

Child Care Quality Improvement Project Evaluation

Final Report Executive Summary



Submitted to:

**Oregon Commission on
Children and Families**

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*Research designed to promote effective decision-making by policymakers
at the national, state and community levels*

EXECUTIVE SUMMARY

In 2001, the Oregon Commission on Children and Families (OCCF) was awarded \$2,000,000 in Child Care and Development Funds for child care quality improvement (CCQI) projects. OCCF awarded 5 grants to 11 counties through a request for proposal process. The grants allowed counties to develop innovative approaches to increase the supply and enhance the quality of child care in Oregon. The CCQI projects were to focus on the following three goals:

- Improving child care quality through efforts directed at providers;
- Improving child care quality through the development or enhancement of the local early childhood system; and
- Increasing the availability of high-quality, hard-to-find child care.

The grants were awarded to Baker County, Benton County, Coos and Curry counties (working collaboratively), Tillamook County, and a six-county collaborative (Clackamas, Jackson, Lane, Marion, Multnomah, and Washington counties). Project activities varied among the sites, but included such strategies as trainings, monetary incentives, mentoring, and fostering provider networks. Clackamas, Multnomah, and Washington counties formed a Tri-County collaborative and took a different approach, focusing on creating a benefits pool, a purchasing cooperative, and a substitute pool.

To help ensure the success of the CCQI projects, OCCF contracted with an external evaluation agency, NPC Research, to document the projects' success in addressing the three key project goals. NPC conducted a process and outcome evaluation, which included information collected from multiple sources: providers participating in the projects (using written surveys, telephone inter-

views, and site visits); key stakeholders involved with the projects (using written surveys and telephone interviews); quarterly reports compiled by project staff; administrative data sources; and site visits.



Key Findings

The evaluation found that there were significant changes in providers' levels of professional development, and that there appeared to be concrete changes in reported provider practices and environments that are indicative of improvements in child care quality. Specifically,

1. Providers who participated in the CCQI project felt that the project helped them feel more professional, helped them learn about education and training opportunities, and gave them useful information they could apply to their work.
2. CCQI participants reported concrete examples of a number of changes they made in specific skill areas, including strategies used to promote social growth and development, observation and assessment, managing children with challenging behavior, and improving physical environments. CCQI providers generally attributed these changes directly to participation in the CCQI projects.

However, the evaluation also found that participating in the CCQI project did not influence several intended provider-centered outcomes. For example, there were no overall changes in provider feelings of being part of a community or feelings of isolation, nor were there overall changes in providers' reported commitment to the field.

The evaluation examined whether the particular strategies used by the projects (e.g., training, monetary incentives, or mentoring) were related to provider outcomes. Although these strategies were offered in combination, and therefore it is somewhat difficult to attribute outcomes solely to one strategy vs. another, results suggest that:

1. Trainings, scholarships, and wage enhancements seem to result in a cluster of outcomes related to increased professionalism among providers. For example, providers who took part in these strategies were more likely (compared to providers who did not participate in these strategies) to: (1) report that the project helped them access the system (teaching them about available training and educational resources); and (2) show increases in feelings of respect as a professional. These providers also reported making more changes in several basic skill areas, including things they do to promote social growth and development, working with children with challenging behavior, and observation and assessment.
2. Providers who took part in mentoring activities reported more changes in specific skill areas rather than in generalized professional development outcomes, compared to those who did not receive mentoring. These providers reported more changes in: balancing work and family life, improvements to their physical environments, how they work with children with physical disabilities, how they approach cultural diversity, and their business practices.

3. Providers who received grants for environmental improvements were more likely to report making changes to their physical environments. Participating in this strategy was not related to any other outcomes. However, these providers typically received mentoring and/or other monetary incentives along with the grants for environmental improvements, and thus received the benefits of each strategy in which they participated.

