Findings from the National Descriptive Study of Early Head Start-Child Care Partnerships

OPRE Report 2020-70

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In 2015, the Administration for Children and Families (ACF) awarded 250 Early Head Start-Child Care (EHS-CC) Partnership grants.[1] The grants were awarded to existing EHS and Head Start grantees and entities new to EHS for the purpose of developing and implementing partnerships with regulated, community-based child care centers and family child care providers serving infants and toddlers. Through these partnerships, ACF aimed to expand the availability of high quality early care and education opportunities for infants and toddlers from low-income families.

EHS-CC Partnerships bring together the best features of EHS and community-based child care 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. EHS and child care partners 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.

Providing comprehensive services to infants and toddlers and their families

Prior research suggests that early care and education partnerships enhance child care partners' ability to offer and provide access to comprehensive services to children and families.[2] Comprehensive services are intended to support families in their role as caregivers and foster the health and well-being of children.[3] Connecting children and families to these services is a foundational feature of the Head Start and EHS models, and is a requirement outlined by the Head Start Program Performance Standards (HSPPS; see Box 1).[4] EHS and child care partners are required to offer comprehensive services that adhere to the HSPPS to all children who were enrolled and directly supported through funds from the EHS-CC Partnership grants (that is, children in partnership slots; see Box 2) as well as their families.

Partnerships in early care and education settings also hold promise for expanding access to comprehensive services to a broader group of children and families than those directly participating in the program.[5] Specifically, the EHS-CC Partnerships may extend the reach of comprehensive services to children enrolled in partnering child care centers and family child care homes that are not directly supported through funding from the grant (that is, children in nonpartnership slots; see Box 2).

This brief draws on data from the national descriptive study of EHS-CC Partnerships to describe the range of services offered to children in both partnership and nonpartnership slots and their families.[6]

This brief addresses the following questions:

- What comprehensive services did EHS-CC Partnerships offer to children enrolled in partnership slots and their families?
- To what extent did EHS-CC Partnerships offer comprehensive services to children in nonpartnership slots and their families?
- Who provides comprehensive services to children and families in EHS-CC Partnerships? That is, does the child care or EHS partner provide services directly to children and families, or does the EHS-CC Partnership refer children and families to services that community partners provide?[7]
- To what extent did child care partners report offering comprehensive services before engaging in the EHS-CC Partnership grant?

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Box 1. HSPPS: Comprehensive services

The HSPPS define standards and minimum requirements for the entire range of services offered through Head Start and EHS, including (but not limited to):

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

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

Box 2. What are partnership and nonpartnership slots?

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

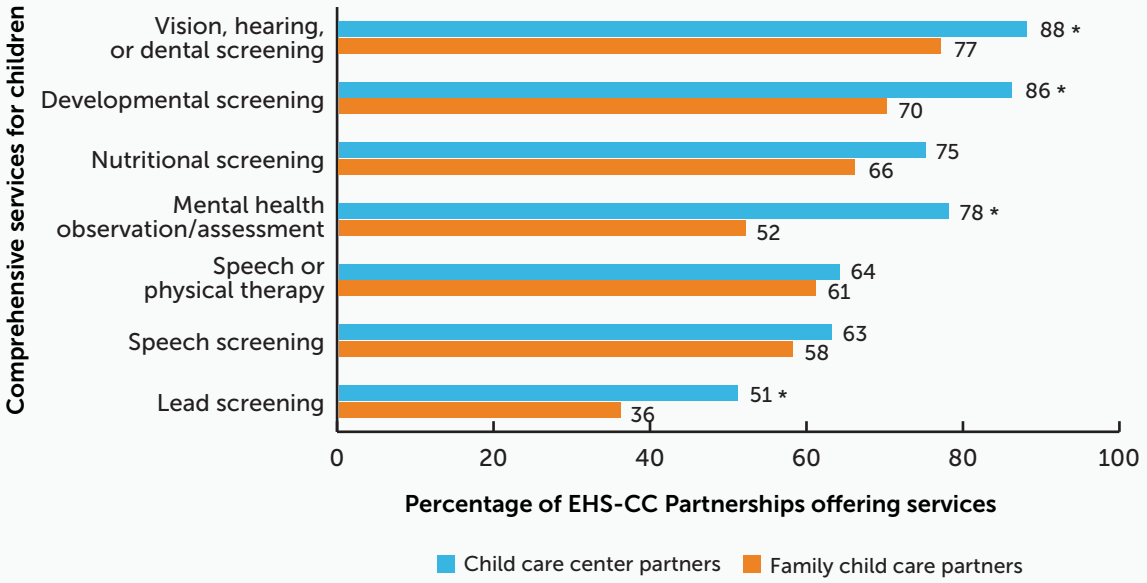
Providing access to comprehensive services: What comprehensive services did EHS-CC Partnerships offer to children enrolled in partnership slots and their families?

