BEST STARTS FOR KIDS CHILD CARE HEALTH CONSULTATION EVALUATION

YEAR 1

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King County
Best Starts for KIDS

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ACKNOWLEDGMENTS

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This work is made possible by the Best Starts for Kids levy. Best Starts for Kids builds on the strengths of communities and families so that babies are born healthy, children thrive and establish a strong foundation for life, and young people grow into happy, healthy adults. Best Starts for Kids is the most comprehensive investment in child development in the nation. King County's investments span from prenatal development all the way through young adulthood, building strength and resilience in our communities along the way.

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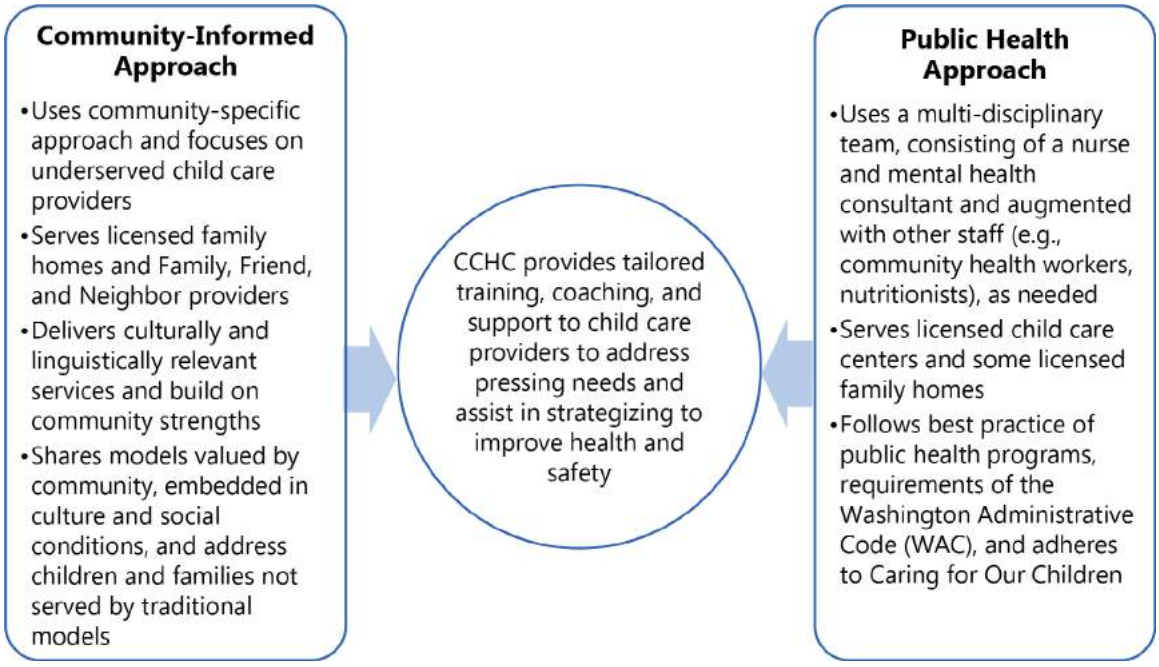
KEY ACRONYMS

BSK — Best Starts for Kids
CCHC — Child Care Health Consultation
CEC — Child Care Health Consultation Evaluation Committee
CI — Community Informed Pilot
FFN — Family, Friend, and Neighbor
PH — Public Health Model
TA — Technical Assistance
WAC — Washington Administrative Code

EXECUTIVE SUMMARY

INTRODUCTION

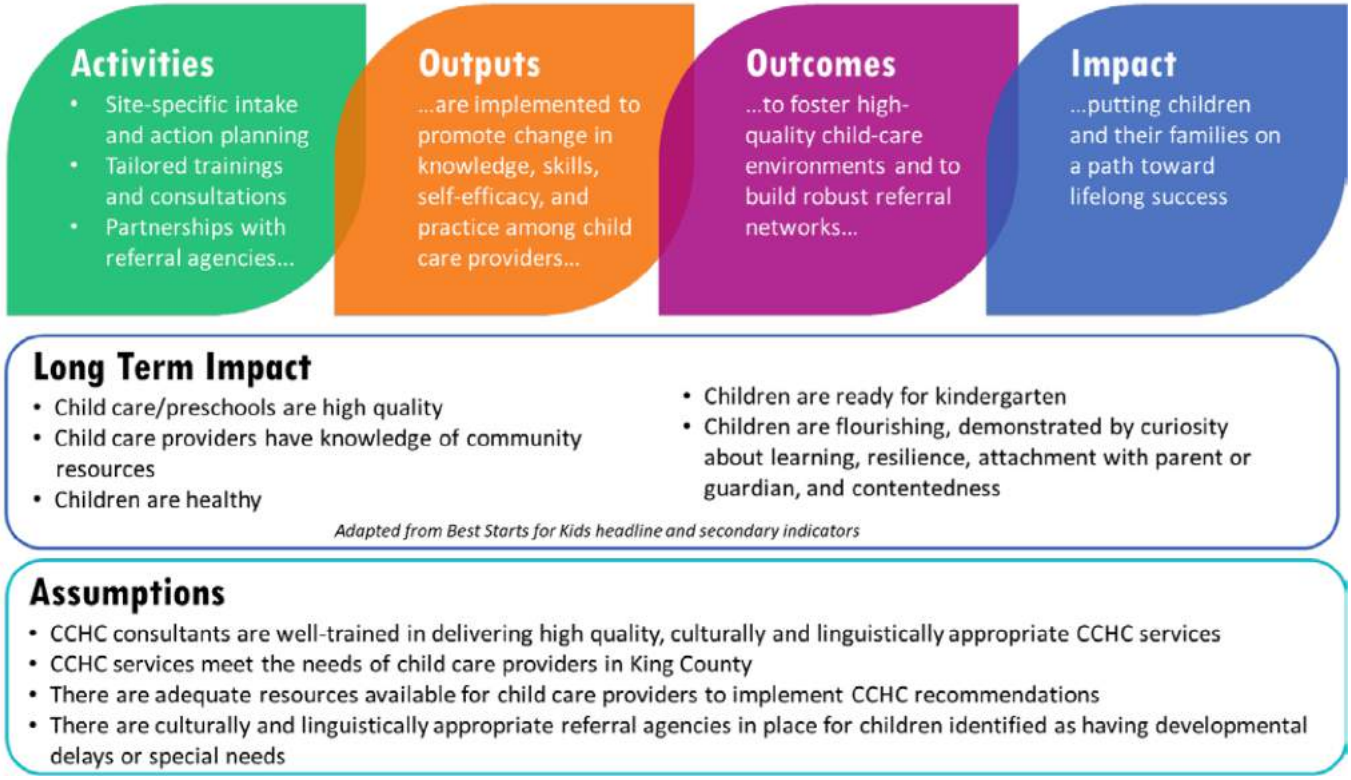
Best Starts for Kids (BSK) builds on the strengths of communities and families so that babies are born healthy, children thrive and establish a strong foundation for life, and young people grow into happy, healthy adults. Child care health consultation (CCHC) is a strategy that promotes the health and development of children, families, and child care providers by ensuring healthy and safe child care environments. In 2018, BSK invested in two CCHC approaches—public health model and community-informed pilots—to leverage communities' strengths and meet the wide range of needs in King County.



GOALS & OBJECTIVES

The purpose of the CCHC evaluation is to: 1) describe the core programmatic elements and values of CCHC and the unique programmatic elements of the public health and community-informed approaches, 2) identify facilitators and barriers to implementation of the public health and community-informed approaches, and 3) explore how CCHC contributes to child care provider outcomes, including improving parent conversations, increasing provider knowledge of supports and resources, and increasing provider ability to improve the child care environment. In addition, this evaluation describes the ways in which CCHC services support child care provider needs in King County across diverse geographic, cultural, and provider communities.

King County Child Care Health Consultation Theory of Change



METHODS

Cardea used a participatory approach for this evaluation, including significant input and feedback from the seven CCHC grantees and CCHC evaluation committee (CEC). Cardea used this intensive, iterative approach throughout the development of the evaluation plan, data collection tools, implementation process, analysis interpretation, and report development. Cardea used a mixed methods prospective design and developed five, primary, quantitative tools to collect service delivery and outcomes data, as well as key informant interview and focus group guides to collect qualitative data. Evaluation planning began in October 2018, and data collection for year one concluded at the end of December 2019. Cardea began data analysis, interpretation, and report development in January and February 2020.

Consistency and quality of data collection varied slightly across CCHC grantees, given differences in capacity/infrastructure, program model, and services provided. One data-driven limitation is incomplete data for CCHC services, due to staff turnover and challenges in differentiating individual consultation from follow-up services. Cardea provided technical assistance throughout the year to support grantees in resolving limitations in data collection. By using a participatory evaluation approach, Cardea prioritized developing strong relationships with members of the CEC and CCHC grantees to build trust and continually work toward a set of common goals.

KEY FINDINGS

COMMON ELEMENTS

Common elements among the services provided by the seven CCHC grantees include:

- Similar subtopics under the four topic areas: 1) growth and development, 2) health and safety, 3) nutrition, and 4) other
- Modality of service delivery
- Time spent on individual consultation and follow up

FACILITATORS AND BARRIERS

Child care providers reported that regular engagement with their consultant facilitated learning. Child care health consultants shared resources (e.g., websites, handouts) to support providers in implementing the skills they learned. Consultants using the community-informed approach (CI consultants) also brought items to help providers plan activities for the children in their care, including toys, books, paper, and writing utensils. Consultants discussed building trust with providers as a key component to supporting positive outcomes. Consultants working with providers who recently immigrated to the U.S. were able to engage providers in their primary language and tailor lessons to be culturally relevant.

Some child care providers faced barriers in implementing what they learned from their consultant. Some providers said that their consultants did not have the necessary cultural and linguistic skills to adequately share concepts or teach skills that were culturally relevant. Other providers said that they would have preferred increased engagement with their consultant. Some providers had difficulty implementing the new skills they learned, due to lack of administrative support and time in their schedule.

UNIQUE STRENGTHS

While there are common elements among the services provided by the seven CCHC grantees, there are also unique strengths of the community-informed and public health approaches. These unique strengths improved consultants' ability to engage child care providers in CCHC services and tailor services to build on providers' current knowledge and skills.

Community-Informed Pilots

A larger number of child care sites received CCHC services through the community-informed vs. public health approach (350 vs. 98 sites), and most sites had one provider and one child, which allowed for meaningful relationship-building. Among consultations using the community-informed approach (CI consultations), primary topics were brain development and milestones, developmental screening, emergency policies and procedures, oral health, and toxics. While family engagement and interaction was not a primary focus of individual consultations, a large proportion of group trainings (41%) covered the topic. Also, Family, Friend, and Neighbor (FFN) and licensed family home providers reported that it was extremely helpful to hear about other providers' challenges and learn from each other in group trainings. Child care providers also noted that CI consultants were culturally and linguistically responsive.

Public Health Model

While fewer child care sites received CCHC services through the public health approach, there were more child care providers at each site and often more than one room at each site, with a higher number of children in care than for the CI approach. Among consultations using the public health approach (PH consultations), primary topics were mental/behavioral health, sensory and self-regulation, children with special needs, infection/communicable disease prevention, physical activity and outdoor time, classroom curriculum, and family engagement and interaction. Group trainings focused heavily on mental/behavioral health to increase training related to supporting and keeping children in care, when challenging behaviors arise.

IMPACT OF CCHC

Initial findings from this evaluation, particularly from the child care provider follow-up survey and key informant interviews, indicate that CCHC services have a positive impact on child care providers across consultation and related to most topics. BSK's investment in bringing seven CCHC grantees with different models and approaches under a common definition of CCHC services is aligned with the Best Starts Equity and Social Justice framework and appears to have advantages in strong service delivery to a wide range of child care providers. In particular, two areas of impact emerged across all child care providers:

Increased ability to manage both current and emerging challenging behaviors, resulting in providers having the confidence and ability to keep children and families in care

> ***We said that we were going to serve all students, but we didn't know how. We didn't have the capacity in our staffing or budget to have the staff support that we really needed…[The consultant] immediately came in, and it was challenging for them, too, but we devised strategies to be inclusive for this child.***
>
> —Partial day provider, public health approach

Increased knowledge and use of developmental screening tools and resources

> ***I learned about referrals from [the consultant]. Before, I didn't have time for all that. Now, I have a board in my place where I stick all the resources that I find out. Sometimes, I have to call to do a referral. If there is a family with the developmental delay, I call the resource and made an appointment for them.***
>
> —Licensed family home provider, community-informed approach

Overall, each of the consultation topics covered by consultants appeared to have positive impact on providers' knowledge and ability.

FUTURE DIRECTION

Initial findings from this evaluation have created a strong foundation for ongoing evaluation of the common elements and unique strengths of the CI and PH approaches. By exploring assumptions related to common elements and unique strengths with CCHC grantees, CEC, and BSK staff, Cardea anticipates that the ongoing evaluation will lead to a better understanding of the core elements of CCHC that can be applied at a broader systems level.

In 2020, Cardea will work with BSK to disseminate findings from the CCHC evaluation, refining the evaluation questions to build on what was learned through this initial evaluation, continuing to provide TA to BSK CCHC grantees, and working with Kindering to support the ongoing systems development work.

INTRODUCTION

BSK CCHC PROGRAM BACKGROUND

Child care health consultation (CCHC) is a strategy that promotes the health and development of children, families, and child care providers by ensuring healthy and safe child care environments. CCHC is one of three key strategies within BSK's prenatal to age five investment area. This investment area also includes service delivery strategies in Home-Based Services and Community-Based Parenting Supports. Child care health consultants provide tailored training, coaching, and support to child care providers to address their most pressing needs and provide overall assistance in identifying and implementing strategies to improve children's health and safety.

[Child care health consultation] is part of the work we're doing through Best Starts for Kids to make sure that every child has the best chance to grow up healthy and ready to take on the world.

—King County Executive Dow Constantine

In 2018, Best Starts for Kids (BSK) invested in two CCHC approaches—public health model and community-informed pilots—to leverage communities' strengths and meet the wide range of needs in King County. Overall, CCHC services are designed to provide tailored consultation, training, and support to child care providers to address their most pressing needs and provide overall assistance in identifying and implementing change to improve health and safety. CCHC services also include strengths-based training and consultation across a broad range of physical, social, and emotional needs and concerns while being centered in trauma-informed practices. The two approaches must meet this definition and add components that expand the reach of consultation to child care providers who are underserved or experience barriers to receiving services, including providers from communities of color and Family, Friend, and Neighbor (FFN) providers.

BSK's seven CCHC grantees include:

- Chinese Information Service Center
- Encompass Northwest
- Kindering Center
- Living Well Kent Collaborative
- Northwest Center for Kids
- Sisters in Common
- Somali Health Board

In 2018, BSK also invested in a CCHC Systems Development effort. Kindering Center received funding from BSK to gather partners and generate recommendations on how to develop an accessible system through which anyone offering child care health consultation services is connected, supported, well-trained, and working together to address unmet needs and alleviate race- and place-based inequities.

The public health model includes programs that meet the following characteristics:

- Uses a multi-disciplinary team, consisting of a nurse and mental health consultant and augmented with other staff (e.g., community health workers, nutritionists), as needed, that primarily serves licensed child care centers and some licensed family homes
- Follows best practice of public health programs and requirements of the Washington Administrative Code (WAC) and adheres to the standards outlined in Caring for Our Children

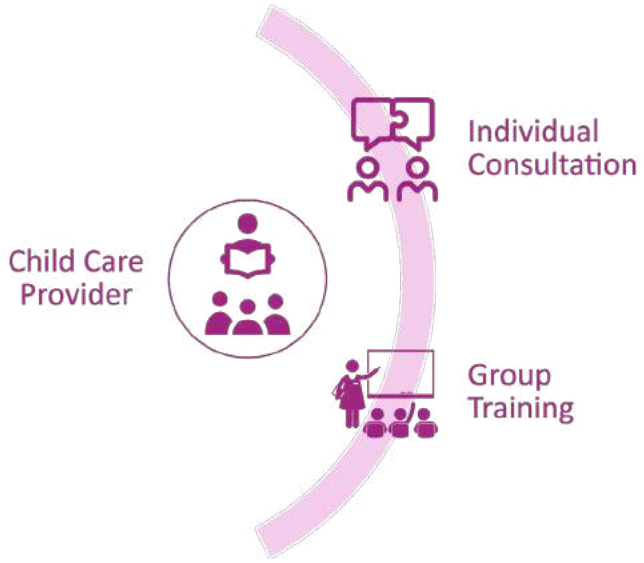
The community-informed pilots include programs that meet the following characteristics:

- Uses approaches that are community-specific and focused on underserved child care providers and primarily serves licensed family homes and FFN providers
- Delivers culturally and linguistically relevant CCHC services that build on communities' strengths to support children and families' well-being
- Shares models that are valued by communities, embedded in culture and social conditions and/or address children and families not served by traditional models
- Takes a holistic view of health and safety

Across both categories, the programs are aligned with the Best Starts Equity and Social Justice framework by investing in organizations that:

- Serve and/or are embedded in communities of color, immigrant and refugee communities, low-income communities, communities with disabilities, and limited-English-speaking communities, in alignment with King County's Equity and Social Justice Ordinance, and as prioritized in the BSK Implementation Plan
- Provide services in communities and/or geographies where there are limited resources or service gaps, including communities where there are few or no services available, the services available are insufficient for the need, or available services are not relevant to specific community needs
- Expand services to child care providers who have been consistently and historically underserved by CCHC resources, including FFN and informal care providers, rural providers, or new providers seeking initial licensing, and, for the community-informed pilots, providers they feel are most underserved within their communities
- Partner with community-based organizations serving diverse communities, including employing staff and leadership who are representative of the communities served, and using clearly defined processes for soliciting family, provider, and community input on needs and services

Consultation Model



OVERVIEW OF LITERATURE ON CCHC EVALUATION

Prior research and evaluation of CCHC programs has focused on CCHC within the context of the public health model. To date, there do not appear to be services funded and evaluated that share a general definition of CCHC, while expanding the scope and reach of services to all licensed, unlicensed, and/or informal child care providers with additional focus on language, culture, and geography. Cardea reviewed both grey and published literature in the development of this evaluation to apply prior methods to this novel programmatic approach.

In a recent, informally published review of literature of unlicensed or informal care providers (e.g., FFN), the authors summarized a variety of programs at the federal, tribal, state, and local levels and concluded that a broad range of services target informal and FFN care providers and often operate within one of four groups: 1) home visiting, 2) collaborations with other early childhood programs, 3) play and learn groups, and 4) education and training. In the review, the authors noted that CCHC had an overall positive impact on provider beliefs, attitudes, practices, and interactions with children and on providers reporting a positive experience with services.[1]

In 2007, Washington State funded a CCHC pilot program that was externally evaluated in 2008. The pilot program directed services to licensed child care providers, and the evaluation reported an impact on provider self-efficacy and knowledge and skills around supporting child behavior, as well as generally high ratings of the usefulness of services among providers.[2] A 2017 study of CCHC in Pennsylvania found similar results with an improvement in compliance with selected Caring for Our Children health and safety standards among child care center providers.[3]

In addition, in 2015, the Administration for Child and Families, Office of Child Care, documented the need to provide CCHC services to licensed home-based providers by describing nationally those who provide care in various settings and where there are gaps in service provision among those operating licensed services from their homes.[4] A brief by Mathematica Policy Research, Inc. in 2010 also documented that CCHC services can improve the quality of care for children being cared for in a licensed family home setting.[5]

Research and evaluation to date has primarily been retrospective, has not had comparison groups, and has not yet explored the integration of licensed and informal care provision under a collaborative and integrated CCHC service delivery system.

TIMELINE & APPROACH

In October 2018, Public Health–Seattle & King County, engaged Cardea in an evaluation of BSK's CCHC portfolio.

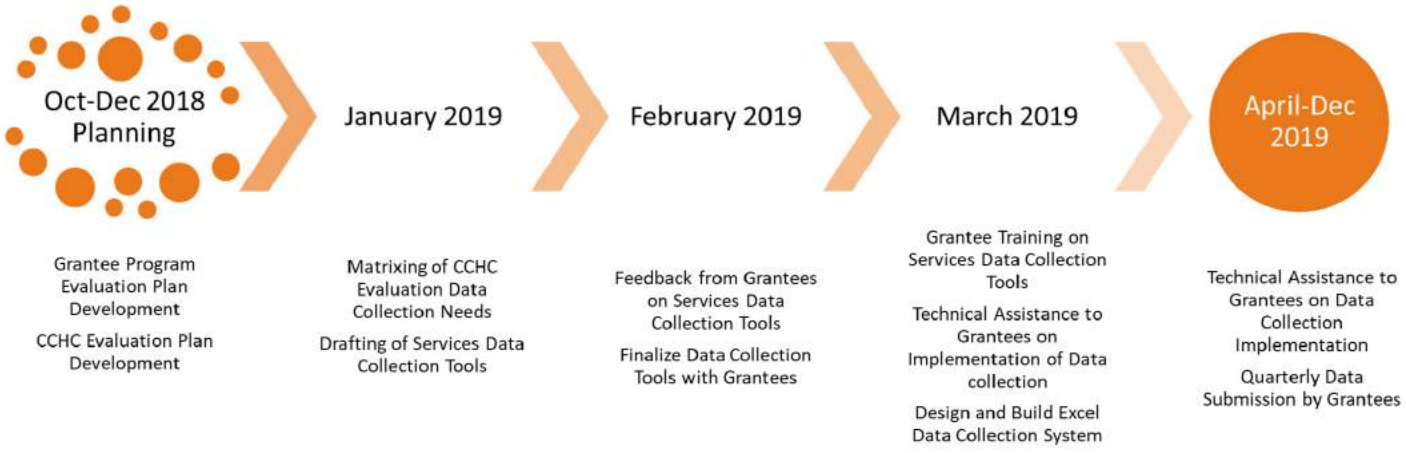
All funded CCHC programs started in 2018. From October 2018 through January 2020, Cardea supported the evaluation of BSK's CCHC portfolio, including developing a performance measurement plan for CCHC grantees, developing an evaluation plan for the CCHC portfolio, implementing the evaluation, and preparing a final report.

EVALUATION TIMELINE

The data collection development and implementation phase required substantial effort in developing a set of programmatic data collection tools that worked across all seven grantees to ensure that data elements and data quality would be comparable and in a format that could be analyzed. Developing the programmatic data collection also required significant technical assistance (TA) to support each grantee's effort to incorporate data collection within their programs. Figure 1 shows the high level timeline of evaluation activities throughout the life of the evaluation. Figure 2 provides a more detailed timeline of activities required to develop and implement programmatic data collection Figure 2.

Figure 1. Evaluation activities timeline including development, implementation, and analysis

Figure 2: Data collection tool development and implementation activities timeline



EVALUATION APPROACH

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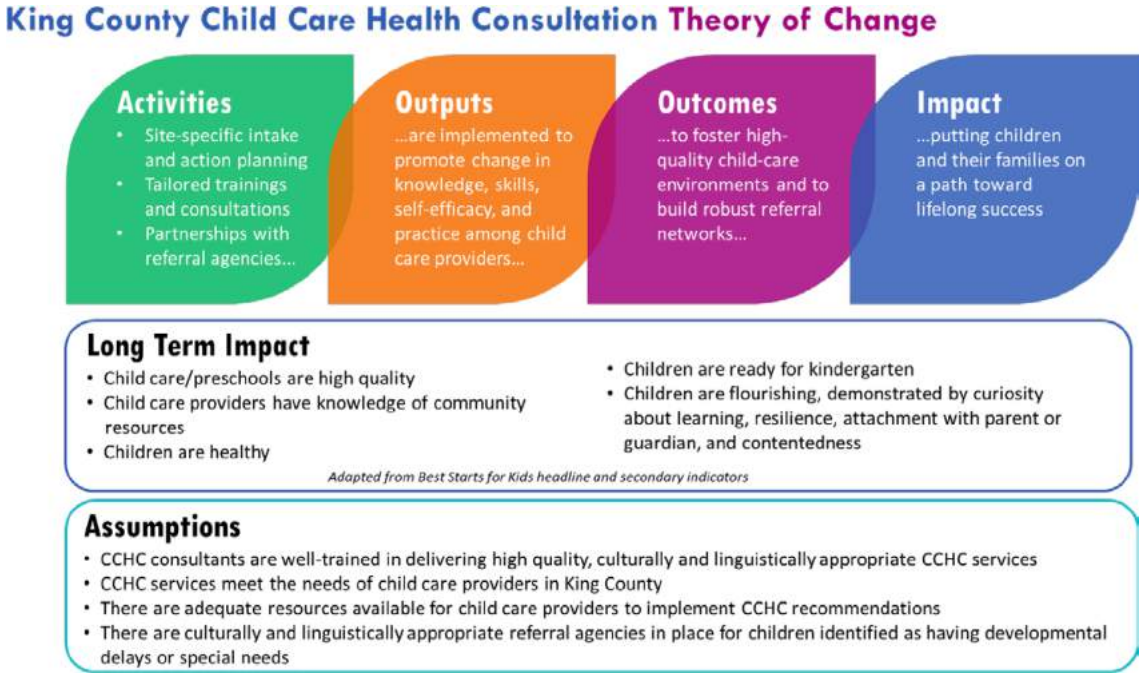
EVALUATION DEVELOPMENT

Cardea used several sources to inform the development of the evaluation questions. Cardea used the literature highlighted in the Introduction to identify questions addressed through other research and evaluation efforts.[1-5] In addition, Cardea had in-depth conversations with CCHC grantees to understand program design. Each grantee began by working with Cardea to complete a logic model and evaluation plan in which they described their program and expected programmatic outcomes.

In October 2018, Cardea met in-person with each of the seven grantees to learn more about program design, anticipated program activities and services, current data collection methods, and current measurement plans and tools. Following this initial meeting, grantees independently drafted evaluation plans, using a template provided by Cardea that aligned with the BSK model. Cardea then facilitated 2-3 virtual meetings with each grantee to review and refine their evaluation plans. Following each virtual meeting, Cardea provided an electronic copy of the draft evaluation plan with comments for grantees to consider, and grantees revised their evaluation plans, based on Cardea's feedback. Grantees finalized their evaluation plans in mid-November 2018.

To develop an evaluation plan for the CCHC portfolio, Cardea used a matrixing process to determine overlapping programmatic elements and outcomes, as well as potential unique programmatic elements, among grantee evaluation plans. This process also informed a preliminary theory of change used to guide the evaluation (Figure 3). Finally, these evaluation questions were informed by a 2017 evaluation of Public Health—Seattle & King County's Child Care Health Program (CCHP), as well as feedback and input from both Public Health—Seattle & King County CCHP and BSK staff.

Figure 3. Theory of Change



GOALS & OBJECTIVES

OBJECTIVES

The purpose of the CCHC evaluation is to: 1) describe the core programmatic elements and values of CCHC and the unique programmatic elements of the public health and community-informed approaches, 2) identify facilitators and barriers to implementation of the public health and community-informed approaches, and 3) explore how CCHC contributes to child care provider outcomes, including improving parent conversations, increasing provider knowledge of supports and resources, and increasing provider ability to improve the child care environment. In addition, this evaluation describes the ways in which CCHC services support child care provider needs in King County across diverse geographic, cultural, and provider communities.

EVALUATION QUESTIONS

The following questions guided the data collection tool development and analysis plan for the evaluation:

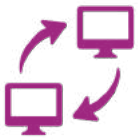
1. What are the core programmatic elements of CCHC and the unique programmatic elements of the public health model and community-informed pilot approaches?
   a. What type and dosage of services do CCHC grantees provide (training, consultation, resources, other support)?
   b. Who is being served by the CCHC strategy and these two approaches?
2. What are facilitators and barriers to implementation of CCHC?
   a. What are the child care provider facilitators of implementation? Barriers to implementation?
   b. What are the social, political, and environmental facilitators of implementation? Barriers to implementation?
3. How do core programmatic elements of CCHC and the unique programmatic elements of the public health and community-informed pilot approaches contribute to child care provider outcomes?
   a. How do core and unique programmatic elements contribute to increasing child care providers' knowledge and use of supports and resources?
   b. How do core and unique programmatic elements contribute to increased child care provider knowledge of consultation and training topics, and their ability to:
      i. Improve provider/parent conversations?
      ii. Manage challenging behaviors?
      iii. Identify and use developmental screening tools and resources?
      iv. Understand child development and plan developmentally appropriate activities?
      v. Implement strategies to increase the health and safety of the child care environment?

METHODS & DATA COLLECTION

Cardea used a mixed methods prospective design. Mixed methods were used to gain a deeper understanding of the evaluation results. Quantitative data were used to describe the components of CCHC service delivery, as well as preliminary understanding of the impact of CCHC services on provider knowledge and skills. In addition, these data provided service-level information about dosage of CCHC services. Qualitative data allowed for deeper insight into provider use and impacts of CCHC services. Mixed methods data better represented the service delivery and preliminary impact of CCHC services than quantitative or qualitative alone.

Please refer to the Appendices for additional details of evaluation methods.

DATA SHARING



Cardea set up data sharing agreements with each grantee and a secure electronic system for grantees to submit quantitative and qualitative data for analysis. During the initial implementation phase (March through May 2019), grantees were asked to submit services data on a monthly basis for Cardea to review and support data quality and to improve the submission process for grantees. Following the implementation phase, grantees were asked to submit services data every three months. Under the data sharing agreements between grantees and BSK and between Cardea and BSK, Public Health – Seattle & King County requested that Cardea share non-identified[1] CCHC individual consultation, group training and provider follow-up survey data files.

DATA COLLECTION

After finalizing the CCHC evaluation plan in quarter four of 2018, Cardea drafted, reviewed, and finalized the data collection process in quarter one of 2019. Cardea began the process by creating a matrix of current data collection elements used by CCHC grantees, data collection elements used in the broader field of CCHC, and additional data elements needed to answer the evaluation questions.

QUANTITATIVE

Data collection tool development

Using the matrix, Cardea identified and developed five, primary, quantitative tools that contain standardized questions across grantees to collect service delivery and outcomes data: 1) child care provider intake and interest form, 2) CCHC consultation summary form, 3) child care provider follow-up survey, 4) group training summary form, and 5) post-group training survey (Figure 4 and 5).

