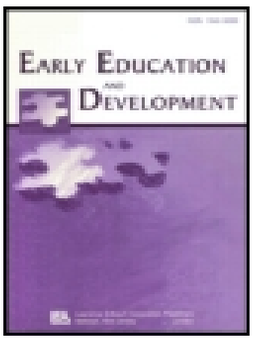

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RESPONSE TO CALL



# Approaches to Collaboration: Experiences of the Early Head Start-Child Care Partnerships

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**ABSTRACT**

This study examined how partnerships between early care and education providers were developed and how they worked together to deliver comprehensive, high-quality services to infants and toddlers from low-income families. Survey data were collected from 220 Early Head Start (EHS) program directors and 386 child care center directors and family child care providers participating in EHS-child care partnerships. *Research Findings*: Nearly half of EHS programs chose partners with whom they had prior relationships, and most engaged them early (often before receiving the grant). Both EHS programs and child care providers described their relationships as mutually respectful and focused on similar goals. Through the partnerships, child care providers had access to professional development opportunities and offered children and families comprehensive services, such as health screenings. *Practice or Policy*: This study provided a nationally representative picture of EHS-child care partnerships. The findings suggest that strong relationships are foundational to the implementation of early care and education collaborations aimed at expanding access to high-quality care for infants and toddlers from low-income families. Collaborations are a potentially important policy lever that can help support the expansion of high-quality early care and education.

More than half of the 12 million infants and toddlers in the United States spend at least some of their day being cared for by someone other than their parents (Mamedova, Redford, & Zukerberg, 2013). Most of these infants and toddlers spend at least some of their time in center-based or home-based early care and education settings. When these settings are high quality, it helps children develop the social, emotional, and cognitive skills they will need for success in school and in their lives outside of school. Unfortunately, affordable high quality early care and education for infants and toddlers is scarce (Jessen-Howard, Malik, Workman, & Hamm, 2018).

Early Head Start (EHS) and the Child Care and Development Fund (CCDF) are two federally-funded programs available to help low-income families access infant and toddler early care and education. EHS is administered by the Office of Head Start in the Administration for Children and Families (ACF), the U.S. government agency that promotes the economic and social well-being of children and families through grants to state and local entities. EHS offers comprehensive, early care and education to infants and toddlers under age 3 from low-income families, as well as social and economic support services to their families. In addition to EHS, ACF also administers Head Start,

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Supplemental data for this article can be accessed here.

a federally funded preschool program for low-income children 3 to 5 years of age. Local agencies receive grant funding to operate EHS and Head Start programs; the Office of Head Start manages the funds and oversees the local service agencies. CCDF is a federal and state partnership program administered by states, territories, and tribes with funding and support from ACF's Office of Child Care. 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 programs.

In 2015, 250 state and local public, nonprofit, and for-profit private entities received funding from ACF to support collaboration between two types of early care and education providers: federally funded EHS programs and center-based or home-based child care settings serving families eligible for financial assistance under CCDF. The grants were called the EHS Expansion and EHS-Child Care Partnership grants. The goal of the grants was to "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 programs that received the grants identified and partnered with child care providers, including child care centers or family child care homes. These EHS programs and child care providers created formalized partnership agreements. The agreements specified how the partners would work together to deliver high quality, comprehensive early care and education services to enrolled infants and toddlers (Office of Early Childhood Development, 2016). One goal of the partnerships was to more effectively serve children whose families receive financial assistance to help offset the cost of child care. Another goal was to increase the supply of high-quality early care and education for infants and toddlers living in low-income working families (Office of Early Childhood Development, 2016).

## *The Potential Benefits of Collaboration in Early Care and Education*

Prior research in early care and education suggests that collaboration may enhance the quality of care and increase the provision of comprehensive services to children and families (e.g., Lim, Schilder, & Chauncey, 2007; Schilder & Smith Leavell, 2015; Schilder et al., 2009). Partnering organizations can achieve this by bringing together the resources and strengths of multiple organizations and funding streams.

A body of research has shown improved quality among center-based child care providers in partnership with Head Start and EHS programs. For example, a matched comparison design study of Head Start–child care partnerships in Ohio found that, for center-based child care classrooms, those that partnered with Head Start exhibited significantly higher quality than those that did not (Schilder et al., 2009). A separate descriptive study found that nine child care centers that partnered with EHS programs had higher observed quality than other infant-toddler child care providers in Nebraska (Edwards et al., 2002). Finally, another descriptive study found that quality increased in 11 classrooms in a child care center that contracted with an EHS program in a mid-sized Midwestern community over nine months (Ontai, Hinrichs, Beard, & Wilcox, 2002).

Though partnerships may have the potential to improve the early care environment in child care centers, findings were mixed regarding whether partnerships with EHS or Head Start could improve the quality of family child care. Schilder et al. (2009) found no significant differences in quality for family child care providers between treatment and comparison groups. Family child care providers partnering with Head Start were more likely to offer an enriched curriculum but performed significantly less favorably on measures of child-caregiver interaction. Another study described the quality of care among family child care providers and family, friend, and neighbor caregiver settings after receiving quality improvement support through EHS (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006).