EHS-CC Partnerships are required to provide comprehensive services, as defined by the HSPPS, to children enrolled in partnership slots and their families. Although some comprehensive services must be made available to all children in partnership slots (for example, developmental screenings), the HSPPS allow considerable flexibility for programs to offer additional comprehensive services based on the needs of enrolled children and families and the local community.

Most EHS-CC Partnerships offered screenings and other services to children; on average, child care center partners offered these services more frequently than family child care partners. Child care center partners offered vision, hearing, or dental screening; developmental screening; mental health observations or assessments; and lead screening significantly more frequently than family child care partners (Exhibit 1).

EHS-CC Partnerships offered a range of services to parents and caregivers of children 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 activities targeted toward parenting skills and knowledge of basic child development); and to help the families move toward self-sufficiency (including educational and employment services, as appropriate). Sixty-eight percent of child care partners offered at least one service to families of children in partnership slots (not shown). Half of child care center partners and 39 percent of family child care partners offered mental health screenings or assessments to families of children in partnership slots. Additionally, 42 percent of child care center partners and 41 percent of family child care partners offered adult, dental, or prenatal health care to families of children in partnership slots (Exhibit 2).

Exhibit 1. EHS-CC Partnerships offered 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.
* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

Box 3. Methods

The national descriptive study was designed to develop a rich knowledge base about the EHS programs, community-based child care centers, and family child care providers participating in a 2015 federal grants program supporting the development of EHS-CC Partnerships and aiming to increase access to high-quality infant-toddler care for low-income families. 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. Data were collected following the first year of implementation, approximately 12 to 18 months after receiving the grant.

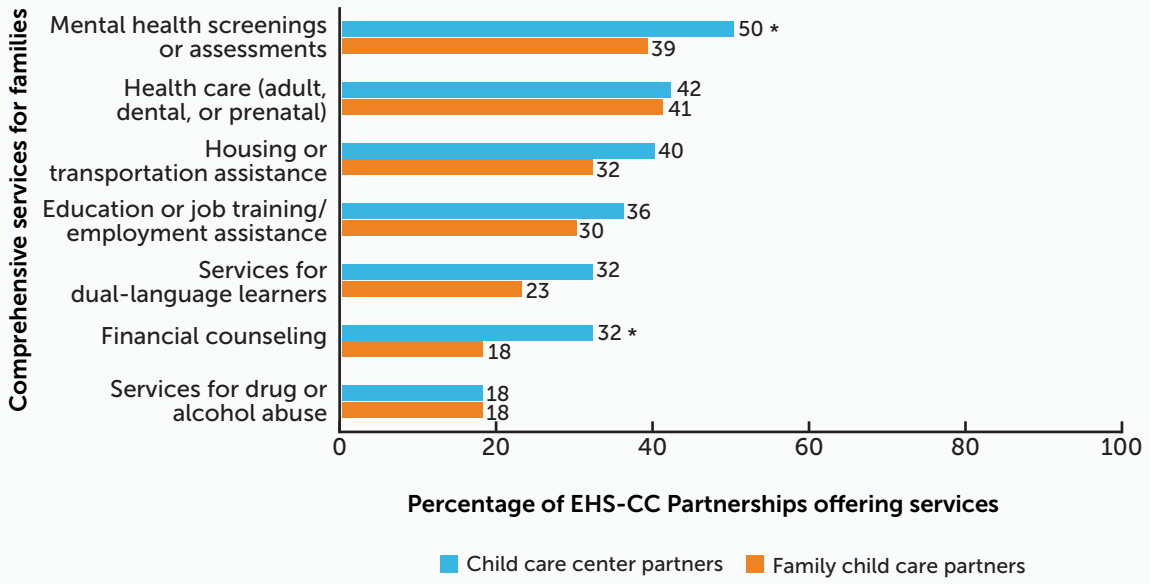
Data presented in this brief were gathered from two sources:

1. A web-based survey of the 250 EHS Expansion and EHS-CC Partnership grantees that received funding in 2015 for EHS-CC Partnership or funding for both EHS-CC Partnership and EHS Expansion. For the 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 EHS-CC Partnership grantee directors. The survey was conducted from February through November 2016; 82 percent of eligible respondents completed the survey.

The evaluation team used descriptive statistics such as frequencies, means, and ranges to describe EHS and child care partners. They conducted tests for statistically significant differences to support comparisons. Sampling weights for the child care partner survey and nonresponse weights for both surveys were used to ensure that responses represent all EHS and child care partners.

This brief includes results for the 220 EHS-CC Partnership grantees and 386 child care partners with completed web-based surveys.

Exhibit 2. EHS-CC Partnerships offered 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.
* Percentages differ significantly between child care center partners and family child care partners at the 0.05 level, two-tailed test.

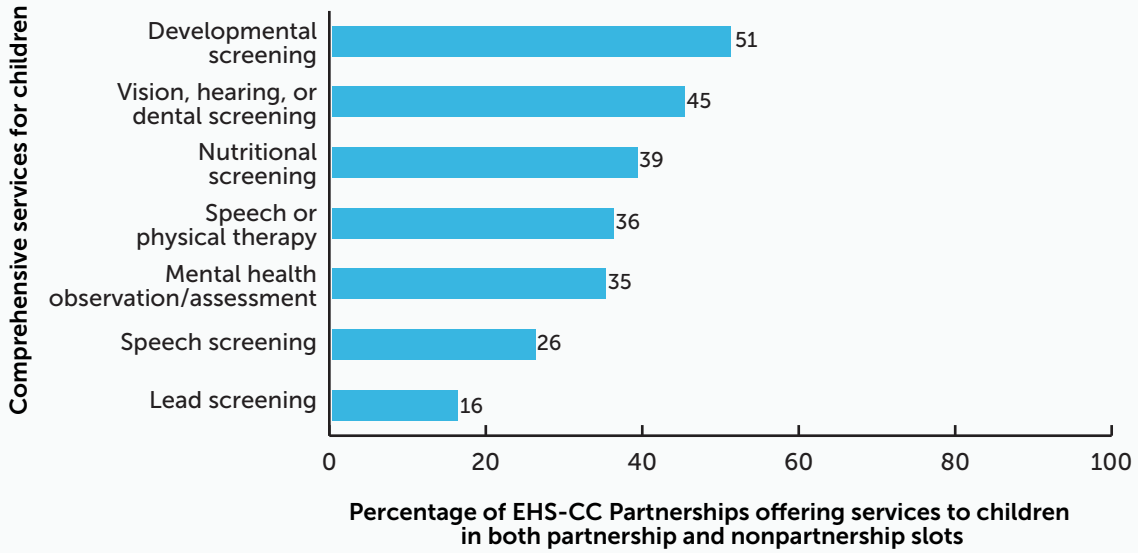
Most child care partners developed Individualized Family Partnership Agreements (IFPAs) and conducted home visits with families of children in partnership slots; child care center partners were more likely to engage in these activities than family child care providers. EHS-CC Partnerships engage in individualized family goal planning that includes developing IFPAs with enrolled families. This process aims 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. EHS-CC Partnerships also offer periodic home visits to enrolled families. Almost three-quarters of all child care partners (72 percent) developed IFPAs and 86 percent conducted home visits with families in partnership slots (not shown). 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).

Expanding the reach of EHS-CC Partnerships: To what extent did EHS-CC Partnerships offer comprehensive services to children in nonpartnership slots and their families?

