Child Care Quality Improvement Project Evaluation

Final Report

Submitted to:

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

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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 interviews, 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. The key findings of the evaluation are highlighted below.

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 cooperatives 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 sensitive 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.

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CHAPTER 1: INTRODUCTION

Over 30% of Oregon's children under the age of five are in some form of paid child care (Oregon Child Care Research Partnership, 2003). Of these children, 41% are in child care centers, 25% are in family child care settings, and the remainder are cared for in their homes or in a relative's home (OCCRP, 2003). Oregon's child care centers and family child care homes are staffed by people with varying levels of education and experience, and these providers face several challenges inherent in the field, such as low wages, long hours, high turnover, lack of recognition and support, and isolation. Whitebook, Howes and Phillips (1998) found that child care workers had low wages that did not increase over the course of a decade, and Whitebook and Sakai (2003) found that providers with lower wages were more likely to leave their positions, and that overall 50% of the providers in their study left their positions over a 4-year period.

"I do love my job! But I constantly wonder: am I providing well enough for my own family? Is it worth it? How can I earn what I deserve, still do what I love and meet my family's needs? Do all providers feel this way?"

As part of the current evaluation effort, some of Oregon's child care providers shared their experiences:

> "I find it interesting, actually hurtful to some degree, that at the center where I work, the grounds crew…make more money than I do. I am not discrediting their work…I am simply stating I work hard, spend many hours of my free time advancing my knowledge or enhancing my classroom, at a very low rate of pay. As a single mom of two I still fall into the poverty range. We need to acknowledge skill and/or education and pay accordingly."
>
> "I do love my job! But I constantly wonder: am I providing well enough for my own family? Is it worth it? How can I earn what I deserve, still do what I love and meet my family's needs? Do all providers feel this way?"
>
> "Sometimes when I share with others what I do for a living, I do not feel so respected…I do wish our culture valued teachers and child care workers more."

At the same time, parents are faced with the challenge of limited availability of high-quality, affordable child care. Statewide in Oregon, the cost of child care for a toddler is almost 50% of minimum wage, and families with income under $25,000 spent almost a quarter of that income on child care (OCCRP, 2003). Furthermore, 38% of parents report that they feel their children do not always get adequate individual attention (OCCRP, 2003).

In response to these challenges for both providers and parents, Oregon's Child Care Quality Improvement (CCQI) Project was created to improve the quality and quantity of child care. This project, described below, supported a variety of provider-directed efforts in 11 counties across the state.

Background of CCQI Project

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 five 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 projects developed by each of the grantees are described here in brief. See Appendices B-H for more detailed site information. Further, it should be noted that many sites had eligibility requirements that limited participation to registered/licensed providers who had been working in the field for over 6 months (in some cases, one year), and who were willing to commit to staying in the field for at least one year. Some sites targeted only those providers who indicated willingness to serve infants, toddlers and/or other harder-to-serve groups. These requirements contribute to the findings (described below) that suggest that the providers served by CCQI projects tended to be more experienced, more committed providers at the project outset.

Baker County Child Care Enhancement Project (QCCEP): Baker County received a grant of $50,000 per year for three years. The Commission on Children and Families, Early Childhood Advisory Council and CCR&R were the core agencies responsible for administering and implementing the project. The Baker CCQI Project, or QCCEP, aimed to open opportunities for existing and new providers to improve their level of education and enhance the quality of child care through scholarship opportunities and incentives. Trainings were offered in a variety of content areas and providers received technical support, consultation, and mentoring to encourage them to enter and advance on the PDR/OR/OR. The Harms Clifford Environmental Rating Scale was used as a self-assessment tool to help providers identify areas where they could improve their programs in terms of space and furnishings, basic care, language and reasoning, learning activities, and social developmental, as well as helping to identify professional/provider needs. Mentors were assigned to help support providers in developing and implementing a plan around the identified need areas. Grant funds were then made available to support these individualized plans.

Benton County CARES Project: Benton County received a grant of $100,000 per year for three years. CCR&R was responsible for administering and implementing the project. The CARES project offered scholarships to providers, which reduced barriers to higher-level training and education, assisted individuals in creating individualized education plans, and offered stipends to providers who achieved a specific level of professional development on the Pathways system.

Coos and Curry counties Child Care Quality Improvement Project: Coos and Curry counties received a grant of $100,000 per year for three years. The CCR&R was responsible for administering and implementing the project. Coos and Curry counties implemented three different types of programming. First, *Special Caring for Special Children*, provided incentives (children's books, stipends) and support (mileage and substitute care reimbursement) for providers to attend training in caring for special needs children. There were three levels of participation, each requiring an increasing level of commitment to providing special needs care accompanied by increasing levels of incentive. Second, the program implemented Pathways to Success to encourage providers to enter and advance on the Professional Development Registry (PDR/OR). Third, a CARES models was adopted with the goal of encouraging providers to access training through financial incentives. The program also offered mentoring, one-on-one technical support, and online trainings.

Clackamas, Jackson, Lane, Marion, Multnomah, and Washington counties Provider Retention and Professional Development Project: These six counties received a grant of $300,000 per year for three years. The Six-County project spent much of the first year completing a compensation study that assessed wages, turnover rate, and training levels among providers; assessed access to benefits including insurance and vacation time; and assessed access to child care equipment and materials at a discounted rate.

Marion and Lane counties implemented a CARES program that made available wage enhancements, scholarships, and training reimbursements. Both of these counties provided outreach and training in targeted areas including special needs and English as a Second Language. They also offered orientations, application, and assessment meetings for providers to enroll on the Oregon Registry. Marion and Lane counties were also the sites for the pilot program to roll out the new Oregon Registry changes.

Jackson County implemented a Scholarship and Compensation Project based on a TEACH model that provided scholarships and compensation for coursework. Stipends for completion of CDA credentials, one-year Certificates and Associate's degrees in Early Childhood Education were provided as well as stipends for enrollment in the Oregon Registry. Outreach and training were provided in targeted areas including special needs, infants and toddlers, and English as a Second Language. In addition, enhancing training capacity in the county was a priority.

Tillamook County Quality Care for Kids Project: Tillamook County Commission on Children and Families received a grant of $50,000 per year for three years. CARE and its Caring Options CCR&R were responsible for administering and implementing the project. The project used a two-pronged approach to increase the quality of child care. First, child care providers evaluated their business using the Harms Clifford Environmental Rating Scale and project staff/mentors worked with providers to identify areas for improvement. Providers were given site visits, consultation, and financial incentives. Second, the project aimed to address the need for more quality infant and toddler and odd hours care through training, mentoring, and technical assistance.

The *Tri-County (Clackamas, Multnomah, and Washington counties)* portion of the Six-County grant devoted the first half of the grant period to researching the feasibility of developing a health insurance benefits pool, a purchasing co-op, and a substitute provider pool. It began implementation during the second half of the grant period. During Year 3 of the project, the work included development of a Web-based tool designed to help child care providers access insurance information. The Tri-County project also provided outreach and training in targeted areas including special needs and English as a Second Language.

Evaluation Purpose and Design

To help ensure the success of the Child Care Quality Improvement (CCQI) projects, OCCF contracted with an external evaluation agency, NPC Research, to document the projects' success in addressing the three key goals outlined above (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).

NPC Research conducted a process and an outcome evaluation. The process evaluation documented the client population served, in order to assess the program's ability to provide services to its target population; the amount, type, and quality of program services delivered, in order to assess how closely the services provided corresponded to program design; and the barriers to program implementation, in order to assess if program services were appropriately designed for the targeted population. The outcome evaluation focused on measuring the immediate and short-term outcomes of the projects, including, but not limited to, increased training levels of providers, increased knowledge and skills among providers, increased professionalism, and increased system collaborations.

As a first step in the evaluation process, NPC worked with each of the sites to create site-specific logic models. These models documented the key strategies and activities used by each site and their expected immediate- and long-term outcomes. NPC then collapsed the site-specific logic models into a statewide logic model, included in Appendix A. This logic model guided the development of the evaluation design. The evaluation focused on measuring the immediate outcomes expected by these projects; it was not possible to directly measure the long-term outcome of enhanced child care quality due to time and resource constraints. The evaluation relied upon four primary sources of data, as outlined below.

Self-reported data from child care providers involved in the CCQI projects: NPC developed some additional questions for the Participant Enrollment Survey (PES – see Appendix W) that was already in use by some of the CCQI projects that captured additional data necessary for the evaluation. The survey was administered by the sites to all participating providers at the start of their involvement in the projects to gather information during an early phase of their involvement with CCQI-related activities. Because some sites were using the PES prior to NPC's modifications, providers at those sites completed the "original PES" pre-test (n = 115). Providers who began participation after NPC's modifications completed the "modified PES" pre-test (n = 116). NPC administered a modified PES post-test via mail in the spring of 2005 to providers who completed either the original or the modified baseline PES in order to obtain information about any changes over time (n = 186, for a response rate of 81%). It should be noted that because of the timeline for the evaluation, there was quite a short time period between baseline and follow-up PES surveys (on average about 6 months); this is a relatively short time frame in which to detect changes in attitudes and behaviors.

Additionally, NPC conducted a provider telephone interview in the spring of 2005 with all providers involved with the CCQI projects. This telephone interview gave providers an opportunity to share more in-depth, qualitative information about their experience with the projects and any changes they may have made as a result of their participation. For the Baker, Benton, Coos-Curry, Jackson, Lane, Marion, and Tillamook projects (see Chapter 2), 168 providers participated in the telephone survey, for a response rate of 73%. For the Tri-County project (described in Chapter 5), 52 providers participated in the phone survey, for a response rate of 69%.

Further information was gathered from providers during site visits, which included in-person conversations and observations of their child care setting at four study sites (Jackson, Baker, Tillamook, and Coos-Curry). The site visits included observations of providers with higher education and experience levels, as well as observations of

providers with lower education and experience levels.

Administrative data provided on quarterly reports: NPC developed a standardized format for the sites' quarterly reports that captured pertinent data about the activities in which the sites were engaged as well as several key outcomes such as PDR/OR enrollments. Data for this report were available for four quarters, starting with the April through June 2004 quarter and ending with the January through March 2005 quarter.

Administrative data provided by existing datasets: NPC used data from the Oregon CCR&R to measure change over time in the number of child care slots in each county, and data from Portland State University's Professional Development Registry (now the Oregon Registry) (PDR/OR) database to measure changes in the number of providers enrolling and advancing on the PDR/OR.[1]

Interview and survey data from key system stakeholders: NPC conducted two rounds of key stakeholder interviews in order to gather information on systems-level outcomes. The first round was conducted in August through October 2004, and the second round was conducted in April and May 2005. During round one, the key stakeholders completed a brief, closed-ended written survey along with an open-ended telephone interview with NPC interviewers; round two consisted of only a telephone interview. The CCQI project coordinator at each site provided NPC with a list of suggested key stakeholders. NPC asked the project coordinators to include on the list representatives from the local Commission on Children and Families, the local Child Care Resource & Referral organization, the Early Childhood Team, Early Intervention, and the Department of Human Services (e.g. child welfare, TANF). In addition, we suggested several optional categories of respondents to include on the list, including child care providers and representatives from early childhood related organizations, Head Start, Early Head Start, and community colleges. Between six and ten key stakeholders were interviewed from each site. A total of 79 key stakeholders participated in the first round of interviews, 68 in the second round.

Focus of the Report

The remainder of this report documents the activities undertaken by the CCQI project sites and the resultant outcomes. The report includes activities documented on sites' quarterly reports between April 1, 2004, and March 30, 2005. Due to the time necessary for data analysis and report writing, data from the sites' final quarterly reports (the April–June 2005 quarter) are not included. Information on outcomes was gathered from provider surveys and interviews, key stake-

[1] In January 2005, the Professional Development Registry transitioned to the Oregon Registry (OR), which had slightly different requirements and levels. In this report we refer to the PDR rather than the OR because much of the data we report is from prior to January 2005.

holder surveys and interviews, administrative data sources, and site visits.

The report is organized to focus on the three primary goals for the CCQI projects. Chapter 2 outlines the strategies used by all sites except Clackamas, Multnomah, and Washington counties, briefly reviews the existing research support for those strategies, and describes the actual activities undertaken and provider satisfaction with those activities. Chapter 3 describes the providers served by these projects, and Chapter 4 summarizes the outcomes associated with the strategies. Chapter 5 focuses on the Tri-County (Clackamas, Multnomah, and Washington) model for improving child care quality; this model differed substantially from the strategies used by other sites. Chapter 6 addresses the second goal, improving child care quality through the development or enhancement of local early childhood systems. This chapter documents the system-level activities undertaken by the sites and the outcomes associated with those activities. Chapter 7 addresses the last of the three CCQI goals, increasing the availability of hard-to-find child care, and includes a documentation of the supply of child care in the CCQI counties over time and information from CCQI providers regarding their willingness to offer hard-to-find care. The final chapter of this report discusses the strengths and weaknesses of the project, summarizes lessons learned, and provides recommendations for future child care quality improvement projects. The data presented in the body of the report are aggregated across sites; the appendices contain site-specific project descriptions and results.

CHAPTER 2: STRATEGIES FOR IMPROVING CHILD CARE QUALITY

Children who receive higher-quality child care enjoy social and cognitive benefits that endure into their school years (NICHD Early Child Care Research Network, 2002; Peisner-Feinberg, Burchinal, Clifford, Culkin, Howes, Kagan, & Yazejian, 2001). With the goal of improving child care quality in the United States, much attention has recently been placed on such regulatable features of child care settings as education and training. For example, hiring procedures could require child care providers to have reached a certain educational level (e.g., high school diploma, bachelor's degree). Another example of regulating education and training is requiring child care providers to attain and document a certain number of early childhood education training hours each year.

While the statewide CCQI project identified three primary goals, improving quality through efforts directed at providers was the goal that was the primary focus of the CCQI sites. Chapters 2, 3, and 4 include data from Baker, Benton, Coos-Curry, Jackson, Lane, Marion, and Tillamook counties. Because much of Tri-Counties' provider-directed efforts differed so markedly, their efforts are documented separately in Chapter 5. However, these counties also conducted some activities within the strategies discussed below, and in those cases, we include counts of these activities in this chapter.

In this chapter we discuss the four primary provider-focused strategies used by the sites: training, monetary incentives, mentoring, and informal provider networks. For each strategy we summarize the existing research in support of the strategy and then discuss the actual program activities undertaken. Finally, we summarize the strengths and weaknesses of the implementation of each strategy and provider satisfaction. This chapter combines data across counties. For site-specific program descriptions see Appendices B-H.

Trainings

Trainings were a primary focus of a majority of the CCQI sites. Training activities, described in more detail below, were varied, and included pre-PDR/OR and PDR/OR orientations, topic area trainings, and links to community college courses.

RESEARCH SUPPORT FOR EDUCATION AND TRAINING AS A STRATEGY TO ENHANCE CHILD CARE QUALITY

Education & Training are Related to Quality of Child Care Environment

Early childhood research has clearly demonstrated a connection between education and training, and child care quality. Providers who have more years of formal education and/or early childhood training provide a more safe, hygienic, and developmentally appropriate physical caregiving environment (Cassidy, Buell, Pugh-Hoese, & Russell, 1995; Howes, 1997; Mueller and Orimoto, 1995). Providers with more education and training also tend to have more developmentally appropriate, sensitive, and positive, and less harsh, detached, and punitive interactions with children (Arnett, 1989; Burchinal, Howes, & Kontos, 2002; Cassidy, et al., 1995; Ghazvini & Mullis, 2002; Howes, 1997; Howes, Whitebook, & Phillips, 1992). Global ratings of child care quality, which include features of the physical and social caregiving environment, have also been linked to higher levels of education and training among child care providers (Blau, 2000; Burchinal, et al., 2002, Cassidy, et al., 1995; Clarke-Stewart, Lowe, Burchinal, O'Brien &

McCartney, 2002; Epstein, 1999; Ghazvini & Mullis, 2002; Kontos, Howes, & Galinsky, 1996; Todd & Deery-Schmitt, 1996). It has been shown that education and training are related to more developmentally appropriate beliefs about caregiving and less authoritarian attitudes toward child rearing (Arnett, 1989; Cassidy, et al., 1995). In fact, there is evidence suggesting that education/training has its effect on child care quality through its influence on teacher's beliefs about caregiving (Cassidy, et al., 1995).

Education and training may work to produce quality child care in different ways for different subgroups of providers. Different kinds of providers (e.g., infant/toddler vs. preschool, family care vs. center care providers) may experience improvements along different dimensions of their caregiving (Ontai, Hinrichs, Beard, & Wilcox, 2002). Further, infants and toddlers may benefit from providers with specialized early childhood training, whereas preschool children may benefit more from providers with college-level education (e.g., bachelor's degree) (Howes, Whitebook, & Phillips, 1992). Providers with more training and less formal education have been shown to exhibit different caregiving skills than providers with more years of formal education (Clarke-Stewart, 2002; Howes, 1997). Another example of subgroup differences is that in one caregiving setting (e.g., public child care centers), education may be associated with higher-quality care, and in another setting (e.g., Head Start, family child care), training may be associated with higher-quality care (Dunn, 1993; Epstein, 1999; Pence & Goelman, 1991). At this point, an optimal or universal combination of training and formal education that promotes high-quality care has not been clearly identified (Whitebook and Sakai, 2003).

Education & Training are Related to Quality of Child Care System

The quality of the child care *system* is in part determined by job turnover among providers. Some research suggests that more years of formal education is associated with job stress, job dissatisfaction, less organizational commitment, and turnover (Gable and Hunting, 2001; Todd and Deery-Schmitt, 1996). However, this may be true only under certain conditions such as low wages and unstable work environments (Whitebook and Sakai, 2003). Training, especially for providers with less formal education, seems to be associated with job satisfaction and less job stress (Mueller and Orimoto, 1995; Todd and Deery-Schmitt, 1996). Education and training are not necessarily accompanied by commensurate compensation, a common reason for job dissatisfaction and turnover in the child care field (Todd and Deery-Schmitt, 1996).

TRAINING ACTIVITIES PROVIDED BY CCQI PROJECTS

NPC Research collected quarterly reports from April 1, 2004, to March 30, 2005. Prior to this date, some information was reported by the programs to OCCF, but did not include detailed information about project-specific activities. One of NPC's first tasks was to develop quarterly report forms that could more reliably capture CCQI project activities. Quarterly reports were tailored to the specific types of strategies being employed within each county.

During the 1-year period for which data are available (thus, not including the final quarter of the project) all of the 10 CCQI sites provided some form of training activities using CCQI funds. On average, across all the projects, 61 providers participated in training during each quarter (with a minimum of 16 and maximum of 162 per quarter).

A total of 97 "workshop" style trainings and 5 for-credit classes were paid for (at least in part) with CCQI funds during the one-year period. These trainings averaged 6.7 hours in length. A total of 474 training hours were offered across the projects. Of all trainings offered, 41 (40%) were focused on children with special needs, 43 (42%) were focused on serving infants and toddlers, and 25 (25%) were focused on serving children with English as a second language (note that trainings could focus on multiple topics).

Trainings spanned a range of PDR/OR categories. Frequent topics included:

- Observation and assessment
- Guidance
- Human growth and development
- Management issues in child care
- Professional development (including help with the PDR/OR-OR/Pathways)
- Working with special needs children
- Diversity
- Working with families
- Child abuse

TRAINING SUCCESSES AND CHALLENGES

Program participants and key stakeholders provided information about the successes and challenges of training activities. Participants were asked on the follow-up PES whether they had participated in trainings, whether they found the trainings useful, whether the trainings helped them reach career development goals, and whether the project helped them learn about training opportunities. Almost all of the 152 providers who indicated on their follow-up PES that they participated in training activities indicated that the trainings were useful (93%, or 135 providers), that the trainings helped them reach their career development goals (89%, or 132 providers), and that the projects helped the providers learn about training opportunities (86%, or 130 providers).

Some providers elaborated on their answers to the above questions by detailing what they appreciated about the trainings and by offering suggestions for improvement. Many providers explained how the trainings were helpful to them:

> "Taking a ten week class has helped me think, learn, and put into practice better child care skills."

Other providers, however, pointed out that while they appreciated the trainings they took, they had some concerns about the availability and variety of trainings:

> "I really like the trainings that come from [project name]. There is just so little of a variety and I have already taken all they've offered. I wish they could develop a new schedule and variety of trainings."

Another provider elaborated further on concerns about training availability:

> "I would like there to be more opportunity to go to classes on weekends and more evening classes (college level) available to meet the needs of providers [sic] hectic work schedules…Also, more opportunities need to be made available to providers to learn and obtain skills in working with children with special needs and learning disabilities."

A third provider stated:

> "…we seem to be facing a lack of the more advanced training and training for my peers that speak Spanish…more funds for better training are needed."

During the second round of key stakeholder interviews, 37 of the 68 respondents indicated that they were familiar with training activities put on by the project. These respondents listed a variety of successes associated with these activities:

- Trainings provided motivation for providers to participate in even more trainings (27%, or 10 respondents);
- The project included good outreach to inform providers about trainings (22%, or 8 respondents);
- There was a good quantity and variety of trainings offered (19%, or 7 respondents);
- Trainings were readily accessible in terms of times and locations (14%, or 5 respondents);
- Trainings increased professionalism among providers (11%, or 4 respondents);
- Trainings helped providers get certificates and degrees (11%, 4 respondents); and
- Trainings met provider needs (11%, or 4 respondents).

During site visits, providers and program staff offered comments similar to those of these key stakeholders. Some sites were particularly proud of the linkages they had made with community colleges and the emphasis placed on helping providers get certificates and degrees. During these visits providers also talked about which trainings had been most helpful to them; for most providers it was the child development classes and classes about handling difficult behavior that were most useful.

Key stakeholders and respondents during site visits also identified several challenges with training activities. Some respondents discussed the need for, and lack of, trainings in languages other than English. Other respondents noted it was difficult to provide trainings that met the varied education and experience levels of providers. Still others commented that it was difficult to find good trainers. Finally, several stakeholders thought the change in requirements associated with the switch from the PDR to the Oregon Registry resulted in confusion among providers and reduced motivation for training.

Monetary Incentives

CCQI sites used a variety of different types of monetary incentives, described in more detail below. These included scholarships for coursework, wage enhancements for completing coursework and/or advancing on the PDR/OR, and grants for environmental improvements.

Research Support for Monetary Incentives as a Strategy to Enhance Child Care Quality

It is well documented that child care providers are paid low wages, with only meager wage increases since 1988 (Whitebook, et al., 1998). Over the past decade, there has been a growing awareness that in order to produce high-quality child care, providers must be adequately compensated (Whitebook, 2001). Indeed, the National Association for the Education of Young Children (NAEYC) has called for compensation commensurate with training, equal pay for educators regardless of child age and care setting, and institutionalized career ladders with associated compensation standards (National Association for the Education of Young Children, 1990).

Monetary Incentives and the Social & Physical Caregiving Environment

Higher wages have been found to be associated with higher-quality social and physical caregiving environments (Ghazvini and Mullis, 2002; Peisner-Feinberg, Burchinal, Clifford, Culkin, Howes, Kagan, Yazejian, Byler, & Rustici, 1999; Whitebook, et al., 1998). It is more difficult to evaluate the efficacy of monetary incentives in *producing* higher-quality child care: even though higher wages are associated with higher-quality child care, it is unclear whether wage enhancements actually *increase* quality. Other types of monetary incentives (e.g., scholarships for training, materials stipends, bonuses) may function to motivate caregivers toward training and professional development, but so far these links have not been empirically examined. Some studies have evaluated the effects of programs aimed to increase child care quality that include monetary incentives. These programs are credited with increasing levels of training, certification, and licensure; use of developmentally appropriate activities; teacher sensitivity; confidence in child-caring skills; gains in knowledge about business practices, child development, and behavior management; and job satisfaction (Buell, Pfister, & Gamel-McCormick, 2002; Cassidy, et al., 1995; Mueller and Orimoto, 1995). However, it is impossible to assess the unique contribution of monetary incentives in producing higher-quality child care.

Monetary incentives and the child care system

Some studies also show that higher wages are associated with less job turnover among child care providers. (Peisner-Feinbert, et al., 1999; Whitebook, et al., 1998). It has been shown that higher wages help child care providers feel more committed to their workplace (Gable and Hunting, 2001), which may then reduce turnover. Interestingly, level of provider training makes a difference. Low-skilled providers who make low wages appear to be committed to their workplace and to their job, whereas highly skilled providers who make low wages report less commitment and experience higher turnover (Gable and Hunting, 2001; Whitebook, et al., 1998). Compensation, therefore, appears to be important for retaining highly skilled child care providers.

MONETARY INCENTIVES PROVIDED BY THE CCQI PROJECTS

Quarterly report data indicated that between April 1, 2004 and March 31, 2005, 497 providers received wage enhancements, 444 received scholarships, and 89 received funds for environmental improvements. However, it is likely that these reports are duplicated counts. Across the state about 124 providers received a wage enhancement each quarter; 111 received a scholarship each quarter, and 22 received funds for environmental improvements. The number of wage enhancements and scholarships ranged considerably across the state:

- Within those counties providing wage enhancements, the number of providers served ranged from 8[2] (Baker County) to about 86 providers in Benton County.

[2] Although only 8 providers were served at the time of this report, 27 providers had received wage enhancements by July 2005.

- Within those counties providing scholarships, the number of providers served ranged from 26 (Baker County) to 151 in Jackson County.

Only two counties provided funds for environmental incentives. In Baker County, 25 providers received these funds; in Tillamook, funds were given to 49 providers. Additionally, these counties conducted 25 (Baker County) and 64 (Tillamook County) Harms-Clifford assessments.

MONETARY INCENTIVES SUCCESSES AND CHALLENGES

Program participants and key stakeholders provided information about the successes and challenges of providing monetary incentives. Participants were asked on the follow-up PES whether they received any scholarships for coursework, financial rewards for completing training or advancing on the PDR/OR, or grants for environmental improvements. As illustrated in Table 1, most of the 106 providers who indicated they received scholarships said that the scholarships made it easier to participate in training, and only one-third said that they would have participated in training even without the scholarship money. Of the 160 providers who indicated receiving financial rewards for completing training or PDR/OR levels, three-quarters indicated that they worked harder because of the reward, and only half said that they would have participated in trainings or the PDR/OR without the reward. Of the 51 providers who indicated that they received grants for environmental improvements, almost all indicated that they were more motivated to make improvements due to the grants, and less than half indicated that they would have made the improvements without the grants.

Table 1. Provider Satisfaction with Monetary Incentives

	Strongly agree or agree % (sample size)
Scholarships	N=106
Scholarships made it easier to take part in trainings	94% (97)
Provider would have participated in trainings without scholarship	34% (35)
Financial Rewards	N=160
Provider worked harder because of the reward	76% (119)
Provider would have participated in trainings without wage enhancement	52% (79)
Grants for Environmental Improvements	N=51
Provider was more motivated to make improvements because of the grants	90% (45)
Provider would have made improvements without the grant	46% (23)

The written responses providers gave on the PES mirrored these quantitative findings. Some providers spoke of the opportunities that the monetary incentives provided to them: "I have been able to attend courses and workshops that I would not have been able to attend because of expenses….I feel that us getting the wage stipend helps with the lack of money that childhood care providers do receive." Providers indicated that the monetary incentives, in addition to helping with training and career development, lowered their stress levels and allowed them to do additional things: "[Project name] has enhanced my wages, making it possible to go back to school…, repaint inside of our home, enhance my classroom, and take family time off of work." Another provider echoed this sentiment: "I appreciate the opportunity to be a part of [project name] and for the stipend, as it helped me pay some bills and afford some "extras" for myself which both relieved a lot of stress." Providers also commented that the incentives made them feel appreciated as child care providers: "I, as many of my colleagues, have been delighted with the stipends! With the cost of living constantly going up and living in an area where bus drivers get paid better than educated professionals who care for and educate young children, it's a welcome relief to qualify and get recognized and appreciated in financial compensation!"

"I, as many of my colleagues, have been delighted with the stipends! With the cost of living constantly going up and living in an area where bus drivers get paid better than educated professionals who care for and educate young children, it's a welcome relief to qualify and get recognized and appreciated in financial compensation!"

During the second round of key stakeholder interviews, 40 of the 68 respondents indicated that they were familiar with monetary incentives provided by the project. These respondents listed a variety of successes associated with these activities. Stakeholders felt that monetary incentives:

- Motivated providers to participate in training and education (45%, or 18 respondents);
- Motivated providers to enroll in the project (25%, or 10 respondents);
- Allowed providers to make environmental improvements (13%, or 5 respondents);
- Kept providers in the field (10%, or 4 providers);
- Motivated providers to make changes in their practice (8%, or 3 providers); and
- Rewarded providers for their professionalism (8%, or 3 providers).

These comments from the key stakeholders mirror comments from project staff and participants that the evaluation team heard during site visits. Monetary incentives were seen as a critical component for drawing providers into the project, and then played a key role in motivating them to keep participating.

Stakeholders also discussed some challenges associated with offering monetary incentives to providers. These challenges were primarily related to the difficulty of creating the process and protocols for the incentives, such as determining the eligibility requirements for providers or the process for disbursing the funds.

Mentoring

Several CCQI sites paired participating providers with mentors. Mentors were more experienced child care providers or educators in early childhood education programs. The

supports provided by mentors varied, as discussed in detail below, and included such assistance as one-on-one consultations, administering the Harms-Clifford Environmental Rating Scale, and providing career counseling and emotional support.

RESEARCH SUPPORT FOR MENTORING AS A STRATEGY TO ENHANCE CHILD CARE QUALITY

Child care workers with more child-specific training tend to provide higher-quality care than providers who are not trained (Arnett, 1989; Burchinal, et al., 2002). In a mentoring or consultation context, child care providers receive collegial support, as well as the knowledge and skills typically received in other more traditional training modalities such as workshops and classes (Wesley, 1994).