Several studies have also found that providers partnering with a Head Start, EHS, or state prekindergarten program were more likely to participate in professional development and specialized

training. Schilder et al. (2009) found this correlation among family child care providers partnering with Head Start. In an earlier study, Schilder et al. (2005) found that partnership was a strong, statistically significant predictor of additional training and professional development opportunities. A study of licensed child care centers in California found that teachers in centers that partnered with Head Start or the state department of education had higher levels of education and were more likely to be trained to work with dual-language learners and/or special-needs children (Whitebook, Kipnis, & Bellm, 2007). A descriptive study of child care quality and characteristics of the child care work force in Nebraska found that staff at child care centers that partnered with EHS programs completed more training than other infant-toddler child care providers in Nebraska (Edwards et al., 2002). They also participated in more training for college credit, training for credit toward a child development associate (CDA) credential, and curriculum training than their Nebraska child care counterparts.

Additional research suggested that partnerships enhance providers' ability to provide comprehensive services. Comprehensive services are designed to promote the health and well-being of children and support families in their role as parents. They are a cornerstone of EHS and are required by the EHS Program Performance Standards. Schilder et al. (2009) found that family child care providers partnering with Head Start were more likely to provide comprehensive services. Another study of child care centers in New York and Virginia found that engaging in a collaboration that brings in preschool and/or Head Start funding provided child care centers with additional services (Selden, Sowa, & Sandfort, 2006). Additional services included an on-site nurse; a full-time family worker to provide parent education and conduct home visits; and additional medical, social, and mental health services for participating children and families.

### *The Role of Relationships in Facilitating Early Care and Education Collaborations*

Prior research on early care and collaborations also points to the role of relationships in helping organizations address and overcome potential challenges. One descriptive study of partnerships between EHS and family child care providers emphasized the importance of establishing these relationships during the planning phase (Del Grosso, Akers, & Heinkel, 2011). A national study of partnerships between Head Start and child care noted that strong relationships between partners, including a shared philosophy and vision for the partnership, helped foster mutual respect and bilateral decision making (Schilder, Kiron, & Elliott, 2003). A study of partnerships between Head Start and child care in Ohio found that good communication and relationships improved classroom environments and quality supervision (Schilder et al., 2009). Findings from case studies of 10 partnerships between EHS programs and child care providers included in a national study of EHS and child care partnerships found that partnerships ran more smoothly when the EHS program made decisions in collaboration with child care providers, rather than unilaterally (Del Grosso et al., 2019). Child care providers that described the EHS program as engaging them as equal partners said they could voice their concerns and work through challenges together as a team with the EHS program. Both EHS program directors and child care providers said that when expectations about partnership program requirements and benefits were clear and realistic, it helped facilitate more positive relationships between EHS programs and child care providers. The study also found that when EHS programs engaged child care providers in the process of developing formalized partnership agreements and when partners communicated regularly through scheduled meetings, communication protocols, and frequent informal communication (such as email and unscheduled calls), they maintained a positive relationship.

### *Gaps in the Knowledge Base*

Although collaboration in early care and education has been the focus of several studies, the existing knowledge base has several gaps. First, few studies report findings from the perspective of the child care provider. The existing literature therefore cannot explore child care providers' motivations to partner, experiences with partnerships, factors that facilitate partnerships, and partnership successes

and challenges. Instead, most studies reported findings from the perspective of the lead partner (Head Start, EHS, or state preschool program). Second, most studies have limited generalizability to a national context. A number of the studies had small sample sizes or were studies of initiatives in a specific state or geographic region (Edwards et al., 2002; Ontai et al., 2002; Paulsell et al., 2006; Schilder et al., 2009; Selden et al., 2006; Whitebook et al., 2007). Third, of the existing literature, many studies do not focus on infants and toddlers, but instead focus on slightly older children who are approaching Kindergarten age.

## Early Head Start-Child Care Partnerships

To better understand the characteristics of early care and education collaborations, the Office of Planning, Research, and Evaluation in ACF commissioned a nationally representative, mixed-method descriptive study of EHS-child care partnerships (Del Grosso et al., 2019).[1] The study focused on the partnerships between EHS programs and child care providers that received federally-funded grants in 2015. It was conducted during the first 12 to 18 months of implementation of the grant (2016–2017). The study was designed to address the gaps in the knowledge base on partnerships between EHS and child care providers by both providing a national picture of these partnerships and describing the viewpoint of a nationally representative sample of child care providers.

Through the partnerships, EHS programs and child care providers were required to deliver full-day, full-year early care and education services to infants and toddlers from low-income families. The partners offered services designed to support children's healthy development and parents' role as their child's first teacher (Office of Early Childhood Development, 2016). Services include, but are not limited to, developmental assessments, health screenings, parenting classes, and linkages to economic supports. The EHS-child care partnerships were expected to combine funding sources, including the federal grant and child care subsidies funded by CCDF or another source (such as Temporary Assistance to Needy Families, Social Services Block Grant, or private funding).

Together, the EHS programs and child care providers were required to meet the EHS Program Performance Standards for children funded under the grant. The performance standards outline requirements for EHS programs related to program governance, financial and administrative requirements, and federal administrative procedures (Administration for Children and Families, 2018). Among other things, the standards include requirements for program operations and comprehensive services for children and families.[2] In addition to the performance standards, child care providers also needed to meet applicable state and local child care licensing requirements. Child care providers that do not receive EHS funding are not required to meet the performance standards; all regulated providers are, however, required to meet applicable state and local child care licensing requirements.