1. In this context, non-identified data refers to data that does not include any information that could be used to identify an individual or child care site (e.g., name, date of birth).

Figure 4. CCHC Data Collection Tools

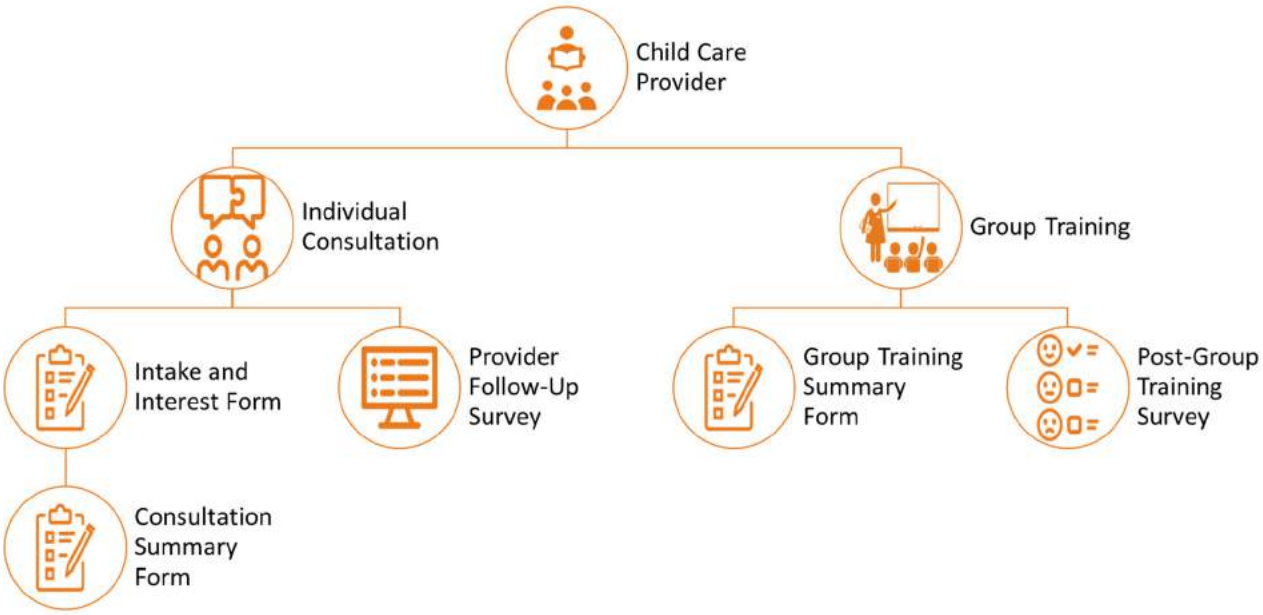
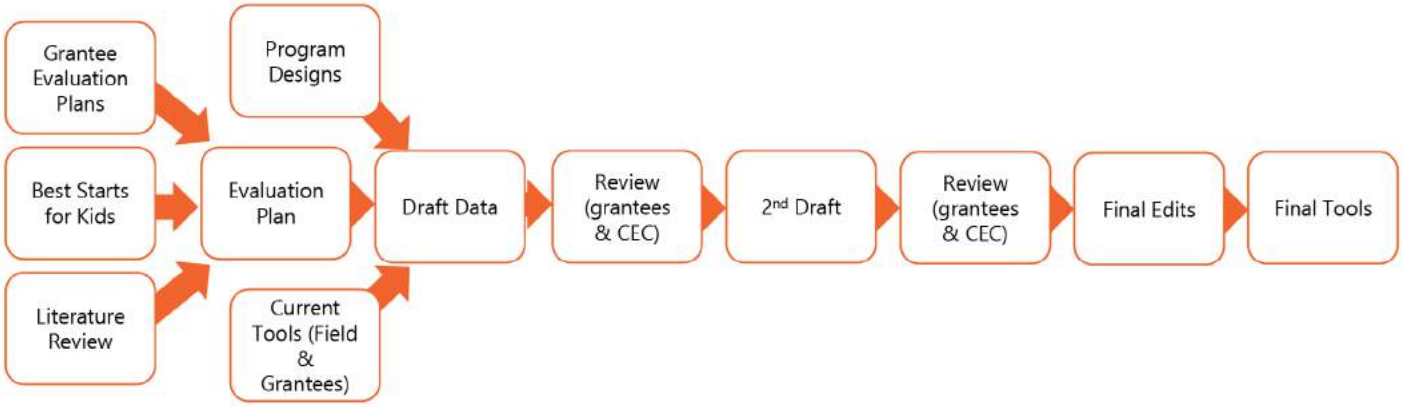


Figure 5: Data Collection Tool Development Process



Data collection tool implementation

In early March 2019, Cardea trained all grantees on the data collection process and tools for individual consultation and group training, using the child care provider intake and interest form, CCHC consultation summary form, group training summary form, and post-group training survey. Grantees practiced using the tools and discussed next steps for implementation within their respective teams.

Cardea provided extensive post-training support to each grantee through individual TA and group drop-in sessions. By the end of quarter one of 2019, all CCHC grantees were using all individual consultation and group training data collection tools.

Cardea primarily managed the provider follow-up survey process to minimize burden on grantees. Cardea translated the survey into eight languages and worked with the grantees in early November 2019 to distribute the survey to child care providers online through SurveyGizmo and on paper. The survey contained logic and dependencies to support an efficient survey experience. Please see Appendix C for additional detail. Online survey respondents received

a $5 gift card and paper survey respondents received a $5 gift that they could use with the children in their care as a thank you for participation. The survey remained open through the end of December 2019.

Data collection Excel data entry system

Grantees entered data collected on all care providers receiving individual consultation or group training into their respective administrative information systems at the time of service delivery. For grantees that did not have an administrative information system, Cardea created an Excel-based data entry system. The data entry system was built over several months to include Visual Basic Macros and cell-based arrays to streamline the data entry process and increase data quality. Post-implementation, Cardea provided TA and ongoing support to manage the use and function of the data entry system.

QUALITATIVE

Cardea collected qualitative data using standardized open-ended questions within the five primary tools. Key informant interviews with child care health consultants from grantee organizations and child care providers provided richer understanding of the facilitators and barriers to CCHC implementation and impact of services from the providers' perspective. As with the quantitative tools, Cardea drafted key informant interview guides using the iterative review process described earlier and included a guide with language tailored to FFN care providers. The interview guides were reviewed twice by grantees and twice by the CEC before finalizing.

Cardea completed 15, semi-structured, in-depth key informant interviews with licensed site administrators, licensed site providers, partial day providers, licensed family home providers, and FFN care providers. Cardea provided consent forms to all interviewees in advance of the interviews and obtained consent at the start of each interview. Interviews averaged 49 minutes in length, and Cardea worked with interpreters to complete interviews with eight providers who spoke Arabic, Cantonese, Mandarin, and Somali. Interviewees received $50 gift cards as a thank you for participation. Cardea completed key informant interviews from September to December 2019.

In addition, Cardea facilitated two focus groups with child care health consultants. One of the two focus groups was conducted with child care health consultants at Public Health—Seattle & King County. Focus groups were completed in September and November 2019.

DATA ANALYSIS

QUANTITATIVE

Cardea used SPSS to generate descriptive statistics, exploring the core and unique programmatic elements associated with the two approaches to service delivery, and describe who is receiving CCHC services. Cardea also generated summary statistics to provide an overview of the preliminary impact of CCHC services provided, analyzing survey results between the two approaches, as well as unique breakouts of provider types, where applicable. Data elements, including language, zip code, and provider type, were used to describe the broad reach and impact of CCHC services through the two approaches and through the seven different grantee program models.

QUALITATIVE

Key informant interviews with child care providers and child care health consultants provided an additional layer of context for understanding who is represented in CCHC service delivery, what elements of CCHC have an impact on providers, and facilitators and barriers to implementation of CCHC. Cardea developed a draft codebook, using prior coding structure provided by BSK and with CEC feedback. Using the codebook, two Cardea staff independently coded two interview transcripts to establish intercoder reliability and finalize the codebook and definitions. Cardea used NVivo to code the remaining interviews, identify themes, and explore relationships between themes.

As outlined in the Goals & Objectives section, the purpose of the CCHC evaluation is to: 1) describe the core programmatic elements and values of CCHC and the unique programmatic elements of the public health and community-informed approaches, 2) identify facilitators and barriers to implementation of the public health and community-informed approaches, and 3) explore how CCHC contributes to child care provider outcomes, including improving parent conversations, increasing provider knowledge of supports and resources, and increasing provider ability to improve the child care environment. The Results section is organized by the overall evaluation questions, recognizing that these questions will continue to be answered as programmatic and evaluative work unfolds.

LIMITATIONS

CCHC grantees began service delivery before this evaluation was in place, limiting the amount of data available for the first year. As one of several services available to child care providers, it is difficult to isolate the specific effect of CCHC services. In addition, since providers are the primary recipients of CCHC services, this evaluation is focused on provider-level changes vs. child/family-level outcomes and longitudinal changes among children and their families, since those outcomes and changes would be difficult to measure, particularly in one year.

The consistency and quality of data collection varied slightly across grantees, given differences in capacity/infrastructure, program model, and services provided. One result was incomplete data for CCHC services, due to:

1. **Staff turnover**—One grantee lost data on individual consultation services, due to inability to recover all data entered by a former staff member during implementation of a new administrative information system
2. **Challenges in differentiating individual consultations from follow-ups**—One grantee collected individual consultation data each time a consultant made contact with a child care provider, resulting in exclusion of this grantee from some analyses.

Cardea's ongoing TA to grantees has largely resolved these issues for 2020. However, since Cardea does not directly oversee data collection for grantees that have administrative information systems, there may be data quality issues in the future. Cardea will continue to provide TA to mitigate future challenges.

While the evaluation questions and data collection tools were largely informed by grantees, the provider follow-up survey and key informant interview guide were translated, which may have led to differences in the ways in which questions are framed. To minimize differences, a professional service was used to translate materials, and grantees reviewed the tools to ensure that translations maintained meaning and semantics. Professional interpreters with a background in social service provision were contracted to provide interpretation.

Cardea conducted qualitative data collection through key informant interviews and focus groups. Cardea relied on grantees to select providers for key informant interviews to maintain confidentiality and trust between consultants and providers, potentially biasing the sampling of providers toward those who had deeper and more positive experiences with CCHC services. In addition, two interviews were conducted with a consultant as an interpreter, potentially biasing the responses of those providers. However, bias may be reduced, as a result of greater provider comfort.

Finally, there also caution within some communities around accessing public services and sharing personal data, due to the current political climate and new federal public charge rule. Cardea worked closely with the CEC and grantees to structure tools and data collection processes to minimize the impact of community caution around sharing personal data. This limited the level of demographic data collection. Cardea also prioritized developing strong relationships with members of the CEC and CCHC grantees to build trust and continually work toward a set of common goals.

RESULTS

WHAT ARE THE CORE PROGRAMMATIC ELEMENTS OF CCHC AND THE UNIQUE PROGRAMMATIC ELEMENTS OF THE PUBLIC HEALTH MODEL AND COMMUNITY-INFORMED PILOT APPROACHES?

WHO IS BEING SERVED BY THE CCHC STRATEGY AND THESE TWO APPROACHES?

Grantees and child care providers completed a child care provider intake and assessment form for all sites that received CCHC services. General information collected at intake is summarized in the tables below. Additional descriptive tables are included in the Appendices.

Overview

- While most sites received CCHC services through the community-informed approach and nearly half were FFN providers, a higher average number of care providers per site received CCHC services through the public health approach
- In general, children served by sites receiving CCHC services were 2-7 years of age, and nearly three-quarters of sites had over 75% children of color in care
- More providers who received CCHC services through the public health approach had over 10 years of experience, compared to providers who received CCHC services through the community-informed approach, who generally had less than 10 years of child care experience

While most sites received CCHC services through the community-informed approach and nearly half were FFN providers, a higher average number of care providers received CCHC services through the public health approach

Between July 2018 and December 2019, CCHC grantees completed an intake and assessment form for CCHC services provided to 448 child care sites.

Table 1: Sites completing intake by consultation approach

Site Completing Intake	Total unique sites	
	#	%
All Sites/Locations	**448**	**100**
Community-informed	350	78
Public health	98	22

Sites were served through one of two consultation approaches: 1) community-informed pilots, and 2) public health model. Of sites receiving CCHC services, nearly half (47%) were FFN providers. Licensed family homes and licensed child care centers were the only types of care provider to receive CCHC services through both consultation approaches (Table 2). Licensed centers and partial day providers made up the smallest proportion of sites (Table 2).

Table 2: Sites completing intake by consultation approach and care provider type

Provider type	Consultation approach	Unique sites	
		#	%
Family Friend and Neighbor (n=204)	Community-informed Public health	204 -	46 -
Licensed Family Home (n=143)	Community-informed Public health	132 11	30 3
Licensed Centers (n=75)	Community-informed Public health	6 69	1 16
Partial Day Providers (n=18)	Community-informed Public health	- 18	- 4

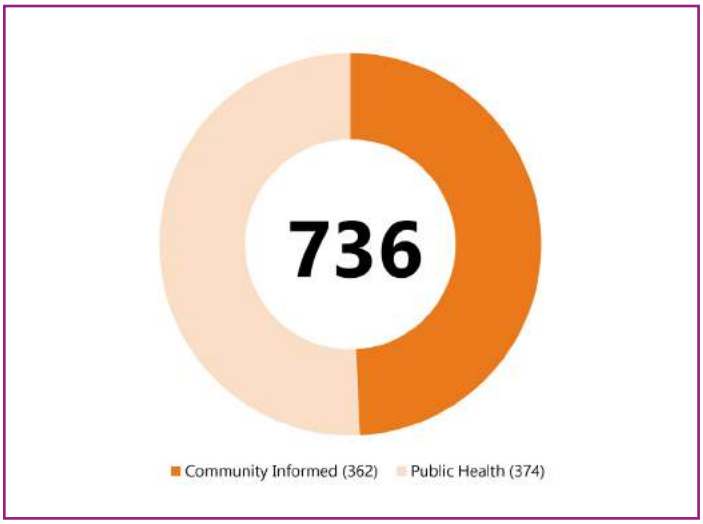
While fewer sites received CCHC services through the public health approach, a higher average number of care providers per site received CCHC services through this approach (Table 3, Figure 6). Licensed centers and partial day providers had a higher average number of children in care per site served through the public health approach (Table 3).

Geographically, CCHC services were provided to child care providers throughout King County in 59 zip codes. More than one-third (36%) of those zip codes were served by both CI and PH consultants. Over one-quarter (27%) of zip codes were served only by CI consultants, and 37% were served only by PH consultants. One grantee's zip code data were excluded, due to inability to differentiate a providers' zip codes and auto-generate zip codes based on a consultant's physical location at the time of data entry. These zip codes are largely clustered in South King County. Please see the Appendices for a services map.

Table 3: Total and average number of children and care providers per site by consultation approach

Site Intake	All Sites/Locations		Community-Informed		Public Health	
	Total	Average per site	Total	Average per site	Total	Average per site
Number of children in care (n=428)	6,913	16	919	3	5,994	69
Number of care providers completed intake	736	1.5	362	1	374	4.5

Figure 6: Total number of care providers who completed intake



Overall, the same proportion of sites received or accepted child care subsidies by consultation approach and learned about consultation services through internal referral or outreach by grantee program staff, with no difference between the two consultation approaches (Table 4).

In general, children served by sites receiving CCHC services were 2-7 years of age, and nearly three-quarters of sites had over 75% children of color in care

The average age range of children served by sites receiving CCHC services was 2-7 years of age. Sites that received CCHC services through the community-informed approach served children from 2-7 years of age, while those that received CCHC services through the public health model served children from 1-7 years of age. Most child care sites had over 75% children of color in care. There were more children of color receiving care among sites that received CCHC services through the community-informed vs. public health approach (Table 5). Data about the proportions of children of color in care appeared to be difficult to collect from larger child care centers, resulting in almost 50% of missing responses for the public health approach. Therefore, these data are largely driven by the data collected by sites receiving CCHC services through the community-informed approach.

Table 4: Sites receiving child care subsidy and learning about CCHC by consultation approach

Site Intake	All Sites/ Locations %	Community-Informed %	Public Health %
Site receives or accepts child care subsidy (n=295)	64	65	62
Site discovered CCHC through internal referral/program (n=305)	40	38	44

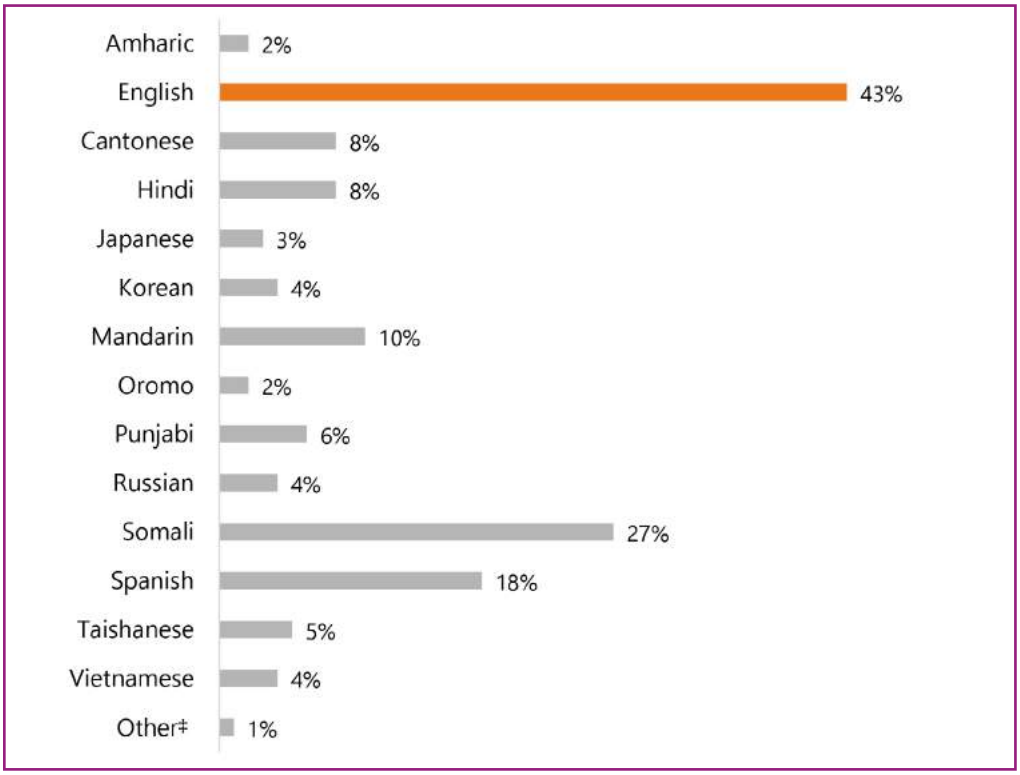
Table 5: Characteristics of children in care by consultation approach

Site Intake	All Sites	Community-Informed	Public Health
Average age range of children in care (n=425)	2 to 7 years	2 to 7 years	1 to 7 years
Approximate proportion of children of color in care at a site (n=448)†			
0%	-	-	1%
1-25%	4%	-	20%
26-50%	4%	1%	14%
51-75%	4%	2%	10%
76-100%	72%	91%	6%
Sites with at least one child in care/family who speaks a language other than English (n=448)‡	52%	55%	43%

† Includes 70 (16%) missing responses in the denominators (23 (6%) from community-informed and 47 (49%) from public health)
‡ Includes 187 (42%) missing responses in the denominators (144 (41%) from community-informed and 43 (44%) from public health)

Sites reported children in care/families who spoke languages, including Amharic, Cantonese, English, Hindi, Japanese, Korean, Mandarin, Oromo, Punjabi, Russian, Somali, Spanish, Tagalog, Taishanese, Ukrainian, and Vietnamese. English, Somali, Spanish, Mandarin, and Hindi and Cantonese (tied) (Figure 7). Data about all languages spoken by children and families appeared to be difficult to collect, resulting in a larger number of missing responses.

Figure 7: Proportion of all sites reporting language spoken by at least one child or family in care†



†Includes 187 missing responses in denominators
‡Other includes Tagalog and Ukrainian

More providers who received CCHC services through the public health approach had over 10 years of experience, compared to providers who received CCHC services through the community-informed approach, who generally had less than 10 years of child care experience

Grantees also completed a child care provider intake and assessment form upon initiation of CCHC services. The proportion of care providers with less than five (5) years of experience (46%) was similar to that of care providers with more than 10 years of experience (53%). More providers who received CCHC services through the public health approach had over 10 years of experience than those who received CCHC services through the community-informed approach (48% vs. 18%) (Table 6).

Figure 8. Percentage of providers who speak a language other than English

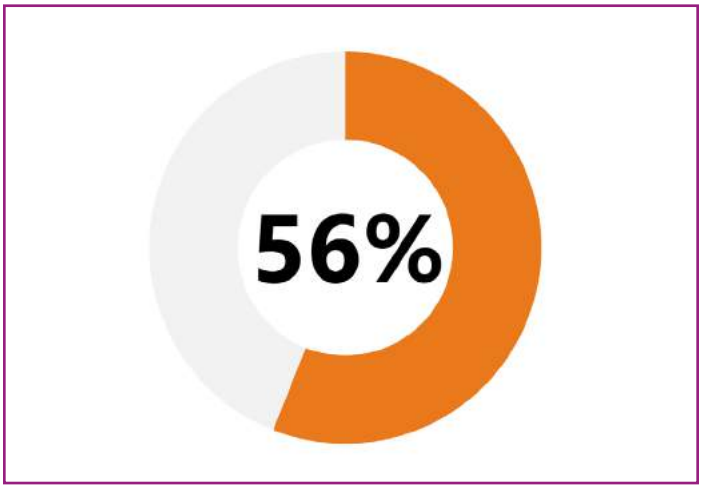


Table 6: Characteristics of care providers by consultation approach

Characteristic	All Sites %	Community-Informed %	Public Health %
Speaks a language other than English (n=448)†	56	58	46
Years providing care (n=377)			
Less than 1 year	8	7	9
1 to 5 years	38	53	27
5 to 10 years	19	22	17
More than 10 years	34	18	48
Role or relationship			
Unlicensed/informal care provider (n=299)			
Grandparent	17	37	-
Other family‡	3	8	-
Friend/neighbor	2	4	-
Licensed care provider (n=362)			
Site administrator	15	-	27
Lead teacher/caregiver	40	44	36
Assistant teacher/caregiver	16	5	25
Support staff	3	-	5
Multiple roles	3	-	5
Other	1	-	2

† Includes 130 missing responses in the denominator (112 from community-informed and 18 from public health)
‡ "Other family" includes brothers, sisters, aunts, uncles, and cousins

Figure 9. Informal care provider relationship to children and families

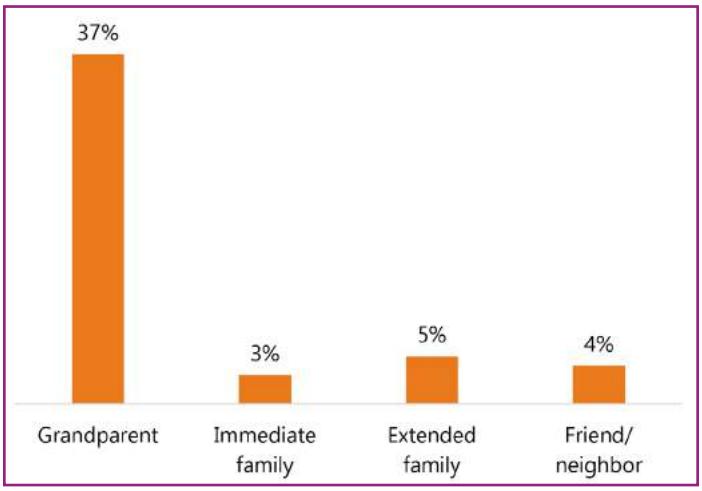
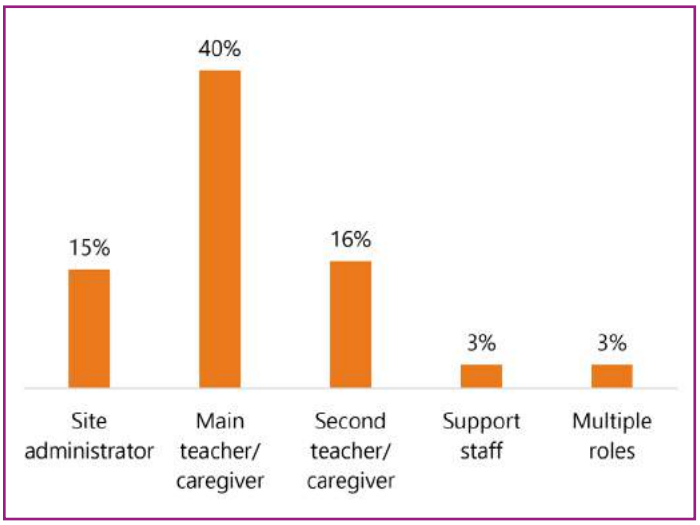


Figure 10. Licensed care provider role



WHAT TYPE AND DOSAGE OF SERVICES DO CCHC GRANTEES PROVIDE?

Grantees completed a consultation summary form at each individual consultation with a child care provider. Between March and December 2019, 351 child care sites received ongoing individual consultation. One grantee was excluded in the service delivery summary, due to data issues that precluded differentiating consultation from follow-up services. Therefore, 136 sites were excluded from the summary of type and dosage of CCHC services, and 215 sites are included in these results.

Overview

- Providers received individual consultation that addressed specific and unique child care needs
- On average, consultations were about 60 minutes and follow-ups were about 20-30 minutes
- Providers reported that in-person consultation often included observation and modeling
- Providers attended group trainings to learn from one another in a community setting

Providers received individual consultation that addressed specific and unique child care needs

On average, consultation was provided to one child care provider, teacher, or director/administrator per consultation across both approaches. There were 822 consultations using the community-informed approach (CI consultation) and 1,138 consultations using the public health approach (PH consultation). On average, providers who received PH consultation had double the number of consultations per site, compared to those who received CI consultation (13 vs. 6.5).

On average, consultations were about 60 minutes and follow-ups were about 20-30 minutes

The average length of time per consultation and follow-up were similar for both approaches at about one hour for initial consultation and 30 minutes for follow-up (Table 7).

Table 7: Number of consultations and average number of consultations and length of time per consultation/follow-up by consultation approach

	All Sites (n=215)	Community - Informed (n=128)	Public Health (n=87)
Number of consultations	1,950	821	1,129
Average number of consultations per site	9	6.5	13
Average consultation time per site (minutes)	58	62	55
Average follow-up time per site (minutes)	27	25	27

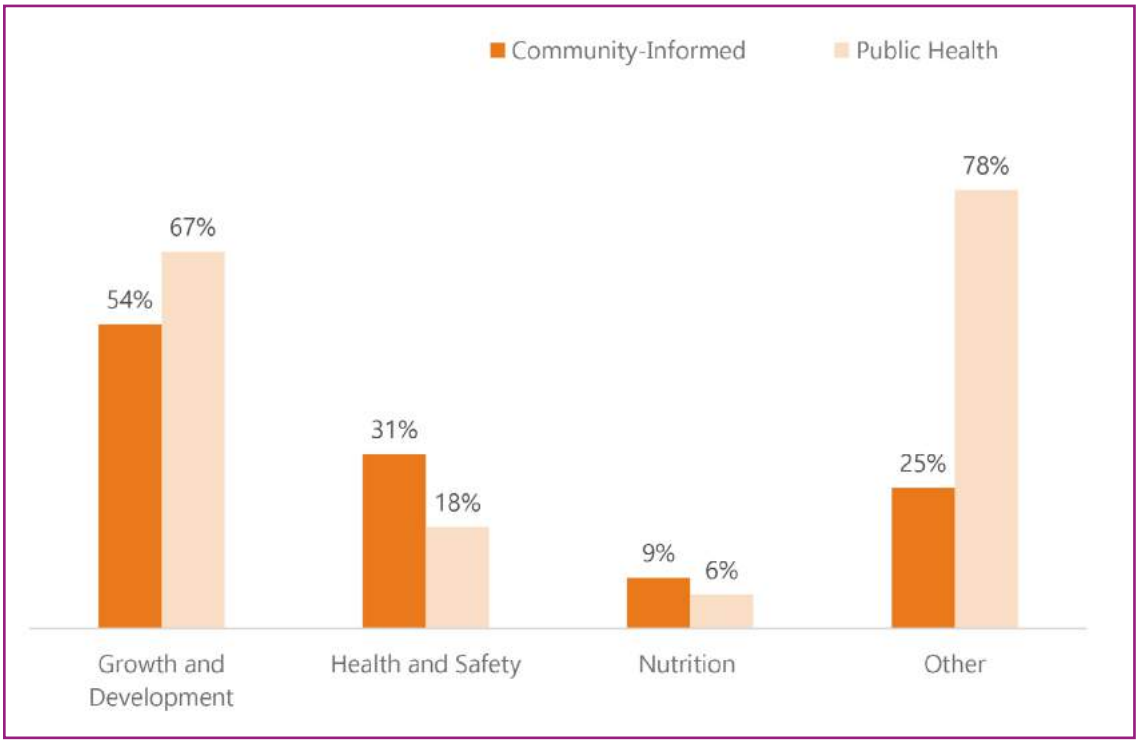
Overall, consultants discussed 27 different consultation topics with providers. Consultation topics were aggregated into four areas: 1) growth and development, 2) health and safety, 3) nutrition, and 4) other (Table 8/ Figure 11). The majority of consultations included some discussion of growth and development (62%) or other topics (63%). In addition, nearly one-quarter (23%) of consultations covered health and safety, and 7% covered nutrition.