Mentorship and the social and physical caregiving environment

The effect of mentoring on the overall quality of the social and physical caregiving environment appears to be modest. Studies have found improvements in child care quality associated with participation in mentoring or consulting projects (Bagnato, Suen, Brickley, Smith-Jones, & Dettore, 2002; Ontai,et al., 2002; Palsha and Wesley, 1998; Wesley, 1994), but often the effects are not statistically significant (DeBord and Sawyers, 1996; Fiene, 2002). In some cases improvements were noted along specific dimensions of caregiving quality, such as planning high-quality learning activities and using developmentally appropriate discipline strategies (Fiene, 2002; Mueller and Orimoto, 1995). The type and extent of improvement made in child care quality may depend upon children's age (Ontai, et al., 2002; Palsha and Wesley, 1998), the caregiving setting (e.g., family care vs. center care) (Feinie, 2002), or the level of caregiving quality produced by the provider before engaging in the mentorship program (DeBord and Sawyers, 1996; Palsha and Wesley, 1998). The nature of the mentor/mentee relationship may also impact child care quality outcomes (Wesley, 1994), but this is rarely addressed in the literature. Research has yet to provide a clear picture of how mentorship works to improve child care quality; nevertheless, mentoring and consultation appears to be a promising avenue for delivering training and professional support to child care providers.

Mentorship and the child care system

Mentorship that offers professional support for child care providers may have positive effects on the providers' sense of professionalism, which could impact the quality of the local child care system. There is some evidence that mentorship is linked with job satisfaction (Buell, et al., 2002; Fiene, 2002; Mueller and Orimoto, 1995; Palsha and Wesley, 1998; Wesley, 1994), attaining early childhood credentials and/or seeking more training (Buell, et al., 2002; Mueller and Orimoto, 1995), and increased knowledge about business practices (Mueller and Orimoto, 1995). These findings imply that the supportive nature of mentorship may indirectly influence larger indicators of systemic health, such as lower rates of job and occupational turnover; however, these relationships have not yet been directly examined.

MENTORING ACTIVITIES PROVIDED BY THE CCQI PROJECTS

Baker, Jackson, Lane, Marion, and Tillamook counties all used CCQI funds to provide mentoring to some providers.[3] During the one-year period that quarterly reports were completed, 87 providers were successfully connected with new mentors, with the number served ranging from 7 in Tillamook

[3] In many counties, mentoring was also provided by the CCR&R. In these cases, it was difficult to separate the mentoring services provided by the CCQI from other mentoring that was occurring.

County to 39 in Lane County. During the year, an average of 17 providers were reported each quarter to be continuing to work with a mentor. Mentors provided a variety of supports to their mentees. In some counties, mentors completed the Harms-Clifford Environmental Rating Scale with mentees to identify areas in need of work, and then offered one-on-one assistance in these target areas. Mentors also provided more general support and assistance, helped providers identify professional development goals, and helped link providers with education and training resources.

MENTORING SUCCESSES AND CHALLENGES

Program participants and key stakeholders provided information about the successes and challenges of mentoring activities. Providers who completed the follow-up PES indicated whether or not they had mentors as part of the project, and if so, whether they found the mentoring useful and whether the mentors helped with career development goals. Three quarters of the 66 people who indicated they had mentors felt that the mentoring was useful, and two-thirds stated that the mentors helped with career development goals.

During the second round of key stakeholder interviews, 14 respondents said they were familiar with mentoring activities sponsored by the CCQI project. These respondents listed several successes of the mentoring activities:

- Mentors helped providers navigate the PDR/OR system (29%, or 4 respondents);
- Mentors helped providers create better physical environments (21%, or 3 respondents);
- There was a focus on care for special needs children (14%, or 2 respondents);
- Mentors helped providers identify professional development goals (7%, or 1 respondent); and
- The project provided good management of mentors (7%, or 1 respondent).

During site visits, providers discussed the mentoring they had received through the project and commented that the mentor helped increase their confidence.

Key stakeholders also identified some challenges associated with mentoring activities. These challenges included building trust between mentees and mentors, coordination of CCQI mentors with other mentoring programs, and not having an adequate quantity of mentors. Several stakeholders also said that mentors used the Harms-Clifford in an inconsistent and unreliable manner.

Informal Networking Among Providers

Several CCQI sites created support groups for providers or encouraged providers to join already existing support groups and other networking opportunities. These activities are described in more detail below.

RESEARCH SUPPORT FOR INFORMAL NETWORKING AS A STRATEGY TO ENHANCE CHILD CARE QUALITY

With so much focus on the regulatable features of child care quality, the 'non-regulatable' features have been largely overlooked. The social support literature suggests that supportive interactions with social partners can be beneficial to individuals in a variety of ways (e.g., more positive self-perceptions, instrumental aid) (Sarason, Pierce, Shearin, Sarason, Waltz, & Poppe, 1991).

Informal networks and the social and physical caregiving environment

Very few studies even include social support and collegial relationships as predictors of high-quality social and physical caregiving environments. The literature hints at the im-

portance of emotionally supportive collegial relationships for child care providers, but few studies examine these relationships directly (Buell, et al., 2002). Social support has been linked with reduced stress, which is a predictor of child care quality (Ghazvini and Mullis, 2002). Programs with a support group component may show positive outcomes (e.g., increased provider knowledge about child development), but it is impossible to evaluate the unique influence of the support groups.

Informal networks and the child care system

Perceived social support has also been linked with greater job satisfaction and job commitment, and lower job-related stress (Kontos and Riessen, 1993; Mueller and Orimoto, 1995). Thus, social support may have a positive influence on the child care system if job satisfaction and commitment lead to less turnover.

"[Project name]…created a bond within the child care community here…It has been wonderful sharing ideas and building relationships. Our profession is very draining. We need encouragement from one another."

PROVIDER NETWORKING ACTIVITIES PROVIDED BY THE CCQI PROJECTS

Eight counties used CCQI funds to offer support groups or other networking opportunities for providers. NPC tracked the number of different kinds of provider support groups offered at each site. From April 2004 to March 2005, 11 provider support groups were offered. On average, counties sponsored the following numbers of support groups each quarter: Baker County (2); Clackamas (1); Coos-Curry (1–2); Jackson (1); Lane (2); Marion (0–1); Tillamook (1); and Washington (1). Overall, CCQI sites held an average of one type of provider support group per quarter.

PROVIDER SATISFACTION WITH SUPPORT GROUPS

On the follow-up PES, providers were asked whether the project helped them meet others in the field. Three quarters of the providers agreed or strongly agreed that the project had, indeed, helped them meet others in the field and only 5% indicated that the project had not helped them with this. As one provider stated on her survey, "[Project name]…created a bond within the child care community here…It has been wonderful sharing ideas and building relationships. Our profession is very draining. We need encouragement from one another." During site visits, providers and project staff shared with the evaluation team that the social networks created by the project have been beneficial, have increased providers' sense of professionalism, and continued outside of the project activities. However, these social networks may not have been the result of the more formal social support groups; providers participating in training and education sessions often formed more informal networks.

CHAPTER 3: CHARACTERISTICS OF PROVIDERS SERVED

In this chapter we document the number and characteristics of the providers served by the projects, including their demographic and professional characteristics.

Demographics

Providers involved with the CCQI projects supplied demographic information on the baseline PES, and these data are summarized in Table 2. More than half (56%) of the providers were over the age of 35, and over one-third were over the age of 45. A majority of the providers (86%) were White and 8% were Hispanic. Almost all providers (91%) spoke English as their primary language. Data from the Oregon Child Care Resource and Referral Network suggests that about 22% of providers in the CCQI counties speak Spanish (although it is unclear whether Spanish is their "primary language"). This does suggest, however, that reaching and serving Spanish-speaking providers was a challenge for the CCQI projects. More than one-fifth of the providers had a Bachelor's or Master's degree, and an additional 28% had an Associate's degree or a certification.

Table 2. Provider Demographics

Characteristic	Percent (sample size)
Gender	N=227
Female	99% (224)
Male	1% (3)
Age	N=206
25 and under	11% (23)
26 to 35	33% (68)
36 to 45	19% (39)
46 and older	37% (76)
Race/ethnicity	N=228
White	86% (198)
Hispanic	9% (20)
African American	1% (1)
Asian/Pacific Islander	1% (3)
American Indian/Native Alaskan	1% (2)
Other	2% (4)
Primary Language	N=227
English	92% (209)
Spanish	7% (16)
Other	1% (2)
Highest Education Level	N=222
Masters degree	3% (7)
Bachelors degree	19% (43)
Associates degree	14% (31)
Certification (child-related or other)	14% (30)
High school diploma/GED	44% (98)
Less than high school	1% (3)
Other	5% (10)

Professional Characteristics

The PES also asked providers for information regarding their professional characteristics, as illustrated in Table 3. The providers involved in the CCQI projects were fairly evenly split between center-based care providers and family child care providers (53% and 48%, respectively). Nearly one-third (30%) of the center-based care providers described themselves as head teachers, 26% were teachers, 32% were directors, and 12% were aides or assistant teachers. Of the family care providers, almost all (97%) described themselves as either owner/operators or owner/teachers, and 3% described themselves as teachers or assistants. The CCQI providers had been in their position and in the field for quite a while: nearly half (49%) had been at their job for over 5 years, and 71% had been in the field for over 5 years.

Table 3. Provider Professional Characteristics

Characteristic	Percent
Type of care	N=223
Center-based care	52% (116)
Family child care	47% (104)
Both center and family care	1% (3)
Type of position for CBC providers	N=118
Head teacher	30% (35)
Teacher	26% (31)
Director/teacher	18% (21)
Director/administrator	14% (17)
Aide/assistant teacher	12% (14)
Type of position for FCC providers	N=104
Owner/operator	41% (43)
Owner/teacher	56% (58)
Teacher	2% (2)
Assistant teacher	1% (1)
Length of time at job	N=192
Over 5 years	49% (93)
3 to 5 years	39% (74)
1 to 2 years	7% (14)
Less than 1 year	6% (11)
Length of time in the field	N=223
Over 5 years	71% (158)
3 to 5 years	19% (42)
1 to 2 years	9% (19)
Less than 1 year	2% (4)

Providers also recorded information on the PES about their income earned from child care and insurance status, as illustrated in Table 4. Almost all providers indicated that their income from child care was less than $30,000 annually, with almost two-thirds indicating that it was less than $15,000 annually. However, for almost half of the providers, income from child care was less than half of their household income and for just a quarter of the providers was income from child care their only source of household income. Three-quarters of the providers indicated that they had health insurance, with half of these providers obtaining insurance through their spouse or partner and slightly less than one-third obtaining insurance through their child care employment.

Table 4: Provider Income and Insurance

Characteristic	Percent
Income from child care	N=229
$15,000 or less	64% (146)
$30,000 or less	97% (223)
Child care percent of total income	N=205
Only source of income	24% (50)
More than half of income	18% (36)
About half of income	11% (22)
Less than half of income	47% (97)
Health insurance	N=226
Percent with health insurance	74% (167)
Source of health insurance	N=165
Spouse or partner	50% (83)
Child care employment	30% (50)
Other	19% (32)
For those with insurance, who pays:	N=156
Family covers all cost	25% (39)
Family and employer share cost	39% (60)
Employer covers all cost	24% (38)
Other financial arrangement	12% (19)

On the whole, the information providers offered about their income and insurance status did not differ between their baseline and follow-up PES. However, on one item, percent of providers with less than $15,000 in child care income, there was a marginally significant difference between the baseline and follow-up PES. Table 5 displays these results for those providers who submitted both a baseline and a follow-up PES (n = 186). As illustrated in the table, at follow-up, fewer providers had child care incomes of less than $15,000, and more had incomes greater than $15,000. This change could be due to the additional income earned through stipends and wage enhancements.

Table 5. Change in Child Care Income

Income from Child care	Percent with Child care Income Less than $15,000	Percent with Child care Income More than $15,000
Baseline	62%	38%
Follow-Up	52%	46%

Note: Statistically significant, $X^2 = 3.42$, p =.06.

CHAPTER 4: OUTCOMES OF PROVIDER-DIRECTED STRATEGIES

The CCQI sites provided training, monetary incentives, mentoring, and opportunities for informal networking in order to influence the quality of child care offered by providers. The evaluation team gathered outcome data from a variety of sources, including the baseline and follow-up PES, provider telephone surveys, site visits, administrative datasets, and key stakeholder interviews. While influencing child care quality was the long-term goal, sites hoped to create change in some more immediate, short-term outcomes that were more readily measurable. Therefore, the evaluation focused on the following short-term outcomes: provider attitudes about being a professional, motivation for professional development, skill in accessing the system, pre-PDR/OR and PDR/OR enrollment and advancement, and degree or certificate attainment, sense of community and isolation, and retention. Below we present data on each of these outcomes.

Provider Attitudes About Being a Professional

To measure provider attitudes about being a professional, we added several items to the modified PES and to the follow-up PES. On the modified PES providers were asked to rate their level of agreement with two statements: "I feel respected for the work I do," and "I feel competent when talking to parents." On the follow-up PES, parents were asked these same two questions again, and they were also asked to rate their level of agreement with a third item: "The project has helped me feel more respected by others as a professional." Because some providers (in particular, in Benton, Jackson, Marion, and Lane counties) were administered the original PES rather than the modified PES, the data reported here is on the subset of providers (n = 93) who completed both the modified PES and the follow-up PES; providers who completed the original (unmodified) baseline PES are necessarily excluded from these analyses. The main findings for these outcomes are as follows:

- There were no changes between baseline and follow-up on providers' feelings of being respected for the work they do or feelings of competence when talking to parents.
- At follow-up, most providers indicated the project helped them feel more respected as a professional.
- Providers who received trainings, scholarships, or wage enhancements were more likely to indicate that the project helped them feel more respected as a professional than providers who did not participate in these strategies.

These results are explained in more detail below. (For site-specific results, please see Appendix L.)

As illustrated in Table 6, there were no changes between baseline and follow-up on providers' feelings of being respected for the work they do and feelings of competence when talking to parents. However, at follow-up, almost three-quarters of providers stated that the project had made them feel more respected by others as a professional. It may be that the PES survey items were not sensitive to change; both items showed fairly high levels of agreement at a baseline (a possible "ceiling" effect). One provider wrote a comment on her follow-up PES that echoed the comments of others: "I realize I am a professional child care provider, not a glorified babysitter." During site visits, providers and project staff mirrored this comment; providers and project staff shared with the evaluation team that feelings of professionalism had increased as a result of program participation.

However, it should also be noted that these "ceiling effects" were probably 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. Because of this, 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. Thus, while ceiling effects were clearly present (and created issues for other outcomes described below) the cause of the ceiling effects may be a combination of measurement insensitivity, provider eligibility requirements screening out lower-scoring providers, the lack of "clean" baseline measures, and/or the short period between baseline and follow-up measures.

We also investigated whether providers who participated in different project strategies had different outcomes related to attitudes about being a professional. Specifically, we investigated whether providers who participated in trainings; received scholarships, wage enhancements, or grants for environmental improvements; or who were paired with a mentor though CCQI had different outcomes (compared to those who did *not* participate in the particular strategy). Significantly more providers who participated in trainings agreed that the project helped them feel more respected as a professional than providers who did not participate in trainings (79% of providers who participated in trainings agreed with this statement compared to 41% of providers who did not participate in trainings). Similarly, significantly more providers who received scholarships or wage enhancements agreed that the project helped them feel more respected as a professional than providers who did not receive scholarships or wage enhancements (82% of providers receiving scholarships agreed with this statement compared to 60% of providers not receiving scholarships, and 77% of providers receiving wage enhancements agreed with this statement compared to 42% of providers not receiving wage enhancements). Receiving grants for environmental improvements or having a mentor were not related to these outcomes.

Table 6. Provider Attitudes About Being a Professional

Item	Agree at Baseline % (sample size)	Agree at Follow-Up % (sample size)	Change
I feel respected for the work I do.	73% (67)	72% (66)	1%, *ns*
I feel competent when talking to parents.	87% (81)	93% (86)	6%, *ns*
The project has helped me feel more respected by others as a professional.	--	72% (134)	--

Note: *ns* = not statistically significant

Additionally, we investigated whether several provider characteristics influenced providers' outcomes related to feelings of professionalism. Length of time spent in the CCQI project, involvement with Pathways or the PDR/OR, type of provider (family care provider or center-based provider) provider age, and provider income level all bore no relationship to these outcomes. However, the length of time providers were in the field was related to feelings of competence when talking to parents: for providers who had been in the field for more than 5 years, their feelings of competence when talking to parents did not change between baseline and follow-up, but providers with less experience actually reported a *decrease* in competence talking to parents between baseline and follow-up. In addition, providers with *lower* educational attainment (high school or less) were significantly more likely to report that the project helped them feel more respected as a professional. Finally, Caucasian providers were significantly more likely to report an increase in feeling respected for the work they do, compared to minority providers (although sample sizes are small).

These results suggest that while we did not find change over time in self-reported provider attitudes about being a professional, most providers agreed at follow-up that the project had helped them feel respected as a professional. We may not have found change over time due to a ceiling effect: at baseline providers ranked themselves high on attitudes about being a professional, leaving little room for improvement at follow-up.

Provider Motivation for Professional Development

The original PES contained little information that assessed providers' motivation for professional development; to capture this outcome, we added two items. Providers were asked at baseline and follow-up whether they would (1) like to improve their education and training and whether (2) it is important to them to improve their education and training. We combined these two items to create one indicator of "motivation for professional development." However, baseline levels of motivation appeared quite high (4.5 on a 5 point scale, with 5 indicating high levels of motivation), and there was no significant change over time. Neither particular strategies used by CCQI projects nor provider characteristics were related to levels of motivation. It seems likely that this measure was simply not sensitive enough to detect any changes in motivation; the high baseline levels indicate a possible "ceiling" effect, leaving little room for increases in motivation over time.

However, we did collect some information about the kinds of professional development goals that providers had, on the modified PES. Specifically:

- 16 providers (17%) indicated they wanted to obtain a CDA or other certificate
- 27 (29%) wanted to obtain a degree;
- 60 (65%) wanted to enroll or advance on the PDR/OR; and
- 29 (31%) wanted to enroll or advance on Pathways/pre-PDR;

One provider described her newfound focus on professional development goals:

"I knew very little about child development before I participated in this program. This program gave me the opportunities to take early childhood education courses…and inspired me to go on to a [college-level] Early Childhood Development program. This program motivated me to work hard in order to accomplish my goal of becoming a professional in this field."

Provider Skill in Accessing the System

To measure provider skill in accessing the early childhood care and education system, we asked providers to indicate their level of agreement with three items on the modified baseline PES and again on the follow-up PES: (1) "In my county there are many education and training opportunities," (2) "I know how to find out about education and training opportunities," and (3) "I have opportunities for professional development." We combined these three items to create one indicator of skill in accessing the system, and were then able to look for change over time. In addition, on the follow-up PES, providers were asked to indicate whether they believed the project had helped them learn about education and training opportunities. The main findings for these outcomes are as follows:

- There were no changes between baseline and follow-up on the indicator of providers' skill in accessing the system.
- More than three-quarters of providers agreed that the project had helped them learn about educational and training opportunities.
- Providers who participated in trainings reported being more skilled at accessing the system at baseline and at follow-up than providers who did not participate in trainings.
- Caucasian providers were more likely to indicate skill at accessing the system at baseline and at follow-up than non-Caucasian providers, although sample sizes are small.

These results are described in more detail below. (For site-specific results, please see Appendix L.)

While there were no changes between baseline and follow-up on the indicator of providers' skill in accessing the system, 79% (146) of providers felt that the project had helped them learn about educational and training opportunities. Again, the lack of change over time on the indicator variable could be due to a ceiling effect; high baseline scores for providers did not leave much room for improvement.

Analysis of individual strategies revealed that participating in trainings was related to perceived skill at accessing the system. Providers who participated in trainings were significantly more likely to indicate that the project had helped them learn about education and training opportunities: 86% of providers participating in trainings felt this way compared to 47% of providers who did not participate in trainings. In addition, providers who participated in trainings indicated more agreement that they had skill at accessing the system at both baseline and follow-up. This suggests a "rich getting richer" phenomenon: those providers who had some skill in accessing the system were the ones to participate in training and thus maintained their skill in accessing the system at follow-up, while providers who were less skilled at accessing the system at baseline were less likely to engage in training and did not show any change in skills for accessing the system at follow-up.

Providers who received scholarships and wage enhancements also were more likely to indicate that the project had helped them learn about training and educational opportunities in their communities compared to pro-

viders who did not take part in these strategies (87% of providers who received scholarships agreed the project helped them compared to 66% of providers who did not receive scholarships, and 84% of providers who received wage enhancements agreed that the project helped them compared to 46% of providers who did not receive wage enhancements). The wage enhancement and scholarship strategies were not related to the indicator variable for skill in accessing the system, but there was a somewhat unlikely result for the strategy of providing grants for environmental improvements: those who received grants for environmental improvements were less likely to report feeling skilled in accessing the system at follow-up than did providers who did not receive grants for environmental improvements. It is not readily apparent why grants for environmental improvements would be related to (less) skill in accessing the system; indeed, this result could be explained by the fact that most grants for environmental improvements were awarded in Baker and Tillamook counties, rural counties with more limited training and education opportunities than the other CCQI counties, which could result in lower scores on the indicator variable. It is also worth noting that variability on this variable was low; most providers scored positively (indicating good skill at accessing the system), and therefore, the lower scores among providers with grants for environmental improvements does not indicate these providers were unskilled at accessing the system, but rather, that they were at the lower range of the high end of the scale, while other providers scored even higher.

Finally, the mentoring strategy also appeared to be related to provider skill in accessing the system. This finding also is somewhat counter-intuitive: providers with mentors reported less agreement that they had skill in accessing the system than providers without mentors. Like with the grants for environmental improvements strategy described above, there are two possible explanations for this finding. First, mentoring activities, while present at several of the CCQI sites, were for the most part concentrated in Tillamook County, another rural county that may have fewer training and educational resources available than other CCQI counties. Second, also discussed above, most providers scored on the high skill end of the range of possible scores on this indicator variable, so while those with mentors did appear to score lower than those without mentors, all of these scores were within the range of high skill at accessing the system.

We also investigated whether several provider characteristics were related to this outcome. Provider age, time in field, education level, type of provider (family care provider or center-based provider), and income were not related to skill at accessing the system. However, race was related to this outcome: 71% of Caucasian providers agreed that they were skilled at accessing the system at both baseline and follow-up, compared to 30% of non-Caucasian providers. Most of the non-Caucasian providers were Hispanic; it could be that this population was less engaged and familiar with the education system in general; projects may need to devote particular attention to providing this population with the information and skills necessary to access the system.

Pathways and PDR/OR Enrollment and Advancement and Certificate and Degree Attainment

The evaluation team examined administrative data from Portland State University as well as data from the CCQI projects (provider PES data and quarterly report data) to gather information about Pathways and PDR/OR outcomes as well as about provider certificate and degree attainment. The main findings for these outcomes are as follows:

- About half of the CCQI providers participated in Pathways or pre-PDR programs, and these providers had a significant increase in Pathways/pre-PDR level between baseline and follow-up[4].
- Administrative data on PDR/OR enrollments suggested that there was not an overall difference between CCQI counties and non-CCQI counties in PDR/OR enrollments. However, when focusing specifically on the subset of providers who participated in the CCQI projects, the data suggests a significant increase in PDR/OR enrollments between baseline and follow-up.
- Administrative data on PDR/OR advancements suggested that more advancement happened among CCQI counties than among non-CCQI counties, and data on the subset of providers who participated in the CCQI projects confirmed this: these providers had significantly higher PDR/OR levels at follow-up than at baseline.
- No particular CCQI strategies were significantly related to Pathways or PDR/OR outcomes.
- Providers who enrolled on the PDR/OR tended to be more experienced than providers who did not enroll on the PDR/OR, and providers who were enrolled on the PDR/OR were more likely to be family care providers rather than center-based providers.
- Quarterly report data indicated that across the state five CCQI providers obtained a certificate such as a CDA, and four CCQI providers completed their Bachelor's or Associate's degrees.

These findings are described in more detail below. For site-specific Pathways, PDR/OR, and certificate and degree data on CCQI participants, see Appendix M; for site-specific administrative data on PDR/OR enrollments and advancements, see Appendix N.

PATHWAYS/PRE-PDR OUTCOMES

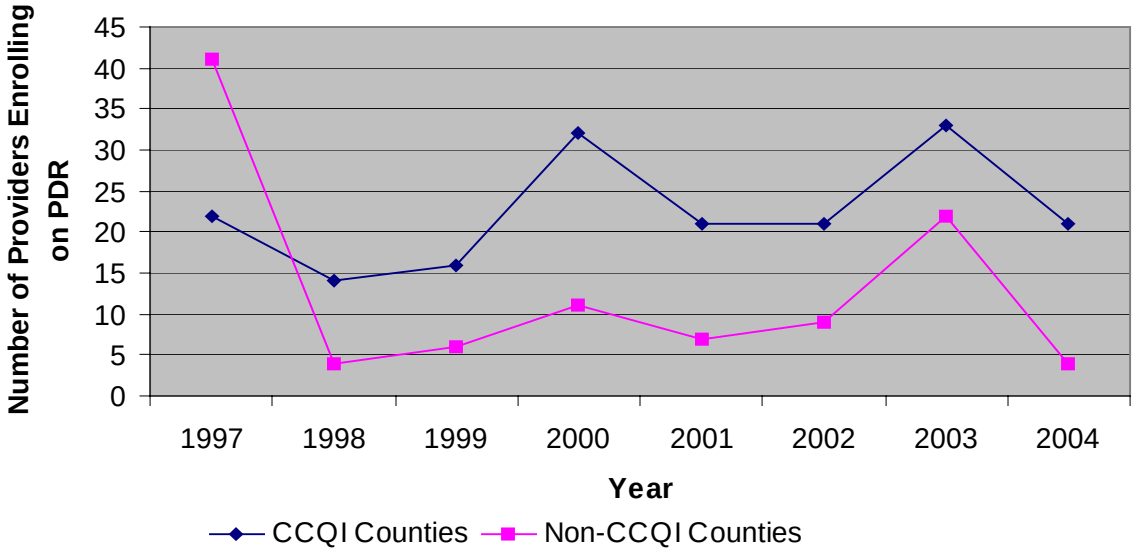
Many of the sites focused on getting providers involved in pre-PDR/OR activities, such as the Pathways program. Indeed, 44% (82) of the providers who completed the follow-up PES indicated that they were enrolled on the Pathways program. No particular CCQI strategies (e.g. training, monetary incentives, mentoring, or informal networking) were significantly related to Pathways enrollment. There was a significant increase in Pathways level over time: at baseline the mean Pathways level was 6.9 and at follow-up the mean level was 7.4. No particular CCQI strategy (training, monetary incentives, or mentoring) was significantly related to Pathways advancement, nor were any provider characteristics (age, race, education, income, length of time in field, or type of provider). Data from quarterly reports indicates that 164 providers took part in Pathways or other pre-PDR/OR activities and 152 of these providers advanced at least one step between April 2004 and March 2005.

PDR/OR OUTCOMES

According to data kept by Portland State University, a total of 181 providers were enrolled on the PDR/OR as of December 31, 2004 in the CCQI counties, and a total of 104 providers were enrolled on the PDR/OR in the non-CCQI counties. Figure 1 displays the number of providers enrolling in the PDR/OR each year between 1997 and 2004 for both the CCQI and non-CCQI counties. While PDR/OR enrollment has been higher in the CCQI counties, this trend is noticeable for the years *prior* to the CCQI project as well as the years since the project, and therefore the higher enrollment in CCQI counties cannot be attributed to the project.

[4] It should be noted, however, that changes in the PDR/OR level system may have influenced these provider-reported results.

Figure 1: PDR/OR Enrollment for CCQI and non-CCQI Counties



However, while there did not appear to be a difference between CCQI and non-CCQI counties in overall PDR/OR enrollment, there was an increase in PDR/OR enrollment for providers participating in CCQI projects. According to PES data, significantly more CCQI providers were enrolled on the PDR/OR at follow-up than at baseline (73% were enrolled at follow-up compared to 62% at baseline). This indicates that while the CCQI project may not have made an impact on overall PDR/OR enrollment among all providers in the CCQI counties, the project did make an impact among the subset of providers who participated in the CCQI project. None of the CCQI strategies (training, monetary incentives, or mentoring) were significantly related to PDR/OR enrollment, nor were most provider characteristics (e.g. age, race, income, education). However, time in the field was related to PDR/OR enrollment: those providers who were not enrolled on the PDR/OR (at baseline and follow-up) were the least experienced providers, and those providers who enrolled on the PDR/OR over the course of the project were more likely to be highly experienced.