In addition to examining the effects of particular strategies, the evaluation examined whether project outcomes were different for particular groups of providers. Specifically we explored outcome differences based on provider age, race, income, time in the field, type of provider (family vs. center-based), and education. In general, few differences were found for these characteristics. However, a few patterns were found:

1. Providers with less experience and education and less income from child care were more likely to report improvements in some basic skill sets, including things they do to foster social growth and development, observing and assessing children's behavior, improvements in business practices, and improvements in balancing work and family life. Providers with a high school degree or less were also more likely than other providers to say that the project helped them feel more respected as a professional.
2. Few provider characteristics were related to feelings of isolation or sense of community. However, length of time spent in the CCQI project *was* related to decreased feelings of isolation; those providers who stayed in the project the longest (two or more years) showed a significant reduction in feelings of isolation between baseline and follow-up.
3. The results indicated some differential findings based on provider race. Caucasian providers indicated a greater increase

over time in feeling respected for the work they do and also felt more skilled at accessing the system than non-Caucasian (primarily Hispanic) providers. Additionally, non-Caucasian providers indicated a greater decrease in willingness to care for children with special needs or challenging behavior. However, these results should be interpreted with care, as the overall sample of non-Caucasian providers was small, and the response rate for Hispanic providers on the provider survey was considerably lower than for White/Caucasian providers.

Data from the process evaluation suggest that the local CCQI projects focused most of their efforts on the goal of increasing the quality of child care through provider-directed efforts such as trainings, scholarships, wage enhancements, grants for environmental improvements, and mentoring. The project sites focused relatively less attention directly on the remaining two overarching CCQI goals, increasing availability of hard-to-find care and systems enhancement. In terms of availability of care, the CCQI project showed no influence on providers' willingness to offer hard-to-find care (special needs, challenging behavior, odd-hours, or infant/toddler care), or on the availability of slots for these types of care. There appeared to be little or no direct impact of the CCQI projects on the actual availability of hard-to-find care. Regarding enhancement of the early childhood care and education system, about 4 out of 5 key stakeholders thought the CCQI project was somewhat or very effective at influencing the quality of the system. Examples of system-level changes included increased community awareness, coordination with community colleges and higher education, information sharing with providers, coordination of trainings, and resource development and sharing.

Lessons Learned

1. The types of strategies adopted by the CCQI project sites, while appropriate for addressing child care quality, were less appropriate for addressing child care quantity.

The evaluation found no change in the availability of child care, either in the CCQI counties at-large, or within the subgroup of providers participating in the CCQI projects. The availability of slots overall, the availability of slots for hard-to-find care, and the CCQI providers' willingness to offer such care did not change significantly over time. Future state initiatives that wish to focus specifically on increasing child care availability may wish to adopt a different programmatic approach. Strategies to address this goal might include such things as providing more substantial financial incentives to providers offering hard-to-find care, help with the recruitment and training of qualified staff, and subsidies to help cover the cost of hiring such staff.

2. Financial incentives for providers are crucial for recruiting providers into the project and for keeping them engaged over time.

Offering financial incentives to providers appeared to be pivotal for project success, whether these are wage enhancements or scholarships for education and training. Incentives served both as a recruitment tool to encourage providers to enroll in the project, as well as a motivational tool to keep providers engaged both in the project and in longer-term professional development activities.

3. Different strategies are associated with different outcomes.

Not all the CCQI strategies had similar impacts on intended outcomes. Mentoring strategies were more likely to be associated with reported changes in specific skill areas, whereas training, wage enhancements and scholarships were more likely to be associated with changes in professionalism and

general child care skills. Grants for environmental improvements, by themselves, had little impact outside of changing provider environments. Overall, CARES-type models appeared to be associated with a broader range of outcomes, and with generally bigger impacts in terms of provider improvements, than the other strategies. Further, those projects that focused more extensively on certain hard-to-serve populations appeared to have more success in increasing providers' feelings of competency in serving these groups.

4. A successful mentoring project needs an adequate supply of mentors, ongoing support and oversight, and ideally, financial incentives for the mentors.

Several of the CCQI sites struggled with creating and maintaining an adequate infrastructure for the mentoring strategy. A successful mentoring component relies upon an adequate supply of mentors and sufficient oversight of the mentoring activities. Mentors should be provided with guidance around where to focus efforts, and should be given support and recognition for their efforts.

5. Communities should structure training offerings to ensure a variety of topic areas, a variety of skill levels, accessibility, and appropriate linkages with for-credit classes at colleges and universities.