Table 8: Consultations that included at least one subtopic per topic category by consultation approach

	All Sites (n=215)		Community-Informed (n=128)		Public Health (n=87)	
	#	%	#	%	#	%
Growth and development	1,206	62	444	54	762	67
Health and safety	453	23	252	31	201	18
Nutrition	140	7	73	9	67	6
Other†	1,078	55	202	25	876	78

†Other subtopics are broken out further in table 11

Figure 11. Percent of consultations per topic category by consultation approach

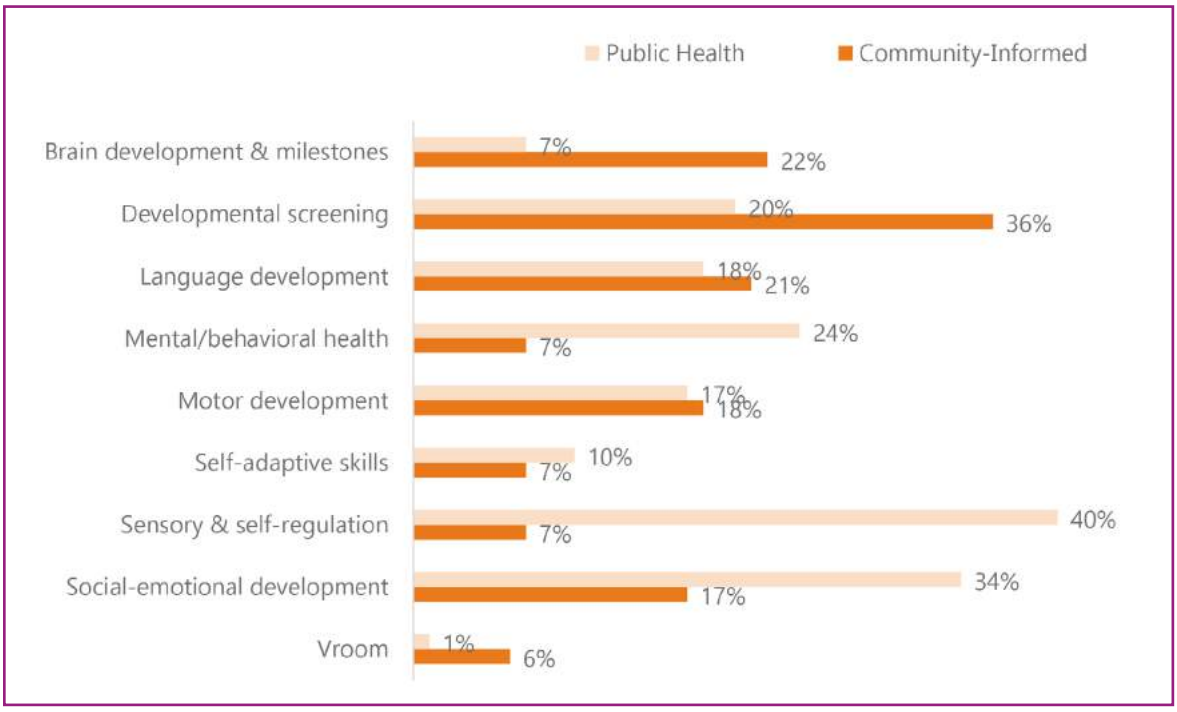


Within the growth and development category, most consultations focused on developmental screening, sensory and self-regulation, and social-emotional development (Table 10). Consultants using the community-informed approach (CI consultants) focused more on developmental screening (26%), while those using the public health approach (PH consultants) focused more on sensory & self-regulation and social-emotional development (24% and 21%, respectively) (Table 9/Figure 12).

Table 9: Proportion of growth and development topic category by subtopic and consultation approach

	All Sites (n=215) %	Community-Informed (n=128)) %	Public Health (n=87) %
Brain development & milestones	12	22	7
Developmental screening	26	36	20
Language development	19	21	18
Mental/behavioral health	18	7	24
Motor development	13	18	17
Self-adaptive skills	9	7	10
Sensory & self-regulation	28	7	40
Social-emotional development	28	17	34
Vroom	3	6	1

Figure 12: Proportion of growth and development topic category by subtopic and consultation approach

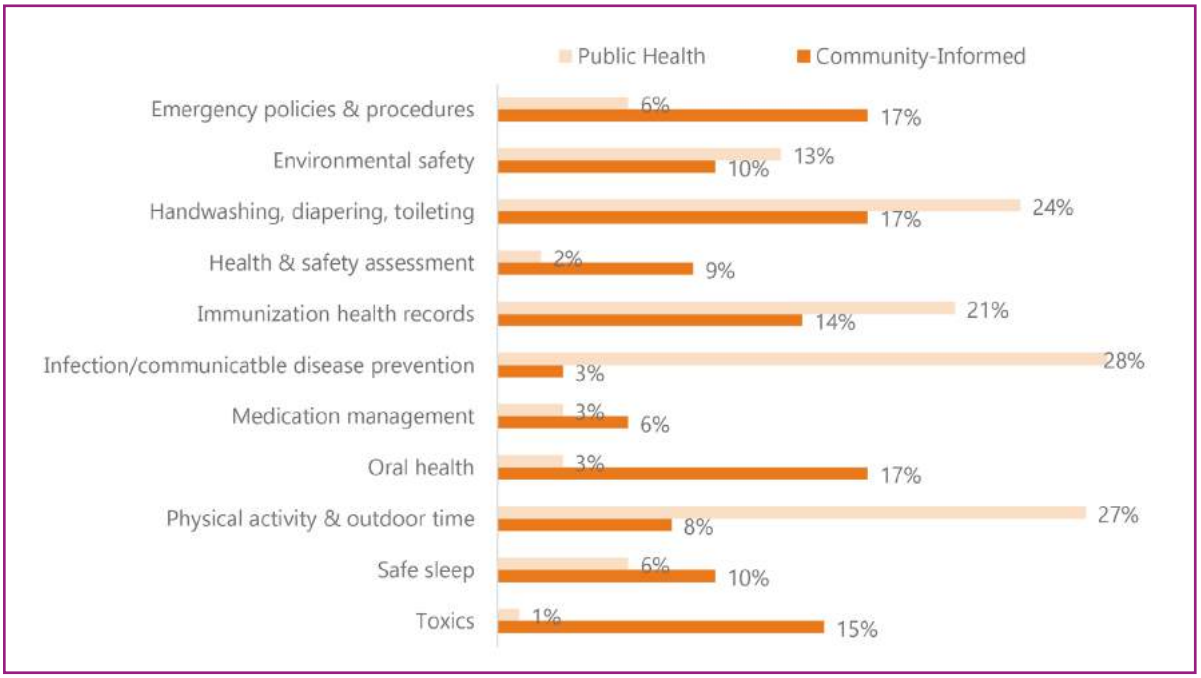


Within the health and safety category, consultations were relatively evenly spread across subtopics (Table 10). CI consultants focused more on emergency policies & procedures, environmental safety, handwashing/ diapering/toileting, and oral health (13% each), while PH consultants focused more on infection/communicable disease prevention and physical activity & outdoor time (20% each) (Table 10/Figure 13).

Table 10: Proportion of health and safety topic category by subtopic and consultation approach

	All Sites (n=215) %	Community-Informed (n=128) %	Public Health (n=87) %
Emergency policies & procedures	12	17	6
Environmental safety	16	10	13
Handwashing, diapering, toileting	20	17	24
Health & safety assessment	6	9	2
Immunization health records	17	14	21
Infection/communicable disease prevention	14	3	28
Medication management	4	6	3
Oral health	11	17	3
Physical activity & outdoor time	17	8	27
Safe sleep	8	10	6
Toxics	9	15	1

Figure 13: Proportion of health and safety topic category by subtopic and consultation approach



Under the other category, PH consultants covered topics that were not addressed (e.g., children with special needs, classroom curriculum) or were addressed less often by CI consultants (Table 11).

Table 11: Proportion of all consultations by other subtopic and consultation approach

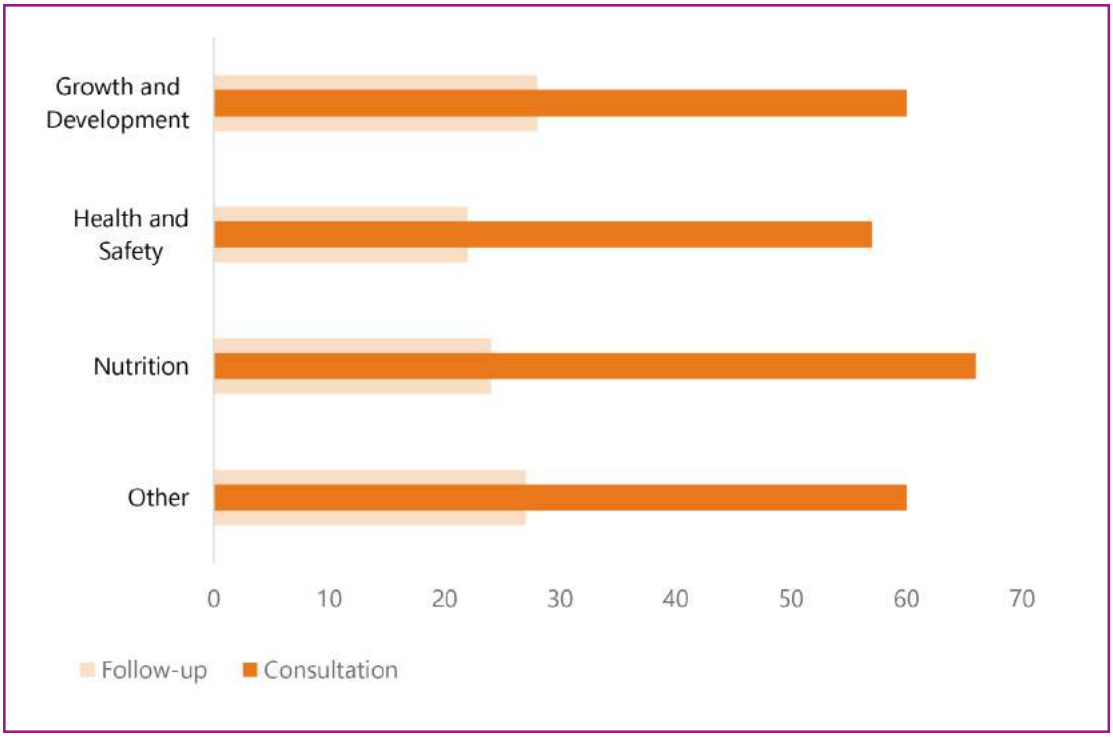
	All Sites (n=215)		Community-Informed (n=128)		Public Health (n=87)	
	#	%	#	%	#	%
Child-to-caregiver relationship	235	12	45	5	190	17
Children with special needs	494	25	2	<1	492	44
Classroom curriculum	272	14	4	<1	268	24
Community resources and referrals	209	11	100	12	109	10
Family engagement and interaction	281	14	46	6	235	21
Staff/Caregiver health and wellness	125	6	12	1	113	10

Overall, consultants spent about one hour on individual consultation and 20-30 minutes on follow up. (Table 12).

Table 12: Average consultation time in minutes by topic category and consultation approach

	All Sites (n=215)		Community-Informed (n=128)		Public Health (n=87)	
	Consultation	Follow-Up	Consultation	Follow-Up	Consultation	Follow-Up
Growth and development	60	28	62	29	59	27
Health and safety	57	22	57	20	59	20
Nutrition	66	24	67	23	65	24
Other	60	27	62	29	59	27

Figure 14: Average consultation time per topic category in minutes



Time for CI consultation was generally longer than for PH consultation for some other topics. For example, CI consultants focused more time on staff/caregiver health and wellness than PH consultants (76 vs. 49 minutes, respectively) (Table 13).

Table 13: Average consultation time by other subtopic and consultation approach

	All Sites		Community-Informed		Public Health	
	Consultation	Follow-Up	Consultation	Follow-Up	Consultation	Follow-Up
Child-to-caregiver relationship	66	25	60	38	68	25
Children with special needs	63	30	83	0	63	30
Classroom curriculum	67	25	90	30	67	25
Community resources and referrals	51	27	48	30	55	27
Family engagement and interaction	60	24	66	30	58	24
Staff/Caregiver health and wellness	52	20	76	15	49	21

About three-quarters (76%) of consultations were provided in person. CI consultants overwhelmingly providing consultation in person (94%), and nearly two-thirds (63%) of PH consultants provided consultation in person. Other modalities included e-mail/messaging, phone, and multiple, with 17% of PH consultants using e-mail/messaging (Table 14).

Table 14: Proportion of consultations provided by modality and consultation approach

	All Sites %	Community-Informed %	Public Health %
In-person	75	94	63
Phone	4	1	6
E-mail/messaging	12	4	17
Multiple	9	1	15

PH consultants primarily used in-person consultation, but also provided more consultations and follow-ups on growth and development and other topics using email/messaging (Figures 14-17).

Figure 15: Proportion of growth and development consultation by approach and modality

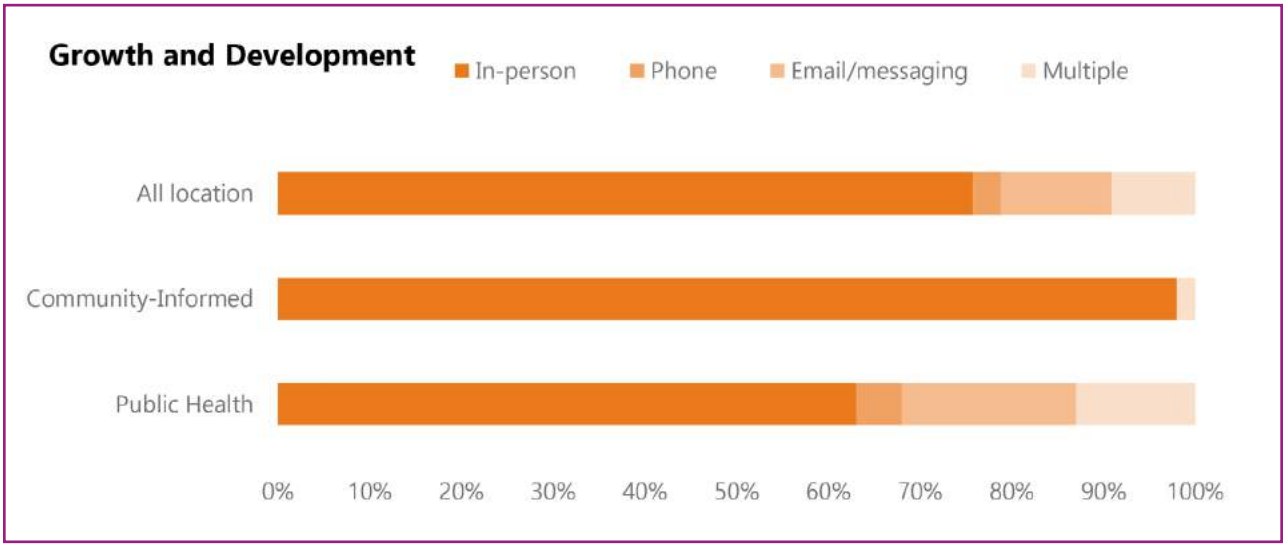


Figure 16: Proportion of health and safety consultation by approach and modality

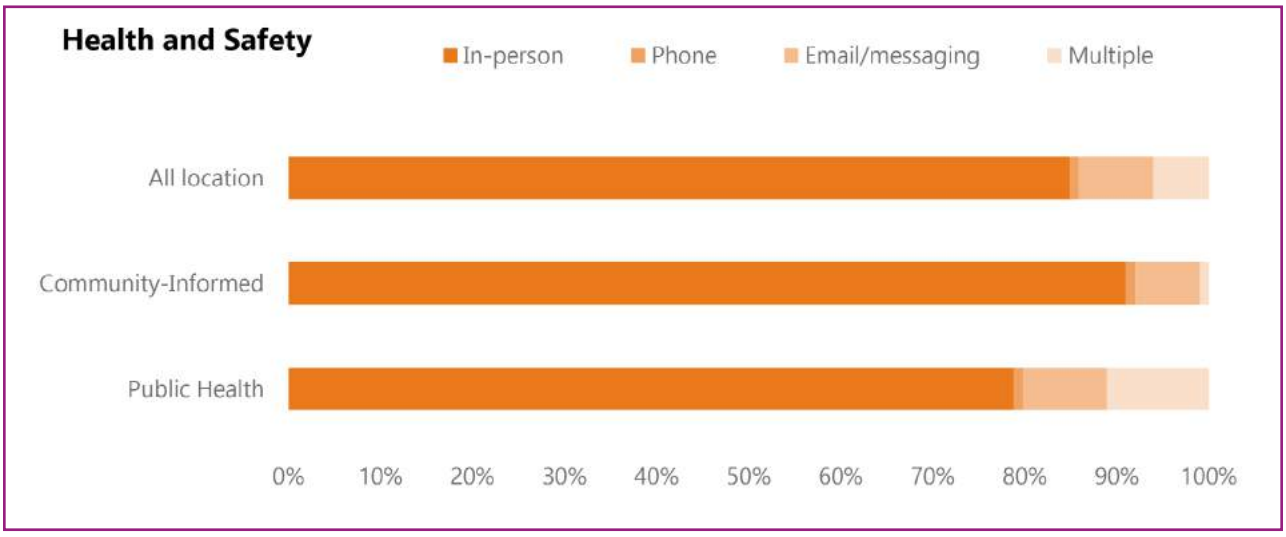


Figure 17: Proportion of nutrition consultation by approach and modality

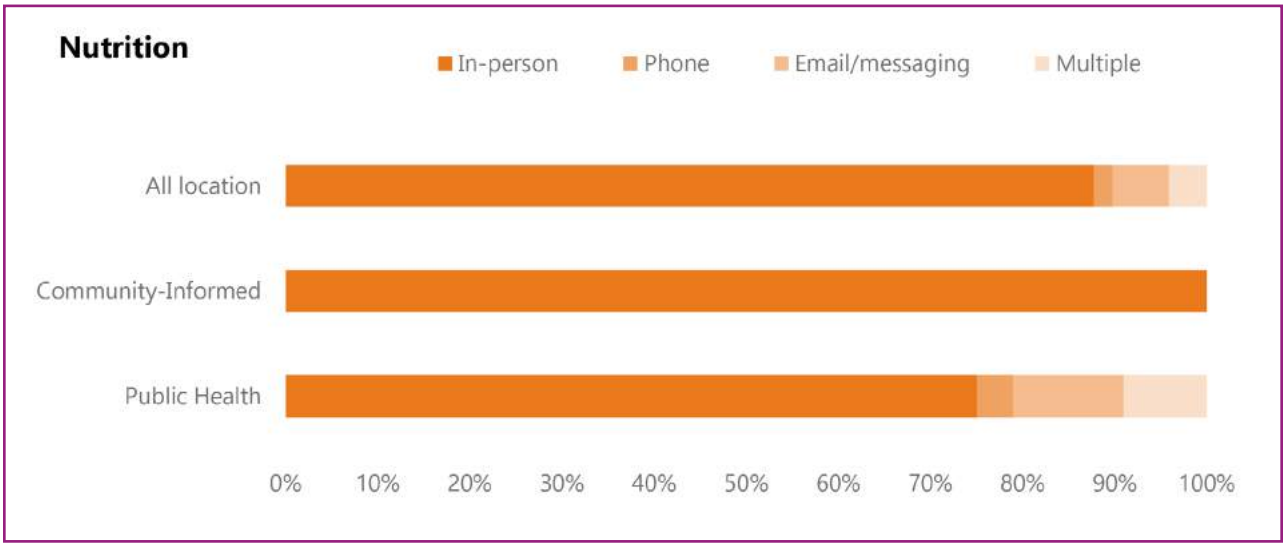
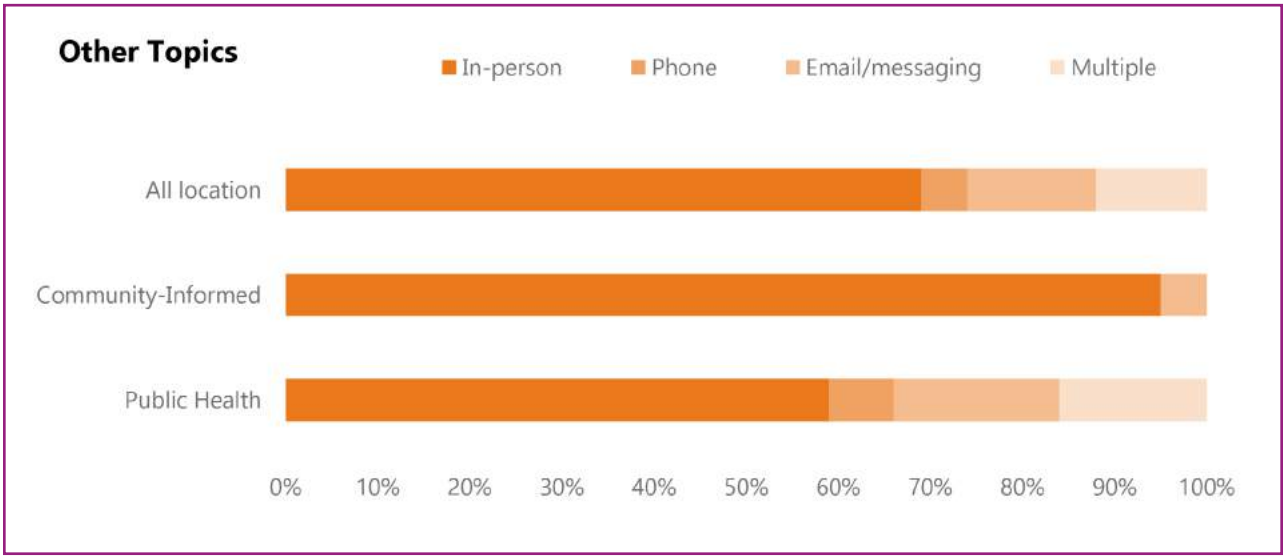


Figure 18: Proportion of other consultation by approach and modality



Providers reported that in-person consultation often included observation and modeling

Among the 15 providers who participated in key informant interviews, all reported receiving individual consultations. Among licensed sites, providers reported that PH consultants met individually with site administrators or had small group meetings with the classroom teaching team and site administrator. Individual consultations took place at the licensed center or family home. Many providers said that the consultant would first observe the child care setting and child(ren) and then discuss observations and care strategies with the provider(s) and/or administrator.

Regardless of consultation approach, providers reported that the consultant taught them a new skill through modeling, including developing a script for difficult conversations with families, demonstrations on how to use sensory tools in the classroom, modeling how to wash children's hands, techniques for playtime, and what to do when a child had a behavioral issue.

> ***[The consultant] would model a conversation — when the child does this or says this — she would script it for us. Because she had been in the classroom, she knew exactly what has happening and the challenges that child was having. She would say, "Try this or try saying that" and would model the language or script.***
>
> —Licensed center provider, public health approach

Providers attended group trainings to learn from one another in a community setting

Between March and December 2019, 1,299 providers from 247 child care sites attended at least one group training. Of the 85 trainings, 42% were facilitated by CI consultants, and 58% were facilitated by PH consultants. On average, more participants attended trainings facilitated by PH consultants than CI consultants (18 vs. 13 participants per training). Multiple sites were represented during each training, with more sites attending trainings facilitated by CI consultants than PH consultants (7 vs. 3 sites). In addition, compared to trainings facilitated by PH consultants, trainings facilitated by CI consultants were longer (3.5 vs 2 hours) (Table 15).

Table 15: Number of group trainings and average numbers and length of time per training

	All Sites	Community-Informed	Public Health
Number of group trainings	85	36	49
Average number of participants per training	16	13	18
Average number of sites per training	4	7	3
Average time per training (minutes)	166	218	128

Group trainings covered a variety of subtopics and primarily focused on 14 subtopics (Table 16).

Table 16: Proportion of group trainings by subtopic and consultation approach†

	All Sites %	Community-Informed %	Public Health %
Growth and development			
Brain development & milestones	5	7	4
Developmental screening	16	6	22
Language development	4	7	2
Mental/behavioral health	28	7	41
Health and safety			
Environmental safety	3	7	-
Handwashing, diapering, toileting	1	-	2
Health & safety assessment	1	3	-
Medication management	4	7	2
Nutrition	4	10	-
Other topics			
Child-to-caregiver relationship	1	-	2
Children with special needs	3	-	4
Community resources and referrals	1	3	-
Family engagement and interaction	17	41	2
Staff/Caregiver health and wellness	6	-	10

† Topics not represented in this table were not recorded as topics covered during group trainings (example: nutrition was not recorded as a topic of group training)

Among the 15 providers who participated in key informant interviews, 10 attended at least one group training. Providers from licensed sites who received PH consultation most often attended a training that took place located at their site and covered a topic tailored to their needs (e.g., sanitation and hygiene, Ages & Stages Questionnaire® (ASQ®), creative ideas for circle time).

Providers from licensed family homes and FFN providers who received CI consultation attended group trainings at CCHC grantees' offices. Group trainings were delivered in the providers' primary language or with interpretation services. Trainings covered topics such as business set-up and licensing, description of the WAC, CPR and first aid, food handling, and management of behavioral issues. Trainings for FFN providers also included topics such as how the public school system works. FFN providers said it was extremely helpful to hear about each other's challenges, because, when they experienced those challenges, they would have the tools to address those issues. In addition, they noted that they especially appreciated the opportunity to learn that other providers were struggling with similar child care issues, connect, and share strategies.

I often attend meetings, because I like to communicate with other families to get more information…the child in my care has a speech delay. I can communicate with other families and see that other children might have a delay as well and can discuss and support each other.

—FFN provider,
community-informed approach

WHAT ARE FACILITATORS AND BARRIERS TO IMPLEMENTATION OF CCHC?

The 15 providers who participated in key informant interviews discussed strategies that consultants used to facilitate learning. In addition, they reflected on barriers to learning and implementation of skills/practices.

Overview

- Most providers appreciated the quantity and quality of their engagement with their consultant, while a few wished for more frequent and focused engagement opportunities
- Most providers found consultants culturally and linguistically responsive
- Providers appreciated the range of consultation topics covered and consultants' depth of knowledge of topics
- Consultants exhibited strong interpersonal skills when working with providers, children, and families
- Some consultants facilitated information-sharing among providers and sites

Most providers appreciated the quantity and quality of their engagement with their consultant, while a few wished for more frequent and focused engagement opportunities

Most providers reported that regular engagement with their consultant facilitated learning. Providers noted that consultants built positive relationships through active communication and regular meetings. They appreciated that consultants actively reached out to arrange meetings and sent meeting reminders. Providers said that consultants were very mindful of their schedules, including not disturbing teachers' planning time, and were flexible with meeting time.

[The consultant] was available. She was always offering. She would take the initiative to schedule a meeting, because we were so busy and understaffed. She was very prompt with correspondence and eager to meet with us.

—Licensed site administrator, public health approach

When providers had a question or request outside of a scheduled meeting, they indicated that consultants were responsive.

Whenever I have concern, we get answered right away. I didn't get the ASQ right away in the group training, so they came [to my house] two more times to explain it until I got it right.

—Licensed family home provider, community-informed approach

Providers said that consultants often communicated outside of the arranged individual consultations and group trainings via text, e-mail, and phone. One provider said that she called her consultant three to four times per week. When there was a last-minute request or problem, providers reported that consultants were available for support.

There was a time that my state licensing person e-mailed me a form and told me to turn it in as soon as possible. I came [to the consultant] and asked them to help me with it, and they filled it out and sent it right away. That was my happiest day.

—Licensed family home provider, community-informed approach

A few providers shared challenges with consultation. Two providers reported that they had challenges with group trainings. One provider reported that they were often unable to attend group trainings, because the trainings very quickly reached capacity, and another provider said that trainings stopped and were not offered for a couple of months. One licensed family home provider found it challenging to fully engage with the consultant when they met at her home because of the demands of the children in her care. Some providers in licensed sites mentioned the desire to have a consultant work with each of their classrooms. Other providers wished the consultants would meet with them more often, indicating that weekly vs. biweekly or monthly visits would be helpful.

Consultants who participated in focus group discussions felt that the positive relationships they built with providers, site administrators, and teaching teams were the greatest indicator of their success in providing CCHC services.

We come in as a facilitator, instead of as an expert or consultant. If you throw out numbers or percentages to teachers, not helpful. Instead, come in as a facilitator.

—Consultant, public health approach

Consultants who work with providers who recently immigrated to the U.S. stressed that, in order to build relationship, they had to consider and understand the providers' cultural background. They indicated that they may need to alter how they approach topics in discussions with providers and families.

Consultants said that they created partnerships through individualized coaching and modeling and followed up to discuss implementation of new practices and results. When facilitating group trainings, consultants noted that they worked to build a community of support among all those in attendance. Consultants reported that they also supported building the provider's relationship with the children in their care and with families. Some consultants noted that it was difficult to gain providers' trust, but that meeting over time helped facilitate a trusting relationship.

Most providers found consultants culturally and linguistically responsive

Among providers who participated in key informant interviews, over half who worked with CI consultants reported that what they learned was culturally and linguistically accessible and relevant. Providers who participated in group trainings said that trainings were in their primary language and that interpretation services were available.

> ***I understood [the lesson] perfectly, I understood the whole idea, and, if I didn't get it, I would ask [the interpreter] to repeat it and they would help with that.***
>
> —Licensed family home provider, community-informed approach

Many CI consultants were from the same communities as the providers with whom they worked, and providers indicated that they explained complex consultation topics (e.g., child development, special needs) in a culturally accessible manner. FFN providers noted that consultants encouraged them to teach children about their culture and primary language through play and story time.

Three providers—two who received PH consultation and one who received CI consultation—said that their consultants did not have the necessary cultural and linguistic skills. One provider described challenges with the ASQ® and what might have been helpful for the consultant to share.

> ***Seeing that [the consultant] has eyes on the metrics they're using, [that they] are as culturally responsive as possible, is something I haven't seen articulated and would like to see articulated, so we can talk to our staff about why we are choosing to use this biased tool.***
>
> —Partial day provider, public health approach

A licensed family home provider whose primary language was not English, but worked with an English-speaking consultant, expressed that they would have preferred interpretation services for more complicated concepts, including those related to licensing, WAC, and the ASQ®. A provider who received interpretation services at a group training reported that they were not able to fully understand the training content, because the interpretation was word-for-word, making it challenging to understand certain concepts. Another provider described the cultural challenge of navigating a conversation related to potentially undiagnosed developmental delays.