EHS-CC Partnerships were encouraged to seek other funding sources to ensure that they could offer comprehensive services to all children and families, including those in nonpartnership slots.[8] Offering comprehensive services to all children and their families has the potential to benefit the local community more broadly.[9]

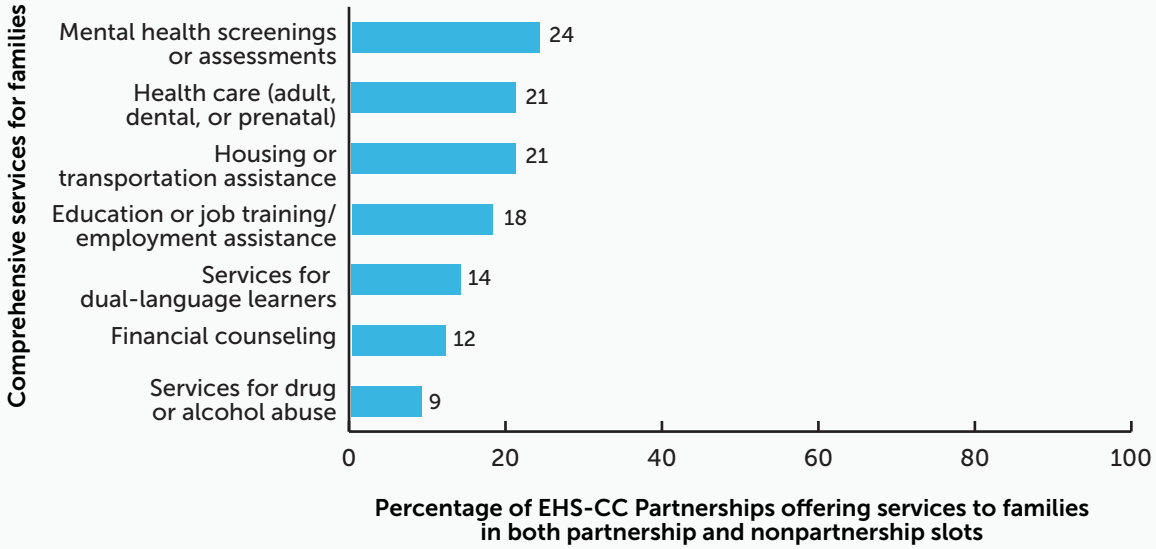
Many EHS-CC Partnerships offered services to children in nonpartnership slots. Seventy percent of child care partners provided at least one service to children in both partnership and nonpartnership slots (not shown). In other words, across EHS-CC Partnerships, about 24,000 (78 percent) of children in nonpartnership slots had access to at least some of these services (not shown). More specifically, at least 35 percent of child care partners offered developmental screening; vision, hearing, or dental screening; nutritional screening; speech or physical therapy; or mental health observations or assessments to children in both partnership and nonpartnership slots (Exhibit 3).

Exhibit 3. Many EHS-CC Partnerships offered comprehensive services to children in nonpartnership 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.

Exhibit 4. Some child care partners provided services to families of children in nonpartnership 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.

Many child care partners also offered services to the families of children in nonpartnership slots. Across all EHS-CC Partnerships, about 48 percent of families in nonpartnership slots (14,500 of a total of just over 30,000 nonpartnership slots) had access to at least one type of comprehensive service (not shown). At least 20 percent of child care partners offered mental health screenings or assessments; adult, dental, or prenatal health care; or housing or transportation assistance to families of children in partnership and nonpartnership slots (Exhibit 4).

Fewer child care partners developed IFPAs and conducted home visits with the families of children in nonpartnership slots. Compared with the large number of EHS-CC Partnerships that offered comprehensive services to children in both partnership and nonpartnership slots (Exhibit 3), fewer partnerships offered IFPAs and home visits to all families—22 percent of child care partners reported offering IFPAs, and 13 percent of child care partners reported offering home visits to families of children in partnership and nonpartnership slots (not shown).

Who provides comprehensive services to children and families in EHS-CC Partnerships?

