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

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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.

Partnering to improve the quality of infant-toddler care

This brief draws on data from the national descriptive study of Early Head Start-Child Care (EHS-CC) Partnerships to describe the activities partnerships engage in to improve the quality of services for infants, toddlers, and their families. 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.[2]

Prior research suggests that partnerships in early care and education have the potential to enhance the quality of care and offer comprehensive services to more children and families.[3] The national descriptive study is the first to examine the quality improvement efforts of partnering EHS programs and child care providers within a national sample. The data presented in this brief are drawn from surveys of 220 EHS-CC Partnership grantee directors and 386 child care center directors and family child care providers. The data provide national estimates of the activities they engaged in through their partnerships. Additionally, this brief highlights findings from in-depth case studies of 10 EHS-CC Partnerships to illustrate some of the quality improvement opportunities and challenges they encountered.[4] As described below, the EHS and child care partners worked together on a range of activities to set high standards for quality, assess their quality improvement needs, and support high quality caregiving and learning environments for infant and toddlers. Specifically, this brief addresses the following questions:

- How do EHS-CC Partnerships ensure all settings serving infant and toddlers are meeting the Head Start Program Performance Standards (HSPPS)?
- How do EHS-CC Partnerships identify quality improvement needs?
- How do EHS-CC Partnerships support the skills and credentials of staff caring for infants and toddlers?
- How do EHS-CC Partnerships support high quality learning environments for infants and toddlers?

Box 1. 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. Data were collected following the first year of implementation, approximately 12 to 18 months after receiving the grant.

The national descriptive study gathered data from three 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.
3. In-depth data from case studies of 10 EHS-CC Partnerships that varied in their characteristics and approaches to implementation. The case studies, which were conducted in 2017, included in-person and telephone interviews with EHS and child care partner directors, other key partnership staff, parents, and state and local stakeholders (such as child care administrators and child care resource and referral agency staff).

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. Analysis of the case study data involved using standard qualitative procedures to analyze and summarize information from semistructured interviews and focus groups. It included 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.

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

How do EHS-CC Partnerships ensure all settings serving infants and toddlers are meeting the HSPPS?

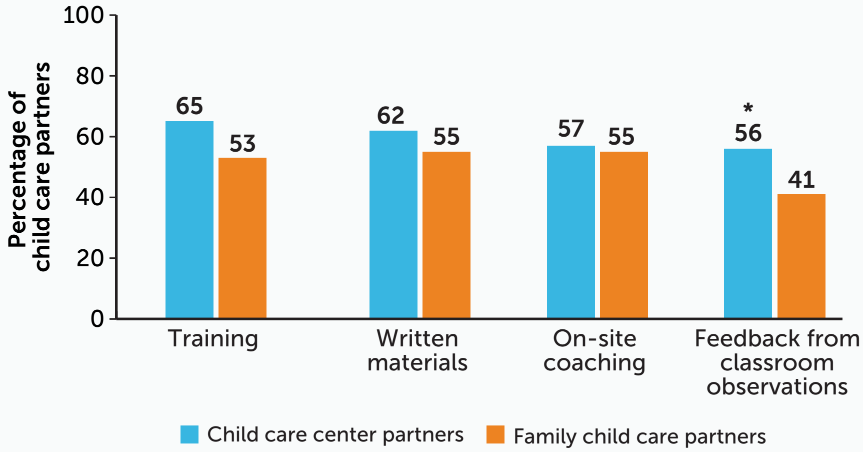
The HSPPS define the standards and minimum requirements for the entire range of EHS services and serve as the foundation for EHS's mission to deliver comprehensive, high quality individualized services supporting the growth and development of children from low-income families. Under the EHS-CC Partnerships, meeting the HSPPS is required for the child care providers partnering with EHS programs.[5,6]

Most child care partners (71 percent) received guidance on implementing the HSPPS from their EHS partners. Seventy-five percent of child care center partners and 65 percent of family child care partners received some form of guidance from EHS partners on implementing the HSPPS, including training, written materials, coaching, and/or feedback from classroom observation from EHS partners on how to meet the HSPPS. Overall, child care centers and family child care partners received similar types of guidance from EHS partners, with one exception: compared to family child care partners, a significantly higher percentage of child care center partners received feedback from classroom observations (Exhibit 1).[7]

"[Implementing] the HSPPS resulted in a focus on child development, the use of a curriculum, and reduced the adult-to-child ratio."