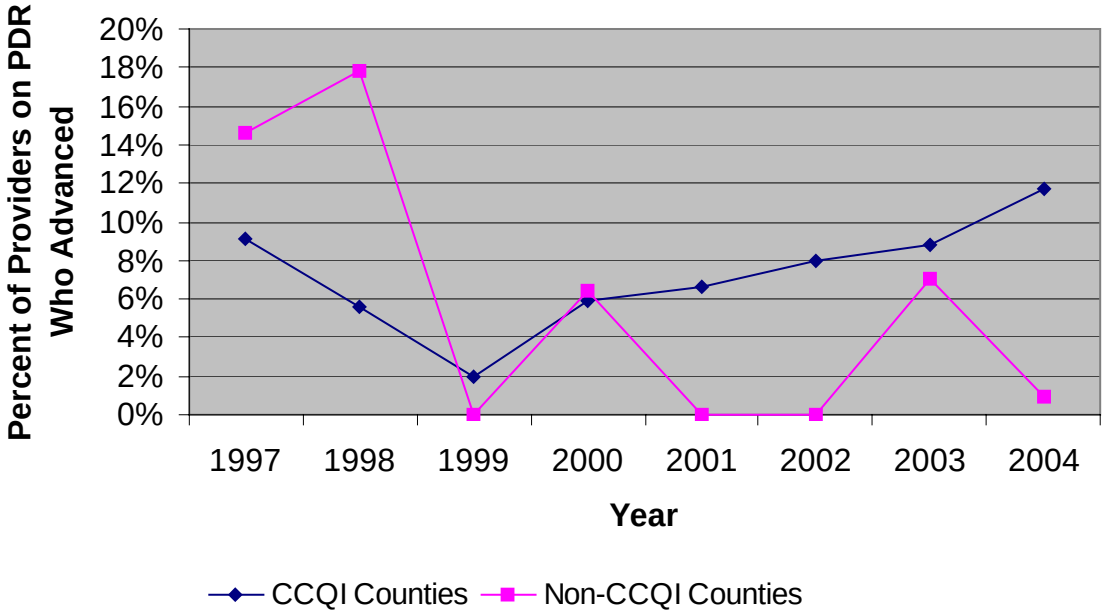
Type of provider also was related to PDR/OR enrollment: those providers who never enrolled on the PDR/OR were more likely to be center care providers, and those who were enrolled the entire time (at baseline and follow-up) were more likely to be family care providers.

In addition to looking at PDR/OR enrollments, we examined providers' advancements on the PDR/OR as well. First, using data from Portland State University, Figure 2 displays the percent of providers on the PDR/OR who advanced on the PDR/OR levels for CCQI and non-CCQI counties. As illustrated in the figure, for the CCQI counties there is a trend toward increased PDR/OR advancements since the start of the CCQI projects, while in the non-CCQI counties there is not a similar trend. In 2004, the most recent year for which data were available, 12% of the providers on the PDR/OR in the CCQI counties advanced their PDR/OR level, while only 1% of providers on the PDR/OR in the non-CCQI counties advanced levels.

In addition to this overall county-level data described above, providers' responses on the PES allowed us to examine PDR/OR advancements specifically for the subset of providers who participated in the CCQI project. There was a significant increase providers' self-reported PDR/OR level between

baseline and follow-up for providers who participated in the CCQI project: at baseline the mean PDR/OR level for CCQI providers was 1.8, and at follow-up the mean level was 2.4. However, it should noted that provider's self-reported PDR/OR level may have been influenced by the change sin the PDR/OR system that occurred in January 2005. At that time, some PDR/OR levels were re-categorized, resulting in a higher "level" for some providers (but no real advancement in training). However, the fact that there were more PDR/OR advancements in CCQI counties using data collected just prior to the PDR system change supports the notion that providers in CCQI projects were, in fact, more likely to advance during the project. None of the CCQI strategies (training, monetary incentives, or mentoring) were specifically related to PDR/OR advancement, nor were provider characteristics (age, race, income, education level, type of provider, or time in the field). Data provided on quarterly reports indicates that from April 1, 2004 to March 30, 2005, 37 providers advanced at least one step on the PDR/OR/OR.

Figure 2: PDR/OR Advancement for CCQI and non-CCQI Counties



Provider Knowledge and Skills

The evaluation team measured changes in provider knowledge and skills through pro vider self-report on the baseline and follow-up PES, the provider telephone survey, and through site visits. On the baseline and follow-up PES, providers were asked to rate their confidence level with a series of skills. In addition, the follow-up PES asked a separate set of questions about whether the project had helped providers feel more confident in several areas. On the provider phone survey, providers were asked to indicate whether they had changed their practice in a variety of skill areas as a result of their participation in the CCQI projects, and if so, were asked for some examples of things they had changed. These answers were reviewed and coded by the project team, and only valid examples of positive changes were scored. Finally, during the site visits, providers had an opportunity to share in-depth information about their practices, and evaluation staff had an opportunity to visit their centers and

homes. The major findings for provider knowledge and skill outcomes are summarized here:

- There was no change between baseline and follow-up PES scores on providers' level of confidence with daily duties, specialized skills, or professional skills.
- For the most part, no single CCQI strategies (training, wage enhancements, grants for environmental improvements, mentoring, or informal networking) were significantly related to changes in providers' levels of confidence with daily duties, specialized skills, or professional skills as measured by the PES.
- Length of time in the field was significantly related to provider confidence with daily duties, specialized skills, and professional skills.
- Nearly 90% of providers who completed the PES indicated that through the project they had learned useful information that they would apply to their work; two-thirds said the project helped them feel more confident working with infants and toddlers; about half said the project helped them feel more confident to serve children with special needs; and one-third believed the project helped them feel more confident to serve children who spoke a language other than English.
- On the phone survey, providers indicated that they implemented the most changes in things they do to promote children's social growth and development, observing and assessing children's behavior, guiding children with challenging behavior, and making physical space and equipment work better.

These results are described in more detail below. For site-specific knowledge and skill outcome data, please see Appendix O.

PROVIDER KNOWLEDGE AND SKILL AS MEASURED BY THE PES

The PES asked providers to rate their level of confidence with a large variety of knowledge and skill areas. We have collapsed those items into three scales: a daily duties scale, a specialized skills scale, and a professional skills scale. The daily duties scale included the following items: childhood health and safety, nutrition and meal planning, social growth and development, school readiness and success, observation and assessment, development of curriculum and activities, guidance of children's behavior, working with families, working with diverse cultures, identifying child abuse and neglect, and creation of physical environments (alpha=.90 at baseline and follow-up). The specialized skill scale included the following items: guidance of children with challenging behavior, infant development and care, working with children with physical disabilities, working with children with emotional disabilities, and working with children with learning delays or developmental disabilities (alpha=.85 at baseline and .83 at follow-up). The third scale, professional skills, included the following items: management and business practices, utilization of community resources, professional development, and self-care and self-management (alpha=.79 at baseline and .78 at follow-up).

Using these three subscales we could then investigate change over time in providers' confidence levels in each of these domains. As displayed in Table 7, overall we found no change in providers' feelings of confidence over time. This could be due to a ceiling effect; providers ranked their confidence levels as high at baseline, and there was little room for improvement at follow-up.

Table 7. Provider Knowledge and Skills as Measured on PES

Skill Area	% Confident at Baseline (N=183)	% Confident at Follow-Up (N=183)	% Change
Daily duties	98%	97%	-1%, *ns*
Specialized skills	72%	72%	0%, *ns*
Professional skills	93%	95%	2%, *ns*

Note: *ns* = not statistically significant

Table 8. Provider Feelings of Competence as Measured on PES Follow-up

Item	% agree (N= 186)
Through the project I learned useful information that I will apply to my work.	89%
The project has helped me feel more competent to serve infants and toddlers.	67%
The project has helped me feel more competent to serve children with special needs.	48%
The project has helped me feel more competent to serve children who speak a language other than English.	33%

We next investigated whether any particular CCQI strategies were related to changes in knowledge and skills over time. Only the scholarship strategy showed any significant relationship with these outcomes: providers who received scholarships tended to report a greater increase in confidence on all these subscales than providers who did not receive scholarships.

We also investigated whether provider characteristics were related to changes in confidence level over time. Most characteristics (e.g., age, education, type of provider, and income) were not related to these outcomes, but two characteristics, length of time in the field and race, were related to these outcomes. Not surprisingly, providers with the most experience (those who have been in the field longest; in some cases, over 20 years), indicated the largest increases in confidence between baseline and follow-up, and had the highest confidence ratings at follow-up. Provider race had a relationship with change in confidence in specialized skills; Caucasian providers remained stable on this subscale over time, while data suggested that non-Caucasian providers actually showed a decrease in their confidence levels over time (although sample sizes were small).

The follow-up PES included several questions to learn whether providers believed the project had helped them increase their competence in several areas. As displayed in Table 8, almost all providers felt that the project gave them useful information that they will apply to their work, and two-thirds felt that

the project helped them feel more confident to work with infants and toddlers. However, slightly less than half of the providers thought the project helped them feel more confident to serve children with special needs, and one-third felt that the project helped them feel more confident to serve non-English speaking children.

Several CCQI strategies appear to be related to providers' feelings of competence as described above. First, providers who participated in trainings were significantly more likely to agree that the project had provided them with useful information that will apply to their work than providers who did not participate in trainings (95% of providers who participated in trainings agreed with this statement, compared to 61% of providers who did not participate in trainings). Providers who participated in trainings also were significantly more likely than providers who did not participate in trainings to agree that the project helped them feel more competent to serve infants and toddlers (75% of providers who participated in trainings agreed with this statement compared to 30% of providers who did not participate in trainings). Participating in trainings was not related to increased feelings of competence around serving children with special needs or children who speak languages other than English. Overall, CCQI projects were more likely to provide infant-toddler trainings, which may account for this finding.

Providers who received scholarships were significantly more likely than providers who did not receive scholarships to agree with all four of these statements. Almost all providers who received scholarships (97%) agreed that the project gave them useful information that they will apply to their work, compared to 79% of providers who did not receive scholarships. In addition, most providers (82%) who received scholarships felt that the project helped them feel more competent to serve infants and toddlers, compared to 51% of providers who did not receive scholarships. Just over half (54%) of providers who received scholarships believed that the project helped them feel more competent to serve special needs children, compared to 40% of providers who did not receive scholarships, and 38% of providers with scholarships felt more competent to serve children who speak a language other than English, compared to 26% of providers who did not receive scholarships.

Receiving wage enhancements was associated with providers' believing the project gave them useful information that they will apply to their work and to feelings of competence to serve infants and toddlers. Nearly all (97%) of the providers who received wage enhancements felt that the project gave them useful information that they will apply to their work, compared to 79% of providers who did not receive wage enhancements, and 82% of providers with wage enhancements believed the project helped them feel more competent to work with infants and toddlers, compared to 51% of the providers who did not receive wage enhancements. Receiving grants for environmental improvements was not associated with any of these items.

The mentoring strategy was marginally associated only with feelings of competence to serve infants and toddlers. Three-quarters of the providers with mentors agreed with this statement compared to 66% of providers without mentors.

We next investigated whether any particular provider characteristics were related to these items. Several items were not related, including age, race, and type of provider. However, several characteristics did have significant relationships with these items. First, length of time in the field was significantly related to agreeing that the project helped build competence to serve infants and toddlers and non-English speaking children, and was marginally significantly related to feeling the project helped build competence to serve special needs children: newer providers were signifi-

cantly more likely to agree that the project helped build competence with these populations than providers with more years of experience. Income earned from child care also was related to whether providers agreed that the project helped them feel more competent to serve infants and toddlers: providers with less income from child care were more likely to state that the project helped them feel more competent serving infants. It could be that less experienced providers had more room for improvement in these areas than providers with more experience.

PROVIDER KNOWLEDGE AND SKILL AS MEASURED BY THE PROVIDER PHONE SURVEY AND SITE VISITS

On the provider phone survey, respondents were asked to indicate the degree to which they had changed their practice in a variety of areas, and to provide examples of the types of changes they had made. These examples were coded by the evaluation team, and only valid examples were scored. Table 9 summarizes providers' perceptions of the degree of change that they made. The areas in which providers indicated the most change were promoting children's social growth and development, observing and assessing children's behavior, guiding children with challenging behavior, and making physical space and equipment work better.

On the phone survey providers were asked for examples of the types of changes they had made in each domain. A summary of the types of changes is reported below.

Providers reported the following changes in things they do to promote social growth and development:

- New activities that promote social growth and development (24%, 38 providers);
- Child-focused promotional strategies (22%, 35 providers) (e.g., positive feedback for sharing);
- Positive guidance strategies (13%, 20 providers);
- Different provider/child interactions (14%, 22 providers);
- Different curriculum (3%, 5 providers);
- No change because no need to change in this domain (23%, 37 providers); and
- No change for other reasons (3%, 4 providers).

Some examples that providers offered of changes they had made included focusing more on games that involved group participation and helping children develop friendship skills such as kindness and turn-taking. Findings from the site visits mirror the provider phone survey findings: during the site visits providers explained that they learned about age appropriate development and activities and have incorporated activities that build social skills into their practice.

Providers reported the following changes in things they do to observe and assess children's behavior:

- Greater awareness of the importance of observation/more diligence in observing and note taking (46%, 74 providers);
- More emphasis on sharing observations with parents and other staff (6%, 9 providers);
- No change because no need to change in this domain (28%, 45 providers); and
- No change for other reasons (18%, 29 providers).

As one provider explained during the phone interview, she now has spiral notebooks for each child in which she writes down observations. Parents are free to take these notebooks home for review. Site visit findings mirror these survey results. For example, during one site visit, a provider explained that because she is being more observant she now has

more stories and observations to share with parents.

Providers reported the following changes in things they do to guide and discipline children with challenging behavior:

- More focus on positive, child-focused guidance (34%, 54 providers);
- Increased provider awareness and prevention of problems (11%, 17 providers);
- New emphasis on structure and boundaries (7%, 11 providers);
- No change because no need to change in this domain (37%, 58 providers); and
- No change for other reasons (5%, 8 providers).

Table 9. Phone Survey Data on Providers Reporting Change in their Practice Due to CCQI Participation (N=161)

	% reporting "a lot" of change (sample size)	% reporting "a little" change (sample size)	% reporting "no change" (sample size)
Promoting children's social growth and development	30% (49)	42% (68)	26% (42)
Observing and assessing children's behavior	21% (34)	32% (51)	46% (74)
Guiding or disciplining children with challenging behavior	24% (38)	31% (50)	44% (71)
Promoting infant development and care	5% (8)	19% (30)	49% (78)
Working with children with physical or medical disabilities	7% (11)	15% (24)	76% (122)
Working with children with learning delays or developmental disabilities	8% (12)	23% (37)	68% (109)
Working with children from different cultures and backgrounds	16% (26)	29% (47)	21% (82)
Making physical space and equipment work better	39% (62)	28% (45)	31% (50)
Changes to business practices	13% (20)	21% (33)	63% (101)
Balancing family and work and stress management	21% (34)	28% (44)	48% (76)

Note: Reflected in this table are only those changes that providers reported as due to participation in the CCQI project. Some providers indicated they had made changes that weren't due to project participation, and these responses are excluded from this table.

During the phone survey providers offered examples of these changes, including being more clear with expectations and consequences, setting up a schedule for daily activities, and helping children problem-solve rather than automatically giving them time-outs. One provider explained during a site visit that she has learned that children need structure, and by using routines the children now know what to expect out of the day, which has decreased problem behavior.

Providers who worked with infants reported the following changes in things they do to promote infant development and care:

- Different ways of interacting with infants (24%, 17 providers);
- More appropriate toys and equipment (18%, 13 providers);
- More awareness of stages of development and appropriate care (17%, 12 providers);
- No change because no need to change in this domain (35%, 25 providers); and
- No change for other reasons (11%, 8 providers).

Some examples of the changes reported by providers include exposing them to more music and physical activity, talking and making eye contact with them more.

Providers who worked with children with physical and medical disabilities reported the following changes in things they do to work with children with physical and medical disabilities:

- Emphasis on creating a more inclusive environment (10%, 6 providers);
- Emphasis on doing things to help develop skills/making individualized plans (7%, 4 providers);
- Emphasis on working more closely with families (5%, 3 providers);
- No change because no need to change in this domain (33%, 21 providers); and
- No change for other reasons (10%, 6 providers).

Some examples of changes reported by providers include ensuring that activities are appropriate for all children and teaching sign language to all children rather than just to a speech delayed child.

Providers who worked with children with developmental delays reported the following changes in things they do to work with children with learning delays or developmental disabilities:

- Emphasis on doing things to help develop skills (29%, 26 providers);
- Emphasis on making individualized plans for children (15%, 14 providers);
- No change because no need to change in this domain (32%, 29 providers); and
- No change for other reasons (11%, 10 providers).

Providers who worked with children with learning delays gave examples of the specific strategies they use to help children, including determining how each child learns best and tailoring lessons appropriately.

Providers reported the following changes in things they do to address cultural diversity:

- Inclusion of multicultural toys, books, foods, posters, etc. (27%, 41 providers);
- Using curricula that include diversity (16%, 25 providers);
- Inclusion of multicultural activities (10%, 16 providers);
- Increased parent involvement (9%, 14 providers);
- No change because no diversity among children in care (17%, 27 providers);

- No change because no need to change in this domain (17%, 27 providers); and
- No change for other reasons (15%, 22 providers).

Providers discussed adding books in Spanish and books featuring families of different backgrounds, celebrating a variety of religious and cultural holidays, and inviting parents to share information and objects from their cultures. During one site visit, a provider commented that she was now aware that cultural diversity is more than just race and language, but also encompasses class and other family characteristics.

Providers reported the following changes in things they do to <u>make their physical space and equipment work better</u>:

- Created different work spaces and zones (31%, 48 providers);
- Purchased new toys or equipment (29%, 45 providers);
- Made materials more accessible to children (4%, 6 providers);
- No change because no need to change in this domain (22%, 34 providers); and
- No change for other reasons (9%, 14 providers).

Many providers discussed rearranging their physical space to create distinct spaces for quiet activities (e.g. a reading corner), arts and crafts activities, dramatic play, etc. Providers also described new toys and equipment they had purchased, including outdoor play equipment and fences and gates to increase safety.

Of the providers who handle business arrangements (e.g. family care providers), providers reported the following changes in <u>their business practices</u>:

- New or modified contracts or payment rates and schedules (38%, 42 providers);
- More professional interactions (13%, 14 providers);
- No change because no need to change in this domain (34%, 37 providers); and
- No change for other reasons (14%, 15 providers).

Some providers explained that they had never had contracts but had developed contracts with parents with help from the project and others discussed becoming more firm in enforcing payment arrangements with families.

Providers reported the following changes in things they do to <u>balance work and home life and stress management</u>:

- Emphasis on setting boundaries (16%, 24 providers);
- Greater awareness of stressors (14%, 21 providers);
- Increased self-care (14%, 21 providers);
- New organization techniques and work habits (7%, 10 providers);

- No change because no need to change in this domain (21%, 32 providers); and
- No change for other reasons (22%, 34 providers).

Providers explained that they learned to be stricter about the hours they worked so that they had enough time for their own families, and others gave examples of things they were doing for themselves, such as jogging or taking relaxing bubble baths.

In addition to examining the types of changes providers made, we examined whether particular CCQI strategies or provider characteristics were related to reported changes. The CCQI strategies were indeed related to provider reports of change in several of these topic areas:

- Providers who took part in trainings were more likely to report changing the things they do to promote social growth and development and guiding children with challenging behavior, whereas providers who did not participate in trainings did not report making these changes.
- Participation in two specific types of trainings was linked to outcomes. First, providers who participated in cultural competency training reported significantly more change in terms of things they were doing to address cultural issues, compared to providers who did not participate in this type of training. Second, providers who participated in trainings related to stress management indicated making more changes in what they did to balance work/family stress. There was also a marginally significant trend such that providers who participated in trainings focused on working with children with challenging behavior reported greater increases in their use of positive guidance techniques in their classrooms.
- Providers who received scholarships for classes reported changing the things they do to promote social growth and development, observing and assessing children's behavior, and guiding children with challenging behavior, and providers who did not receive scholarships did not indicate change in these areas.
- Providers who received wage enhancements improved their ability to balance work and family and stress management, and providers who did not receive wage enhancements did not report change in this area.
- Providers who received grants for environmental improvements reported changing their physical space and equipment work better, and providers who did not receive grants for environmental improvements did not report change in this area.
- Providers who received mentoring reported change in working with children with physical or mental disabilities, working with children from different cultures and backgrounds, things they did to make their physical space and equipment work better, things they did to change their business practices, and their ability to balance work and family and stress management, and providers who did not receive mentoring did not report change in these areas.

We also examined whether particular provider characteristics were related to reports of change in these domains:

- Providers with lower income were more likely to report changing the things they did to promote social growth and development, changes in business practices, and changing their ability to balance work and family and stress management than providers with higher incomes.
- Providers with less education were more likely to report changing the things they did to promote social growth and development, observing and assessing children's behavior, and working with chil-

dren with learning delays than providers with more education.

- Providers with less time in the field were more likely to report changing the things they did to promote social growth and development and observing and assessing children's behavior than providers with more time in the field.
- Non-Caucasian providers were more likely to report improving how they work with children with physical or medical disabilities, compared to Caucasian providers, although sample sizes are small.
- Providers who participated in a professional development program were more likely to report changing the way they guide children with challenging behavior, compared to providers who did not participate in a professional development program.
- Center-based care providers were more likely to report changes in how they work with children from different cultures and backgrounds and were less likely than family care providers to report changes in making their physical space and equipment work better or changes in business practices.

Thus, it appears that overall, less experienced providers (those with less time in the field, less education, and less income) reported making changes in a variety of skill areas, while more experienced providers reported less change (perhaps because they felt less need for improvement).

While results from the PES did not show significant change over time in provider confidence with various knowledge and skill areas, the qualitative nature of the provider telephone interview was more successful at capturing information about provider changes. The open-ended, conversational nature of the phone interview appears to be a more appropriate methodology for capturing subtle and detailed descriptions of providers' practices.

Sense of Community Among Providers and Provider Isolation

In order to measure providers' sense of community, the modified baseline PES and follow-up PES included four questions related to networking and support among providers (whether providers agreed that they had opportunities to network, were part of a support group, got support from other providers, and felt part of a community). We created one scale using these four items (alpha=.85 at baseline and .87 at follow-up). There was no change over time on this scale; 60% of providers at baseline agreed that they were part of a community of providers, and 62% of providers at follow-up felt they were part of a community of providers. In addition, no CCQI strategies or provider characteristics were related to scores on this scale.

Provider isolation was measured on the PES using one item: the level of providers' agreement with the statement "I often feel isolated as a child care provider." There was no statistically significant change between baseline and follow-up on providers' level of agreement with this statement; at baseline, 13% of providers agreed they felt isolated, and at follow-up 20% agreed they felt iso-

lated. No CCQI strategies were related to scores on this item, but several provider characteristics did show a relationship with this item. First, feelings of isolation were related to length of time spent in the CCQI project: those providers who had been in the CCQI project for more than two years felt less isolated over time and were least isolated at follow-up compared to providers who were in the project for less than two years. Second, education level was related to feelings of isolation: those providers with a CDA or higher had lower feelings of isolation at both baseline and follow-up than did other providers. Finally, type of provider was related to feelings of isolation: family care providers showed a significant *increase* in feelings of isolation between baseline and follow-up, and had significantly more feelings of isolation at follow-up than did center-based providers.

For site-specific data on sense of community and isolation, please see Appendix P.

Provider Retention

Provider retention was measured on the PES using several items: providers were asked on the baseline and follow-up PES how long they planned on staying in their current position, their current place of employment, and in the child care profession. The findings for these outcomes are summarized below:

- There was no change between baseline and follow-up in providers' plans to stay in their current position or in the child care field.
- A majority of providers were committed to staying in the field for five or more years.
- No CCQI strategies were related to retention.
- Older providers, more experienced providers, and providers involved in a professional development program exhibited greater commitment to the field than other providers.

These findings are discussed in more detail below. For site-specific retention data, please refer to Appendix Q.

As displayed in Table 10, there was no significant change over time in providers' plans to stay in their current position; slightly more than half planned on staying at their position for more than 5 years, and almost none planned on leaving their position in less than a year. There was a statistically significant increase in the number of providers who planned on leaving their current place of employment in less than one year. However, more than half of the providers indicated they planned on staying at their place of employment for more than 5 years, and more than three-quarters said they planned on staying in the child care profession for more than 5 years. Thus, the providers who participated in the CCQI project exhibited high retention, and there was not room for change over time because providers' plans for retention were already in place at baseline.

No CCQI strategies were related to retention, but several provider characteristics were significantly related to retention plans. First, providers involved with a professional development program (e.g., Pathways) remained committed to staying in their position, while providers not involved in such a program showed a decline in commitment between baseline and follow-up.

Provider age was also related to retention: older providers had a greater commitment to their current place of employment and younger providers had the lowest commitment to their place of employment at follow-up (and also had a significant *decrease* in commitment between baseline and follow-up). Similarly, providers under the age of 25 showed a decline between baseline and follow-up in the number of years they were planning to stay in the child care field, while for all other age groups, the level of com-

mitment to the child care field remained stable between baseline and follow-up. A similar pattern emerged regarding length of time in the field: those providers who had been in the field for over ten years showed the highest commitment to their position, their place of employment, and the child care field, and those who had been in the field for less than 5 years showed the lowest commitment at follow-up and a significant decline in commitment between baseline and follow-up.

It follows that providers involved with professional development programs and those providers who have been in the field for longer periods of time and are older would have more of a commitment to their jobs and career than younger providers. More puzzling is the finding that for less experienced and younger providers, their level of commitment appeared to decrease between baseline and follow-up. However, this may not be the case: if these providers were clear from the outset that they wanted to stay at their job or in the field, for example, for three years, they would have indicated this on the baseline interview. Then, when they completed the follow-up interview (anywhere from six to eighteen months after the baseline), they would indicate that they were going to stay at their job or in the field for two years. Thus, their actual level of commitment may not have changed, but simply by the passage of time, the number of years left in their commitment decreased.

Provider race also was related to plans for retention: Caucasian providers reported more commitment over time to their current position and place of employment than non-Caucasian providers, whose reported commitment decreased somewhat between baseline and follow-up. This finding should be interpreted with care, however, as the sample of non-Caucasian providers was small and the response rate was generally lower for these providers. Finally, whether providers were family care or center-based providers was related to plans for retention. Center care providers reported fewer years of commitment to their place of employment between baseline and follow-up, and at follow-up had levels of commitment significantly lower than family care providers, while family care providers' commitment remained stable over time. Similarly, family care providers were significantly more committed to their position at both baseline and follow-up than were center-based providers.

Summary of Outcomes for Quality Improvement Strategies

The data presented in this chapter highlighted quality improvement outcomes. Overall, the data suggest that providers felt the CCQI project helped them feel more professional and helped them gain skill in accessing the system. CCQI providers also showed increased enrollment and advancement in Pathways and the PDR/OR, and reported change in specific skill areas, including fostering social growth and development, observation and assessment, working with children with challenging behavior, and creating appropriate physical environments.

In addition, certain CCQI strategies were related to particular outcomes. For example, providers who participated in trainings, scholarships, or wage enhancements reported changes in overall professionalization (e.g., feelings of respect as a professional, and ability to accessing the professional development system). Providers who took part in mentoring, on the other hand, reported changes in specific skill areas, including creating appropriate physical environments, working with families of different cultures, improving business practices, working with children with physical disabilities, and improving balance between work and home life.

Table 10. Provider Retention

Providers planning to stay:	% at Baseline (sample size)	% at Follow-up (sample size)
In their current position	N=168	N=168
Less than one year	2% (4)	7% (12)
1 to 2 years	15% (25)	14% (23)
3 to 5 years	26% (44)	21% (36)
More than 5 years	57% (95)	58% (97)
At their current place of employment	N=177	N=177
Less than one year	1% (2)*	7% (12)*
1 to 2 years	12% (21)	12% (21)
3 to 5 years	27% (48)	23% (41)
More than 5 years	60% (106)	58% (103)
In the field in any position or setting	N=135	N=135
Less than one year	0% (0)	2% (20
1 to 2 years	4% (5)	6% (8)
3 to 5 years	18% (24)	14% (19)
More than 5 years	79% (106)	79% (106)

* indicates marginally significant ($p < .07$) change over time

Providers usually took part in a combination of strategies; for example, the largest group of CCQI providers received training and some sort of financial incentive (most commonly scholarships or wage enhancements). Other providers took part in mentoring, training, and scholarships or wage enhancements. Offering providers such packages of strategies only serves to reinforce and strengthen the effects of each individual strategy.

Certain provider characteristics also were related to particular outcomes. Providers with lower education, lower income, and fewer years in the field all reported changes in specific skills, such as fostering social growth and development, observing and assessing behavior, working with children with developmental delays, improving business practices, and improving balance between work and family life. These providers may have had lower skill levels and were best able to benefit from the project.

Responses from key stakeholder interviews mirrors some of the findings discussed above. During the second round of key stakeholder interviews, respondents were asked how much they believed the project had influenced the quality of child care in their communities. Of the 60 respondents who answered this question, 50% (30) said

they believed the project had been very effective at influencing quality, 28% (17) said they thought the project had been somewhat effective at influencing quality, one respondent did not think the project had influenced quality, and 12 respondents were unsure. Respondents also were asked to describe what changes in quality they had observed that made them believe the project had influenced quality. While some stakeholders could not articulate what changes they had observed, several offered the following examples:

- Providers were using better curricula, techniques, and activities (20%, or 12 respondents);
- Providers had made environmental improvements (12%, or 7 respondents);
- Providers were exhibiting increased motivation for providing high-quality care (10%, or 6 respondents); and
- Provider retention had increased (3%, or 2 respondents).

It also is worth noting that for many of the outcomes of interest, the PES was not able to capture change over time. While providers were able to discuss changes they had made during the qualitative interview and indicated on the PES that the project had helped them in many of these domains, actual pre- and post-test scores on many of the indicator variables developed for this evaluation did not yield results. Providers tended to rank themselves at the high end of scales even on the baseline PES, thus limiting the room for growth on the follow-up PES. It appears that a qualitative methodology is more successful at capturing the subtle and complex changes made by providers than a closed-ended paper-and-pencil questionnaire.

CHAPTER 5: IMPROVING CHILD CARE QUALITY: THE TRI-COUNTY APPROACH

As described previously, Clackamas, Multnomah, and Washington Counties took a somewhat different approach to enhancing child care quality than the other counties in the CCQI project. After participating in the Compensation Study contracted by the Six-County Consortium, the Tri-Counties focused on enhancing the system of supports for early childhood educators by piloting three projects: (1) a health benefits pool; (2) a substitute pool; and (3) a purchasing cooperative. In addition to these primary activities, several additional trainings were provided (including the TRACS training, a 60-hour training in working with children with disabilities; and the Creating a Climate for Growth training), and funds were contributed to a certification program for child care center directors.