Our conceptual framework demonstrates how EHS-child care partnerships rely on collaboration to achieve shared goals. The EHS programs and child care providers jointly delivered services to children and families. They operated under formalized agreements and were required to jointly adhere to performance standards. As shown in Figure 1, which depicts our conceptual framework, EHS programs and child care providers invest in inputs and carry out activities designed to achieve key outcomes, such as improved staff competencies and increased community supply of high-quality infant-toddler care. The key collaborative activities undertaken by partnership programs to improve outcomes include developing and maintaining partnerships and delivering comprehensive, high-quality, individualized services to children and their families.

## The Present Study

Given prior research showing that strong relationships may help facilitate early care and education collaborations, we sought to understand how the EHS programs and child care providers funded under the EHS-child care partnership grant developed and formalized the partnerships, as well as the activities they engaged in to build and maintain relationships among staff across organizations. We

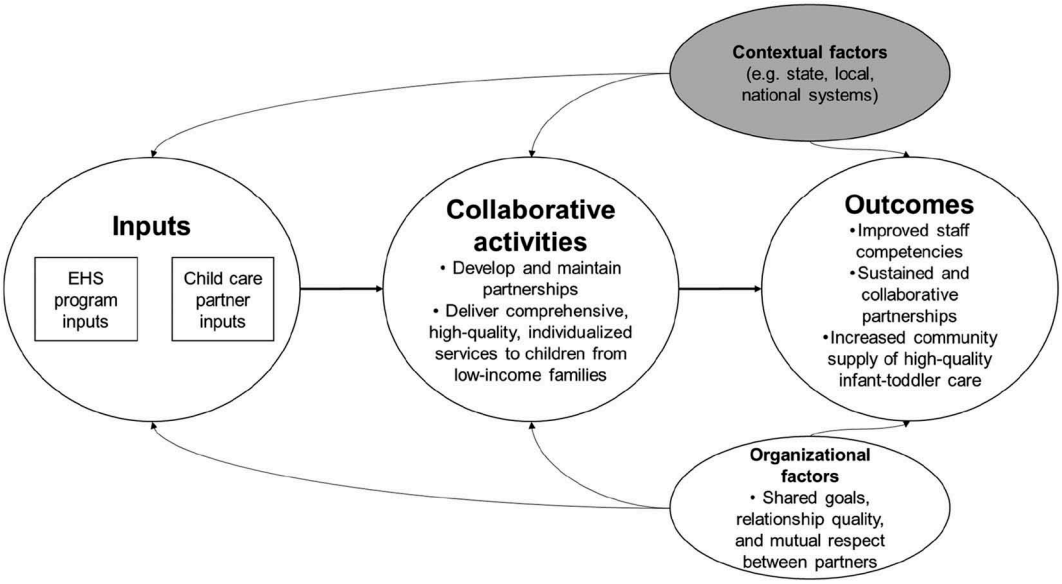


**Figure 1.** Early Head Start-child care partnership conceptual framework.

also explored the partnership activities that increased the provision of comprehensive, high-quality, individualized services, such as increasing teacher and family child care provider credentials, monitoring quality, and enhancing the caregiving environments through the provision of materials. Given prior research suggesting that early care and education collaborations may enhance provision of comprehensive services, we also documented the comprehensive services offered to children and families. In particular, we assessed the services EHS programs and child care providers offered to children whose care was funded under the grant (which we refer to in this study as children in partnership slots) as well as the services extended to other children cared for in the same setting but whose care was not supported by the grants (which we refer to as children in non-partnership slots).

This article addressed two research questions:

(1) How are partnerships between EHS programs and child care providers developed and maintained; and
(2) How do partners work together to deliver comprehensive, high-quality, individualized services to children from low-income families.

These primary research questions correspond to the key collaborative activities included in the conceptual framework. The study measured several inputs of EHS programs and child care providers (such as their years of experience providing EHS services and their prior collaboration experience), as well as organizational factors that may affect the partnerships (such as the quality of the collaborative relationships). This study does not address the contextual factors, such as state, local, or national systems, that can also affect outcomes.

## Method

This study draws on survey data gathered from two surveys of participants in an EHS-CC partnership – one focusing on EHS programs and one focusing on child care providers. Data were collected as part of the nationally representative, mixed-method descriptive study of EHS-child care partnerships (Del Grosso et al., 2019).

### Participants

All 250 EHS programs that received grant funds for EHS-CC partnerships in 2015 were contacted. As part of the survey, EHS programs listed all child care providers they were partnered with. A random sample of these providers was then chosen to participate in a separate child care provider survey.

EHS program directors identified 1,749 child care providers. A random sample of at least 20% of child care centers and family child care homes, with a minimum of one child care provider of each type the EHS program was partnered with, was selected. Sampling occurred separately by provider type to ensure a robust sample of family child care homes. The resulting sample consisted of 470 child care providers to participate in the provider survey.

Random selection was dynamic in the web-based survey so that EHS program directors could be asked a series of questions about the selected child care providers. This approach allowed sampled child care providers to be linked to the EHS program they partnered with.