> ***[The script provided] was something we cannot do culturally….There's no way I can go to this family and say, "I want to talk to you about this issue about your son or your daughter." In our culture, that is mean. You need to do it slowly, every day some example…. So, it's very hard to tell parents that their child should go to a specialist, because it's a very sensitive topic.***
>
> —Licensed family home provider, community-informed approach

In addition, consultants who participated in focus group discussions highlighted challenges related to cultural and linguistic accessibility (e.g., resources and referral processes in English). Consultants said that the ASQ® was particularly challenging, because the ASQ® and process of developmental screening are not culturally or linguistically accessible.

When the child is born in U.S. and the provider is raised back in their native country, providers find the food, activities, language to all be challenging to adjust to. The cultural paradigm is so different that it's challenging to translate culturally. Example is the ASQ/developmental screening – it does not occur to the provider to screen when the child is a baby. It's very unheard of, so we need to step back the discussion to development knowledge and understanding of purpose to ensure the provider culturally understands developmental screening.

—Consultant,
community-informed approach

Providers appreciated the range of consultation topics covered and consultants' depth of knowledge of topics

Regardless of consultation approach, nearly two-thirds of providers who participated in key informant interviews appreciated the breadth of topics covered in individual consultations and group trainings. These providers said that the consultant addressed every topic that they wanted to cover in their time together and provided resolutions to issues that the providers had not identified. Providers said that consultants were extremely knowledgeable about the topics covered.

Consultants exhibited strong interpersonal skills when working with providers, children, and families

Providers shared how their consultant's interpersonal skills—coming from a place of empathy, creating positive relationships and building community, being easy to understand, listening actively, being passionate, and being friendly and patient—facilitated relationship and learning.

The consultants come from a place of empathy and not wanting to create an additional burden by being there, an extra pressure….They come to help. There's no judgement. It has felt like a partnership where their suggestions really honor the values and realities of our program.

—Partial day provider,
public health approach

Some consultants facilitated information-sharing among providers and sites

Three providers—two who received CI consultation and one who received PH consultation–described the value of sharing information among other providers in group trainings. Licensed family home providers appreciated the opportunity to meet and talk with other providers.

One person may have a concern, and the teacher gives us all answers back, so it is very resourceful for us, because we learn how to deal with situations before they may have happened to us.

—Licensed family home provider,
community-informed approach

One licensed site administrator noted the challenge of sharing information from their consultant with all classrooms in the site.

HOW DO CORE PROGRAMMATIC ELEMENTS OF CCHC AND THE UNIQUE PROGRAMMATIC ELEMENTS OF THE PUBLIC HEALTH AND COMMUNITY-INFORMED PILOT APPROACHES CONTRIBUTE TO CHILD CARE PROVIDER OUTCOMES?

Between July 2018 and December 2019, 164 providers from 129 child care sites that received CCHC services completed the child care provider survey (35% response rate). In addition, 15 providers participated in key informant interviews, sharing their perceptions of and experiences with CCHC services.

Of those who responded to the child care provider survey, 44% were licensed center providers. Nearly one-third (32%) were family home providers, and a little less than one-quarter (22%) were FFN providers. Nearly all (99%) providers who received CI consultation worked in FFN and family home settings, while most (88%) providers who received PH consultation worked in licensed centers. The majority (69%) completed the survey in English, and almost three-quarters (70%) were actively receiving CCHC services. Among providers working in licensed settings, about half (52%) were lead teachers/caregivers. Most FFN providers (81%) were the grandparents of the child(ren) in their care (Table 17).

Table 17. Characteristics of providers completing the child care provider survey

	All Respondents %	Community-Informed %	Public Health %
Provider type (n=164)			
Family, Friend, and Neighbor	22	43	0
Family Home	32	56	6
Licensed Child Care Center	44	1	89
Partial Day Provider	2	0	5
Language in which survey was completed (n=164)			
Amharic	1	3	0
Arabic	1	1	0
Chinese	9	18	0
English	69	43	97
Oromo	1	1	0
Somali	17	33	0
Spanish	2	1	3
Actively receiving CCHC services (n=164)†			
Yes	70	81	59
No	30	19	41
Primary role—licensed (n=128)			
Lead teacher/caregiver	52	75	39
Assistant teacher/caregiver	5	2	6
Site administrator	43	23	55
Relationship to child—FFN (n=36)			
Grandparent	81	81	0
Other immediate family	14	14	0
Family friend	5	5	0

† Actively receiving services means that the child care provider was currently engaged with a consultant at the time of the survey

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASING CHILD CARE PROVIDERS' KNOWLEDGE AND USE OF SUPPORTS AND RESOURCES?

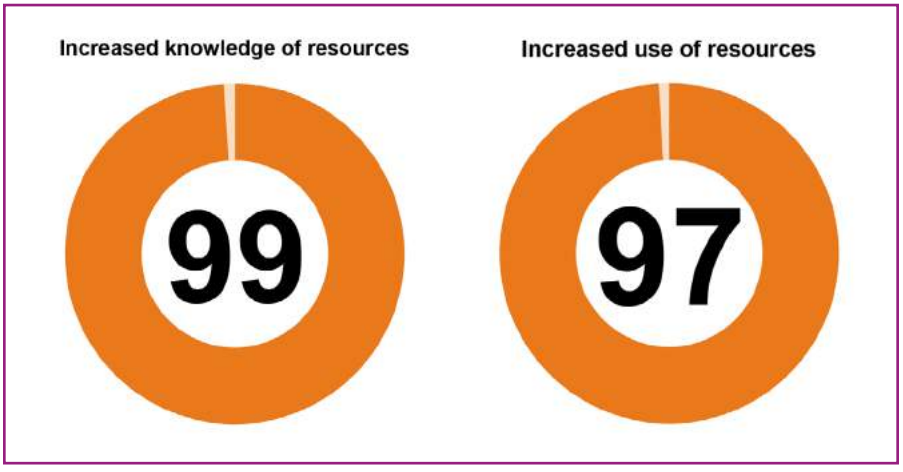
Overview

- Providers increased their knowledge of available resources and said they will more frequently access resources as a result of CCHC
- Providers connected children and families to resources and provided referrals that supported children's development

Providers increased their knowledge of available resources and said they will more frequently access resources as a result of CCHC

Nearly all (99%) providers who responded to the child care provider survey reported increasing their knowledge of available resources, with no difference between providers receiving consultation from CI and PH consultants. The vast majority (97%) of providers reported that they would more frequently access community resources as a result of CCHC, again with no difference between providers receiving consultation from CI and PH consultants (Figure 19).

Figure 19: Provider knowledge and use of available resources increased as a result of CCHC



Providers connected children and families to resources and provided referrals that supported children's development

Among providers who participated in key informant interviews, almost all reported that they connected children and families to available resources and provided referrals, with support from their consultant. Providers noted that consultants connected them and the families they serve with mental health practitioners, speech therapists, and other specialists who work with children with special needs. For those who received CI consultation, they indicated that consultants assisted them in navigating stigma related to seeking mental health services. Most providers said that they were successful in connecting children and families to a specialist. However, in some cases, families did not agree that a specialist was needed and refused that connection.

We had a child enrolled who we had concerns about, and we thought a social worker could address these concerns. We used the list [of referrals provided by the consultant] as a resource with the family. We connected the family with the social worker. [The] child is now in a class that the [the consultant] is serving. They can talk with the teaching team about have you communicated with the other professional, are parents sharing goals with you.

—Licensed site administrator, public health approach

FFN providers reported that consultants connected them to community resources (e.g., library reading groups, community center play and learn activities). For providers who cared for one child, consultants encouraged these types of activities, to allow the child to interact with other children.

[The consultant] let us know that, on Wednesdays at the local library, they have activities for younger kids, story time, so there are other kids that go there, too. We also go to the community center on Tuesdays and Thursdays. In the gym, they have activities to play and interact.

—FFN provider, community-informed approach

More than half of the providers—four who received PH consultation and four who received CI consultation—shared how their consultant informed them about and assisted in connecting a child and family to needed resources. For example, providers commented that consultants assisted them in determining which referral was most appropriate for the child and family and supported providers in making that connection. They also shared a list of various resources with the providers, so they would be prepared with that information in the future.

I learned about referrals from [the consultant]. Before, I didn't have time for all that. Now, I have a board in my place where I stick all the resources that I find out. Sometimes, I have to call to do a referral. If there is a family with the developmental delay, I call the resource and made an appointment for them.

—Licensed family home provider, community-informed approach

Providers who received PH consultation said that consultants supported them in connecting children and families to specialists, including occupational therapists and social workers, to assist with developmental delays and acute behavioral issues. Across consultation approaches, providers indicated that consultants connected families with speech therapists to assist children with delayed speech development.

This child was 5 years old and had never been in a socialization program, so we started with a speech referral. His parent had zero idea that there was help. They were very receptive and open to having help.

—Partial day provider, public health approach

Providers who received CI consultation said that consultants supported them and the families they serve, particularly those who recently immigrated to the U.S., navigate systems and services (e.g., SNAP benefits, medical appointments, public transit system). In some cases, FFN providers reported that consultants helped them navigate the medical system and connect the children in their care with appropriate health care professionals.

We listened to [the consultant's] suggestion and took him to the clinic for an allergy test....His skin has been improving, since working with [the consultant] and going to the doctor.

—FFN provider,
community-informed approach

Providers indicated that families generally agreed to engage with specialists and that children have benefited from that engagement.

We ended up introducing the family of a child with behavior issues in the classroom and at home to [the grantee] parent interaction program via [the consultant's] suggestion. Worked out really well, child is doing well, really flipped for the child and the behavior, and the family was really supportive with the process.

—Licensed site administrator,
public health approach

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER KNOWLEDGE OF AND ABILITY TO USE CONSULTATION AND TRAINING TOPICS?

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER KNOWLEDGE OF CONSULTATION AND TRAINING TOPICS?

To comprehensively represent how child care providers increased knowledge and skills of consultation and training topics, the following sections include quantitative findings from the child care provider survey and qualitative findings from key informant interviews with providers and focus groups with child care health consultants. Additional information is included in Appendix G.

Overview

- Providers most often discussed topics related to growth and development, child behavior, and health and safety with their consultants
- Providers increased their knowledge about consultation topics and community resources, and most providers who received CI consultation reported increased ability to identify or use developmentally appropriate activities

Providers most often discussed topics related to growth and development, child behavior, and health and safety with their consultants

In the child care provider survey, providers identified the topics they covered with their consultant. Over three-quarters (77%) of respondents discussed growth and development. Over half of all providers also reported discussing health and safety (62%), child behavior (66%), and community resources and referrals (55%) with their consultant (Table 18).

Table 18. Consultation topics covered by consultation approach

	All Respondents (n=164) %	Community-Informed (n=84) %	Public Health (n=80) %
Growth and development	77	83	71
Health and safety†	62	76	46
Child behavior	66	54	79
Family engagement and interaction (licensed only)	34	30	39
Child/parent to provider relationship (FFN only)	16	32	0
Community resources and referrals	55	70	41

† Includes nutrition

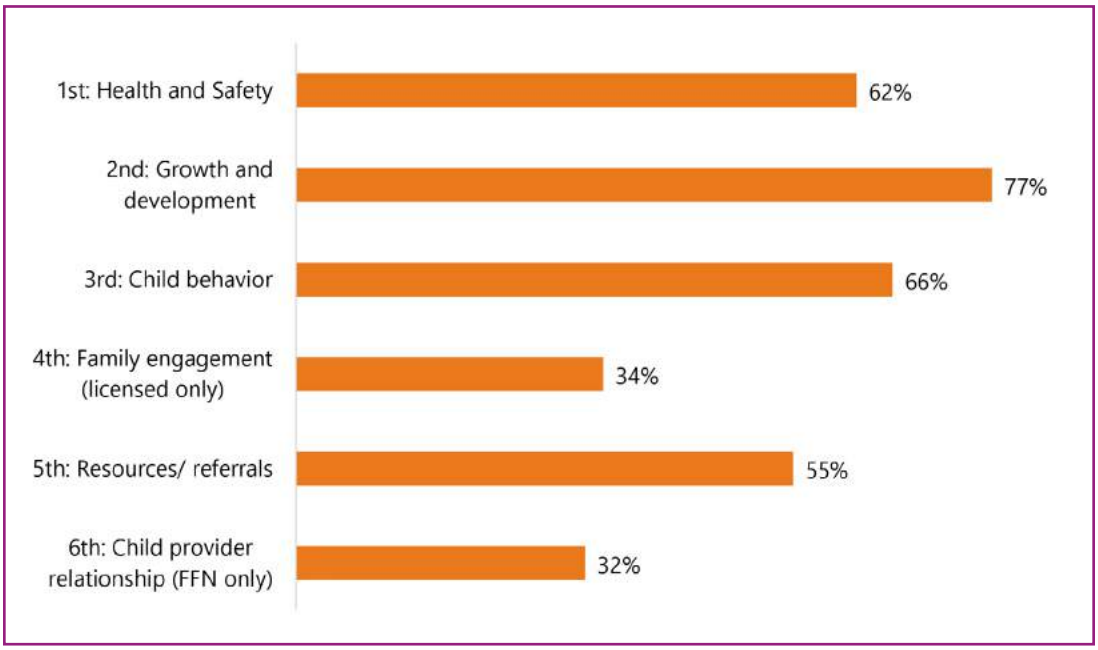
Providers ranked the usefulness of consultation topics. The topics that providers spent the most time covering with their consultant (Table 19) were also ranked the most useful. All providers found discussions about health and safety, growth and development, and child behavior to be the most useful, although in differing orders among providers who received CI and PH consultation (Table 19).

Table 19. Provider ranking of the most useful consultation topics

	All Respondents (n=82)	Community-Informed (n=53)	Public Health (n=29)
First	Health and safety†	Health and safety†	Child behavior
Second	Growth and development	Growth and development	Growth and development
Third	Child behavior	Child behavior	Health and safety†
Fourth	Family engagement (licensed)	Family engagement (licensed)	Family engagement (licensed)
Fifth	Community resources/referrals	Community resources/referrals	Community resources/referrals
Sixth	Child/parent to provider relationship (FFN only)	Child/parent to provider relationship (FFN only)	

† Includes nutrition

Figure 20. Percentage of providers who covered consultation topics with their consultant, ranked by usefulness



Consultants who participated in focus group discussions reported that supporting with child behavior, connecting providers to resources and referrals, and assisting with basic child care needs were most important for providers. They indicated that providers who had a child with challenging behaviors wanted immediate relief and that often meant a change in the child care environment.

A lot of teachers do not have enough experience to understand how much the classroom environment affects the behavior of students. Teachers looking for immediate relief for that problem.

—Consultant,
public health approach

After assisting with changes in the classroom environment to support children, consultants reported that providers sought support in connecting children to outside referrals and resources. Consultants who worked with providers who recently immigrated to the U.S. said that providers often needed interpretation services and basic supplies.

When the providers need resources and are not able to read, the consultants can interpret letters and resources.... Navigation support is most important, especially because so many do not read or write in their native language. Consultants are striving to make sure there is awareness of what is out there available and how to access it.

—Consultant,
community-informed approach

Providers increased their knowledge about consultation topics and community resources, and most providers who received CI consultation reported increased ability to identify or use developmentally appropriate activities

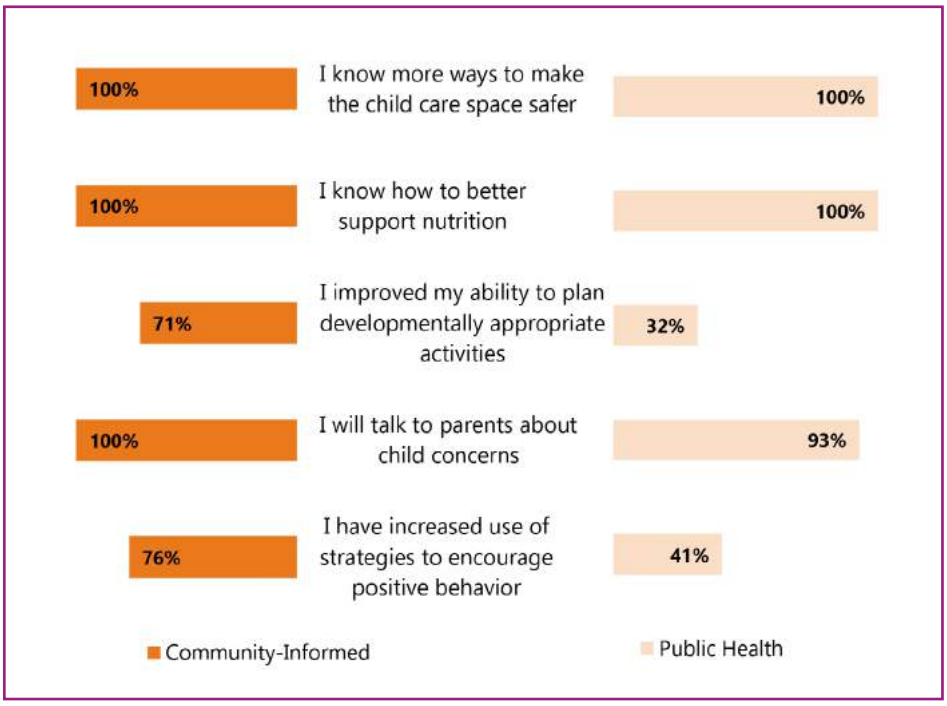
Virtually all providers (99%) who participated in the child care provider survey said that their knowledge about consultation topics and community resources increased, as a result of receiving CCHC services. Eighty-three percent (83%) of providers who received CI consultation reported increased ability to identify or use developmentally appropriate activities vs. only 35% of providers who received PH consultation, with about two-thirds (67%) of providers receiving PH consultation remaining at the same ability level.

Table 20: Reported increase in provider knowledge of and ability to apply consultation topics in daily practice

	All Respondents %	Community-Informed %	Public Health %
Increased knowledge of consultation topics	99	99	99
Increased knowledge of community resources	99	98	100
Improved provider/parent conversations	82	79	87
Increased use of developmental screening tools and resources	91	96	86
Increased ability to identify or use developmentally appropriate activities	61	83	35
Increased ability to enhance health and safety	76	91	51
Increased ability to support child behaviors†	69	82	59

† Includes challenging behavior

Figure 21. Percentage of respondents who agreed or strongly agreed with statements about knowledge and ability



HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER ABILITY TO IMPLEMENT STRATEGIES TO INCREASE THE HEALTH AND SAFETY OF THE CHILD CARE ENVIRONMENT?

Overview

- Providers learned and implemented more ways to make the child care space safer
- Providers learned about how to support better nutrition and used those skills to better support the nutrition of children in their care
- Providers learned how to support children's health, including the need for immunizations and safe sleep practices

Providers learned and implemented more ways to make the child care space safer

All providers who completed the child care provider survey said that they knew more ways to make the child care space safer. Of those, about half (48%) strongly agreed with the statement, with more providers who worked with CI consultants (61%) than those who worked with PH consultants (21%) strongly agreeing.

All providers who participated in key informant interviews reported that they discussed environmental safety with their consultants. Providers indicated that consultants assisted with assessments of and changes in the child care space, including identifying toxins, checking refrigerator and freezer temperatures, removing potential choking hazards, ensuring that electrical outlets were covered, and putting medications in a locked cabinet. Consultants who participated in focus groups noted that providers worked to create safe spaces by putting child locks on cabinets with cleaning supplies and checking for choking hazards within the child care space.

[The consultant] checked the water temperature and that the freezer was the right temperature, arrangement in the fridge where the meats were at the bottom.

—Licensed family home provider, community-informed approach

Providers indicated that they worked with consultants on having written or well-understood health and emergency policies. Over half of providers interviewed who received consultation on the topic reported an increase in knowledge or confidence of emergency policies/procedures for the children in their care.

One of the major things they helped us with is the fire exit. They said we should change it to one window which faces the street.

—Licensed family home provider, community-informed approach

Providers learned about how to support better nutrition and used those skills to better support the nutrition of children in their care

All providers who participated in the child care provider survey agreed that they both learned how to better support the nutrition of the children in their care and used the skills they learned from their consultant to support nutrition. A smaller percentage of providers who worked with PH consultants, as compared to CI consultants, strongly agreed that they learned about and used skills related to nutrition (19% and 11%, respectively). Consultants who worked with licensed sites with cooks taught the cooks about early childhood nutrition. For providers based in their homes, consultants shared easy-to-prepare, nutritious meals.

It's really important to [feed the children food that is] more nutritious, not too fat, not too salty, don't give the kids too much sugar and candy, eat more vegetables.

—FFN provider, community-informed approach

Providers reported that consultants also taught them how to feed children who refused to eat at child care.

When the child says no, put the child at the table and have them do something else…write or draw and put the food next to them and then they will eat it. Because some kids, when they go to different houses, they may not eat, but, if they are distracted and you put the food next to them at the same time, they just eat.

—Licensed family home provider, community-informed approach

Providers learned how to support children's health, including the need for immunizations and safe sleep practices

Half of all providers who participated in key informant interviews said that they talked with their consultant about children's health. Licensed providers indicated that they discussed new immunization requirements in the WACs and were given flyers with this information for families. Licensed family home providers said that they developed policies for how to handle children's illness, and nearly all FFN providers (96%) who received consultation in health and safety reported that the children in their care were up-to-date on their vaccinations. FFN providers commented on how consultants assisted them in navigating the health care process, including setting up appointments for the children and assisting with medication administration.

My elder grandson has an allergy…. [The consultant] helped write down what he is allergic to…grass, flowers…animal fur. [The consultant] tried to find out why he has the allergy and suggested to see a doctor….So, we took him to the clinic to do the allergy test to find out what [he is allergic to].

—FFN provider, community-informed approach

Consultants who supported FFN providers agreed that providers were better prepared for emergencies, as a result of receiving CCHC services.

One provider had never been to any type of training or certificate before and attended CPR/first aid training and was so excited to have the skills. They hoped to never need to use the skills, but was so happy and excited to know and feel confident that, if needed, they could save someone's life.

—Consultant, community-informed approach

Two providers who participated in key informant interviews said that they implemented safe sleep strategies for the infants in their care. The providers noted that they were giving children bottles in their cribs and laying infants on their sides before receiving consultation, but now lay children on their backs for naps without anything in the crib.

[The consultant] told me to stop feeding milk when the child is sleeping. We used to put a small cup with the child in bed. They say not to do this, because the child can choke on the milk….Additionally, the pillow should not be fabric, because they can grab it and choke themselves.

—Licensed family home provider, community-informed approach

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER ABILITY TO IMPROVE PROVIDER/PARENT CONVERSATIONS?

Overview

- Consultants shared strategies and tools to increase provider engagement with families, resulting in a partnership between families and providers to support children's development
- Providers learned how to effectively navigate and engage in conversations with families about potential developmental delays
- Providers created stronger relationships with families through increased, purposeful communication

Consultants shared strategies and tools to increase provider engagement with families, resulting in a partnership between families and providers to support children's development

All providers who received CI consultation and nearly all (93%) providers who received PH consultation agreed or strongly agreed that they will talk to parents and caregivers about concerns with children in their care. Since working with their consultant, over half (54%) of providers noted that they increased the frequency of communication with parents and caregivers.

Providers learned how to effectively navigate and engage in conversations with families about potential developmental delays

Twelve (12) of the fifteen (15) providers who participated in key informant interviews discussed how their consultant supported communication with families. Providers were interested in learning how to effectively navigate and engage in conversations with families, including about potential developmental delays. Five providers interviewed learned to use the ASQ® as a tool to start these conversation with families.

> ***Before…we would tell the families we had concerns [about the child's development], but families would say, "Maybe [my child has difficulties because of] the teacher and their style". [The ASQ is a] tool that helps the families participate in the process. It gives them something that is organized with a purpose that is designed to be supportive.***
>
> —Licensed site administrator, public health approach

Consultants helped providers build partnerships with families in these conversations, so they could be a team in supporting the child,

> ***[Providers] approach the conversation as "Parents – help me get more information", instead of the provider saying there is something wrong with their kid and deal with the potential response….Consultants are both providing concrete tools to have the conversation, but also some self-efficacy and confidence building… [providers say] it's validating that they know what they're seeing and giving little guidelines that backs what they're seeing. "I hear what you say. Here is the resource, here is the benchmark for speech development and sounds."***
>
> —Consultant, public health approach

Communication about potential developmental delays was especially challenging for providers who worked with families who recently immigrated to the U.S., due to stigma related to developmental delays. Consultants who worked with these providers helped them have these conversations in a culturally accessible way.

FFN have problems with stigma surround special ed from their home country – need to tell them that, here, government and schools are supportive and need to get support instead of waiting. Providers have a paradigm shift – need consultants to have a good relationship with the families, we're able to care for the child.

—Consultant,
community-informed approach

Providers used the ASQ® and had supportive conversations with families to share that their child may need additional support to be successful.

I shared [the ASQ results] with [the child's] mother. She was not satisfied. She didn't believe what I was talking about, so I scheduled a time for the mom, the child, and me to sit down and fill out the ASQ together. Then, the mother agreed with me that there was a potential developmental delay.

—Licensed family home provider,
community-informed approach

One FFN provider discussed how their consultant helped them approach these conversations in a culturally accessible manner. The provider said that she believed a child in her care had Down Syndrome. The family did not accept this possibility because of stigma related to Down Syndrome. After additional conversations with the provider, including about how support at an early age can help later development, the family agreed to seek supportive services.

Providers created stronger relationships with families through increased, purposeful communication

Consultants reported that they encouraged providers to increase daily conversation and engagement with families. To support these conversations, they provided handouts on topics related to nutrition, immunization, and growth and development. In addition, consultants encouraged providers to share basic daily updates with families, including what and how much the child ate that day and the child's daily activities. Providers said that families enjoyed hearing these updates and that these conversations helped providers and families come together as a team to support children's development.

Before, I was teaching the children by myself, and I was not sharing information with the families. But, since I started engaging with the family, telling them what their child did at day care that day, saying that tonight the parents should work together on some homework to help the child, we feel as though the child's learning has improved…how they hold the pen, how to write words.

—Licensed family home provider,
community-informed approach

Through their work with the consultant, providers indicated that they have improved their relationship with families.

Our overall approach to working with families and being team members with families has improved. We now have resources and processes for things. We… encourage partnership with families. [This has] improved the child's experience in preschool, because they have the buy-in from all of the adults caring for them.

—Partial day administrator, public health approach

FFN providers reported building relationships with children by providing more opportunities for play. Nearly all indicated that they read more with the child in their care and have less TV time. All FFN providers reported that they feel more involved in the child's development with the parent/caregiver. In key informant interviews, two providers said that the consultant's close relationship with the child in their care was a facilitator in the work they did together and that seeing the consultant build that relationship with the child helped the providers build their own relationships with the child.

[The consultant] comes and builds a good relationship with the child. He loves her….[The child] would not listen to me. [The consultant] helped to build up the relationship with the child, so that the child will listen to me.

—FFN provider, community-informed approach

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER ABILITY TO MANAGE CHALLENGING BEHAVIORS?

Overview

- Providers increased their ability to support challenging child behaviors and have become more inclusive of all children in their child care setting
- Since working with the consultant, providers increased their ability to include children throughout the day and are less likely to ask families to leave their care

Providers increased their ability to support challenging child behaviors and have become more inclusive of all children in their child care setting

Providers reported increased ability to support challenging child behaviors, after working with the consultant. Almost all providers (93%) surveyed said that, since working with the consultant, they are better able to support and know who to contact for support with challenging behaviors. More than half (55%) of providers reported increased use of strategies to encourage positive behavior, including 76% of providers who received CI consultation and 41% of providers who received PH consultation. Among licensed providers, 95% indicated increased knowledge of how to prevent challenging behaviors and 44% indicated increased creation of individual child support plans with parents.

Of those who participated in key informant interviews, 10 providers, including six who received PH consultation and four who received CI consultation, said that working with the consultant helped them manage challenging behaviors among the children in their care. Consultants described how they assisted providers in understanding why challenging behaviors were occurring and how to document those behaviors to support conversations with parents. In

general, providers thought that children in their care were seeking more sensory activation when being physical in the classroom or trying to gain additional attention by not following the provider's instructions or being aggressive with their peers. They indicated that consultants gave them strategies to manage these behaviors while the child was in their care and then shared those strategies with families,

The child wouldn't eat, and his dad did not know what to do with that. When I passed on to him what we were doing in the classroom, he was very excited. He used the same strategies for feeding and was very in favor of implementing that tool and helping his son eat more.

—Licensed site provider, public health approach

Providers noted that they used information gathered about challenging behaviors to work with their consultant on developing tools and strategies to manage those behaviors. Across consultation approaches, providers implemented daily routines with visuals to help guide children throughout the school day and manage transitions. They gave children who were physically aggressive or moving, when they should have been still during circle time, additional sensory activities (e.g., playdough or wiggling feet). Providers observed that implementing these strategies mitigated unwanted and harmful physical behaviors, and increased the child's inclusion in the daily activities, and had a positive impact on other children.

He always had playdough or someone could rub his back, wiggle feet — textured feet that wiggle a little bit — good for students where it hard to sit still. [These strategies were] super helpful for a lot of the children [as well].

—Licensed care provider, public health approach

Half of licensed care providers interviewed specifically discussed inclusion of children during circle time. Before working with the consultant, providers reported difficultly with managing challenging behaviors and noted that the consultants provided strategies to encourage all children to take part in the activity.

For children with sensory concerns, coming to sit with a group with children can be challenging. [The consultant] gave tips on how to get kids to join, like giving verbal cues about what is happening and adjusting our expectations on how circle time works.

—Licensed site administrator, public health approach

Half of all providers interviewed, including those who received CI and PH consultation, discussed creating a daily routine for the children in their care. The licensed site administrators and teachers described how creating a clear daily routine with accompanying visuals reduced some behavioral issues among children. Licensed family home and FFN providers said that, before working with the consultant, they would allow the children to do whatever they wanted throughout the day. Now, they have schedules and time for meals and group activities (e.g., coloring, reading, music).

Before, if the child said "I'm hungry", I would go to the fridge and feed them. Now, they have their lunch, they have their snack, and then they have to wait until dinner. From this time to this time, children play, then time is up, and we do painting, then time is up, and we go outside and do outdoor activities.