Overall, the work done in the Tri-County area is best considered exploratory; most of the effort was expended to test the feasibility of several ideas for benefits enhancements that could inform future efforts and/or develop sustainable "toolkits" or other systems for providing benefit enhancements to child care providers. The primary effort during the first year and a half of the project was on the compensation study (described previously). Between March and September 2004, disruptions in the Metro CCR&R as well as staff turnover within the Tri-County project hindered progress. By the fall of 2004, the key Tri-County stakeholders were meeting regularly as a group and had developed a workplan for the three primary project components. Accomplishments related to these activities are described in more detail below.

Health Benefits Pool

While the original goal of the project was to create a benefits pool that would provide health insurance to providers, the first project consultant discovered that this was not feasible; the issue of how to provide benefits to a large pool of mostly self-employed workers turned out to be considerably more complicated than the project staff had imagined. After recognizing this, the project shifted its energies into developing a sustainable resource system that could be accessed by child care providers, and help guide them through their choices of benefits options. Informational meetings were held with providers to explain benefits options. Two meetings were held, and 28 providers participated. Below we summarize the characteristics of the providers who participated in the health insurance informational meetings, including demographic and professional characteristics; present customer satisfaction data from these meetings; and report whether the providers obtained insurance since participating in the meetings.

CHARACTERISTICS OF PROVIDERS WHO PARTICIPATED IN HEALTH INSURANCE INFORMATIONAL MEETINGS

Twenty-eight providers attended the two health benefits informational meetings, and all of these providers completed a written survey at the end of the meeting. The survey

asked for basic demographic information, information about providers' insurance needs, and information about their satisfaction with the meeting.

Participants' ages ranged from 27 to 63, with an average age of 39. Of the 28 participants, 26 were female (93%) and 2 were male (7%). 75% (21) of the providers were Caucasian, 15% (5) were Hispanic, and 4% (1) were multi-racial. Most (71%, or 20 providers) spoke English as their primary language, 17% (4) spoke Spanish as their primary language, one provider spoke Russian, and one spoke Sinhalese.

89% (24) of the providers were in family care and 11% (3) were center-based care providers. Table 11 displays the types of children cared for by these providers. Three-quarters of the providers indicated that they plan to stay in the child care field more than 5 years, and two-thirds plan to stay at their current place of employment for more than 5 years.

Table 12 presents data on the type of insurance the participating providers had at the time of their participation in the informational meeting. As illustrated in the table, nearly half (46%, or 13 providers) did not have any form of insurance.

Table 11. Children Cared for by Providers at Health Benefits Informational Meetings

	% (number of participants)
Infants	73% (19)
Toddlers	81% (21)
ESL Children	48% (12)
Children needing odd hours care	46% (12)
Children with special needs	23% (6)

Table 12. Insurance Profile of Providers Participating in Health Insurance Information Meetings

	Self	Family
Health	32% (9)	43% (12)
Dental	14% (4)	25% (7)
Vision	7% (2)	14% (4)
Other: Children on OHP	---	7% (2)
None	46% (13)	---

Providers also indicated their current insurance needs, as displayed in Table 13. Providers needed insurance both for themselves and for their families.

Most (89%) providers reported at least one barrier to obtaining health insurance, and Table 14 displays the percent and number of providers reporting each barrier.

Table 13. Insurance Needs of Providers Participating in the Health Insurance Information Meetings

	Self	Family
Need health insurance	36% (9)	48% (12)
Need dental insurance	40% (10)	48% (12)
Need vision insurance	24% (6)	36% (9)
Need Other: business/ employee	8% (2)	---
More affordable health insurance	32% (8)	---

Table 14. Barriers to Obtaining Health Insurance

	% (number of participants)
Cost – too expensive	85% (22)
Confusing to choose a plan	35% (9)
Do not know where to get information	15% (4)
Don't understand how health insurance works	15% (4)
Pre-existing conditions	11% (3)
Already have some type of coverage	11% (3)
Health insurance is not important to me	4% (1)
Too much paperwork	4% (1)
Worried about privacy	0

Table 15. Provider Satisfaction with Health Insurance Informational Meetings

% (number of participants)	Disagree	Neutral	Agree	Strongly Agree
Information was presented clearly	11% (3)	7% (2)	70% (19)	11% (3)
Information presented was useful	4% (1)	14% (4)	36% (10)	46% (13)
Information provided will help me to obtain health insurance	7% (2)	19% (5)	41% (11)	33% (9)
Having health insurance would make it easier to continue working as a child care & education professional	7% (2)	15% (4)	22% (6)	56% (15)
Having the opportunity to get health insurance makes me feel more like a professional	12% (3)	12% (3)	35% (9)	42% (11)
I believe people with health insurance are healthier than people without it	14% (4)	25% (7)	25% (7)	36% (10)

As can be seen, cost was by far the biggest concern for these providers. Further, despite these barriers, 64% of providers indicated at the close of the meetings that they were somewhat or very likely to obtain health insurance within the next 60 days.

SATISFACTION WITH THE HEALTH INSURANCE INFORMATIONAL MEETINGS

A majority of the participating providers (54%, or 15 providers) were very satisfied with the informational meetings and an additional 29% (8 providers) were somewhat satisfied. The area with the lowest ratings appears to be related to clarity of presentation of information; project planners should take note of this for future meetings. Table 15 below presents providers' answers to some specific questions about the meetings.

STATUS OF HEALTH INSURANCE BENEFITS SUPPORT AT PROJECT END

NPC Research conducted telephone interviews with 22 of the 28 providers who participated in the health benefits informational meetings. Of these, six providers had obtained health insurance since the meeting; all of these providers indicated that the information obtained during the meeting was helpful in this process. Three indicated that the meeting had given them information about the kind of plan they qualified for and one indicated that s/he had learned who to contact for more information. Of those who hadn't obtained insurance, eight already had sufficient insurance; six indicated that cost was still a barrier; and others were concerned about their eligibility for health insurance. Over half (12) of the participating providers indicated that the information about different plans and options was the most valuable aspect of the informational sessions; five providers said the information about where to go for more information was the most helpful. Most thought the meetings were quite positive and offered few suggestions for improvements.

During the final round of key stakeholder interviews, thirteen persons in the Tri-County area commented on the success and challenges of the health benefits supports developed by this project. Five respondents said that it was too soon to tell whether this piece was successful, three felt that the project had been successful in meeting its goals in terms of developing health benefit supports, three people felt that the goals had not been met, largely because they felt that merely giving providers information about health insurance was insufficient, and two stakeholders indicated that they didn't know whether this piece had been a success. Stakeholders discussed several challenges in implementing the health benefits support, most frequently noting the complexity of the health insurance system and related legalities - as one stated, "the learning curve was huge." Several also mentioned that the initial person hired to manage this piece did not have enough understanding of the needs of child care providers and was not a good fit, and that having to

replace this person significantly impeded progress on the project. Some stakeholders also questioned whether the energy spent developing the health benefits supports were really responsive to providers' needs, and suggested that investing in the CARES program would have had a greater impact on more providers. Data from the compensation study suggests that the need for health insurance (at least among family child care providers) varied considerably across the three counties. In Clackamas County, 100% of the interviewed registered providers reported having health insurance coverage, while in Multnomah County only about 60% reported coverage. Rates were slightly lower for certified providers.

Discussions of how to sustain the health benefits supports were begun during the final year of the project. Because many project activities did not occur until the final 6 months of the grant, the Tri-County leadership team felt strongly that it was important to be able to have a system in place to ensure that the information gathered for the health benefit pool was not lost. As of June 2005, a Web site was developed and posted: www.healthcareforchildcare.org. This site is currently being hosted by the Oregon Child Care Resource and Referral Network (OCCRRN). The site uses the information gathered by the CCQI project and provides information and linkages for child care providers and helps to guide them through the process of determining health insurance needs and cost options. A Web site was felt to be the most sustainable way of ensuring that the information gathered by the project consultant was not "lost" and providing a useful toolkit that providers could use even after the CCQI funds were expended. Additionally, information packets, including translated versions, are being created so that they can be disseminated through the CCR&Rs after the project is completed.

Substitute Pool

The idea behind the substitute pool was to provide child care providers, especially family child care providers, with trained and experienced people they could call on for planned absences, such as vacations or trainings. A project consultant was hired to research the feasibility of such a system, and to develop a pilot project. Originally, it was hoped that a pool of 15-20 substitutes could be recruited and organized, and that paperwork and systems for accessing the pool would be developed. As of May, 2005, there were 11 providers in the substitute pool, 9 of whom had been used as substitutes. Substitutes were to be paid $10 per hour, and as an incentive to providers to use the substitute pool, providers in the CCQI target groups (infant/toddler, special needs, non-English speaking) received a 25% subsidy to support the cost of the substitute. Substitutes were hired as employees of the center or family child care provider desiring the substitute. Substitutes were required to have liability insurance. Paying for the costs of liability insurance was used as an incentive to recruit substitutes into the pool. Substitutes were also required to have criminal back ground checks, and basic child care training required by the Oregon Child Care Division. Costs of the background check and training was provided by the CCQI project. Project funds were used to cover these expenses through the CCR&R. Information was sent to providers through the CCR&R newsletters, and through flyers developed by the project consultant. Substitutes were also recruited through presentations made by the project consultant at community colleges and other child care provider training venues, and through direct phone calling of providers on the CCR&R database.

Below we summarize the characteristics of the providers who participated in the substitute pool informational meetings, including demographic and professional characteristics;

present customer satisfaction data from these meetings; and report whether the providers used the substitute pool since participating in the meetings.

CHARACTERISTICS OF PROVIDERS INTERESTED IN HIRING SUBSTITUTES

A total of 22 providers seeking substitutes filled out surveys at the substitute pool informational meetings. Participants' ages ranged from 20 to 61, with an average age of 37. All 22 participants were female. 73% (16 providers) were Caucasian, 9% (2 providers) were Hispanic, 9% (2 providers) were multiracial, one provider was African American, and one was Asian American. All but one spoke English as her primary language; the remaining provider spoke Spanish as her primary language.

Most providers were family care providers (82%, or 18 providers). Table 16 displays the types of children cared for by these providers. Approximately 75% of the providers plan on staying at their current place of employment and in the child care field for more than 5 years.

Table 16. Children Cared for by Providers at Substitute Pool Informational Meetings

	% (number of participants)
Infants	82% (18)
Toddlers	91% (20)
Children who speak language other than English	32% (7)
Children who require odd hours care	32% (7)
Children with verified special needs	32% (7)

Fifty percent of the participating providers listed at least one potential barrier to using a substitute pool. Table 17 lists all barriers reported by the providers. Participants could afford to pay substitutes between $7 and $10 per hour, with an average of $9.25 per hour. As was the case for health benefits, cost was reported by these providers to be the primary barrier to using the substitute pool. Despite these barriers, 77% (17 providers) indicated they were somewhat or very likely to use the substitute pool within the next 60 days.

Table 17. Barriers to Using a Substitute Pool

	% (number of participants)
Can't afford to pay a substitute	33% (4)
I do not feel comfortable hiring a substitute	25% (3)
Won't need a substitute in the next 60 days	17% (2)
Uncertain about tax responsibility	17% (2)
Concerned about the 48 hour notice	8% (1)
Parents of the children in my care would not approve of a substitute	8% (1)
Not meeting the substitutes or getting to know them	8% (1)
Don't understand how the substitute pool works	0

Table 18. Provider Satisfaction with Substitute Pool Informational Meetings

% (number of participants)	Disagree	Neutral	Agree	Strongly Agree
Information was presented clearly	0	0	36% (8)	64% (14)
Information presented was useful	0	0	38% (8)	62% (13)
Information provided will help me to find and use substitutes	0	9% (2)	14% (3)	77% (17)
Being part of a substitute pool would make it easier to continue working as a child care & education professional	0	14% (3)	23% (5)	64% (14)
Having the opportunity to access a substitute pool makes me feel more like a professional	0	14% (3)	23% (5)	64% (14)
I believe people with health insurance are healthier than people without it	0	14% (3)	23% (5)	64% (14)

SATISFACTION WITH THE SUBSTITUTE POOL INFORMATIONAL MEETINGS AMONG PROVIDERS INTERESTED IN HIRING SUBSTITUTES

All providers indicated that they were somewhat or very satisfied with the substitute pool informational meetings. Table 18 presents providers' answers to some specific questions about the meetings.

CHARACTERISTICS OF PROVIDERS INTERESTED IN BEING SUBSTITUTES

A total of 17 providers interested in being substitutes filled out surveys. Participants' ages ranged from 25 to 62, with an average age of 42. All were women. Nine were Caucasian, three were Hispanic, three were Asian, one was African American, and one provider indicated "other" race. Most (71%) spoke English as their primary language, three spoke Spanish, one spoke Russian, and one spoke Chinese as their primary languages.

35% reported at least one barrier to becoming a substitute. Table 19 lists all the barriers reported. Participants reported that they would need to make an average of $10 per hour in order to be substitutes, which is somewhat more than providers seeking substitutes indicated they would be willing to pay. Despite these barriers, all participants were interested in becoming substitutes.

SATISFACTION WITH THE SUBSTITUTE POOL INFORMATIONAL MEETINGS AMONG PROVIDERS INTERESTED IN BEING SUBSTITUTES

All but one participant indicated they were somewhat or very satisfied with the informational meetings. Table 20 presents providers' answers to some specific questions about the meetings.

Table 19. Barriers to Becoming a Substitute

	% (number of participants)
I do not feel comfortable being a substitute	25% (2)
I am still doing family child care in my home	13% (1)
My own child has to be able to come to work with me	13% (1)
My schedule and [residency] status	13% (1)
Would have to take on too much responsibility as a substitute	13% (1)
Won't have the necessary training	0
Don't understand how the substitute pool works	0

Table 20. Substitute Satisfaction with Informational Meetings

	% (number of participants)			
	Disagree	**Neutral**	**Agree**	**Strongly Agree**
Information was presented clearly	0	0	19% (3)	81% (13)
Information presented was useful	0	0	19% (3)	81% (13)
Information provided will help me to find and use substitutes	0	0	25% (4)	75% (12)

STATUS OF SUBSTITUTE POOL AT PROJECT END

As of May 1, 2005, there were 11 substitutes in the pool, 9 of whom had been placed at least once (the remaining 2 had extremely limited availability). Seven substitutes had dropped out of the pool, and one was in the process of being added. A telephone survey of 6 of the registered substitute providers found that half of them had been placed at least once. Generally, these providers indicated that their experience in the substitute pool was a positive one. Scheduling difficulties in terms of the times requested by providers vs. the times these individuals were available appeared to be the biggest challenge. Only one provider indicated that she had decided that she did not feel comfortable being a substitute. The primary reasons for participating in the substitute pool were (1) to make additional money; and (2) to gain more child care experience.

As of June 2005, a total of 32 providers had completed all necessary paperwork to receive substitute care from the pool, although only 19 providers had actually used substitutes. The wage subsidy (a 25% discount provided to substitute pool users who provided, or were to receive training to provide, infant/toddler care, special needs care, or care

for non-English speaking children) appeared important in generating interest in using the substitutes. In the period February-April when substitutes were available, almost all of the time slots for which a substitute was provided were covered by the subsidy (39 out of 43 time slots).

Telephone interviews with 16 of the 20 providers who registered to receive substitutes found that only 6 of them had used the substitute pool; of these, all found it to be a "positive" or "very positive" experience. Most indicated that they had no other way of getting a temporary replacement so that they could be absent from work. All indicated that they would use the pool again, although three suggested that the process for accessing substitutes could be made easier and more streamlined. Only one of the 10 providers who had not used a substitute indicated that she was unlikely to use the pool for cost reasons. Another indicated that she had tried to use the pool but that the substitute had not shown up. Six indicated that they simply had not yet needed a substitute. Suggestions for improving the way the pool was managed included: (1) have opportunities for the substitutes and the providers using the substitutes to meet each other; (2) be more clear about tax and liability issues; (3) have more substitutes with more availability.

Interviews were conducted at the end of the project with key stakeholders in the Tri-County region. Of 16 stakeholders interviewed, nine felt knowledgeable enough about the substitute pool to respond to questions. Of these, four respondents indicated that the substitute pool had been a success, but that they had concerns about sustainability, one respondent said that it was a success except that substitutes kept getting hired by the providers who use them as substitutes (thus constantly depleting the pool of substitutes), two respondents said it was too soon to tell whether this piece had been a success, and two respondents did not know whether it had been a success. Thus, the key issue appears to be sustainability of both the pool itself (given that the substitutes may be hired by the providers they substitute for) and the need for someone to continue to manage the logistics of the substitute pool at the end of the grant. Currently the project plans to try to have the CCR&R manage the substitute pool, and is providing a manual for CCR&R staff of all project forms, flyers, and procedures. Given the issues that had to be addressed to successfully develop a substitute pool, these materials seem like a useful toolkit that could be provided to other counties or entities interested in developing a substitute resource for their child care providers. However, it also should be noted that given the difficulty in recruiting, maintaining, and facilitating use of the substitute pool, that alternative strategies for supporting child care providers needs for flexible time off might be more appropriate. Teaching providers how to build in personal and vacation days as a strategy for self care might be an alternative to creating substitute pools that is more feasible, especially for family child care providers.

Purchasing Co-Op

The Purchasing-Co-op was implemented to give providers a means for accessing lower-cost materials and supplies. Overall, however, this component appeared to be the least successful of the three strategies, due primarily to lack of interest in the provider community. Despite extensive recruitment efforts, only 12 providers actually participated in the 5 information sessions. The following summary addresses the characteristics of the providers who participated in the Purchasing Co-op Informational Meetings, including demographic and professional characteristics; presents customer satisfaction data from these meetings; and reports whether the providers used the purchasing co-op since participating in the meetings.

CHARACTERISTICS OF PROVIDERS WHO PARTICIPATED IN THE PURCHASING CO-OP INFORMATIONAL MEETINGS

A total of 12 participants filled out surveys at the purchasing co-op informational meetings. Participants' ages ranged from 27 to 61, with an average age of 40. All were women. Just over half (58%, or 7 providers) were Caucasian, two were African American, one was Hispanic, one was Asian, and one was multi-racial. All but one spoke English as their primary language; the remaining provider spoke Spanish as her primary language. All 12 providers were family care providers.

Sixty-seven percent of the providers listed at least one barrier to using a purchasing co-op. Table 21 lists all barriers reported by the providers. Despite these barriers, 82% of the providers said they were somewhat or very likely to use the purchasing co-op within the next 60 days.

Table 21. Providers' Reports of Barriers to Using the Purchasing Co-op

	% (number of participants)
Won't need supplies in the next 60 days	63% (5)
Can't afford the co-op	13% (1)
Do not feel comfortable using the co-op	13% (1)
Concerned about pick up times and locations	13% (1)
This is all new to me	13% (1)
The co-op is inconvenient	0
Don't understand how the co-op works	0

Table 22. Provider Satisfaction with Purchasing Co-Op Informational Meetings

% (number of participants)	Disagree	Neutral	Agree	Strongly Agree
Information was presented clearly	0	0	42% (5)	58% (7)
Information presented was useful	0	0	25% (3)	75% (9)
Being part of a purchasing co-op would make it more economical for me to purchase supplies	0	0	50% (6)	50% (6)
Being part of a purchasing co-op would make it easier for me to continue working in the child care & education field	8% (1)	8% (1)	33% (4)	50% (6)
Having the opportunity to be part of a purchasing co-op makes me feel more like a professional	8% (1)	17% (2)	33% (4)	42% (5)

SATISFACTION WITH THE PURCHASING CO-OP INFORMATIONAL MEETINGS

All providers were somewhat or very satisfied with the purchasing co-op informational meetings. Table 22 presents providers' answers to some specific questions about the meetings.

STATUS OF PURCHASING CO-OP AT PROJECT COMPLETION

Telephone interviews conducted with 8 of the 12 providers who participated in the purchasing co-op found that only 3 had actually used the co-op since the meeting. All used the co-op to purchase toys and craft materials, and indicated that they would like to use it again, although two commented that they felt the process could be easier. Of those who had not used the purchasing co-op, two indicated that they didn't feel comfortable with the process; one indicated she didn't need to purchase supplies, and the others simply hadn't had time to purchase anything yet or just hadn't needed supplies.

Half of the 16 key stakeholders in the Tri-County area felt knowledgeable enough to provide opinions about the purchasing cooperative. Five said the cooperative had not been successful; three respondents said this was because providers have other ways to get affordable materials, and two said there was not enough interest among providers and the process was too much trouble. Three key stakeholders said they had no way to know whether or not the cooperative had been successful. Overall, the primary problem with the purchasing co-op appeared to be lack of provider interest, raising the question of whether such a service is needed. Providers may be able to buy discounted toys and other materials in enough locations already (CostCo, Walmart, on-line, etc.) that the extra effort needed to use this more formal purchasing co-op is not warranted. Currently the information and materials developed through the purchasing cooperative pilot project are being converted into a workshop that could be offered through local CCR&Rs, with the goal teaching providers cost-saving techniques.

Other Tri-County Activities

In addition to the Tri-County focus on creating health insurance, substitute, and purchasing pools, the three counties engaged in several other activities supported by the CCQI grant. These activities included the compensation study described previously, and several training activities including a Director Certificate Pilot Project, the Creating a Climate for Growth training, and the TRACS training, as well as smaller-scale, one-time training opportunities sponsored, in part or in whole, by the CCQI grant. The evaluation team collected data from the participants in the Director Certificate Pilot Project, as described in Appendix S.

"Lessons Learned" from the Tri County Project

During the final round of stakeholder interviews, we asked respondents "What advice would you give to others attempting these strategies?" Several themes emerged from these comments. First, the need for a clear strategy and strong leadership from the beginning of the project was seen as important. Respondents felt that the lack of a clear direction and a shared vision from the begin-

ning significantly hindered the project's progress. A lack of clear consensus among key stakeholders that the targeted activities were appropriate for meeting providers' needs was also a concern; the need for benefits support may not have been equally great in all three counties. Some stakeholders felt that the focus of the project should have been shifted when the compensation study found that benefits was not as significant a need as originally thought. Second, many respondents acknowledged that the projects were much more complex than they originally thought they would be, especially the health benefits and substitute pools. Implementing these supports took longer than originally planned. The collaboration between the three metro regional counties and the other counties in the Six-County collaboration was generally seen as not particularly useful, since the Tri-Counties were engaged in significantly different kinds of activities. Time spent engaged with the Six-County consortium was generally not seen as helpful. Finally, turnover in contract staff significantly impeded progress: "transition in the staff, consultants and the contract with the CCR&R has pointed out the need for more formal institutional memory with formalized work plans and deliverables." The final two contractors did have clear workplans and deliverables, and provided a good foundation that can be used as the basis for future work, either in the Tri-Counties or in other communities.

CHAPTER 6: IMPROVING CHILD CARE QUALITY THROUGH THE DEVELOPMENT AND ENHANCEMENT OF THE LOCAL EARLY CHILDHOOD PROFESSIONAL SUPPORT SYSTEM

The second goal of the statewide CCQI project was to enhance the quality of the childhood care and education system. Early discussions with key CCQI stakeholders and funders clarified that these projects were primarily focused on those portions of the early childhood system that provide support for early childhood educators and child care providers. We refer to this as the "early childhood professional support system." Below we present the research support for enhancing the early childhood professional support system as a strategy for enhancing child care quality, followed by a summary of the sites' activities related to this goal, as documented on the sites' quarterly reports. We then discuss findings from key stakeholder interviews related to this goal, including the status of system coordination around training, the sense of community between system leaders and providers, coordination and collaboration among system leaders, and overall strengths and weaknesses of the system.

Research Support for Enhancing the Early childhood professional support system as a Strategy to Enhance Child Care Quality

In the past decade, the definition of 'quality' child care has broadened from what the child care center or home provides to a more comprehensive perspective that includes system-level quality concepts such as integrated service delivery systems, professional development systems, collaborative partnerships, and inter-agency collaboration. A high-quality child care system promotes high-quality child care. Indeed, community-based initiatives that aimed to improve local child care systems (e.g., training incentives, quality improvement plans, support groups, training programs, mentoring, small business grants, partnerships with community agencies, technical assistance, child care subsidy enhancements) have had positive effects on provider-level child care quality (Bradford, 1993; Bryant, Maxwell and Burchinal, 1999; Buell, Pfister, & Gamel-McCormick, 2002; Mueller and Orimoto, 1995; Onati, et al., 2002).

Underlying systemic quality is infrastructure, or the supports necessary to maintain a coordinated system of care (e.g., adequate, sustained funding, leadership, professional development and training, and quality control mechanisms) (Kagan and Neuman, 2003). Some argue that the professionalization of the child care field has been hampered by a lack of infrastructure (Beker, 2001; Cohen, 1992; Erwin and Rainforth, 1996; Kagan and Neuman, 2003; National Association for the Education of Young Children, 1994). The following is a consensus of guidelines, recommendations, and principles thought to promote infrastructure development and child care system coordination.

- *Shared vision*. Collaborators must agree on and subscribe to an overarching vision, mission statement, or purpose that is long-term and comprehensive, above and beyond their own immediate interests. This involves adopting a broad perspective and an understanding of the system as a whole (DeBord and Boling, 2002; Ellison and Barbour, 1992).
- *Sustainability*. Partnerships and programs must be supported by adequate ongoing funding, commitment from key stake-

holders, and public awareness in order to remain viable (Bryant, Maxwell, & Burchinal, 1999; Ellison and Barbour, 1992; Kagan and Neuman, 2003).

- *Goals, monitoring, evaluation, and feedback*. Systems must develop goals and benchmarks, monitor progress, engage in evaluation (e.g., data collection), and use the information for continuous quality improvement (Ellison and Barbour, 1992; Fiene, 1995; Kagan and Neuman, 2003; Mann, 2002; National Association for the Education of Young Children, 1994).
- *Localized control*. Decision-making and control at the local level promotes autonomy in various parts of the system, and ensures individualized attention to specific populations, programs, and providers (Galinsky, Friedman, & Lombardi, 1996; Mann, 2002).
- *Leadership*. Leaders must be trained and mentored in order to maintain the shared vision while allowing autonomy among components of the system (DeBord and Boling, 2002; Galinsky, et al., 1996; Kagan and Neuman, 2003).
- *High-quality components*. Each part of the system (e.g., programs, providers) must strive for high quality in order to function well as a whole (Erwin and Rainforth, 1996; Kagan and Neuman, 2003; National Association for the Education of Young Children, 1994).

Specifically focusing on professional development and training, the following is a consensus of guidelines, recommendations, and requirements for a quality professional development system.

- *Core knowledge.* The field of child care must develop its own core knowledge base to inform training and establish a standard for all providers (Beker, 2001; Bredekamp and Willer, 1992; Morgaine, 1999: National Association for the Education of Young Children, 1993).
- *Diversity and individualization.* Professional development experiences should take into account a variety of career paths, diversity among child care providers, and value experience and background (Beker, 2001; Bredekamp and Willer, 1992; Morgaine, 1999; National Association for the Education of Young Children, 1993).
- *Providers take part in system development.* Child care providers should help develop the system in which they take part (Cassidy, Vardell, & Buell, 1995; National Association for the Education of Young Children, 1993).
- *Incentives.* Training must be linked with compensation (e.g., wages, benefits, training scholarships, materials grants, transportation reimbursements) to provide motivation for professional development (DeBord and Boling, 2002; Kagan and Neuman, 2003).
- *Accessibility.* Training and education opportunities should be available to providers (e.g., odd hours, weekends, geographic location), streamlined, organized, and transferable from one institution to another (DeBord and Boling, 2002; National Association for the Education of Young Children, 1993; National Association for the Education of Young Children, 1994).
- *Support.* Professional development systems must support the education and training of child care providers at a variety of levels: workplace, educational institutions, licensing/credentialing entities, community (Cassidy, et al., 1995; DeBord and Boling, 2002).
- *Public awareness/engagement.* The public must be made aware of the importance of professionalization in the child care field in order to legitimize and value its work (Kagan and Neuman, 2003).

Program Activities for Systems Enhancement

Part of the process of systems development involves building and strengthening existing collaborations between key stakeholders within the early childhood community. As a part of this effort, CCQI project coordinators often met with other professionals in their community to share information, seek advice or guidance, or contribute to other early childhood community developments. NPC tallied the number of different kinds of collaborative meetings that took place each quarter for each site using quarterly report data. Aggregating across all sites the number of different kinds of collaborative meetings that took place between April 2004 and March 2005 resulted in a total of 147 collaborative group meetings. On average, the number of different kinds of meetings varied by county, from a low of 1 in Tillamook County to a maximum of 5–6 in Clackamas and Jackson counties. Across the state, sites held an average of 4 different kinds of collaborative meetings per quarter.

Systems Enhancement Findings

As described in Chapter 1, the evaluation team conducted in-depth key stakeholder interviews at two points in time along with a closed-ended key stakeholder survey (administered concurrently with the first round of key stakeholder interviews) to gather information about several facets of the early childhood care and education systems in the CCQI communities. The findings below cover several areas, including system coordination around training, sense of community between system leaders and providers, coordination and collaboration among system leaders, overall system strengths and weaknesses, and the CCQI project's effectiveness at enhancing the system.

System Coordination around Training

The first round of key stakeholder interviews included open-ended questions about the training being provided at each site. Specifically, we asked:

1. What is working well in terms of training activities in your county?
2. What is working well in terms of coordination of trainings in your county?
3. What needs to be improved in terms of trainings/coordination of trainings?