Source: Parent focus group, Case study interviews, 2017.

Exhibit 1. Guidance received by child care partners from their EHS partners on implementing HSPPS



Source: EHS-CC Partnership Child Care Partner Survey.
Note: N = 386. Information was missing from 2 to 23 child care partners, depending on the type of guidance. 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.

After approximately one year of implementing the partnership, nearly all child care partners (94 percent) reported that they met most or all of the HSPPS.[8] Only 21 percent reported meeting the standards before participating in the EHS-CC Partnership. Only 6 percent reported they found the standards difficult to meet, although the case studies describe some specific challenges (see Box 2).

How do EHS-CC Partnerships identify quality improvement needs?

As noted above, only about one-fifth of child care partners felt they were already meeting the HSPPS before entering a partnership with EHS. Differences in child care partners' readiness to implement the standards required EHS and child care partners to work together to identify the specific strengths, challenges, and types of supports they needed to provide high quality services and meet and maintain the HSPPS.

Nearly all EHS partners engaged in activities with child care partners to monitor the quality of services offered. The most common quality monitoring activities the partners engaged in were observations of teachers or family child care providers in the classroom or home to assess practice (97 percent of EHS partners), followed by the use of checklists to assess HSPPS compliance (96 percent of EHS partners), and review of program files (95 percent of EHS partners). A large majority (90 percent) of EHS partners also offered reviews of program data to monitor progress toward goals and lesson plans. More than 70 percent of EHS partners said that EHS partner staff, rather than child care partner or other staff, were primarily responsible for quality monitoring activities (Exhibit 2). During the case studies, EHS and child care partner staff described strategies that improved child care partner engagement in the quality monitoring process (see Box 3).

Box 2. Lessons learned from the case studies: Challenges meeting the HSPPS

Implementing the HSPPS was challenging for some EHS-CC Partnerships. The types of challenges encountered by partnerships included the following:

- **Meeting the staff–child ratio requirements of the HSPPS.** A low supply of qualified teachers, combined with high turnover rates of staff hindered child care center partners' efforts to employ enough qualified teachers. Some child care partners also said that maintaining the required staff–child ratios led to lower revenues (because settings had to serve fewer children or hire additional staff).
- **Meeting health and safety standards, especially for family child care partners.** Renovations to homes were sometimes required for family child care partners to meet the health and safety standards, and the renovations could be very costly. In addition, family child care partners in urban areas had trouble meeting the space and playground requirements.
- **Completing paperwork and documentation required for the EHS-CC Partnership.** Teachers in child care center partners and family child care partners found the required paperwork, documentation, and assessments overwhelming.

Box 3. Lessons learned from the case studies: Identifying and addressing quality improvement needs

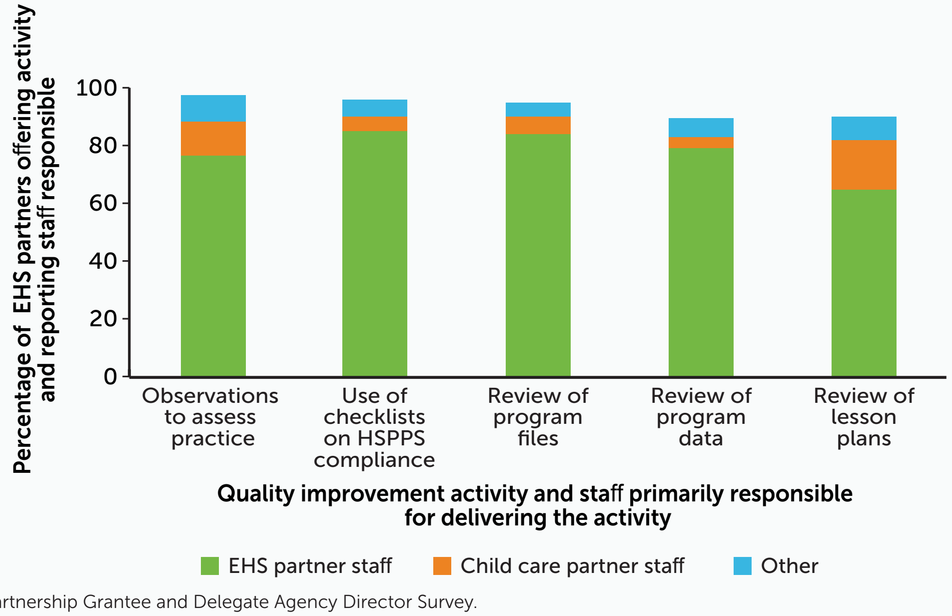
EHS partner staff found it difficult to address quality improvement needs when child care partners were resistant to change or disagreed with assessment findings. To address this challenge, EHS and child care partners worked together to build child care partners' engagement in the quality monitoring process in the following ways:

Actively involve the child care partners in the assessment or monitoring process. By actively involving child care partners in the assessment and monitoring process, EHS partners both gained child care partners' buy-in on needed changes and ensured that quality improvement plans were tailored appropriately to the specific circumstances and needs of each child care partner. In one program, the child care partners were actively involved in collecting the data that informed their quality improvement plans. EHS 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 EHS staff.

Build relationships between EHS and child care partner staff before recommending changes. By taking time to build relationships between EHS and child care partner staff and getting their buy-in on changes they needed to make to meet the HSPPS, EHS partners found it easier to work together to support needed changes. One EHS partner worked with a family child care partner after an observation to determine why something did or did not work. The family child care partner liked that the EHS partner observed and listened first, rather than just telling them what to do. The child care partner center directors in another program appreciated that the EHS staff took the time to understand their unique needs and how processes and procedures would actually work at the centers.

EHS partners used information gathered during quality monitoring activities to provide staff training. At least 90 percent of EHS partners used information gathered during each of the quality monitoring activities shown in Exhibit 2 to provide staff training. At least 88 percent also used information gathered during these activities to schedule follow-up reviews or observations, develop written implementation plans, or obtain technical assistance.

Exhibit 2. Quality monitoring activities and the staff who were primarily responsible for delivering the activities



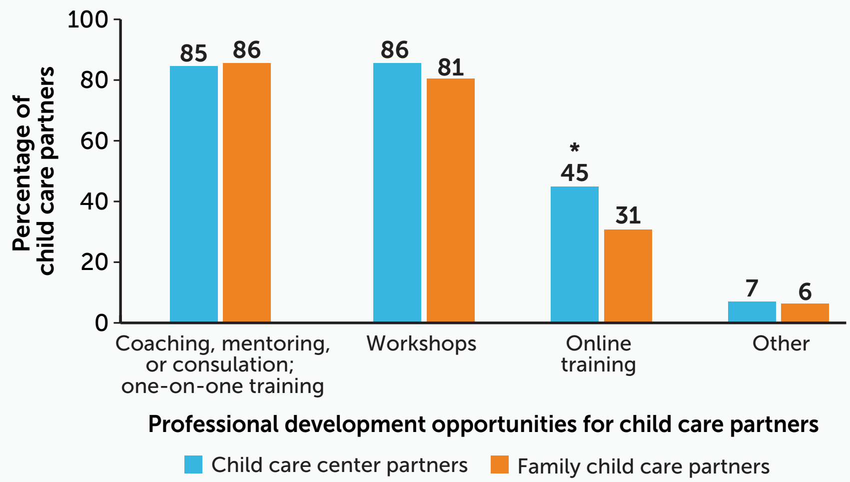
Source: EHS-CC Partnership Grantee and Delegate Agency Director Survey.
Note: N = 220. Information was missing for zero to eight grantees. Results are weighted to account for nonresponse. Percentages do not sum to 100 because respondents selected all activities that applied.
HSPPS = Head Start Program Performance Standards.

How do EHS-CC Partnerships support the skills and credentials of staff caring for infants and toddlers?

Nurturing and responsive relationships with caring adults are the cornerstone of high quality infant-toddler care. Infants and toddlers are most likely to benefit from their early learning experiences through responsive interactions with teachers and caregivers. To this end, supporting the skills, competencies, and credentials of those teachers and caregivers are key priorities for high quality infant-toddler care. The HSPPS include specific requirements for teacher/caregiver credentials, as well as ongoing training and skill development; accordingly, the EHS-CC partnerships engaged in a number of activities aimed at promoting the skills and credentials of staff caring for infants and toddlers.[9]

EHS partners offered professional development opportunities to most child care partners. Eighty-five percent of child care center partners and 86 percent of family child care partners said that their EHS partners offered them the opportunity to receive coaching or one-on-one training; similar percentages had the opportunity to participate in workshops (Exhibit 3). During the case studies, EHS partner staff discussed strategies for addressing barriers to engaging child care partner staff in professional development (see Box 4).