The respondents to the EHS program and child care provider surveys had different educational backgrounds (Table 1). EHS program directors had higher educational attainment than child care center directors or family child care managers; nearly two-thirds of EHS program directors had a graduate degree and less than 5% had less than a college degree, while only one-quarter of directors or managers had a graduate degree and one-third had less than a college degree. Among those with a degree, child care center directors or family child care managers were more likely to have a degree in child development, developmental psychology, or early childhood education than EHS program directors. Both types of respondents had similar experience in early childhood education. The experience and education levels of surveyed EHS program directors was in line with those of EHS program directors nationally (Vogel et al., 2011). The average EHS program served about 50% more children than the average child care provider before the partnership began (42 versus 28).

### EHS Programs

EHS programs were geographically diverse. Survey respondents came from 48 of the 50 states, plus Washington, DC and Puerto Rico. About half of the EHS programs operated in large urban areas with populations of 1 million or more. One-third of the programs were in smaller metropolitan areas, 13% were in urban areas with a population of at least 2,500, and the rest came from completely rural locations or a region with fewer than 2,500 people.

Most EHS programs were nonprofit organizations (about three-quarters). A large share of EHS programs were also community-based organizations (about one-quarter), or community action agencies or community action partnerships (another one-quarter). This distribution of organization types was broadly similar to that of EHS programs as a whole; nearly half of all EHS programs were

**Table 1.** Characteristics of survey respondents.

| Characteristic | EHS programs ($n$ = 220) | Child care providers ($n$ = 386) |
|---|---|---|
| Educational attainment | | |
| Less than a college degree | 2% | 33% |
| Associate's or Bachelor's degree | 34% | 43% |
| Some graduate degree (Master's, Ph. D., or other professional degree) | 65% | 24% |
| Field of highest degree (among those with an Associate's degree or higher) | | |
| Child development or developmental psychology | 10% | 17% |
| Early childhood education | 29% | 43% |
| Other | 61% | 39% |
| Average years of experience in early childhood education | 15.5 | 15.4 |
| Average years in current position | 8.0 | 11.1 |
| Average number of infant-toddler slots before the partnership | 42.4 | 28.3 |

Data from EHS program survey and child care provider survey. Results are weighted to account for nonresponse and, for child care providers, sampling probability. Information was missing for 1 to 20 EHS programs and for 14 to 38 child care providers. EHS = Early Head Start.

nonprofit organizations, about 30% were community action agencies, 11% were school systems, and 7% were government agencies (Mayoral, 2013).

### Child Care Providers

Nearly all child care providers offered full-day, full-year care. Ninety-eight percent of child care providers offered at least 1,380 annual hours of service. Child care providers were open a median number of 11 hours per day, 5 days per week, and 52 weeks per year. According to the National Survey of Early Care and Education, about 30% of child care centers offered fewer than 30 hours per week of care (National Survey of Early Care and Education Project Team, 2014).

## Procedures

Both web-based surveys were administered in 2016. The first survey collected information from EHS programs. The survey included all 250 EHS programs that received funds for EHS-CC partnerships in 2015. Of the 250 programs eligible to complete the survey, 220 completed it, for a response rate of 88%. The second survey collected information from child care providers. Of the 470 child care providers partnered with the EHS programs contacted for participation, 302 were child care centers and 168 were family child care homes. The response rate was 82% with 386 eligible child care providers completing the survey.

## Measures

The two surveys included questions asking EHS program directors and child care center directors and family child care managers or owners about their partnerships. Key topics included partnership development activities, quality improvement activities, and services for children and families. Example questions in the EHS program survey[3] included asking if partnerships with any child care providers had been terminated, and if so for what reason; and the processes in place to support quality relationships with the child care providers and the frequency of those activities. Example questions from the child care provider survey[4] included the types of professional development opportunities and equipment and supplies provided by the EHS program, and opportunities to obtain various education credentials.

Most of the questions were based on those used in previous studies with the exception of new items that were included to capture new constructs unique to EHS-CC partnerships. For example, questions were used or adapted from a longitudinal national study of EHS programs (Vogel et al., 2011), a study of partnerships between Head Start programs and child care providers (Schilder et al., 2009), and a national survey of early care and education (National Survey of Early Care and Education Project Team, 2013). Where applicable, questions included a list – for example, specific equipment and supplies, or particular types of comprehensive services – that made it easier for respondents to select from a common set of responses. Lists always included an option for "other," where the respondent could then provide more details. Detailed other responses that fell into an existing category included in the primary list of options were re-coded.

## Analysis

To address the research questions posed in this article, we performed descriptive statistical analyses from the surveys, such as reporting frequencies and means. To ensure that survey responses were representative of the entire cohort of 2015 EHS-CC partnership grantees, we developed weights for EHS programs and child care providers. These weights accounted for survey nonresponse in both the EHS program and child care provider surveys. To identify EHS programs that were comparable to those that did not complete the survey, we used information available about the grants from the Head Start Program Information Report and basic information about funded enrollment and

location. We used information about EHS program type (if a program had partnerships with child care center providers only or had a partnership with at least one family child care provider) and census region to develop these weights. To identify child care providers that were comparable to those that did not complete the survey, we used information the EHS program reported about the providers they partnered with to weight responding child care providers within type (child care center or family child care home) and census region to account for the non-responding providers. The child care provider weights also adjusted for the probability of selection for the provider survey.