In terms of what was working well in regards to trainings, respondents were most likely to describe specific trainings or training programs that were being offered locally (35 respondents, or 57%). A variety of other strengths were mentioned as well, however, including:

- Availability of trainings (14, 23%);
- Variety of levels of trainings being provided (7, 12%);
- Supports provided that encourage providers to work towards college credits or de-

grees (7, 12%; however all these respondents were from Benton County);

- The financial assistance/scholarships being offered (7, 11%);
- The integration of training with mentoring (4, 7%);
- The use of theory-based ideas and concepts in trainings (4, 7%); and
- Involvement of providers in developing trainings (3, 5%).

In regards to strengths related to coordination of training, the most frequent responses were attending inter-agency meetings, such as Early Childhood Team meetings or meetings of other similar groups (28 respondents, 41%) and working with others to do coordinated planning of trainings (24, 39%). Other responses included:

- The use of newsletters and email lists for distributing information (20, 33%);
- The central role of the CCR&R in the community (13, 21%);
- Specific, dedicated individuals working to coordinate trainings (8, 13%); and
- Integration of workshops and trainings into systems for obtaining college credits (8, 13%).

Respondents had a wide variety of suggestions for improving trainings in their communities. These included:

- Improving the availability of trainings (times, days, etc.) (29, 48%);
- Improving the types of trainings available (specific topics, different training formats such as on-line trainings, and different training structures, e.g., intensive weekend courses rather than traditional 11-week college courses) (23, 38%);
- Improving outreach to providers (e.g., better advertising of trainings) (20, 31%);
- Improving the coordination of the workshop/training system with college/certification programs (9, 15%);
- Reducing duplication of trainings (10, 15%); and
- Making release time and/or substitute pools more available to providers to allow them to attend trainings (9, 15%).

The key stakeholder survey (completed concurrently with the first round of key stakeholder interviews) also asked respondents a series of questions about provider trainings offered in their communities. The 5-point response scale ranged from *strongly disagree* to *strongly agree*. Respondents (n = 82) were asked about their perception of training availability, attendance, usefulness, and quantity. The questions addressed separately family child care (FCC) providers and center-based care (CBC) providers. Table 23 displays respondents' answers.

As illustrated in the table, while respondents felt that there were sufficient training opportunities and that providers knew about trainings, most felt that providers were not well trained. We followed-up on this finding during the second round of key stakeholder interviews to find out why key stakeholders believed that providers were not well trained despite adequate training opportunities. Stakeholders explained that while trainings may exist, accessibility issues make it hard or impossible for many providers to attend. For example, trainings may not be offered at times or locations that would make it possible for providers to attend. Stakeholders also believed that while there are some providers who *are* well trained, there are other groups of unengaged providers who do not take advantage of training opportunities. Some stakeholders also explained that there are gaps in the trainings that are offered; some subject areas may be well represented among trainings, while finding trainings in other areas may be difficult.

Table 23. Key Stakeholder Survey Provider Training Questions

Question	% Agreement (sample size)		
	Neutral to Disagree	Agree	Strongly Agree
FCC[1] providers know about training opportunities in their community	20% (16)	60% (48)	20% (16)
CBC[2] providers know about training opportunities in their community	21% (15)	52% (37)	27% (19)
FCC providers attend training opportunities	41% (32)	54% (43)	5% (4)
CBC providers attend training opportunities	31% (22)	56% (39)	13% (9)
FCC providers find trainings useful	20% (16)	55% (43)	25% (20)
CBC providers find trainings useful	27% (19)	53% (37)	20% (14)
FCC providers have a sufficient quantity of training opportunities	31% (24)	51% (40)	18% (14)
CBC providers have a sufficient quantity of training opportunities	35% (24)	46% (32)	19% (13)
FCC providers are sufficiently trained to provide quality care	67% (52)	29% (22)	4% (3)
CBC providers are sufficiently trained to provide quality care	57% (39)	37% (25)	6% (4)
Overall, programs for training providers in my community are well-coordinated	28% (23)	57% (46)	15% (13)

[1] FCC = family child care
[2] CBC = center-based care

SENSE OF COMMUNITY BETWEEN SYSTEM LEADERS AND PROVIDERS

Several items on the key stakeholder survey touched on aspects of community between system leaders and providers. These three items were the extent to which system leaders coordinate or communicate with providers when (1) deciding where to focus efforts, (2) evaluating progress toward improving the child care and education system, and (3) establishing a sense of community between the system and providers. These items were aggregated together to form an overall indicator of the sense of community between systems leaders and child care providers. Sixty-three percent of the 82 key stakeholders agreed (51%) or strongly agreed (12%) that there is a sense of community between providers and system leaders within the child care and education system.

COORDINATION AND COLLABORATION AMONG SYSTEM LEADERS

Key stakeholders responded to a series of questions on the survey regarding different

ways in which coordination occurs within the child care and education system in their county. Survey questions asked respondents about whether the system works to identify gaps and duplication of services, collectively decides where to focus efforts, evaluates progress, leverages and shares resources, and shares information. Respondents felt that their child care and education systems were successful at these collaborative activities with the exception of planning for sustained funding. Table 24 displays the percent of respondents agreeing or strongly agreeing that their county's early childhood education system partakes in each of these activities.

Table 24. Key Stakeholder Survey Collaboration and Coordination Questions

Question	% Agree (sample)
My local child care and education system works to identify gaps and duplications in services	87% (82)
My local child care and education system works to collectively decide where to focus efforts	82% (82)
System leaders regularly review and evaluate progress made toward improving the child care and education system	80% (81)
System leaders leverage resources between organizations	73% (81)
System leaders work jointly to develop new funding sources and projects	73% (81)
System leaders share resources for training providers	88% (82)
System leaders regularly share information about projects and programs	83% (81)
Overall, my community's child care and education system can be described as a network of closely linked services and supports	62% (82)
In our community, there is an agreed upon plan for sustaining funding for the child care and education system	37% (80)

We also included open-ended questions in the first stakeholder interview to collect more in-depth information about the nature of collaboration among early childhood partners in these communities.

First, we asked key stakeholders to describe the strategies being used to coordinate the early childhood education system with other systems serving young children and families. Perhaps not surprisingly, the most frequently mentioned strategy was attendance at interagency meetings (such as the Early Childhood Team meetings), mentioned by two-thirds of the respondents. Over half also described more general "information sharing" between agencies, citing a number of different mechanisms for this communication (including meetings, emails, newsletters, and cross-training). Approximately one-third of respondents described specific collaborative

projects that they saw as successful in coordinating services in their communities. Seven individuals mentioned co-location of DHS and other providers with the CCR&Rs as a successful strategy, and several respondents said that much of the system coordination occurs in the context of working on grants that call for a collaborative effort.

We next asked respondents to describe the major barriers to coordination of early childhood services in their community. Not surprisingly, the most frequent response was the lack of resources available for collaborative work, including funding for staff and staff time. More than half of the respondents mentioned this issue. Approximately 10% of respondents cited problems related to the absence of key partners "at the table," lack of communication between key agencies, or a general lack of understanding of other agencies' resources.

Finally, we asked respondents whether they believed that (1) providers and (2) parents experienced the early childhood professional support system as being coordinated. In terms of providers, out of 59 individuals who answered this question, 23 (39%) said they generally thought providers would experience it as coordinated, especially if those providers were linked into the local CCR&R; 18 (34%) said they did not think providers would experience the system as coordinated, citing a lack of knowledge among providers of the kinds of services provided by agencies and the lack of time to pursue services children might need (especially for family child care providers). The remaining respondents said that they "did not know" enough to answer this question.

In terms of parents, over half of respondents (32 of 55) indicated that they did **not** think that parents experience the system as coordinated. Primary reasons for this included parents' lack of knowledge of available services (and time to pursue them), lack of outreach to parents by CCR&Rs, and cultural barriers.

We revisited these questions on the second round of key stakeholder interviews. We were interested in the apparent contradiction in the data from the first round of interviews: while stakeholders during the first round of interviews and on the survey on the whole described their systems as coordinated, when talking specifically about providers, and especially parents, many said these constituents would not find the system coordinated. Respondents who took part in the second round of key stakeholder interviews explained that while professionals involved in the system may find it coordinated, this did not mean that providers or parents would find it coordinated. Stakeholders said that there needs to be better communication and education with parents and providers so that they know how to access services provided by the system. In addition, some stakeholders explained that one-stop shopping simply is not possible, and that this can cause confusion and frustration for parents and providers, especially given how large the system is and how many agencies and services are represented within the system. Finally, several stakeholders thought that the system does not do an adequate job of meeting the needs of family care providers, and therefore these providers may be likely to see the system as uncoordinated and unhelpful.

Overall System Strengths and Weaknesses

As part of the first round of key stakeholder interviews, respondents were asked:

1. What are the strengths of your local early childhood care and education system?
2. What could be done to improve the early childhood care and education system?

Answers to both these questions varied considerably across respondents as well as across counties. The three most frequently mentioned strengths were dedicated people and/or agencies (mentioned by over two-

thirds of respondents), long-term, ongoing relationships between agencies (mentioned by one-third of respondents), and strong local leadership (mentioned by one-fifth of respondents).

Other strengths mentioned included having a common vision across stakeholders for the early childhood care and education system, the quality of trainings being provided, the good relationships between agencies and community providers, the level of coordination among trainings, and the connection of the CCR&R with community colleges and higher education institutions.

In terms of ongoing challenges, only one particular challenge was mentioned by more than 25% of respondents: the need for more resources. Other areas that were mentioned as needing improvements included:

- Providing more types of trainings;
- Increased publicity and outreach to both providers and parents;
- More support for providers (e.g., support groups, networking, etc.);
- Better communication across agencies;
- Inclusion of missing partners in planning;
- Better coordination with the higher education system;
- Improved efforts to deal with issues such as staff turnover, cultural competency, and services to rural providers;
- More education of the public on the importance of early childhood education;
- Reduced rates of staff turnover; and
- Development of substitute pools to allow greater participation in trainings.

Summary of Early Childhood Professional Support System Findings

Key stakeholders provided information on trainings, system coordination, and overall strengths and weaknesses of their counties' early childhood professional support systems. Stakeholders believed that while there were some groups of well-trained providers, other groups of providers were not well trained. Existing trainings may not meet the needs of these providers in terms of availability, accessibility, content, and level. Similarly, stakeholders generally characterized the level of coordination between agencies within their early childhood professional support systems as good, but acknowledge that more needs to be done to educate parents and providers so that they are able to understand and access the system. The strengths of the local systems, as described by stakeholders, included strong agency connections, committed individuals, and shared vision.

During the second round of key stakeholder interviews, respondents were asked how effective they believe the CCQI project had been at influencing the quality of the early childhood care and education system. Of the 59 respondents who answered this question,

41% (24) said they thought the project was very effective, 40% (23) thought the project was somewhat effective, 5% (3) thought the project was not effective, and 15% (9) did not know whether the project had been effective at addressing this goal. Those providers who believed the project had effectively addressed this goal were asked what changes they saw in the system as a result of the project. Respondents said that the project had resulted in increased:

- Community awareness of early childhood education (20%, or 12 respondents);
- Coordination with community colleges and higher education (19%, or 11 respondents);
- Emphasis on sharing information with providers and fostering networks of providers (15%, or 9 respondents);
- Coordination of trainings (14%, or 8 respondents); and
- Resource development and resource sharing (14%, or 8 respondents).

These changes, in turn, create an environment conducive to fostering quality improvement among providers.

CHAPTER 7: INCREASING THE AVAILABILITY OF HARD-TO-FIND CHILD CARE

The final goal of the statewide CCQI project was to increase the availability of child care, specifically focusing on hard-to-find care such as infant and toddler care, care for special needs children, odd-hours care, and care for families speaking languages other than English. In this chapter we include statewide data on child care availability, PES data regarding the type of care CCQI participants offer and their willingness to offer hard-to-find care, impressions from key stakeholders regarding the effectiveness of the project at addressing this goal, and the barriers providers face to offering such care.

Statewide Changes in Child Care Availability

The evaluation team requested data from the Oregon Child Care Resource and Referral (OCCRRN) Network to determine whether there have been any changes in child care availability since the start of the CCQI projects. Data were obtained for 2002 and 2005 on the number of child care centers and family child care providers along with capacity and vacancies. Data were also gathered to determine the number of providers serving infants and toddlers, offering odd-hours care, and speaking languages other than English. Data on providers offering care for special needs children are not reported here; significant changes in the CCR&R variables related to special needs care took place between 2002 and 2005, and therefore comparable data over time was not available. A summary of the major findings are reported here:

- There was a *decrease* in capacity and vacancy at both child care centers and family child care homes in the CCQI counties and non-CCQI counties between 2002 and 2005.
- There was a small increase in the proportion of child care centers that served infants and toddlers in both the CCQI counties and non-CCQI counties between 2002 and 2005. There was a slight decrease in the proportion of family child care homes serving infants and toddlers.
- There was no increase over time in the number of child care centers of family child care homes that offered odd-hours care in both the CCQI counties and non-CCQI counties between 2002 and 2005.
- There was an increase over time in the number of providers speaking a language other than English at both child care centers and family child care homes.

For a more detailed discussion of these results, please see Appendix T.

Changes in Number of CCQI Participants Providing Hard-to-Find Care

Providers were asked on the baseline and follow-up PES to indicate whether they offered care for several types of children: infants, toddlers, children with special needs, children with challenging behavior, low income families, children of migrant workers, and children who speak a language other than English. We then looked for change over time in the number of providers offering this care. The main findings for these outcomes are as follows:

- There was no change over time in the number of providers offering hard-to-find care.

- Providers who received grants for environmental improvements were less likely to work with toddlers and special needs children than providers who did not receive grants for environmental improvements. No other CCQI strategies were related to these outcomes.
- Providers with more education were more likely to care for special needs children than providers with less education.
- Family care providers were less likely than center-based providers to care for children with special needs or challenging behavior at both baseline and follow-up.

These results are described in more detail below. For site-specific results, please see Appendix U.

Overall, there was no change between baseline and follow-up on the number of providers offering hard-to-find care, as illustrated in Table 25. Approximately half of the providers indicated serving children with special needs or challenging behavior, more than half provided care to infants, and more than three-quarters provided care to toddlers.

We next investigated whether any CCQI strategies were related to whether providers offered hard-to-find care. Most strategies bore no relationship to offering hard-to-find care, except that providers who received grants for environmental improvements were less likely to serve infants or children with special needs. The majority of providers who received grants for environmental improvements were from Baker and Tillamook counties. Providers in those counties may be less likely to serve those populations than providers in other counties (for any number of reasons, including less willingness, less training in these areas, or less demand for this type of care), and therefore, this finding is not likely to be due to receiving grants for environmental improvements per-se.

Table 25. CCQI Participants Providing Hard-to-find Care

Type of care	% at baseline (number of providers)	% at follow-up (number of providers)
Infants (n=153)	61% (93)	56% (86)
Toddlers (n=165)	85% (140)	87% (144)
Children with special needs (n=155)	54% (83)	49% (79)
Children with challenging behaviors (n=148)	51% (75)	59% (87)
Low-income families (n=152)	67% (102)	68% (106)
Children of migrant workers (n=123)	7% (9)	7% (8)
Children who speak a language other than English (n=57)	40% (23)	40% (23)

We also investigated whether any provider characteristics were related to whether providers offered hard-to-find care. Provider education level and type of provider (family care or center-based care provider) were related to offering hard-to-find care. Those providers with a college degree were more likely to work with special needs children at baseline and follow-up than other providers, providers with high school or less were least likely to work with special needs children, and providers with CDAs were more likely to begin working with special needs children over the course of their involvement with the CCQI project.

While type of provider was not related to *change over time* in offering hard-to-find care, type of provider was related to whether providers offered such care at both baseline and follow-up: family care providers were less likely than center-based providers to serve children with special needs or challenging behavior at both baseline and follow-up (28% of family care providers served special needs children at both baseline and follow-up compared to 62% of center-based providers, and 26% of family care providers served children with challenging behaviors at both baseline and follow-up compared to 51% of center-based providers.)

CCQI Provider Willingness to Offer Hard-to-Find Care

The baseline and follow-up PES also included questions about providers' *willingness* to offer certain types of care, including care for infants, toddlers, children with special needs, children with challenging behavior, and odd hours care. Below is a summary of the findings for these outcomes:

- There was no significant change over time in the proportion of providers willing to offer care to infants, toddlers, children with special needs, children with challenging behavior, or odd-hours care.
- None of the CCQI strategies were associated with helping unwilling providers become willing to offer hard-to-find care.
- No provider characteristics were associated with an increase in willingness between baseline and follow-up.

These results are described in more detail below. For site-specific results, please see Appendix V.

As illustrated in Table 26, there was no change over time in providers' willingness to offer hard-to-find care. Over three-quarters of the providers at baseline and follow-up indicated they were willing to serve infants, toddlers, and children with special needs. Over two-thirds of providers indicated at baseline and follow-up that they were willing to serve children with challenging behavior. Just under one-quarter of providers indicated at baseline and follow-up that they were willing to offer odd-hours care.

We next examined the relationship between the CCQI strategies and willingness, and found that none of the strategies were associated with helping unwilling providers become willing to offer hard-to-find care. The data suggest that providers with mentors did have an increase in willingness to serve toddlers, but this group of providers were willing to offer such care at baseline and simply were reporting more willingness at follow-up. Similarly, at baseline, providers who received scholarships were significantly more willing to serve toddlers than providers who did not receive scholarships, but at follow-up there was no significant difference between the groups (and both groups expressed high willingness at baseline and follow-up). Therefore, this did not represent an increase in the number of providers willing to offer hard-to-find care.

Table 26. Provider Willingness to Offer Hard-to-Find Care

Type of Care	% Willing at Baseline (number of providers)	% Willing at Follow-up (number of providers)
Infants (n=168)	78% (131)	71% (119)
Toddlers (n=91)	90% (82)	89% (81)
Special needs care (n=179)	77% (138)	77% (138)
Care for children with challenging behaviors (n=177)	71% (126)	70% (124)
Odd hours (n=179)	24% (43)	22% (40)

We also investigated the relationship between provider characteristics and willingness to offer hard-to-find care. While no characteristics were significantly related to an increase in willingness over time, several provider characteristics were related to overall feelings of willingness, including education level, race, and type of provider. At both baseline and follow-up, providers with high school degrees or less were more willing to offer odd-hours care than providers with higher education. Caucasian providers' level of willingness to provide care to children with special needs or challenging behavior remained stable between baseline and follow-up, while non-Caucasian providers reported a decrease in willingness between baseline and follow-up (although sample sizes were small). At baseline and follow-up, family care providers were more willing than center-based providers to care for toddlers and to offer odd-hours care.

Barriers to Providing Hard-to-Find Care

Providers were asked on the provider phone survey whether they cared for infants, toddlers, children with special needs, or children with challenging behavior. Those providers who did not offer such care were asked to describe the barriers they faced to providing that type of care. In addition, providers who served children with special needs or challenging behavior were asked to talk about the types of children they served and what support or assistance could better help them serve these children.

Slightly more than half (57%, or 91 providers) of the 161 providers who took part in the phone survey said that they did not provide care for infants and 19% (30 providers) said that they did not provide care for toddlers. Table 27 lists the reasons given by these providers for not offering such care. The most common response, both among those providers not serving infants and those not serving toddlers, was that the providers' centers and classrooms were for other age groups. Other providers explained that they were willing to provide such care, but just did not happen to have any infants or toddlers currently in their care. Almost 20% of the providers not serving infants, however, indicated that they were unwilling to do so because infants require more work than older children. Several providers also explained that they were unwilling to provide this care because required staff to child ratios for infants and toddlers would mean hiring more staff or serving fewer children; this would not be cost-effective for the providers.

Providers' comments during site visits mirrored these findings from the provider phone survey. Several providers stated that they used to care for infants, but no longer do so because they are too much work and take time away from other children. Furthermore, providers explained that due to the different ratio requirements, it is not cost-effective to care for infants. Other providers explained that they do take infants, but often only one or two at a time, and only younger siblings of other children already in their care.

Providers on the phone survey also indicated whether they offered care to children with special needs and children with challenging behavior. Just under half (44%, or 70 providers) indicated that they did provide care to children with special needs, and 62% (86 providers) indicated that they provided care to children with challenging behavior. Table 28 displays the types of children in these providers' care.

Providers who served children with special needs and challenging behavior were asked to describe whether there were any types of support or assistance that could help them better serve these children. Approximately half of the respondents felt that they did not need any additional support, but nearly one-quarter said that they would like additional training or information about specific conditions, 15% said they could benefit from additional or specialized staff, and approximately 20% said they could benefit from other types of support, such as increased funding and more parental involvement. Providers who served special needs children also were asked whether there were any types of special needs children they would not serve: 70% of these respondents listed out particular types of special needs children they were unwilling to serve. Most commonly, this included those children with severe or one-on-one physical needs and other physical impairments (providers explained their houses were not accessible). Similarly, providers who served children with challenging behavior were asked whether there were any types of challenging behavior they would be unwilling to accommodate: most common on this list were children with violent behavior.

Those providers who did not currently serve children with special needs or challenging behavior were asked to describe the reasons why they did not offer such care, as displayed in Table 29. The most common answers were either that providers' were willing to offer such care but just currently did not have any of these children, or that providers felt they needed more training before they would be qualified to offer such care.

Table 27. Provider Reasons for Not Serving Infants and Toddlers

Reason for Not Offering Care	Providers Not Serving Infants (N=91)	Providers Not Serving Toddlers (N=30)
Center/class is for another age group	39%	53%
Willing, just don't have any right now	26%	9%
Too much work and needs conflict with older kids	18%	3%
Staff ratio requirements make it not cost-effective	8%	3%
Other	11%	15%

Table 28. Types of Special Needs and Challenging Behaviors Served by CCQI Providers

Types of Children Served	Percent of Providers Serving these Children (sample size)
Children with diagnosed special needs:	
Learning or language delays	**51% (36)**
Behavioral or emotional delays	**63% (45)**
Physical or medical needs	**37% (26)**
Other	**6% (4)**
Children with Challenging Behavior:	
Aggression towards others	**45% (37)**
Other externalizing behavior	**29% (24)**
Other (withdrawn, moodiness, language delays)	**25% (21)**

Table 29. Reasons why Some CCQI Providers do not Serve Children with Special Needs and Challenging Behavior

Reason for not Offering Care:	Providers not serving Children with Special Needs (N=90)	Providers not serving Children with Challenging Behavior (N=56)
Willing, just don't have any right now	**27%**	**29%**
Willing, depending on the severity of problems	**12%**	**2%**
Need more training	**34%**	**18%**
Need specialized staff or aide	**13%**	**11%**
Too much work	**2%**	**7%**
Need adaptive equip-ment/accessible facility	**9%**	**0%**
Parents of other children will not approve	**1%**	**0%**
Other	**7%**	**7%**

Summary of Outcomes Related to Availability of Care

Increasing child care availability was the goal least directly addressed by the CCQI projects and perhaps was the area most difficult to influence. It is not surprising, therefore, that the outcomes in this area were the weakest of the three CCQI goals. There was no change over time in availability (both overall and for hard-to-find care) in the CCQI counties as compared to non-CCQI counties. Furthermore, even within the subset of providers taking part in the CCQI projects, there was no change over time in the number offering hard-to-find care and the number willing to offer such care. Particular CCQI strategies were not related to any of these outcomes, though some provider characteristics were: family care providers were more willing than center-based providers to offer odd-hour and infant and toddler care, but were less willing to offer care to children with special needs or challenging behavior. Non-Caucasian providers reported being somewhat less willing to offer care to children with special needs and challenging behavior.

During the provider phone survey, providers shared information about why they did not offer hard-to-find care. While some providers said they were willing to offer such care but just had not had the opportunity to do so, others stated that serving infants and toddlers or children with special needs or challenging behavior was simply too much work, was not cost effective, or would require additional staff. Some providers said that they would want more training before serving children with special needs. A large group of providers also stated that their child care center or home was for preschool aged children only, and therefore they simply had no opportunity to serve infants and toddlers.

During the second round of key stakeholder interviews, respondents were asked how effective they believed the project had been at increasing the availability of child care, particularly for hard-to-serve populations. Of the 59 respondents who answered this question, 17% (10) said the project had not been effective at addressing this goal, 42% (25) believed the project had been somewhat effective at addressing this goal, 9% (5) thought the project had been very effective at addressing this goal, and 32% (19) said they were unsure about whether the project had been effective at addressing this goal.

Those respondents who believed the project had been effective at addressing this goal were asked for which populations of children the project had been effective: of the 41 respondents who answered this question, 46% (19) said the project had increased the availability of care for infants and toddlers, 42% (17) said the project had increased availability for children with special needs, and 12% (5) said that the project had increased the availability of odd-hours care. Those respondents who believed that there had been an increase offered several reasons for this, including an increase in the number of providers offering hard-to-serve care, an increase in willingness among providers to offer this care, and increased retention among providers offering this care.

A sizeable portion of stakeholders were unsure whether the project had addressed this goal or thought the project had not been effective at addressing this goal, confirming the findings above regarding the lack of change in the number of providers offering hard-to-find care.

CHAPTER 8: SUMMARY AND CONCLUSIONS

In this chapter we first present a summary of the findings, both overall and for specific CCQI strategies and provider characteristics. We next discuss some lessons learned based on the experiences of the local CCQI project sites.

Summary of Findings

The data presented in this report suggest that the local CCQI projects focused most heavily on the goal of increasing the quality of child care through provider directed efforts. The strategies selected by the sites included trainings, scholarships, wage enhancements, grants for environmental improvements, and mentoring. The project sites focused less attention on the remaining two overarching CCQI goals (systems enhancement and increasing availability of hard-to-find care), as confirmed by the outcome results.

Overall, 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. CCQI providers were also more likely to have enrolled and/or advanced in Pathways or the PDR/OR. CCQI participants also reported that the project helped them make changes in specific skill areas, most commonly in things they did to promote social growth and development, observation and assessment, managing children with challenging behavior, and improving physical environments.

CCQI participation was not related to several outcomes of interest. 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' commitment to the field. The project also showed no influence on providers' willingness to offer hard-to-find care (special needs, challenging behavior, odd-hours, or infant/toddler care).

OUTCOMES FOR CCQI STRATEGIES

In addition to investigating outcomes overall for all CCQI participants, the evaluation team investigated whether different CCQI strategies were related to particular outcomes. Table 30 indicates which CCQI strategies were related to which outcomes. It is important to note, as illustrated in Table 31, that most providers took part in more than one strategy; that is, providers took part in a package of strategies, and thus, were likely to experience a package of outcomes associated with those strategies.

As illustrated in the Table 30, trainings, scholarships, and wage enhancements seem to result in a cluster of outcomes related to generalized increased professionalism among providers. For example, providers who took part in these strategies reported that the project helped them access the system (teaching them about available training and educational resources), and showed significant increases in feelings of respect as a professional. These providers also indicated making 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.

Table 30. Relationship Between CCQI Strategies and Outcomes

	CCQI Strategies				
Outcome	**Training**	**Scholarship**	**Wage Enhancement**	**Environment Grant**	**Mentoring**
Feeling respected as a professional	✓	✓	✓		
Feelings of skill at accessing system	✓				
Project helped access the system	✓	✓	✓		
PDR/OR enrollment and advancement					
Confidence with skill areas					
Change: social growth & development	✓	✓			
Change: challenging behavior	✓	✓			
Change: observation and assessment		✓			
Change: stress management			✓		✓
Change: physical space				✓	✓
Change phys/med disabilities					✓
Change: cultural diversity					✓
Change: business practices					✓

	CCQI Strategies				
Outcome	**Training**	**Scholarship**	**Wage Enhancement**	**Environment Grant**	**Mentoring**
Change: infants					
Change: developmental delays					
Sense of community					
Isolation					
Retention					
Offering hard-to-find care					
Willingness to offer hard-to-find care					

Table 31. Combinations of CCQI Strategies Received By Providers

Strategies	Number of Providers (n = 186)
Training and monetary incentives[5]	99 (53%)
Training, mentoring, and monetary incentives	50 (27%)
Monetary incentives only	19 (10%)
Mentoring and grants for environmental improvements	10 (5%)
Mentoring and monetary incentives	5 (3%)
Training only	2 (1%)
Training and mentoring	1 (1%)

[5] Monetary incentives include wage enhancements, scholarships, and grants for environmental improvements.

The existing literature suggests a strong link between training and education and improvements in child care quality. Indeed, education and training are associated with higher-quality physical and social caregiving environments. Results from the CCQI project are in line with these findings. The research literature on the effect of monetary incentives on child care quality is more preliminary, but suggests that compensation appears to be related to workplace satisfaction and job commitment, which have positive effects on the child care system (e.g. a reduction in turnover). Interestingly, we did not find that monetary incentives (scholarships, wage enhancements, or grants for environmental improvements) were related to retention, but did find that these strategies were related to the same sort of professional development outcomes as the training strategy. Most participants received a package of strategies, oftentimes trainings paired with one or more forms of monetary incentives; it appears that this package is associated with increased professionalization among providers.

"It is important to me to see each of us in this field always staying current with our education—always learning all we can to better care for the children we come in touch with every day. The [Project Name] has allowed me to receive that help that I could not have otherwise afforded."

Providers who took part in the mentoring strategy, on the other hand, reported changes in specific skill areas rather than in generalized professional development outcomes. These providers reported changes in balancing work and family life, improvements to their physical environments, changes in how they work with children with physical disabilities, changes in how they approach cultural diversity, and changes in their business practices. The research literature on the effects of mentoring is somewhat mixed, but does suggest that mentoring is associated with higher-quality physical and social caregiving environments. Our results support these findings; by making changes in specific skill areas, providers are increasing the quality of the care they offer. Furthermore, the CCQI providers involved with mentoring were also involved with other strategies as well; these providers received mentoring along with training and/or monetary incentives, and therefore, likely benefited from the changes in specific skills associated with mentoring along with the increased professionalization associated with the training and monetary incentives strategies.

Not surprisingly, providers who received grants for environmental improvements reported changes to their physical environments. 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.