Different entities in the EHS-CC Partnerships were responsible for providing comprehensive services to children and families. That is, the child care or EHS partner provided some services directly to children and families, or the EHS-CC Partnership referred children and families to community partners to receive services.

For most types of comprehensive services for children, EHS partners were responsible for providing services. Similar percentages of EHS partners (29 percent) and child care partners (25 percent) were responsible for providing developmental screenings. Many child care partners reported that service provision was not the responsibility of a single entity, but rather that services were provided by a combination of EHS partners, child care partners, or via referrals to community partners (Exhibit 5).

Comprehensive services for families were provided primarily by community partners via referral or by the EHS partner directly. Many child care partners also reported that services were provided by a combination of EHS partners, child care partners, or via referrals to community partners. Few child care partners reported that they were responsible for providing comprehensive services to families directly (Exhibit 6).

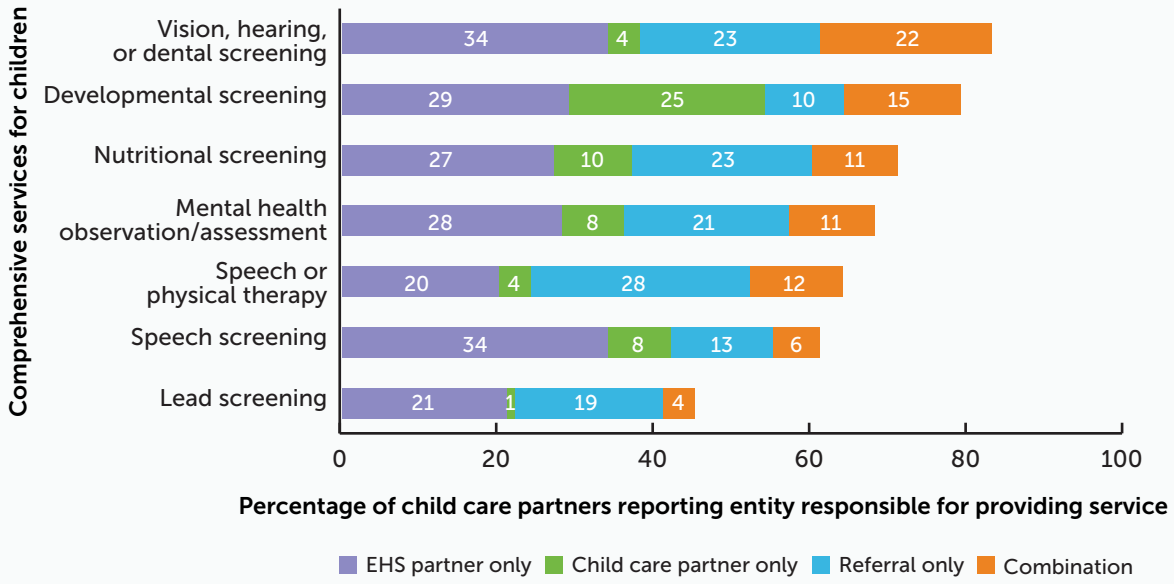
Reported changes in comprehensive services offered: To what extent did child care partners report offering comprehensive services before engaging in the EHS-CC Partnership grant?

Child care partners described their perceptions about how service offerings had changed since engaging in the EHS-CC Partnerships. 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 Partnerships, the following analyses are exploratory and cannot be solely attributed to the implementation of the EHS-CC Partnerships.

Child care partners reported offering more 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 reported offering developmental and other screenings, mental health observations or assessments, and speech or physical therapy to children before receiving the EHS-CC Partnership grant. In comparison, at least two-thirds of partners reported offering these services to at least some children in care after joining the EHS-CC Partnerships.