## Results

### *Developing and Maintaining Partnerships*

#### *Developing Partnerships*

Almost half (46%) of the child care providers reported having experience collaborating with the EHS program before the partnership began (Figure 2). Prior collaboration experience took several forms. EHS programs reported a previous partnership to serve EHS or Head Start children and families with 18% of child care providers they partnered with. They collaborated with 14% of the providers as part of a community collaborative group and with 11% as part of a joint training event.

EHS programs engaged child care providers early in the planning process for the grant. EHS programs recruited 60% of the child care providers they partnered with before or during the grant application process and the rest after grant award (Table A1, top panel). EHS programs recruited most child care center providers (73%) during the application process; they recruited most family child care providers (59%) after award.

EHS programs used a range of strategies to recruit child care providers and they often used multiple strategies (with about half of providers). The most common strategy EHS programs used to recruit child care providers was to initiate a discussion directly. According to EHS program directors, almost half (48%) of child care providers were recruited during discussions initiated by the EHS program, whereas only 14% were recruited through discussions initiated by child care providers (Table A1, bottom panel). EHS programs recruited 30% as an extension of a prior partnership between the child care center or family child care home and the EHS program, 27% through conducting observations to assess the baseline quality of child care providers, and 26% through consulting with local child care resource and referral agencies.

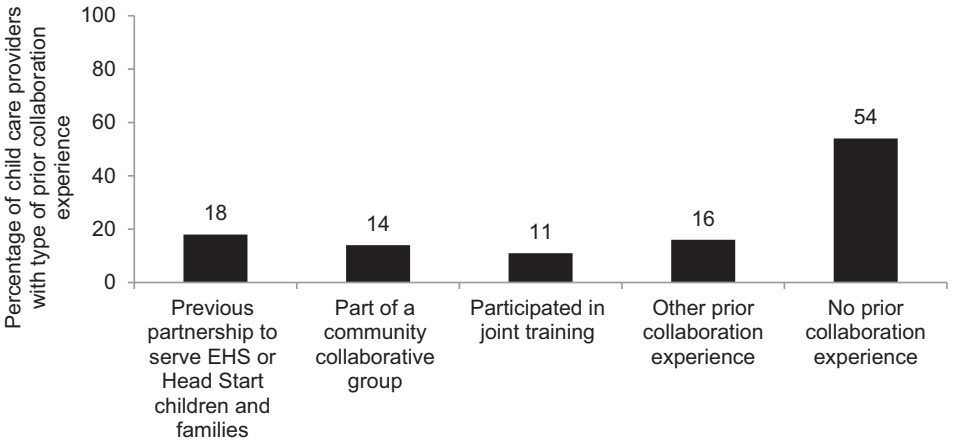


**Figure 2.** Prior collaboration experience between EHS programs and child care providers. Data from EHS program director survey; $N = 1{,}749$. Items in this figure are based on EHS program director responses about all child care providers they are partnered with. Information was missing in EHS program director responses for 158 of the child care providers. Results are weighted to account for nonresponse. EHS = Early Head Start.

One year after the partnership grants were awarded, surveyed EHS programs reported that they developed written agreements to formalize the partnerships with 97% of child care providers they partnered with (Figure 3). Agreements commonly included roles and responsibilities of the provider to comply with the EHS Program Performance Standards, 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 EHS program, among other topics (Table A2). EHS programs developed these agreements jointly with 12% of child care providers, with some input from the provider for 42% of child care providers, with input from a committee of providers for 10% of child care providers, and no provider input for 32% of child care providers (Figure 3).

### *Maintaining Partnerships*

According to EHS program directors, EHS programs and child care providers engaged in a variety of activities to maintain and support ongoing relationships across organizations (Table 2). Nearly all EHS programs (98%) held regular meetings with lead staff, with the majority either meeting monthly or as needed. Other common activities included participating in discussions with frontline staff (84% of EHS programs) and reviewing the partnership agreement (73% of EHS programs), which both occurred as often as needed. Discussions with frontline staff also regularly took place weekly or multiple times per month. Reviews of partnership agreements most often occurred annually.

In surveys, most EHS program directors and child care center directors and family child care managers described their relationships as mutually respectful and focused on similar goals (Figure 4). More than 90% of EHS program directors agreed or somewhat agreed with statements about mutual respect between the EHS program and child care providers they partnered with 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% of child care provider directors and managers agreed or somewhat agreed with statements about mutual respect between the child care provider and the EHS program. However, only 84% of child care provider directors and managers agreed or somewhat agreed with statements describing EHS program directors as full and equal partners.