—Licensed family home provider, community-informed approach

Providers indicated that they learned different scripts to use with children when they were not following direction, giving them positive cues and direction to participate in activities throughout the day with the other children. They indicated that they provided additional focused attention to children who were seeking attention, including increased eye contact and repeating what the child said back to them.

> ***Before, when I have a kid who was misbehaving, I didn't know how to act. But now, they teach me that, if a child misbehaves, the child wants something but doesn't know what to say, I sit with the child and give them strong eye contact and give them time. I ask, "What do you want? What do you need?" I give them the time.***
>
> —Licensed family home provider, community-informed approach

Providers reported that, in turn, these strategies helped them develop positive relationships with children.

> ***[The child] would not listen to us. With [the consultant's help], we learned to build up our relationship with the child, so that the child will listen to us and follow directions.***
>
> —FFN provider, community-informed approach

Since working with the consultant, providers increased their ability to include children throughout the day and are less likely to ask families to leave their care

Since working with their consultants, providers reported increased knowledge and skill in strategies to support children they may have previously asked to seek care at a different location. In the child care provider survey, providers were asked to respond to a series of three statements related to inclusion: 1) I know more ways to prevent and manage challenging behaviors; 2) I am better able to support and respond to challenging behavior(s); 3) I know who to contact to ask for help managing a child's behavior. Almost all providers (97%) improved in one or more area, with 94% improving in two or more areas. Nearly two thirds of providers (63%), including 81% of providers who received PH consultation and 38% of those who received CI consultation, improved in all three areas.

Figure 22: Proportion of providers reporting improved ability to manage challenging behaviors

During the focus group, consultants said that providers called them as a last resort in a crisis with a child who was exhibiting challenging behaviors. Providers who participated in key informant interviews shared the challenges they had with inclusion of all children, before initiating work with their consultant. When working with a child who did not follow directions or was physically harmful to other students and staff, providers would regretfully inform the child's parents that they were unable to provide the care that child needed. Since working with their consultants, providers reported that they gained the tools necessary to manage harmful behaviors and have stopped asking children to leave their care.

I had a child who, whenever he get in the house, he would pull everything on the walls down, and he did this every day for two months. After two months of this behavior, I asked his mom to pull him out. Now, the kids that I work with are way worse than that child, but I know how to calm them and work with them.

—Licensed family home provider, community-informed approach

A few licensed providers said that their sites have always had non-expulsion policies, but they sometimes had children they did not know how to support.

We said that we were going to serve all students, but we didn't know how. We didn't have the capacity in our staffing or budget to have the staff support that we really needed. The family is committed to being here, family loved the program and wanted the child to be there.... So, we said "How do we say 'yes' to this child?" [The consultant] immediately came in, and it was challenging for them, too, but we devised strategies to be inclusive for this child.

—Partial day provider, public health approach

Providers said that consultants gave teaching teams the confidence to try different approaches to manage challenging behaviors. Due to their work with the consultant, providers were able to enroll more children with special needs, and providers have seen success with children who have special needs.

They have more empathy from other students, being able to participate throughout the school day in ways they weren't before, supported throughout the school day. Families feel seen and heard.

Partial day provider,
public health approach

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER ABILITY TO USE DEVELOPMENTAL SCREENING TOOLS AND RESOURCES?

Overview

- Providers gained confidence in and increased use of developmental screening tools
- Providers connected children and families to resources and referrals related to developmental delays and other services

Providers gained confidence in and increased use of developmental screening tools

Almost all (96%) FFN providers surveyed said that, since working with their consultants, they are more aware of developmental screening tools and are more comfortable with an outside organization completing a developmental screening of the children in their care. Since working with the consultant, nearly half (47%) of FFN providers screened a child in their care who had not previously been screened. Most (93%) licensed care providers planned to complete screening more regularly. Among licensed respondents, 57% reported an increase in the percentage of children in care receiving a developmental screening. These respondents also had increased knowledge on where to send families for additional resources and services.

All providers interviewed who received PH consultation and half of providers who received CI consultation discussed undiagnosed developmental delays among children in their care and inclusion of those children with their consultant. Providers said that their consultants taught them about and helped them implement the ASQ® with children in their care and provided guidance on how to adapt their engagement of children with special needs to ensure inclusion throughout the school day.

We do have some children with special needs, both identified and unidentified. [The consultants] are working with teaching teams to provide support in observation of classroom and children. They provide resources, including ideas, strategies, environmental changes, as well as strategies for teacher interaction. They have also provided us for access to other childcare professionals such as speech and occupational therapists.

—Licensed site administrator, public health approach

Providers connected children and families to resources and referrals related to developmental delays and other services

Eight providers—four who received PH consultation and four who received CI consultation—shared how their consultant informed and assisted in connecting a child and family to needed supports and resources. Consultants assisted providers in determining which referral was most appropriate for the child and family and supported providers in making that connection. They also shared a list of various supports and resources with the providers, so they would be prepared with that information in the future.

I learned about referrals from [the consultant]. Before, I didn't have time for all that. Now, I have a board in my place where I stick all the resources that I find out. Sometimes, I have to call to do a referral. If there is a family with the developmental delay, I call the resource and make an appointment for them.

—Licensed family home provider, community-informed approach

Providers who received PH consultation connected children and families in their care to specialists, including occupational therapists and social workers, to assist with developmental delays and acute behavioral issues. Across consultation approaches, consultants connected children with speech therapists to assist with delayed speech development.

This child was 5 years old and had never been in a socialization program, so we started with a speech referral. His parent had zero idea that there was help. They were very receptive and open to having help.

—Partial day provider, public health approach

CI consultants also helped providers and families who were new to the U.S. navigate systems and services (e.g., SNAP benefits, medical appointments, public transit system). In some cases, they helped FFN providers navigate the medical system and connect the children in their care with appropriate health care professionals.

We listened to [the consultant's] suggestion and took him to the clinic for an allergy test....His skin has been improving, since working with [the consultant] and going to the doctor.

—FFN provider, community-informed approach

Providers indicated that families have agreed to engage with specialists, and children have benefitted from that engagement.

We ended up introducing the family of a child with behavior issues in the classroom and at home to [the grantee] parent interaction program via [the consultant's] suggestion. Worked out really well, child is doing well, really flipped for the child and the behavior, and the family was really supportive with the process.

—Licensed site administrator, public health approach

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASED CHILD CARE PROVIDER ABILITY TO PLAN DEVELOPMENTALLY APPROPRIATE ACTIVITIES?

Overview

- Providers learned to identify and use developmentally appropriate activities with the children in their care, resulting in children's increased development and learning
- Consultants facilitated creating supportive environments for well-being and learning

Providers learned to identify and use developmentally appropriate activities with the children in their care, resulting in children's increased development and learning

Providers indicated that consultants worked with them on incorporating developmentally appropriate activities into their daily child care routine. About half (53%) of all providers, including nearly three-quarters (71%) of those who received CI consultation and one-third (32%) of those who received PH consultation, reported improved ability to plan developmentally appropriate activities. Seventy percent (70%) of providers who received CI consultation and 19% of those who received PH consultation indicated that they talked more to children about their feelings. More than half (58%) of FFN providers indicated increased opportunities for children to explore the child care environment.

Consultants observed that, with their support, providers altered the way they take care of children. They noted that providers communicated with children at a developmentally appropriate level, had developmentally appropriate expectations of children, and addressed children's emotions and challenging behaviors in a supportive manner. In addition, they noted that providers did more early childhood learning activities with the children in their care, such as taking children outdoors to explore and learn about the natural environment.

Similarly, in key informant interviews, providers who received CI consultation reported an increase in planning developmentally appropriate activities. Three providers who worked with PH consultants and seven providers who worked with CI consultants noted that they learned to incorporate infant and child learning and development activities throughout the day.

> ***The whole group [of children] will play music, and then, after, we do building block activities…It's organized. It's not just passing the time. While they are here, they are learning something.***
>
> —Licensed family home provider, community-informed approach

Among providers who received CI consultation, this was especially helpful in creating planned activities to do with the children throughout the day.

> ***Before, I didn't know what the kids like or what is helpful for them. Now, I know what helps kids mental development. The kids like it and learn from it also.***
>
> —Licensed family home provider, community-informed approach

Nine providers, including seven providers who received CI consultation, learned about child development and developmental activities for children in their care.

> ***It makes a big difference to begin seeing a child's development through the child's eyes. I think just, initially, we do things through our adult viewpoint. It takes effort to see what the child is seeing, but, when you do that, it brings a lot of understanding.***
>
> —Licensed site provider, public health approach

Providers learned a variety of developmentally appropriate activities such as "serve and return" strategies in an infant room, implementation of visual schedules, and helping children learn how to talk. Six providers who received CI consultation also learned activities to do with the children to help them learn.

[The consultant] will bring a lot of toys to help him develop, also a paper, scissor, and pencil helping him to play. Through teaching him drawing, cutting, and glue, we are teaching him to interact and start talking, that is helpful... I didn't know that, during his age, I should teach him colors. [The consultant] teaching him the color and shape saying, "Oh, it's a square, a red square." Now, he says what each color the square is right away.

—FFN provider,
community-informed approach

One provider said that they tailored her development activities for what the children will need to know when they go to kindergarten,

They told us how to prepare a child for kindergarten They should know coloring, writing ABC, numbers, how to hold a pen. We applied that into the child care... before, I was not focusing on child education. It was too much, because I was not well trained. Now, I learned what school they will go for kindergarten. I will meet with kindergarten teacher to learn what the child needs to know before kindergarten. I prepare the child, so they know all the rules.

—Licensed family home provider,
community-informed approach

Providers say that children are learning quickly and are able to do activities faster than before they started doing them regularly together.

Consultants facilitated creating supportive environments for well-being and learning

Consultants helped providers create physical space to encourage children's development and learning. Almost all providers and consultants discussed how the child care environment can impact children's behavior and well-being.

In one of our classrooms, the cozy space was not meeting the needs of all the kids. They needed a secondary area of the classroom that was less visually stimulating, a quieter more individual experience.

—Licensed site administrator,
public health approach

Consultants who supported licensed family home providers helped create the child care environment in their home, including discussing what furniture, toys, and other supplies needed to both meet the needs of the children and to become licensed. Consultants also encouraged FFN providers to have designated spaces in their homes for various playtime and learning activities, including a reading area, a block area, and a dramatic play area.

I know this is the reading book area. I let the child know, when they want to read the book, go to this area.

—FFN provider,
community-informed approach

Consultants who participated in focus group discussions noted that, to help support children with behavioral issues, providers often added a quiet space and removed punishment spaces, in favor of area to do activities (e.g., reading, dramatic play).

HOW DO CORE AND UNIQUE PROGRAMMATIC ELEMENTS CONTRIBUTE TO INCREASING CHILD CARE PROVIDERS' KNOWLEDGE OF OTHER TOPICS?

Overview

- Consultants supported providers in navigating licensing requirements and in setting up their licensed family home business
- Providers learned how to care for their own health and wellness from consultants

Consultants supported providers in navigating licensing requirements and in setting up their licensed family home business

Two PH consultants reported that they assisted their providers in topics related to the WAC and licensing. Three CI consultants supported providers with the licensing process to start their licensed family home. These consultants supported providers in understanding the process to become licensed, and helped them stay up-to-date with licensing requirements.

> ***[The consultants] helped us get a business license. They shared the website and told us how to fill out the forms. They helped with the state license and the business license.***
>
> —Licensed family home provider, community-informed approach

Consultants also conducted assessments of the licensed family home, checking for environmental hazards and health and safety concerns and helping providers organize files before the licensing agency representative visit.

> ***The DSHS licensing inspector was coming to my house to inspect. The consultant came to my house to help me organize files, because the people from the state... One day, [the consultant] spent 5 hours getting organized and ready.***
>
> —Licensed family home provider, community-informed approach

Providers learned how to care for their own health and wellness from consultants

Two licensed site administrators talked with their consultant about their own health and wellness considerations while caring for children. This included conversations around how to protect their back when changing diapers and what nutritious foods providers should include in their diet. Two CI consultants supported FFN providers with their own chronic disease management.

> ***I have diabetes. If I have any questions [about it], I will ask [the consultant] right away, and, next time we meet, [the consultant] will bring resources... [The consultant] is not only taking care of the kids, she is also taking care of us.***
>
> —FFN provider, community-informed approach

One element that was unique to providers who received CI consultation was the provision of basic child care needs. One provider noted that her consultant gave her health care products necessary to care for children,

> ***Sometimes I can't afford to buy diapers, [the consultant] gives diapers, wipes, and school supplies.***
>
> —FFN provider, community-informed approach

Three licensed care center and two licensed family home providers said that their consultant increased their confidence in providing child care and managing difficult situations. Providers said that they gained the skills and knowledge on how to manage different situations, and are now confident in their ability to apply what they learned in the future.

We now have the resources and knowledge. The providers [the consultant] worked with directly are changed for the better. They are independent and know what to do...don't rely on consultants coming into the classrooms.

—Licensed site administrator, public health approach

WHAT ARE THE IMPACT-RELATED FACILITATORS AND BARRIERS TO IMPLEMENTATION OF CCHC?

Overview

- Providers appreciated the amount and variety of resources they received
- Strategies were easiest for providers to implement when consultants shared all the necessary tools, although providers often faced other challenges to fully implementing strategies
- Some providers said that the skills they learned from consultants were changes to how they historically provided care

Providers appreciated the amount and variety of resources they received

Ten (10) providers said they greatly appreciated the amount and variety of resources they received from their consultants, including websites, handouts, and copies of and consent forms for the ASQ®. Providers noted that they have very little time to conduct research on various topics and appreciated their consultants doing research for them.

[The resources] felt very supportive and easy to use. Tools are quick and accessible...[and match our] approach. [The consultant provides us with] easy handouts that we can take and run with.

—Licensed site provider, public health approach

Providers commented that CI consultants brought different items to help them plan activities, including toys, books, paper, and writing utensils. One even indicated that their consultant gave them a slow cooker and taught them how to use it to cook nutritious lunches. Two providers said that their consultant brought resources to help them manage their own health issues.

Strategies were easiest for providers to implement when consultants shared all the necessary tools, although providers often faced other challenges to fully implementing strategies

Strategies were easiest for providers to implement when the consultants shared all the necessary tools. A consultant helped one licensed family home provider by researching and writing a curriculum.

> ***[The curriculum was] very easy to learn….I didn't have to spend too much time searching. I saved time and money. [The consultant] just opened up the curriculum, and it has helped for nine months.***
>
> —Licensed family home provider, public health approach

In addition, providers found it easy to implement a new skill after it was demonstrated by the consultant (e.g., proper tooth brushing, how to help children follow directions).

Providers noted that, initially, it was challenging to implement strategies, because these strategies often required change and persistence.

> ***Everything is challenging at first, and, with young children, things take multiple, multiple, multiple times to actually see results. The challenging part was having the time and space to actually be persistent with what we were trying.***
>
> —Partial day provider, public health approach

Among those who participated in focus group discussions, consultants indicated that they often face various challenges to fully implementing strategies. For example, licensed care centers experience high staff burnout, due to limitations on paid time off and inadequate breaks, and to turnover, which leads to limited consistency with implementing the skills they have learned from the consultants. In addition, turnover impacts relationship-building with children and their families.

Some providers said that the skills they learned from consultants were changes to how they historically provided care

Five providers who received CI consultation said that the skills their consultants taught them were changes to how they historically provided care.

> ***I never thought that taking care of the kid meant that you should play with him, sing song even though he doesn't talk. You still need to have communication with him through the books and the toys.***
>
> —FFN provider, community-informed approach

As a result of receiving CCHC services, these providers started creating daily routines to support children's development.

One provider learned about safe sleep from their consultant. They said that, in their home country, it was normal practice to put babies to sleep on their sides, often with a bottle of milk. The consultant taught them to put the baby to sleep on their back.

Two providers also discussed changes in how they communicate with families. Previously, they were very hesitant to talk with families about potential developmental delays. As a result of receiving CCHC services, providers indicated that they now talk with parents about potential developmental delays and strategies to set up children for success through community resources and referrals.

DISCUSSION

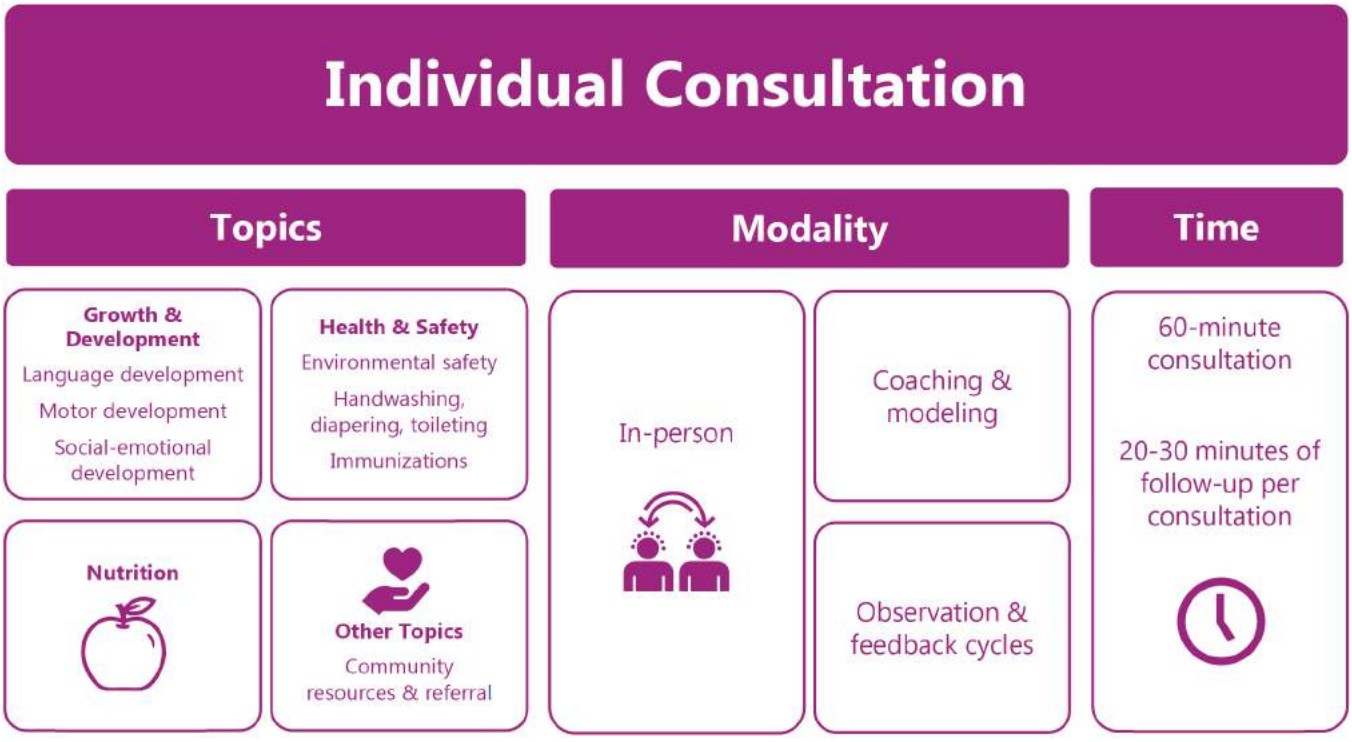
Under the CCHC evaluation, BSK grantees shared a general definition of child care health consultation, while expanding the scope and reach of services to all licensed, unlicensed, and/or informal child care providers with additional focus on culture and geography. From these initial results, common elements of service delivery are emerging, as well as an initial understanding of the broader impact of bringing these approaches under a shared evaluation.

COMMON ELEMENTS OF SERVICE DELIVERY

Common elements among the services provided by the seven CCHC grantees include:

- Subtopics under the four topic areas: 1) growth and development, 2) health and safety, 3) nutrition, and 4) other
- Modality of service delivery
- Time spent on individual consultation and follow up

Common to all service delivery was consultants' high level of: 1) interpersonal skills and empathy, 2) flexibility to meet care providers needs and schedules, and 3) ability to cover a wide range of topics at a significant depth. Group training appeared to have fewer common elements, although group trainings across both approaches had similar numbers of participants.



UNIQUE STRENGTHS—CI AND PH SERVICE DELIVERY

While there are common elements among the services provided by the seven CCHC grantees, there are also unique strengths of the CI and PH consultation approaches. These unique strengths improved consultants' ability to engage child care providers in CCHC services and tailor services to build on providers' current knowledge and skills.

Community-Informed Pilots

A larger number of child care sites received CCHC services through the CI approach, and most sites had one provider and one child, which allowed for meaningful relationship-building. Among CI consultations, the following topics were primary areas of focus:

- Brain development and milestones
- Developmental screening
- Emergency policies and procedures
- Oral health
- Toxics

While family engagement and interaction was not a primary focus of individual consultations, a large proportion of group trainings (41%) covered the topic. Also, FFN and licensed family home providers reported that it was extremely helpful to hear about other providers' challenges and learn from each other in group trainings. Child care providers also noted culturally and linguistically responsive services as a facilitator to receiving and understanding consultation information. Several child care providers who received CI consultation said the skills they learned were changes to how they historically provided care.

Public Health Model

While fewer child care sites received CCHC services through the PH approach, there were more providers at each site and often more than one room at each site with a higher number of children in care than for the CI approach. Among PH consultations, the following topics were primary areas of focus:

- Mental/behavioral health
- Sensory and self-regulation
- Infection/communicable disease prevention
- Physical activity and outdoor time
- Children with special needs
- Classroom curriculum
- Family engagement and interaction

Group trainings focused heavily on mental/behavioral health to increase training related to supporting and keeping children in care, when challenging behaviors arise.

IMPACT OF CCHC

Initial findings from initial evaluation, particularly from the child care provider follow-up survey and key informant interviews, indicate that CCHC services have a positive impact on child care providers across consultation and related to most topics. BSK's investment in bringing seven CCHC grantees with different models and approaches under a com- mon definition of CCHC services is aligned with the Best Starts Equity and Social Justice framework and appears to have advantages in strong service delivery to a wide range of child care providers. In particular, the strength of centering culture and language in service delivery emerged in both the provider follow-up survey as well as the provider key informant interviews. Additionally, two areas of impact emerged across all child care providers:

- Increased ability to manage both current and emerging challenging behaviors, resulting in providers having the confidence and ability to keep children and families in care
- Increased knowledge and use of developmental screening tools and resources

Overall, each of the consultation topics covered also appeared to be areas of positive impact on provider's knowledge and ability.

FUTURE DIRECTION

Initial findings from this evaluation have created a strong foundation for ongoing evaluation of the common elements and unique strengths of the CI and PH approaches. By exploring assumptions related to common elements and unique strengths with CCHC grantees, CEC, and BSK staff, Cardea anticipates that the ongoing evaluation will lead to a better understanding of the core elements of CCHC that can be applied at a broader systems level. Potential areas of exploration include, for example, dosage related to topic trajectories—how many times topics are discussed over what period of time—and assumptions underlying dosage (e.g., if time across consultants/grantees is due to organizational-level policies or due to meeting the need of providers).

Finally, as this evaluation work continues, there are clear intersections with broader systems development work. In 2018, Kindering received funding from BSK to gather partners and generate recommendations on how to develop an accessible system through which anyone offering CCHC services is connected, supported, well-trained, and working together to address unmet needs and alleviate race- and place-based inequities. Cardea has been working with Kindering to ensure that the CCHC evaluation informs and supports the development of the CCHC system and, in particular, considers the common and unique elements, as well as the impacts of CCHC, as critical components of the systems development work.

In 2020, Cardea will work with BSK to disseminate findings from the CCHC evaluation, refining the evaluation questions to build on what was learned through this initial evaluation, continuing to provide TA to BSK CCHC grantees, and working with Kindering to support the ongoing systems development work. The results presented in this report represent year one of a three-year evaluation. As data collection continues and additional questions are added to test underlying assumptions, Cardea anticipates that findings may evolve.

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APPENDIX A. GLOSSARY OF TERMS

GENERAL TERMS

Child care sites: A "site" refers to a single location where child care is provided by any type of provider. A larger child care system may have multiple sites. For this evaluation, each physical location is counted as a unique "site" to account for the unique consultation services provided to child care providers/staff at different locations.

CONSULTATION TOPIC CATEGORIES

Growth and development: CCHC services include information about how children's brains and bodies develop. This could be information about developmental screenings (questions about the child's actions, responses, or ability to complete tasks) or information and suggestions about how children learn, act, respond, or manage their feelings. Growth and development subtopics include:

- Brain development & milestones
- Developmental screening, including how to use the ASQ
- Language development
- Mental/behavioral health
- Motor development – fine and/or gross
- Self-adaptive skills (ability to put on a coat, brush teeth, follow routine)
- Social-emotional development
- Sensory and self-regulation
- Vroom

Health and Safety: CCHC services include information about how to improve the overall health and/or safety of children in care. This could be new ideas for snacks or certain foods, how to store food safely, new ideas for outdoor activities, how to help children use the potty or wash their hands, or ways to change diapers. Health and safety subtopics include:

- Emergency policies and procedures
- Environmental safety
- Handwashing, diapering, toileting
- Health and safety assessment
- Immunization and health records
- Infection/communicable disease prevention
- Medication management
- Oral health
- Physical activity & outdoor time
- Safe sleep
- Toxics

Nutrition: CCHC services include information about food allergy management, breastfeeding/infant feeding, food safety, meal planning, and introducing foods. This could be information on to to safety prepare or store food and beverages, when to serve meals and snacks throughout the day, and how to make healthier snacks and meals, which can include menu reviews.

Other: CCHC services include information on topics that are outside of the other three topic categories, including:

Child-to-caregiver relationship: CCHC services provide information about activities to do while providing child care.

Children with special needs: CCHC services provide information and skill building related to providing care to children with special needs. This could be management of special health care needs and how to support children with special needs in group settings. Services may also increase child care providers' ability to include children with special needs in typical group activities or settings throughout the day.

Classroom curriculum: CCHC services include information about how to structure the day in a group child care setting, including a variety of activities that support the growth, development, and health of children in care.

Community resources and referrals: CCHC services include information and connections to organizations and services outside of the child care setting.

Family engagement and interaction: CCHC services include information about how to share information and resources with parents/caregivers and support in how to have difficult conversations with parents/caregivers.

Staff/Caregiver health and wellness: CCHC services include information about ways that child care providers can support their own health and wellness. This could be mental and physical health support, as well as basic needs for informal child care providers.

CHILD CARE PROVIDER TYPES

Licensed child care center: A child care setting that is licensed to provide care to a large group in a commercial building with multiple rooms. Typically provides child care to a wide age range and employs staff with a range of skills from caring for children to administrative or specialization in certain skills.

Licensed family home: A child care setting that is licensed to provide care to a small or large group in a house.

Partial day provider: A child care setting that provides child care for half of a day. This means the child care site is completely closed to providing child care for at least half of the day. Partial day providers are usually located in community buildings such as religious buildings, community centers, or community organizations and are non-licensed.

Family, Friend, and Neighbor: FFN providers are informal, non-licensed care providers such as an extended family member, a friend, or a neighbor. Care is typically provided to two or less children and never more than the state mandate for becoming a licensed provider.

APPENDIX B. CHILD CARE HEALTH CONSULTATION EVALUATION COMMITTEE (CEC)

In December 2018, Cardea invited key stakeholders to participate in a CCHC evaluation committee (CEC). The CEC was formed to provide ongoing guidance and input throughout the evaluation. CEC members include grantees, experts in early childhood/CCHC, and evaluation professionals. Cardea hosted the CEC kick-off meeting in January 2019. During the meeting, CEC members had the opportunity to get to know each other, and Cardea shared the CCHC evaluation plan with the CEC. Throughout 2019, the CEC met on the first Tuesday of every month and provided ongoing input and support around the following activities:

EVALUATION ACTIVITIES	CEC ROLE
Draft, review, and finalize follow-up survey	Review draft of tool and recommend best practices for survey implementation
Conduct data analysis	Review data analysis plan and provide feedback
Stakeholder review of data and key findings	Respond to data and provide input on findings and interpretation
Qualitative data collection with CCHC grantees and child care providers	Review qualitative data collection instruments
Produce final dissemination products that highlight major findings from the evaluation	Review and respond to products as they are being developed

Cardea greatly appreciates the time put in by the following CEC members to participate in ongoing meetings:

- Anna Freeman – Child Care Health Consultation Systems Development Coordinator – Kindering Center
- Anne McNair, MPH – Social Research Scientist – Public Health—Seattle & King County
- Caitlin Young, BSN, RN – Child Care Consultation Nurse – Encompass Northwest
- Cameron Clark, MPA – Strategic Advisor – City of Seattle Department of Education and Early Learning
- Hueiling Chan, MSW – Program Director & Case Management Clinical Director – Chinese Information Service Center
- Jessica Tollenaar Cafferty, MPA – Program Manager, Best Starts for Kids Child Care Health Consultation – Public Health—Seattle & King County
- Steven Shapiro – Program Manager, Child Care Health Program – Public Health—Seattle & King County

APPENDIX C. METHODS & DATA COLLECTION

Cardea used a mixed methods prospective design. Mixed methods were used to gain a deeper understanding of the evaluation results. Quantitative data were used to describe the components of CCHC service delivery, as well as preliminary understanding of the impact of CCHC services on provider knowledge and skills. In addition, these data provided service-level information about dosage of CCHC services. Qualitative data allowed for deeper insight into provider use and impacts of CCHC services. Mixed methods data better represented the service delivery and preliminary impact of CCHC services than quantitative or qualitative alone.

Cardea identified and developed five, primary, quantitative tools that contain standardized questions across CCHC grantees to collect service delivery and outcomes data: 1) child care provider intake and interest form, 2) CCHC consultation summary form, 3) child care provider follow-up assessment, 4) group training summary form, and 5) post-group training survey. Through an intensive, iterative feedback process, Cardea co-designed the data collection tools with the seven grantees to ensure usability of forms and strong evaluation data quality. Data collection was primarily implemented by grantees and consisted of data collection from providers receiving individual consultation and providers receiving group training. Providers receiving individual consultation were also asked to complete a follow-up survey about satisfaction and impact of CCHC services on knowledge and skills.