Exhibit 3. Most child care partners were offered coaching and workshops through the EHS-CC Partnership



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.

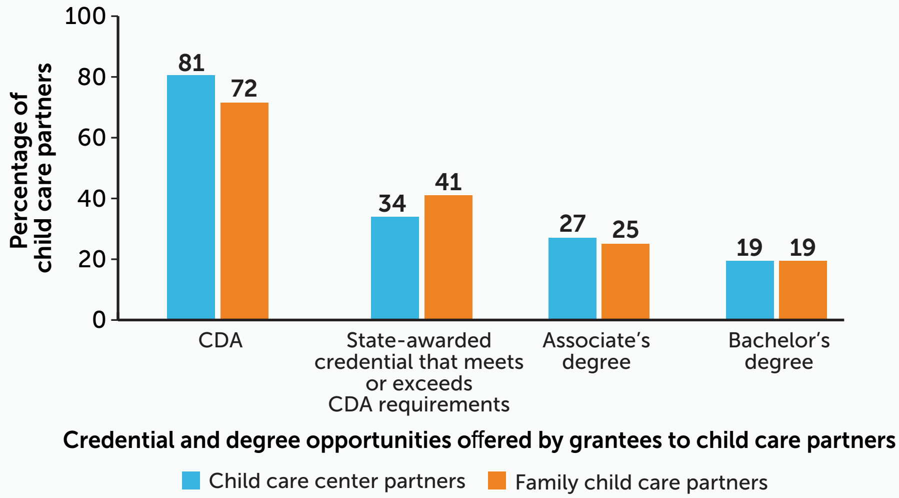
Box 4. Lessons learned from the case studies: Addressing barriers to engaging child care partners in professional development

Child care partner staff often struggled to attend trainings offered by EHS partners. EHS-CC Partnerships used several strategies to address barriers:

- Provided trainings at night or on weekends
- Alternated training times to attempt to accommodate everyone's schedules
- Provided food, child care, and pay to incentivize attendance at trainings outside of work hours
- Provided training during planned shutdown weeks or days when the child care centers or family child care providers were closed
- Used online training options
- Built connections with local organizations, such as child care resource and referral agencies, that offered training opportunities

More than three-quarters of child care partners said staff had the opportunity to obtain a Child Development Associate credential through the EHS-CC Partnership. Thirty-seven percent of child care partners said that staff had the opportunity to obtain a state-awarded credential that met or exceeded Child Development Associate 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 (Exhibit 4).

Exhibit 4. 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.

How do EHS-CC Partnerships support high quality learning environments for infants and toddlers?

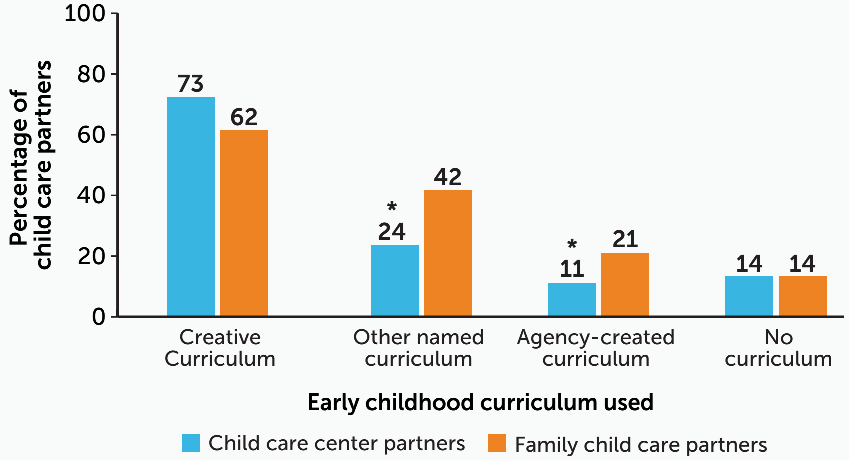
In addition to supporting responsive relationships between caregivers and children, high quality early learning environments for infants and toddlers are characterized by evidence-based curricula and individualized services implemented within the context of safe, structured, and stimulating settings. As noted above, EHS-CC Partnerships supported high quality infant-toddler care through professional development and training opportunities for staff. The partnerships also supported quality improvement in the broader learning environment in several ways described below.

Most EHS and child care partners met regularly to discuss individualizing services for children and families. Seventy-eight percent of child care partners met regularly with EHS partners 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.

A large majority (86 percent) of child care partners used an early childhood education curriculum. The most commonly used curriculum was Creative Curriculum, which about 70 percent of partners used (Exhibit 5). 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. (By "named" curriculum, we mean a curriculum other than an agency-created curriculum.[10])

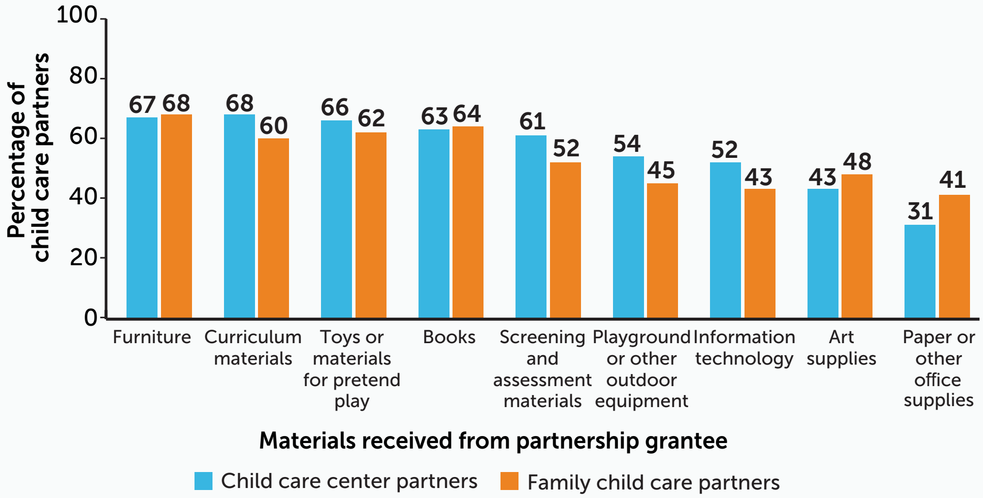
Child care partners received a variety of materials and supplies through the EHS-CC Partnerships to support safe and stimulating learning environments. In addition to receiving funds through the EHS-CC Partnership to purchase equipment and supplies, child care partners also received such items directly from their EHS partners. The most common materials child care partners received were furniture, such as cribs or bookshelves; curriculum materials; toys or materials for pretend play; and books. At least 50 percent of child care partners also received screening and assessment materials and playground or other outdoor equipment (Exhibit 6).

Exhibit 5. Most child care partners used an early childhood education 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.

Exhibit 6. Child care partners received a variety of materials from their EHS partners



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.

Endnotes

[1] ACF awarded 275 Early Head Start 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] For information about the study methods, see Box 1. 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.

[3] See for example, Edwards et al. (2002), Ontai et al. (2002), Paulsell et al. (2006), and Schilder et al. (2009).

[4] In this brief, the case study findings are presented separately from findings from the surveys (in pull-out boxes) and do not represent national estimates.

[5] 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.

[6] 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.

[7] One reason for this discrepancy may be that the survey item referred specifically to classrooms, and family child care homes do not contain classrooms per se. Thus, family child care manager/owner respondents may have reported that classroom observations do not occur because they did not consider the family child care setting to be a classroom.

[8] It is important to note that the views of the child care partners regarding their compliance with the HSPPS at various time points are self-reported and retrospective; this finding is not based on results of Head Start's formal monitoring process, and surveys of child care partners were conducted 12 to 18 months after award of the EHS-CC Partnership grant. In addition, most data collection for this study took place before any formal monitoring by Office of Head Start.

[9] The HSPPS stipulate that center-based teachers must have a minimum of an infant-toddler Child Development Associate credential (or a comparable credential) and family child care providers must have or acquire a minimum credential within 18 months of beginning to provide services.

[10] 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.

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