Despite efforts to maintain partnerships, within one year after the EHS-CC partnership grants were awarded, 32% of EHS programs had terminated at least one partnership with a child care

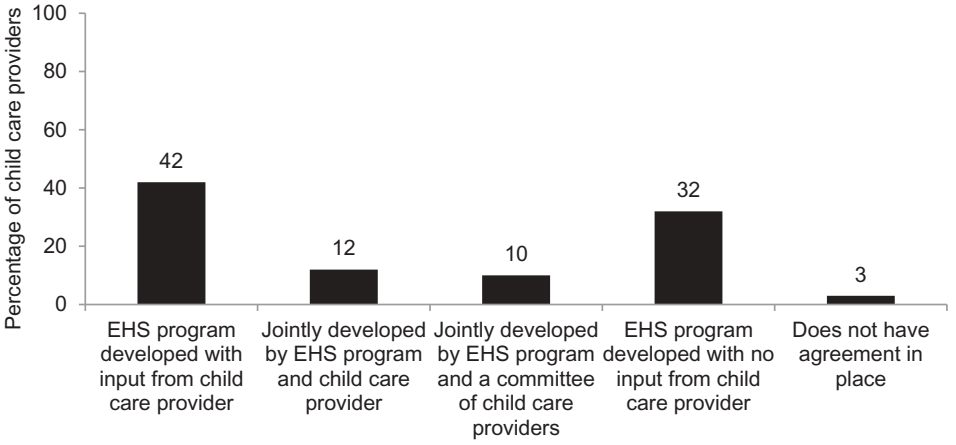


**Figure 3.** Methods for developing formal agreements between EHS programs and child care providers. Data from EHS program director survey; *N* = 470. Items in this figure are based on EHS program director responses about a randomly selected sample of child care providers. Information was missing for 0 to 12 EHS programs. Results are weighted to account for EHS program nonresponse and child care provider sampling probability.. EHS = Early Head Start.

**Table 2.** Processes EHS programs engaged in to support quality relationships with child care providers (percentage of EHS programs).

| Process to support quality relationships | EHS programs ($n$ = 220) | Of EHS programs reporting activity, percentage reporting frequency | | | | | |
|---|---|---|---|---|---|---|---|
| | | Annually | Quarterly | Monthly | Weekly or multiple times per month | As needed | Other |
| Hold regular meetings with lead staff | 98 | 0 | 14 | 42 | 11 | 30 | 2 |
| Participate in discussions with frontline staff | 84 | 1 | 4 | 14 | 28 | 49 | 4 |
| Review the partnership agreement | 73 | 45 | 7 | 1 | 0 | 43 | 3 |
| Conduct staff surveys | 28 | 63 | 10 | 2 | 2 | 24 | 0 |
| Other | 19 | 0 | 3 | 6 | 18 | 37 | 29 |

Data from EHS program director survey. Information was missing for 0–11 EHS programs. Percentages of individual processes do not sum to 100 because respondents selected all activities that applied. For each activity, percentages with each frequency do sum to 100 as only one option could be selected. Results are weighted to account for nonresponse. Common "other" processes to support quality relationships included regular meetings/communications (not specifically with lead staff), trainings/professional development, and on-site visits. EHS = Early Head Start.

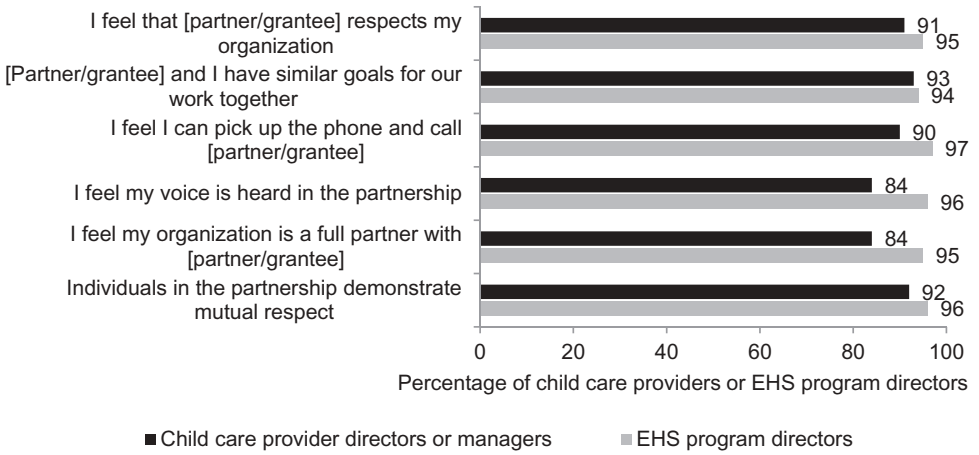


**Figure 4.** Mutual perceptions between EHS program directors and child care center directors or family child care managers. Data from EHS program director survey and child care provider survey; $N$ = 470 EHS programs; $N$ = 386 child care providers. EHS program director items are based on EHS program director responses about a randomly selected sample of child care providers. Information was missing for 1 to 11 EHS programs. Information was missing for 19 to 30 child care providers. 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 EHS program director and were adapted for the child care provider survey. Results are weighted to account for sampling probability and nonresponse. EHS = Early Head Start.

provider (Table A3). Most commonly, partnerships were terminated because providers had difficulty complying with the EHS Program Performance Standards, especially the staff-child ratio and group size requirements. Other common reasons reported for terminating partnerships with child care providers were differences in philosophy and mission, administrative burden of reporting requirements, misunderstanding of roles and responsibilities, and perceived inadequacy of funding.

## Offering Comprehensive, High-Quality Early Care and Education to Infants and Toddlers from Low-Income Families

### Professional Development and Quality Improvement Opportunities Offered through Partnerships

Most EHS programs offered professional development opportunities and quality monitoring activities to child care providers. Eighty-six percent of child care providers reported that EHS programs provided coaching or one-on-one training, and 84% reported that EHS programs provided workshops (Figure A1). Thirty-nine percent of child care providers reported that EHS programs provided online training. At least 90% of EHS programs reported offering classroom observations to assess practices, using checklists on compliance with performance standards, and reviewing program files, program data, and lesson plans to promote quality care (Table A4). EHS programs 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 providers had opportunities to obtain a CDA credential or other degree (Figure 5). Seventy-seven percent of child care providers reported that the EHS program offered provider staff the opportunity to obtain a CDA credential. Thirty-seven percent of child care providers reported that their staff had the opportunity to obtain a state-awarded credential that met or exceeded CDA requirements, 26% reported that staff had the opportunity to obtain an associate's degree, and 19% reported staff had the opportunity to obtain a bachelor's degree.

### Materials and Supplies Offered through Partnerships

EHS programs also supplied materials and other resources to enhance the environments. Child care providers most commonly reported receiving furniture, such as cribs or bookshelves; curriculum materials; toys or materials for pretend play; and books (all reported by 60%–70% of child care providers; Table A5). At least 40% of child care providers also reported receiving screening and assessment materials, playground or other outdoor equipment, information technology, and art supplies.

### Comprehensive Services Offered through Partnerships

As required by the EHS Program Performance Standards, EHS programs and child care providers offered comprehensive services (including health screenings, developmental screenings, and referrals) to

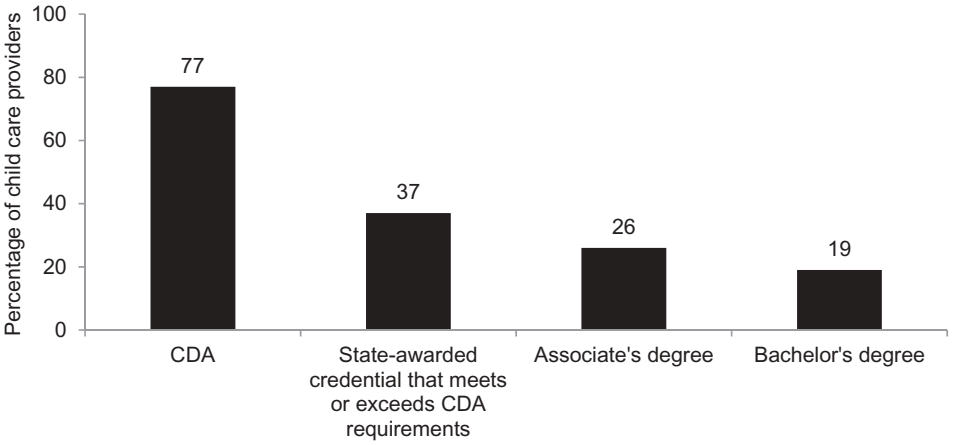


**Figure 5.** Child care providers' opportunities to obtain credentials and degrees through partnerships. Data from child care provider survey; $N = 386$. Information was missing for six child care providers. Results are weighted to account for sampling probability and nonresponse. EHS = Early Head Start; CDA = child development associate.

**Table 3.** Selected comprehensive services provided to children in partnership and non-partnership 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 non-partnership slots |
|---|---|---|---|
| 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% |

Data from child care partner survey; $N = 386$. 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.

enrolled children and families. About 80% of child care providers reported offering developmental screenings and about 70%–80% offered health screenings such as hearing, vision, and speech screenings to enrolled children (Table 3). Although not a requirement of the grant, some child care providers extended comprehensive services to children in non-partnership slots (but cared for in the same settings). The most common services offered to children in non-partnership slots included developmental screenings and social service referrals; at least 40% of partners offered these services to children in both partnership and non-partnership slots.

## Discussion

Our results provide a detailed look into how collaborations among EHS programs, child care centers, and family child care providers support implementation of high-quality services for infants, toddlers, and their families. In particular, because this study included a representative sample of the child care providers engaged in the partnerships, our results provide new insights into the perspectives and experiences of the child care centers and family child care homes engaging in early care and education collaborations. Specifically, our results point to child care providers' particular interest in and need for forming strong, collaborative relationships with EHS programs to provide high-quality early care and education services for infants and toddlers. Our findings are consistent with previous research describing the importance of relationship-building and collaborative practices in establishing and maintaining mutually beneficial early care and education collaborations (Schilder et al., 2009).

In this study, we found evidence that EHS programs and child care providers often capitalized and built on the existing strengths of their respective programs to achieve the goals of the partnership program. The partnerships were largely characterized by EHS programs with extensive experience implementing the EHS Program Performance Standards and child care providers with a long history of providing early care and education services to the community. Data showed some EHS programs expanded or formalized existing partnerships with child care providers.