Cardea used qualitative methods to gain a richer understanding of the core and unique programmatic elements of the two CCHC approaches, the facilitators and barriers of CCHC implementation, and the impact of CCHC services on children and families. The qualitative evaluation included 15, semi-structured, in-depth key informant interviews with licensed site administrators, licensed site providers, license-exempt administrators, licensed family home providers, and FFN care providers. In addition, Cardea facilitated two focus group discussions with a total of 27 child care health consultants. These conversations contributed to an understanding of the experiences and perceptions of providers and child care health consultants in grantee organizations about CCHC. Cardea facilitated one of the two focus groups with 11 child care health consultants at Public Health—Seattle & King County. Cardea completed key informant interviews and focus groups from September to December 2019.

DATA COLLECTION

DATA SHARING

Cardea set up data sharing agreements with each grantee and a secure electronic system for grantees to submit quantitative and qualitative data for analysis.

During the initial implementation phase (March through May 2019), grantees were asked to submit services data on a monthly basis for Cardea to review and support data quality and to improve the submission process for grantees. Following the implementation phase, grantees were asked to submit services data every three months. Under the data sharing agreements between grantees and BSK and between Cardea and BSK, Public Health—Seattle & King County requested that Cardea share non-identified[1] CCHC individual consultation, group training and provider follow-up survey data files.

1. In this context, non-identified data refers to data that does not include any information that could be used to identify an individual or child care site (e.g., name, date of birth).

QUANTITATIVE

After finalizing the CCHC evaluation plan in December of 2018, Cardea drafted, reviewed, and finalized the data collection process from January to March of 2019. Cardea began the process by creating a matrix of current data collection elements used by CCHC grantees, data collection elements used in the broader field of CCHC, and additional data elements needed to answer the evaluation questions.

DATA COLLECTION TOOL DEVELOPMENT

Using the matrix, Cardea identified and developed five, primary, quantitative tools that contain standardized questions across grantees to collect service delivery and outcomes data: 1) child care provider intake and interest form, 2) CCHC consultation summary form, 3) child care provider follow-up survey, 4) group training summary form, and 5) post-group training survey (Figure 4 and 5).

Figure 4. CCHC Data Collection Tools

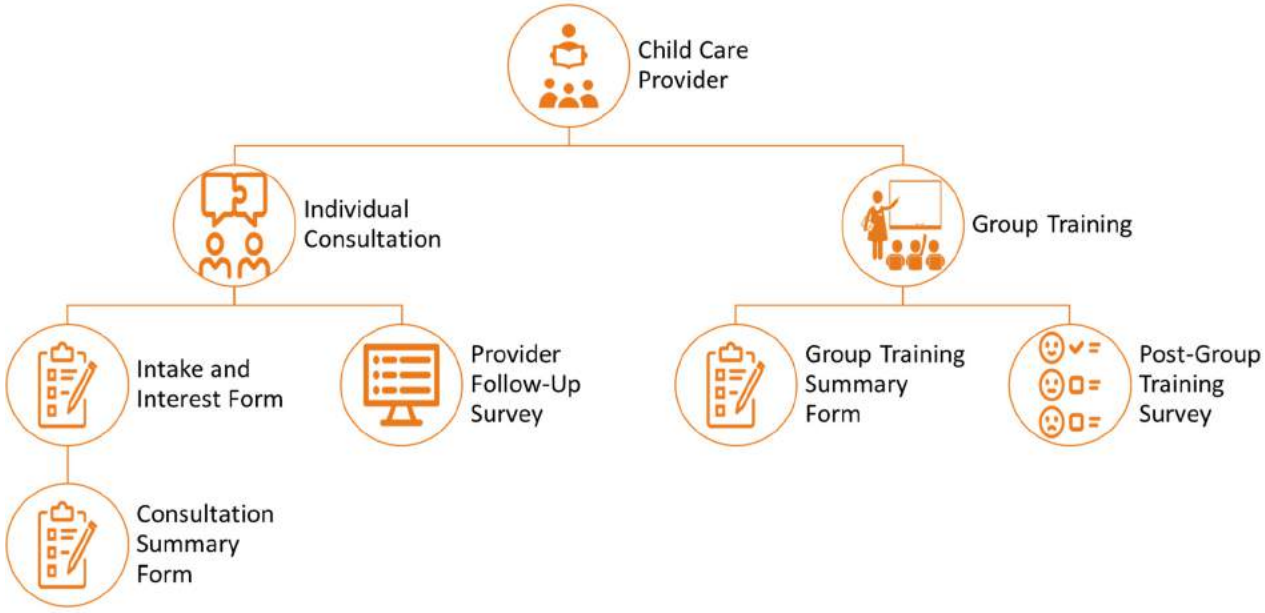
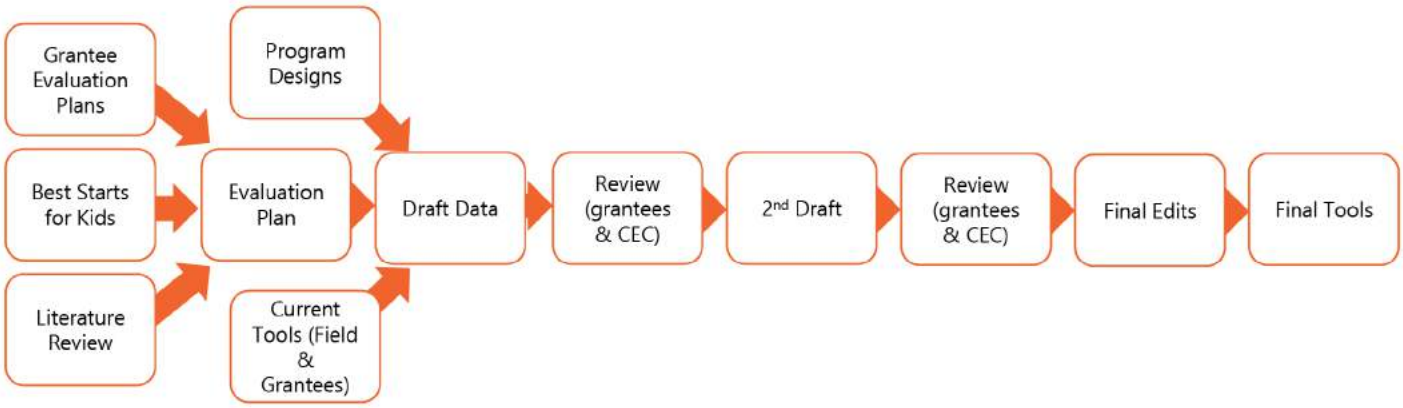


Figure 5: Data Collection Tool Development Process



Data collection tool development included unique versions of all quantitative tools for Family, Friend and Neighbor (FFN) care providers. Cardea reviewed tools with the CCHC grantees and other key stakeholders via eight virtual meetings, lasting 60-90 minutes each, and with the CEC during four, 90-minute meetings. During the virtual meetings, participants reviewed each form in detail and provided feedback on quality of the data elements, wording, response options, and ordering of questions. Cardea then incorporated the feedback into updated drafts that were again reviewed by service provider grantees for final feedback and input. Cardea provided tools to grantees in PDF formats via Dropbox.

DATA COLLECTION TOOL IMPLEMENTATION

In early March 2019, Cardea trained all grantees on the data collection process and tools—intake and interest form, CCHC consultation summary form, group training summary form, and post-group training survey–during a three-hour training. During the training, grantees practiced using the data collection tools and spent time discussing next steps for staff training and implementing the tools within their respective CCHC teams.

Cardea provided extensive post-training support to each grantee through individual technical assistance (TA) sessions, including one-on-one and group drop-in sessions. Through one-on-one sessions, Cardea provided support with data collection implementation and strategies for integrating data collection into current organizational practices. During group drop-in sessions, Cardea and the grantees discussed challenges with the data collection processes. By the end of March 2019, all CCHC grantees were using all individual consultation and group training data collection tools.

Cardea primarily managed the provider follow-up survey process to minimize burden on grantees. Cardea translated the survey into nine languages—Amharic, Arabic, Chinese Simplified, Chinese Traditional, Oromo, Somali, Spanish, Tigrinya, Vietnamese–and built all versions of the survey in Survey-Gizmo. The survey contained logic and dependencies to support an efficient survey experience. A paper version of the survey was also created and translated into all nine languages to support respondents who chose not to complete the online survey. Online survey respondents received a $5 gift card, and paper survey respondents received a $5 gift that they could use with the children in their care as a thank you for participation. In early November 2019, Cardea facilitated a training for grantees and provided recruitment resources—sample e-mail, conversational text, and instructions for using SurveyGizmo and the paper survey—to grantees in early November 2019. The survey remained open through the end of December of 2019, and the response rate was approximately 35%.

DATA COLLECTION EXCEL DATA ENTRY SYSTEM

Grantees entered data collected on all care providers receiving either individual consultation or group training into their respective administrative information systems at the time of service delivery. For grantees that did not have an administrative information system, Cardea created an Excel-based data entry system. The Excel-based data entry system was built over several months to include Visual Basic Macros and cell-based arrays to streamline the data entry process and increase data quality. Post-implementation, Cardea provided TA and ongoing support to manage the use and function of the data entry system.

QUALITATIVE

DATA COLLECTION TOOL DEVELOPMENT

Cardea collected qualitative data using standardized open-ended questions within the five primary tools. Key informant interviews with child care health consultants from grantee organizations and child care providers provided richer understanding of the facilitators and barriers to CCHC implementation and impact of services from the providers' perspective. As with the quantitative tools, Cardea drafted key informant interview guides using the iterative review process described earlier and included a guide with language tailored to FFN care providers. The eval-

uation questions informed the development of the key informant interview and focus group discussion guides. Cardea developed one key informant interview guide for licensed providers and one for FFN care providers. Both interview guides included a core set of content/questions: 1) background, 2) CCHC feedback, 3) CCHC impact, and 4) implementation. The questions in the focus group guide for child care health consultants who were grantee program staff included questions regarding CCHC services, CCHC implementation facilitators and barriers, and CCHC impact. Questions and probes were open-ended to encourage conversation. The interview guides were reviewed twice by grantees and twice by the CEC before finalizing.

DATA COLLECTION IMPLEMENTATION

Cardea completed 15, semi-structured, in-depth key informant interviews with licensed site administrators, licensed site providers, license-exempt administrators, licensed family home providers, and FFN care providers. Cardea provided consent forms to all interviewees in advance of the interviews and obtained consent at the start of each interview. Cardea worked with the seven CCHC grantees to recruit child care providers for key informant interviews. Grantees invited providers to take part in the interviews and shared the name and contact information of interested providers with Cardea. Providers were eligible to be interviewed if they were 18 years or older and were either currently receiving or had previously received individual consultation. To obtain a more representative sample, Cardea interviewed all provider types from all seven grantees. Interviews averaged 49 minutes in length, and Cardea worked with interpreters to complete interviews with eight providers who spoke Arabic, Cantonese, Mandarin, and Somali. Recruitment and interviews took place from August 2019 and ended in January 2020. Providers received a $50 gift card as a thank you for interview participation.

Seven of the 15 key informant interviews were conducted in English via phone. Two interpreters from Open Doors for Multicultural Families provided interpretation for six interviews in Arabic, Cantonese, Mandarin, and Somali. Two interpreters from a grantee organization provided interpretation for the remaining two interviews in Somali. Cardea conducted interviews in-person in a private room most comfortable for the key informant. Locations included the grantee's offices, a library, and the provider's home. Before starting the interview, Cardea completed the informed consent process, and all key informants consented to participate in the interview. Thirteen (13) of the participants consented to being recorded and to including de-identified quotations in the report. Interviews arranged from 25 to 79 minutes, and the interviewer took detailed notes.

In addition, Cardea facilitated two focus groups with child care health consultants from grantee organizations and one focus group with child care health consultants from the Public Health—Seattle & King County Child Care Health Program. Focus groups were completed in September and November 2019. The in-person focus group with grantee child care health consultants had 14 participants and was held in a private room at a Seattle Public Library location. The focus group lasted 70 minutes and was recorded. The virtual focus group with grantee child care health consultants from grantee organizations had two participants and was about 60 minutes long. The focus group with child care health consultants from the Public Health—Seattle & King County child care health program had 11 participants, was 97 minutes and was recorded. During all focus group discussions, a Cardea team member took detailed notes. Lunch was provided as a thank you for in-person participation.

Cardea fully de-identified the transcripts before analysis and stored data and completed consent forms in encrypted databases to ensure participant confidentiality.

DATA ANALYSIS

As outlined in the Goals & Objectives section, the purpose of the CCHC evaluation is to: 1) describe the core programmatic elements and values of CCHC and the unique programmatic elements of the public health and community-informed approaches, 2) identify facilitators and barriers to implementation of the public health and community-informed approaches, and 3) explore how CCHC contributes to child care provider outcomes, including improving parent conversations, increasing provider knowledge of supports and resources, and increasing provider ability to improve the child care environment. The analysis is therefore organized by the overall evaluation questions, recognizing that these questions will continue to be answered as programmatic and evaluative work unfolds.

QUANTITATIVE

Cardea used SPSS to generate descriptive statistics, exploring the core and unique programmatic elements associated with the two approaches to service delivery, and to describe who is receiving CCHC services. Cardea also generated summary statistics to provide an overview of the preliminary impact of CCHC services provided, analyzing survey results between the two approaches, as well as unique breakouts of provider types, where applicable. Data elements, including language, zip code, and provider type, were used to describe the broad reach and impact of CCHC services through the two approaches and through the seven different grantee program models.

QUALITATIVE

Key informant interviews with child care providers and child care health consultants provided an additional layer of context for understanding who is represented in CCHC service delivery, what elements of CCHC have an impact on providers, and facilitators and barriers to implementation of CCHC. Cardea developed a draft codebook, using prior coding structure provided by BSK and with CEC feedback. Using the codebook, two Cardea staff independently coded two interview transcripts to establish intercoder reliability and finalize the codebook and definitions. Cardea applied a thematic approach to the qualitative analysis. Cardea reviewed detailed notes for each key informant interview and focus group and wrote memos on initial observations about themes. Similarly for the focus groups, Cardea reviewed detailed notes and extracted and summarized themes.

To analyze the key informant interview data, Cardea created a draft codebook, using previously obtained memos. The draft codebook was presented to the CEC for additional input and feedback. After incorporating feedback, two coders independently coded a subset of two transcripts, discussed discrepancies in coding, and revised codes and definitions to establish inter-coder reliability. Cardea used NVivo to code the remaining interviews, identify themes, and explore relationships between themes.

LIMITATIONS

CCHC grantees began service delivery before this evaluation was in place, limiting the amount of data available for the first year. As one of several services available to child care providers, it is difficult to isolate the specific effect of CCHC services. In addition, since providers are the primary recipients of CCHC services, this evaluation is focused on provider-level changes vs. child/family-level outcomes and longitudinal changes among children and their families, since those outcomes and changes would be difficult to measure, particularly in one year.

The consistency and quality of data collection varied slightly across grantees, given differences in capacity/infrastructure, program model, and services provided. One result was incomplete data for CCHC services, due to:

1. **Staff turnover**—one grantee lost data on individual consultation services, due to inability to recover all data entered by a former staff member during implementation of a new administrative information system
2. **Challenges in differentiating individual consultations from follow-ups**—one grantee collected individual consultation data each time a consultant made contact with a child care provider, resulting in exclusion of this grantee from some analyses.

Cardea's ongoing TA to grantees has largely resolved these issues for 2020. However, since Cardea does not directly oversee data collection for grantees that have administrative information systems, there may be data quality issues in the future. Cardea will continue to provide TA to mitigate future challenges.

While the evaluation questions and data collection tools were largely informed by grantees, the provider follow-up survey and key informant interview guide were translated, which may have led to differences in the ways in which questions are framed. To minimize differences, a professional service was used to translate materials, and grantees reviewed the tools to ensure that translations maintained meaning and semantics. Professional interpreters with a background in social service provision were contracted to provide interpretation.

Cardea conducted qualitative data collection through key informant interviews and focus groups. Cardea relied on grantees to select providers for key informant interviews to maintain confidentiality and trust between consultants and providers, potentially biasing the sampling of providers toward those who had deeper and more positive experiences with CCHC services. In addition, two interviews were conducted with a consultant as the interpreter, potentially biasing the responses of those providers. However, bias may be reduced, as a result of greater provider comfort.

Finally, there also caution within some communities around accessing public services and sharing personal data, due to the current political climate and new federal public charge rule. Cardea worked closely with the CEC and grantees to structure tools and data collection processes to minimize the impact of community caution around sharing personal data. This limited the level of demographic data collection. Cardea also prioritized developing strong relationships with members of the CEC and CCHC grantees to build trust and continually work toward a set of common goals.

APPENDIX D. SERVICE DELIVERY DATA COLLECTION FORMS

Child Care Health Consultation Intake Form

Family, Friend and Neighbor Caregiver Information

Staff Completing Intake _____ Intake Date ____ / ____ / ____
(m m / d d / y y)

FFN Caregiver Name _____

Street Address _____ Main Phone _____

City _____ Zip Code _____ Main E-mail _____

Caregiver Information	
Relationship to child in care	☐ Grandparent ☐ Aunt/Uncle ☐ Other Extended Family ☐ Family Friend ☐ Neighbor ☐ Other (please specify) _____
Lives with child?	☐ Yes ☐ No ☐ Choose not to answer

If Applicable- Assistant Caregiver Information			
First Name		Last Name	
Phone		Email	

Childcare Information	
Care Frequency	About how many times (days) a month is child care provided? _____days per month
How many children are in care at your site?	
What is the age range of children you provide care for?	
Do you receive a DSHS Working Connections Child Care subsidy?	☐ Yes ☐ No
How did you learn about the program? (check all that apply)	☐ Agency Website ☐ Childcare Resources ☐ Flyer/Brochure ☐ Friends/Word of Mouth/Social Media ☐ Internal Agency Referrals ☐ King County Website ☐ Parent requested consultation ☐ Public Health Nurse ☐ Other (please specify)
What languages do the children speak? (check all that apply)	☐ Amharic ☐ English ☐ Cantonese ☐ Hindi ☐ Japanese ☐ Korean ☐ Mandarin ☐ Oromo ☐ Punjabi ☐ Russian ☐ Somali ☐ Spanish ☐ Tagalog ☐ Taisanese ☐ Tigrinya ☐ Ukrainian ☐ Vietnamese ☐ Other (please specify)
What languages do you speak with the children? (check all that apply)	☐ Amharic ☐ English ☐ Cantonese ☐ Hindi ☐ Japanese ☐ Korean ☐ Mandarin ☐ Oromo ☐ Punjabi ☐ Russian ☐ Somali ☐ Spanish ☐ Tagalog ☐ Taisanese ☐ Tigrinya ☐ Ukrainian ☐ Vietnamese ☐ Other (please specify)
Approximately what percentage of children are children of color?	☐ 0% ☐ 1-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

FFN Intake Page 1 of 1

Child Care Health Consultation FFN Intake Interest Form

Consultant Name _____ Date ____/____/____ (m m d d y y)

FFN First Name _____ FFN Last Name _____

Zip Code _____

Number of years providing childcare? ☐ Less than 1 year ☐ 1 to 5 years ☐ 5 to 10 years ☐ More than 10 years

What is working well for you?	What concerns do you have? What support would you like?

Childcare Practices		
Is there a philosophy and/or curriculum used for providing childcare?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?
Are developmental screening assessments currently completed with children in care?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?
Are there currently any other screenings and/or assessments being completed with children in care?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?

Please discuss provider's interest level in receiving support in the following areas:

Growth and Development	Very interested	A little interested	Need more information	Not interested/ not discussed	Notes
Brain development and milestones	☐	☐	☐	☐	
Developmental screening & early identification	☐	☐	☐	☐	
Mental/behavioral health	☐	☐	☐	☐	
Motor development – fine and/or gross	☐	☐	☐	☐	
Self-adaptive skills (put on coat, brush teeth, follow routine etc)	☐	☐	☐	☐	
Sensory and self-regulation	☐	☐	☐	☐	

Social-emotional development	☐	☐	☐	☐	
Vroom	☐	☐	☐	☐	
Health and Safety	**Very interested**	**A little interested**	**Need more information**	**Not interested/ not discussed**	**Notes**
Emergency policies and procedures	☐	☐	☐	☐	
Environmental safety	☐	☐	☐	☐	
Handwashing, diapering, toileting	☐	☐	☐	☐	
Health and safety assessment	☐	☐	☐	☐	
Immunization and health records	☐	☐	☐	☐	
Infection/communicable disease prevention	☐	☐	☐	☐	
Medication management	☐	☐	☐	☐	
Oral health	☐	☐	☐	☐	
Physical activity & outdoor time	☐	☐	☐	☐	
Safe sleep	☐	☐	☐	☐	
Toxics	☐	☐	☐	☐	
Nutrition					
Allergy management; breastfeeding/infant feeding; food safety; meal planning; menu review; introducing foods	☐	☐	☐	☐	
Other					
Child-caregiver relationship	☐	☐	☐	☐	
Community resources and referrals	☐	☐	☐	☐	
Family engagement and interaction	☐	☐	☐	☐	
Staff/Caregiver health and wellness	☐	☐	☐	☐	
Children with special needs	☐	☐	☐	☐	
Other_____	☐	☐	☐	☐	
Other_____	☐	☐	☐	☐	
Other_____	☐	☐	☐	☐	

FFN Intake Interest Page 2 of 2

Child Care Health Consultation Visit Summary Form

FFN Caregiver Information

Consultant Name _____ Consultation Date __ __/__ __/ __ __
m m d d y y

FFN First Name _____FFN Last Name_____

Site Zip Code _____ Number of caregiver(s) consulted:_____

Activity Format	Activity Type	Length of time in consult
☐ In person ☐ Talking by phone ☐ Written communication (email, text messaging, etc) ☐ Video chat (zoom, facetime, whatsapp, skype, etc)	☐ Standard Consultation ☐ WAC Infant Nurse Consultation ☐ Other (please specify)	Hours_____ ☐15 min ☐30 min ☐45 min **Time spent on follow-up** Hours_____ ☐15 min ☐30 min ☐45 min

Primary content covered during consultation (check 1-3)

Growth and Development
- ☐ Brain development and milestones
- ☐ Developmental screening & early identification
  - ☐ ASQ specific # Children Screened_____ (if applicable)
- ☐ Language development
- ☐ Mental/behavioral health
- ☐ Motor development – fine and/or gross
- ☐ Self-adaptive skills (put on coat, brush teeth, follow routine etc)
- ☐ Sensory and self-regulation
- ☐ Social-emotional development
- ☐ Vroom

Other
- ☐ Child-caregiver relationship
- ☐ Children with special health care needs
- ☐ Classroom curriculum/environment
- ☐ Community resources and referrals
- ☐ Family engagement and interaction
- ☐ Staff/Caregiver health and wellness
- ☐ Other_____

Health and Safety
- ☐ Emergency policies and procedures
- ☐ Environmental safety
- ☐ Handwashing, diapering, toileting
- ☐ Health and safety assessment
- ☐ Immunization and health records
- ☐ Infection/Communicable disease prevention
- ☐ Medication management
- ☐ Oral health
- ☐ Physical activity & outdoor time
- ☐ Safe sleep
- ☐ Toxics

☐ **Nutrition** (allergy management; breastfeeding/infant feeding; food safety; meal planning; menu review; introducing foods)

Additional Comments:

Child Care Health Consultation Visit Observation Summary (Optional)

Content Area	Strengths/ Successes	Areas of Growth/ Goals	Next Steps
☐ Health and Safety ☐ Growth and Development ☐ Nutrition ☐ Other (specify) _____			☐ Consultation ☐ Group Training
☐ Health and Safety ☐ Growth and Development ☐ Nutrition ☐ Other (specify) _____			☐ Consultation ☐ Group Training
☐ Health and Safety ☐ Growth and Development ☐ Nutrition ☐ Other (specify) _____			☐ Consultation ☐ Group Training
☐ Health and Safety ☐ Growth and Development ☐ Nutrition ☐ Other (specify) _____			☐ Consultation ☐ Group Training

Additional Comments:

Child Care Health Consultation Intake Form

Licensed Childcare Site Intake Information

Staff Completing Intake _____ Intake Date ___/___/___ (m m d d y y)

Site Name _____

Site Street Address _____ Main Phone _____

City _____ Zip Code _____ Main Email _____

Type of Provider ☐ Licensed Child Care Center ☐ Licensed Family Home ☐ Partial Day Provider

About the Center/Childcare site		
Care Schedule/Hours	Days of the Week ☐ Monday ☐ Thursday ☐ Saturday ☐ Tuesday ☐ Friday ☐ Sunday ☐ Wednesday	Weekday Hours: ___am/pm to ___am/pm Weekend Hours: ___am/pm to ___am/pm
How many rooms or classrooms do you have onsite?		
How many Caregivers or Teachers are assigned to each room?		
What childcare subsidies do you accept? (check all that apply)	☐ Child Care Assistance Program (CCAP) ☐ DSHS Working Connections Child Care (WCCC) ☐ Early Childhood Education Assistance Program (ECEAP) ☐ Early Head Start/Head Start (EHS/HS) ☐ Seattle Preschool Program (SPP) ☐ Step Ahead (SA) ☐ Do not accept childcare subsidies	
How did you learn about our CCHC services? (check all that apply)	☐ Agency Website ☐ Childcare Resources ☐ Flyer/Brochure/Social Media ☐ Friends/Word of Mouth ☐ Internal Agency Referral ☐ King County Website ☐ Parent requested consultation ☐ Public Health Nurse ☐ External Community Organization ☐ Other (please specify)	

About the Children in Care		
How many children are in care at your site?		
Approximately how many of those children have an Individual Education Plan (IEP)?		☐ Don't Know
Approximately how many of those children have an Individual Family Service Plan (IFSP)?		☐ Don't Know
What is the age range of children you provide care?		
What languages do children and their families speak? (check all that apply)	☐ Amharic ☐ English ☐ Cantonese ☐ Hindi ☐ Japanese ☐ Korean ☐ Mandarin ☐ Oromo ☐ Punjabi ☐ Russian ☐ Somali ☐ Spanish ☐ Tagalog ☐ Taisanese ☐ Tigrinya ☐ Ukrainian ☐ Vietnamese ☐ Other (please specify)	
What languages do providers speak with the children? (check all that apply)	☐ Amharic ☐ English ☐ Cantonese ☐ Hindi ☐ Japanese ☐ Korean ☐ Mandarin ☐ Oromo ☐ Punjabi ☐ Russian ☐ Somali ☐ Spanish ☐ Tagalog ☐ Taisanese ☐ Tigrinya ☐ Ukrainian ☐ Vietnamese ☐ Other (please specify)	
Approximately what percentage of children are children of color?	☐ 0% ☐ 1-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%	

Licensed Child Care Health Consultation Intake Interest Form

Consultant Name ______________________ Date ___/___/___ (m m d d y y)

Site Name ______________________ Site Zip Code ______________

This interest form was conducted with: ☐ Site Administrator ☐ Classroom Providers			
Admin First Name:	Admin Last Name:	Role:	Number of years working in childcare? ☐ Less than 1 year ☐ 5 to 10 years ☐ 1 to 5 years ☐ More than 10 years

Classroom name		Number of children in classroom	Age range of children
Provider First Name	Provider Last Name	Role	Number of years providing childcare?
		☐ Main Teacher/Caregiver ☐ Second Teacher/Caregiver ☐ Support Staff ☐ Other (specify)	☐ Less than 1 year ☐ 5 to 10 years ☐ 1 to 5 years ☐ More than 10 years
		☐ Main Teacher/Caregiver ☐ Second Teacher/Caregiver ☐ Support Staff ☐ Other (specify)	☐ Less than 1 year ☐ 5 to 10 years ☐ 1 to 5 years ☐ More than 10 years
		☐ Main Teacher/Caregiver ☐ Second Teacher/Caregiver ☐ Support Staff ☐ Other (specify)	☐ Less than 1 year ☐ 5 to 10 years ☐ 1 to 5 years ☐ More than 10 years

What is working well for you?	What concerns do you have? What support would you like?

Childcare Practices		
Is there a philosophy and/or curriculum used for providing childcare?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?
Are developmental screening assessments currently completed with children in care?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?
Are there currently any other screenings and/or assessments being completed with children in care?	☐ Yes ☐ No ☐ Don't Know	If yes, which one(s)?