PROVIDER CHARACTERISTICS RELATED TO OUTCOMES

In addition to examining whether specific CCQI strategies were related to outcomes, we examined whether certain provider characteristics were related to outcomes. Several trends emerged from this analysis.

First, it appears that providers with less experience (those with less time in the field, less education, and lower income) were more likely to report changes in some basic skill sets, including things providers 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 low education levels also were more likely than other providers to say

that the project helped them feel more respected as a professional. These changes are likely due to the fact that providers with less experience had fewer skills in these areas than other providers, and thus could benefit most from activities focused in these areas.

Second, 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 the most decrease in feelings of isolation between baseline and follow-up. Thus, project participation does appear to be associated with reducing feelings of isolation among providers, and length of time spent in the project is an important component of this reduction.

"With a project like [project name] it really can give you a small leg up, so that you can work toward improving your business…The project brings hope and respect to providers."

Third, the results indicated some differential findings based on provider race. Caucasian providers indicated an increase over time in feeling respected for the work they do and also felt more skilled at accessing the system than non-Caucasian providers. Caucasian providers traditionally may have had more connections with, and knowledge about how to navigate, the child care and education system than non-Caucasian providers. Furthermore, non-Caucasian providers reported a slight decrease in willingness to care for children with special needs or challenging behavior. Upon receiving some basic training in this area, these providers may have realized there was further knowledge and skill they wanted to obtain prior to serving these children.

Lessons Learned

INFLUENCING AVAILABILITY OF HARD–TO–FIND CARE

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, both in the CCQI counties at-large, and 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 over time.

Future state initiatives that wish to focus specifically on the availability goal may wish to adopt a different programmatic approach. Influencing availability may be harder than influencing the quality of care offered by individual child care providers. For example, many providers in our study indicated that they did not offer hard-to-find care because their place of employment was not set up to offer that type of care (e.g. preschools not serving infants and toddlers) or because offering such care would require additional work and staff and therefore not be cost-effective. Strategies to address these barriers 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. The strategies adopted by the CCQI project sites, namely, increasing providers' knowledge of these populations through trainings, mentoring, and financial incentives, were not adequate to address the barriers to serving such populations.

DIFFERENT STRATEGIES INFLUENCE DIFFERENT OUTCOMES

Counties varied in their success at influencing intended outcomes, and different strategies were associated with different impacts.

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 were only associated with changes in provider environments. However, it should be noted that environmental grants were rarely given in isolation; typically these grants were paired with other activities such as mentoring and training (see Table 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.

IMPORTANCE OF FINANCIAL INCENTIVES

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

Providers and key stakeholders stressed that offering financial incentives to providers is pivotal for project success. Incentives can serve as a recruitment tool to encourage providers to enroll in the project, and then serve as a motivational tool to keep providers engaged in the project. Indeed, during the provider telephone interviews, more than half indicated that they had joined the project because they were interested in the financial incentives, and a third said that the financial incentives were what they most liked about the project.

MENTORING INFRASTRUCTURE

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. Several key stakeholders suggested providing financial incentives to mentors as well as to mentees; providing incentives to mentors could help with recruitment and with long-term engagement.

TRAINING INFRASTRUCTURE

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.

Almost one-half of the providers who took part in the telephone survey indicated that participating in trainings and/or working toward career development goals (e.g. degree obtainment) were motivating factors in their CCQI project participation. Furthermore, almost two-thirds of the providers indicated that what they liked best about the project was the classes they took, the knowledge they gained, and/or the progress they made toward their career development goals.

However, providers and key stakeholders alike identified some weaknesses in the training infrastructure in the CCQI communities. First, there is not always an adequate variety of trainings offered; some providers noted that they sometimes could not locate trainings in topic areas necessary to advance PDR/OR levels. Second, providers' skill lev-

els range from basic to advanced, and there are not often trainings available for this wide variety of provider backgrounds. Third, accessibility 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; therefore, linkages with local colleges and universities are crucial to ensuring that providers can work toward their professional development goals.

STATE AND LOCAL OVERSIGHT

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

During the second round of key stakeholder interviews, we asked respondents about the Oregon Commission on Children and Families (OCCF) role in the CCQI project. Most respondents (81%) felt that the grant program was flexible enough to allow localities to design the program that best fit community needs. Just under half the respondents (49%) believed that OCCF provided adequate guidance about the desired goals of the CCQI project, with 40% of respondents unsure and only 4% of respondents believing that OCCF had not provided adequate guidance. Similarly, 41% of respondents felt that OCCF provided adequate technical assistance and support to the local projects, 63% of respondents were unsure, and 7% felt that OCCF had not provided adequate support and assistance. Several respondents highlighted some areas in which they would have liked more support and assistance from OCCF:

- Guidance on state-level changes and regulations, such as the switch from the PDR/OR to the OR;
- Guidance on how to spend down unused funds;
- Help determining an appropriate incentive structure; and
- Assistance with confusing reporting requirements.

These findings were mirrored by site visit findings: during site visits, project staff shared with the evaluation team how important they found local control of the projects to be. Project staff were grateful that the projects had been designed at the local level to best suit the needs of their communities.

IMPLEMENTATION AND START-UP

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

"As a result of participating in [project name] I have learned how important it is to have support from the community and people around me… During the trainings provided…I learned to evaluate issues from many different angles...I have also re-evaluated myself and my philosophies on how to help the children get ready for kindergarten."

Each CCQI site spent necessary time planning their projects, hiring staff, and creating procedures and protocols before beginning service delivery. These activities are an important, and indeed, a pivotal, part of the implementation process, and therefore adequate time and resources should be allotted. However, as several key stakeholders pointed out, it is not necessary to "reinvent the wheel." Information, policy and procedure manuals, and advice should be shared between experienced and new projects in order to facilitate an efficient start-up process for new projects. Sharing of information can be beneficial to all aspects of project development, but may be especially helpful for com-

plex issues, such as the development of policies and procedures for the award and disbursement of financial incentives. The procedures developed by these projects could be merged to develop a core set of materials and processes for use by new projects.

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.

SUBSTITUTE POOLS & PURCHASING CO-OPERATIVES

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 day care providers.

SUSTAINABILITY

Plan ahead and seek multiple sources for continuation funding.

Key stakeholders were asked to discuss sustainability plans for the projects during the second round of key stakeholder interviews. Just over half (57%) of respondents were able to describe sustainability plans. These respondents identified several sources of potential funding to continue the project: some sites had written grants to foundations (and some proposals had already been funded), some sites were relying on a state bill that would provide funding for CARES projects, some sites had requested (and some received) funding from local Commissions on Children and Families, and some sites had received funds from other agencies that were committed to continuing project activities.

Interviews with key stakeholders and project staff point to the importance of planning ahead for sustainability and allowing adequate time to secure needed continuation funding.

EVALUATION METHODOLOGY

Multiple evaluation strategies may be needed to measure the subtle and complex changes that result from these projects.

The CCQI project evaluation relied upon several sources of data, including the PES, provider telephone interviews, site visits, and key stakeholder interviews and surveys. Much of the data on quality change outcomes were gathered through the baseline and follow-up PES, the provider telephone surveys, and the site visits. We found that 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 sensitive enough to measure such outcomes. Indeed, the PES was designed as an enrollment survey, and for the purposes of this project we added questions aimed at measuring quality outcomes of interest. However, 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 probably 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.

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Child Care Institutes/Research Centers

0 – 3: National Center for Infants, Toddlers, & Families	www.zerotothree.org
Center for Career Development in Early Care & Education	www.celcee.edu
Center for the Study of Child Care Employment	www.iir.berkeley.edu/cscce
Child Care Services Association	www.childcareservices.org/TEACH
Child Welfare League of America	www.cwla.org
Families and Work Institute	www.familiesandwork.org
High/Scope Educational Research Foundation	www.highscope.org
National Association for the Education of Young Children	www.naeyc.org
National Association for Family Child Care	www.nafcc.org
National Center for Early Development & Learning	www.fpg.unc.edu/~ncedl
NICHD Early Child Care Research Network	www.nichd.nih.gov/about/od/secc/index.htm

APPENDIX A: STATEWIDE LOGIC MODEL

STATEWIDE LOGIC MODEL

Strategies	Immediate and Shorter Term Outcomes	Longer-term Outcomes: Quality of Physical/Social Environments	Longer-term Outcomes: Systems that Support Quality	Sites Employing this Strategy
Strategy 1: Provide Training (E.g., Linking to community college courses, trainings focused on special needs children, trainings focused on fostering pre-PDR/OR and PDR/OR enrollment and advancement, participation in Six-County training inventory)	Changes in provider attitudes about being a professional Increased motivation for professional development Increased skill in accessing the early childhood professional support system) Increased number of providers engaged in training Increased pre-PDR/OR and PDR/OR enrollment and advancement and early childhood certificates or degrees Increased knowledge and skills Increased sense of community among providers Reduced provider isolation Increased number of trainers/training options Increased community education/awareness	Increased environmental quality of care Increased social quality of care	Increased number of well qualified providers Increased retention to the field	Baker Benton Coos-Curry Jackson Lane Marion Metro Counties
Strategy 2: Monetary Incentives	Reduced financial stress	Increased environmental quality of care	Reduced position turnover	Baker

Strategies	Immediate and Shorter Term Outcomes	Longer-term Outcomes: Quality of Physical/Social Environments	Longer-term Outcomes: Systems that Support Quality	Sites Employing this Strategy
(E.g., stipends and scholarships for classes, wage enhancements, grants for environmental improvements, incentives for serving children with special needs)	Reduced emotional stress Increased motivation Increased number of providers engaged in trainings, pre-PDR/OR, and PDR/OR Increased provider knowledge and skills Change in provider attitudes about being a professional Increased sense of community among providers	Increased social quality of care	Increased availability of slots Increased sustained coordinated planning Increased resource (personnel, financial, and creative) development and sharing Increased continuity of care	Benton Coos-Curry Jackson Lane Marion Tillamook
Strategy 3: Mentoring/Coaching (E.g., providers paired with mentors, online discussion boards)	Changes in provider attitude about being a professional Increased sense of community among providers Reduced provider isolation Increased skills and knowledge Increased motivation for professional development Increased pre-PDR/OR and PDR/OR enrollment and advancement and early childhood certificates or degrees	Increased environmental quality of care Increased social quality of care	Increased number of well qualified providers Increased self-sustaining networks of providers Increased retention to the field Reduced position turnover Increased resource (personnel, financial, and creative) development and sharing Increased availability of slots	Baker Coos-Curry Jackson Lane Marion Metro Counties Tillamook
Strategy 4: Pooled benefits packages and purchasing cooperatives	Reduced financial stress Reduced emotional stress		Increased number of providers who have benefits	Metro Counties

Strategies	Immediate and Shorter Term Outcomes	Longer-term Outcomes: Quality of Physical/Social Environments	Longer-term Outcomes: Systems that Support Quality	Sites Employing this Strategy
(E.g., pooled benefits packages, purchasing cooperatives, substitute pool)	Increased use of day-to-day resources (e.g. more crayons) Increased skills and knowledge		Increased numbers of providers who have access to resources Increased number of providers who have substitutes	
Strategy 5: Encourage licensing/registration (E.g. project services not offered to un-registered providers)	Increased motivation for registration, licensing, and listing/exempt status Increased pre-PDR/OR and PDR/OR enrollment and advancement and early childhood certificates or degrees	Increased environmental quality of care Increased social quality of care	Increased numbers of well-qualified providers Increased retention to the field	Baker Coos-Curry Lane Marion Tillamook
Strategy 6: Employer outreach regarding sick/odd hours care (E.g. working with employers to raise awareness about sick/odd hours care, strategies for increasing slots)	Increased awareness among employers for supporting sick/odd hours care		Increased availability of slots	Baker
Strategy 7: Develop informal networks for providers (E.g. support groups)	Reduced emotional stress Increased sense of community among providers Reduced provider isolation		Increased self-sustaining networks of providers	Coos-Curry Metro Counties

Strategies	Immediate and Shorter Term Outcomes	Longer-term Outcomes: Quality of Physical/Social Environments	Longer-term Outcomes: Systems that Support Quality	Sites Employing this Strategy
	Changes in provider attitude about being a professional Increased skills and knowledge			
Strategy 8: Misc. activities supporting systems coordination (E.g. regular meetings of system players/collaborative partners, coordinated curricula & certificate programs)	Increased sense of community between "system leaders" and providers Increased information sharing among "system leaders" Increased contact among "system leaders" Increased steps toward interagency agreements to recognize diversity among providers Increased ease to achieve certificates Increased number of providers in training of working on certificates Changes in provider attitudes about being a professional		Increased sustained coordinated planning Increased resource (personnel, financial and creative) development and sharing Increased retention to the field Reduced position turnover Increased continuity of care Increased availability of training options Increased number of well qualified providers Increased number completing certificates	Baker Benton Coos-Curry Jackson Lane Marion Metro Counties Tillamook

APPENDIX B: SITE SUMMARY FOR BAKER COUNTY

SITE SUMMARY FOR BAKER COUNTY

Site Description

Baker County received a grant of $50,000 per year for three years. The Commission on Children and Families, Early Childhood Advisory Council and CCR&R were the core agencies responsible for administering and implementing the project. The Baker County Child Care Enhancement Project or QCCEP, aimed to open opportunities for existing and new providers to improve their level of education and enhance the quality of child care through scholarship opportunities and incentives. Trainings were offered in a variety of content areas and providers received technical support, consultation, and mentoring to encourage them to enter and advance on the PDR/OR/OR. The Harms Clifford Environmental Rating Scale was used as a self-assessment tool to help providers identify areas where they could improve their programs in terms of space and furnishings, basic care, language and reasoning, learning activities, and social developmental, as well as helping to identify professional/provider needs. Mentors were assigned to help support providers in developing and implementing a plan around the identified need areas. Grant funds were then made available to support these individualized plans.

Eligibility Requirements

To participate in the Baker County project, providers had to meet the following eligibility requirements:

- Be actively provider child care/education to preschool age children or school age children out of school;
- Intend to continue working in ECE settings for a minimum of 18 months, and return all equipment paid for with project funds if they left the field prior to 18 months.

Services Provided and Participation

A total of 19 providers completed the PES surveys in Baker County. Most were family childcare providers (89%), and had been in the field for over 5 years (84%). Providers in Baker County tended to be older (79% over age 35), and were all White/Caucasian. Most had a high school diploma or GED (68%); none had a Bachelor's degree.

Data provided through Baker County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	66
Newly connected with mentors	14 (undup)
Wage enhancements	8[6]
Scholarships	26
Clifford-Harms Assessments conducted	25
Environmental Improvement Stipends	39

Workshops and Classes	Number Offered
Workshops	20
For-Credit Classes	1
Trainings focused on serving children with special needs	1
Trainings focused on serving infants/ toddlers	0
Trainings focused on ESL providers	0
Support Groups	8

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that in Baker County, most providers felt that the CCQI project provided them with information that was helpful and useful, and reported making some key changes in their way of working with children and families. The areas in which the most change was reported (via the telephone interviews) were things done to promote children's social growth and development and environmental changes. More than half of the providers served also reported making changes in terms of cultural sensitivity and awareness and in their own ability to manage family and work-related stress. Providers also indicated that the project helped them feel more competent to serve infants and toddlers (82%) and to serve children with special needs (67%). Fewer reported that it helped them feel more competent to serve non-English speaking children. Providers in Baker County started the project generally reporting feeling respected in their work, and motivated for professional development, although 80% reported that the project helped them to feel even more respected as a professional.

[6] Note that because Baker County wage enhancements were predicated on PDR enrollment/advancement, many wage enhancements were not provided until the final quarter of the project. Communications with the site indicate that a total of 27 wage enhancements had been provided as of July 1, 2005.

APPENDIX C: SITE SUMMARY FOR BENTON COUNTY

SITE SUMMARY FOR BENTON COUNTY

Site Description

Benton County received a grant of $100,000 per year for 3 years. CCR&R was responsible for administering and implementing the project. The Benton County CARES project offered scholarships to providers, which reduced barriers to higher-level training and education, assisted individuals in creating individualized education plans, and offered stipends to providers who achieve a specific level of professional development on the Pathways system.

Eligibility Requirements

To qualify for the Benton County CARES project, providers had to meet the following eligibility requirements:

- Work directly with children/families for 20 or more hours per week at a Registered or certified family child care home or certified child care center;
- Work at the same setting for the past year, and pledge to remain in that setting for one additional year;
- Early less than $12.00/hour (center) or $15.00/hour (family)
- Care for at least 3 children not their own (family child care)
- Be registered on Pathways or the PDR/OR
- Enrolled with Family Connections

Scholarship recipients had to work 15 hours per week (minimum), had to have worked in the same setting for 6 months, and be on Pathways or the PDR/OR.

Services Provided and Participation

A total of 60 providers completed the PES surveys in Benton County. Most were center-based childcare providers (70%), and had been in the field for over 5 years (68%). Providers in Benton County tended to be older (54% over age 46), and were primarily White/Caucasian (90%). Many had a Bachelor's degree (40%; the highest rate in any county); only 23% had a high school diploma, GED, or less.

Data provided through Benton County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	174
Newly connected with mentors	Na
Wage enhancements	149
Scholarships	55
Clifford-Harms Assessments conducted	Na
Environmental Improvement Stipends	Na

Workshops and Classes	Number Offered
Workshops	1
For-Credit Classes	60
Trainings focused on serving children with special needs	1
Trainings focused on serving infants/ toddlers	1
Trainings focused on ESL providers	0
Support Groups	5

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that almost all participating providers felt that the project gave them information that was useful to their work, and many (72%) felt that it helped them to feel more competent in serving infants and toddlers. There was a statistically significant and marked increase in the number of providers who reported having professional goals (from 0 at baseline to 41 at follow-up). About two-thirds indicated the project helped them feel more respected in their work, and 87% reported that it helped them learn about education and training opportunities. Fewer reported that the project helped them feel more competent in serving children with special needs (44%) or non-English speaking children (25%). During the telephone survey, Benton County providers were able to describe making positive changes in their environments and behavior in a number of areas. The areas that were reported most frequently were: things done to pr0mote children's social-emotional development (69%); the ways they discipline children with challenging behavior; things done to assess and observe children's behavior (50%); their physical environments (50%); and their ability to manage work-family stress (50%).

APPENDIX D: SITE SUMMARY FOR COOS-CURRY COUNTIES

SITE SUMMARY FOR COOS-CURRY COUNTIES

Site Description

Coos and Curry Counties received a grant of $100,000 per year for three years. CCR&R was responsible for administering and implementing the project. Coos and Curry Counties implemented three different types of programming. First, *Special Caring for Special Children*, provided incentives (children's books, stipends) and support (mileage and substitute care reimbursement) for providers to attend training in caring for special needs children. There were three levels of participation, each requiring an increasing level of commitment to providing special needs care accompanied by increasing levels of incentive. Second, the program implemented Pathways to Success to encourage providers to enter, and advance on, the Professional Development Registry (PDR/OR). Third, a CARES models was adopted with the goal of encouraging providers to access training through financial incentives. The program also offered mentoring, one-on-one technical support, and online trainings.

Eligibility Requirements

To qualify for the Coos-Curry project, providers had to:

- Be currently working with young children
- Be a registered family child care provider, or work in a certified child care center
- Be registered on Pathways or the PDR/OR (for wage enhancements)
- Have worked as a child care provider for over one year (wage enhancements)
- Meet project wage restrictions (wage enhancements)

Services Provided and Participation

A total of 36 providers completed the PES surveys in Coos-Curry County. Most were family childcare providers (61%), and had been in the field for over 5 years (67%). Providers in Coos-Curry County tended to be older (64% over age 35), and were all White/Caucasian. Most had a high school diploma or GED (75%).

Data provided through Coos-Curry County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	78
Newly connected with mentors	Na
Wage enhancements	17
Scholarships	40
Clifford-Harms Assessments conducted	Na
Environmental Improvement Stipends	Na

Workshops and Classes	Number Offered
Workshops	7
For-Credit Classes	0
Trainings focused on serving children with special needs	3
Trainings focused on serving infants/toddlers	3
Trainings focused on ESL providers	0
Support Groups	6

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that providers in Coos-Curry Counties began the project feeling generally respected for what they do, feeling motivated for professional development, and having professional goals in place. Many also reported that the program helped them feel more respected as professionals (84%) and helped them to learn about educational and training opportunities. Many providers enrolled (29) and/or advanced (50) in pre-PDR/Pathways activities. Almost all providers reported the project provided information that was helpful to them in their work, and about 70% reported that the project helped them to feel more competent serving infants and toddlers and special needs children; fewer (38%) reported that they felt more competent to serve non-English speaking children. About over three-fourths of participating providers provided descriptions of concrete changes they had made in terms of their physical environments and the things they do to promote children's social-emotional development, and over half described changes in their ability to observe and assess children's behavior, use more positive guidance/discipline techniques, work with children form other cultures, and in their ability to manage work-family stress.

APPENDIX E: SITE SUMMARY FOR JACKSON COUNTY

SITE SUMMARY FOR JACKSON COUNTY

Site Description

Jackson County implemented a Scholarship and Compensation Project based on a TEACH model that provided scholarships and compensation for coursework. Stipends for completion of CDA credentials, One-Year Certificates and Associate degrees in ECE were also provided as well as stipends for enrollment in the Oregon Registry. Outreach and training were provided in targeted areas including special needs, infants and toddlers, and English as a Second Language. In addition, enhancing training capacity in the county was a priority.

Eligibility Requirements

Not provided.

Services Provided and Participation

A total of 27 providers completed the PES surveys in Jackson County. Most were center-based childcare providers (70%), and about half had been in the field for over 5 years (46%); most of the remainder had been in the field 3-5 years. Providers in Jackson County tended to be younger (76% under age 35); 77% were White/Caucasian and 23% were Hispanic (11% were Spanish-speaking). Most had a high school diploma or GED (65%); a few had other certifications or degrees (28%).

Data provided through Jackson County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	225
Newly connected with mentors	17
Wage enhancements	59
Scholarships	151
Clifford-Harms Assessments conducted	Na
Environmental Improvement Stipends	Na

Workshops and Classes	Number Offered
Workshops	3
For-Credit Classes	0
Trainings focused on serving children with special needs	2
Trainings focused on serving infants/ toddlers	2
Trainings focused on ESL providers	1
Support Groups	4

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that one of the most important changes among providers in Jackson County was the significant increase in the number of providers with clear professional goals (from 0 at baseline to 19 at the end of the project). Further, a large number of providers in Jackson County enrolled in the pre-PDR/Pathways system (33). Four providers obtained an educational certificate during the project, and one completed her degree. Almost all providers (95%) agreed that the program provided information that was useful to them in their work and helped them learn about training opportunities. 85% reported that the project helped them feel more respected, and 90% reported that they felt more competent serving infants and toddlers. Jackson County had the highest percentage of providers (compared to other counties) who reported feeling more competent to serve non-English speaking children (67%), while 39% reported feeling more competent to serve children with special needs. Over three-fourths of participating providers in Jackson County were able to describe concrete changes in what they did to promote children's social growth and development, and in how they observe and assess children. About half reported concrete changes in their physical environments, things they do to work with children of different cultural backgrounds, and children with challenging behavior

APPENDIX F: SITE SUMMARY FOR LANE COUNTY

SITE SUMMARY FOR LANE COUNTY

Site Description

Six (Clackamas, Jackson, Lane, Marion, Multnomah, and Washington) counties received a grant of $300,000 per year for three years. The Six-County Consortium spent part of the first year completing a compensation study that assessed wages, turnover rate, and training levels among providers; assessed access to benefits including insurance and vacation time; and assessed access to child care equipment and materials at a discounted rate. *Lane County* implemented a CARES program that made available wage enhancements, scholarships, and training reimbursements. It provided outreach and training in targeted areas including special needs and English as a Second Language. Lane County also offered orientations, application, and assessment meetings for providers to enroll on the Oregon Registry, and was one of the first sites for the pilot program to roll out the new Oregon Registry changes.

Eligibility Requirements

To be eligible for monetary incentives, Lane County participants had to:

- Be teaching children ages 6 weeks to 5 years at least 20 hours per week
- Work in a registered/certified child care setting
- Be enrolled in Lane Family Connections
- Make less than $12.00 per hour ($15.00 for directors)
- Care for at least 3 children
- Have worked in their current setting for at least one year
- Be on the Oregon Registry (new levels) at step 3 or higher

Providers were prioritized for services if they served children whose parents received DHS funds, had special needs, were infants/toddlers, or if they provided odd-hours care.

Services Provided and Participation

A total of 52 providers completed the PES surveys in Lane County. About half were center-based childcare providers (56%); most had been in the field for over 5 years (80%). Providers in Lane County ranged in age: 35% 25-35 years old; 14% 36-45, and 41% 46 and older. About two-thirds were White/Caucasian (69%); the remainder were mostly Hispanic (19%); 2% were African American, 4% Asian and 6% “other race/ethnicities”. 18% spoke Spanish as their primary language. Provider education also ranged widely: 26% had a Bachelor’s degree; 33% held Associate’s degrees or other certification; and 32% had a high school diploma or GED.

Data provided through Lane County’s quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	218
Newly connected with mentors	39
Wage enhancements	157
Scholarships	75
Clifford-Harms Assessments conducted	Na
Environmental Improvement Stipends	Na

Workshops and Classes	Number Offered
Workshops	13
For-Credit Classes	0
Trainings focused on serving children with special needs	0
Trainings focused on serving infants/ toddlers	0
Trainings focused on ESL providers	4
Support Groups	7

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that providers in Lane County started out feeling generally respected for what they do, and having high levels of professional motivation. About three-fourths also reported that the project helped them feel more respected, and helped them learn about education and training opportunities. Quarterly report data submitted by Lane County indicates that a large number of providers enrolled (46) and/or advanced (88) in pre-PDR/Pathways, and that 62 providers enrolled on the PDR/OR (these numbers may include some duplication). Data obtained from the Oregon PDR system do indicate that there was a marked increase in the number of providers enrolled on the PDR in Lane County during 2002-2004 (n=33, the largest number of providers in the state during this period).

Most Lane County providers indicated that the project gave them useful information, although compared to other counties relatively fewer reported that the project helped them feel more competent to serve infants/toddlers (57%), children with special needs (31%) or non-English speaking children (19%). Lane County providers were most likely to describe concrete changes they had made in terms of helping to promote children's general social-emotional development (62%); things done to observe/assess children (50%), things done to work with children from different cultures (47%); and things they do to discipline children with challenging behaviors.

APPENDIX G: SITE SUMMARY FOR MARION COUNTY

SITE SUMMARY FOR MARION COUNTY

Site Description

Six (Clackamas, Jackson, Lane, Marion, Multnomah, and Washington) counties received a grant of $300,000 per year for three years. The Six-County Consortium spent part of the first year completing a compensation study that assessed wages, turnover rate, and training levels among providers; assessed access to benefits including insurance and vacation time; and assessed access to child care equipment and materials at a discounted rate. *Marion County* implemented a CARES program that made available wage enhancements, scholarships, and training reimbursements. It provided outreach and training in targeted areas including special needs and English as a Second Language. Marion County also offered orientations, application, and assessment meetings for providers to enroll on the Oregon Registry, and was one of the first sites for the pilot program to roll out the new Oregon Registry changes.

Eligibility Requirements

To be eligible for wage enhancements, providers had to: (1) earn less than $12 per hour ($15 for directors); (2) work at least 20 hours per week in child care; (3) must agree to stay in the same position for one year following the awards.

Services Provided and Participation

A total of 21 providers completed the PES surveys in Marion County. Most were family childcare providers (65%), and had been in the field for over 5 years (85%). Providers in Marion County varied in age, with 33% over age 46 and 67% ages 25-35. Most were White/Caucasian (90%). Most providers indicated some form of education beyond high school (40% had "other" certifications; 20% had Associates' degrees, and 20% had a Bachelor's or Master's degree.

Data provided through Marion County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	109
Newly connected with mentors	10
Wage enhancements	88
Scholarships	97
Clifford-Harms Assessments conducted	Na
Environmental Improvement Stipends	Na

Workshops and Classes	Number Offered
Workshops	7
For-Credit Classes	9
Trainings focused on serving children with special needs	6
Trainings focused on serving infants/ toddlers	5
Trainings focused on ESL providers	3
Support Groups	1

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that a relatively large number of providers in Marion County reported enrolling in either pre-PDR (n=34) or the PDR/OR (n=11) during the project period. Data from the Oregon PDR system did show a slight increase in the number of providers enrolled during 2003-04 from Marion County (a total of 15), and a marked increase in the number of PDR advancements (n=11, the largest in the state). Most providers (88%) indicated that the project helped them feel more respected as professionals, and provided them with useful information and helped them learn about education and training opportunities. Over half reported that the project helped them feel more competent serving infants and toddlers (77%); children with special needs (58%); and non-English speaking children. Providers also described a number of concrete changes they made to improve quality in their work, most frequently describing changes in how they promote children's social-emotional development (88%); their physical environments (88%); how they discipline children with challenging behavior (71%); how they work with children with developmental disabilities (75%, the largest percentage of providers describing change in this area); and how they manage work/family stress.

APPENDIX H: SITE SUMMARY FOR TILLAMOOK COUNTY

SITE SUMMARY FOR TILLAMOOK COUNTY

Site Description

Tillamook County Commission on Children and Families received a grant of $50,000 per year for three years. CARE and it's Caring Options CCR&R were responsible for administering and implementing the project. The Quality Care for Kids Project used a two-pronged approach to increase the quality of childcare. First, childcare providers evaluated their workplace using the Harms Clifford Environmental Rating Scale and project staff/mentors worked with providers to identify areas for improvement. Providers were given site visits, consultation, and financial incentives. Second, the project aimed to address the need for more quality infant and toddler and odd hours care through training, mentoring, and technical assistance.