Data suggested that despite the increases in trainings offered through CCQI projects, there is not always an adequate variety of trainings at appropriate levels offered. For example, providers sometimes could not locate trainings in topic areas necessary to advance PDR/OR levels. Second, providers' skill levels ranged from basic to advanced, and there are not often trainings available for providers with such varied backgrounds. Third, accessibility of trainings remains a barrier and a challenge for providers. Classes need to be offered at various times and days and in a variety of locations and formats (e.g. online classes) in order to maximize provider participation. Finally, providers expressed a

genuine interest in furthering their education with for-credit classes and degrees; linkages with local colleges and universities are crucial to ensuring that providers can work toward these professional development goals.

6. Local control over design and implementation is key for program success.

Local control of the design and implementation process allowed for the development of projects that best suited community needs. However, several sites indicated that it would have been helpful to receive some guidance from the OCCF around particular issues, including help with sustainability planning and information on how spend down unused funds. Further, the "lessons learned" from these projects should be used to improve the efficiency with which future provider development projects can be implemented (see below).

7. Allow adequate time for start-up activities, and follow the models of other sites that have successfully implemented similar projects.

Each CCQI site spent necessary time planning their projects, hiring staff, and creating procedures and protocols before beginning service delivery. However, it is not necessary to "reinvent the wheel." Information, policy and procedure manuals, and advice from these projects should be shared with new projects in order to facilitate more efficient start-up process for future projects. In particular, CARES communities spent considerable time and energy deciding on the details of how wage enhancements and stipends should be allocated, to whom, and for what amounts. These protocols should be shared with other communities wishing to implement CARES-type projects, or used to develop a core set of guidelines that could be shared statewide or nationally.

Additionally, the Tri-County project created a Web site (www.healthcareforchildcare.org) that organizes considerable information about health benefit options for child care

providers, and which is a valuable resource for the provider community. The Oregon Child Care Resource and Referral Network currently hosts the Web site.

8. Substitute pools and purchasing co-operatives were difficult to implement, and may not be feasible and/or needed.

Despite considerable efforts to recruit participants, it appeared that few providers were interested in attending informational meetings about the purchasing co-operative or the substitute pools. The purchasing co-operative may not be needed by providers who have the ability to access lower-cost items through such commercial venues as Wal-Mart and Costco. The substitute pool, while valued by those who did participate, was not used by a large number of providers, and recruiting and maintaining substitutes proved difficult. Teaching providers how to build in time for personal days and vacation as a strategy for self-care may be a more effective way to provide this type of support, especially for family child care providers.

9. Plan ahead and seek multiple sources for continuation funding.

While the local projects were all engaged in creating sustainability plans, for many projects continuation funding had not been secured by Spring 2005, pointing to the importance of planning ahead for sustainability and allowing adequate time to secure needed continuation funding.

10. Evaluation needs to use multiple strategies to measure the subtle and complex changes that result from these projects.

The CCQI project evaluation relied upon several sources of data, including a paper-and-pencil provider survey (the Provider Enrollment Survey, or PES), provider telephone interviews, site visits, and key stakeholder interviews and surveys. While the qualitative interview and site visit data yielded valuable information on provider change due to the projects, the PES did not appear to be sensi-

tive enough to measure such outcomes, and included many questions that showed extremely high self-reported ratings at baseline (“ceiling effects”). Such a paper-and-pencil instrument may not be the most appropriate methodology for measuring the subtle and complex changes documented by providers during interviews and site visits.

However, it should also be noted that these “ceiling effects” were influenced by at least three additional factors. First, programs often had eligibility criteria that screened out providers who might have had less knowledge, skills, motivation, or history of professional development (e.g., requiring providers to be willing to serve children with special needs; limiting participation to providers who had been in the field more than one year). Second, the data suggest that many providers were, in fact, involved with other professional development-type programs prior to their participation in the CCQI projects. Thus, their “baseline” ratings are likely to have been influenced by these prior activities. Finally, because the programs were implemented roughly 1½ years prior to the start date of the evaluation, the time between the baseline and follow-up PES surveys was often quite short (on average, about 6 months). This is a very short time frame to see significant changes in provider attitudes and skills. Together, these issues suggest that future evaluation studies should (1) allow adequate resources for more qualitative data collection, including in-depth interviews and observations; (2) document and measure prior participation in other, similar projects as thoroughly as possible; and (3) work closely with programs in designing recruitment and enrollment strategies early in the program design phase, and consider the possibility of random assignment to these specialized programs from among the group of eligible providers. This would allow a much more rigorous evaluation of program effectiveness. Minimally, evaluation processes for data collection should begin in tandem with program start-up.