Licensed Provider Intake Interest Page 1 of 2

Please provider's interest level in receiving support in the following areas based on initial conversation:					
Growth and Development	**Very interested**	**A little interested**	**Need more information**	**Not interested/ not discussed**	**Notes**
Brain development and milestones	☐	☐	☐	☐	
Developmental screening & early identification	☐	☐	☐	☐	
Mental/behavioral health	☐	☐	☐	☐	
Motor development – fine and/or gross	☐	☐	☐	☐	
Self-adaptive skills (put on coat, brush teeth, follow routine etc)	☐	☐	☐	☐	
Sensory and self-regulation	☐	☐	☐	☐	
Social-emotional development	☐	☐	☐	☐	
Vroom	☐	☐	☐	☐	
Health and Safety					
Emergency policies and procedures	☐	☐	☐	☐	
Environmental safety	☐	☐	☐	☐	
Handwashing, diapering, toileting	☐	☐	☐	☐	
Health and safety assessment	☐	☐	☐	☐	
Immunization and health records	☐	☐	☐	☐	
Infection/communicable disease prevention	☐	☐	☐	☐	
Medication management	☐	☐	☐	☐	
Oral Health	☐	☐	☐	☐	
Physical activity & outdoor time	☐	☐	☐	☐	
Safe sleep	☐	☐	☐	☐	
Toxics	☐	☐	☐	☐	
Nutrition					
Allergy management; breastfeeding/infant feeding; food safety; meal planning; menu review; introducing foods	☐	☐	☐	☐	
Other					
Child-caregiver relationship	☐	☐	☐	☐	
Children with special needs	☐	☐	☐	☐	
Community resources and referrals	☐	☐	☐	☐	
Family engagement and interaction	☐	☐	☐	☐	
Staff/Caregiver health and wellness	☐	☐	☐	☐	
Other_____	☐	☐	☐	☐	
Other_____	☐	☐	☐	☐	

Child Care Health Consultation Visit Summary Form

Licensed Site/Provider Information

Consultant Name _____ Consultation Date __ __/__ __/ __ __
m m d d y y

Site Name _____ Site Zip Code _____

Classroom name (if applicable) _____

Number of provider(s) consulted: ___ Number of director(s)/administrator(s) consulted _____

Provider/Teacher name(s) _____

Director/Administrator name(s) _____

Activity Format	Activity Type	Length of time in consult
☐ In person ☐ Talking by phone ☐ Written communication (email, text messaging, etc) ☐ Video chat (zoom, facetime, whatsapp, skype, etc)	☐ Standard Consultation ☐ WAC Infant Nurse Consultation ☐ Other (please specify)	Hours_____ ☐15 min ☐30 min ☐45 min **Time spent on follow-up** Hours_____ ☐15 min ☐30 min ☐45 min

Primary content covered during consultation (check 1-3)

Growth and Development
- ☐ Brain development and milestones
- ☐ Developmental screening & early identification
  - ☐ ASQ specific # Children Screened_____ (if applicable)
- ☐ Language development
- ☐ Mental/behavioral health
- ☐ Motor development – fine and/or gross
- ☐ Self-adaptive skills (put on coat, brush teeth, follow routine etc)
- ☐ Sensory and self-regulation
- ☐ Social-emotional development
- ☐ Vroom

Other
- ☐ Child-caregiver relationship
- ☐ Children with special health care needs
- ☐ Classroom curriculum/environment
- ☐ Community resources and referrals
- ☐ Family engagement and interaction
- ☐ Staff/Caregiver health and wellness
- ☐ Other_____

Health and Safety
- ☐ Emergency policies and procedures
- ☐ Environmental safety
- ☐ Handwashing, diapering, toileting
- ☐ Health and safety assessment
- ☐ Immunization and health records
- ☐ Infection/Communicable disease prevention
- ☐ Medication management
- ☐ Oral health
- ☐ Physical activity & outdoor time
- ☐ Safe sleep
- ☐ Toxics

☐ **Nutrition** (allergy management; breastfeeding/infant feeding; food safety; meal planning; menu review; introducing foods)

Additional Comments:

Child Care Health Consultation Visit Observation Summary (Optional)

Content Area	Strengths/ Successes	Areas of Growth/ Goals	Next Steps
☐Health and Safety ☐Growth and Development ☐Nutrition ☐Other (specify) _____			☐Consultation ☐Group Training
☐Health and Safety ☐Growth and Development ☐Nutrition ☐Other (specify) _____			☐Consultation ☐Group Training
☐Health and Safety ☐Growth and Development ☐Nutrition ☐Other (specify) _____			☐Consultation ☐Group Training
☐Health and Safety ☐Growth and Development ☐Nutrition ☐Other (specify) _____			☐Consultation ☐Group Training

Additional Comments:

Child Care Health Consultation Group Training Summary Form

Training Title		Training Date	/ /
			m m d d y y

Name of Trainer(s)	
Length of time training	_____Hours _____Minutes
Training Open to Public? ☐ Yes Zip Code of Training Location_____	

Primary training topic(s) (check 1-3)

Growth and Development
- ☐ Brain development and milestones
- ☐ Developmental screening & early identification
  - ☐ ASQ specific
- ☐ Language development
- ☐ Mental/behavioral health
- ☐ Motor development – fine and/or gross
- ☐ Self-adaptive skills (put on coat, brush teeth, follow routine etc)
- ☐ Social-emotional development
- ☐ Sensory and self-regulation
- ☐ Vroom

Health and Safety
- ☐ Emergency policies and procedures
- ☐ Environmental safety
- ☐ Handwashing, diapering, toileting
- ☐ Health and safety assessment
- ☐ Immunization and health records
- ☐ Infection/Communicable disease prevention
- ☐ Medication management
- ☐ Oral health
- ☐ Physical activity & outdoor time
- ☐ Safe sleep
- ☐ Toxics

Other
- ☐ Child-caregiver relationship
- ☐ Classroom curriculum/environment
- ☐ Community resources and referrals
- ☐ Family engagement and interaction
- ☐ Staff/Caregiver health and wellness
- ☐ Children with special health care needs
- ☐ Other(specify)_____

☐ **Nutrition (a**llergy management; breastfeeding/infant feeding; food safety; meal planning; menu review; introducing foods)

Total number of people attended today's training		**Total Individual Sites Attended Training**	

Notes

Group Training Summary Form Page 1 of 1

Training Title		Training Date			/			/		
			m	m		d	d		y	y

Child Care Health Consultation Post Group Training Survey

Thank you for attending today's training! We hope you liked the training.
Your response to this evaluation will be used to help us improve our trainings and the related resources.
Your answers are confidential.

How satisfied were you with the training? ☐ Very Dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very Satisfied

Please rate each statement		Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
AFTER the training	My understanding of the training content	☐	☐	☐	☐	☐
	My knowledge of informational resources related to the training content	☐	☐	☐	☐	☐

Do you intend to incorporate the skills you practiced/learned during this training into your work? ☐ Yes ☐ No

If yes, describe how you plan to incorporate these skills:	If no, please describe why not:

		Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
BEFORE the training	My understanding of the training content	☐	☐	☐	☐	☐
	My knowledge of informational resources related to the training content	☐	☐	☐	☐	☐

Please rate each statement	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
The training content was culturally relevant to my work	☐	☐	☐	☐
As a result of the training, I can think of ways to improve my work with children and/or families	☐	☐	☐	☐

Additional Comments	
What was most helpful about the training?	What topics are you interested in for future trainings?
What was least helpful about the training?	

(Optional)

How Was Today's Training?				
Please rate the following statements	Strongly Disagree	Disagree	Agree	Strongly Agree
The training built on my knowledge and skills	☐	☐	☐	☐
The trainer used their knowledge, experience, and expertise in ways that improved the training	☐	☐	☐	☐
The trainer provided opportunities for us to practice or apply skills learned in the training	☐	☐	☐	☐
The trainer spoke clearly and used a tone that is warm, respectful and energetic	☐	☐	☐	☐
The trainer used a several teaching methods to address our needs	☐	☐	☐	☐
The training facility was a good place to learn	☐	☐	☐	☐
The training materials (handouts, presentation, videos etc) were helpful	☐	☐	☐	☐

APPENDIX E. FOLLOW-UP SURVEY

Child Care Health Consultation Follow-up Assessment Form
Licensed Providers

King County's Best Starts for Kids is partnering with Cardea Services to evaluate child care health consultation (CCHC). We are sending this survey to you and other child care providers across King County who received CCHC services between May 2018 and September 2019. Your feedback will help us to improve future CCHC services, and also to learn more about the best ways to bring CCHC to more child care providers across King County.

Your participation in this survey is voluntary and confidential; your responses will not be shared with your CCHC consultant. Instead, Cardea evaluation staff will combine your response with responses from other child care providers. No one else who is reviewing the data will know how you responded to this survey. By taking this survey, you agree to allow Cardea to combine your response with responses from other child care providers and share that combined data with CCHC agencies and King County in reports and other types of formats. You can choose to answer some questions and not others. The survey should take approximately 10-20 minutes to complete.

We greatly appreciate your feedback!

1) In what language was this survey completed?*

- ☐ English
- ☐ Arabic
- ☐ Amharic
- ☐ Chinese
- ☐ Oromo
- ☐ Somali
- ☐ Spanish
- ☐ Tigrinya
- ☐ Vietnamese
- ☐ Other (please specify):

Licensed Provider Follow-Up Survey

General Information

2) Which of the following best describes your child care setting? *

☐ **Licensed child care center**: licensed to provide child care in a large group setting that is located in a commercial building with multiple rooms. Typically provides child care to a wide age range and employs staff with a range of skills from caring for children to administrative or specialization.

☐ **Licensed family home**: a licensed home child care that can be a small or large group setting that is located in a house. Can have one or multiple rooms and can provide child care to a range of ages.

☐ **Partial day provider**: child care that is only open to provide child care for half of a day. This means the child care site is completely closed to providing child care for at least half of the day. These types of child care are usually located in community buildings such as religious buildings, community centers or community organizations.

3) Please write your site name and zip code below:*

The collection of site name is to be able to aggregate information and will not be used to provide individual responses back to anyone you have received services from.

Site Name_____

Zip Code_____

4) What is your role?*

☐ Site Administrator

☐ Assistant Teacher/Caregiver

☐ Lead Teacher/Caregiver

☐ Classroom Aid/Support Staff

*5) Are you currently receiving CCHC services?**

☐ Yes → **How many months have you received CCHC services?*** _____
☐ No → **How many months did you receive CCHC services?*** _____

7) On average, how often did you meet with a CCHC consultant? *

☐ More than once a week

☐ Twice a month

☐ Less than once a month

☐ Once a week

☐ Once a month

☐ Do not remember

8) Did you have experience with CCHC *prior* to receiving services from the CCHC consultant?*

☐ Yes → 10) **Please describe your *prior experience* with CCHC.***

☐ No

CCHC Content Areas

Licensed Provider Follow-Up Survey

9) What types of CCHC services did you receive between May 2018 and September 2019? (select all that apply)

☐ **Child care health and safety** Services provided information to improve overall health and/or safety of the child or children in your care. You may have learned new ideas for snacks or certain foods or new ideas for outdoor activities to do. You may also have learned things like how to store food safely, how to help the child wash their hands, or ways to change diapers or help the child use the potty.

☐ **Child development** Services provided information about how children's brains and physical body develop. This could be information about developmental screenings (screenings ask questions about the child's actions, responses, or ability to complete tasks) or information and suggestions about how children learn, act, respond, or manage their feelings.

☐ **Communication with primary caregivers/parents/guardians** Services provided information about how to communicate information and resources to parent(s)/primary caregiver(s). You may also have been provided training/ways to have difficult conversations.

☐ **Managing behaviors** Services provided information about why a child may have bad feelings, challenging behavior or act in a way that is difficult for you to care for.

☐ **Community resources and referrals** Community resources and referrals are information, organizations or services outside of your child care that you learn about through CCHC services.

☐ Other (please specify): ☐

☐ All of the above

---

10) Please rank how useful the following CCHC service topics have been to you:

☐ **Child care health and safety**

☐ **Child development**

☐ **Communication with primary caregivers/parents/guardians**

☐ **Managing behaviors**

☐ **Community resources and referrals**

☐ **Other**

Licensed Provider Follow-Up Survey

Child Care Health and Safety

Child care health and safety consultation means the consultant provided information and ideas for you to improve overall health and/or safety of the child or children in your care. Some examples of you may have learned are new ideas for snacks or certain foods like fruit to feed the child or new ideas for outdoor activities to do. You may also have learned things like how to store food safely, how to help the child wash their hands, or ways to change diapers or help the child use the potty.

11) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more ways to make the childcare space safer	☐	☐	☐	☐	☐
I know more ways to better support the nutrition of children in my care	☐	☐	☐	☐	☐
I am using new ways to support the nutrition of children in my care	☐	☐	☐	☐	☐

Licensed Provider Follow-Up Survey

12) Please indicate your level of agreement with the following statements *NOW* and *BEFORE* CCHC

Now

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I am confident I am implementing safety and emergency policies correctly	☐	☐	☐	☐	☐
I can accurately resolve and update discrepancies in immunization records for the children in my care	☐	☐	☐	☐	☐
Children with special health care needs in my care have comprehensive individualized health care plans	☐	☐	☐	☐	☐

Before CCHC

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I am confident I am implementing safety and emergency policies correctly	☐	☐	☐	☐	☐

Licensed Provider Follow-Up Survey

I can accurately resolve and update discrepancies in immunization records for the children in my care	☐	☐	☐	☐	☐
Children with special health care needs in my care have comprehensive individualized health care plans	☐	☐	☐	☐	☐

13) Please tell us anything else you would like to share about Child Care Health and Safety.

Child Development

Child development consultation means the consultant provided information about how children's brains and physical body develop. This could be information about developmental screenings (screenings ask questions about the child's actions, responses, or ability to complete tasks) or information and suggestions about how children learn, act, respond, or manage their feelings.

14) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more about child development milestones for children in my care	☐	☐	☐	☐	☐
I will more regularly complete a developmental screening tool with	☐	☐	☐	☐	☐

children in my care, such as the Ages and Stages Questionnaire (ASQ)					

15) Please indicate your level of agreement with the following statements NOW and BEFORE CCHC

Now

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I talk to the children in my care about their feelings	☐	☐	☐	☐	☐
I plan activities that are appropriate for the developmental stage of children in my care	☐	☐	☐	☐	☐

Before CCHC

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I talk to the children in my care about their feelings	☐	☐	☐	☐	☐
I plan activities that are appropriate for the developmental stage of children in my care	☐	☐	☐	☐	☐

16) The percent of children that I know have received developmental screening in my care *NOW* and *BEFORE* CCHC:

Developmental screening means that a tool such as the ASQ or similar has been completed with the child. The screening could be completed by you as a child care provider, someone you have on staff, or by an organization such as parent123, WithinReach, etc. This question is NOT asking about early intervention or referral for further evaluation, that will be asked in the next question

Now

- ☐ *0%*
- ☐ *1% - 25%*
- ☐ *26 - 50%*
- ☐ *51 - 75%*
- ☐ *76 - 100%*

Before CCHC

- ☐ *0%*
- ☐ *1% - 25%*
- ☐ *26 - 50%*
- ☐ *51 - 75%*
- ☐ *76 - 100%*

17) Please indicate your level of agreement with the following statement *NOW* and *BEFORE* CCHC

Now

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know where to send families for additional developmental evaluation and services when there are developmental concerns	☐	☐	☐	☐	☐

Before CCHC

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I know where to send families for additional developmental evaluation and services when there are developmental concerns	☐	☐	☐	☐	☐

18) Please tell us anything else you would like to share about Child Development.

Supporting and Managing Behaviors

Consultation on managing behaviors means the consultant provided information about why a child may have bad feelings, challenging behavior or act in a way that is difficult for you to care for. By challenging behavior, we mean behavior that makes it difficult to do things like play or eat, or stops the child from learning, being successful when doing activities, or behavior that is harmful or physically hurtful to themselves or you.

19) Please indicate your level of agreement with the following statements *NOW* and *BEFORE* CCHC

Now

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I look for underlying reasons why a child is behaving in a challenging way	☐	☐	☐	☐	☐

Licensed Provider Follow-Up Survey

I use a variety of strategies to encourage positive behavior	☐	☐	☐	☐	☐
I create individualized behavior support plans for children with a parent or guardian	☐	☐	☐	☐	☐

Before CCHC

	Strongly Disagree 	**Disagree** 	**Agree** 	**Strongly Agree** 	**Did not receive consultation on the topic**
I look for underlying reasons why a child is behaving in a challenging way	☐	☐	☐	☐	☐
I use a variety of strategies to encourage positive behavior	☐	☐	☐	☐	☐
I create individualized behavior support plans for children with a parent or guardian	☐	☐	☐	☐	☐

Licensed Provider Follow-Up Survey

20) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more ways to prevent and manage challenging behaviors	☐	☐	☐	☐	☐
I am better able to support and respond to challenging behavior(s)	☐	☐	☐	☐	☐
I know who to contact to ask for help managing a child's behavior	☐	☐	☐	☐	☐
I am more confident I won't have to ask a child to leave child care due to behavior	☐	☐	☐	☐	☐

21) Please tell us anything else you would like to share about Supporting and Managing Behaviors.

Licensed Provider Follow-Up Survey

Communication with Primary Caregivers

Consultation on communicating with parent(s)/primary caregiver(s) means the consultant provided information about information and resources to provide parent(s)/primary caregiver(s) and training/ways to have difficult conversations.

Difficult conversations with a child's parent(s)/primary caregiver(s) could mean talking about something uncomfortable like a child's challenging behaviors or developmental concerns you have about the child. Difficult conversations could also mean talking with a parent(s)/primary caregiver(s) about a child no longer being able to come to child care.

22) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more resources and information to provide to parents/guardians	☐	☐	☐	☐	☐
I know more strategies I can use if I need to have a difficult conversation with a parent or guardian	☐	☐	☐	☐	☐
I will talk to parents/guardians about concerns I have about their child's development	☐	☐	☐	☐	☐

23) When you have an issue or concern about the child, how often do you have a difficult conversation with the child's primary caregiver/parent/guardian?
Difficult conversations with a child's parent(s)/primary caregiver(s) could mean talking about something uncomfortable like a child's challenging behaviors or developmental concerns you have about the child. Difficult conversations could also mean talking with a parent(s)/primary caregiver(s) about a child no longer being able to come to child care.

When there is a concern about the child,

Now	Before CCHC
☐ Every time (I always talk with their parent/caregiver(s))	☐ Every time (I always talk with their parent/caregiver(s))
☐ Sometimes (I will try to talk with their parent/caregiver(s), but not always)	☐ Sometimes (I will try to talk with their parent/caregiver(s), but not always)
☐ Rarely (I do not usually talk with their parent/caregiver(s))	☐ Rarely (I do not usually talk with their parent/caregiver(s))
☐ Never (I do not ever talk with their parent/caregiver(s))	☐ Never (I do not ever talk with their parent/caregiver(s))

24) Please describe one new strategy you learned from your CCHC consultant that helped you have a difficult conversation.

25) Please tell us anything else you would like to share about Communication with Primary Caregivers.

Licensed Provider Follow-Up Survey

Community Resources and Referrals

Community resources and referrals are information, organizations or services outside of your child care that you learn about through your consultant. Your consultant does not provide the information or services but gives you the tools or knowledge for how to find what you need in out in the community.

26) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic	Resources not available
I know more about resources in my community that can support my ability to provide child care	☐	☐	☐	☐	☐	☐
I will more frequently access resources in my community that support my ability to provide child care	☐	☐	☐	☐	☐	☐

27) Please tell us anything else you would like to share about Community Resources and Referrals.

Consultant Feedback

28) Please indicate your level of agreement with the following statements.
CCHC consultants...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 
Approached interaction with us in a collaborative and engaging manner	☐	☐	☐	☐
Built on my knowledge and skills	☐	☐	☐	☐
Encouraged us to generate ideas, ask questions, and share our concerns	☐	☐	☐	☐
Engaged us through interactive coaching (demonstrating activities, talking through ideas, etc)	☐	☐	☐	☐
Provided opportunities for us to practice or apply skills	☐	☐	☐	☐
Used a variety of consultation methods to address our needs	☐	☐	☐	☐

Overall Experience with CCHC

29) How satisfied were you with the CCHC services you received this year?*

☐ Very Unsatisfied ☐ Satisfied

☐ Unsatisfied ☐ Very Satisfied

[If very unsatisfied or unsatisfied]

32) Why were you unsatisfied with the CCHC services you received this year? *

Licensed Provider Follow-Up Survey

30) Have you incorporated the skills you learned/practiced during CCHC into your work? *

☐ Yes **Please share at least one example of how you've incorporated these skills.***
☐ No Please describe why not.*

31) Do you plan to continue using CCHC services in 2020?

☐ Yes	Why? **What would encourage you to use CCHC services more often in 2020?**
☐ No ☐ Not Sure	**Why? What would encourage you to use CCHC services in 2020?**

32) Please rate your level agreement with the following statement:
The consultant helped me reach my goal

☐ Strongly Disagree ☐ Disagree	Please explain why CCHC did not help you reach your goals:
☐ Agree ☐ Strongly Agree	Please explain how CCHC helped you reach your goals:

Licensed Provider Follow-Up Survey

33) On a scale from 1 to 10, how likely are you to refer CCHC to a friend or colleague? (circle one)

1 2 3 4 5 6 7 8 9 10

34) What other suggestions do you have for improving CCHC?

35) Is there anything else you'd like to share?

Licensed Provider Follow-Up Survey

Child Care Health Consultation Provider Survey
Family Friend and Neighbor

King County's Best Starts for Kids is partnering with Cardea Services to evaluate child care health consultation (CCHC). We are sending this survey to you and other child care providers across King County who received CCHC services between May 2018 and September 2019. Your feedback will help us to improve future CCHC services, and also to learn more about the best ways to bring CCHC to more child care providers across King County.

Your participation in this survey is voluntary and confidential; your responses will not be shared with your CCHC consultant. Instead, Cardea evaluation staff will combine your response with responses from other child care providers. No one else who is reviewing the data will know how you responded to this survey. By taking this survey, you agree to allow Cardea to combine your response with responses from other child care providers and share that combined data with CCHC agencies and King County in reports and other types of formats. You can choose to answer some questions and not others. The survey should take approximately 10-20 minutes to complete.

We greatly appreciate your feedback!

1) In what language was this survey completed?*

- ☐ English
- ☐ Arabic
- ☐ Amharic
- ☐ Chinese
- ☐ Oromo
- ☐ Somali
- ☐ Spanish
- ☐ Tigrinya
- ☐ Vietnamese
- ☐ Other (please specify): _____

Family, Friend and Neighbor Follow-Up Survey

General Information

2) Please provide:*

Client Name and Zip Code: _____

First Name Last Name Zip Code

OR Write in Client ID Number:_____

3) What is your relationship to the child or children?*

- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ Other Extended Family
- ☐ Family Friend
- ☐ Neighbor
- ☐ Other (please specify):

4) Are you currently receiving CCHC services?*

- ☐ Yes
- ☐ No

5) How many months have/did you received CCHC services?*

6) On average, how often did you meet with a CCHC consultant? *

- ☐ More than once a week
- ☐ Once a week
- ☐ Twice a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Do not remember

Family, Friend and Neighbor Follow-Up Survey

CCHC Content Areas

7) What types of CCHC services did you receive between May 2018 and September 2019 (select all that apply)

☐ **Child care health and safety**: Services provided information to improve overall health and/or safety of the child or children in your care. You may have learned new ideas for snacks or certain foods or new ideas for outdoor activities to do. You may also have learned things like how to store food safely, how to help the child wash their hands, or ways to change diapers or help the child use the potty.

☐ **Child development**: Services provided information about how children's brains and physical body develop. This could be information about developmental screenings (screenings ask questions about the child's actions, responses, or ability to complete tasks) or information and suggestions about how children learn, act, respond, or manage their feelings.

☐ **Managing behaviors**: Services provided information about why a child may have bad feelings, challenging behavior or act in a way that is difficult for you to care for.

☐ **Relationship with child and primary caregivers/ parents/ guardians**: Services provided information about what you can do with your time providing child care the child/children. Services may also have provided information about your interaction and conversations with the child's parent(s)/primary caregiver(s).

☐ **Community resources and referrals**: Community resources and referrals are information, organizations or services outside of your child care that you learn about through CCHC services.

☐ **Other (please specify)**: _____

☐ **All of the above**

8) Please rank how useful the following CCHC service topics have been to you:

☐ Child care health and safety

☐ Child development

☐ Community resources and referrals

☐ Managing behaviors

☐ Relationship with child and primary caregivers/ parents/ guardians

☐ Other (please specify):_____

Child Care Health and Safety

Child care health and safety consultation means the community liaison provided information and ideas for you to improve overall health and/or safety of the child or children in your care. Some examples of you may have learned are new ideas for snacks or certain foods like fruit to feed the child or new ideas for outdoor activities to do. You may also have learned things like how to store food safely, how to help the child wash their hands, or ways to change diapers or help the child use the potty.

9) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more ways to make the home safer	☐	☐	☐	☐	☐
I know more ways to better support the nutrition of children in my care	☐	☐	☐	☐	☐

I am using new ways to support the nutrition of children in my care	☐	☐	☐	☐	☐
I am more comfortable supporting children with special health care needs	☐	☐	☐	☐	☐

10) Please indicate your level of agreement with the following statements NOW and BEFORE CCHC

Before CCHC

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know the safety and emergency plan for children in my care	☐	☐	☐	☐	☐
Children with special health care needs in my care have an individualized health care plan	☐	☐	☐	☐	☐

Now

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know the safety and emergency plan for children in my care	☐	☐	☐	☐	☐
Children with special health care needs in my care have an	☐	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

individualized health care plan					

11) The children in my care are up to date in their immunizations (vaccines)

☐ Yes

☐ No

☐ Don't know

12) Please tell us anything else you would like to share about Child Care Health and Safety.

Child Development

Child development consultation means the consultant provided information about how children's brains and physical body develop. This could be information about developmental screenings (screenings ask questions about the child's actions, responses, or ability to complete tasks) or information and suggestions about how children learn, act, respond, or manage their feelings.

13) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more about child development milestones for children in my care	☐	☐	☐	☐	☐
I am more aware of available developmental screening tools,	☐	☐	☐	☐	☐

such as the Ages in Stages Questionnaire (ASQ)					
I am comfortable having someone complete a developmental screening tool with the children in my care	☐	☐	☐	☐	☐

14) Please indicate your level of agreement with the following statements NOW and BEFORE CCHC

Before CCHC

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I talk to the children in my care about their feelings	☐	☐	☐	☐	☐
I plan activities that are appropriate for the developmental stage of children in my care individualized health care plan	☐	☐	☐	☐	☐
I create opportunities for the child/children to explore their environment	☐	☐	☐	☐	☐

Now

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I talk to the children in my care about their feelings	☐	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

I plan activities that are appropriate for the developmental stage of children in my care	☐	☐	☐	☐	☐
I create opportunities for the child/children to explore their environment	☐	☐	☐	☐	☐

15) Please indicate the following NOW and BEFORE CCHC

Before CCHC

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
Has the child or children in your care received a developmental screening?	☐	☐	☐	☐	☐
I know where to go (or send the child's parents) to have additional evaluation and services when there is a developmental concern	☐	☐	☐	☐	☐

Now

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
Has the child or children in your care received a developmental screening?	☐	☐	☐	☐	☐
I know where to go (or send the child's parents) to have additional evaluation and services when there is a developmental concern	☐	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

16) Please tell us anything else

Supporting and Managing Behaviors

Consultation on managing behaviors means the community liaison provided information about why a child may have bad feelings, challenging behavior or act in a way that is difficult for you to care for. By challenging behavior, we mean behavior that makes it difficult to do things like play or eat, or stops the child from learning, being successful when doing activities, or behavior that is harmful or physically hurtful to themselves or you.

17) Please indicate your level of agreement with the following statements NOW and BEFORE CCHC

Before CCHC

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I look for underlying reasons why a child is behaving in a challenging way	☐	☐	☐	☐	☐
I use a variety of strategies to encourage positive behavior	☐	☐	☐	☐	☐

Now

	Strongly Disagree	Disagree	Agree	Strongly Agree	Did not receive consultation on the topic
I look for underlying reasons why a child is behaving in a challenging way	☐	☐	☐	☐	☐
I use a variety of strategies to encourage positive behavior	☐	☐	☐	☐	☐

18) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I am better able to support and respond to challenging behavior(s)	☐	☐	☐	☐	☐
I know who to contact to ask for help managing a child's behavior Questionnaire (ASQ)	☐	☐	☐	☐	☐

19) Please tell us anything else you would like to share about Supporting and Managing Behaviors.

Family, Friend and Neighbor Follow-Up Survey

Relationship with Child and Primary Caregivers

Consultation on relationship building with a child or parent(s)/primary caregiver(s) means the community liaison provided information about what you can do with your time providing child care the child/children. The community liaison could also have provided information about your interaction and conversations with the child's parent(s)/primary caregiver(s).

20) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
The child in my care does more play activities (such as going outside, doing activities with me, or going to play and learn groups, etc)	☐	☐	☐	☐	☐
I read more with the child in my care	☐	☐	☐	☐	☐
The child in my care has less screen time (watching tv shows or movies, using a phone or iPad to play games, etc)	☐	☐	☐	☐	☐
I feel more involved in supporting the child's development with the parents	☐	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

21) When you have an issue or concern about the child, how often do you have a difficult conversation with the child's primary caregiver/parent/guardian?

When there is a concern about the child,

Now	Before CCHC
☐ Every time (I always talk with their parent/caregiver(s))	☐ Every time (I always talk with their parent/caregiver(s))
☐ Sometimes (I will try to talk with their parent/caregiver(s), but not always)	☐ Sometimes (I will try to talk with their parent/caregiver(s), but not always)
☐ Rarely (I do not usually talk with their parent/caregiver(s))	☐ Rarely (I do not usually talk with their parent/caregiver(s))
☐ Never (I do not ever talk with their parent/caregiver(s))	☐ Never (I do not ever talk with their parent/caregiver(s))

22) Please describe one new strategy you learned from your CCHC consultant that helped you have a difficult conversation with the child's primary caregiver/parent/guardian?

23) Please tell us anything else you would like to share about your Relationship with Child and Primary Caregiver.

Community Resources and Referrals

Community resources and referrals are information, organizations or services outside of your child care that you learn about through your consultant. Your consultant does not provide the information or services but gives you the tools or knowledge for how to find what you need out in the community.

24) Please indicate your level of agreement with the following statements.
As a result of CCHC...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 	Did not receive consultation on the topic
I know more about resources in my	☐	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

community that can support my ability to provide child care					
I will more frequently access resources in my community that support my ability to provide child care	☐	☐	☐	☐	☐

25) Please tell us anything else you would like to share about Community Resources and Referrals.

Consultant Feedback

26) Please indicate your level of agreement with the following statements.

CCHC consultants...

	Strongly Disagree 	Disagree 	Agree 	Strongly Agree 
Approached interaction with us in a collaborative and engaging manner	☐	☐	☐	☐
Built on my knowledge and skills	☐	☐	☐	☐
Encouraged us to generate ideas, ask questions, and share our concerns	☐	☐	☐	☐
Engaged us through interactive coaching (demonstrating activities, talking through ideas, etc)	☐	☐	☐	☐

Family, Friend and Neighbor Follow-Up Survey

Provided opportunities for us to practice or apply skills	☐	☐	☐	☐
Used a variety of consultation methods to address our needs	☐	☐	☐	☐

Overall Experience with CCHC

27) How satisfied were you with the CCHC services you received this year?*

☐ Very Unsatisfied

☐ Unsatisfied

☐ Satisfied

☐ Very Satisfied

28) If you marked very unsatisfied or unsatisfied, why were you unsatisfied with the CCHC services you received

29) Have you used the skills you learned/practiced from the CCHC consultant/community liaison with the child/children in your care? *

☐ Yes Please share at least one example of how you've incorporated these skills.*
☐ No Please describe why not.*

30) Do you plan to continue using CCHC services in 2020?