Eligibility Requirements

Tillamook County served all providers who worked in certified/registered and exempt child care settings.

Services Provided and Participation

A total of 16 providers completed the PES surveys in Tillamook County. About half were center-based childcare providers (54%), and many had been in the field for over 5 years (71%). Providers in Tillamook County varied in age, with 33% over age 46 and 47% ages 26-45; 13% were under age 25. All were White/Caucasian, and most providers had a high school diploma or GED (64%; although 14% had a Bachelor's degree).

Data provided through Tillamook County's quarterly reports indicates that providers participated in the following services during the 1-year period for which quarterly report data were available (note that this does not include the last quarter during which program services were provided):

Type of Service	Number of Providers (duplicated)
Training	0
Newly connected with mentors	7
Wage enhancements	19
Scholarships	0
Clifford-Harms Assessments conducted	64
Environmental Improvement Stipends	49

Workshops and Classes	Number Offered
Workshops	1
For-Credit Classes	0
Trainings focused on serving children with special needs	0
Trainings focused on serving infants/ toddlers	0
Trainings focused on ESL providers	0
Support Groups	5

Outcome Summary

Data for site-specific outcomes are provided in Appendices L-Q. Generally, these data suggest that providers in Tillamook County felt that the information provided was helpful to them in their work (79%); however, these providers were least likely, compared to other counties, to report that the project helped them to feel more respected as professionals (36%) or that it helped them learn about education and training opportunities (36%). Providers in Tillamook County were also less likely, compared to other counties, to report that the project helped them to feel more competent serving infants/toddlers, children with special needs, and children who do not speak English. Compared to other counties, Tillamook providers were also somewhat less likely to describe concrete changes made because of the project, with two exceptions: 100% of providers in Tillamook County described clear environmental changes that they made in response to project activities; and over two-thirds made changes in how they work with children from other cultures, the highest percentage of providers reporting change in this category. Over half of Tillamook providers also reported making changes in the kinds of activities they do to promote social-emotional development in children.

APPENDIX I: PROVIDER DEMOGRAPHICS

PROVIDER DEMOGRAPHICS

Characteristic	County						
	Baker (N=19)	Benton (N=60)	Coos-Curry (N=36)	Jackson (N=27)	Lane (N=52)	Marion (N=21)	Tillamook (N=16)
Gender							
Female	100%	98%	100%	100%	96%	100%	100%
Male	0%	2%	0%	0%	4%	0%	0%
Age							
25 and under	11%	10%	6%	33%	10%	0%	13%
26 to 35	11%	33%	31%	43%	35%	67%	7%
36 to 45	47%	2%	42%	0%	14%	0%	47%
46 and older	32%	54%	22%	24%	41%	33%	33%
Race/ethnicity							
White	100%	90%	100%	77%	69%	90%	100%
Hispanic	0%	5%	0%	23%	19%	5%	0%
African American	0%	0%	0%	0%	2%	0%	0%
Asian/Pacific Islander	0%	0%	0%	0%	4%	5%	0%
American Indian/Alaskan Native	0%	3%	0%	0%	0%	0%	0%
Other	0%	2%	0%	0%	6%	0%	0%

Characteristic	County						
	Baker (N=19)	**Benton** (N=60)	**Coos-Curry** (N=36)	**Jackson** (N=27)	**Lane** (N=52)	**Marion** (N=21)	**Tillamook** (N=16)
Primary Language							
English	95%	97%	100%	89%	77%	86%	100%
Spanish	0%	3%	0%	11%	18%	9%	0%
Other	0%	0%	0%	0%	2%	5%	0%
Not reported	5%	0%	0%	0%	4%	0%	0%
Highest Education Level							
Masters degree	0%	7%	0%	4%	2%	5%	0%
Bachelors degree	0%	40%	6%	0%	26%	15%	14%
Associates degree	21%	12%	6%	12%	21%	20%	7%
Other certification	5%	13%	6%	12%	13%	40%	14%
High school diploma/GED	68%	23%	75%	65%	32%	15%	64%
Less than high school	0%	0%	3%	0%	4%	0%	0%
Other type of education	5%	5%	6%	8%	2%	5%	0%

APPENDIX J: PROVIDER PROFESSIONAL CHARACTERISTICS

PROVIDER PROFESSIONAL CHARACTERISTICS

Characteristic	County						
	Baker (N=19)	Benton (N=60)	Coos-Curry (N=36)	Jackson (N=27)	Lane (N=52)	Marion (N=21)	Tillamook (N=14)
Type of care							
Center-based care	11%	70%	33%	70%	56%	35%	54%
Family child care	89%	30%	61%	30%	44%	65%	39%
Both	0%	0%	6%	0%	0%	0%	8%
Type of position for CBC providers							
Head teacher	0%	33%	29%	37%	39%	29%	0%
Teacher	0%	38%	21%	26%	8%	43%	13%
Director/teacher	100%	10%	14%	11%	23%	14%	50%
Director/administrator	0%	14%	14%	0%	23%	0%	38%
Aide/assistant teacher	0%	7%	21%	26%	8%	14%	0%
Type of position for FCC providers							
Assistant teacher	0%	0%	4%	0%	0%	0%	0%
Teacher	0%	0%	4%	0%	5%	0%	0%
Owner/operator	0%	89%	%	100%	30%	100%	0%
Owner/teacher	100%	11%	91%	0%	65%	0%	100%

Characteristic	County						
	Baker (N=19)	**Benton** (N=60)	**Coos-Curry** (N=36)	**Jackson** (N=27)	**Lane** (N=52)	**Marion** (N=21)	**Tillamook** (N=14)
Length of time at job							
Over 5 years	63%	51%	38%	26%	59%	82%	36%
3 to 5 years	31%	47%	28%	61%	32%	12%	55%
1 to 2 years	25%	2%	3%	13%	10%	6%	0%
Less than 1 year	6%	0%	31%	0%	0%	0%	9%
Length of time in the field							
Over 5 years	84%	68%	67%	46%	80%	85%	71%
3 to 5 years	0%	20%	22%	42%	12%	10%	21%
1 to 2 years	11%	12%	6%	12%	8%	5%	0%
Less than 1 year	5%	0%	6%	0%	0%	0%	7%

APPENDIX K: PROVIDER BASELINE INCOME AND INSURANCE STATUS

PROVIDER BASELINE INCOME AND INSURANCE STATUS

Characteristic	County						
	Baker (N=19)	**Benton** (N=60)	**Coos-Curry** (N=36)	**Jackson** (N=27)	**Lane** (N=52)	**Marion** (N=21)	**Tillamook** (N=16)
Income from child care							
$15,000 or less	79%	52%	71%	82%	62%**	62%	53%
$30,000 or less	95%	97%	97%	96%	100%	100%	93%
Child care percent of total income							
Only source of income	16%	33%	17%	17%	28%	41%	7%
More than half of income	26%	10%	14%	21%	23%	18%	14%
About half of income	26%	2%	20%	4%	15%	0%	7%
Less than half of income	32%	55%	49%	58%	34%	41%	71%
Health insurance							
Percent with health insurance	58%	83%	60%	82%*	71%	71%	87%
Source of health insurance							
Spouse or partner	82%	50%	67%	43%	34%	53%	50%
Child care employment	0%	36%	10%	29%	49%	33%	17%
Other	18%	14%	24%	29%	17%	13%	33%
For those with insurance, who pays:							

Characteristic	County						
	Baker (N=19)	**Benton** (N=60)	**Coos-Curry** (N=36)	**Jackson** (N=27)	**Lane** (N=52)	**Marion** (N=21)	**Tillamook** (N=16)
Family covers all cost	40%	17%	35%	19%	28%	20%	36%
Family and employer share cost	40%	47%	25%	23%	23%	33%	27%
Employer covers all cost	20%	13%	35%	19%	34%	27%	36%

*In Jackson County, significantly fewer providers had health insurance at follow-up than at baseline.

** In Lane County, marginally more providers had child care incomes above $15,000 at follow-up than at baseline.

APPENDIX L: OUTCOMES BY SITE: PROVIDER ATTITUDES ABOUT BEING A PROFESSIONAL, MOTIVATION FOR PROFESSIONAL DEVELOPMENT, AND SKILL IN ACCESSING THE SYSTEM

OUTCOMES BY SITE: PROVIDER ATTITUDES ABOUT BEING A PROFESSIONAL, MOTIVATION FOR PROFESSIONAL DEVELOPMENT, AND SKILL IN ACCESSING THE SYSTEM

	County													
	Baker (N=15)		Benton* (N=44)		Coos-Curry (N=31)		Jackson* (N=20)		Lane** (N=31)		Marion* (N=17)		Tillamook (N=14)	
	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up
Number of providers who:														
Feel respected for the work they do	10 (67%)	12 (80%)	Not available	Not available	22 (71%)	22 (71%)	Not available	Not available	23 (74%)	21 (68%)	Not available	Not available	10 (71%)	10 (71%)
Feel competent when talking to parents	14 (93%)	14 (93%)	Not available	Not available	24 (77%)	28 (90%)	Not available	Not available	28 (90%)	29 (94%)	Not available	Not available	12 (86%)	13 (93%)
Have motivation for professional development	15 (100%)	15 (100%)	Not available	Not available	30 (97%)	30 (97%)	Not available	Not available	28 (90%)	28 (90%)	Not available	Not available	11 (78%)	10 (71%)
Have skill in accessing the system	14 (93%)	13 (87%)	Not available	Not available	23 (74%)	23 (74%)	Not available	Not available	25 (81%)	24 (77%)	Not available	Not available	7 (50%)	6 (43%)
Percent of providers who agree the project has helped them:														
Feel more respected as a professional	80%		66%		84%		85%		73%		77%		36%	

	County													
	Baker (N=15)		Benton* (N=44)		Coos-Curry (N=31)		Jackson* (N=20)		Lane** (N=31)		Marion* (N=17)		Tillamook (N=14)	
	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up	Base-line	Follow-up
Learn about education and training opportunities	73%		87%		84%		95%		77%		71%		36%	

Note: † indicates significant change over time ($p < .05$).

* Benton, Jackson, and Marion counties administered the original PES prior to NPC's development of the modified PES. Several of these outcome measures were included on the modified PES and not on the original PES, and therefore, we are unable to report on these outcomes for these counties.

** In Lane County, some providers completed the original PES and some completed the modified PES. The data reported here is for the subset of providers (n=31) who completed the modified PES and the follow-up PES.

APPENDIX M: OUTCOMES BY SITE: CCQI PROVIDER PATHWAYS, PDR/OR, AND CERTIFICATE AND DEGREE OUTCOMES

OUTCOMES BY SITE: CCQI PROVIDER PATHWAYS, PDR/OR, AND CERTIFICATE AND DEGREE OUTCOMES

Outcome	County						
	Baker	Benton	Coos-Curry	Jackson	Lane	Marion	Tillamook
Number of CCQI providers enrolled in pre-PDR/OR activities	N/a	Not reported	10	33	46	34	1
Number of CCQI providers enrolled in Pathways	N/a	18	19	0	N/a	N/a	N/a
Number of CCQI providers who advanced in Pathways or pre-PDR/OR activities	N/a	13	50	0	88	N/a	1
Number of CCQI providers enrolled on the PDR/OR	10	Not reported	6	0	62	11	0
Number of CCQI providers who advanced on the PDR/OR	2	Not reported	0	0	0	2	0
Number of CCQI providers who obtained a certificate	0	Not reported	N/a	4	0	1	0
Number of CCQI providers who obtained a degree	3	Not reported	N/a	1	0	0	0

Note: N/a refers to outcome that is not applicable for the goals of this site.

APPENDIX N: OUTCOMES BY SITE: PDR/OR ENROLLMENT AND ADVANCEMENT

OUTCOMES BY SITE: PDR/OR ENROLLMENT AND ADVANCEMENT

Enrollments								
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Baker	0	0	0	3	2	1	0	1
Benton	0	0	0	0	3	1	1	0
Clackamas	0	1	3	0	1	0	1	1
Coos-Curry	0	0	0	2	1	0	0	3
Jackson	4	0	0	1	0	0	0	0
Lane	0	0	2	2	2	9	19	5
Marion	6	1	4	10	3	3	7	8
Multnomah	3	3	3	3	3	4	2	3
Tillamook	6	5	0	3	2	2	2	0
Washington	3	4	4	8	4	1	1	0
Advancements								
	1997	1998	1999	2000	2001	2002	2003	2004
Baker	0	0	0	0	0	0	0	2
Benton	0	0	0	0	0	0	0	0
Clackamas	0	0	0	0	1	0	0	0
Coos-Curry	0	0	0	0	0	0	0	2
Jackson	0	0	0	0	0	1	0	0
Lane	0	0	0	0	0	2	5	5
Marion	0	1	0	2	1	2	1	11
Multnomah	0	0	0	0	0	0	6	1
Tillamook	2	1	1	1	3	0	0	0
Washington	0	0	0	2	2	5	2	0

APPENDIX O: OUTCOMES BY SITE: PROVIDER KNOWLEDGE AND SKILLS

OUTCOMES BY SITE: PROVIDER KNOWLEDGE AND SKILLS

	County						
	Baker	Benton	Coos-Curry	Jackson	Lane	Marion	Tillamook
Percentage of Providers Who (PES Data):	**(N=15)**	**(N=44)**	**(N=31)**	**(N=20)**	**(N=45)**	**(N=17)**	**(N=14)**
Agree the project gave them information useful to their work	87%	93%	94%	95%	84%	88%	79%
Agree the project helped them feel more competent to serve infants and toddlers	82%	72%	71%	90%	57%	77%	33%
Agree the project helped them feel more competent to serve children with special needs	67%	44%	70%	39%	31%	58%	30%
Agree the project helped them feel more confident to serve children who speak a language other than English	33%	25%	38%	67%	19%	60%	22%
Percent of Providers Who (Telephone Survey Data):	(N=15)	(N=38)	(N=25)	(N=19)	(N=34)	(N=17)	(N=13)
Changed things they do to promote children's social growth and development	87%	69%	76%	74%	62%	88%	62%
Changed things they do to observe and assess children's behavior	53%	50%	48%	89%	50%	41%	18%

	County						
	Baker	**Benton**	**Coos-Curry**	**Jackson**	**Lane**	**Marion**	**Tillamook**
Changed things they do to discipline children with challenging behavior	47%	63%	68%	47%	41%	71%	39%
Changed things they do to promote infant development and care	20%	26%	17%	32%	18%	41%	17%
Changed things they do to work with children with physical or medical disabilities	20%	24%	20%	16%	15%	35%	31%
Changed things they do to work with children with learning delays or developmental disabilities	27%	16%	60%	16%	26%	75%	39%%
Changed things they do to work with children from different cultures and backgrounds	60%	50%	28%	47%	47%	29%	67%
Changed things to make the physical space and equipment work better for the provider and children	80%	55%	84%	58%	44%	88%	100%
Changed business practices	53%	29%	52%	16%	29%	35%	17%
Changed how they balance family and work, and stress management	60%	50%	64%	32%	47%	53%	25%

APPENDIX P: OUTCOMES BY SITE: PROVIDER SENSE OF COMMUNITY AND ISOLATION

OUTCOMES BY SITE: PROVIDER SENSE OF COMMUNITY AND ISOLATION

Number of Providers Who:	County													
	Baker (N=15)		Benton (N=44)		Coos-Curry (N=31)		Jackson (N=20)		Lane (N=31)		Marion (N=17)		Tillamook (N=14)	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Agreed they were part of a community of providers	14	14	Not available	Not available	21	21	Not available	Not available	11	11	Not available	Not available	8	10
Felt isolated as a child care provider	3	3	Not available	Not available	5	9	Not available	Not available	2	4	Not available	Not available	2	2

APPENDIX Q: OUTCOMES BY SITE: PROVIDER RETENTION

OUTCOMES BY SITE: PROVIDER RETENTION

Number of providers:	County													
	Baker (N=15)		Benton (N=44)		Coos-Curry (N=31)		Jackson (N=20)		Lane (N=45)		Marion (N=17)		Tillamook (N=14)	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Planning to stay in their current position:														
Less than one year	0	0	2	5	1	2	0	3	0	2	0	0	1	0
1 to 2 years	2	1	5	6	4	3	7	4	5	6	2	2	0	1
3 to 5 years	1	0	15	11	4	6	5	5	10	6	4	5	5	3
More than 5 years	11	13	16	16	20	18	8	8	24	25	11	10	5	7
Not reported	1	1	6	6	2	2	0	0	6	6	0	0	3	3
Planning to stay at their current place of employment:														
Less than one year	0	0	0*	7*	1	3	0	1	1	1	0	0	0	0
1 to 2 years	2	2	5	7	4	2	2	3	5	3	3	4	0	0
3 to 5 years	2	0	17	10	6	7	7	5	9	10	3	4	4	5

Number of providers:	County													
	Baker (N=15)		Benton (N=44)		Coos-Curry (N=31)		Jackson (N=20)		Lane (N=45)		Marion (N=17)		Tillamook (N=14)	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
More than 5 years	11	13	18	16	20	19	10	10	27	28	11	9	9	8
Not reported	0	0	4	4	0	0	1	1	3	3	0	0	1	1
Planning to stay in the field in any position or setting:														
Less than one year	0	0	0	1	0	1	0	0	0	0	0	0	0	0
1 to 2 years	0	0	2	5	1	0	1	2	1	0	0	1	0	0
3 to 5 years	1	0	8	3	5	8	1	2	7	3	1	2	1	1
More than 5 years	10	11	18	19	18	15	14	12	25	30	14	12	7	7
Not reported	4	4	16	16	7	7	4	4	12	12	2	2	6	6

Note: * indicates significant change over time ($p < .05$).

APPENDIX R: SIX-COUNTY COMPENSATION STUDY

SIX-COUNTY COMPENSATION STUDY

The Compensation Study was completed before NPC Research became the contracted project evaluator for the CCQI. The study was commissioned by the Six-County Collaborative (Clackamas, Jackson, Marion, Lane, Multnomah, and Washington counties) to "generate information for use by the six counties as a foundation for continued development of wage and benefits enhancement programs that support a well-trained and stable provider workforce" (MacDougal and Associates, 2003). The study involved surveys, telephone interviews, and focus groups with a random probability sample of 439 family care providers and 2,595 teachers and teaching assistants in child care centers from the six counties drawn from the Oregon Child Care Resource and Referral Network (OCCRRN) database. The study collected information about child care providers' wages, benefits, participation and access to training, retention in the field, and barriers to working in child care. The report highlights include the following findings:

1. Child care salaries in all settings are low relative to non-skilled occupations such as janitors, cafeteria workers, recreational workers, tree trimmers, restaurant workers, bartenders, and fast food servers.
2. The vast majority of family child care providers do not receive paid vacation time.
3. Between 20-62% of family child care providers do not have substitute coverage, with rates of coverage highest in Clackamas, Washington, and Lane counties.
4. On average, about half of all family child care providers have to close in order to take time off for vacation, illness, or training.
5. Across the six counties, 72% of registered family care providers and 75% of certified family care providers indicated that they had health insurance coverage, with rates of coverage highest in Clackamas, Washington, and Lane counties.
6. Across counties, 88% of centers offer health insurance benefits to full time teachers; 62% offer benefits to full time teacher aides. 54% of centers offer benefits to part-time teachers, and only 42% offer health benefits to part-time teacher aides.
7. Fewer than half of all family child care providers have retirement savings. Centers are much more likely to offer retirement plans, although this varies by county (over 80% of centers in Clackamas, Jackson, Washington, and Multnomah offer retirement, whereas retirement is only offered by 14% of centers in Marion County and 36% in Lane County).
8. The majority of family child care providers have a high school diploma, GED, or less education. Only 21%-31% have an Associates or Bachelor's degree. Education for center-based teachers is higher, with 41% having a high school diploma/GED, and 50% having an A.A. or B.A/B.S. 27% of center-based teachers had a CDA, while only 9-19% of family-based providers had a CDA.
9. A relatively high number of family child care providers (slightly less than half) indicated that they were enrolled in the PDR/OR. However, enrollment reported by center-based staff was much lower (about 3%). Focus groups with center-based teaching staff indicated quite negative attitudes about the PDR/OR, citing difficulty in compil-

ing needed paperwork, lack of professional value, and lack of knowledge about the benefits of the PDR/OR.

10. Over 80% of family child care providers indicated that they plan to stay in the field more than 5 years. About half of center-based teaching staff have worked at their current center for more than 2 years; about 25% on average have worked at the same place for more than 5 years.
11. The barriers to remaining in the field that were most frequently identified by family care providers were pay, long hours, and level of benefits.

APPENDIX S: TRI-COUNTY DIRECTOR CERTIFICATION SUMMARY

TRI-COUNTY DIRECTOR CERTIFICATION SUMMARY

Characteristics of participating providers

A total of 20 individuals participating in the Director Certificate Pilot Project filled out a Participant Enrollment Survey on the first day of class, and 19 continued with the project and filled out a follow-up survey on the last day of class.

DEMOGRAPHIC CHARACTERISTICS

All of the participants were female; 74% were white, and the rest of the participants were either black (*n* = 4) or Hispanic/Latino (*n* = 1). Ages ranged from 23 to 54 years, with an average age of 41. English was the primary language for 95% of the participants, and one person spoke primarily Spanish. Five of the participants spoke languages other than their primary language (American Sign Language, Spanish, English, French, and German). All of the participants in the program had their high school diploma or GED; five participants had a CDA, one had a Montessori credential, four had Associate's degrees, four had Bachelor's degrees, and one participant had a Master's degree.

WORKPLACE CHARACTERISTICS

All of the participants worked in center-based certified child care programs in Multnomah County. Seventy percent of the participants reported that they worked for a child care center; of the remaining participants, four worked in school-age care, two worked at a Head Start or pre-K center, two worked in a preschool-only setting, one worked at a drop-in center, one worked with children in pre-K to eighth grade, and one participant worked with toddlers, pre-K, and kindergarten children. Participants had an average of 73 children in care at their centers (ranged from 16 to 127 children). An average of 13 staff worked at these centers (ranged from 2 to 30 staff), and they had an average of 5 classrooms (ranged from 1 to 11 classrooms).

Fifty-five percent of the participants were child care center directors (administrators or coordinators), and the remaining participants were directors and teachers (*n* = 5), teachers or head teachers (*n* = 3), assistant directors (*n* = 2), and education coordinators (*n* = 1).

Participants worked an average of 43 hours per week (ranged from 20 to 55 hours), for an average of 47 weeks per year (ranged from 4 to 52 weeks). Half of the participants made $30K per year or less. For 25% of the participants, their childhood care and education employment was the only source of household income.

Almost all of the participants reported having health insurance (95%). Of the participants with health insurance (*n* = 19), 61% had coverage offered through their childhood care and education employment. The remaining participants had coverage offered through their spouse/partner's employment (*n* = 6), or had private insurance (*n* = 1). Just over 44% of the participants had their health insurance paid for by their childhood care and education employer, and 44% made contributions along with their employer. Two participants paid for health insurance on their own.

PROFESSIONAL CHARACTERISTICS

Since age 18, participants worked as paid child care and education providers for 13 years on average (ranged from 2 to 33 years), and as directors for 4 years on average (ranged from 0 to 25 years). About 63% of the participants planned to stay in their current place

of employment, 50% planned to stay in their current position, and 93% planned to stay in the field of childhood care and education for at least 5 more years. None of the participants planned to leave their current place of employment, their position, or the field in the next year.

Ninety-five percent of the participants reported that they received some type of training in the six months before they enrolled in the pilot project. While participating in the pilot project, 74% of the participants received some type of additional training. Table S1 presents the percentage of participants who received each type of training, and the average number of hours of training they received.

Both before and during the pilot project, the most popular training topics were the development of curriculum and activities and social growth and development. Before the pilot project, other popular training topics included working with parents and families, and identifying child abuse and neglect. At both points in time, relatively few participants received training in children's special needs (e.g., developmental disabilities) or in infant care.

Table S1. Amount and Type of Training Received by Providers in the Past 6 Months

	Baseline		Follow-Up	
Training Topic	**% of participants (*n*)**	**Average # hours per participant**	**% of participants (*n*)**	**Average # hours per participant**
Development of curriculum & activities	50 (10)	5.0	32 (6)	5.5
Social growth & development	35 (7)	4.0	21 (4)	3.0
Working with families & parents	35 (7)	6.0	5 (1)	---
Identifying child abuse & neglect	35 (7)	3.0	11 (2)	8.0
Guidance of children with challenging behavior	30 (6)	3.5	11 (2)	1.5
Childhood health & safety	25 (5)	3.5	16 (3)	3.0
Management & business practices	25 (5)	7.0	11 (2)	5.5
Observation & assessment	20 (4)	2.5	11 (2)	1.5
Guidance of children's behavior	20 (4)	5.5	16 (3)	2.0
Children with emotional disabilities	20 (4)	3.5	5 (1)	---
Working with diverse cultures & backgrounds	20 (4)	4.0	16 (3)	6.0
Professional development	20 (4)	4.5	11 (2)	16.5

	Baseline		Follow-Up	
Training Topic	% of participants (*n*)	Average # hours per participant	% of participants (*n*)	Average # hours per participant
Self-care/self-management/balance	20 (4)	6.0	11 (2)	6.5
Utilization of community resources	15 (3)	2.0	11 (2)	9.0
Nutrition & meal planning	10 (2)	1.5	0	---
Creation of physical environments	10 (2)	2.5	5 (1)	---
Birth order in families	10 (2)	2.0	0	---
School readiness & success	5 (1)	---	16 (3)	15.0
Children with learning delays/developmental disabilities	5 (1)	---	11 (2)	5.0
Communication	5 (1)	---	5 (1)	---
Medically fragile children	5 (1)	---	0	---
Distinguishing ADHD from pediatric bipolar disorder	5 (1)	---	0	---
Infant development & care	0	---	5 (1)	---
Children with physical disabilities	0	---	0	---
Total Training Hours	**---**	**374**	**---**	**250**

Notes. A '---' indicates the inability to calculate an average because one or no participants received training in that area. It is important to note that training hours that took place in the six months between baseline and follow-up are over and above the Director Certification training hours that each participant acquired.

Provider satisfaction with activities

Participants responded to eleven statements that tapped into the extent to which they were satisfied with the Director Certificate Pilot Project. Table S2 presents the percentage of participants who agreed or disagreed with each satisfaction statement. All of the participants agreed that the pilot project helped them to meet others working in the child care field, they learned useful information that applies to their work, the program activities were useful, and that they would recommend the program to other child care directors. The stated goals of the CCQI Project included improving services to infants and toddlers, special needs children, and to children who speak languages other than English. About 71% of participants agreed that the pilot project helped them to feel more competent serv-

ing infants and toddlers, and about half agreed that they felt more competent serving children with special needs and non-English speaking children.

Table S2. Provider Satisfaction with the Director Certificate Pilot Project

% (number of participants)	Disagree	Neutral	Agree	Strongly Agree
The program helped me meet others working in the child care field.	0% (0)	0% (0)	0% (0)	100% (19)
I would recommend this program to other child care directors.	0% (0)	0% (0)	5% (1)	95% (18)
Through the program I learned useful information that I will apply to my work.	0% (0)	0% (0)	11% (2)	89% (17)
The program activities were helpful to me.	0% (0)	0% (0)	16% (3)	84% (16)
The program has helped me feel more respected by others as a professional.	0% (0)	11% (2)	11% (2)	79% (15)
The program helped me learn about education and training opportunities in early childhood care and education.	0% (0)	11% (2)	47% (9)	42% (8)
The program will help me reach my career goals.	0% (0)	16% (3)	32% (6)	53% (10)
The program has helped me feel more competent to serve infants and toddlers.	0% (0)	29% (4)	21% (3)	50% (7)
The program has helped me feel more competent to serve children who speak a language other than English.	8% (1)	38% (5)	46% (6)	8% (1)
The program has helped me feel more competent to serve children with special needs.	25% (4)	25% (4)	25% (4)	25% (4)

Provider change

PROFESSIONAL DEVELOPMENT REGISTRY

Three participants were registered on the Oregon Registry or *OR* (formerly the Professional Development Registry or *PDR/OR*) at the start of the pilot project, and 4 participants were registered at the end of the project.

WILLINGNESS TO CARE FOR SPECIAL POPULATIONS

Participants indicated the extent to which they were willing to care for eight different subgroups of children on a scale from 1 to 6 (1 = *not at all willing*, 6 = *very willing*). Table S3 presents the percentage of providers willing (4, 5, or 6 on response scale) to serve each subgroup at the beginning and end of the pilot project, as well as the percent change in willingness. It should be noted that none of the changes reported were statistically significant.

At the start and end of the pilot project, most or all of the participants were willing to serve children with challenging behavior, verified special needs, and toddlers. Approximately 3 out of 5 participants were willing to serve infants. Participants were generally not willing to serve children during odd hours.

Table S3. Participants' Willingness to Provide Care for Different Subgroups of Children

Willingness to care for:	Start (*n*=19)	End (*n*=18)	% Change
Children with challenging behavior	100% (19)	94% (17)	-6%
Children with verified special needs	100% (19)	94% (17)	-6%
Infants	63% (12)	56% (10)	-7%
Toddlers	84% (16)	83% (15)	-1%
Children who require evening care (after 6 pm)	17% (3)	11% (2)	-6%
Children who require overnight care	6% (1)	0% (0)	-6%
Children who require early morning care (before 6 am)	16% (3)	0% (0)	-16%
Children who require weekend care	17% (3)	11% (2)	-6%

CONFIDENCE ACROSS SKILL AREAS

Participants were asked to report on the extent to which they felt confident across a variety of skill areas. The response scale ranged from 1 *not very confident* to 6 *very confident.* Table S4 presents the percentage of providers who reported that they were confident (4, 5, or 6 on the response scale) in their abilities in each skill area.

