care partners had a system in place to prioritize enrollment at the time of the survey than before the partnership began (Figure V.3; Appendix C, Table C.V.5).[29]

Having affordable child care eased many parents' stress. For example, one parent described being very stressed about being able to afford care but was relieved when she learned the family would receive help paying for child care. Grantee staff at another program shared that a parent once told them that the affordable care provided by the program has allowed the parent to "put more food on the table."

Source: Case study interviews, 2017

[29]Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.

Table V.2. Factors child care partners considered for prioritizing enrollment

Factors for prioritizing enrollment	Percentage		
	All child care partners	Child care center partners	Family child care partners
Currently has a system to prioritize enrollment based on family risks or needs	46%	56%*	31%*
Of those that currently have a system to prioritize enrollment, factors considered			
Child is homeless	70%	73%	62%
Child has been diagnosed with any special needs	63%	71%*	42%*
Parent or guardian employment status	62%	65%	56%
Mother had child as a teenager	62%	61%	65%
Parent or guardian receives welfare/TANF	59%	63%	51%
Single parent household	58%	55%	63%
Child is eligible for a child care subsidy (CCDF eligibility)	52%	53%	49%
Number of children in the family	48%	44%	59%
Parent or guardian has mental health needs	45%	46%	42%
Parent or guardian has a history of family violence	45%	48%	38%
Child is a dual-language learner	40%	40%	40%
Child receives a child care subsidy (CCDF receipt)	38%	37%	40%
Parent or guardian has a history of substance use disorder	36%	38%	34%
Other	14%	15%	11%
Sample size	**386**	**255**	**131**

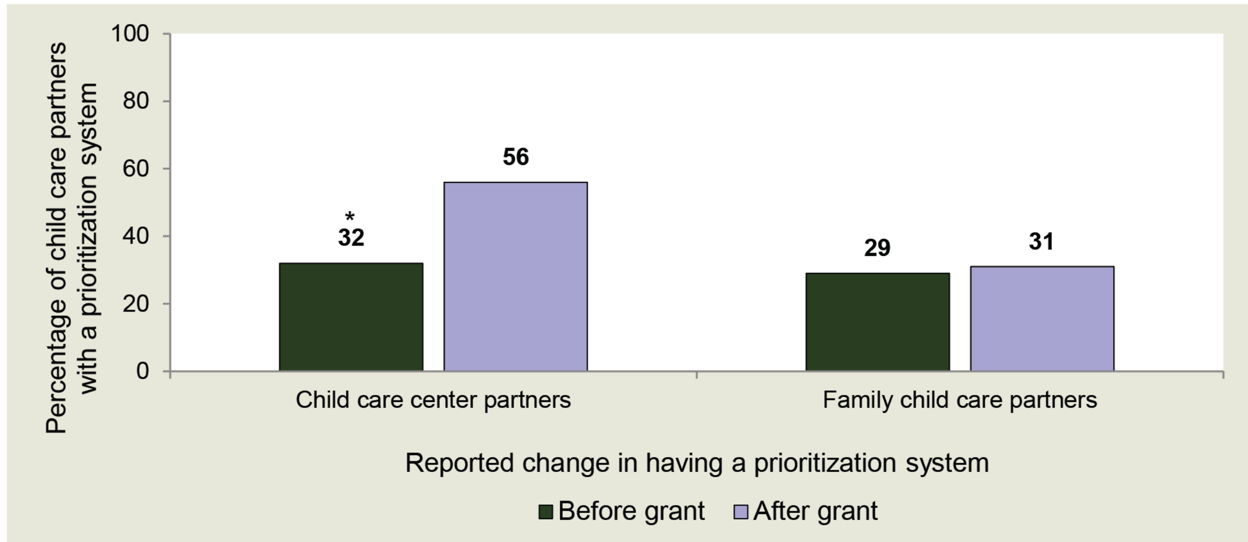
Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 8 to 17 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

CCDF = Child Care and Development Fund; TANF = Temporary Assistance for Needy Families.

Figure V.3. A higher percentage of child care centers had a system for prioritizing enrollment after the grant than before the grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 15 to 17 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

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VI. DELIVERING COMPREHENSIVE SERVICES

In addition to providing early care and education to children, some early care and education programs offer services designed to promote the health and well-being of children and support families in their role as parents (Johnson-Staub 2012). In particular, EHS-CC Partnership programs offer comprehensive services that adhere to the HSPPS. These services include (but are not limited to) the following:

- Connection and access to preventive health care services, such as assistance in connecting families to health care providers and insurance, preventive dental screenings, and tracking of vaccination and medical screening records
- Support for emotional, social, and cognitive development, including screening children to identify developmental delays, mental health concerns, and other conditions that may warrant early intervention, mental health services, or educational interventions
- Family engagement, including parent leadership development, parenting support, and connecting families to needed economic supports and social services

Prior research suggests that early care and education partnerships enhance child care partners' ability to provide comprehensive services to children and families (Schilder et al. 2009; Selden et al. 2006). Indeed, extending comprehensive services to children and families in partnership slots in child care settings was a goal of the EHS-CC Partnerships. In addition, an aim of the EHS-CC Partnerships was to extend some of these services to children and families in nonpartnership slots (see box with information from the FOA for the EHS-CC Partnerships).

Potential benefits of the EHS-CC Partnerships for children and families in nonpartnership slots as described in the FOA

All infants and toddlers in a Partnership site will benefit from facilities and homes that are licensed and meet EHS facility safety requirements. Children in classrooms with EHS-CC Partnership enrolled children will benefit from low ratios and class size, qualification of their teachers including their ongoing supervision and coaching, curriculum, and broad-scale parent engagement activities. While only enrolled EHS-CC Partnership children will be eligible for direct family specific benefits such as home visits, health tracking and promotion, and family partnership agreements, programs must operationalize services to ensure there is no segregation or stigmatization of EHS-CC Partnership children due to the additional requirements or services.

−Office of Head Start 2016

In this chapter, we use data from the EHS-CC Partnership Child Care Partner Survey and case studies of 10 partnership programs to answer the following research question: *How do EHS-CC Partnership programs provide comprehensive services to children and families?*[30, 31]

Key findings: How do EHS-CC Partnership programs provide comprehensive services to children and families?

- Nearly all child care partners (93 percent) offered screenings, referrals, assessments, and other services to children in partnership slots; most (70 percent) offered services to children in nonpartnership slots as well.
- Nearly all child care partners developed Individualized Family Partnership Agreements (99 percent) and conducted home visits (100 percent) with families of children in partnership slots.
- Partnership programs offered a range of other services to families of children in partnership and nonpartnership slots.
- Higher percentages of child care partners provided comprehensive services to children and families after EHS-CC Partnership grants were awarded, compared to before the grants.

A. Comprehensive services for children in partnership slots

Comprehensive services for children include health and mental health services (including helping families access physical, dental, and mental health services and offering mental health consultation); developmental screenings; and formal linkages with providers of early intervention services for infants and toddlers with disabilities.

1. Child care partners offered a range of services to children and families, including screenings, referrals, and assessments

Overall, 86 percent of child care partners offered developmental assessments and other screenings to children in partnership slots.[32] Most partners offered referrals to children, including medical, dental, mental health, and social service referrals (ranging from 70 to 79 percent by type of referral). Sixty-seven percent of all child care partners offered mental health observations or

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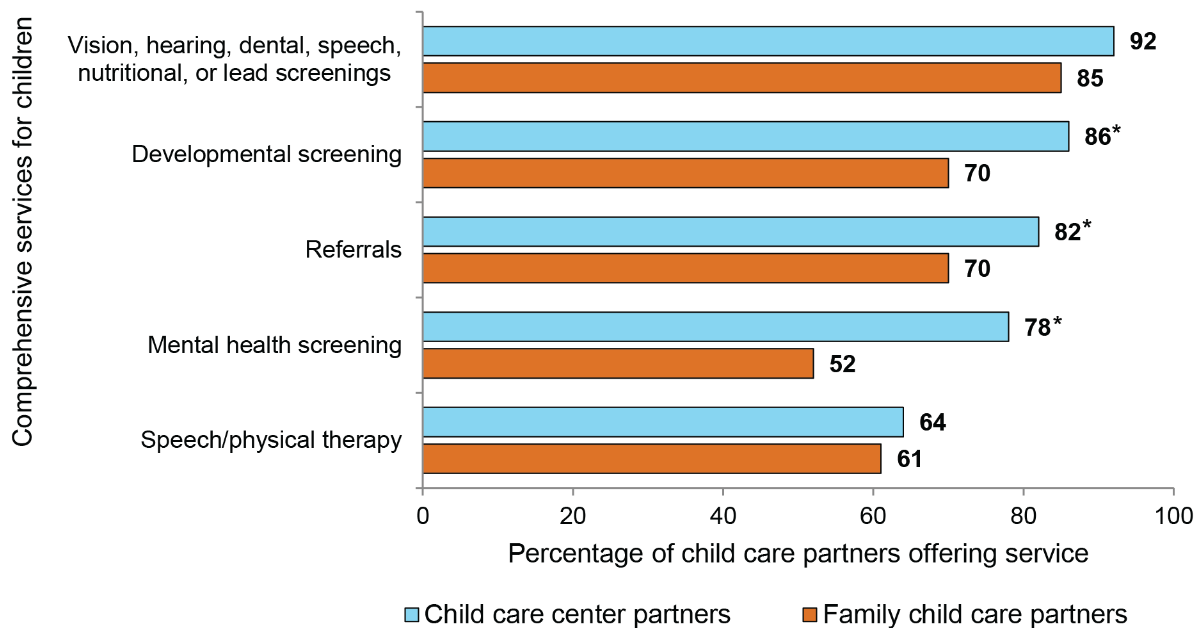
[30] For this study, we collected information about the delivery of comprehensive services to children and families in partnership and nonpartnership slots (we did not collect information about comprehensive services offered to children and families enrolled in EHS Expansion slots).

[31] We include data from the EHS-CC Partnership Grantee Director Survey in Appendix C. Because grantees reported information aggregated across all of their child care partners, we include data from the Child Care Partner Survey in this chapter.

[32] Partnership grantees provided services to children and families at higher rates than child care partners. Ninety percent or more of grantees provided developmental and other screenings; medical, dental, mental health, and social service referrals; and mental health observations or assessments to children in partnership slots (Appendix C, Table C.VI.4). This finding is consistent with findings from Baby FACES, where nearly all EHS program directors said that all children in the program receive developmental screenings. Responses from grantees and child care partners to similar survey items could differ because if only a subset of child care partners provided services to children and families, the grantee would report that services were provided but not all child care partners would report providing services.

assessments. Child care center partners more frequently offered developmental, hearing, vision, and lead screenings and mental health observations and referrals than did family child care partners (Figure VI.1; Appendix C, Table C.VI.1).

Figure VI.1. Child care partners provided a wide array of services to children in partnership slots



Source: EHS-CC Partnership Child Care Partner Survey.

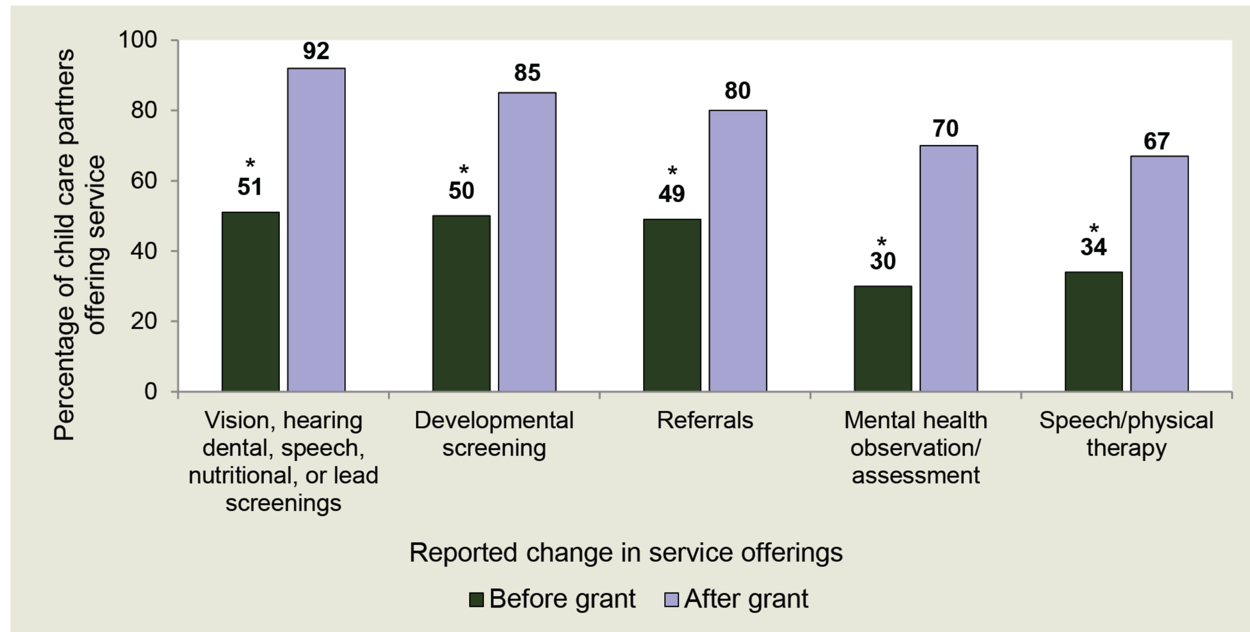
Note: *N* = 386. Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse. Referrals include medical, dental, mental health, and social service referrals.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

2. More child care partners offered comprehensive services to children at the time of the survey than before the EHS-CC Partnership grant

About one-third to one-half of child care partners offered developmental and other screenings, referrals, mental health observations, and speech or physical therapy to children before the EHS-CC Partnership grant. After joining the partnership program, at least two-thirds of partners offered these services to at least some children in care (Figure VI.2; Appendix C, Table C.VI.2). (Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.)

Figure VI.2. More child care partners offered comprehensive services to children after the EHS-CC Partnership grant than before the grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse. Referrals include medical, dental, mental health, and social service referrals.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

B. Comprehensive services for families in partnership slots

Comprehensive services for families include services to support families as children transition to new early care and education programs; to support their role as parents (including training in parenting skills and basic child development); and to help the families move toward self-sufficiency (including educational and employment services, as appropriate). Like EHS programs, EHS-CC Partnership programs also engage in individualized family goal planning that includes developing Individualized Family Partnership Agreements (IFPAs) with enrolled families. This process is designed to help families identify and reach their goals, offer opportunities for family members to enhance or build new skills, and provide access to community resources including crisis assistance when needed (ACF 2018). Partnership programs also offer periodic home visits to enrolled families.

1. Most child care partners developed IFPAs and conducted home visits with children in partnership slots

Seventy-two percent of child care partners developed IFPAs and 86 percent conducted home visits with families in partnership slots (Table VI.1). Child care center partners were significantly more likely than family child care partners to develop IFPAs with families in partnership slots (78 versus 64 percent; not shown) and to offer home visits to families in partnership slots (94 versus 74 percent; not shown).

Of those partners that developed IFPAs, most said that grantee staff were primarily responsible for working with families to develop them (68 percent), compared with only 25 percent that said child care partner staff were responsible for providing this service. Of those child care partners conducting home visits, the percentage reporting that grantee staff were responsible for providing home visits was about the same as the percentage reporting that child care partner staff were responsible for providing this service (46 and 48 percent, respectively; Table VI.1).[33]

Table VI.1. Provision of IFPAs and home visits

	Percentage of child care partners reporting service provided to			Of child care partners reporting service, percentage reporting entity responsible		
Service	Families in partnership slots	Families in partnership slots only	Families in both partnership and nonpartnership slots	Partnership grantee staff	Child care partner staff	Other
IFPAs	72%	50%	22%	68%*	25%*	6%
Home visits	86%	73%	13%	46%	48%	6%
Sample size	**386**					

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 4 to 40 child care partners. Percentages do not sum to 100 because the survey item asked respondents to indicate all categories that applied. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between those reporting partnership grantee and child care partner staff are responsible for providing service at the 0.05 level, two-tailed test.

IFPA = Individual Family Partnership Agreement.

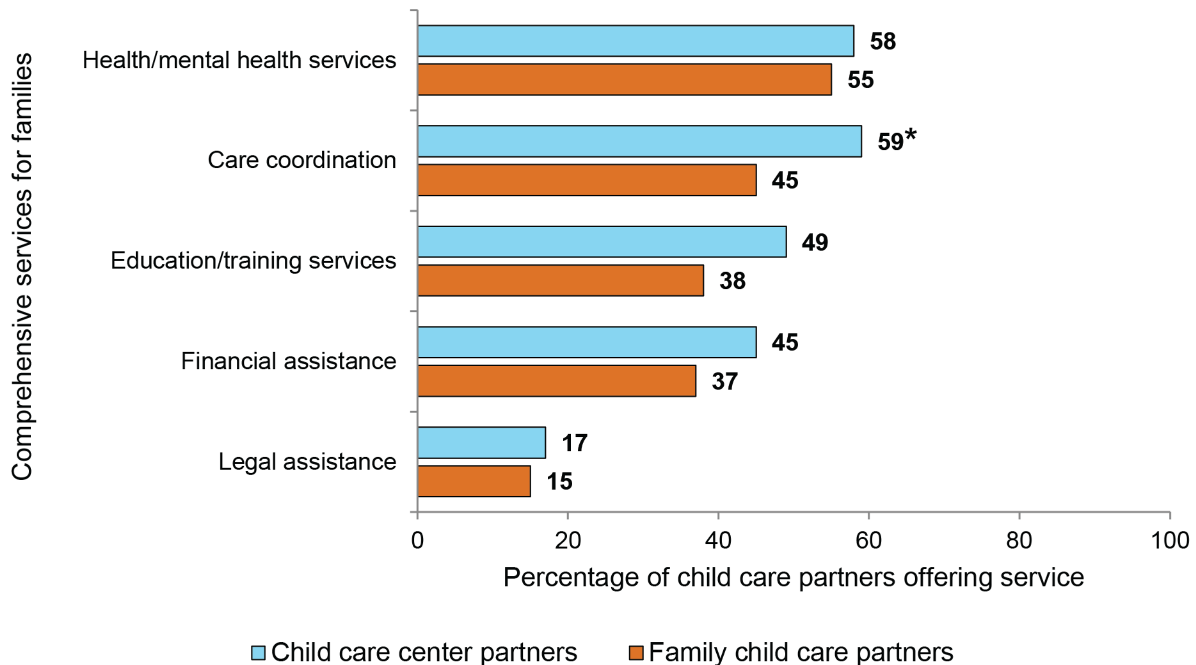
2. Child care partners also offered a range of other services to parents and caregivers of children in partnership slots

Sixty-eight percent of child care partners offered at least one service to families of children in partnership slots (Appendix C, Table C.VI.4). More than half of child care partners offered health or mental health services to families of children in partnership slots (58 percent of child care center partners and 55 percent of family child care partners). Additionally, 59 percent of child care center partners and 45 percent of family child care partners offered care coordination

[33] Nearly all grantees developed IFPAs and conducting home visits with families in partnership slots (99 and 100 percent, respectively; Appendix C, Table C.VI.3).

or follow-up to families about findings from screenings or assessments of children. (Figure VI.3; Appendix C, Table C.VI.4).[34]

Figure VI.3. Child care partners provided a wide range of services to families of children in partnership slots



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse. Health/mental health services include adult health care, prenatal care or OB/GYN, dental care, mental health screenings, mental health assessments, therapy, services for drug or alcohol abuse, and disability services for parents. Financial assistance services include transportation assistance, emergency assistance, housing assistance, and financial counseling. Education/training services include employment assistance, education or job training, family literacy services, and services for dual language learners. Care coordination services include care coordination and follow-up with families about screening/assessment results.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

OB/GYN = obstetrics and gynecology.

[34] Higher percentages of grantees, compared with child care partners, offered services to families, such as consultation or follow-up to families about findings from screenings or assessments of children and mental health or health care screenings, assessments, or referrals for parents (Appendix C, Table C.VI.12). One reason for the discrepancy between grantee and child care partner reports could be that not all of a grantee's child care partners offered services to families. For example, consider a grantee with four child care partners. If only one partner offered services to families, the grantee would report that the partnership program offered services, even though three out of four child care partners did not report offering services.

Lessons learned from the case studies: Engaging with families

Finding ways to connect with and engage parents, most of whom worked or attended school, was a challenge for most of the programs. Parents were often rushed at drop-off and pick-up and did not return telephone calls. A few grantees found it particularly difficult to engage families that lacked stable housing. And in a few cases, teachers believed that parents viewed the child care provider as a babysitter and did not appreciate the program.

Partnership grantee staff who were charged with engaging families and who were not physically on site at child care partner locations viewed this arrangement as an added obstacle to engaging families. At these partnership programs, grantees typically employed staff (referred to as family service workers) who worked with families enrolled at multiple child care partners and could not be at one center or family child care home every day to interact with families. Staff said that not being physically present daily affected their relationships with families and their ability provide all the resources that the families needed.

In addition to challenges engaging parents in services, teachers and parents described the challenges of getting parents to participate in the Policy Council (a governing body that includes families enrolled in EHS-CC Partnership slots that is responsible for the direction of the program at the agency level) and attend parent meetings. Parents from a small number of programs described the barriers they faced in participating in these meetings. They explained they could not take time off from work for events such as Policy Council and parent meetings and often found the timing of the events difficult for their schedule. They added that they would be more likely to attend if these events happened immediately after pick-up and included child care and meals. To encourage parents' involvement, staff at one partnership program offered morning and evening sessions for all activities and meetings. They also offered child care, raffles, and prizes and paid special attention to making the events worthwhile for the parents.

To better engage families, a few EHS-CC Partnership grantees considered using technology to communicate with parents and connect them with resources. Grantee staff from one program explained that they looked into using technology (including web-based applications and text messages) to disseminate information to parents because the parents had limited time to engage with grantee staff when dropping off and picking up their children. At another program, grantee staff observed that parents gravitated toward using websites to learn about community resources, as opposed to calling the organizations. As a result, the grantee staff were intentional about using technology to help families access resources.

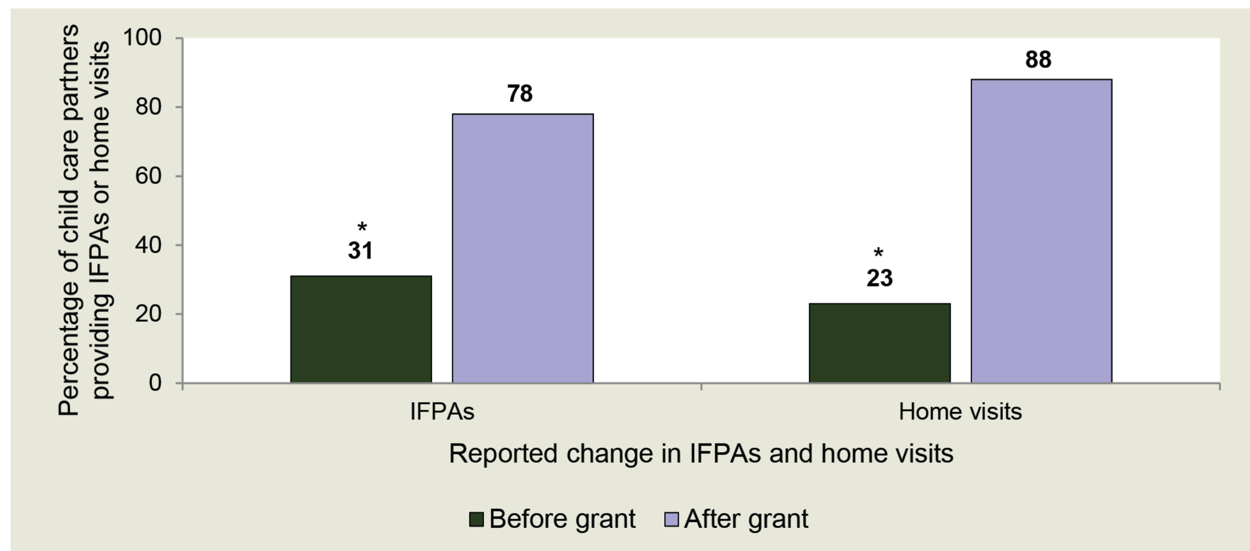
Partnership grantee staff engaged in many strategies to build relationships with families:

- Introducing family service workers to parents during recruitment and enrollment to immediately begin building relationships with families
- Making an effort to meet an immediate need of families as soon as possible after enrollment in the program
- Engaging parents during drop-off and pick-up to build rapport and signal that staff were available for parents
- Providing daily or monthly reports to families about children's activities and progress
- Accommodating parents' work schedules when planning appointments, including offering appointments in the evening

3. More child care partners offered comprehensive services to families at the time of the survey than before the EHS-CC Partnership grant

Before the EHS-CC Partnership grant, 31 percent of partners offered IFPAs and 23 percent offered home visits, compared with 78 percent offering IFPAs and 88 percent offering home visits after the grant (Figure VI.4; Appendix C, Table C.VI.5). In addition, the percentage of child care partners that offered other services to families was consistently higher after the grant than before the partnership began (Figure VI.5; Appendix C, Table C.VI.6). (Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.)

Figure VI.4. More child care partners offered IFPAs and home visits after the EHS-CC Partnership grant than before the grant



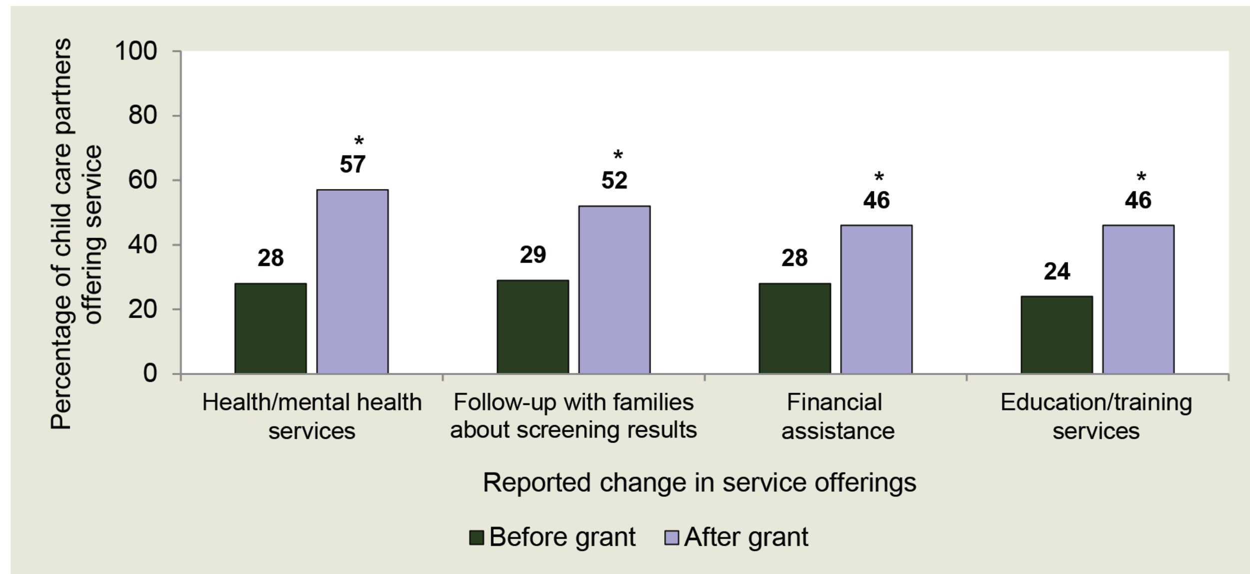
Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 26 to 40 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

IFPA = Individual Family Partnership Agreement.

Figure VI.5. More child care partners offered other services to families after the EHS-CC Partnership grant than before the grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse. Health/mental health services include adult health care, prenatal care or OB/GYN, dental care, mental health screenings, and mental health assessments. Financial assistance services include transportation assistance, emergency assistance, housing assistance, and financial counseling. Education/training services include employment assistance, education or job training, and family literacy services.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

OB/GYN = obstetrics and gynecology.

C. Comprehensive services for children and families in nonpartnership slots

EHS-CC Partnerships offer the opportunity for children whose care is not supported by EHS-CC Partnership grant funds and their families to benefit from comprehensive services offered to EHS-enrolled children and families. Offering comprehensive services to all children and their families has the potential to benefit their community as well (Lim et al. 2007).

1. Many child care partners offered services to children in nonpartnership slots

EHS-CC Partnership programs enhanced comprehensive services for children whose care was not supported through funds from the grant (that is, children in nonpartnership slots). Many child care partners offered screenings, referrals, and assessments to children birth to age 3 who were in nonpartnership slots. Seventy percent of child care partners offered at least one of the comprehensive services listed in Table VI.2 to children in both partnership and nonpartnership slots. A significantly larger percentage of child care partners offered developmental screenings, social service referrals, mental health referrals, and speech therapy to children in partnership and nonpartnership slots, compared with partners that offered these services to children in partnership slots only. A significantly smaller percentage of child care partners offered lead screenings to children in both types of slots, compared with partners that offered these services to children in partnership slots only (Table VI.2).

Table VI.2. Services provided to children in partnership and nonpartnership slots

Type of service	Percentage of partners reporting service provided to children in partnership slots	Percentage of partners reporting service provided to children in partnership slots only	Percentage of partners reporting service provided to children in both partnership slots and nonpartnership slots
Any service	93%	22%*	70%*
Developmental screening	79%	29%*	51%*
Hearing screening	78%	42%	36%
Vision screening	76%	39%	38%
Speech screening	71%	32%	39%
Social service referrals	70%	29%*	40%*
Dental screening	70%	38%	32%
Mental health observation or assessment	67%	33%	35%
Dental referrals	65%	36%	29%
Mental health referrals	64%	27%*	37%*
Medical referrals	63%	31%	31%
Nutritional screening	61%	35%	26%
Speech therapy	60%	25%*	35%*
Physical therapy	47%	24%	23%
Lead screening	45%	29%*	16%*
Sample size	**386**		

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse. The sum of the percentages in columns 2 and 3 may not equal the percentage in column 1 because of rounding.

* Percentages differ significantly between those providing service to children in partnership slots only and those providing service to children in both partnership slots and nonpartnership slots at the 0.05 level, two-tailed test.

Another way to assess the extent to which partnership programs may have extended comprehensive services to children in nonpartnership slots is to examine the number or percentage of children in nonpartnership slots who could access comprehensive services. Seventy-eight percent of children in nonpartnership slots had access to at least one of the comprehensive services listed in Table VI.3. In other words, there were nearly 24,000 nonpartnership slots (out of slightly more than 30,000 total nonpartnership slots) in partnership programs that offered at least one of the listed comprehensive services to children in both partnership and nonpartnership slots. The percentage of children in nonpartnership slots with access to comprehensive services varied by the type of service, ranging from a low of 19 percent for lead screenings to a high of 54 percent for developmental screenings (Table VI.3).

Table VI.3. Children in nonpartnership slots with access to comprehensive services

Type of service	Percentage of partners reporting service provided to children in both partnership slots and nonpartnership slots	Number of nonpartnership slots with access to these services	Percentage of children enrolled in nonpartnership slots with access to these services[a]
Any service	70%	23,592	78%
Developmental screening	51%	16,400	54%
Hearing screening	36%	11,987	40%
Vision screening	38%	12,413	41%
Speech screening	39%	13,715	46%
Social service referrals	40%	14,194	47%
Dental screening	32%	9,607	32%
Mental health observation or assessment	35%	12,836	43%
Dental referrals	29%	8,171	27%
Mental health referrals	37%	13,327	44%
Medical referrals	31%	10,261	34%
Nutritional screening	26%	6,429	21%
Speech therapy	35%	12,436	41%
Physical therapy	23%	8,633	29%
Lead screening	16%	5,814	19%
Sample size	**386**		

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

[a] The total number of nonpartnership slots across all child care partners, used in the denominator of the percentages calculated in this column, is 30,104.

2. Many child care partners also offered services to families of children in nonpartnership slots

Compared with the large numbers of partnership programs that offered comprehensive services such as screenings and referrals to children and families in both partnership and nonpartnership slots, fewer programs offered IFPAs and home visits to all families. Twenty-two percent offered IPFAs, and 13 percent offered home visits to families in both partnership and nonpartnership slots. In other words, 21 percent of children enrolled in nonpartnership slots had IFPAs, and 10 percent of children in nonpartnership slots received home visits (Table VI.4).

Table VI.4. Children in nonpartnership slots with access to IFPAs and home visits

Service	Percentage of partners reporting service provided to families in both partnership slots and nonpartnership slots	Number of nonpartnership slots with access to these services	Percentage of children enrolled in nonpartnership slots with access to these services[a]
IFPAs	22%	6,356	21%
Home visits	13%	2,738	10%
Sample size	**386**		

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 28 to 40 child care partners. Results are weighted to account for sampling probability and nonresponse.

[a] The total number of nonpartnership slots across all child care partners, used in the denominator of the percentages calculated in this column, is 29,830 for IFPAs and 27,711 for home visits.

IFPA = Individual Family Partnership Agreement.

Almost half of child care partners offered at least one of the comprehensive services listed in Table VI.5 to families of children in both partnership and nonpartnership slots. A significantly larger percentage of child care partners offered staff consultations about results of screening or assessments to families of children in partnership and nonpartnership slots, compared with partners that offered this service to families of children in partnership slots only (Table VI.5).

Table VI.5. Services provided to families of children in partnership and nonpartnership slots

Type of service	Percentage of partners reporting service provided to families of children in partnership slots	Percentage of partners reporting service provided to families of children in partnership slots only	Percentage of partners reporting service provided to families of children in both partnership slots and nonpartnership slots
Any service	68%	19%*	49%*
Staff consultation or follow-up with families about results of screenings or assessments	49%	18%*	31%*
Mental health screenings	42%	20%	22%
Mental health assessments	38%	20%	17%
Dental care	38%	18%	19%
Family literacy services	32%	18%	14%
Emergency assistance	29%	14%	15%
Education or job training	28%	14%	14%
Services for dual-language learners	28%	14%	14%

Table VI.5. ***(continued)***

Type of service	Percentage of partners reporting service provided to families of children in partnership slots	Percentage of partners reporting service provided to families of children in partnership slots only	Percentage of partners reporting service provided to families of children in both partnership slots and nonpartnership slots
Care coordination	28%	13%	15%
Employment assistance	27%	12%	15%
Housing assistance	27%	12%	15%
Therapy	27%	12%	15%
Pediatrician services	26%	13%	13%
Financial counseling	26%	14%	12%
Transportation assistance	25%	12%	14%
Services for drug or alcohol abuse	18%	9%	9%
Disability services for parents	17%	9%	8%
Prenatal care or OB/GYN	16%	9%	7%
Legal assistance	16%	8%	8%
Adult health care	15%	7%	8%
Sample size	**386**		

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

OB/GYN = obstetrics and gynecology.

* Percentages differ significantly between those providing service to families of children in partnership slots only and those providing service to families of children in both partnership slots and nonpartnership slots at the 0.05 level, two-tailed test.

In addition, nearly half of families of children in nonpartnership slots had access to at least one of the services listed in Table VI.6. That is, there were more than 14,500 nonpartnership slots (out of slightly more than 30,000 total nonpartnership slots) in partnership programs that offered at least one of the listed services to families of children in both partnership and nonpartnership slots. The percentage of children in nonpartnership slots with access to comprehensive services varied by the type of service, ranging from a low of 4 percent for adult health care to a high of 34 percent for staff consultation or follow-up about results of screenings or assessments (Table VI.6).

Table VI.6. Families of children in nonpartnership slots with access to comprehensive services

Type of service	Percentage of partners reporting service provided to families of children in both partnership slots and nonpartnership slots	Number of nonpartnership slots with access to these services	Percentage of children enrolled in nonpartnership slots with access to these services[a]
Any service	49%	14,599	48%
Staff consultation or follow-up with families about results of screenings or assessments	31%	10,347	34%
Mental health screenings	22%	7,448	25%
Mental health assessments	17%	5,785	19%
Dental care	19%	4,502	15%
Family literacy services	14%	3,878	13%
Emergency assistance	15%	3,854	13%
Education or job training	14%	4,020	13%
Services for dual-language learners	14%	4,451	15%
Care coordination	15%	4,610	15%
Employment assistance	15%	3,720	12%
Housing assistance	15%	4,320	14%
Therapy	15%	4,946	16%
Pediatrician services	13%	2,588	9%
Financial counseling	12%	3,877	13%
Transportation assistance	14%	3,335	11%
Services for drug or alcohol abuse	9%	2,210	7%
Disability services for parents	8%	2,678	9%
Prenatal care or OB/GYN	7%	1,396	5%
Legal assistance	8%	2,088	7%
Adult health care	8%	1,332	4%
Sample size	**386**		

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

[a] The total number of nonpartnership slots across all child care partners, used in the denominator of the percentages calculated in this column, is 30,104.

OB/GYN = obstetrics and gynecology.

VII. SUPPORTING QUALITY IMPROVEMENT

A key goal of the EHS-CC Partnership grant program was to increase the community supply of high quality early learning environments for infants and toddlers (Office of Early Childhood Development 2017). To accomplish this goal, partnership programs can implement a variety of strategies to enhance the quality of services, including opportunities for staff training and professional development and enhancements to learning environments.[35] A small body of research suggests partnerships in early care and education may help to increase the quality of early care and education settings (Schilder et al. 2009; Ontai et al. 2002) through increasing access to shared resources, materials, supervision, training, and knowledge (Del Grosso et al. 2014). In addition, these partnerships may have the potential to enhance the quality of care for all children in the settings, including children not eligible for or enrolled in partnership-funded slots, although more research is needed (see Del Grosso et al. 2014).

In this chapter, we use data from the EHS-CC Partnership Grantee and Delegate Agency Director Survey, the Child Care Partner Survey, and case studies of 10 partnership programs to answer the following research question: *What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?*[36] We begin by discussing how grantees and child care partners establish expectations for meeting the HSPPS. We then describe the use of early childhood education curricula, how programs individualize services for children and families, and how they enhance learning environments for children. Next, we describe how grantees support child care partner staff by offering professional development and continuing education opportunities. Throughout the chapter, we discuss challenges and lessons learned, based primarily on findings from the case studies.

Key findings: What activities do EHS-CC Partnership programs engage in to improve the quality of child development services?

- Most child care partners (71 percent) received guidance from grantees on meeting the HSPPS.
- A large majority (86 percent) of child care partners used an early childhood education curriculum. The most commonly used curriculum was Creative Curriculum; about 70 percent of partners used it.
- Seventy-eight percent of child care partners met regularly with grantees to discuss services for individual children and families. Forty-one percent met once or twice a month, and 27 percent met almost every week or more frequently.
- Child care partners received a variety of materials and supplies from grantees. The most common materials partners received were furniture, such as cribs or bookshelves (74 percent of partners); curriculum materials (71 percent); toys or materials for pretend play (70 percent); and books (69 percent).

[35] Some grantees served as hubs and, rather than providing quality improvement activities directly, worked with providers to ensure that there was appropriate documentation of compliance with HSPPS (see box in Chapter III). However, we did not collect information via web-based surveys about hub models.

[36] For this study, we collected information about the strategies grantees and child care partners used to support quality improvement in child care partner settings (we did not collect information about strategies to support quality improvement in EHS Expansion settings).

Key findings (continued)

- Eighty-six percent of child care partners said that grantees provided them the opportunity to receive coaching or one-on-one training, and a similar percentage had the opportunity to participate in workshops.
- Grantees offered a variety of quality improvement activities to child care partners and used information gathered during these activities to provide training. Grantees commonly offered classroom observations to assess practice (97 percent of grantees), using checklists to assess HSPPS compliance (96 percent of grantees), and reviewing program files (95 percent of grantees).
- Child care partners had opportunities to obtain a CDA credential or other degrees through their involvement in partnership programs. Seventy-seven percent of partners said that the grantee offered staff the opportunity to obtain a CDA.

A. Establishing expectations for meeting the HSPPS

All EHS-CC Partnership grantees and child care partners must meet the HSPPS. However, individual child care partners can be in different stages of readiness to meet the HSPPS. Because meeting the HSPPS was a new requirement for grantees without previous EHS experience and for many child care partners, partnership programs were not subject to the formal monitoring process or the Designation Renewal System until 18 months after the grant award (ACF 2015). In this section, we report findings from the Child Care Partner Survey and the case studies about the experiences of child care partners and grantees in meeting the HSPPS.

1. Most child care partners received guidance on implementing the HSPPS from the grantee

Three-quarters of child care center partners and 65 percent of family child care partners received some form of guidance from the grantee on implementing the HSPPS. Specifically, at least 50 percent of child care center partners and family child care partners received training, written materials, coaching, or classroom observation and feedback from the grantee. Fifty-five percent of child care partners participated with the grantee in developing documentation on meeting the HSPPS. Overall, child care centers and family child care providers received similar types of guidance from grantees, with one exception: a significantly higher percentage of child care center partners received classroom observation and feedback (Table VII.1).

Parents valued the quality of care their children received. During focus groups, many parents discussed the value they placed on high quality child care, and many described considering program quality when selecting child care arrangements. Many described considering the curriculum, low staff-child ratios, and the quality of interactions between caregivers and children when selecting their arrangements. One parent said she was willing to drive to a child care provider farther from her home because she liked the high quality of care and the level of attention her child received. Some parents also discussed seeing growth in their children's development since enrolling in a child care setting. A few parents from one program felt the new curriculum that the child care partner was implementing played a role in their child's development. One parent said, "[Implementing] the HSPPS resulted in a focus on child development, the use of a curriculum, and reduced the adult-to-child ratio."

Source: Case study interviews, 2017.

HSPPS: Monitoring program performance in EHS

Ongoing compliance oversight and correction. In order to ensure effective ongoing oversight and correction, a program must establish and implement a system of ongoing oversight that ensures effective implementation of the program performance standards, including ensuring child safety, and other applicable federal regulations as described in this part, and must: (1) collect and use data to inform this process; (2) correct quality and compliance issues immediately, or as quickly as possible; (3) work with the governing body and the policy council to address issues during the ongoing oversight and correction process and during federal oversight; and,(4) implement procedures that prevent recurrence of previous quality and compliance issues, including previously identified deficiencies, safety incidents, and audit findings.

−HSPPS 1302, Subpart J: Program management and quality improvement

Table VII.1. Guidance received by child care partners from grantees on implementing HSPPS

	Percentage		
Guidance on implementing HSPPS from grantee	**All child care partners**	**Child care center partners**	**Family child care partners**
Partner received guidance on implementing HSPPS from grantee	71%	75%	65%
Types of guidance partner received from grantee			
Training	60%	65%	53%
Written materials	59%	62%	55%
On-site coaching	56%	57%	55%
Classroom observation and feedback	50%	56%*	41%*
Other	4%	5%	3%
Written documentation on meeting HSPPS developed with input from both grantee and partner	55%	57%	52%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 2 to 23 child care partners. Percentages do not sum to 100 because respondents selected all types that applied. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

HSPPS = Head Start Program Performance Standards.

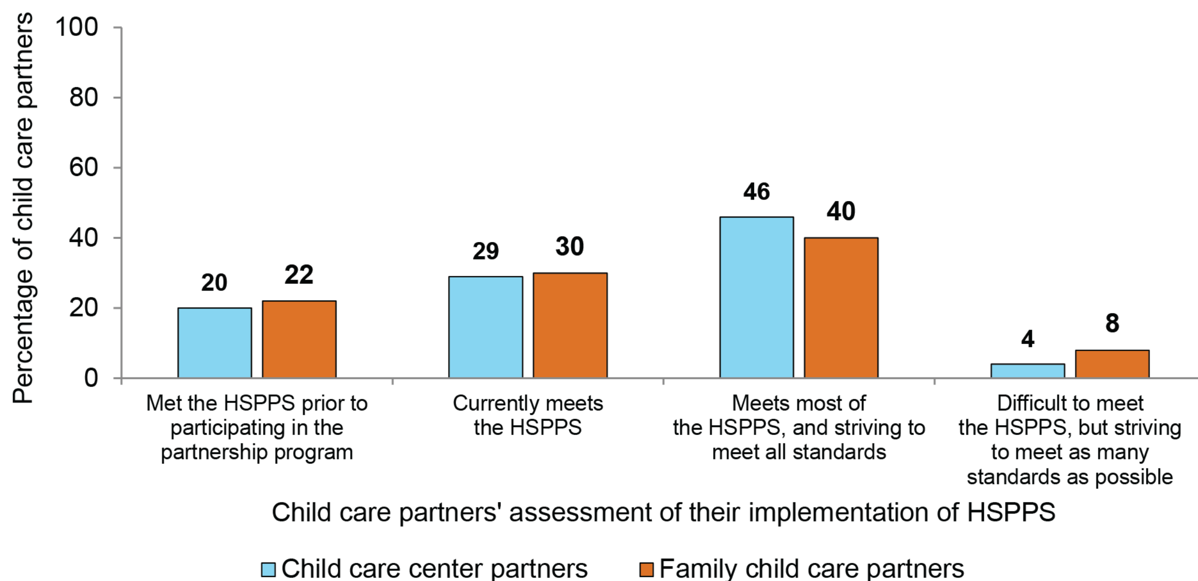
2. Nearly all child care partners met most or all of the HSPPS

Ninety-four percent of child care partners met most or all of the HSPPS by the time the Child Care Partner Survey was administered.[37] Twenty-one percent of child care partners met the HSPPS before participating in EHS-CC Partnerships. By the time of the survey, 30 percent of child care partners met all the HSPPS and 44 percent met most of the standards. Only 6 percent said that they found it difficult to meet the HSPPS (Figure VII.1; Appendix C, Table C.VII.1).

Lessons learned from the case studies: QRIS ratings and the HSPPS

Findings from the case studies suggest that child care partners rated highly in their state's QRIS found it less challenging to meet the HSPPS. Grantee staff in one program, for example, said that the state's QRIS standards aligned nicely with the HSPPS, which made compliance easier. All family child care partners in another program were QRIS-rated providers, and many were at the highest rating or working toward it. Grantee staff in this program said that the high ratings meant that the family child care partners were already meeting many of the HSPPS.

Figure VII.1. Few child care partners found it difficult to meet the HSPPS



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 36 child care partners. Results are weighted to account for sampling probability and nonresponse.

There were no significant differences between child care center partners and family child care partners.

HSPPS = Head Start Program Performance Standards.

[37] It is important to note that these views of the child care partners are self-reported; this finding is not based on results of the formal monitoring process or Designation Renewal System. In addition, most data collection for this study took place before any formal monitoring.

Lessons learned from the case studies: Identifying and addressing quality improvement needs

Partnership grantee staff found it difficult to work with child care partners who resisted change or disagreed with assessment findings. Staff from several grantees described partners who were eager to take advantage of the supports offered by the grantee; these child care partners were aware that they had needs and were eager to reach the next level of quality. Grantee staff in other programs noted that some partner staff were resistant to change, defensive, or disagreed with the assessment findings. In one program, the family child care partners had been in the field for a long time, and they were not as open to changing practices. In some programs, disagreement about assessment findings were related to the tools used for monitoring. The tools sometimes did not match the type of provider that was being monitored, therefore making the process seem very negative. For example, the environmental rating scale used in one program was geared toward larger settings, so the family child care partners could not achieve many of the goals.

Instead of using a specific observation tool or checklist to identify quality improvement needs when they first began working with a child care partner, one grantee invited partners to visit an established EHS center operated by the grantee. The grantee director said that by showing partners an example of a quality center, the center directors identified quality improvements they wanted to make on their own. Taking this "back-seat" approach at the beginning allowed the grantee to get buy-in from the child care partners. The child care partners drove future changes; the grantee followed and made sure the changes would meet standards.

Source: Case study interviews, 2017.

Getting buy-in from and building a relationship with child care partners made it easier for EHS-CC Partnership grantees to give feedback about changes that partners had to make to meet the HSPPS. Grantee and child care partner staff from a few partnership programs described that grantee staff taking a "back-seat" approach to identifying and implementing necessary changes was a helpful way to ensure buy-in. A coach from one grantee, for example, spent a month in the child care partner classrooms building relationships with teachers before she actually began to coach. This approach helped ensure that the teachers were first comfortable with her presence.

Actively involving the child care partners in the assessment or monitoring process helped partnership grantees ensure that plans were tailored appropriately to the specific circumstances and needs of each partner. The EHS-CC Partnership grantee from one partnership program worked with the family child care partner after an observation to determine why something did or did not work. The family child care providers liked that the grantee observed and listened first, rather than just telling them what to do. Another grantee took a similar approach with family child care partners. If the grantee staff saw something out of compliance, grantee staff walked through the day with the provider and helped find ways to address the issue that were practical for the provider to address. In a different partnership program, the child care partners were actively involved in collecting the data that informed their quality improvement plans. Grantee staff and child care partner staff reviewed the data together to identify strengths and weaknesses. Developing processes with the child care partners and taking their unique circumstances into account worked better than imposing an existing structure and procedure onto them, according to the grantee staff. The child care partner center directors in another partnership program appreciated that the grantee staff took the time to understand their unique needs and how processes and procedures would actually work at the centers.

B. Using an early childhood education curriculum, individualizing services, and enhancing learning environments

In accordance with the HSPPS, EHS-CC Partnership grantees implement a research-based early childhood curriculum to facilitate responsive care, effective teaching, and an organized learning environment that promotes healthy development (ACF 2018). In this section, we describe the experiences of the partnership programs in implementing strategies to meet these requirements.

1. Most child care partners used an early childhood education curriculum

A large majority (86 percent) of child care partners used an early childhood education curriculum. This percentage is higher than the percentage of center- or home-based providers who used a curriculum in the NSECE (74 percent of center-based providers and 55 percent of listed home-based providers; NSECE Project Team 2015b). The most commonly used curriculum was Creative Curriculum; about 70 percent of partners used it. Family child care partners were more likely than child care centers to use an agency-created curriculum or a "named" curriculum other than Creative Curriculum (Figure VII.2; Appendix C, Table C.VII.2). (By "named" curriculum, we mean a curriculum other than an agency-created curriculum.[38])

HSPPS: Use of a curriculum

Curricula. Center-based and family child care programs must implement developmentally appropriate research-based early childhood curricula, including additional curricular enhancements, as appropriate that: (1) are based on scientifically valid research and have standardized training procedures and curriculum materials to support implementation; (2) are aligned with the *Head Start Early Learning Outcomes Framework: Ages Birth to Five* and, as appropriate, state early learning and development standards; and are sufficiently content-rich to promote measurable progress toward development and learning outlined in the Framework; and (3) have an organized developmental scope and sequence that include plans and materials for learning experiences based on developmental progressions and how children learn.

A program must support staff to effectively implement curricula and at a minimum monitor curriculum implementation and fidelity, and provide support, feedback, and supervision for continuous improvement of its implementation through the system of training and professional development.

−HSPPS Part 1302, Subpart C: Education and child development program services

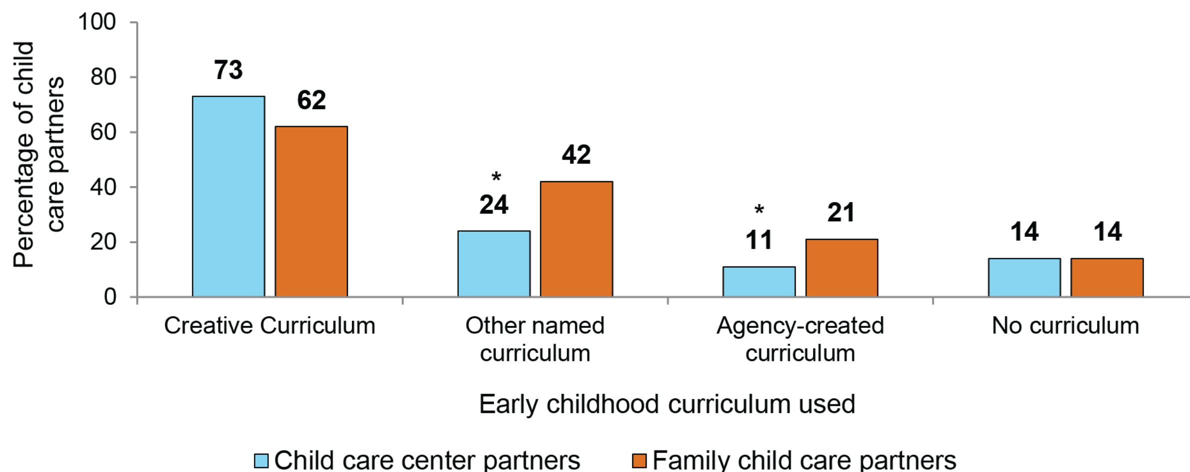
[38] The Child Care Partner Survey listed many named curricula: Assessment, Evaluation, and Programming System; Beautiful Beginnings; Early Learning Accomplishments Profile; Emotional Beginnings; Games to Play with Babies; Games to Play with Toddlers; Hawaii Early Learning Profile; High/Scope; Learning Activities for Infants; Montessori; Ones and Twos; Partners as Primary Caregivers; Partners in Learning; Playtime Learning Games for Young Children; Resources for Infant Educators; Talking to Your Baby; The Anti-Bias Curriculum; and Program for Infant–Toddler Care. Respondents could also write in other curricula.

Most child care partners (62 percent) implemented one curriculum; one-quarter of partners implemented two or more curricula. Family child care homes were significantly more likely than centers to use three or more curricula (25 versus 7 percent; Appendix C, Table C.VII.2).

Lessons learned from the case studies: Using new curricula

Some partnership grantees required their child care partners to use new curricula. The teachers in several of these programs felt that the new curriculum they were required to use as a result of their partnership helped them better meet children's needs. The curriculum helped teachers in a few programs target their lesson planning through individualization. For example, one teacher in a center-based child care setting highlighted the promises and challenges of implementing the new curriculum. Specifically, the teacher explained that the new curriculum was more age appropriate, but the accompanying assessment tools were not user friendly. Alternatively, a different teacher from another program believed the assessments were helpful when discussing the children's progress with parents in parent-teacher conferences.

Figure VII.2. Most child care partners used Creative Curriculum



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 5 to 20 child care partners. Results are weighted to account for sampling probability and nonresponse. By "named curriculum," we mean a curriculum other than an agency-created curriculum. The five most common other named curricula offered by all partners were Games to Play with Babies (12 percent), Games to Play with Toddlers (10 percent), Learning Activities for Infants (10 percent), Program for Infant-Toddler Care (9 percent), and High/Scope (8 percent).

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Lessons learned from the case studies: Challenges meeting the HSPPS

Almost all of the partnership programs found it difficult to meet the staff-child ratio requirements of the HSPPS. The lower staff-child ratios led to lower revenues (because they had to serve fewer children or hire additional staff), and low supply and high turnover made it difficult to ensure that child care center partners had enough qualified teachers. Child care partner center directors from one partnership program mentioned that ratios were a challenge in the beginning, but when the center worked out its staffing, ratios were no longer a challenge.

Health and safety standards were also some of the most challenging standards to meet for child care partners, for several reasons. For one, renovations to homes were sometimes required for family child care partners to meet standards, and the renovations could be very costly. Also, family child care partners in urban areas had trouble meeting the space and playground requirements. For example, the HSPPS specifies a separation between each child's sleeping mat for nap time, but some family child care partners operated in very small spaces, which made meeting that requirement very difficult.

Child care partner staff found it challenging to make time for the paperwork and documentation required for the partnership. Developing systems for child care partners to use for documentation could help ease the burden. Child care partner center teachers from several partnership programs found the paperwork and documentation required by their curriculum and its associated assessments overwhelming. Family child care partners in a few partnership programs were not comfortable with using a computer or writing, and this factor added to the challenges. Some family child care partners found it especially challenging to complete required paperwork in the midst of their other tasks to meet health requirements and look after children (brushing teeth, washing hands, and so on). Child care center and family child care partners from a few partnership programs also discussed challenges related to requirements for documenting children's well visits. They found it difficult to get families to the doctor for this purpose. Grantee staff in one partnership program worked to engrain systems into the partners' regular practices that helped them collect the data and documentation necessary to ensure they met the standards.

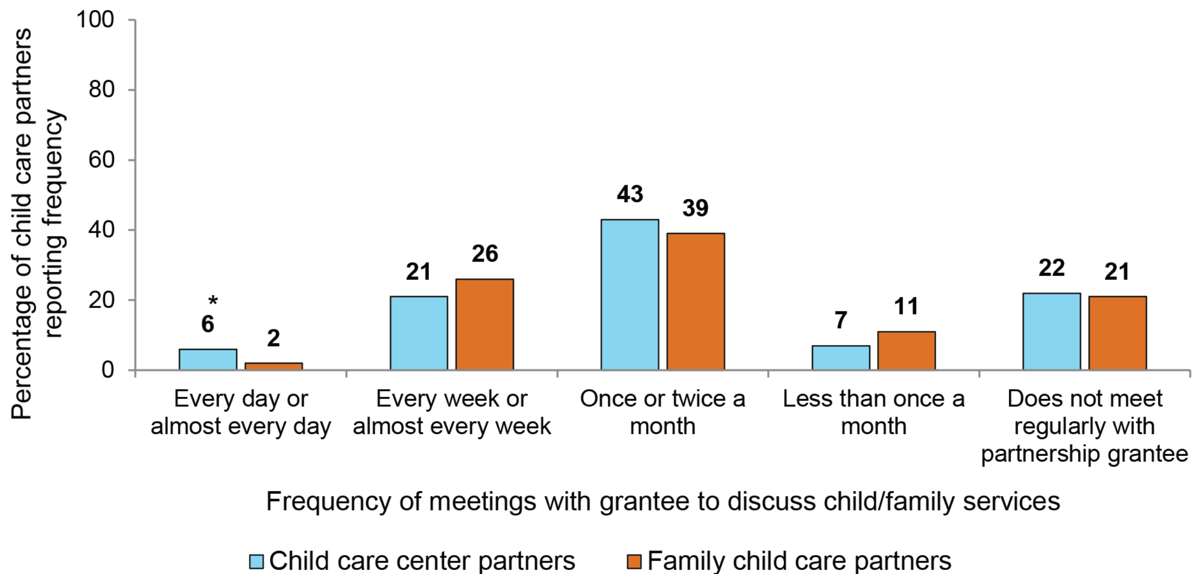
Despite the challenges, child care partners in some partnership programs found what they had to do to meet the HSPPS, such as implementing a new curriculum, useful. In a few partnership programs, the child care partners saw improvements in the quality of care they provided and the successes the children had. In one partnership program, the grantee staff attributed the successes to the child care partners' dedication to the children they serve and to providing quality care despite challenges.

2. Most child care partners met regularly with partnership grantees to discuss child and family services

Seventy-eight percent of child care partners met regularly with EHS-CC Partnership grantees to discuss services for individual children and families. Forty-one percent met once or twice a month and 27 percent met almost every week or more frequently (Figure VII.3; Appendix C, Table C.VII.4).

> Training and networking opportunities for center directors to solidify the relationships between center directors and grantee staff and with other center directors helped center directors provide support to their teachers. Grantee staff from one program said that training the center directors to better understand the roles and responsibilities of participating in the program was a useful way to indirectly support the teachers. The grantee director said there was a need to have ongoing meetings and trainings for center directors so that they could better support their teachers in adhering to the HSPPS. Center directors in a few programs also met regularly with one another. These meetings enabled the center directors to build good relationships with one another and to share best practices. Center directors in programs that did not offer trainings or networking opportunities for center directors wished they had those opportunities.
>
> *Source: Case study interviews, 2017.*

Figure VII.3. Most child care partners met regularly with partnership grantees to discuss services for individual children and families



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for 7 to 21 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

The most common meeting topics were child assessment results and communication with parents, with 86 percent of partners reporting meeting with grantees and discussing these topics with grantee staff. Other common meeting topics were child or family needs or barriers, coordination with other service providers or other child care arrangements, family service plans, transition plans, and classroom lesson plans. More than two-thirds of partners discussed each of these topics (Appendix C, Table C.VII.5).

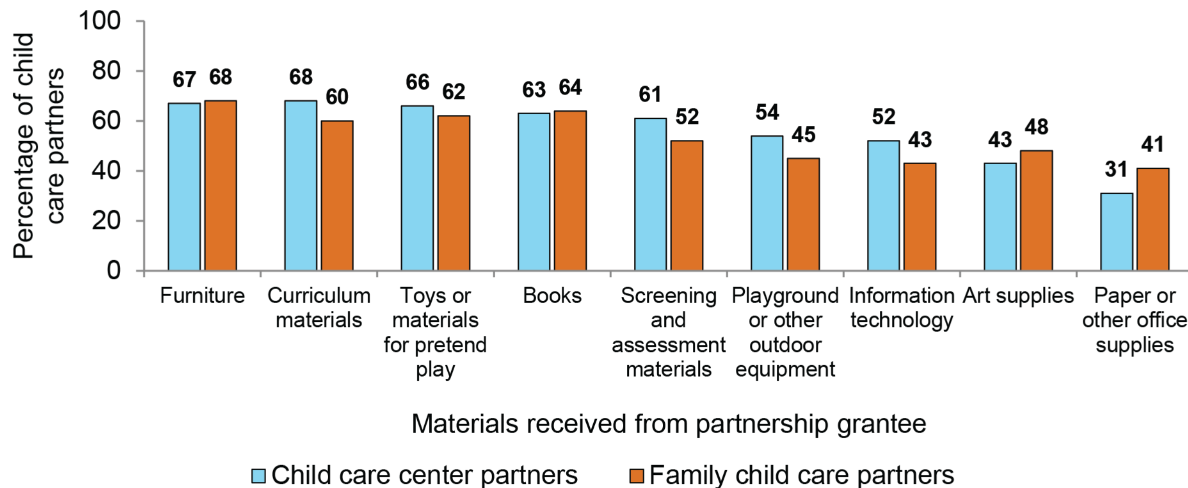
> It was sometimes difficult for child care partner staff to take a break from regular duties to receive one-on-one support (such as coaching and mentoring) from grantee staff. Family child care providers and child care center teachers were often unable to devote their attention to grantee staff during visits to receive feedback or other support because they were caring for children at the same time. They did not often have the opportunity to step out of the room and let someone else take over their duties. Despite the challenges, most child care partners appreciated the support they received from grantee staff and found it to be just the right amount. Most child care partners felt that they received help from the staff without being micromanaged, learned new ideas from grantee staff, and received individualized and practical one-on-one support that helped them meet the HSPPS.
>
> *Source: Case study interviews, 2017.*

3. Child care partners received a variety of materials and supplies directly from partnership grantees

Separate from funds received from EHS-CC Partnership grantees to purchase equipment and supplies, child care partners received such items directly from grantees. The most common materials partners received were furniture, such as cribs or bookshelves (67 percent of partners); curriculum materials (65 percent); toys or materials for pretend play (64 percent); and books

(63 percent). At least 50 percent of partners also received screening and assessment materials and playground or other outdoor equipment (Figure VII.4; Appendix C, Table C.VII.6).

Figure VII.4. Child care partners received a variety of materials from partnership grantees



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for two child care partners. Results are weighted to account for sampling probability and nonresponse.

There were no significant differences between child care center partners and family child care partners.

C. Supporting staff skills and credentials

The HSPPS require grantees, including EHS-CC Partnership grantees, to establish and implement a systematic approach to staff training and professional development (ACF 2018). The HSPPS also stipulate that center-based teachers must have a minimum of an infant–toddler CDA (or a comparable credential) and family child care providers must have or acquire a minimum credential within 18 months of beginning service (ACF 2018). In this section, we report findings from the Grantee and Delegate Agency Director Survey, the Child Care Partner Survey, and the case studies on the strategies they implemented to support staff skills and credentials.

> Many parents appreciated how EHS-CC Partnerships provided free supplies and other supports for families. Programs offered parents supplies, including diapers and wipes. Parents also discussed the role staff played in supporting families. For example, one parent described how staff helped her sign up to receive Christmas gifts for her children. Parents also valued the screenings and connections to services provided by grantee staff.
>
> Many parents valued healthy meals and snacks. A few parents wanted their children to have meals that excluded sugar and appreciated that their child care center provided fresh fruit and vegetables for children. Some parents noted that their child care providers began serving healthier food options to children after joining the partnership.
>
> *Source: Case study interviews, 2017.*

HSPPS: Training and professional development

Staff training and professional development. A program must establish and implement a systematic approach to staff training and professional development designed to assist staff in acquiring or increasing the knowledge and skills needed to provide high-quality, comprehensive services within the scope of their job responsibilities, and attached to academic credit as appropriate. At a minimum, the system must include:

- Staff completing a minimum of 15 clock hours of professional development per year.
- Training on methods to handle suspected or known child abuse and neglect cases, that comply with applicable federal, state, local, and tribal laws;
- Training for child and family services staff on best practices for implementing family engagement strategies in a systemic way, as described throughout this part;
- Training for child and family services staff, including staff that work on family services, health, and disabilities, that builds their knowledge, experience, and competencies to improve child and family outcomes; and,
- Research-based approaches to professional development for education staff, that are focused on effective curricula implementation, knowledge of the content in Head Start Early Learning Outcomes Framework: Ages Birth to Five, partnering with families, supporting children with disabilities and their families, providing effective and nurturing adult-child interactions, supporting dual language learners as appropriate, addressing challenging behaviors, preparing children and families for transitions, and use of data to individualize learning experiences to improve outcomes for all children.

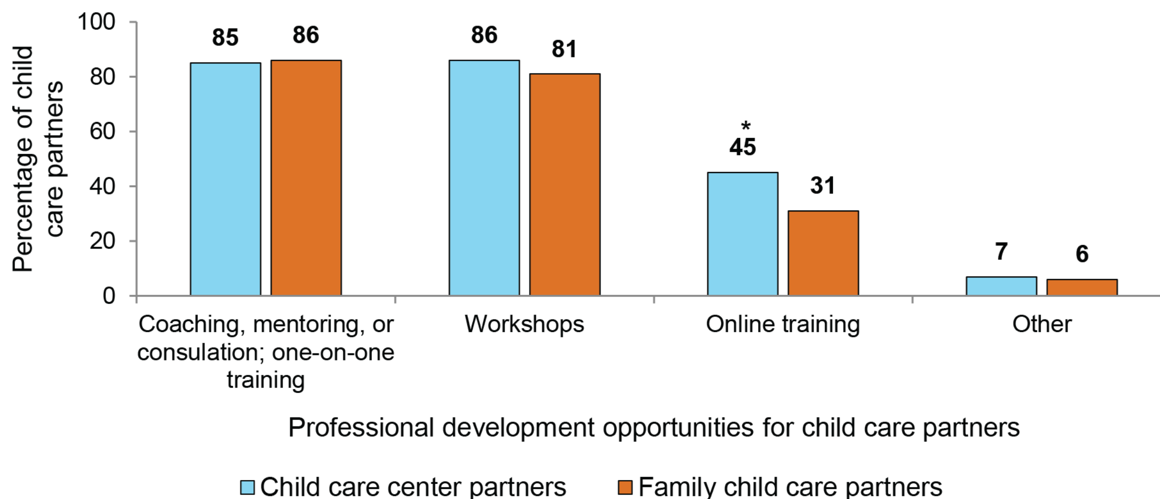
Coaching. A program must implement a research-based, coordinated coaching strategy for education staff that: (1) assesses all education staff to identify strengths, areas of needed support, and which staff would benefit most from intensive coaching; (2) at a minimum, provides opportunities for intensive coaching to those education staff identified it, including opportunities to be observed and receive feedback and modeling of effective teacher practices directly related to program performance goals; (3) at a minimum, provides opportunities for education staff not identified for intensive coaching to receive other forms of research-based professional development aligned with program performance goals; (4) ensures intensive coaching opportunities for the staff that align with the program's school readiness goals, curricula, and other approaches to professional development; utilize a coach with adequate training and experience in adult learning and in using assessment data to drive coaching strategies aligned with program performance goals; provide ongoing communication between the coach, program director, education director, and any other relevant staff; and, include clearly articulated goals informed by the program's goals, and a process for achieving those goals; and, (5) establishes policies that ensure assessment results are not used to solely determine punitive actions for staff identified as needing support, without providing time and resources for staff to improve.

−HSPPS Part 1302, Subpart I: Human resources management

1. Most child care partners were offered professional development opportunities from partnership grantees

Eighty-six percent of child care partners said that EHS-CC Partnership grantees offered them the opportunity to receive coaching or one-on-one training, and a similar percentage (84 percent) had the opportunity to participate in workshops. Thirty-nine percent of all partners were offered online training (45 percent of child care center partners and 31 percent of family child care partners; Figure VII.5; Appendix C, Table C.VII.7).

Figure VII.5. Most child care partners were offered coaching and workshops by the partnership grantee



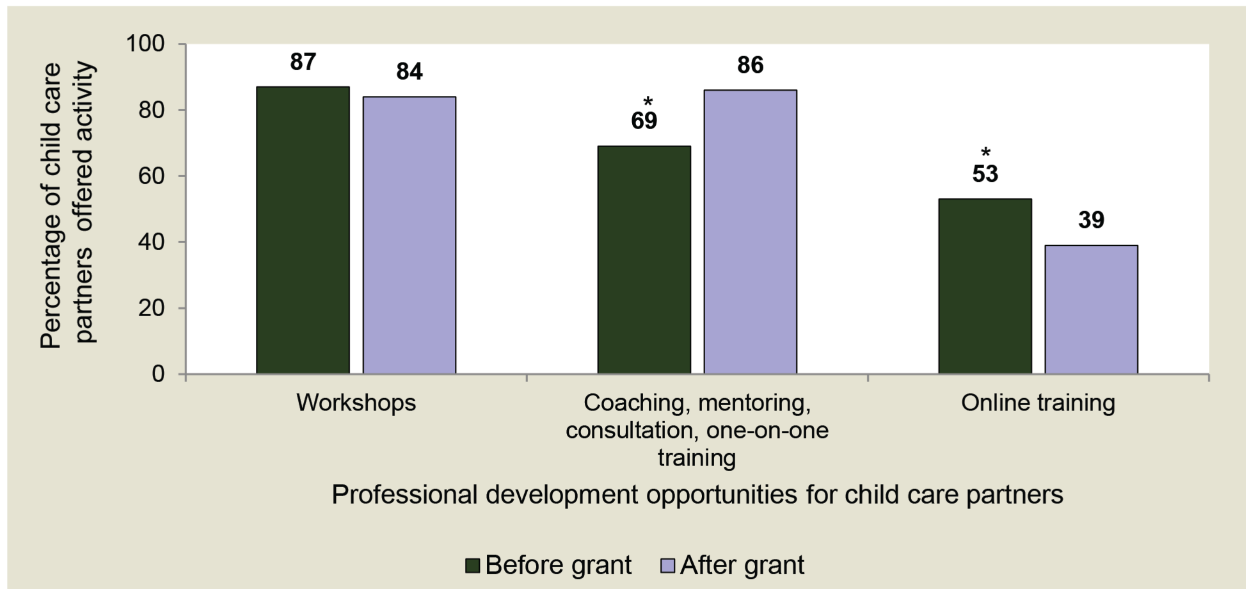
Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for four child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

After the partnership was in place, child care partners were about as likely to participate in workshops as they were before the partnership. However, they were more likely to receive coaching, mentoring, consultation, or one-on-one training than before the partnership (Figure VII.6; Appendix C, Table C.VII.8). (Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.)

Figure VII.6. Child care partners received more coaching and mentoring after the EHS-CC Partnership grant than before the grant



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for four or five child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly at the 0.05 level, two-tailed test.

2. Nearly all grantees offered quality monitoring activities to child care partners and used information from these activities to provide staff training

The EHS-CC Partnership Grantee and Delegate Agency Director Survey asked grantees about strategies used to monitor quality in child care partner settings. The most common quality improvement monitoring offered by grantees was classroom observations to assess practice (97 percent of grantees), followed by the use of checklists on HSPPS compliance (96 percent of grantees) and review of program files (95 percent of grantees). A large majority (90 percent) of grantees offered reviews of program data and lesson plans. More than 70 percent of grantees said that grantee staff, rather than child care partner or other staff, were primarily responsible for offering quality improvement activities (Table VII.2).

A large majority (90 percent or more) of grantees used information gathered during quality monitoring activities to provide staff training. A large proportion of grantees also used this information to schedule follow-up reviews or observations, develop written implementation plans, or obtain technical assistance (Table VII.3).

Table VII.2. Quality monitoring activities and staff primarily responsible

Type of activity	Percentage of grantees reporting activity[a]	Of grantees reporting activity, percentage reporting staff with primary responsibility		
		Grantee staff	Child care partner staff	Other
Classroom observations to assess practice	97%	79%	12%	9%
Use of checklists on HSPPS compliance	96%	89%	5%	6%
Review of program files	95%	89%	6%	6%
Review of program data	90%	88%	5%	7%
Review of lesson plans	90%	73%	19%	9%
Sample size	**220**			

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for zero to eight grantees. Results are weighted to account for nonresponse.

[a] Percentages do not sum to 100 because respondents selected all activities that applied.

HSPPS = Head Start Program Performance Standards.

Table VII.3. Use of information gathered during quality monitoring activities

Type of activity	Percentage of grantees reporting activity[a]	Of grantees reporting activity, percentage reporting method					
		Provide staff training	Schedule follow-up review or observation	Develop written improvement plan	Obtain technical assistance	Terminate partnership	Other
Classroom observations to assess practice	97%	99%	94%	83%	81%	21%	7%
Use of checklists on HSPPS compliance	96%	98%	96%	87%	84%	29%	4%
Review of program files	95%	90%	90%	81%	74%	22%	2%
Review of program data	90%	95%	90%	86%	81%	22%	3%
Review of lesson plans	90%	99%	88%	76%	78%	17%	3%
Sample size	**220**						

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information on quality improvement activities was missing for 8 to 15 grantees. Percentages are out of the number of grantees engaging in each type of activity. Percentages do not sum to 100 because this survey item asked respondents to select all methods that applied. Results are weighted to account for nonresponse.

[a] Percentages do not sum to 100 because respondents selected all activities that applied.

HSPPS = Head Start Program Performance Standards.

The Child Care Partner Survey asked child care partners about quality monitoring activities they engaged in with the grantee. Most child care partners engaged in quality monitoring activities with the grantee. Overall, 86 percent of partners met with grantee staff. However, a significantly higher percentage of child care center partners (91 percent) met with grantee staff, compared with family child care partners (80 percent). Eight-three percent of all child care partners received observations to assess practice, 76 percent received feedback on teaching practices, and 75 percent received guidance on developmentally appropriate emotional and behavioral support. Two-thirds or more received guidance on developmentally appropriate teaching practices, guidance on linking curricula to children's developmental needs, guidance on implementing curricula, and review of program data. These activities did not differ significantly between child care center and family child care partners (Appendix C, Table C.VII.9).

3. Through their involvement in the partnership program, child care partners had opportunities to obtain a CDA credential or other degrees

To understand how the partnership programs support staff in meeting the HSPPS on staff credentials, the Child Care Partner Survey also asked partners about opportunities to obtain further education. To assist child care partner staff in achieving a CDA (as required by the HSPPS), more than three-quarters of partners said that the grantee offered staff the opportunity to obtain this credential (81 percent of child care center partners and 72 percent of family child care partners). Thirty-seven percent of partners said that staff had the opportunity to obtain a state-awarded credential that met or exceeded CDA requirements, 26 percent said that staff had the opportunity to obtain an associate's degree, and 19 percent reported that staff had the opportunity to earn a bachelor's degree (Figure VII.7; Appendix C, Table C.VII.10).

HSPPS: Child and family services staff qualifications and competency requirements

EHS center-based teacher qualification requirements. A program must ensure center-based teachers that provide direct services to infants and toddlers in EHS centers have a minimum of a CDA credential or comparable credential and have been trained or have equivalent coursework in early childhood development with a focus on infant and toddler development.

Family child care provider qualification requirements. A program must ensure family child care providers have previous early child care experience and, at a minimum, are enrolled in a Family Child Care CDA program or state equivalent, or an associate or baccalaureate degree program in child development or early childhood education prior to beginning service provision, and for the credential acquire it within 18 months of beginning to provide services.

Center-based teachers, assistant teachers, and family child care provider competencies. A program must ensure center-based teachers, assistant teachers, and family child care providers demonstrate competency to provide effective and nurturing teacher-child interactions, plan and implement learning experiences that ensure effective curriculum implementation and use of assessment and promote children's progress across the standards described in the *Head Start Early Learning Outcomes Framework: Ages Birth to Five* and applicable state early learning and development standards, including for children with disabilities and dual language learners, as appropriate.

−HSPPS Part 1302, Subpart I: Human resources management

Lessons learned from the case studies: Barriers to meeting the training needs of child care partner staff and some strategies for overcoming those barriers

It was often difficult for child care partner staff to attend trainings provided by EHS-CC Partnership grantees, but grantees used several strategies to overcome this barrier:

- Many grantees provided trainings at night or on weekends, and some alternated training times to attempt to accommodate everyone's schedules.
- Some grantees found other ways to address barriers for partner staff to attend trainings outside of work hours, such as providing food, child care, or pay.
- Grantee staff in a few partnership programs said they provided training during planned shutdown weeks or days when the child care centers or family child care providers were closed, but this strategy was not feasible for all child care partners and could also inconvenience families.
- Grantees also viewed technology as a possible strategy for addressing the challenge of finding times to provide in-person trainings, but some identified drawbacks to this approach, such as teachers being uncomfortable with technology or preferring a more hands-on approach to training.

Some child care partners said they needed additional training on working with families, delivering curriculum, and managing challenging behaviors. Child care partner staff in a few partnership programs mentioned needing training on working with families, including topics such as overcoming obstacles to parental engagement, relationship building with families, and conducting home visits. Child care partners or grantee directors from several partnership programs said they needed more training on curriculum. Some teachers said they would like more training on behavior guidance.

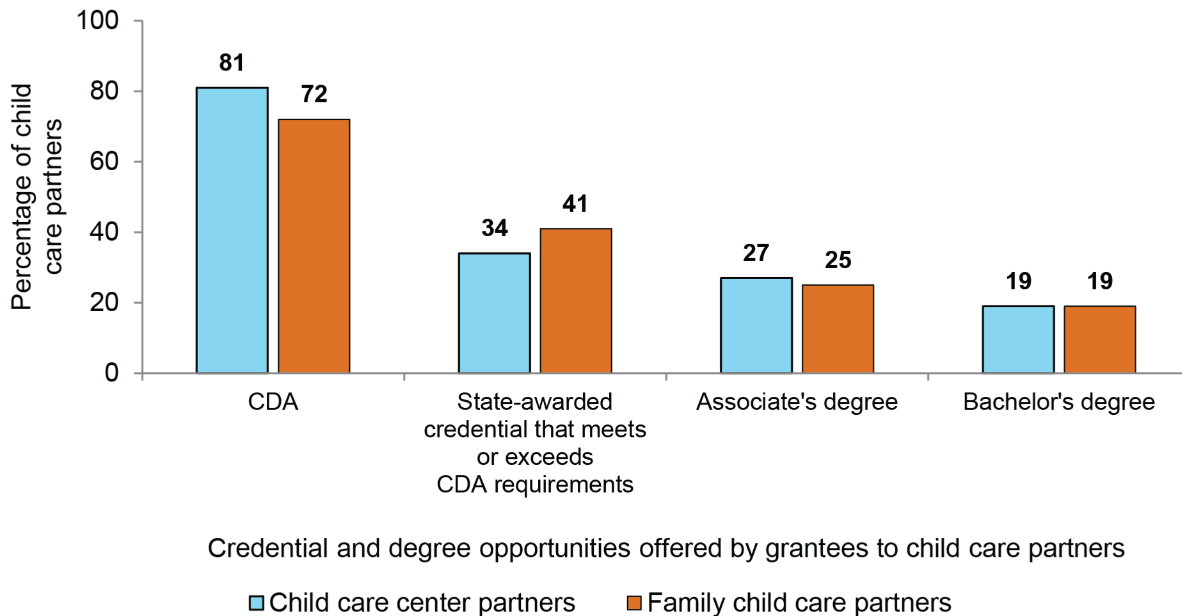
Partnership grantee staff discussed how connections with other agencies or organizations helped child care partner staff access training opportunities. For example, grantee staff said that child care partners in several programs could access trainings through their local CCR&R agencies. Grantees also took advantage of existing training events and conferences offered by other agencies, including the state department of education, local school districts, or the state's Head Start Collaboration office.

Several partnership programs dealt with a lack of existing training options and trainers or inadequate funding for training or conferences. This issue was mentioned most often by EHS-CC Partnership grantees in rural communities. Staff from a few grantees mentioned few local training options, or that there were not many high quality trainers available, because the programs were located in rural areas. A stakeholder of one partnership program mentioned that the local CCR&R that supports the program was located more than 1.5 hours away by car, so the grantee director often passed up training opportunities provided by the CCR&R because of distance. Inadequate funding for training also limited training options, according to staff from a few partnership programs.

Gaining access to training options and trainers in Spanish was a challenge for partnership programs that had Spanish-speaking child care partners, but one partnership program was able to hire bilingual trainers. Family child care partners from one partnership program said that trainings were offered only in English, and some of the providers did not understand English. This issue also affected hub staff who come to support the providers; hubs found it difficult to secure health consultants who spoke Spanish. One partnership program hired bilingual trainers or brought in a translator to address the language barrier. The partnership program also translated some procedure documents for the providers.

Child care partner staff wanted the opportunity for more interaction with staff from other child care center or family child care partners. Teachers and family child care providers said they would use networking opportunities, if offered, to discuss challenges and successes and share ideas. Scheduling trainings at times that work for multiple child care partners could facilitate the use of these networking opportunities. Teachers in one partnership program said they spent time with teachers from other child care partners during trainings, and they found it valuable; they liked to share different perspectives and ideas with one another.

Figure VII.7. Child care partners had opportunities to obtain credentials and degrees



Source: EHS-CC Partnership Child Care Partner Survey.

Note: *N* = 386. Information was missing for six child care partners. Results are weighted to account for sampling probability and nonresponse.

There were no significant differences between child care center partners and family child care partners.

CDA = child development associate.

Lessons learned from the case studies: Supporting child care partner staff to obtain CDA credentials

Obtaining CDA credentials was time consuming for child care partner staff, but technology and the availability of online courses eased the burden in some cases. It was difficult for teachers and family child care providers to complete the CDA coursework requirements while working full time. Center directors in one partnership program felt that the difficult and time-consuming nature of obtaining the CDA credential took away from the partnership quality because the CDA had priority over everything else. In a few partnership programs, child care partner staff were able to obtain their CDA credentials through online training. Teachers found it easier to do the work online than to go to in-person classes.

Investments in training and CDA credentials were lost when teachers left the child care partners and new staff had to be trained or take coursework. Partnership grantee staff mentioned that teacher turnover posed a challenge because training new teachers added to budget pressures. Child care center directors from a few partnership programs said that when teachers had their CDA credentials, they looked for other jobs. Grantee staff from one of these partnership programs attributed the turnover to being unable to raise salaries for staff after they obtained their CDA credentials. One child care center director offered bonuses for teachers when they completed their CDA credentials, but she was unable to provide more money per hour. One partnership program increased teacher salaries when the CDA was awarded.

One partnership grantee worked with a community college in the area that has an early childhood program to recruit qualified teaching staff. This EHS-CC Partnership grantee also reached out to other colleges and universities with credential programs to make sure those schools knew about the grantee organization and could send graduates its way.

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VIII. SUMMARY, LIMITATIONS, AND DIRECTIONS FOR FUTURE RESEARCH

This report provides detailed information about the EHS-CC Partnership grantees and child care partners and the activities they engaged in to develop and deliver services to children and families. In this chapter, we provide a study and key findings summary, discuss limitations of the study, and recommend directions for future research.

A. Study and key findings summary

In addition to providing comprehensive, nationally representative information about the first cohort of EHS-CC Partnership grantees, this is the first study of EHS-CC Partnerships to include a representative sample of the child care providers engaged in the partnerships. As such, it highlights their perspectives and details how partnerships were implemented in child care centers and family child care homes. To supplement the nationally representative data on EHS-CC Partnership grantees and child care partners, we conducted case studies of 10 partnership programs. We purposively selected grantees that differed along dimensions prioritized by ACF, including grantee agency auspice, percentage of grant funds transferred to child care partners, experience with Head Start or EHS, child care partner type and number of partners, partnership termination status, and urbanicity of the grantee agency. The findings from the case studies allowed us to further explore some of the findings from the surveys and capture information about successes and challenges faced by the partnership programs.

Key findings from the national descriptive study of EHS-CC Partnerships include the following:

- Most partnership grantees were nonprofit, community-based organizations with experience providing EHS or Head Start services. About 60 percent of grantees had partnerships with child care centers only, about 30 percent had partnerships with child care centers and family child care homes, and about 10 percent had partnerships with family child care homes only.
- About half of grantees and their child care partners had experience collaborating before the EHS-CC Partnership grant. The most frequently cited factor motivating child care partners to participate in the partnership program was improving the quality of infant and toddler care and education.
- Though grantees and child care partners engaged in many strategies to maintain partnerships, about a third of grantees had terminated at least one partnership by the time of the survey, which occurred approximately one year after grants were awarded. The most common reason for terminations was because of issues complying with the HSPPS.
- Grantees transferred slightly more than half of EHS-CC Partnership grant funds to child care partners. In addition to annual funding for slots, partners reported using these funds in several ways, including purchasing materials and supplies and providing staff training and professional development. Child care partners also leveraged funds from other sources, including child care subsidies and the Child and Adult Care Food Program (CACFP).
- Child care partners most often relied on word-of-mouth to recruit children and families. Most had a waiting list, and about half used an enrollment prioritization system.

- Consistent with EHS requirements, partnership programs offered a wide range of comprehensive services to children and families who received care through EHS-CC Partnership grant funds. Many child care partners (about 70 percent) also offered at least one service (such as screenings, referral, or assessment) to children and families whose care was not supported by the EHS-CC Partnership grant (that is, children in nonpartnership slots).
- Partnership programs engaged in a variety of activities for improving the quality of care and ensuring child care partners were meeting the HSPPS.
  - Three-quarters of child care center partners and more than two-thirds of family child care partners reported receiving guidance from the grantee on implementing the HSPPS.
  - About 70 percent of child care partners reported receiving a variety of materials and supplies directly from grantees. Materials included cribs or bookshelves; curriculum materials; toys; books; screening and assessment materials; outdoor equipment; information technology; and art supplies.
  - Nearly all grantees offered quality monitoring activities to child care partners and used information from these activities to provide staff training.
  - About 85 percent of child care partners reported that grantees provided professional development opportunities to staff, including coaching or one-on-one training, and a similar percentage reported that grantees provided workshops.
  - More than three-quarters of partners reported that the grantee offered child care partner staff the opportunity to obtain a Child Development Associate (CDA) credential.

B. Limitations of the study

An additional goal of the national descriptive study was to identify models of partnerships. Although grantees had to work within the framework of the HSPPS and guidance from ACF specific to the EHS-CC Partnerships, they had substantial leeway in how they structured their partnership programs. For example, they could choose whether to work with child care centers, family child care providers, or both. They also determined how to structure the delivery of comprehensive services, including parent engagement strategies. Similarly, grantees determined how they would deliver quality improvement activities, including how and when they delivered training and professional development to child care partner staff. Most assigned these duties to grantee staff, but as we discuss in Chapter III, some grantees worked with third-party organizations (referred to as hubs). Grantees also configured funding arrangements with the child care partners and determined how much funding they would allocate per enrollment slot. The structure of some partnership programs may have been driven by the context in which they operated. For example, contextual factors such as the types of child care providers in the community or the policies and regulations that facilitated or hindered access to child care subsidies for families could have informed the structure of the partnership program. Other characteristics of the grantees included the type of organization that received the grant and whether they had experience delivering EHS or Head Start.

To understand how characteristics of the grantees might have driven the ways they structured their programs, we explored ways to group partnership programs across multiple dimensions captured in the survey data. These methods included contextual factors and partnership program characteristics (for example, location, funding amount, grantee EHS or

Head Start experience, and partner type) and process features of the partnership (such as partnership agreement components, processes to support quality improvement, services offered to children and families, and measures of mutual respect and collaboration). However, correlations among these characteristics and features were low, and exploratory cluster analyses to define partnership models using the survey data yielded inconclusive results. Different analyses yielded different groupings, and no clear patterns emerged to distinguish groups from each other. Our conclusion from these analyses was that the implementation approach was heavily confounded by contextual factors (such as the type and characteristics of providers available to the grantee to partner with and the state CCDF child care subsidy policies). As a result, we could not identify a set of "models" and did not present these analyses in this report.

This finding likely reflects both the diversity of the ways partnership programs were structured as well as some limitations in the survey data. For example, the surveys were not designed to capture EHS-CC Partnership grantees that worked with third-party organizations (or hubs) to support the implementation of the EHS-CC Partnership grant. Through the case studies, we learned that some grantees engaged hubs to provide child care partners with technical assistance and provide comprehensive services to families enrolled in partnership slots. For example, the hub may employ family service workers and health, disability, and nutrition consultants as well as support and monitor certain administrative procedures, including ensuring that there is appropriate documentation of compliance with HSPPS.

C. Directions for future research

This report summarizes findings from the national descriptive study of EHS-CC Partnerships and provides the first national picture of these partnerships. In particular, the study fills an important gap in our knowledge base around the experiences of child care providers engaged in these partnerships. Nonetheless, the report points to several topics worth further exploration. These topics include the following:

- **Structure and features of the partnership programs that support quality improvement and access to high quality infant and toddler care.** Future studies are needed to more thoroughly catalog the range of partnership structures or models that may facilitate access to high quality infant and toddler care. Gathering more detailed information about the various funding streams partnership programs use to provide early care and education services could be useful in this regard. In addition, future studies of the EHS-CC Partnerships should be designed to capture the role of hubs,[39] including the roles and responsibilities allocated to these organizations; the funding structures used to fund hubs; and the communication processes established to facilitate the coordination of services among grantees, child care partners, and hubs.
- **Structure and features of professional development offerings for child development staff and how those offerings support improvements in caregiving practices.** Further research is needed to better understand the strategies partnerships implement to ensure that teachers and family child care providers meet professional development goals, including

[39] A hub is a third-party organization that grantees work with to support the implementation of the EHS-CC Partnership grant.

minimum education requirements (in the case of EHS-CC Partnerships, a CDA credential). A study could examine how partners combine federal, state, and local funds to deliver coaching to teachers and providers and to help them complete coursework. It could also explore the coaching models used to support teachers and providers, as well as new ways of working with institutions of higher education (including community colleges) to build the pool of qualified teachers and family child care providers. Such a study could also explore how partners address turnover and strategies they use to retain qualified teachers and providers. In addition, this future research could examine how these professional development offerings may support improvements in caregiving practices, such as curricular implementation, teacher or provider support for infant and toddler development, and the quality of teacher- and provider-child relationships.

- **Structure and approaches to the delivery of comprehensive services to meet the needs of families and support family well-being.** In light of the findings about the delivery of comprehensive services to children and families, including those in partnership and nonpartnership slots, more research is needed about whether these were new or existing offerings among child care partners. Further research could also examine how partnership programs leveraged resources to extend comprehensive services to families in nonpartnership slots and the extent to which the services meet families' needs and support their well-being.
- **Funding approaches for partnership programs, including the sources of funding and the allocation of funds across partners, and use of funds to support access and quality.** More detailed information is needed about the funding arrangements between early care and education partners. We identified large ranges in the amount of funding allocated per partnership slot. Detailed expenditure data could help identify the content of these per-slot allocations. These data could also provide information about the implications of participating in partnerships for child care partner revenue. Moreover, future research could explore how and why grantees and child care partners make funding decisions and specify funding arrangements (such as whether materials will be purchased by the grantee or partner) to support access and quality.
- **Short- and long-term outcomes that the partnership programs achieve.** Future descriptive research is needed to assess whether partnerships in early care and education can meet short- and long-term outcomes identified in the theory of change. In addition, future studies could examine the impact of partnerships on the quality and availability of infant–toddler care and child and family well-being. Future research could also focus on how partnerships meet families' (including those in partnership and nonpartnership slots) needs, such as by providing economic and parent educational supports.
- **State-level policies and procedures that help facilitate early care and education partnerships.** Additional research is needed that explores state-level policies and procedures that support the implementation of early care and education partnerships. Future studies could document how states adjust their policies to accommodate the implementation of partnerships (for example, by aligning standards).

REFERENCES

Aarons, Gregory A., Mark G. Ehrhart, and Lauren R. Farahnak. "The Implementation Leadership Scale (ILS): Development of a Brief Measure of Unit Level Implementation Leadership." *Implementation Science,* vol. 9, no. 45, 2014.

Administration for Children and Families. "Head Start Program Performance Standards." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, 2018.

Administration for Children and Families. "Policy and Program Guidance for the Early Head Start-Child Care Partnerships." Administration for Children and Families-Information Memorandum-Head Start-15-03. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, 2015.

Boller, Kimberly, Patricia Del Grosso, Randall Blair, Yumiko Jolly, Ken Fortson, Diane Paulsell, Eric Lundquist, Kristin Hallgren, and Martha Kovac. "The Seeds to Success Modified Field Test: Findings from the Impact and Implementation Studies." Princeton, NJ: Mathematica Policy Research, June 28, 2010.

Chaudry, Ajay, Juan M. Pedroza, Heather Sandstrom, Anna Danziger, Michel Grosz, Molly Scott, and Sarah Ting. "Study of Child Care Choices for Low-Income Working Families." Washington, DC: Urban Institute, January 2011.

Child Trends. "Head Start: Indicators of Child and Youth Well-being." Bethesda, MD: Child Trends, March 2015. Available at: https://www.childtrends.org/wp-content/uploads/2015/03/97_Head_Start.pdf. Accessed December 20, 2018.

Damschroder, Laura J., David C. Aron, Rosalind E. Keith, Susan R. Kirsh, Jeffrey A. Alexander, and Julie C. Lowery. "Fostering Implementation of Health Services Research Findings into Practice: A Consolidated Framework for Advancing Implementation Science." *Implementation Science,* vol. 4, no. 50, 2009.

Del Grosso, Patricia, Lauren Akers, Andrea Mraz Esposito, and Diane Paulsell. "Early Care and Education Partnerships: A Review of the Literature." OPRE Report 2014-64. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation, 2014.

Del Grosso, Patricia, Nikki Aikens, Diane Paulsell, Kimberly Boller, Todd Honeycutt, and Subuhi Asheer. "Building a Community-Wide Early Learning System: East Yakima at Baseline." Submitted to the Bill & Melinda Gates Foundation. Princeton, NJ: Mathematica Policy Research, May 5, 2008.

Duncan, Greg J., and Aaron J. Sojourner. "Can Intensive Early Childhood Intervention Programs Eliminate Income-Based Cognitive and Achievement Gaps?" *Journal of Human Resources,* vol. 48, no. 4, 2013, pp. 945–968.

Food and Nutrition Service. "Child and Adult Care Food Program (CACFP)". Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service, March 2017. Available at https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program. Accessed July 12, 2017.

Hicks, Susan A., Kristi Lekies, and Mon Cochran. *Promising Practices: New York State Universal Prekindergarten: Expanded Edition*. Ithaca, NY: Cornell University, Department of Human Development, Cornell Early Childhood Program, 1999.

Johnson-Staub, Christine. "Putting it Together: A Guide to Financing Comprehensive Services in Child Care and Early Education." Washington, DC: Center for Law and Social Policy, 2012.

Mayoral, Maria V. "Early Head Start Fact Sheet." Washington, DC: Zero to Three, 2013.

National Survey of Early Care and Education Project Team. "Characteristics of Home-Based Early Care and Education Providers: Initial Findings from the National Survey of Early Care and Education." OPRE Report #2016-13. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2016.

National Survey of Early Care and Education Project Team. "Fact Sheet: Characteristics of Center-Based Early Care and Education Programs." OPRE Report No. 2014-73b. Washington DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2014.

National Survey of Early Care and Education Project Team. "Fact Sheet: Provision of Early Care and Education During Non-Standard Hours." OPRE Report No. 2015-44. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2015a.

National Survey of Early Care and Education Project Team. "Measuring Predictors of Quality in Early Care and Education Settings in the National Survey of Early Care and Education." OPRE Report #2015-93. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2015b.

National Survey of Early Care and Education Project Team. "Number and Characteristics of Early Care and Education (ECE) Teachers and Caregivers: Initial Findings from the National Survey of Early Care and Education (NSECE)." OPRE Report #2013-38. Washington DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2013.

Office of Child Care. "Child Care Development Fund Final Rule Frequently Asked Questions." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, December 2016. Available at https://www.acf.hhs.gov/occ/resource/ccdf-final-rule-faq. Accessed July 12, 2017.

Office of Child Care. "OCC Fact Sheet." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, June 2018. Available at https://www.acf.hhs.gov/occ/fact-sheet-occ. Accessed September 18, 2018.

Office of Early Childhood Development, Administration for Children and Families. "Early Head Start-Child Care Partnerships." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, February 2017. Available at https://www.acf.hhs.gov/ecd/early-learning/ehs-cc-partnerships. Accessed June 12, 2017.

Office of Early Childhood Development, Administration for Children and Families. "Early Head Start-Child Care Partnerships: Growing the Supply of Early Learning Opportunities for More Infants and Toddlers. Year One Report. January 2015–January 2016." Washington, DC: Office of Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services, 2016.

Office of Head Start. "Early Head Start Services Snapshot (2015-2016)." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Available at https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/service-snapshot-EHS-2015-2016.pdf. Accessed December 20, 2018.

Office of Head Start. "Early Head Start Expansion and Early Head Start-Child Care Partnership Grants." Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, June 2016. Available at https://ami.grantsolutions.gov/files/HHS-2016-ACF-OHS-HP-1181_2.htm. Accessed June 6, 2017.

Ontai, L.L., S. Hinrichs, M. Beard, and B.L. Wilcox. "Improving Child Care Quality in Early Head Start Programs: A Partnership Model." *Infant Mental Health Journal,* vol. 23, no. 1, 2002, pp. 48–61.

Paulsell, Diane, Julie Cohen, Ail Stieglitz, Erica Lurie-Hurvitz, Emily Fenichel, and Ellen Kisker. *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families*. Princeton, NJ: Mathematica Policy Research, 2002.

Paulsell, Diane, Kimberly Boller, Patricia Del Grosso, Nikki Aikens, Todd Honeycutt, and Subuhi Asheer. "Building a Community-Wide Early Learning System: White Center at Baseline." Submitted to the Bill & Melinda Gates Foundation. Princeton, NJ: Mathematica Policy Research, May 5, 2008.

Paulsell, Diane, Patricia Del Grosso, Sarah Bernstein, and Eileen Bandel. "Approaches to Measuring Early Head Start-Child Care Partnerships: Recommendations and Considerations." OPRE Report 2015-62. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research & Evaluation, September 2015.

Ruhm, Christopher, and Jane Waldfogel. "Long-Term Effects of Early Childhood Care and Education." *Nordic Economic Policy Review,* vol. 1, no. 1, 2012, pp. 23–51.

Sandfort, Jodi R., and Sally C. Selden. “Blurring the Boundaries: Local Collaborations Among Head Start, Preschool, and Child Care Programs.” *Policy & Practice of Public Human Services*, vol. 59, no. 1, 2001, pp. 18–23.

Schilder, Diane, Meghan Broadstone, Benjamin W. Chauncey, Ellen Kiron, Candy Miller, and Youngok Lim. “Child Care Quality Study: The Impact of Head Start Partnership on Child Care Quality Final Report.” Newton, MA: Education Development Center, 2009.

Schilder, Diane, Benjamin W. Chauncey, Meghan Broadstone, Candy Miller, Ashley Smith, Sheila Skiffington, and Kimberly Elliott. “Child Care/Head Start Partnership Study: Final Report.” Newton, MA: Education Development Center, 2005.

Selden, S.C., J.E. Sowa, and J. Sandfort. “The Impact of Nonprofit Collaboration in Early Child Care and Education on Management and Program Outcomes.” *Public Administration Review,* vol. 66, no. 3, 2006, 412–425.

Sowa, J. E. “Implementing Interagency Collaborations: Exploring Variation in Collaborative Ventures in Human Service Organizations.” *Administration & Society*, vol. 49, no. 3, 2008, 298– 323.

Vogel, Cheri, Nikki Aikens, Andrew Burwick, Laura Hawkinson, Angela Richardson, Linda Mendenko, and Rachel Chazan-Cohen. “Findings from the Survey of Early Head Start Programs: Communities, Programs, and Families.” Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, 2006.

Vogel, Cheri A., Kimberly Boller, Yange Xue, Randall Blair, Nikki Aikens, Andrew Burwick, Yevgeny Shrago, Barbara Lepidus Carlton, Lara Kalb, Linda Mendenko, Judy Cannon, Sean Harrington, and Jillian Stein. “Learning As We Go: A First Snapshot of Early Head Start Programs, Staff, Families, and Children.” OPRE Report #2011-7. Washington, DC. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2011.

APPENDIX A

THEORY OF CHANGE FOR THE STUDY OF EHS-CC PARTNERSHIPS

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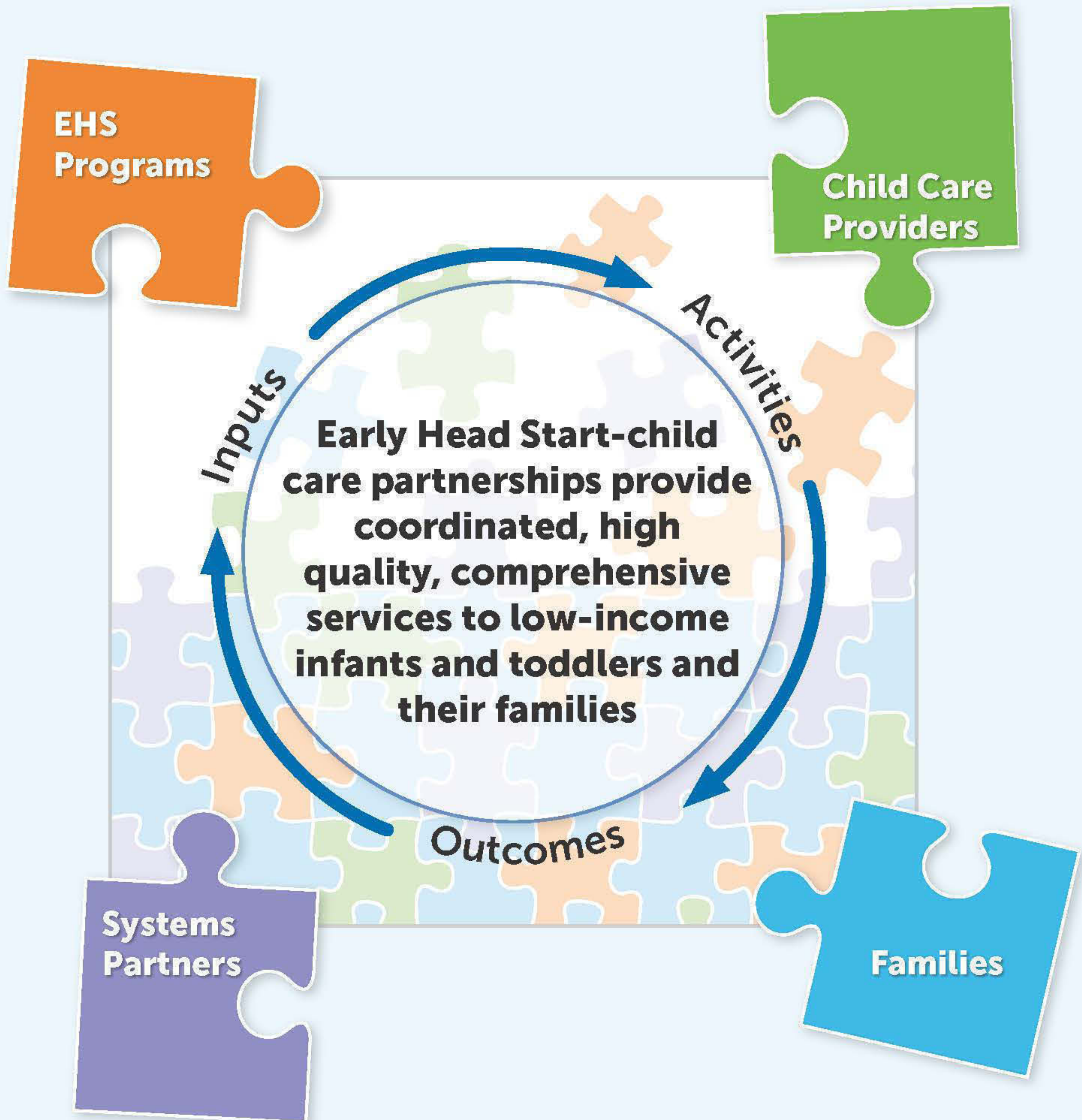
Theory of Change for the **Study of EHS-Child Care Partnerships**

Presented at the Technical Work Group Meeting for the Study of EHS-Child Care Partnerships on May 6, 2014



INPUTS

EHS Programs

- EHS grantee type and prior service delivery experience
- Program size
- Motivation to partner and readiness to change
- Attitudes toward and experience with collaboration
- Knowledge and linkages to community child care providers
- Qualified staff to provide QI support to child care providers

Child Care Providers

- Provider type (family child care or center), size, and regulatory status
- Hours of operation
- Age range of children served; ability to care for sibling groups
- Provider experience and staff credentials
- Motivation to partner and readiness to change
- Attitudes toward and experience with collaboration
- Openness to complying with the HSPPS
- Participation in QRIS or other QI initiatives

Families

- Socioeconomic and demographic characteristics
- Child care needs and preferences (family configuration, work schedules, transportation, culture, language)
- Motivation to participate in partnership programs
- Eligibility for EHS and CCDF subsidies

Systems Partners
(National, State, Local)

- Policies, regulations, and standards (HSPPS, child care licensing, QRIS, other state initiatives)
- Funding (EHS grant funds, CCDF subsidies, other sources)
- QI supports (Head Start and OCC T/TA, QRIS, CCDF quality set aside, accreditation, other initiatives)
- Professional development (community colleges and other institutions of higher education)

ACTIVITIES

Partnership Programs: Partnership Development

- EHS programs actively recruit partners and child care providers express interest in partnering

Partners jointly:

- Discuss and clarify partnership expectations
- Develop partnership agreements (contract, MOU), including funding arrangements

Partnership Programs: Partnership Operation

Partners jointly:

- Assess strengths and needs of each partner
- Develop QI plans to achieve HSPPS compliance
- Seek other QI opportunities
- Monitor implementation of QI plans and HSPPS compliance
- Facilitate networking among infant-toddler service providers
- Assess partnership quality
- Regular communication to ensure continuity of care and smooth transitions for children
- Recruit and enroll families
- Implement family partnership agreements; provide families with comprehensive services and referrals
- Provide flexible, high-quality child care that meets families' needs
- Facilitate continuity of care and transitions between settings
- Provide direct QI support and supplemental materials
- Provide training and support to staff working in the partnership

Families

- Enroll in EHS and child care subsidy program
- Communicate child care needs and preferences and select child care arrangements
- Develop and implement family partnership agreements
- Maintain communication with partnership programs for continuity of care and smooth transitions for children

Systems Partners
(National, State, Local)

- Identify rule misalignment challenges and consider rule accommodations to support partnerships
- Coordinate with partners to provide QI and professional development

CCDF=Child Care & Development Fund
EHS=Early Head Start
HSPPS=Head Start Program Performance Standards
MOU=Memorandum of Understanding
OCC=Office of Child Care
QI=Quality Improvement
QRIS=Quality Rating & Improvement System
T/TA=Training & Technical Assistance

OUTCOMES

Partnership Programs

Families

Systems Partners
(National, State, Local)

Short-Term Outcomes (within two years)

Partnership Programs

- Enhanced capacity to offer high quality service options that meet families' needs
- Organizational leadership that values and supports EHS-child care partnerships
- Staff attitudes that value each partner's contribution to the partnership
- Improved staff competencies to develop mutually respectful and collaborative partnerships, provide effective QI support, and provide developmentally appropriate infant-toddler care
- Improved quality of infant-toddler care and compliance with HSPPS
- Reduced isolation; increased membership in professional networks of infant-toddler service providers
- Increased professionalism and staff credentials
- Increased financial stability for partners

Families

- Stable access to high quality care and comprehensive services that meet families' needs
- Continuity of caregiving across settings where children receive care
- Parents more likely to be employed or in school
- Parents more involved in children's early learning

Systems Partners

- Rule accommodations are implemented as needed to align requirements and stabilize funding
- QI and professional development supports are aligned to address needs of the partnerships

Long-Term Outcomes (two years or longer)

- **Sustained, mutually respectful, and collaborative EHS-child care partnerships in place**
- **Increased community supply of high-quality infant-toddler care**
- **Improved family well-being**
- **Improved child well-being and school readiness**
- **Well-aligned infant-toddler policies, regulations, and QI supports at the national, state, and local levels**

Organizational Factors (partnership programs)

- Years of operation and staff stability
- Organizational culture and leadership promoting the partnerships
- Shared goals, relationship quality, and mutual respect between partners
- Systems to support continuous QI

Contextual Factors

- Local: Type and supply of infant-toddler child care for low-income families
- State: Supports for QI (QRIS, CCDF quality dollars, etc.); policy environment
- National: Initiatives such as Head Start Designation Renewal System, President's Early Learning Initiative, Race to the Top-Early Learning Challenge

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APPENDIX B

DATA COLLECTION AND ANALYSIS METHODS

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We used three primary sources of data to conduct analyses for this report.

1. **Grantee and Delegate Agency Director Survey.** We sent this web-based survey to all 250 EHS-CC Partnership grantee directors and 55 delegate agency directors. The survey asked about their experiences implementing the partnership grants and asked them to identify all their child care partners. This survey was fielded from January to July 2016.
2. **Child Care Partner Survey.** We sent this web-based survey to a subset of the child care partners identified in the Grantee and Delegate Agency Directors Survey. We randomly sampled approximately one-fifth of child care partners to participate in this survey, sampling both child care center and family child care partners. We sent the survey to 470 child care partners (including 302 child care center partners and 168 family child care partners). This survey was fielded from February to November 2016.
3. **Case studies of partnership programs.** Mathematica conducted case studies of 10 partnership programs. Based on data from the Grantee and Delegate Agency Director Survey, we purposively selected partnership programs that differed along dimensions prioritized by the Administration for Children and Families, including grantee agency auspice, percentage of grant funds transferred to child care partners, previous experience with Head Start or EHS, child care partner type and number of partners, partnership termination status, and urbanicity of the grantee agency. The case studies included in-person and telephone interviews with partnership grantee directors and key staff, child care partner staff, parents, and state and local stakeholders (such as child care administrators and CCR&R agency staff).

For the survey data, we used descriptive statistics such as frequencies, medians, means, and ranges to describe the partnership grantees, child care partners, and partnership programs. For the case study data, we used standard qualitative procedures to analyze and summarize information from semistructured interviews and focus groups. In the remainder of this appendix, we describe the two main surveys and the specific methods we used to conduct the main analyses of the survey data. We then describe the case study data and our analysis approach.

A. Grantee and Delegate Agency Director Survey

We fielded a web-based survey of directors of partnership grantees and delegate agencies from January through July 2016. We invited all 250 organizations that received an EHS-CC Partnership grant in 2015 to participate in the survey.[40] We also invited 55 delegate agencies to complete the survey. ACF provided the study team with contact information for all grantees and all known delegate agencies. In the survey, we asked grantees with identified delegate agencies to confirm our list and provide any updates. All other grantees were asked to confirm whether they worked with delegate agencies and, if so, to provide contact information for them. Of the 55 eligible delegate agency directors we asked to complete the survey, 42 were identified by ACF in advance and 13 were identified by grantees as they completed their surveys.

[40] In 2015, ACF awarded 275 EHS-CC Partnership and EHS Expansion grants. This report focuses on the 250 grantees that received EHS-CC Partnership grants. We did not survey grantees that received only EHS Expansion grants.

The Grantee and Delegate Agency Director Survey collected data on seven main topic areas: (1) basic information about the agency, (2) partnership development, (3) quality improvement activities, (4) services for children and families, (5) information about the child care partners, (6) partnership funding arrangements, and (7) background and experience. To the extent possible, we drew on questions used in previous studies when developing the survey. Table B.1 includes information about the studies and instruments from which we pulled or adapted survey questions.

Table B.1. Overview of existing study instruments from which items were drawn or adapted

Study	Instruments	Respondents	Samples
Early Head Start Family and Child Experiences Survey (Baby FACES; Vogel et al. 2011)	Parent Interview 2009 and 2010; Program Director Interview 2009 and 2011; Program Director Self-Administered Questionnaire 2009	Early Head Start parents; Early Head Start program directors	National sample of 89 Early Head Start programs
Evaluation of the Early Learning Initiative, Baseline Implementation Study (Del Grosso et al. 2008; Paulsell et al. 2008)	Survey of Early Learning Initiative Community Service Providers	Community service providers	26 community service providers in White Center and 31 in East Yakima, Washington
Evaluation of the Early Learning Initiative, Seeds to Success Modified Field Test (Boller et al. 2010)	Self-administered questionnaires for center directors and lead and assistant teachers	Child care center directors and lead and assistant teachers	52 family child care providers and 14 child care centers in White Center and East Yakima, Washington
Head Start/Child Care Partnership Study (Schilder et al. 2009)	Child Care Partner Questionnaire; Family Child Care Partner Questionnaire; Head Start Partnership Questionnaire	Head Start program staff, child care center directors, family child care providers, classrooms, children	Random sample of 63 child care centers and 135 family child care homes in Ohio
National Survey of Early Care and Education (National Survey of Early Care and Education Project Team 2013)	Center-based provider questionnaire; home-based provider questionnaire; household questionnaire	Households with children under 13, home-based providers, center-based providers, center-based provider workforce employees	Nationally representative samples of (1) 11,629 households with children under 13; (2) 3,934 home-based providers, plus 2,052 unlisted home-based providers; (3) 8,265 center-based providers; and (4) 5,556 center-based provider workforce employees
Study of Child Care Choices for Low-Income Working Families (Chaudry et al. 2011)	Family Study Interview One Protocol; Family Study Interview Two Protocol	Families drawn from the sample of families surveyed for the Annie E. Casey Foundation's Making Connections initiative	86 families (43 in Providence, Rhode Island, and 43 in Seattle-White Center, Washington)

Table B.1. ***(continued)***

Study	Instruments	Respondents	Samples
Study of Community Strategies for Infant-Toddler Care (Paulsell et al. 2002)	Child care resource and referral agency director interview guide; state child care administrator interview guide; local child care administrator interview guide; child care coordinators interview guide	Child care resource and referral agency directors; state and local child care administrators; child care coordinators	Early childhood education agency administrators and staff at the state and local levels from four communities: El Paso County, Colorado; Kansas City, Kansas; Sedalia, Missouri; and Buncombe County, North Carolina
Survey of Early Head Start Programs (Vogel et al. 2006)	Survey of Early Head Start programs	Early Head Start program directors	748 Early Head Start programs nationwide

A total of 220 of 250 EHS-CC Partnership grantees completed the survey, for a response rate of 88 percent. An additional 40 delegate agencies of the 55 we contacted completed the survey, for a response rate of 73 percent. For respondents to be included in the analysis, we required that they completed and submitted the survey. Respondents could have chosen not to answer particular questions, but they must have clicked through and submitted the entire survey. Partial respondents, who answered some questions but did not officially submit the survey, were left out of the analysis because none provided a list of child care partners, which was an important goal of the survey.

The survey asked grantee and delegate agency directors to provide the names and contact information for all of their child care partners as well as key characteristics such as the type of care setting (child care center or family child care home) and the number of enrollment slots funded by the partnership program. Respondents who completed the survey provided the contact information for 1,786 child care partners; some of these, however, were duplicates—for example, listed by both a grantee and a delegate agency or listed twice by the same grantee. We removed the 37 duplicates, yielding 1,749 partners: 988 child care center partners and 761 family child care partners.

We then randomly selected child care partners from this list to participate in the Child Care Partner Survey. Random selection was dynamic in the web-based survey, and grantees could be asked a series of questions about the set of randomly selected partners. We selected an explicitly stratified random sample of partners by dividing the partners listed by the partnership grantee and delegate agency director into two groups: child care centers and family child care providers. Within each group, the web-based survey automatically selected a random sample of at least 20 percent of the partners, with a minimum of one. For example, if a grantee listed 1 to 5 child care center partners, 1 was randomly selected; if the grantee listed 6 to 10 child care center partners, 2 were randomly selected, and so on. The same process applied to family child care homes. We sampled partners of each type separately because we expected that the partnerships' approaches to implementation and, in particular, supporting quality improvement and delivering comprehensive services differed between partnerships with child care centers and those with family child care providers. We randomly selected 470 partners to participate in the Child Care Partner Survey.

Note that the final total sample of randomly selected partners (470) is substantially higher than one-fifth of the total number of partners (1,749). This discrepancy is due to the random sampling procedure, specifically because we required that a minimum of one child care partner of either type be selected regardless of how many partners a grantee had. For example, suppose a grantee had one child care center and one family child care partner. We would have randomly selected both of these partners—that is, 100 percent of the grantee's partners—to participate in the Child Care Partner Survey.

We used descriptive statistics such as frequencies, means, and ranges to describe the grantee and delegate agencies and partnership programs, accounting for weights (described below) to ensure statistics are representative of the entire grant program. We tested for statistically significant differences to support any explicit comparisons we made in the report. All statistical tests were two-sided *t*-tests estimated using a regression coefficient to compare means. When performing statistical tests, we used listwise deletion for missing responses—apart from the logical imputation discussed elsewhere in the methods appendix, we did not impute child care partner or grantee responses.

B. Child Care Partner Survey

From February through November 2016, we fielded a web-based survey of 470 directors and managers of child care centers and family child care homes that had been randomly selected from the grantee survey. We contacted 302 child care centers and 168 family child care homes.

The Child Care Partner Survey consisted of seven main sections: (1) basic information about the child care business, (2) partnership development activities, (3) partnership funding arrangements, (4) quality improvement activities, (5) services for children and families, (6) partnership quality, and (7) background and experience. Some questions between the grantee and partner survey were the same, allowing for a direct comparison of their answers. Additionally, in the Child Care Partner Survey, some questions asked about a practice both before the partnership and at the time of the survey. This allowed us to compare how the practice had changed since the beginning of the partnership. However, because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant. As with the Grantee and Delegate Agency Director Survey, we used or adapted questions from previous studies to the extent possible (see Table B.1).

For respondents to be included in the analysis, we required that they either completed and submitted the survey or responded to the survey through the section on quality improvement activities.[41] A total of 386 of 470 child care partners completed the survey, for a response rate of 82 percent. Of the 386 child care partners that completed the survey, 374 completed and submitted the survey, and another 12 were included in the analysis for having met the partial completion criteria discussed above. The completion rate for child care center partners was 84 percent (255 of 302) and for family child care partners was 78 percent (131 of 168).

We used descriptive statistics such as frequencies, means, and ranges to describe the child care partners, using weights to ensure that results are representative of all child care partners in the EHS-CC Partnership grant program. We tested for statistically significant differences to support explicit comparisons made in the report. All statistical tests were two-sided *t*-tests estimated using a regression coefficient to compare means. When performing statistical tests, we used listwise deletion for missing responses—apart from the logical imputation discussed elsewhere in the methods appendix, we did not impute child care partner or grantee responses.

C. Adapting the Implementation Leadership Scale

To assess the degree to which leadership, defined as the grantee director for this study, supported effective implementation of the EHS-CC Partnerships, we adapted the Implementation Leadership Scale (Aarons et al. 2014). In the Child Care Partner Survey, child care partner directors or managers indicated their agreement with a series of statements about the leadership provided by the grantee director. The Grantee and Delegate Agency Director Survey asked grantee directors to reflect on their own leadership by indicating their agreement with the same set of statements. The statements focused on the extent to which leadership was proactive, knowledgeable, supportive, and perseverant. Respondents ranked their agreement with each statement on a 5-point scale ranging from not at all (1) to a very great extent (5).

[41] More specifically, respondents who did not submit the survey must have completed the question asking whether the child care center or family child care home had an overall quality rating. Though this is not technically the last question in the section, the remaining questions may not have been applicable for some respondents; thus, having a missing value does not imply the respondents necessarily skipped the question. We chose this section of the survey as the cutoff for child care partner survey respondents to be included in the analysis because partners that responded to the survey through this section tended to have low rates of missingness on the preceding sections, whereas partners that dropped out of the survey before this section had higher rates of missingness on previous sections. For example, we are missing responses to the last question in the preceding survey section from only 8 percent of partial respondents we are counting as complete, but we are missing responses to this question for 77 percent of the partial respondents we are counting as incomplete.

Implementation Leadership Scale domains and items

Domain	Items
Proactive	• Developed a plan to help implement the partnerships • Removed obstacles to implementing the partnerships • Established clear standards for implementing the partnerships
Knowledgeable	• Knowledgeable about the partnerships • Able to answer staffs' questions about the partnerships • Knows what he or she is talking about when it comes to the partnerships
Supportive	• Recognizes and appreciates child care partner staff efforts toward successful implementation of the partnerships • Supports child care partner staff efforts to learn more about the partnerships • Supports child care partner staff efforts to deliver services through the partnerships
Perseverant	• Perseveres through the ups and downs of implementing the partnerships • Carries on through the challenges of implementing the partnerships • Reacts to critical issues regarding implementation of the partnerships

D. Weights for survey responses

We developed a series of weights to make survey responses representative of the entire EHS-CC Partnership grant program. We developed weights at the grant level, the program level, and the partner level.

At the grant level, these weights accounted for nonresponse—as noted above, 30 of the 250 partnership grantees did not complete the survey and were therefore not included in the analysis. We used information available about the grants from the Head Start Program Information Report and basic information about funded enrollment and location to identify grantees that were comparable to those that did not complete the survey. Within grantee type (if a grantee had child care center partners only or had one or more family child care partners) and census region, we weighted up responding grantees to account for nonresponding grantees. We used the grant-level weights in all analyses of grantee responses, with the exception of any questions grantees answered about their complete set of child care partners or their randomly selected partners. This analysis aimed to be representative of all grants and therefore did not include responses from the delegate agency directors.

At the program level, where programs were defined as either grantees or their delegate agencies, we further accounted for delegate-level nonresponse. For grantees without any delegate agencies, the program weight was set equal to the final grantee-level weight. However, for grantees with delegate agencies, we adjusted the final grantee weight to account for the nonresponse of delegate agencies within each grantee. We used the program-level weights in analyzing the set of questions that grantees and delegate agencies answered about their complete set of partners. This analysis was therefore intended to be representative of all partners that participated in the EHS-CC Partnership grant program. These program-level weights were an important building block to produce the partner-level weights.

At the partner level, we first generated weights to account for child care partners' probability of selection. In most instances, the probability of selection could be calculated precisely based on the random selection methodology described above. There were several instances that we needed to account for separately; this occurred when some partners were listed multiple times and therefore had multiple chances of selection. This applied to some instances in which a grantee and its delegate agency both listed the same partner and to some instances in which a grantee listed its own partner more than once. As mentioned previously, 37 partners were listed as duplicates and were excluded from all analyses. By multiplying the program weight by the inverse of the partner selection probability, we computed a partner sampling weight that we used to analyze grantee and delegate agency responses about their randomly selected partners. Such analyses are representative of all partners in the EHS-CC Partnership grant program.

To analyze responses to the partner survey, we used a partner-level weight that adjusted the partner sampling weight for nonresponse at the partner level. We used information the grantees provided about each of their partners to develop this weight. The procedure mirrored that of generating nonresponse weights for grantees. Within partner type (child care center versus family child care home) and census region, we weighted up responding partners to account for the nonresponding partners. Analyses using these partner-level weights are therefore representative of all partners in the EHS-CC Partnership grant program and account for nonresponse at the grantee, delegate agency, and partner levels, and for the probability of a particular partner being selected to participate in the survey. All analyses of data from the Child Care Partner Survey used these final partner-level weights.

E. Imputing and cleaning survey data

In several instances, we imputed responses to the Grantee and Delegate Agency Director Survey. Specifically, in a few instances, based on our understanding of a particular partnership program gleaned from grantee responses, delegate agency responses, and information from ACF and the Head Start Program Information Report, we corrected one or all of the following: the number of child care center or family child care partners reported by a grantee, the number of child care center or family child care slots reported by a grantee, or whether a grantee had terminated a partnership. Additionally, to exclude potential outliers, we trimmed continuous partnership funding variables. That is, in analyses involving these variables, we excluded observations that were above the 95th percentile or below the 5th percentile of responses. Any calculated variables that use the funding amounts, such as the percentage of total annual funding transferred to child care partners, exclude these outliers. We also removed outliers for the number of slots in child care centers (values greater than 1,000) and the number of slots in family child care homes (values greater than 300) for children birth to age 3 before the partnership. Finally, we truncated the percentage of total annual funding transferred to child care partners at a maximum of 100 percent, so we revised any responses indicating a value of greater than 100 percent to be exactly 100 percent.

For the data from the Child Care Partner Survey, we implemented four main types of imputations. The first main revision was to infer responses that should have been marked as zero but were not, either because there was no option for responding zero on a given question or because a partner did not check any of the relevant zero boxes. As an example, we asked respondents to select the services they offered to children before the partnership award from a

list of 14 services. No separate box was available to select if a partner did not offer any of these services, so in this case the respondent would not select any of the boxes and continue the survey. However, this response is indistinguishable from a scenario in which someone intentionally skipped the question without trying to answer it. We therefore used neighboring questions to infer whether the partner meant that it did not offer any of the services or meant to skip the question. Using the same example, if a partner did not answer the question about services before the partnership but did answer either of the related questions about provision of services to children or to families currently in partnership or nonpartnership slots or to families before the partnership, then we inferred that the partner meant to indicate that it did not offer any services to children before the partnership.[42] Similarly, when offered a checklist of yes/no responses, many partners checked *yes* boxes but not *no* boxes (for example, in a question asking about the reasons child development staff left the program). In those cases, if someone answered some of the choices but left others blank, we inferred that the missing value was intended to be a *no* response and updated the data accordingly.[43]

The second main revision for the partner survey data was to trim variables for outliers and inconsistencies. To exclude any potential outliers above the 95th percentile or below the 5th percentile of responses, we trimmed continuous partnership funding and salary variables using the method described for funding variables above. Any calculated variables that use these trimmed variables, such as average start-up funds per slot, exclude these outliers. We also removed outliers on the questions about enrollment capacity. All questions about enrollment capacity were set to missing in the following scenarios: if a child care center reported licensed enrollment capacity greater than 1,000 children, a family child care home reported licensed enrollment capacity greater than 25 children, or any type of partner reported zero enrollment capacity across all ages or for children birth to age 3. We updated responses regarding afternoon closing times when respondents entered the time in a 12-hour format rather than a 24-hour format.

The third type of revision for the partner survey data was to truncate some calculated variables that yielded potentially inconsistent results. We truncated the percentage of total licensed enrollment slots and of actual enrollment slots for children birth to age 3 that are EHS-CC Partnership slots at a maximum of 100 percent, so that any responses indicating a value of

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[42] This situation applies to many variables. In the instances described above, if a respondent answered any of the questions about provision of services to children or to families either before the partnership, to children or to families in partnership slots, or to children or to families in nonpartnership slots, and any of the others were missing, then we inferred that the intent behind the missing values was that the respondent does not offer any of the services. We took the same approach for professional development opportunities (filling in missing values to zero for particular opportunities either before or since the partnership grant if one of those is not missing), the current provision of Individualized Family Partnership Agreements (filling in missing values to zero if the respondent indicated offering any Individualized Family Partnership Agreement before the partnership), quality monitoring activities received by the partner (filling in missing values to zero if the respondent answered either the preceding or following survey question), provisions of equipment and supplies (filling in missing values to zero if the respondent answered either the preceding or following question), and components of the agreement with the grantee (filling in missing values to zero if the respondent answered how the partnership was developed).

[43] We recoded two other variables in a similar fashion. We filled missing values to zero in the number of child care center and the number of family child care home staff with varying degree levels and when some but not all of the other degree fields are nonmissing.

greater than 100 percent were revised to be exactly 100 percent. The same holds true for the percentage of children in EHS-CC Partnership slots receiving a subsidy either currently or before the partnership, the percentage of staff who care for children in EHS-CC Partnership slots, and the percentage of center staff that left the program since the start of the partnership. We also ensured that the percentage of staff with various types of degrees could not exceed 100 percent, dividing by the total number of staff reported across all degree types rather than the total number of staff a child care partner reported overall.

The fourth main revision was to backcode many detailed “other” responses into category groups that were not included in the survey. For example, common reasons cited why child development staff left the program included that staff moved, staff did not show up, staff went back to school, or that staff did not want to get a child development associate credential. We added separate variables for these types of responses to quantify the percentage of partners that had staff leave for this reason. Other backcoded variables included the following: additional ways that partners learned about the EHS-CC Partnership grant opportunity, additional types of collaboration experience with the partnership grantee before the partnership, additional uses of start-up funds, additional reasons that funding from the grantee varied from month to month, additional sources of funding to offset the cost of care for children in partnership slots, additional agencies or groups that provided a quality rating, additional infant/toddler curricula implemented currently and before the partnership grant, and additional fields in which the respondent obtained his or her highest degree.

F. Exploratory analysis to identify partnership models

To understand how characteristics of the grantees might have driven the ways they structured their programs, we explored ways to group partnership programs across multiple dimensions captured in the survey data. These included contextual factors and partnership program characteristics (for example, location, funding amount, prior grantee EHS or Head Start experience, and partner type) and process features of the partnership (such as partnership agreement components, processes to support quality improvement, services offered to children and families, and measures of mutual respect and collaboration). However, correlations among these characteristics and features were low, and exploratory cluster analyses to define partnership models using the survey data yielded inconclusive results. Different analyses yielded different groupings, and no clear patterns emerged to distinguish groups from each other. As such, rather than relying on survey data alone to define partnership models, we integrated survey and case study data throughout this report to describe the characteristics and activities of partnership programs.

Our conclusion from these analyses was that the implementation approach was heavily confounded by contextual factors (such as the type and characteristics of providers available to the grantee to partner with and the state CCDF child care subsidy policies). As a result, we could not identify a set of “models.”

G. Case study data and analysis methods

Mathematica conducted case studies of 10 partnership grantees from February to April 2017. In this section, we describe the process for selecting grantees, the case study activities, and our analysis methods.

1. Methods for selecting case study sites

Based on data from the Grantee and Delegate Agency Director Survey, we identified grantees for in-depth case studies. We purposively selected grantees that differed along dimensions prioritized by ACF. Table B.2 lists these criteria in order of priority (high to low).

Table B.2. Criteria for case study site selection, in order of priority (high to low)

Criterion	Categories
Grantee auspice	Community-based organization Community action agency or partnership University Child care resource and referral agency Child care network
Transfer of funds to child care partners	High percentage of funds transferred (80 percent or more) Low percentage of funds transferred (less than 20 percent)
EHS or Head Start experience	Grantees that did/did not receive EHS or Head Start funding
Child care partner type	Child care center partners only Family child care partners only Both center and family child care partners
Partnership size	Number of enrollment slots Number of child care partners
Partnership termination status	Grantees that have and have not terminated partnerships with child care center or family child care providers
Urbanicity	Grantees located in counties with an urban population no larger than 19,999

We identified pairs of grantees (20 total) so that we had a backup site in case we were unable to schedule a visit with a particular site. We began with the highest-priority dimension, grantee auspice. For the less common auspices (universities, CCR&R agencies, and child care networks), we identified pairs of sites that exhibited patterns of characteristics shared by grantees within each auspice.[44] For example, university grantees tended to have moderate fund transfer rates, have EHS and/or Head Start experience, and have child care center partners only; CCR&R agencies tended to have no EHS or Head Start experience and have child care center partners only; and child care networks tended to have family child care partners. For the more common auspices (CBOs and CAAs/CAPs), we identified pairs of sites that shared other prioritized characteristics. For example, CBO grantees exhibited both high and low fund transfer rates to child care partners, so we identified a pair of CBOs with high fund transfer rates and a pair with low fund transfer rates. In addition, CAAs/CAPs had the largest proportion of rural grantees (16 percent compared to 11 percent for universities, 3 percent for CBOs, and 0 percent for CCR&R agencies and child care networks), so we identified two rural and two nonrural CAAs/CAPs.

[44] We identified a pair of CCR&R agencies and a pair of child care networks because the focus of each type of organization is different. Child care networks focus primarily on supporting providers, whereas CCR&R agencies provide referral services to parents (though they may also support providers).

The eight pairs of sites we identified based on grantee auspice also exhibited variation along the dimensions of fund transfer rates, EHS and Head Start experience, child care partner type, partnership program size, and urbanicity. Within these eight pairs, however, only one identified grantee had family child care partners only. To ensure we would visit at least one site with family child care partners only, we identified two grantees with family child care partners only as the ninth pair of sites. Finally, as the tenth and last pair of sites, we identified grantees in ACF regions VII and X to ensure we had adequate representation of ACF regions.

Ultimately, we conducted outreach to 12 grantees to recruit 10. Table B.3 lists the characteristics of the 10 grantees that participated in the case studies.

Table B.3. Characteristics of the case study sites

Grantee	Auspice	Reason for identification
1	State grantee	Recommended state grantee
2*	University	Typified university grantee
3	CCR&R agency	Typified CCR&R agency grantee
4	Child care network	Child care network grantee with family child care partners
5*	CBO	CBO with low fund transfer rates
6	CBO	CBO with high fund transfer rates
7	CAA/CAP	Rural CAA/CAP
8	CAA/CAP	Nonrural CAA/CAP in ACF region 3
9	CBO	FCC-only grantee that is not a CCR&R agency or child care network
10	Other (community college)	Community college in ACF region 10

* Indicates the grantee was a backup.

CCR&R = child care resource and referral; CBO = community-based organization; CAA = community action agency; CAP = community action partnership; FCC = family child care; ACF = Administration for Children and Families.

2. Case study activities and respondents

During in-person visits, we conducted four types of activities. These included (1) individual semistructured interviews with partnership grantee directors and partnership grantee key staff; (2) focus group interviews with child care partner staff, including child care center directors, child care center teachers, and family child care providers (as applicable); (3) focus group interviews with parents of children enrolled in partnership slots; and (4) telephone interviews with state and local stakeholders identified by the grantees. Table B.4 lists the type and number of respondents who participated in the case studies.

In-person visits lasted one-and-a-half to three days and were conducted by two trained Mathematica site visitors. A researcher led each visit, and a second site visitor took notes and provided logistical support. In four sites, we conducted focus groups with parents and family child care providers in English and Spanish.

Table B.4. Respondents interviewed for case studies

Respondent type	Total number of respondents (if applicable, range of respondents per site)
Partnership grantee directors	15
Partnership grantee key staff	28
Stakeholders	29
CCR&R agency staff	7
Head Start collaboration office directors/staff	7
CCDF administrators/staff	6
Child care licensing staff	2
QRIS staff	3
Other staff	4
Child care center directors	26 (1–5)
Child care center teachers	53 (4–11)
Family child care providers	37 (2–17)
Parents	66 (2–11)
Total	**254**

Source: Case study interviews, 2017.

Note: *N* = 10 case study sites.

CCR&R = child care resource and referral; CCDF = Child Care Development Fund; QRIS = Quality Rating and Improvement System.

3. Methods for case study analysis

Site visitors used a standard template to write up the notes from semistructured interviews and focus groups. We then used standard qualitative procedures to analyze and summarize information from case study semistructured interviews and focus groups. Analysis involved organizing, coding, triangulating, and identifying themes. To code the qualitative data for key subtopics and themes, the evaluation team developed a coding scheme based on the research questions. We also used the constructs included in the Consolidated Framework for Implementation Research (CFIR) to systematically code facilitators and barriers to successful implementation (Damschroder et al. 2009). The framework identifies a set of 39 constructs in five domains that, according to implementation research, are factors most likely to influence the implementation of interventions.[45] For this study, we used a subset of 15 CFIR constructs,

[45] To develop the CFIR, Damschroder et al. (2009) reviewed many published implementation theories and reports of empirical studies to identify factors associated with effective implementation. They considered a spectrum of construct terminology and definitions and from those compiled an overarching framework. For this study, we used these constructs as a framework but modified them to meet the specific context of EHS-CC Partnerships. Specifically, we used 15 of the 39 constructs to code the data collected from the case study interviews and focus groups.

adapted to the specific context of EHS-CC Partnerships, to code the data from the case study interviews and focus groups. We drew these constructs from three CFIR domains:[46]

- **Contextual factors**, including factors related to state and local policies and regulations to which grantees and their partners had to adhere, the communities in which the grantees and child care partners operated, and the extent to which grantees and their partners were connected with other organizations in their communities and states
- **Grantee and child care partner factors**, including factors related to characteristics of the grantees and child care partners; the structure of the partnership programs (such has how training was delivered and funding was allocated); the management approach of the grantees; the nature and quality of formal and informal communications among grantees, child care partners, and other organizations involved in the programs; and grantees' and child care partners' motivation for change
- **Implementation process factors**, including involving appropriate individuals in the partnerships and reflecting on and evaluating program activities

A team of three trained staff coded the interview and focus group data in a software program for analyzing qualitative data. The coders met regularly with the task leader to discuss questions and ensure they were applying codes consistently. Using coded data, we compared responses and identified themes across respondents within and across partnership programs.

[46] The CFIR framework has five domains: (1) intervention characteristics, (2) outer setting (which we called contextual factors), (3) inner setting (which we called grantee and child care partner factors), (4) implementation process, and (5) characteristics of individuals. In this appendix, we discuss three of these factors only. Because our data collection activities were conducted at the program or organization level, we did not collect data on factors related to individuals involved in the partnerships. We did not identify factors related to intervention characteristics.

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APPENDIX C

SUPPLEMENTAL TABLES

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Table C.II.1. Number and type of child care partners recruited by grantees

		Number of child care center partners			Number of family child care partners		
Grantee with type of child care partner	Percentage of grantees	1–5	6–10	11 or more	1–10	11–20	21 or more
Partners at the time of the survey							
Child care center partners only	59%	45%	11%	3%	n.a.	n.a.	n.a.
Family child care partners only	7%	n.a.	n.a.	n.a.	3%	2%	2%
Both center and family child care partners	32%	20%	7%	5%	25%	4%	2%
No partners (at the time of the survey)	2%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total (all grantees)	98%[a]	65%	18%	8%	28%	7%	4%
Partners grantees plan to recruit[b]							
Total (all grantees)	23%[a]	15%	2%	2%	11%	2%	2%
Sample size	**220**						

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for one to three grantees. Results are weighted to account for nonresponse.

[a] Numbers in subsequent columns do not sum to the number in this column because grantees have (or plan on recruiting) partners of both types.

[b] The first column of results in this panel provides the number and percentage of grantees that plan to recruit additional partners. The subsequent columns in this panel provide the number and percentage of grantees planning to recruit the number of child care partners in the specified ranges.

n.a. = not applicable.

Table C.II.2. Enrollment slots offered by partnership grantees

		For grantees with each type of enrollment slot	
Type of partnership slot	Percentage of grantees that offer slots	Median number (range) of enrollment slots per grantee	Median number (range) of enrollment slots available before the partnership grant[a]
Any partnership slots	96%[b]	80 (2–1,100)	0 (0–559)
Child care center partnership slots	89%	72 (2–1,050)	0 (0–509)
Family child care partnership slots	39%	28 (2–240)	0 (0–300)
Child care center partnership slots only	58%	80 (2–750)	0 (0–432)
Family child care partnership slots only	7%	72 (17–176)	0 (0–200)
Both child care center and family child care partnership slots	32%	88 (16–1,100)	8 (0–559)
Sample size	**220**		

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for zero to nine grantees. Results are weighted to account for nonresponse.

[a] We trimmed these variables to remove outliers. We removed one observation in which the number of center slots was 5,000, and we removed two observations in which the number of family child care slots exceeded 700 (see Appendix B). Because these findings are based on answers to retrospective questions administered about one year after receiving the grant and because we cannot know what would have happened had the child care partner not participated in the EHS-CC Partnership program, we cannot attribute any changes to the EHS-CC Partnership grant.

[b] The percentage of grantees with any partner (Table C.II.1) and with any partnership enrollment slots (reported in this table) differ slightly because of different amounts of missing information on the relevant survey items. This number is less than 100 percent because at the time of the survey, not all grantees had finished recruiting partners and not all partners had enrolled children in partnership slots.

Table C.II.3. Location of grantee or delegate agency, by Administration for Children and Families region

ACF region	Percentage of grantees
Region I	5%
Region II	9%
Region III	10%
Region IV	17%
Region V	13%
Region VI	13%
Region VII	5%
Region VIII	6%
Region IX	15%
Region X	3%
Region XI	4%
Region XII	2%
Sample size	**220**

Source: The Administration for Children and Families provided the location of all grantees.

ACF = Administration for Children and Families.

Table C.II.4. Location of grantee or delegate agency, by urbanicity

Urbanicity category	Percentage of grantees
Metro area of 1 million people or more	53%
Metro area of 250,000 to 1 million people	23%
Metro area of fewer than 250,000 people	10%
Urban population of 20,000 or more, adjacent to a metro area	6%
Urban population of 20,000 or more, not adjacent to a metro area	0%
Urban population of 2,500 to 19,999, adjacent to a metro area	5%
Urban population of 2,500 to 19,999, not adjacent to a metro area	2%
Completely rural or urban population less than 2,500, adjacent to a metro area	1%
Completely rural or urban population less than 2,500, not adjacent to a metro area	1%
Sample size	**220**

Source: 2013 Rural-Urban Continuum Codes by County, United States Department of Agriculture Economic Research Service; EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Table C.II.5. Experience providing Early Head Start and Head Start services

Type of experience	Percentage of grantees, unless otherwise noted
Received funds to provide Early Head Start services in addition to the partnership program	74%
Of those providing Early Head Start services	
Median years of experience providing Early Head Start services	15.0 (1–21)
Median number of funded enrollment slots	144.0 (20–1,065)
Those providing Early Head Start services reported experience providing the following service options	
Center-based option	90%
Home-based option	75%
Family child care option	11%
Combination option	20%
Locally designed option	4%
Received funds to provide Head Start services[a]	74%
Of those providing Head Start services	
Median years of experience providing Head Start services	44.0 (1–52)
Median number of funded enrollment slots	570.0 (20–15,000)
Received Early Head Start and Head Start funds	61%
Received Early Head Start funds only	13%
Received Head Start funds only	13%
Received neither Early Head Start nor Head Start funds	13%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 2 to 8 grantees. Results are weighted to account for nonresponse.

[a] The survey distinguished between receiving funds to provide Early Head Start and to provide Head Start services.

Table C.II.6. Years of experience as an Early Head Start or Head Start grantee

Type of experience	Percentage of grantees
Years of experience as an Early Head Start grantee	
0	26%
1–5	11%
6–10	16%
11–15	14%
16 or more	34%
Years of experience as a Head Start grantee	
0	27%
1–5	4%
6–10	3%
11–15	4%
16 or more	61%
No experience as an Early Head Start or Head Start grantee	13%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for five to eight grantees. Results are weighted to account for nonresponse.

Table C.II.7. Child care partner enrollment capacity

	Amount (range) or percentage		
	All partners	Child care center partners	Family child care partners
Median licensed enrollment capacity across all ages	33.0 (4–534)	80.0 (8–534)	12.0 (4–24)
Median licensed enrollment capacity for children birth to age 3	16.0 (2–224)	38.0 (8–224)	6.0 (2–16)
Median enrollment across all ages in the past month	27.0 (0–534)	59.0 (0–534)	10.0 (0–20)
Median enrollment for children birth through age 3 in the past month	13.0 (0–200)	28.0 (0–200)	4.0 (0–12)
Median number of EHS-CC Partnership slots	8.0 (0–160)	16.0 (0–160)	4.0 (0–12)
Median percentage of total licensed enrollment slots for children birth to age 3 that are EHS-CC Partnership slots[a]	50% (0%–100%)	42% (0%–100%)	75% (0%–100%)
Median percentage of actual enrollment slots for children birth to age 3 that are EHS-CC Partnership slots[a]	67% (0%–100%)	54% (0%–100%)	100% (0%–100%)
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 0 to 9 child care partners and was trimmed to remove outliers for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. This analysis excludes centers with enrollment capacity greater than 1,000 and family child care partners with enrollment capacity greater than 25 (see Appendix B). The percentage of total licensed enrollment slots and actual enrollment slots for children birth to age 3 that are EHS-CC Partnership slots is capped at 100 percent.

[a] To obtain this percentage, we first calculated the percentage for each partner separately. We then took the median of the percentages across all relevant partners.

Table C.II.8. Change in enrollment capacity, child care partner report

	Amount (range) or percentage		
	All partners	Child care center partners	Family child care partners
Median licensed enrollment capacity for children birth to age 3, current	16.0 (2–224)	38.0 (8–224)	6.0 (2–16)
Median licensed enrollment capacity for children birth to age 3, before partnership	16.0 (0–180)	36.0 (0–180)	6.0 (0–16)
Change in median licensed enrollment capacity	0.0	2.0	0.0
Percentage that increased, decreased, or stayed the same			
Percentage reporting an increase in enrollment capacity	24%	26%	22%
Percentage reporting a decrease in enrollment capacity	21%	24%	17%
Percentage reporting no change in enrollment capacity	54%	50%	61%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 4 child care partners and was trimmed to remove outliers for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. This analysis excludes centers with enrollment capacity greater than 1,000 and family child care partners with enrollment capacity greater than 25 (see Appendix B).

No changes from before the grant to after the grant were significantly different from zero at the 0.05 level, two-tailed test.

Table C.II.9. Hours, days, and weeks child care partners are in operation

	Time, number, or percentage		
	All partners	Child care center partners	Family child care partners
Median opening time	6:30 a.m.	6:30 a.m.	6:40 a.m.
Median closing time	18:00 p.m.	18:00 p.m.	18:00 p.m.
Median hours per day in operation (range)	11.0 (6–23)	12.0 (6–18)	11.0 (6–23)
Median number of hours per year in operation (range)	4,004 (210–8,050)	4,004 (385–6,552)	3,927 (210–8,050)
Median number of days per week in operation (range)	5.0 (3–7)	5.0 (3–7)	5.0 (4–7)
Percentage operating five weekdays	96%	97%	96%
Percentage operating on weekends (Saturday or Sunday)	9%	3%	17%
Percentage offering care outside normal business hours	17%	8%	29%
Percentage allowing parents to use varying hours of care each week	81%	81%	80%
Percentage allowing hours to vary at parents' convenience	38%	38%	39%
Percentage allowing hours to vary from a set of options	31%	32%	31%
Percentage allowing hours to vary beyond a minimum number of hours	12%	12%	11%
Percentage not allowing parents to use varying hours of care each week	19%	19%	20%
Median number of weeks open per year (range)	52.0 (4–52)	52.0 (5–52)	51.0 (4–52)
Percentage open year-round	78%	78%	79%
Percentage offering full-day, full-year care	98%	98%	97%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 4 to 21 child care partners. Results are weighted to account for sampling probability and nonresponse.

Table C.II.10. Change in hours and weeks child care partners operate

	Percentage		
	All partners	Child care center partners	Family child care partners
Percentage open more hours per week than before partnership	8%	5%	13%
Percentage open fewer hours per week than before partnership	7%	5%	8%
Percentage with no change to the hours open per week	85%	90%	79%
Percentage open more weeks per year than before partnership	3%	2%	4%
Percentage open fewer weeks per year than before partnership	5%	3%	9%
Percentage with no change to the weeks open per year	92%	95%	87%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 7 to 10 child care partners. Results are weighted to account for sampling probability and nonresponse.

Table C.II.11. Child care center staffing

	Number (range) or percentage
Median number of child care development staff who care for children birth to age 3	8.0 (2–100)
Median number of child care development staff who care for children birth to age 3 in EHS-CC Partnership slots	6.0 (0–60)
Median percentage of child care development staff who care for children birth to age 3 in EHS-CC Partnership slots [a]	88% (0%–100%)
Sample size	**255**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for one to three child care partners. Results are weighted to account for sampling probability and nonresponse. The percentage of child care development staff who care for children birth to age 3 in EHS-CC Partnership slots is capped at 100 percent.

[a] We first calculate the percentage for each separate partner. We then take the median of the percentage across all relevant partners.

Table C.II.12. Family child care provider staffing

	Number (range)
Median number of adults who regularly work with or provide care to children	2.0 (1–10)
Sample size	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for one child care partner. Results are weighted to account for sampling probability and nonresponse.

Table C.II.13. Child care partner staff highest level of education

	Percentage of staff		
	All partners	Child care center partners	Family child care partners
Graduate/professional degree	5%	3%	9%
Bachelor's degree	12%	14%	9%
Associate's degree	14%	15%	13%
Child development associate or higher qualification	25%	29%	20%
In training for child development associate	30%	32%	28%
High school diploma/equivalent	13%	7%	21%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for seven child care partners. Results are weighted to account for sampling probability and nonresponse.

Table C.II.14. Change in child care partner staffing

	Number (range) or percentage		
	All partners	Child care center partners	Family child care partners
Median number of child development staff caring for children birth to age 3 with a CDA or higher qualification, current	2.0 (0–65)	4.0 (0–65)	1.0 (0–5)
Median number of child development staff caring for children birth to age 3 with a CDA or higher qualification, before partnership	1.0 (0–100)	2.0 (0–100)	1.0 (0–5)
Change in median number of child development staff caring for children birth to age 3 with a CDA or higher qualification	1.0	2.0*	0.0
Percentage that increased, decreased, or stayed the same			
Percentage reporting an increase in staff with at least a CDA	41%	52%	25%
Percentage reporting a decrease in staff with at least a CDA	12%	11%	14%
Percentage reporting no change in staff with at least a CDA	47%	37%	60%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 6 to 13 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

CDA = child development associate.

Table C.II.15. Change in child care partner staff salaries

	Amount (range) or percentage		
	All partners	Child care center partners	Family child care partners
Median annual salary of child care development staff or family child care provider, current	$23,900 ($14,400–$60,000)	$22,880 ($14,843–$51,200)	$27,300 ($14,400–$60,000)
Median annual salary of child care development staff or family child care provider, before partnership	$20,000 ($11,500–$51,000)	$20,000 ($11,500–$51,000)	$22,000 ($12,000–$50,000)
Change in median annual salary of child care development staff or family child care provider	$3,900*	$2,880*	$5,300*
Percentage that increased, decreased, or stayed the same			
Percentage reporting an increase in average annual salary	69%	70%	68%
Percentage reporting a decrease in average annual salary	5%	2%	11%
Percentage reporting no change in average annual salary	26%	28%	21%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 53 to 70 child care partners and was trimmed to remove outliers for 32 to 52 child care partners. Results are weighted to account for sampling probability and nonresponse. For average annual salaries, we report amounts only within the 5th and 95th percentiles (see Appendix B).

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

Table C.II.16. Change in benefits provided to staff, all partners

Benefit	Percentage offering before grant	Percentage offering after grant	Percentage change	Percentage of partners that did not offer before the grant but began offering after grant
Sick days	44%	48%	4%	6%
Vacation days	57%	58%	2%	6%
Paid holidays	62%	64%	2%	9%
Health benefits	28%	29%	2%	4%
Retirement benefits	24%	25%	1%	3%
Reduced tuition rates for continuing education	22%	33%	11%*	13%
Other	7%	9%	n.a.	n.a.
Any benefits offered	77%	81%	4%	10%
Sample size	**386**			

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. Some partners offered a benefit before the grant but stopped offering it afterward. The final column excludes those partners and only reports the percentage of partners that began offering a benefit after the grant.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

n.a. = not applicable.

Table C.III.1. Child care partner recruitment, grantee report

	Percentage		
	All child care partners	Child care center partners	Family child care partners
Timing of partner recruitment			
Before or during grant writing	60%	73%*	41%*
After grant award	40%	27%*	59%*
Recruitment strategies			
Discussion initiated by you or your organization	48%	55%*	38%*
Community planning process	30%	39%*	18%*
Prior partnership with the child care provider to serve children and families	30%	34%*	23%*
Conducted quality observations	27%	26%	28%
Consultation with CCR&R agency	26%	16%*	39%*
Consultation with QRIS administrators	16%	19%	13%
Discussion initiated by child care partner	14%	19%*	7%*
Competitive RFP process	14%	17%	11%
Consultation with local planning council	3%	5%*	1%*
Other	12%	10%	13%
Sample size	**470**	**301**	**168**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Items in this table are based on grantee and delegate agency director responses about a randomly selected sample of child care partners. Information was missing for 2 to 4 grantees. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

CCR&R = child care resource and referral; QRIS = quality rating and improvement system; RFP = request for proposal.

Table C.III.2. Child care partner recruitment, child care partner report

	Percentage		
	All partners	Child care center partners	Family child care partners
Timing of partner recruitment			
Before or during grant writing	67%	76%*	54%*
After grant award	33%	24%*	46%*
Recruitment strategies			
Prior partnership with the grantee to serve children and families	20%	23%	16%
Competitive RFP process	7%	9%	4%
Community planning process	8%	10%*	4%*
Discussion initiated by partnership grantee	55%	63%*	45%*
Discussion initiated by you or your organization	14%	16%	10%
Consultation with local planning council	4%	4%	4%
Consultation with a local CCR&R agency	15%	8%*	25%*
Consultation with a state or local QRIS administrator	6%	5%	6%
Through another child care provider	2%	1%	4%
Through parents	1%	0%	2%
Through a state or local early childhood organization or advisory council	2%	2%	2%
Other	8%	7%	9%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for eight child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

CCR&R = child care resource and referral; QRIS = quality rating and improvement system; RFP = request for proposal.

Table C.III.3. Experience collaborating before EHS-CC Partnership grant, grantee report

	Percentage		
	All partners	Child care center partners	Family child care partners
Prior collaboration experience			
Has prior collaboration experience	46%	50%*	39%*
Previous partnership to serve EHS or Head Start children and families	18%	22%*	12%*
Part of a community collaborative group	14%	18%*	9%*
Participated in joint training	11%	14%*	8%*
Other	16%	15%*	18%*
No prior collaboration experience	54%	50%*	61%*
Of those with a previous partnership to serve EHS or Head Start children and families			
Length of prior collaboration			
Less than 1 year	7%	9%*	2%*
1–3 years	32%	31%	35%
4–5 years	12%	13%	11%
More than 5 years	49%	48%	51%
Formal partnership agreement before EHS-CC Partnership grant	93%	90%*	99%*
Grantee provided funds for services provided through prior partnership	83%	78%*	95%*
Sample size	**1,749**	**988**	**761**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Items in this table are based on grantee and delegate agency director responses about all of their child care partners. Information was missing from grantee responses for about 158 to 165 of their partners. Results are weighted to account for nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.III.4. Experience collaborating before EHS-CC Partnership grant, child care partner report

	Percentage		
	All partners	Child care center partners	Family child care partners
Prior collaboration experience			
Has prior collaboration experience	50%	56%*	42%*
Previous partnership to serve EHS or Head Start children and families	20%	22%	18%
Part of a community collaborative group	13%	18%*	7%*
Participated in joint training	16%	14%	18%
Other	13%	14%	11%
No prior collaboration experience	50%	44%*	58%*
Of those with a previous partnership to serve EHS or Head Start children and families			
Length of prior collaboration			
Less than 1 year	17%	12%	26%
1–3 years	25%	24%	26%
4–5 years	12%	17%	4%
More than 5 years	46%	47%	43%
Formal partnership agreement before EHS-CC Partnership grant	87%	90%	80%
Grantee provided funds for services provided through prior partnership	84%	87%	80%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for one to seven child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.III.5. Partnership agreement characteristics and development, grantee report

Partnership agreement characteristics	Percentage		
	All child care partners	Child care center partners	Family child care partners
Status of partnership agreement at time of survey			
Written agreement in place	97%	97%	96%
Written agreement in progress	1%	1%	1%
No written agreement	2%	2%	3%
Roles in partnership agreement development			
Grantee developed the agreement with input from child care partner	42%	51%*	30%*
Grantee developed the agreement with no input from child care partner	32%	21%*	48%*
Agreement jointly developed by grantee and child care partner	12%	16%*	7%*
Agreement jointly developed by grantee and a committee of child care partners	10%	9%	11%
Sample size	**470**	**301**	**168**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Items in this table are based on grantee and delegate agency director responses about a randomly selected sample of child care partners. Information was missing for 0 to 12 grantees. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.III.6. Partnership agreement characteristics and development, child care partner report

	Percentage		
	All partners	Child care center partners	Family child care partners
Status of partnership agreement at time of survey			
Written agreement in place	95%	96%	93%
Written agreement in progress	2%	1%	4%
No written agreement	3%	3%	2%
Of those partners with an agreement in place, roles in partnership agreement development			
Grantee developed agreement with no input from child care partner	30%	25%	36%
Grantee developed agreement and partner provided input	34%	24%*	48%*
Agreement jointly developed by grantee and partner	36%	50%*	16%*
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 7 to 14 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.III.7. Components of partnership agreements, child care partner report

	Percentage		
	All partners	Child care center partners	Family child care partners
A statement of the partnership's goals	82%	88%*	74%*
The number of children and families to be served in the partnership	79%	87%*	69%*
The number of children to be served in the partnership who receive child care subsidies	71%	75%	65%
Information about procedures for recruitment and enrollment	63%	67%	56%
Start-up and ongoing procedures for filling partnership slots	63%	72%*	50%*
Eligibility criteria for partnership slots	65%	76%*	50%*
Actions partners will take to meet the goals specified in the agreement	68%	75%*	57%*
Specific roles and responsibilities of partners to comply with the HSPPS	76%	84%*	67%*
Enhancements to teacher and staff salaries	42%	43%	41%
Amount and purpose of the funds to be provided	66%	76%*	51%*
Agreement specifies amount of funding partner receives per year	66%	67%	64%
Agreement specifies amount of funding partner receives per child per year	77%	76%	78%
Training and technical assistance to be provided or arranged by the partnership grantee to child care partners	73%	79%*	66%*
Materials and supplies to be provided by the partnership grantee to child care partners	69%	74%*	61%*
A statement of each party's rights, including the right to terminate the agreement	84%	89%*	78%*
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for four to eight child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages are expressed as a share of all partners (that is, partners that did not have an agreement in place are counted as not having that component of the agreement).

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

HSPPS = Head Start Program Performance Standards.

Table C.III.8. Partnership termination, by partner type

Termination status	Percentage of grantees, unless otherwise noted		
	Terminations with any child care partners	Terminations with child care center partners	Terminations with family child care partners
Percentage of grantees reporting partnership terminations[a]	32%	22%*	14%*
Of those reporting terminations, average number (range) of terminations per grantee or delegate	2 (1–12)	1 (1–5)	2 (1–7)
Of those reporting terminations, primary reasons for termination			
Difficulty complying with the HSPPS	44%	47%	51%
Differences in program philosophy and mission	36%	42%	24%
Difficulty meeting child-to-adult ratio and group size requirements	34%	33%	38%
Administrative burden of reporting requirements	28%	27%	37%
Misunderstanding of roles and responsibilities	27%	26%	28%
Perceived inadequacy of funding	24%	23%	23%
Difficulty meeting teacher credential requirements	13%	19%*	3%*
Too many vacant slots	11%	11%	14%
Perceived lack of respect among partners	8%	9%	8%
Other	35%	36%	26%
Sample sizes	**220**	**220**	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 11 to 12 grantees. Percentages in each column do not sum to 100 because respondents could select multiple response categories. Results are weighted to account for nonresponse.

[a] The percentages for child care center partners and family child care partners sum to more than the percentage for any partner because a grantee could have terminated a partnership with both a child care center and a family child care provider.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

HSPPS = Head Start Program Performance Standards.

Table C.III.9. Leadership of the partnership programs

	Average score (1 = not at all; 5 = to a very great extent)	
Perceptions of leadership	Grantee directors	Child care partner directors or managers
Director has developed plan to facilitate partnership implementation	4.1	4.0
Director has removed obstacles to partnership implementation	3.6*	3.9*
Director has established clear standards	3.9	4.0
Director is knowledgeable about partnerships	4.2	4.2
Director is able to answer staff questions	4.2	4.2
Director knows what he or she is talking about	4.2	4.2
Director recognizes and appreciates child care partner staff	4.5*	4.2*
Director supports child care partner efforts to learn more about the partnership	4.5*	4.2*
Director supports child care partner efforts to deliver services through partnerships	4.5*	4.3*
Director perseveres through the ups and downs of partnership implementation	4.4	4.3
Director carries on through the challenges of partnership implementation	4.5*	4.3*
Director openly and effectively addresses problems	4.4*	4.2*
Sample size	**220**	**386**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey; EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for four to six grantees. Information was missing for 33 to 43 child care partners. Grantee results are weighted to account for nonresponse. Partner results are weighted to account for sampling probability and nonresponse. Questions directed both to the grantee director and the child care partner director or manager were asked about the grantee director’s leadership.

* Average scores differ significantly between grantee director and child care partner director or manager reports at the 0.05 level, two-tailed test.

Table C.III.10. Perceptions of mutual respect and collaboration

	Average score (1 = disagree; 4 = agree)	
Perceptions of mutual respect and collaboration	Grantee directors	Child care partner directors or managers
Individuals in partnership demonstrate mutual respect	3.8*	3.7*
Partnership grantee/child care partner are full partners	3.7*	3.5*
Partnership grantee/child care partner feels voice is heard	3.8*	3.4*
Partnership grantee/child care partner feels they can pick up the phone and call	3.9*	3.7*
Grantee and partner have similar goals for working together	3.7	3.7
Partnership grantee/child care partner feels respected	3.8*	3.7*
Partnership grantee/child care partner views partner/grantee as a partner	3.5*	3.2*
Sample size	**470**	**386**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey; EHS-CC Partnership Child Care Partner Survey.

Note: Grantee director items are based on grantee and delegate agency director responses about a randomly selected sample of child care partners. Information was missing for 1 to 15 grantees. Information was missing for 19 to 33 child care partners. Grantee and partner results are weighted to account for sampling probability and nonresponse.

* Average scores differ significantly between grantee director and child care partner director or manager reports at the 0.05 level, two-tailed test.

Table C.IV.1. Transfer of funds to child care partners, grantee report

Funding allocation	Median grant amount (range), unless otherwise noted
Percentage of total funding transferred to child care partners	
Percentage transferred to child care partners, on average[a]	54% (1%–100%)
Percentage transferred to child care partners, by category	**Percentage of grantees**
Less than 20%	11%
20–39%	18%
40–59%	30%
60–79%	26%
80% or more	15%
Median amount of funding transferred to partners per partnership slot	
All partnership slots[b]	$7,875 ($1,400–$18,900)
Child care center partnership slots	$8,000 ($1,400–$19,000)
Family child care partnership slots	$7,280 ($1,200–$14,000)
Amount of funding per partnership slot, by category	**Percentage of grantees**
Less than $5,000	14%
$5,000–$9,999	54%
$10,000–$14,999	24%
$15,000 or more	8%
Sample sizes	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey; funding information provided by the Office of Head Start.

Note: Information was missing for 7 to 28 grantees and was trimmed to remove outliers for 6 to 18 grantees. Results are weighted to account for nonresponse. For funding amount variables, we report amounts only within the 5th and 95th percentiles (see Appendix B). The percentage of total funding transferred to child care partners is capped at 100 percent.

[a] To obtain this percentage, we first calculated the percentage for each partner separately. We then took the median of the percentages across all relevant partners.

[b] For grantees with child care center and family child care slots, we computed a weighted average: (number of child care center slots/total number of slots) * average amount in child care center slots + (number of family child care slots/total number of slots) * average amount in family child care slots.

Table C.IV.2. Regular funding provided to child care partners

	Amount or percentage		
	All partners	Child care center partners	Family child care partners
Median amount (range) of funding per year	$50,000 ($1,500–$550,000)	$100,000 ($5,000–$464,597)*	$24,000 ($1,500–$550,000)*
Funding per slot is less than $5,000	32%	27%	38%
Funding per slot is $5,000 to $9,999	41%	42%	39%
Funding per slot is $10,000 to $14,999	16%	21%*	9%*
Funding per child is $15,000 or more	12%	9%	14%
Median amount (range) of funding per month	$4,500 ($375–$38,716)	$8,400 ($504–$38,716)*	$2,120 ($375–$10,000)*
Consistency of monthly funding amounts			
Percentage of child care partners reporting receiving a varying amount each month	58%	58%	57%
Percentage of child care partners reporting reasons for varying funding amounts			
Receipt of subsidies	43%	54%*	29%*
Mix of children's ages	34%	31%	37%
Number of children enrolled	20%	21%	18%
Number of service days in month	10%	8%	13%
Reimbursed based on actual expenses	6%	9%*	2%*
Number of days attended per child	5%	2%	8%
Other	14%	13%	14%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 4 to 101 child care partners and was trimmed for 27 to 30 child care partners. Results are weighted to account for sampling probability and nonresponse. For funding amount variables, we report amounts only within the 5th and 95th percentiles.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.IV.3. Start-up funds

	Amount or percentage		
	All partners	Child care center partners	Family child care partners
Percentage of child care partners that received start-up funds	42%	59%*	20%*
Start-up fund amounts (of those receiving start-up funds)			
Less than $10,000	32%	23%*	73%*
$10,000 to $19,999	23%	27%*	3%*
$20,000 to $29,999	13%	16%*	0%*
$30,000 or more	32%	34%	24%
Percentage of child care partners reporting uses of start-up funds			
Materials, supplies, furniture, and equipment	37%	54%	15%
Staff training and professional development	15%	25%*	3%*
Enhanced salaries and/or benefits for staff	9%	14%	3%
Administration and overhead	8%	11%	3%
Building or playground renovations or other capital investments	4%	6%*	0%*
Other	2%	2%	2%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 to 42 child care partners and was trimmed to remove outliers for 16 child care partners. Results are weighted to account for sampling probability and nonresponse. For funding amount variables, we report amounts only within the 5th and 95th percentiles (see Appendix B). In the final panel, percentages of child care partners reporting uses of start-up funds are expressed as a share of all partners (that is, partners that did not receive start-up funds are counted as not using them).

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.IV.4. Additional funds received from partnership grantee

	Percentage		
	All partners	Child care center partners	Family child care partners
Percentage of child care partners that received additional funds	46%	56%*	33%*
Purpose of additional funds			
Staff training and professional development	31%	37%*	24%*
Funds for materials, supplies, furniture, and equipment[a]	26%	33%*	17%*
Enhanced salaries or benefits for staff	8%	12%*	2%*
Administration and overhead	7%	10%*	3%*
Other	5%	7%	3%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 36 child care partners. Results are weighted to account for sampling probability and nonresponse. Additional funds are any funds besides start-up funds and regular funding received for partnership slots.

[a] Not including items that the partnership grantee purchased on the child care partner's behalf.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.IV.5. Use of partnership funds to pay for vacant enrollment slots

	Percentage of grantees
Timing of payment to the child care partner	
Payment provided until slot is filled	24%
Payment provided for limited period of time	24%
No payment provided for unfilled slots	52%
Of those reporting payment for unfilled slots, amount of payment	
Full payment	89%
Partial payment	5%
Other	6%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 13 to 46 grantees. Results are weighted to account for nonresponse. A larger percentage of grantee directors than child care partners reported using partnership funds to pay for vacant enrollment slots (see Table IV.1 for findings on these items from the Child Care Partner Survey). Responses from grantees and child care partners to similar survey items could differ because a grantee may pay for unfilled slots for only some of its partners. In this case, the grantee would say it pays for unfilled slots whereas only a subset of its partners would report receiving payment for unfilled slots.

Table C.IV.6. Funding received from other sources aside from the grantee

	Percentage		
	All partners	Child care center partners	Family child care partners
Percentage of child care partners that received funds from other sources	34%	46%*	20%*
Additional sources of funds			
Subsidies paid by state or county government	27%	37%	15%
Child and Adult Care Food Program funds	25%	33%	16%
State preschool funding	2%	4%*	0%*
Donations and private grants	2%	4%*	0%*
Subsidies or programs paid by local government	1%	2%	0%
Other	5%	7%	1%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 1 to 20 child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages of child care partners receiving various types of additional funds are expressed as a share of all partners (that is, partners that did not any additional funds are counted as not getting each type).

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.IV.7. Partnership slots funded by state child care subsidies

Type of partnership slots grantee has	Median percentage (range) of partnership slots funded by child care subsidies
Any partnership slots	50% (0%–100%)
Child care center partnership slots only	50% (0%–100%)
Family child care partnership slots only	60% (0%–100%)
Both center and family child care partnership slots	68% (0%–100%)
Percentage of all partnership slots funded by state child care subsidies	
Less than 25	25%
25–39	7%
40–79	34%
80 or more	35%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for zero to three grantees. Results are weighted to account for nonresponse.

Table C.IV.8. Funds provided by grantees to child care partners to offset loss of child care subsidies

	Percentage of partners		
	All partners	Child care center partners	Family child care partners
Timing of funds provided			
Funds provided by grantee to offset loss of subsidy funds	51%	58%*	42%*
Funds provided for the entire period of time the child is enrolled	34%	41%*	24%*
Funds provided for limited period of time	17%	17%	17%
No funds provided by grantee to offset loss of subsidy funds	49%	42%*	58%*
Of those reporting payment for lost subsidy funds			
Funds completely offset lost subsidy funds	55%	56%	55%
Funds partially offset lost subsidy funds	38%	40%	36%
Other	6%	5%	9%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 12 to 34 child care partners. Results are weighted to account for sampling probability and nonresponse. A smaller percentage of child care partners than grantee directors reported receiving funds to offset the loss of child care subsidies (see Table IV.2 for findings on these items from the Grantee and Delegate Agency Director Survey). Responses from grantees and child care partners to similar survey items could differ because a grantee may offset the loss of child care subsidies for only some of its partners. In this case, the grantee would say it offsets the loss of child care subsidies, whereas only a subset of its partners would report receiving such an offset.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.V.1. Strategies for recruiting families for partnership slots, child care partner report

	Percentage		
Recruitment strategies	All child care partners	Child care center partners	Family child care partners
Word of mouth	75%	78%	70%
Referrals from the partnership grantee	52%	49%	55%
Referrals from community agencies and partners	40%	48%*	30%*
Referrals from child care resource and referral	40%	35%*	47%*
Outreach efforts in the community by child care partner staff	40%	54%*	21%*
Local advertising (such as flyers, newspaper ads, or radio spots)	36%	41%	30%
Other	6%	8%*	2%*
No need to recruit	9%	10%	8%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for seven child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.V.2. Strategies for recruiting families for partnership slots, grantee report

Recruitment strategies	Percentage of grantees
Outreach efforts in the community by grantee staff	89%
Word of mouth	87%
Referrals from community agencies	86%
Referrals from child care partners	84%
Local advertising (such as flyers, newspaper ads, or radio spots)	73%
Families are recruited from the Early Head Start waiting list	71%
Referrals from child care resource and referral agency	58%
Families are recruited from the Early Head Start center- or home-based programs	51%
Other	3%
No need to recruit	2%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for three grantees. Results are weighted to account for nonresponse.

Table C.V.3. Factors grantees considered for prioritizing enrollment

Factors for prioritizing enrollment	Percentage of grantees
Currently has a system to prioritize enrollment based on family risks or needs	93%
Of those that currently have a system to prioritize enrollment, factors considered	
Child is homeless	96%
Child has been diagnosed with any special needs	95%
Parent or guardian's employment status	86%
Parent or guardian receives welfare or TANF	86%
Mother had child as a teenager	85%
Single parent household	78%
Child is eligible for a child care subsidy (CCDF eligibility)	72%
Parent or guardian has mental health needs	67%
Parent or guardian has a history of family violence	65%
Child receives a child care subsidy (CCDF receipt)	64%
Parent or guardian has a history of substance use disorder	62%
Number of children in the family	57%
Child is a dual-language learner	55%
Other	25%
Sample size	**220**

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for five grantees. Results are weighted to account for nonresponse.

CCDF = Child Care and Development Fund; TANF = Temporary Assistance for Needy Families.

Table C.V.4. Change in waiting list status for enrollment of infants and toddlers, by child care partners

	Percentage		
	All partners	Child care center partners	Family child care partners
Percentage with a waiting list for infant and toddler slots, current	68%	82%	51%
Percentage with a waiting list for infant and toddler slots, before partnership	53%	58%	45%
Percentage change	16%*	24%*	5%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 or 11 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

Table C.V.5. Change in system of prioritizing enrollment

	Percentage		
	All partners	Child care center partners	Family child care partners
Percentage with a system to prioritize enrollment, current	46%	56%	31%
Percentage with a system to prioritize enrollment, before partnership	31%	32%	29%
Percentage change	15%*	24%*	2%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 15 to 17 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

Table C.VI.1. Services provided to children in partnership slots, child care partner report

	Percentage of child care partners reporting providing service to children in partnership slots		
Type of service	All child care partners	Child care center partners	Family child care partners
Any service	93%	96%*	88%*
Developmental screening	79%	86%*	70%*
Hearing screening	78%	85%*	69%*
Vision screening	76%	83%*	67%*
Speech screening	71%	75%	66%
Social service referrals	70%	74%	63%
Dental screening	70%	73%	64%
Mental health observation or assessment	67%	78%*	52%*
Dental referrals	65%	69%	59%
Mental health referrals	64%	71%*	54%*
Medical referrals	63%	69%*	54%*
Nutritional screening	61%	63%	58%
Speech therapy	60%	62%	57%
Physical therapy	47%	49%	45%
Lead screening	45%	51%*	36%*
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VI.2. Change in provision of services for children

Type of service	Percentage offering before grant	Percentage offering after grant	Percentage change	Percentage of partners that did not offer before the grant but began offering after grant
Developmental screening	50%	85%	35%*	39%
Hearing screening	29%	81%	51%*	52%
Vision screening	33%	79%	46%*	47%
Speech screening	35%	78%	43%*	45%
Social service referrals	36%	73%	37%*	40%
Dental screening	25%	72%	48%*	49%
Mental health observation or assessment	30%	70%	40%*	44%
Dental referrals	25%	67%	42%*	43%
Mental health referrals	30%	67%	37%*	39%
Medical referrals	29%	65%	36%*	38%
Nutritional screening	19%	64%	45%*	47%
Speech therapy	33%	65%	32%*	35%
Physical therapy	20%	51%	31%*	33%
Lead screening	11%	47%	36%*	38%
Sample size	**386**			

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

Table C.VI.3. Provision of Individual Family Partnership Agreements and home visits, grantee report

Service	Percentage of grantees reporting service provided to		Of grantees reporting service, percentage reporting entity responsible		
	Families in partnership slots	Families in nonpartnership slots	Partnership grantee staff	Child care partner staff	Referrals to a community partner or agency
Individual Family Partnership Agreements	99%	17%	82%	9%	9%
Home visits	100%	17%	51%	42%	7%
Sample size	**220**				

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 7 to 10 grantees. Results are weighted to account for nonresponse. Percentages do not sum to 100 because the survey item asked respondents to indicate all categories that applied.

Table C.VI.4. Services provided to families in partnership slots, child care partner report

Type of service	Percentage		
	All child care partners	Child care center partners	Family child care partners
Any service	68%	70%	63%
Staff consultation or follow-up with families about results of screenings or assessments	49%	57%*	37%*
Mental health screenings	42%	48%*	34%*
Mental health assessments	38%	43%*	30%*
Dental care	38%	38%	37%
Family literacy services	32%	35%	28%
Emergency assistance	29%	30%	27%
Education or job training	28%	30%	25%
Services for dual-language learners	28%	32%	23%
Care coordination	28%	28%	28%
Employment assistance	27%	30%	24%
Housing assistance	27%	30%	23%
Therapy	27%	25%	29%
Pediatrician services	26%	25%	27%
Financial counseling	26%	32%*	18%*
Transportation assistance	25%	28%	21%
Services for drug or alcohol abuse	18%	18%	18%
Disability services for parents	17%	18%	16%
Prenatal care or obstetrics and gynecology	16%	16%	17%
Legal assistance	16%	17%	15%
Adult health care	15%	14%	17%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VI.5. Change in provision of Individual Family Partnership Agreements and home visits

	Percentage	
	IFPAs	Home visits
Percentage offering, current	78%	88%
Percentage offering, before partnership	31%	23%
Percentage change	47%*	65%*
Sample size	**386**	**386**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 to 40 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

IFPA = Individual Family Partnership Agreement.

Table C.VI.6. Change in provision of services for families

Type of service	Percentage offering before grant	Percentage offering after grant	Percentage change	Percentage of partners that did not offer before the grant but began offering after grant
Staff consultation or follow-up with families about results of screenings or assessments	29%	52%	23%*	26%
Mental health screenings	18%	46%	28%*	30%
Mental health assessments	15%	41%	25%*	28%
Dental care	13%	41%	28%*	29%
Family literacy services	14%	35%	21%*	24%
Emergency assistance	16%	31%	15%*	17%
Education or job training	16%	31%	15%*	18%
Services for dual-language learners	13%	30%	17%*	19%
Care coordination	11%	31%	20%*	22%
Employment assistance	15%	29%	14%*	18%
Housing assistance	12%	29%	17%*	18%
Therapy	13%	28%	15%*	16%
Pediatrician services	11%	29%	18%*	19%
Financial counseling	10%	28%	18%*	19%
Transportation assistance	17%	29%	12%*	17%
Services for drug or alcohol abuse	6%	19%	13%*	14%
Disability services for parents	7%	20%	14%*	15%
Prenatal care or obstetrics and gynecology	7%	18%	11%*	12%
Legal assistance	7%	17%	10%*	11%
Adult health care	6%	16%	10%*	11%
Sample size	**386**			

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

Table C.VI.7. Services provided to children in partnership slots only, child care partner report

Type of service	Percentage of child care partners reporting service provided to children in partnership slots only: All child care partners	Child care center partners	Family child care partners
Any service	22%	19%	27%
Developmental screening	29%	27%	32%
Hearing screening	42%	43%	41%
Vision screening	39%	39%	39%
Speech screening	32%	28%	39%
Social service referrals	29%	25%	35%
Dental screening	38%	38%	38%
Mental health observation or assessment	33%	35%	30%
Dental referrals	36%	35%	37%
Mental health referrals	27%	26%	27%
Medical referrals	31%	32%	30%
Nutritional screening	35%	37%	32%
Speech therapy	25%	23%	28%
Physical therapy	24%	23%	27%
Lead screening	29%	31%	25%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

Table C.VI.8. Services provided to children in both partnership slots and nonpartnership slots, child care partner report

Type of service	Percentage		
	All child care partners	Child care center partners	Family child care partners
Any service	70%	77%*	60%*
Developmental screening	51%	59%*	38%*
Hearing screening	36%	42%*	28%*
Vision screening	38%	44%*	29%*
Speech screening	39%	47%*	27%*
Social service referrals	40%	49%*	28%*
Dental screening	32%	35%	27%
Mental health observation or assessment	35%	43%*	22%*
Dental referrals	29%	34%*	22%*
Mental health referrals	37%	44%*	27%*
Medical referrals	31%	37%*	24%*
Nutritional screening	26%	27%	26%
Speech therapy	35%	39%	29%
Physical therapy	23%	26%	18%
Lead screening	16%	19%*	11%*
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VI.9. Services provided to children in partnership and nonpartnership slots, grantee report

Type of service	Percentage of partners reporting service provided to children in partnership slots	Percentage providing to children in partnership slots only	Percentage providing to children in both partnership slots and nonpartnership slots
Any service	100%	22%*	77%*
Developmental screening	99%	38%*	61%*
Hearing screening	96%	43%*	53%*
Vision screening	95%	43%	52%
Speech screening	91%	43%	48%
Social service referrals	99%	40%*	59%*
Dental screening	94%	46%	48%
Mental health observation or assessment	96%	43%*	53%*
Dental referrals	99%	47%	52%
Mental health referrals	99%	43%*	56%*
Medical referrals	99%	45%	54%
Nutritional screening	98%	50%	48%
Speech therapy	82%	37%	45%
Physical therapy	77%	34%*	43%*
Lead screening	90%	50%*	40%*
Sample size	**220**		

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 5 to 21 grantees. Results are weighted to account for nonresponse.

* Percentages differ significantly between those providing service to children in partnership slots only and those providing service to children in both partnership slots and nonpartnership slots at the 0.05 level, two-tailed test.

Table C.VI.10. Services provided to families in partnership slots only, child care partner report

Type of service	Percentage		
	All child care partners	Child care center partners	Family child care partners
Any service	19%	19%	19%
Staff consultation or follow-up with families about results of screenings or assessments	18%	20%	14%
Mental health screenings	20%	22%	17%
Mental health assessments	20%	22%	18%
Dental care	18%	20%	16%
Family literacy services	18%	18%	17%
Emergency assistance	14%	14%	13%
Education or job training	14%	13%	16%
Services for dual-language learners	14%	14%	14%
Care coordination	13%	13%	14%
Employment assistance	12%	13%	11%
Housing assistance	12%	12%	11%
Therapy	12%	11%	13%
Pediatrician services	13%	13%	13%
Financial counseling	14%	15%	12%
Transportation assistance	12%	13%	10%
Services for drug or alcohol abuse	9%	9%	10%
Disability services for parents	9%	9%	10%
Prenatal care or obstetrics and gynecology	9%	8%	10%
Legal assistance	8%	8%	8%
Adult health care	7%	6%	9%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

Table C.VI.11. Services provided to families of children in both partnership slots and nonpartnership slots, child care partner report

	Percentage		
Type of service	All child care partners	Child care center partners	Family child care partners
Any service	49%	51%	44%
Staff consultation or follow-up with families about results of screenings or assessments	31%	36%*	23%*
Mental health screenings	22%	27%	16%
Mental health assessments	17%	21%*	12%*
Dental care	19%	18%	21%
Family literacy services	14%	16%	12%
Emergency assistance	15%	16%	14%
Education or job training	14%	18%*	9%*
Services for dual-language learners	14%	18%*	8%*
Care coordination	15%	15%	15%
Employment assistance	15%	17%	13%
Housing assistance	15%	18%	12%
Therapy	15%	14%	16%
Pediatrician services	13%	12%	14%
Financial counseling	12%	16%*	6%*
Transportation assistance	14%	15%	11%
Services for drug or alcohol abuse	9%	9%	8%
Disability services for parents	8%	10%	6%
Prenatal care or obstetrics and gynecology	7%	8%	7%
Legal assistance	8%	9%	7%
Adult health care	8%	8%	8%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 26 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VI.12. Services provided to families of children in partnership and nonpartnership slots, grantee report

Type of service	Percentage of partners providing service to families of children in partnership slots	Percentage of partners providing service to families of children in partnership slots only	Percentage of partners providing service to families of children in both partnership slots and nonpartnership slots
Any service	100%	30%*	70%*
Staff consultation or follow-up with families about results of screenings or assessments	95%	48%	47%
Mental health screenings	91%	45%	46%
Mental health assessments	85%	43%	42%
Dental care	76%	36%	40%
Family literacy services	92%	39%*	54%*
Emergency assistance	87%	35%*	52%*
Education or job training	86%	38%*	48%*
Services for dual-language learners	85%	40%	45%
Care coordination	74%	36%	38%
Employment assistance	83%	40%	42%
Housing assistance	80%	33%*	46%*
Therapy	70%	31%*	40%*
Pediatrician services	67%	30%	37%
Financial counseling	80%	35%*	44%*
Transportation assistance	71%	34%	37%
Services for drug or alcohol abuse	71%	34%	38%
Disability services for parents	58%	26%	32%
Prenatal care or obstetrics and gynecology	58%	25%*	33%*
Legal assistance	60%	25%*	35%*
Adult health care	50%	23%	28%
Sample size	**220**		

Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.

Note: Information was missing for 6 to 25 grantees. Results are weighted to account for nonresponse.

* Percentages differ significantly between those providing service to families of children in partnership slots only and those providing service to families of children in both partnership slots and nonpartnership slots at the 0.05 level, two-tailed test.

Table C.VII.1. Child care partners' assessments of their implementation of HSPPS

Status of implementation	Percentage		
	All child care partners[a]	Child care center partners	Family child care partners
Met the HSPPS before participating in the partnership program	21%	20%	22%
Currently meets the HSPPS	30%	29%	30%
Meets most of the HSPPS and striving to meet all standards	44%	46%	40%
Difficult to meet the HSPPS but striving to meet as many standards as possible	6%	4%	8%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 36 child care partners. Results are weighted to account for sampling probability and nonresponse.

[a] Percentages do not sum to 100 due to rounding.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

HSPPS = Head Start Program Performance Standards.

Table C.VII.2. Use of infant and toddler curriculum

Status of curriculum implementation	Percentage or amount		
	All child care partners	Child care center partners	Family child care partners
Currently implement an infant and toddler curriculum	86%	86%	86%
Implementing one curriculum	62%	67%*	54%*
Implementing two curricula	10%	12%	6%
Implementing three or more curricula	15%	7%*	25%*
Does not currently implement an infant and toddler curriculum	14%	14%	14%
Specific curricula implemented[a]			
Creative Curriculum	68%	73%	62%
Other named curriculum	32%	24%*	42%*
Agency-created curriculum	15%	11%*	21%*
Number of infant and toddler curricula implemented			
Median number of curricula implemented (range)	1.0 (0–15)	1.0 (0–12)	1.0 (0–15)
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 5 to 25 child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages of child care partners reporting specific curricula implemented are expressed as a share of all partners (that is, partners that did not implement any curriculum are counted as not implementing them).

[a] Percentages of curricula implemented do not sum to 100 because some partners implemented multiple curricula.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VII.3. Change in number of curricula used

	Number or percentage		
	All partners	Child care center partners	Family child care partners
Median number of curricula used, current	1.0 (0–15)	1.0 (0–12)	1.0 (0–15)
Median number of curricula used, before partnership	1.0 (0–17)	1.0 (0–10)	1.0 (0–17)
Change in median number of curricula used	0.0	0.0	0.0
Percentage that increased, decreased, or stayed the same			
Percentage reporting an increase in the number of curricula	29%	23%	38%
Percentage reporting a decrease in the number of curricula	18%	18%	18%
Percentage reporting no change in the number of curricula	53%	59%	44%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 25 to 36 child care partners. Results are weighted to account for sampling probability and nonresponse.

No changes from before the grant to after the grant were significantly different from zero at the 0.05 level, two-tailed test.

Table C.VII.4. Meetings to discuss services for individual children and families

	Percentage		
Meetings to discuss services for individual children and families	All child care partners	Child care center partners	Family child care partners
Child care partner staff meet with partnership grantee staff	78%	78%	79%
Meets every day or almost every day	4%	6%*	2%*
Meets every week or almost every week	23%	21%	26%
Meets once or twice a month	41%	43%	39%
Meets less than once a month	9%	7%	11%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 6 to 21 child care partners. Results are weighted to account for sampling probability and nonresponse.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VII.5. Content of meetings to discuss services for individual children and families

	Of child care partners that met with grantees, percentage that discussed each topic		
Topics discussed during meetings	All child care partners	Child care center partners	Family child care partners
Child assessment results	86%	88%	84%
Communication with parents	86%	88%	83%
Child or family needs or barriers	75%	80%	68%
Coordination with early intervention or other service providers and other child care arrangements	73%	76%	68%
Family service plans	73%	74%	72%
Transition plans	70%	75%	64%
Classroom lesson plans	68%	68%	69%
Transportation for children	25%	26%	24%
Other	3%	4%	1%
Sample size	**295**	**197**	**98**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for six child care partners. Percentages are expressed as shares of child care partners that reported meeting with the grantee. Percentages do not sum to 100 because respondents selected all types that applied. Results are weighted to account for sampling probability and nonresponse.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

Table C.VII.6. Materials directly provided to child care partners by grantees

Type of materials	Percentage		
	All child care partners	Child care center partners	Family child care partners
Furniture	67%	67%	68%
Curriculum materials	65%	68%	60%
Toys or materials for pretend play	64%	66%	62%
Books	63%	63%	64%
Screening and assessment materials	57%	61%	52%
Playground or other outdoor equipment	50%	54%	45%
Information technology (such as computer, internet access, or program management software)	48%	52%	43%
Art supplies	45%	43%	48%
Paper or other office supplies	35%	31%	41%
Other	11%	11%	10%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for two child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages do not sum to 100 because respondents selected all materials that applied.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

Table C.VII.7. Professional development activities offered to child care partner staff by grantees

Type of activity	Percentage		
	All child care partners	Child care center partners	Family child care partners
Coaching, mentoring, or consultation; one-on-one training	86%	85%	86%
Workshops	84%	86%	81%
Online training	39%	45%*	31%*
Other	6%	7%	6%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for four child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages do not sum to 100 because respondents selected all activities that applied.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VII.8. Change in professional development activities

Benefit	Percentage offered before grant	Percentage offered after grant	Percentage change	Percentage of partners that did not offer before the grant but began offering after grant
Workshops	87%	84%	-3%	61%
Coaching, mentoring, or consultation; one-on-one training	69%	86%	17%*	73%
Online training	53%	39%	-14%*	20%
Other	8%	6%	n.a.	n.a.
Sample size	**386**			

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for four child care partners. Results are weighted to account for sampling probability and nonresponse.

* The change from before the grant to after the grant differs significantly from zero at the 0.05 level, two-tailed test.

n.a. = not applicable.

Table C.VII.9. Quality monitoring activities received by child care partners

	Percentage		
Type of activity	All child care partners	Child care center partners	Family child care partners
Meetings with directors	86%	91%*	80%*
Observations to assess practice	83%	85%	79%
Feedback on teaching practice	76%	79%	71%
Guidance on developmentally appropriate emotional and behavioral support for children	75%	76%	73%
Guidance on developmentally appropriate teaching practices	74%	76%	71%
Guidance on linking curriculum to children's developmental needs	72%	71%	73%
Guidance on implementing curriculum	69%	69%	70%
Review of program data	69%	70%	67%
Review of lesson plans	64%	64%	64%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for 10 child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages do not sum to 100 because respondents selected all activities that applied.

* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Table C.VII.10. Opportunities for child care partner staff to obtain credentials and degrees offered by grantees under the partnership grant

	Percentage		
Type of opportunity	All child care partners	Child care center partners	Family child care partners
Child development associate credential	77%	81%	72%
State-awarded certificate, credential, or licensure that meets or exceeds child development associate requirements	37%	34%	41%
Associate's degree	26%	27%	25%
Bachelor's degree	19%	19%	19%
Sample size	**386**	**255**	**131**

Source: EHS-CC Partnership Child Care Partner Survey.

Note: Information was missing for six child care partners. Results are weighted to account for sampling probability and nonresponse. Percentages do not sum to 100 because respondents selected all opportunities that applied.

Percentages of child care center partners and family child care partners were not significantly different at the 0.05 level, two-tailed test for any items.

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