We found both EHS programs and child care providers viewed their partnership relationship as mutually respectful with well-aligned goals. Case study findings of EHS-child care partnerships documented elsewhere indicate collaboration and mutual engagement by both EHS programs and child care providers were key factors in how they developed and maintained partnerships (Del Grosso et al., 2019). For example, regular meetings between EHS program and child care staff and collaborative engagement during the process of developing partnership agreements facilitated relationship building and clear communication among partners. Additionally, collaboration during the process of developing partnership agreements, as well as collaborative decision-making in general, were perceived as leading to more accepting and effective partnership relationships. EHS programs

and child care providers discussed their interests and concerns, defined roles and expectations, and created a shared vision for the partnership. In particular, we found alignment of partnering programs' vision for quality early care and education was a critical ingredient to establishing and sustaining collaborative partnerships, as well as a challenge. We found challenges to collaboration arose, however, when EHS programs and child care providers differed in their vision for providing high-quality services. In addition, terminations of partnerships occurred when there were differences between EHS programs and child care providers in philosophy and vision. These findings confirm the findings of previous work, which identified shared philosophy and vision as two key components to effective early care and education collaborations (Schilder et al., 2009).

The time and effort spent developing strong collaborative relationships among EHS programs and child care providers established an important foundation for shared provision of high-quality services for infants, toddlers, and families. We found EHS programs and child care providers worked together through the partnerships to ensure all children and families had access to comprehensive services, including health, developmental, nutritional, and behavioral screenings; as well as other health or social supports for families. Through the partnerships, child care providers received materials and guidance in support of meeting the EHS Program Performance Standards. A large share of child care staff were offered training and coaching opportunities, as well as support for obtaining a CDA credential. Consistent with findings from case studies reported elsewhere, we found that collaborative and mutually respectful relationships between partners were viewed as important in supporting improvements to the quality of services through the partnership (Del Grosso et al., 2019). That is, a strong collaborative relationship and mutual engagement in quality monitoring and assessment activities were perceived as allowing EHS programs and child care providers to remain open to feedback and change. However, we acknowledge an important limitation of our study is that we cannot attribute the high-quality services and quality improvement efforts reported by respondents to the partnership; that is, we cannot know whether EHS programs and child care providers would have engaged in these quality efforts in the absence of the collaborative relationship. We also did not assess the contextual factors described in the conceptual framework that can also affect outcomes.

Another key limitation of the study is that data were collected at a point in time approximately one year after grant award and do not necessarily reflect the complete history of the partnerships. It is possible that partnerships evolved over time; for example, different quality improvement activities may have been offered since data were collected for the study. In addition, because respondents could have perceived the information they reported as sensitive and answered in ways that conform to their expectations of what researchers or funding agencies would want to hear, responses may not have always been accurate. For example, a respondent's belief that information could be used for monitoring purposes could affect the accuracy of the responses, despite clear assurances that the study was unrelated to monitoring. However, the study was designed to minimize social desirability and other types of response bias – in particular, results from self-administered, web-based surveys like the main data source for this study tend to be less subject to social desirability bias than results from data collected via other modes (Kreuter, Presser, & Tourangeau, 2008).

The implications of these findings for policy and practice are particularly important in light of studies reporting on the lack of high-quality care available for infants and toddlers for low-income families (Jessen-Howard et al., 2018). The results of our study suggest strong collaborative relationships were foundational to the implementation of the EHS-child care partnerships, one type of early care and education collaboration, aimed at expanding access to high-quality care for infants and toddlers from low-income families. This is consistent with and extends to infant-toddler settings the findings from previous research showing that collaborations facilitated the expansion of high-quality early care and education for preschool-aged children (Schilder et al., 2009; Selden et al., 2006). Taken together, this body of research points to collaborations as a potentially key mechanism for supporting the expansion of high-quality early care and

education for infants, toddlers, and preschool-aged children. It therefore suggests collaboration as a potentially important policy lever.

Our findings also point to several areas needing further exploration. First, more research is needed to understand whether the findings from this study, as they relate to EHS-child care partnerships, apply broadly to other types of early care and education collaborations, particularly those serving infants and toddlers from low-income families. In addition, more work is needed to understand the pathways from collaborative practices to high-quality infant and toddler care and education. Our study provides a descriptive snap-shot of the strategies used by EHS programs and child care providers to support collaboration, the nature of the partnerships, and efforts to provide and improve the quality of infant-toddler care via the partnerships. This study does not, however, empirically test the relationships among these. Furthermore, it will be important to look at whether particular strategies are more or less effective in supporting collaboration and building relationships between EHS programs and child care providers; and whether the effectiveness of those strategies varies by different features of the partnership model (e.g., structural program features, state policy features, child care center versus family child care home). Particularly relevant to policy and practice, additional work is needed to understand the pitfalls and challenges of collaboration that lead to terminations in EHS-CC partnerships.

## Notes

1. The Office of Planning, Research, and Evaluation is an office within ACF responsible for studying ACF programs.
2. Additional standards include requirements for program operations, including requirements for eligibility, recruitment, selection, enrollment, and attendance of children and families; program structure including adult-child ratio and group size requirements; and education and child development program services, including requirements for the teaching and learning environment, the use of research-based curricula and screening and assessment procedures.
3. The complete survey is available online (https://www.reginfo.gov/public/do/DownloadDocument?objectID=58527401).
4. The complete survey is available online (https://www.reginfo.gov/public/do/DownloadDocument?objectID=58527501).

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No potential conflict of interest was reported by the authors.

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