As shown in Table S4, at the start of the pilot project, participants felt most confident in their staff supervision skills, followed by their ability to partner with parents and families, and in their internal communications skills. Collaborating with the community, financial planning, accounting principles, and legal issues in child care were the skill areas in which participants felt the least confident.

All of the skill areas showed improvements, and change in eight of the skill areas was statistically significant. Not surprisingly, the skill areas in which participants felt most

confident at the start of the project changed the least, and skill areas in which fewer participants felt competent changed the most. Skill areas that showed the largest increases in confidence included community collaborations, resource development, marketing, legal issues, and staffing costs.

Table S4. Participants' confidence across a variety of skill areas

Skill Area	% Confident (*n*)	% Confident (*n*)	% Change
Staff supervision	100 (20)	100 (19)	0%
Partnerships with families	95 (19)	100 (19)	5%
Internal communications	95 (19)	95 (18)	0%
Planning & evaluation	90 (18)	95 (18)	5%
Developing environments	95 (18)	100 (19)	5%
Education program philosophies & frameworks	85 (17)	95 (19)	10%
Professional development of staff	85 (17)	100 (19)	15%
Developing childhood care & education programs	80 (16)	90 (17)	10%
Organizational skills in child care management	80 (16)	100 (19)	20%*
Best practices	79 (15)	95 (18)	16%
Staff recruitment & selection	65 (13)	100 (19)	35%*
Facility maintenance	65 (13)	100 (18)	35%*
Marketing	55 (11)	90 (17)	45%*
Resource development	53 (10)	100 (19)	47%*
Staffing costs	50 (10)	90 (17)	40%*
Community collaborations	35 (7)	90 (17)	55%*
Financial planning	35 (7)	63 (12)	28%
Accounting principles	35 (7)	58 (11)	23%
Legal issues	26 (5)	68 (13)	42%*

Note: * indicates a statistically significant finding ($p < .05$)

ATTITUDES TOWARD CHILDHOOD CARE AND EDUCATION FIELD

Participants were asked to report on a variety of attitudes that they held about the childhood care and education field. They responded on a scale from 1 *strongly disagree* to 5 *strongly agree*. Table S5 presents the percentage of providers who 4 *agreed* or 5 *strongly agreed* with various attitude statements at the start and end of the pilot project, the per-

cent change in agreement, and whether the change was statistically significant. Attitudes toward the field are divided into three main areas: training and education, sense of community, and job satisfaction. In general, participants' sense of community improved significantly over the course of the pilot project (e.g., networking, support). There were no statistically significant changes in attitudes toward training and education: most participants valued training and education, but felt that there were not enough training and education opportunities. Similarly, job satisfaction did not change significantly over the course of the pilot project, with the majority of participants reporting that they were satisfied with their jobs.

Table S5. Participants' Attitudes Toward the Childhood Care and Education Field

	Attitude Statement	Start % Agree (*n*)	End % Agree (*n*)	% Change
Training & Education	I would like to improve my child care training and education.	100 (18)	100 (19)	0%
	It is important to me to improve my child care training and education.	100 (18)	100 (19)	0%
	In my county, there are many training and education opportunities for directors.	22 (4)	17 (3)	-5%
	I know how to find out about training and education opportunities in my county.	56 (10)	72 (13)	16%
	I have an opportunity to give input on what trainings are offered in my community.	28 (5)	17 (3)	-11%
	I have opportunities for professional development.	61 (11)	74 (14)	13%
Sense of Community	I have opportunities to network with other directors in my area.	22 (4)	79 (15)	57%*
	I am part of a formal or informal support network of directors.	11 (2)	78 (14)	67%*
	I get support from other directors.	22 (4)	74 (14)	52%*
	I often feel isolated as a director.	19 (3)	27 (4)	8%
	I feel I am part of a community of directors.	18 (3)	79 (15)	61%*
	Community leaders are effective in supporting child care professionals.	12 (2)	26 (5)	14%
Job Satisfaction	I feel respected for work I do.	83 (15)	79 (15)	-4%
	I feel confident when talking to parents.	94 (17)	95 (18)	1%
	If I had to decide over again, I would work as a provider or director again.	83 (15)	95 (18)	12%
	I would recommend child care as a job to a friend.	78 (14)	63 (12)	-15%
	I get satisfaction through my work as a director.	82 (14)	82 (14)	0%

Note: * indicates statistically significant change ($p < .05$).

Several directors provided comments on their surveys that compliment the data presented above:

“I have developed a confidence, as well as a new perspective for myself as a director. I feel that I have an overall better foundation and understanding for my role in this community.”

“It [the Director Credentialing Program] has given my ‘tool box’ more tools to work with. I am now more confident when something is broken—I can now fix it!”

APPENDIX T: STATEWIDE CHILD CARE AVAILABILITY DATA

STATEWIDE CHILD CARE AVAILABILITY DATA

Table T1 presents the number of child care centers along with their capacity and vacancies for the CCQI and non-CCQI counties in 2002 and 2005. Table T2 presents the number of family child care providers along with their capacity and vacancies for the CCQI and non-CCQI counties. As illustrated in the tables, for both CCQI and non-CCQI counties, there was a *decrease* in the number of centers and family child care providers between 2002 and 2005.

Table T1. Child Care Center Availability

	CCQI Counties			Non-CCQI Counties		
	Number of Centers	Capacity	Vacancy	Number of Centers	Capacity	Vacancy
2002	863	46,358	5,557	377	15,495	2,828
2005	517	29,568	4,745	190	8,207	1,016
Change	-346	-16,790	-812	-187	-7,288	-1,812
% Change	-40%	-36%	-15%	-50%	-47%	-64%

Table T2. Family Child Care Availability

	CCQI Counties			Non-CCQI Counties		
	Number of FCC	Capacity	Vacancy	Number of FCC	Capacity	Vacancy
2002	3,485	23,121	6,941	2,074	12,380	3,066
2005	3,360	22,120	7,187	1,977	11,291	3,202
Change	-125	-1,001	246	-97	-1,089	136
% Change	-4%	-4%	4%	-5%	-9%	4%

The CCQI goal of increasing child care availability was to be especially focused upon increasing availability for hard-to-serve populations, including infants and toddlers, special needs children, odd-hours care, and in some counties, care for families speaking a language other than English. As discussed above, CCR&R data on providers serving special needs children is not reported here. Table T3 reports the number of providers with infant/toddler slots. As illustrated in this table, for both CCQI and non-CCQI counties, there was a *decrease* in the number of providers (center and family child care providers) serving infants and toddlers. However, when controlling for the overall decrease in the number of providers (illustrated above in tables T1 and T2), there actually was a small increase in the proportion of centers in both the CCQI and non-CCQI counties serving

infants and toddlers (a 5% increase in the proportion of centers in CCQI counties and a 12% increase in the proportion of centers in non-CCQI counties). There was no increase in the proportion of family child care providers serving infants and toddlers, however; in fact, there was a 6% decrease for CCQI counties and a 7% decrease for non-CCQI counties.

Table T3. Providers With Infant/Toddler Slots

	CCQI Counties				Non-CCQI Counties			
	Centers		FCC		Centers		FCC	
	N	%	N	%	N	%	N	%
2002	396	50%	3,231	91%	166	44%	1,924	93%
2005	265	55%	2,810	85%	106	56%	1,694	86%
Change	-131	5%	-421	-6%	-60	12%	-230	-7%

As illustrated in Table T4, few providers offer odd-hours care, and there has been no increase over time in the availability of odd-hours care.

Table T4. Providers Offering Odd Hours Care

	CCQI Counties				Non-CCQI Counties			
	Centers		FCC		Centers		FCC	
	N	%	N	%	N	%	N	%
2002	24	3%	1,008	32%	10	3%	742	36%
2005	15	3%	1,110	32%	14	7%	720	36%
Change	-9	0%	102	0%	4	4%	-22	0%

Table T5 presents data on the number of providers speaking a language other than English. As illustrated in the table, few providers speak another language, though there has been an increase over time in both the CCQI and non-CCQI counties in the number of Spanish and Russian speaking providers.

Table T5. Change in Number of Providers Speaking Languages other than English

	CCQI Counties			Non-CCQI Counties		
	2002	2005	Change (%)	2002	2005	Change (%)
Spanish	738	782	44 (6%)	279	338	59 (21%)
Russian	54	137	83 (154%)	3	9	6 (200%)
Sign	189	134	-55 (-29%)	100	110	10 (10%)
Other	181	167	-14 (8%)	42	37	-5 (-12%)

These CCR&R data suggest that the CCQI projects have not had an impact on child care availability. This finding is perhaps not surprising, given that the project sites for the most part served a subset (and in some cases a small subset) of the overall number of providers in their counties. Furthermore, the CCQI sites seemed to focus their activities and strategies around the other two goals (increased quality and increased systems collaboration) rather than on this goal of increased availability.

APPENDIX U: OUTCOMES BY SITE: CCQI PROVIDERS OFFERING HARD-TO-FIND CARE

OUTCOMES BY SITE: CCQI PROVIDERS OFFERING HARD-TO-FIND CARE

Number of Providers Who Serve:	County													
	Baker (N=14)		Benton* (N=35)		Coos-Curry (N=28)		Jackson* (N=16)		Lane (N=36)		Marion* (N=14)		Tillamook (N=11)	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Infants	7	8	24	20	17	15	9	8	22	23	10	8	4	4
Toddlers	12	11	35	35	26	26	15	15	34*	38*	11	11	7	8
Children with special needs	6	4	20	16	15	15	10	8	24	23	5	9	3	4
Children with challenging behavior	9	6	16	17	12	15	7	7	21	26	6	9	4	7
Low-income families	10	10	21	21	19	22	11	10	31	31	5	5	5	5
Children of migrant workers	1	0	2	1	0	2	2	2	4	3	0	0	0	0
Children who speak a language other than English	0	0	Not available	Not available	8	8	Not available	Not available	9	10	Not available	Not available	5	4

Note: * indicates significant change between baseline and follow-up ($p < .05$).

* Benton, Jackson, and Marion counties administered the original PES prior to NPC's development of the modified PES. The question about care for children who speak a language other than English was included on the modified PES and not on the original PES, and therefore, we are unable to report on this outcome for these counties.

APPENDIX V: CCQI PROVIDERS WILLING TO OFFER HARD-TO-FIND CARE

CCQI Providers Willing to Offer Hard-to-Find Care

Number of Providers Willing to Serve:	County													
	Baker (N=15)		Benton* (N=43)		Coos-Curry (N=31)		Jackson* (N=18)		Lane (N=40)		Marion* (N=17)		Tillamook (N=12)	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
Infants	12	10	27	25	26	23	13	14	33	30	13	10	7	7
Toddlers	13	13	Not available	Not available	28	28	Not available	Not available	30	28	Not available	Not available	8	10
Children with special needs	13	11	29	26	24	25	16	16	37	38	14	15	5	7
Children with challenging behavior	12	11	26	27	21	19	16	16	10	11	12	12	6	7
Odd-hours care	7	6	4	3	10	10	9	10	7	4	4	5	2	2

* Benton, Jackson, and Marion counties administered the original PES prior to NPC's development of the modified PES. The question about care for toddlers was included on the modified PES and not on the original PES, and therefore, we are unable to report on this outcome for these counties.

APPENDIX W: PARTICIPANT ENROLLMENT SURVEY

PARTICIPANT ENROLLMENT SURVEY

Informed Consent Statement

The following survey asks you questions about your experience as a child care provider. You are being asked to take part in this survey as part of a statewide evaluation of child care quality improvement projects conducted by NPC Research. Participation in this survey is voluntary and does not affect your ability to receive any services.

Your privacy is very important to us. We won't tell anyone whether or not you participate in the survey. What you tell us in the survey will be kept private. This means that we will not share your answers with anyone else. Your name and other personal information, which we need in order to keep track of who we survey, will be kept in a locked file cabinet or in a locked file on the computer so that no one other than the research staff will be able to see it. When we write or talk about what we learned in this study, we will leave things out so no one will be able to tell whom we are talking about.

As a thank you for your participation in this evaluation, we will send you a gift certificate to a local vendor. Please update your contact information below; we will send the gift certificate when we receive your completed survey. This cover sheet with your contact information will be removed from your survey so that your name does not appear anywhere on your survey. If you have any questions about this study, please contact Carrie Furrer at NPC Research at 503-243-2436 x110 or at furrer@npcresearch.com.

By signing below you indicate that you have read this informed consent statement and agree to take part in the survey.

_____ _____ _____

Your Signature Today's Date Staff Member Witness Signature

Print Your Name:

_____

Your Address:

_____

Your Phone Number: _____ Your Email Address: _____

To keep your answers confidential, we need you to create a personal identification number. This number will be used to match your responses on this survey with the survey you may have filled out at the start of your involvement with [ ]. This personal identification number combines letters from your mother's first name and your month and day of birth. Please write your personal identification number by answering the questions in the box below:

What are the first three letters of your mother's first name? (EXAMPLE: B E R for Bertha)	**What month and day (date) were you born?** (EXAMPLE: January 13)
_____ _____ _____	_____ _____

PARTICIPANT ENROLLMENT SURVEY

Today's Date: _____

The following questions ask about your work and background as a provider of childhood care and education services.

As you answer the questions, remember that the information you provide will help us to better serve you and other participants.

- Most questions ask you to **CHECK** √ or **CIRCLE** ◯ an answer.
- Some questions ask you to **WRITE** a word or two.
- If you are not quite sure of an answer, please give your best **ESTIMATE**.
- If you have no idea at all how to answer a question, just mark **DON'T KNOW**.

REMEMBER, YOUR ANSWERS ARE CONFIDENTIAL – YOUR NAME WILL NEVER BE USED.

Please write your personal identification number by answering the questions in the box below:

What are the first three letters of your mother's first name? (EXAMPLE: B E R for Bertha)	**What month and day (date) were you born?** (EXAMPLE: January 13)
_____ _____ _____	_____ _____

1. **As a childhood care and education provider, do YOU currently work with one or more children in the following categories? CIRCLE your answers.**

Infants – 12 months or younger	YES	NO	DON'T KNOW
Toddlers - ages 13 to 36 months	YES	NO	DON'T KNOW
Children – ages 3 to 5 years	YES	NO	DON'T KNOW
Children – ages 6 to 8 years	YES	NO	DON'T KNOW
Children - age 9 years or older	YES	NO	DON'T KNOW
Low-income children whose service costs are partially paid by the state	YES	NO	DON'T KNOW
Children whose families are migrant workers	YES	NO	DON'T KNOW
Children with *verified* special needs, including physical, developmental, mental, behavioral, and/or medical disabilities	YES	NO	DON'T KNOW
Children with extremely challenging behaviors but who are not verified as special needs If YES, briefly describe these challenging behaviors: _____	YES	NO	DON'T KNOW
Children who speak a language other than English	YES	NO	DON'T KNOW

2. **Do you currently work in a family child care home – that is, care offered in a private home?**

___ **NO:** Go to question 3 on next page.

___ **YES:** Please answer the questions below about your work in this family child care setting.

NOTE: If you work in more than one family care setting, report on where you work the MOST time.

2.a. When did you begin providing care in THIS family care home? _____(Month/Year)

2.b. Is this child care:

__Certified (Group Home) __Registered Family Child Care __Exempt __Don't know

2.c. How many HOURS per week do you work in this family child care home? _____

2.d. How many WEEKS per year do you work in this family child care home? _____

2.e. How many TOTAL children are currently enrolled in this family child care home? _____

2.f. On a typical day, how many children on average do YOU personally supervise? _____

2.g. What is the maximum number of children you serve in your home at any one time (not your legal capacity, but the actual number of child care slots you offer)? _____

2.h. What title BEST describes your position?

__ Owner/Operator; Owner/Teacher

__ Teacher

__ Assistant; Assistant Teacher

__ Other; please describe: _____

2.i. What are the zip code and county location of this family care home?

ZIP CODE: _____ COUNTY: _____

3. Do you currently work in a center-based childhood care and education program?

__ **NO**: Go to question 4 on next page.

__ **YES**: Please answer the questions below about your work in this program.

NOTE: If you work in more than one program, report on where you work the MOST time.

3.a. When did you begin working in THIS program? _____ (Month/Year)

3.b. What BEST describes this program?

__Child care center

__Head Start/Pre-Kindergarten

__Preschool-only program

__Before and/or after school/school-age care

__Other; please describe _____

3.c. Is this program: __ Certified __Exempt __ Other __Don't know

3.d. About how many HOURS per week do you typically work in this center? _____

3.e. About how many WEEKS per year do you typically work in this center? _____

3.f. About how many TOTAL children are currently enrolled in this center? _____

3.g. On a typical day, about how many children on average do YOU personally directly supervise? ____

3.h. How many children are in your class at one time on a typical day? _____

(*Skip if you work in more than one class*.)

3.i. How many workers are in your class at one time on a typical day? _____

(*Skip if you work in more than one class*.)

3.j. What title BEST describes your current position?

___Director/Administrator

___Director/Teacher

___Head Teacher

___Teacher

___Aide or Assistant Teacher

___Other; please describe: _____

3.k. What are the zip code and county location of this care setting?

ZIP CODE: _____ COUNTY: _____

4. Some kinds of childhood care and education are hard to find. Please rate your current personal willingness to provide the following types of care. (Indicate that you are willing to provide a particular type of care even if you are unable to do so right now, as long as in general you are willing to provide this type of care.)

Would you be willing to provide:	NOT AT ALL WILLING					VERY WILLING
Care for children with challenging behaviors	1	2	3	4	5	6
Care for children with verified special needs	1	2	3	4	5	6
Infant care (12 months or younger)	1	2	3	4	5	6
Toddler care (13-36 months of age)	1	2	3	4	5	6
Evening child care (after 6 p.m.)	1	2	3	4	5	6
Overnight child care	1	2	3	4	5	6
Early morning care (before 6 a.m.)	1	2	3	4	5	6
Weekend care	1	2	3	4	5	6

YOUR BACKGROUND AND PROFESSIONAL DEVELOPMENT

5. Since age 18, how many TOTAL years (or months) have you worked as a PAID provider of childhood care and education services?

_____ TOTAL years

6. What is the *HIGHEST* level of education you have completed? Check ONE.

___	Less than high school diploma
___	High school diploma; year _____
___	General Educational Development (GED); year _____
___	Child Development Associate (CDA); year _____
___	Certificate from college, school, or professional association in: _____; year: _____
___	AA, AS, AAS, or other 2-year college degree in _____; year: _____
___	BA, BS, or other 4-year college degree in: _____; year: _____
___	MA, MS, MEd, or other master's degree in:_____; year: _____
___	Other; please specify degree and field of study: _____; year: _____

7. *PATHWAYS* is a program that identifies the professional development level of childhood care and education providers. Are you enrolled in *PATHWAYS*?

___ **NO:** Go to question 8.

___ **DON'T KNOW:** Go to question 8.

___ **YES**

7.a. About when did you enroll in the *PATHWAYS* program? _____ (Month/Year)

7.b. CIRCLE below the level or step you hold on *PATHWAYS.*

1 2 3 4 5 6 7 8 8+ Associate degree 8+ Bachelor or higher degree

___ I am in the *PATHWAYS* program but I am not sure of my level or step.

8. The *Professional Development Registry (PDR)* is a professional development program offered by the Oregon Center for Career Development in Childhood Care and Education. Are you enrolled in the *PDR*?

___ **NO:** Go to question 9 on next page.

___ **DON'T KNOW:** Go to question 9 on next page.

___ **YES:**

8.a. About when did you enroll in the PDR program? _____ (month/year)

8.b. CIRCLE below the level that you hold in the PDR system.

ENTRY LEVEL 1 2 3 4 5 6

___ I am in the PDR but I am not sure of my level.

9. Some childhood care and education professionals feel very confident about their skills. Others feel less confident in some areas. Please CIRCLE the number that best reflects YOUR LEVEL OF CONFIDENCE in each of the following skill areas.

SKILL AREAS	NOT VERY CONFIDENT					VERY CONFIDENT
Childhood health & safety	1	2	3	4	5	6
Childhood nutrition and meal planning	1	2	3	4	5	6
Children's social growth and development (e.g., social skills, peer relationships)	1	2	3	4	5	6
Children's school readiness and success	1	2	3	4	5	6
Observation and assessment of children	1	2	3	4	5	6
Development of curriculum & activities	1	2	3	4	5	6
Guidance of children's behavior (discipline)	1	2	3	4	5	6
Guidance of children with challenging behavior	1	2	3	4	5	6
Infant development/care (12 months or younger)	1	2	3	4	5	6
Children with physical disabilities	1	2	3	4	5	6
Children with emotional disabilities	1	2	3	4	5	6
Children with learning delays or developmental disabilities	1	2	3	4	5	6
Work with parents & families	1	2	3	4	5	6
Work with different cultures and backgrounds	1	2	3	4	5	6
Identifying child abuse and neglect	1	2	3	4	5	6
Creation of physical environments for children (developmentally appropriate rooms and equipment)	1	2	3	4	5	6
Management and business practices	1	2	3	4	5	6
Utilization of community resources (e.g., libraries, parks)	1	2	3	4	5	6
Development as a childhood care and education professional	1	2	3	4	5	6
Self-care, family and work, stress management	1	2	3	4	5	6

10. Most childhood care and education providers have areas in which they wish they could improve their skills. In what two or three skill areas would you MOST like to learn more and improve?

1._____
_

2._____

3._____

11. Think about the PAST 6 months. In the last 6 months, did you complete any workshops/training or college credit courses?

___ **NO:** Go to question 12 on next page.

___ ***YES:*** *Below please CHECK the topics and type of education and WRITE the approximate number of training hours or credits for this education.*

MAIN TOPIC OF COURSE OR OTHER EDUCATION:	CHECK IF WORKSHOP/ TRAINING	WRITE TOTAL HOURS	CHECK IF COLLEGE CREDIT COURSE	WRITE TOTAL CREDITS
Childhood health & safety	___	___	___	___
Childhood nutrition and meal planning	___	___	___	___
Children's social growth and development (e.g., social skills, peer relationships)	___	___	___	___
Children's school readiness and success	___	___	___	___
Observation and assessment of children	___	___	___	___
Development of curriculum & activities	___	___	___	___
Guidance of children's behavior (discipline)	___	___	___	___
Guidance of children with challenging behavior	___	___	___	___
Infant development/care (12 months or younger)	___	___	___	___
Children with physical disabilities	___	___	___	___
Children with emotional disabilities	___	___	___	___
Children with learning delays or developmental disabilities	___	___	___	___
Work with parents & families	___	___	___	___
Work with different cultures and backgrounds	___	___	___	___
Identifying child abuse and neglect	___	___	___	___
Creation of physical environments for children (developmentally appropriate rooms and equipment)	___	___	___	___
Management and business practices	___	___	___	___
Utilization of community resources (e.g., libraries, parks)	___	___	___	___

MAIN TOPIC OF COURSE OR OTHER EDUCATION:	CHECK IF WORKSHOP/ TRAINING	WRITE TOTAL HOURS	CHECK IF COLLEGE CREDIT COURSE	WRITE TOTAL CREDITS
Development as a childhood care and education professional	___	___	___	___
Self-care, family and work, stress management	___	___	___	___
Other topic; describe: _____	___	___	___	___
Other topic; describe: _____	___	___	___	___

12. When you think about your future, how long do you plan to continue working in childhood care and education?

	LESS THAN 1 YEAR	1 TO 2 YEARS	FROM 3 TO 5 YEARS	OVER 5 YEARS
Your current primary place of employment	___	___	___	___
Your current primary position	___	___	___	___
The field in any setting or position?	___	___	___	___

13. Do you have health insurance coverage?

___ **NO:** Go to question 14.

___ **YES:** Please CHECK the best descriptions below.

18.a. Is this coverage offered through:
__Your childhood care and education employment?
__Your other employment?
__Your spouse's or partner's employment?
__Oregon Health Plan (OHP)?
__Private, individual plan?
__Other; describe: _____

18.b. Who pays the premium for this insurance coverage?
__You or your spouse ONLY?
__Employer or spouse's employer ONLY?
__You or your spouse AND employer or spouse's employer?
__Other; describe: _____

14. CHECK your approximate ANNUAL INCOME from your work in childhood care and education.

- If you are a salaried or hourly worker, please report your TOTAL ANNUAL PAY, BEFORE TAXES.

- If you operate a childhood care and education business, please report your NET BUSINESS INCOME AFTER EXPENSES AND BEFORE TAXES.

.

___Under $5,000
___$5,001 to $10,000
___$10,001 to $15,000
___$15,001 to $20,000
___$20,001 to $25,000
___$25,001 to $30,000
___$30,000 to $35,000
___$35,001 to $40,000
___Over $40,000

15. Approximately how much does your childhood care and education income contribute to your TOTAL HOUSEHOLD ANNUAL INCOME? Is your childhood care and education income:

___ the ONLY source of income in your household?
___ OVER HALF, but not the only source, of household income?
___ ABOUT HALF of total household income?
___ LESS THAN HALF of total household income?

Addendum:

Child Care Quality Improvement Project Evaluation

16. How long have you been participating in [ ]?

_____ MONTHS

17. What are your early childhood education and child care training and education goals? [Check all that apply]

_____ Meet licensing requirements
_____ Obtain a credential or one-year certificate
_____ Obtain a degree
_____ Enroll or advance on the PDR
_____ Enroll or advance on Pathways
_____ Improve my child care services
_____ Learning about available resources
_____ Not sure
_____ Other: _____

18. Please circle the answer that represents your level of agreement with the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
a. I feel respected for the work I do.	1	2	3	4	5
b. I feel confident when talking to parents.	1	2	3	4	5
c. I would like to improve my education and training in childhood care and education.	1	2	3	4	5
d. It is important to me to improve my education and training in childhood care and education.	1	2	3	4	5
e. In my county there are many education and training opportunities for child care providers.	1	2	3	4	5
f. I know how to find out about training and education opportunities in my county.	1	2	3	4	5
g. I have opportunities for professional development (expanding my knowledge and skills).	1	2	3	4	5
h. I have opportunities to network (interact, associate, meet) with other child care providers in my area.	1	2	3	4	5
i. I am part of a formal or informal support group of child care providers.	1	2	3	4	5
j. I get support from other child care providers.	1	2	3	4	5
k. I often feel isolated as a child care provider.	1	2	3	4	5
l. I feel I am part of a community of child care providers.	1	2	3	4	5
m. Community leaders are effective in supporting child care professionals.	1	2	3	4	5
n. I have an opportunity to give input on what trainings are offered in my community.	1	2	3	4	5
o. If I had to decide over again, I would work as a child care provider again.	1	2	3	4	5
p. I would recommend child care as a job to a friend.	1	2	3	4	5

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
q. I get satisfaction through my work as a child care provider.	1	2	3	4	5

19a. Did you participate in any classes or trainings as part of your participation in [ ]?

_____ **Yes**

_____ **No [Skip to question 20a]**

19b. Please answer the following questions if you participated in any classes or trainings:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
i. The classes or trainings I participated in were useful to me.	1	2	3	4	5
ii. The classes or trainings I participated in will help me reach my career development goals.	1	2	3	4	5

20a. Did you receive any scholarships for coursework through [ ]?

_____ Yes

_____ No [Skip to question 21a on next page]

20b. If you received a scholarship, please answer the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
i. The scholarship made it easier for me to take part in classes or trainings.	1	2	3	4	5
ii. I would have participated in classes or trainings even without a scholarship.	1	2	3	4	5

21a. Did [ ] give you any financial rewards (e.g., incentives or wage enhancements) for completing trainings, coursework, or PDR levels?

_____Yes

_____ No [Skip to question 22a]

21b. If you received financial rewards (e.g., incentives or wage enhancements), please answer the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
i. I worked harder at my coursework or PDR advancement because of the wage enhancement.	1	2	3	4	5
ii. I would have participated in the coursework or tried to advance on the PDR even without the wage enhancement.	1	2	3	4	5

22a. Did [ ] provide you with money to make environmental improvements (e.g. new materials or equipment) at your child care home/center?

_____ Yes

_____ No [Skip to question 23a on next page]

22b. If you received grants for environmental improvements, please answer the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
i. I was more motivated to make environmental improvements because of the money from the project.	1	2	3	4	5
ii. I would have made environmental improvements to my child care setting even without the money from the project.	1	2	3	4	5

23a. Did you receive any other sort of monetary incentive (money) from [ ]?

_____ Yes

_____ No [Skip to question 24a.)

23b. If yes, please describe:

_____

24a. Did [ ] pair you with a mentor?

_____ Yes

_____ No [Skip to question 25]

24b. If you were paired with a mentor, please answer the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
i. The mentoring was useful for me.	1	2	3	4	5
ii. My mentor helped me with my career development goals.	1	2	3	4	5

25. Please answer the following questions about your participation overall with the [ ] project.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	
a. The project's activities were helpful to me.	1	2	3	4	5	
b. The project helped me learn about education and training opportunities in early childhood care and education.	1	2	3	4	5	
c. The project helped me meet others working in the child care field.	1	2	3	4	5	
d. The project has helped me feel more respected by others as an professional.	1	2	3	4	5	
e. I would recommend this project to other child care providers.	1	2	3	4	5	

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	
f. Through the project I learned useful information that I will apply to my work.	1	2	3	4	5	
g. The project has helped me feel more competent to serve infants and toddlers.	1	2	3	4	5	NA—don't serve this group
h. The project has helped me feel more competent to serve children with special needs.	1	2	3	4	5	NA—don't serve this group
i. The project has helped me feel more competent to serve children who speak a language other than English.	1	2	3	4	5	NA—don't serve this group

26. What have you learned as a result of participating in [ ]? How have you developed as a professional? If you have used the Harms-Clifford Assessment as part of participating in [ ], please describe whether/how it has helped you.

27. THANK YOU!

Now, is there anything you want to say to help us understand your experiences or needs as a childhood care and education provider? Please use extra sheets if needed!

PLEASE RETURN THIS COMPLETED SURVEY TO: