Executive Summary

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

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DISCLAIMER

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FINAL REPORT: EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

The purpose of the final 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, the final 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 the final 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 the 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 the 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 the 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

The 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

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