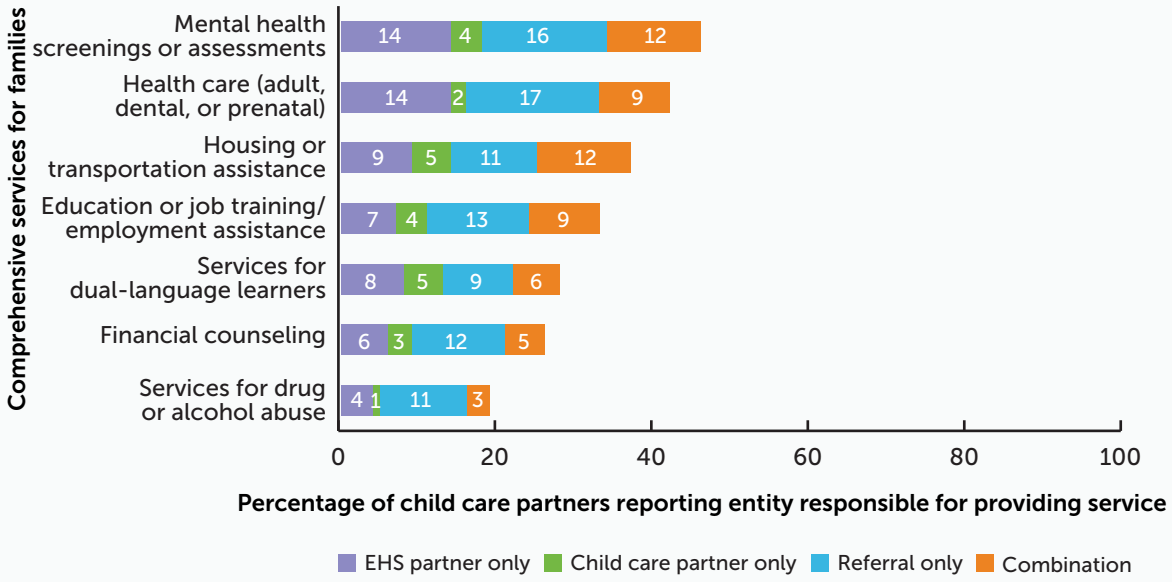
Child care partners reported offering more comprehensive services to families at the time of the survey than before the EHS-CC Partnership grant. Child care partners reported offering more mental health screenings or assessments, health care, housing or transportation assistance, education or job training/employment assistance, and financial counseling to families after the grant than before the partnership began. In addition, 31 percent of partners reported offering IFPAs and 23 percent offered home visits before the grant, compared with 72 percent offering IFPAs and 86 percent offering home visits after the grant.

Exhibit 5. EHS partners were primarily responsible for providing most comprehensive services to children



Source: EHS-CC Partnership Child Care Partner Survey.
Note: N = 386. Information was missing for 11 to 17 child care partners. Results are weighted to account for sampling probability and nonresponse.
"Combination" denotes that more than one entity (EHS partners, child care partners, or community partners) were responsible for providing the service.

Exhibit 6. Comprehensive services for families were primarily provided via referral



Source: EHS-CC Partnership Child Care Partner Survey.
Note: N = 386. Information was missing for 4 to 12 child care partners. Results are weighted to account for sampling probability and nonresponse.
"Combination" denotes that more than one entity (EHS partners, child care partners, or community partners) were responsible for providing the service.

Endnotes

[1] 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. The entities receiving funding under these 250 grants are these focus of this brief.

[2] 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; 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, pp. 412–425.

[3] 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.

[4] 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.

[5] Lim, Youngok, Diane Schilder, and Benjamin W. Chauncey. "Supporting Parents Through Head Start-Child Care Center Partnerships." *International Journal of Economic Development*, vol. 9, no. 3, 2007, pp. 205–238; 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.

[6] For more information about the study methods, see Box 3. For more detailed information, see the final report available at https://www.acf.hhs.gov/opre/resource/working-together-children-families-findings-national-descriptive-study-early-head-start-child-care-partnerships.

[7] An EHS partner is an existing or new EHS or Head Start organization that received an EHS-CC Partnership grant award in 2015. Eighty-seven percent of EHS-CC Partnership grantees had prior experience implementing EHS or Head Start.

[8] 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.

[9] Lim, Youngok, Diane Schilder, and Benjamin W. Chauncey. "Supporting Parents Through Head Start-Child Care Center Partnerships." *International Journal of Economic Development*, vol. 9, no. 3, 2007, pp. 205–238.

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