☐ Yes Why? What would encourage you to use CCHC services more often in 2020?
☐ No Why? What would encourage you to use CCHC services in 2020? ☐ Not Sure

Family, Friend and Neighbor Follow-Up Survey

31) Please rate your level agreement with the following statement:

The consultant helped me reach my goals

☐ Strongly Disagree ☐ Disagree	Please explain why CCHC did not help you reach your goals:
☐ Agree ☐ Strongly Agree	Please explain how CCHC helped you reach your goals:

32) On a scale from 1 to 10, how likely are you to refer CCHC services to a friend or colleague? (circle one)

1 2 3 4 5 6 7 8 9 10

Extremely unlikely Definitely will recommend

33) What other suggestions do you have for improving CCHC?

34) Is there anything else you'd like to share?

THANK YOU!!

Family, Friend and Neighbor Follow-Up Survey

Key Informant Interview Guide

CHILD CARE HEALTH CONSULTATION—GROUP/LICENSED PROVIDERS

Interviewee: Click here to enter text.

Affiliation(s): Click here to enter text.

Interviewer: Choose an item.

Date: Click here to enter a date.

INTRODUCTION AND ASSENT

Hi, my name is Choose an item. from Cardea. Thanks for taking the time to speak with us today about your experience with child care health consultations.

Cardea is partnering with Public Health—Seattle & King County to evaluate the Best Starts for Kids Child Care Health Consultation strategy. Best Starts is an initiative to improve the health and well-being of King County by investing in promotion, prevention, and early intervention for children, youth, families, and communities. Cardea is completing an evaluation to learn more about what services you have received. This evaluation will help Best Starts for Kids and others understand how well the services are working, how the services can be improved and help inform the future delivery of child care health consultation services in King County.

We are interviewing a providers who received support from child care health consultants in the last 12 months to learn about experiences with the services they received and how those services changed their work, if at all. This conversation will inform the future CCHC services and a report on the Child Care Health Consultation Strategy in King County.

The conversation today will take approximately 60 minutes. Please note that this conversation is voluntary and confidential. You can choose to answer some questions and not others. With your permission, I would like to audio record the discussion, so I have an accurate record of what you said for the purposes of taking notes. If you do not give permission to tape the discussion, then it will not be taped. Any recording will be destroyed once we have completed our review.

Do you have any questions about the purpose of today's interview?	☐YES	☐NO
Do you want to continue to participate in today's interview?	☐YES	☐NO
Do I have your permission to record the discussion?	☐YES	☐NO
Do I have your permission to use de-identified quotes in summaries or reports?	☐YES	☐NO

BACKGROUND

1. How long have you been providing child care services to children ages 0-5?

2. How long have you been using CCHC services? What types of CCHC services have you used?
   - **PROBE**: Have you been to group trainings?
   - **PROBE**: Had a consultant guide you through modeling (show you how to do something)?
   - **PROBE**: Received individualized consultations?
   - **PROBE**: Are there certain things you wanted to learn or reasons you decided to use CCHC services? Such as to learn about behavior, child development, health and safety practices, etc?

Click here to enter text.

CCHC FEEDBACK

3. How well did the CCHC services meet your needs? Why?
   - PROBE: Did you feel you were able to learn or receive support for the reasons you originally decided to use CCHC services [Q2 probe]?

Click here to enter text.

4. What did you like about the CCHC services you received? What are strengths of the CCHC services?
   - **PROBE**: Availability of services? Were you able to receive consultation at a time that worked for your schedule? If not, can you explain?
   - **PROBE**: Topics covered?

5. What could be improved about the CCHC services you received? If you could change any aspect(s) of CCHC services, what change(s) would you make?

CCHC IMPACT

6. How have CCHC services changed the way you do things and/or set up your center/home?

Licensed Provider Key Informant Interview Guide

7. How have CCHC services changed the way in which you (and/or others you work with/colleagues) work with children and families?
   - **PROBE**: Changes in ability to include all children in activities throughout the day in the classroom/program?

8. How have CCHC services changed how you care for a child that you had difficulty caring for in the past?
   - **PROBE**: Think back to a time when you had a challenge caring for a child (or alternatively can you think of a time did not feel you had support to care for a child) or a time when you could not enroll a child. Describe what that looked like.
   - **PROBE**: Did CCHC provide the support you needed to provide care for that child (or other children)? If so in what way?
   - **PROBE**: Did CCHC provide the support you needed to make changes in enrollment? If so in what way?

9. How have CCHC services changed how you connect families to resources outside of child care?
   - **PROBE**: Can you share an example of a time you were successfully able to connect a family to a resource?
   - **PROBE**: Can you share an example of a time you were unable to successfully connect a family to a resource? (reasons could be resource did not exist, language barrier, financial etc).

10. How have the children and families you serve benefitted from CCHC services?
    ASQ has been the primary focus and families and children are benefitting from better connection and education about behavior and development

IMPLEMENTATION

11. What new skills or practices, if anything, makes have you (and/or others you work with/colleagues) been successful using? What new skills or practices, if anything, have you had challenges using?

- **PROBE:** Can you think of a skill or new practice you learned from the consultant? What happened when you tried to use that skill or new practice? What made it successful to use? What made it challenging?
- **PROBE:** Do you have the resources you need to use the skills or new practices you learn through CCHC? Financial resources? Information resource?

12. What additional services/supports would be most helpful?
    Click here to enter text.

13. Are there any questions that you wish I would have asked and did not?
    Click here to enter text.

THANK YOU

Thank you so much for sharing your experiences and time with us today. Your input will be very helpful for our efforts to assess and improve CCHC services in King County. The gift card will be emailed electronically, we send them out in batches after completing this week's interviews. Any final questions? Thank you!

Licensed Provider Key Informant Interview Guide

Key Informant Interview Guide

CHILD CARE HEALTH CONSULTATION—FFN

Interviewee: Click here to enter text.

Affiliation(s): Click here to enter text.

Interviewer: Choose an item.

Date: Click here to enter a date.

INTRODUCTION AND ASSENT

Hi, my name is Choose an item. from Cardea. Thanks for taking the time to speak with us today about your experience with developmental screening.

Cardea is partnering with Public Health—Seattle & King County to evaluate the Best Starts for Kids Child Care Health Consultation strategy. Best Starts is an initiative to improve the health and well-being of King County by investing in promotion, prevention, and early intervention for children, youth, families, and communities. Cardea is completing an evaluation to learn more about what services you have received. This evaluation will help Best Starts for Kids and others understand how well the services are working, how the services can be improved and help inform the future delivery of child care health consultation services in King County.

We are interviewing a providers who received support from child care health consultants in the last 12 months to learn about experiences with the services they received and how those services changed their work, if at all. This conversation will inform the future CCHC services and a report on the Child Care Health Consultation Strategy in King County.

The conversation today will take approximately 60 minutes. Please note that this conversation is voluntary and confidential. You can choose to answer some questions and not others. With your permission, I would like to audio record the discussion, so I have an accurate record of what you said for the purposes of taking notes. If you do not give permission to tape the discussion, then it will not be taped. Any recording will be destroyed once we have completed our review.

Do you have any questions about the purpose of today's interview?	☐YES	☐NO
Do you want to continue to participate in today's interview?	☐YES	☐NO
Do I have your permission to record the discussion?	☐YES	☐NO
Do I have your permission to use de-identified quotes in summaries or reports?	☐YES	☐NO

BACKGROUND

14. How long have you been providing child care for a child under 5 years old?

- Where do you provide child care?

Click here to enter text.

15. How long have you been working with a child care health consultant? What types of CCHC services have you used?
    - **PROBE**: Have you attended group trainings?
    - **PROBE**: Had a consultant guide you through modeling?
    - **PROBE**: Received individualized support for concerns/questions you have?
    - **PROBE**: Are there certain topics or reasons you decided to use CCHC services? Such as to learn about behavior, child development, health and safety practices, etc?

Click here to enter text.

CCHC FEEDBACK

16. How well did the CCHC services meet your needs? Why?
    - **PROBE:** Did you feel you were able to learn or receive support for the reasons you originally decided to use CCHC services [Q2 probe]?

Click here to enter text.

17. What did you like about the CCHC services you received? What worked well for you, what was helpful?
    - **PROBE**: Availability of services? Were you able to receive consultation at a time that worked for your schedule? If not, can you explain?
    - **PROBE**: Topics covered?

Click here to enter text.

18. What would make CCHC services that you have received better? If you could change something about CCHC services, what change(s) would you make?

Click here to enter text.

CCHC IMPACT

19. How have CCHC services changed the way you set up your home for the child/children you care for?
    - **PROBE:** Changes in the type or location of furniture?
    - **PROBE:** Changes in how you keep your home?

Click here to enter text.

20. How have CCHC services changed the way in which you interact with the child's/children's parents/families?

- **PROBE**: Can you think of any conversations you have now that you did not have before you started working with the consultant? What are those conversations about? Why do you think you have those conversations now?

21. How have the CCHC services you received changed how you take of the child/children?
    - **PROBE**: What kind of activities do you do with the child as a result of CCHC?
    - **PROBE**: Did CCHC provide the support you needed to provide care for the child/children? If so in what way?

    Click here to enter text.

22. How have the child and parents/families benefitted from your conversations, work, and referrals with the CCHC community health worker/consultant?
    Click here to enter text.

IMPLEMENTATION

23. Is there anything that you are doing differently that is better for the child/children?
    - **PROBE:** What is something that you learned from the CCHC community health worker/consultant that was easy to do differently? Why was is easy?
    - **PROBE:** What is something that you learned from the CCHC community health worker/consultant that was more difficult to do differently? Why was is difficult?
    - **PROBE:** Do you have the resources you need to use the skills or new practices you learn through CCHC? Financial resources? Information resource?

    Click here to enter text.

24. What additional services/supports would be most helpful?
    Click here to enter text.

25. Are there any questions that you wish I would have asked and did not?
    Click here to enter text.

THANK YOU AND PROJECT UPDATES

Thank you so much for sharing your experiences and time with us today. Your input will be very helpful for our efforts to assess and improve CCHC services in King County. Any final questions? Thank you!

Focus Group Guide

CHILD CARE HEALTH CONSULTATION SERVICES
BSK GRANTEE CONSULTANT GUIDE

Facilitator

Interpreter/Translator:

Language: Click here to enter text.

Note-taker: Choose an item.

Location: Click here to enter text.

Date: Click here to enter a date.

OPENING DIALOGUE & GROUP AGREEMENTS

Hi, my name is Choose an item. from Cardea and Choose an item. is taking notes. Thank you very much for joining us today to share your experience providing Child Care Health Consultation services. This evaluation will help Best Starts for Kids and others understand how well the services are working, how the services can be improved and help inform the future delivery of child care health consultation services in King County.

Today we will be discussing your experiences, successes and challenges you have had providing consulting services to child care providers. Your perceptions and experiences are valuable to us, we look forward to hearing from you.

Your responses are **confidential,** meaning we will summarize what we learn from you as a group, but no one will be identified by their name. Your responses will be used to inform our understanding of developmental screening and referrals in King County and to inform improvements to that system. Our goal in King County is to build a system where all families get the information they need at the right time. Your voice matters in helping to build this system. Please honor the confidentiality of everyone here today. If you wish to describe today's experience with others, please share themes and ideas rather than stories with names.

Your participation is completely **voluntary** and you can choose to answer some questions and not others. If you would like to stop your participation at any time, please just let us know.

Also, we would like to tape this discussion to help us take better notes. Any tape will be destroyed after we have finished typing our notes.

Does anyone not want us to tape the discussion?	☐YES	☐NO

[IF "YES"] Ok, Lizzy will be taking written notes during our discussion.

[IF "NO"] Ok, we will start the recording in a few minutes. Once we've completed our report on the current state of developmental screening and connection to services, the audio recording will be destroyed.

Do I have your permission to use your stories or phrases in summaries or reports? We will not identify you by name.	☐YES	☐NO

[IF "YES," Proceed to group agreements.]

[If "NO," Ok, we will not use direct quotes from this group.]

We value the contribution of each member in this group. To ensure each person is heard and respected, we believe it's important to have the following **group agreements.**

A. Please support one person talking at a time.
B. Please remember that people have different ideas and ways of looking at things—there are no right or wrong answers.
C. We'll ask everyone to share their thoughts and ideas. Please feel free to pass, if you aren't comfortable with the question or don't have an opinion to share.
D. Please use respectful language. And,
E. Please remember that what is said in this room should stay in this room.
F. Please feel free to step out of the room and re-enter, as needed. When you re-enter, please do that respectfully.
G. Please feel free to get more <<food and beverage>> during the discussion.
H. If you have a cell phone, please turn it off or to vibrate. No texting please.

Does anyone have any group agreements they would like to add?	☐YES	☐NO

[IF "YES," Acknowledge the suggestions.]

[IF "NO," Proceed to next question.]

Do you have any questions about the purpose of our discussion?	☐YES	☐NO

[IF "YES," Answer questions.]

[If "NO," Proceed to final opening remarks.]

Ok, we will start the recording now and start our discussion.

Let's begin with introductions, so we're all familiar with each other.

INTRODUCTIONS

26. Please tell us your name and one reason why you wanted to participate in this conversation.
Click here to enter text.

INTERVIEW QUESTIONS

27. What types of CCHC services are most important for the child care providers you serve?
    - **PROBE:** What topics are most important?

    Click here to enter text.

28. What successes have you had in providing CCHC services?
    - **PROBE:** What challenges have you had?
    - **PROBE:** If you could change any aspect(s) of CCHC services, what change(s) would you make?

    Click here to enter text.

29. How have CCHC services changed the environment in/way in which child care providers set up their centers/homes?

    Click here to enter text.

30. How have child care providers you serve changed the way they work with children and parents/families, based on the CCHC services you provide?
    - **PROBE for licensed centers/family homes:** Have any child care providers made any changes to enrollment eligibility? For example become more inclusive of children with a range of health needs?

    Click here to enter text.

31. **[Licensed centers/family homes]** Have you seen changes in how likely child care providers are to expel or consider expelling children, based on the CCHC services you provide?
    - **PROBE:** Can you describe any incremental changes you have noticed such as a provider reaching out to you for support before deciding to expel a child?
    - **PROBE:** have you worked with a provider who either expelled or considered expulsion of a family/child? Describe how you worked with the provider.

    Click here to enter text.

32. What, if anything makes it easier or harder for child care providers to fully implement what they learn or gain from you through CCHC services?
    - **PROBE:** Are there informational resources child care provider needs available to you? Why or why not? Are there resources and referrals available that are culturally and linguistically supportive to child care providers?
    - **PROBE:** have you experienced a child care provider who could not make changes in their child care practices as a result of financial barriers? What did that look like?

    Click here to enter text.

33. How have children and families benefitted from CCHC services? What additional services/supports would be most helpful?
Click here to enter text.

THANK YOU

Thank you so much for sharing your insights and time with us today. Your input will be very helpful for honing and implementing this strategic plan. If you're also interested in receiving periodic updates (summary reports, strategic plans, etc.), please let us know before you leave today—we'd be happy to keep you informed.

Focus Group Guide
Public Health—Seattle & King County
CHILD CARE HEALTH CONSULTATION TEAM

Facilitator(s): Choose an item.

Note-taker: Choose an item.

Location: Click here to enter text.

Date: Click here to enter a date.

OPENING DIALOGUE & GROUP AGREEMENTS

Hi, my name is Lizzy Menstell, and I am a Research and Evaluation Manager for Cardea. As you may know, Cardea is working with Best Starts for Kids on a CCHC evaluation, primarily focused on the seven organizations that were funded under the public health model and community informed approaches.

Thank you very much for joining us to share your experience providing Child Care Health Consultation services. During our time together, we will be discussing the CCHC services that you provide, as well as the experiences, successes, and challenges you have had providing these services to child care providers. Your perceptions and experiences are valuable to us, we look forward to hearing from you. This conversation will be about 90 minutes.

Your responses are **confidential,** meaning we will summarize what we learn from you as a group, but no one will be identified by their name. Your responses will be used to inform our understanding of child care health consultation in King County and to inform improvements to that system. Our goal in King County is to continue building a system where all providers and families get the information they need at the right time. Your voice matters in helping to grow this system. Please honor the confidentiality of everyone here today. If you wish to describe today's experience with others, please share themes and ideas rather than stories with names.

Your participation is completely **voluntary** and you can choose to answer some questions and not others. If you would like to stop your participation at any time, please just let us know.

Also, we would like to record this discussion to help us take better notes. The recording will be destroyed after we have finished typing our notes.

Does anyone not want us to tape the discussion?	☐YES	☐NO

[IF "YES"] Ok, Michelle will be taking written notes during our discussion.

[IF "NO"] Ok, we will start the recording in a few minutes. Once we've completed our report on the current state of child care health consultation, the audio recording will be destroyed.

Do I have your permission to use your stories or phrases in summaries or reports? We will not identify you by name.	☐YES	☐NO

[IF "YES," Proceed to group agreements.]

[If "NO," Ok, we will not use direct quotes from this group.]

We value the contribution of each member in this group. To ensure each person is heard and respected, we believe it's important to have the following **group agreements.**

I. Please support one person talking at a time.
J. Please remember that people have different ideas and ways of looking at things—there are no right or wrong answers.
K. We'll ask everyone to share their thoughts and ideas. Please feel free to pass, if you aren't comfortable with the question or don't have an opinion to share.
L. Please use respectful language.
M. Please remember that what is said in this room should stay in this room.
N. Please feel free to step out of the room and re-enter, as needed. When you re-enter, please do that respectfully.
O. Please feel free to get more <<food and beverage>> during the discussion.
P. If you have a cell phone, please turn it off or to vibrate. No texting please.

Does anyone have any group agreements they would like to add?	☐YES	☐NO

[IF "YES," Acknowledge the suggestions.]

[IF "NO," Proceed to next question.]

Do you have any questions about the purpose of our discussion?	☐YES	☐NO

[IF "YES," Answer questions.]

[If "NO," Proceed to final opening remarks.]

Ok, we will start the recording now and start our discussion.

Let's begin with introductions, so we're all familiar with each other.

INTRODUCTIONS

34. Please tell us your name, educational background and professional experience, and how long you have provided CCHC services at PHSKC. If you have provided CCHC services as a private consultant or for another organization, we would greatly appreciate hearing about that experience, too.
    Click here to enter text.

INTERVIEW QUESTIONS

35. Please describe how you engage with child care providers. What does your first engagement look like?
    - **PROBE:** How are providers referred to you?
    - **PROBE:** Please describe your intake process.

    Click here to enter text.

36. Do you develop a plan of action to address the provider's needs? If so, what are core elements of the plan of action and what is the process of developing the plan of action?
    - **PROBE:** How often do you update the plan of action?

    Click here to enter text.

37. What do subsequent engagements look like?
    - **PROBE:** How often do you connect with providers?
    - **PROBE:** How do you typically connect with providers (e.g., in-person, phone, e-mail, text)?
    - **PROBE:** If/when you meet in-person, how long is the average meeting?
    - **PROBE:** How many meetings do you have with each provider?

    Click here to enter text.

38. What types of CCHC services do you provide?
    - **PROBE:** What topics are most important or requested by providers?
    - **PROBE:** What do you consider to be core elements of CCHC services?
    - **PROBE:** What techniques do you use to facilitate learning? Individualized consultations? Group trainings? Modeling?

    Click here to enter text.

39. What successes have you had in providing CCHC services?
    - **PROBE:** What challenges have you had?

    Click here to enter text.

40. How have child care providers you serve changed the way they work with children and families, based on the CCHC services you provide?
    - **PROBE:** Have any child care providers made any changes to enrollment eligibility? For example become more inclusive of children with a range of health needs?

    Click here to enter text.

41. Have you seen changes in how likely child care providers are to expel or consider expelling children, based on the CCHC services you provide?
    - **PROBE:** Can you describe any incremental changes you have noticed such as a provider reaching out to you for support before deciding to expel a child?
    - **PROBE:** Have you worked with a provider who either expelled or considered expulsion of a child? Describe how you worked with the provider.

    Click here to enter text.

42. What, if anything makes it easier or harder for child care providers to fully implement what they learn or gain from you through CCHC services?
    - **PROBE:** Are there informational resources child care provider needs available to you? Why or why not? Are there resources and referrals available that are culturally and linguistically supportive to child care providers?
    - **PROBE:** have you experienced a child care provider who could not make changes in their child care practices as a result of financial barriers? What did that look like?

    Click here to enter text.

43. How have children and families benefitted from CCHC services?
    - **PROBE**: What additional services/supports would be most helpful?

    Click here to enter text.

THANK YOU

Thank you so much for sharing your insights and time with us today. Your input will be very helpful for further understanding child care health consultation services. If you're also interested in receiving periodic updates (summary reports, strategic plans, etc.), please let us know before you leave today—we'd be happy to keep you informed.

APPENDIX G. CHARACTERISTICS—QUALITATIVE PARTICIPANTS

CHARACTERISTICS—KEY INFORMANT INTERVIEW PARTICIPANTS

Of the 15 key informants, seven received CCHC services through the public health approach, and eight through the community-informed approach. The interviews were split evenly among site administrators, licensed family home providers, and FFN care providers. At least one provider who worked with each grantee was interviewed. Key informants had been providing child care from three months to 33 years and had been working with child care health consultants from seven months to one year, with the majority working with a child care health consultant for one year.

Table 1: Characteristics—Key Informant Interview Participants

	Percent
Overall	
Community-Informed	53
Public Health	47
Provider type	
Family, Friend, and Neighbor	33
Licensed center	33
Licensed family home	27
Partial day	7
Role	
Administrator	33
Provider	40
Both	27
Length of time providing care	
Less than 1 year	7
1 to 5 years	20
5 to 10 years	40
More than 10 years	33
Interview language	
Arabic	7
Cantonese	13
English	47
Mandarin	7
Somali	26
Interview length	
Less than 50 minutes	33
More than 50 minutes	77

CHARACTERISTICS—BSK GRANTEE CHILD CARE HEALTH CONSULTANT FOCUS GROUP

The participating child care health consultants had been providing CCHC services for three months to 10 years. Participants provided support related to inclusion for children with special needs, early childhood development, nutrition, mental health, certification and licensing support, child health and safety, and connections to community resources and referrals. In addition, they reported having expertise in CPR training, managing challenging behaviors, administering the Ages and Stages Questionnaire (ASQ), medication administration, health and safety environmental assessment, and cultural child care practices. Participants said that they supported child care providers with any support they needed. They indicated that they provided both individual consultation with one child care provider or with teaching teams and group trainings for all child care providers at one site or at multiple sites.

CHARACTERISTICS—PUBLIC HEALTH—SEATTLE & KING COUNTY CHILD CARE HEALTH CONSULTANT FOCUS GROUP

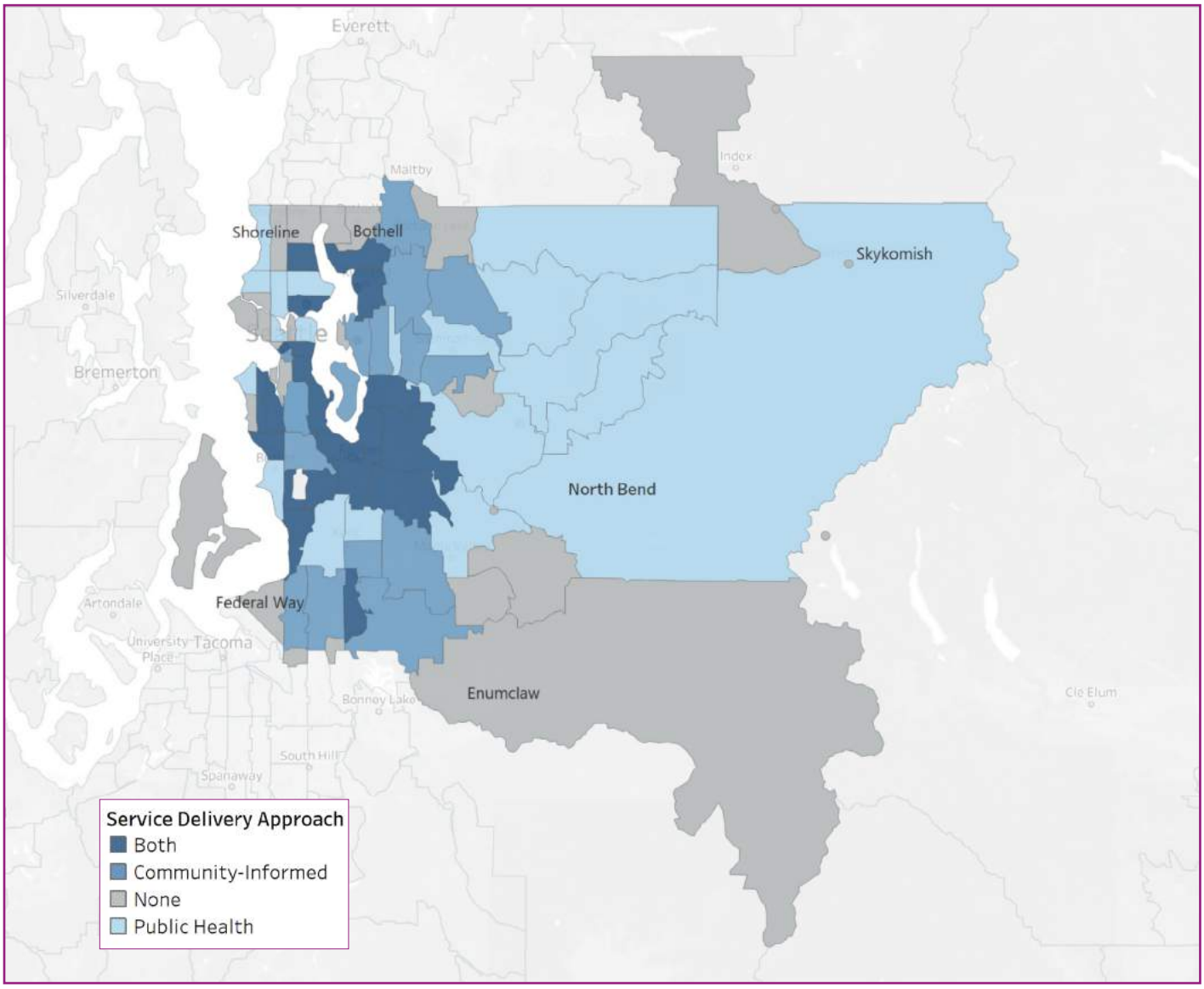
Participating Public Health—Seattle & King County (PHSKC) child care health consultants had been providing consultation services from one to 20 years. Participants provided support related to mental health, infant room care, Early Childhood Education and Assistance Program (ECEAP) consultation, health screening (vision, healthy growth, health education, child growth and development screening and education), and linkage to resources and referrals. In addition, they reported having expertise in mental health services including intergenerational trauma, parent-infant psychotherapy and motivational interviewing and reflective practices; child health and safety including medication management, communicable disease prevention, food allergies, asthma, safe sleep, sanitation, physical activity, nutrition, menu development, and feeding, environmental safety, tooth brushing, infant care, blood borne pathogens; and inclusion including special needs, child development and growth, and developmental screening. Almost all participants were licensed professionals. Like the BSK child care health consultants, participants indicated that they provided both individual consultation with one child care provider or with teaching teams and group trainings for all child care providers at one site or at multiple sites.

APPENDIX H. ADDITIONAL ANALYSIS TABLES

Tables in Appendix H mirror the tables in the Results section of the report and differ in breakout categories to show disaggregation by the provider type receiving child care health consultation. Tables are therefore labeled with the corresponding table number from the Results section for referencing between Appendix H and the Results section. Tables 1 and 2 were excluded to avoid redundancy. The tables below exclude responses that are missing corresponding provider types and therefore n's differ between the responses in these tables and the Results section. Missing provider types resulted in 4% of missing intake responses, and 5% of consultation responses. The partial day provider follow-up survey responses in table 17 through 20 are excluded, due to responses size less than five.

Finally, Table 15 and 16 (group training data) are not available for breakout by provider type due to inability to collect needed data. The nature of group trainings does not allow for provider type to be feasibly collected.

CCHC service delivery in King County by approach



CHILD CARE PROVIDER INTAKE ADDITIONAL ANALYSIS

Table 3: Total and average number of children and care providers per site by provider type

Site Intake	All Sites/Locations		FFN		Family Home		Licensed Centers		Partial Day Providers	
	Total	Average per site	Total	Average per site	Total	Average per site	Total	Average per site	Total	Average per site
Number of children in care (n=428)	6,913	16	387	1	567	1	5,595	13	364	1
Number of care providers completed intake	736	1.5	204	1	154	2	324	2	43	3

Table 4: Sites receiving child care subsidy and learning about CCHC by provider type

Site Intake	All Sites/ Locations	FFN	Family Home	Licensed Centers	Partial Day Providers
	%	%	%		
Site receives or accepts child care subsidy (n=295)	64	1.3	96	77	14
Site discovered CCHC through internal referral/ program (n=305)	40	53	35	30	61

Table 5: Characteristics of children in care by provider type

Site Intake	All Sites	FFN	Family Home	Licensed Centers	Partial Day Providers
Average age range of children in care (n=358)	2 to 7 years	2 to 6	1.5 to 7	1 to 7	3 to 6.5
Approximate proportion of children of color in care at a site (n=428)†					
0%	-	-	<1%	-	-
1-25%	4%	-	2.0%	19%	4%
26-50%	4%	-	<1%	17%	3%
51-75%	4%	-	4.2%	15%	-
76-100%	72%	97%	84%	8%	-
Sites with at least one child in care/family who speaks a language other than English (n=428)‡	55%	27%	84%	61%	27%

† Includes 62 (14%) missing responses in the denominators (6 (3%) from FFN; 12 (8.4%) from family homes; 31 (41%) from licensed centers; 13 (72%) from partial day providers

‡ Includes 187 (42%) missing responses in the denominators (132 (65%) from FFN; 6 (4%) from family homes; 19 (28%) licensed centers; 10 (67%) from partial day providers

Table 6: Characteristics of care providers by consultation approaches

Characteristic	All Sites	FFN	Family Home	Licensed Centers	Partial Day Providers
	%	%	%		
Care provider speaks a language other than English (n=448)	56	71	86	30	20
Care provider years providing care (n=377)					
Less than 1 year	8	6	5	10	14
1 to 5 years	38	54	51	24	52
5 to 10 years	19	6	29	17	14
More than 10 years	34	35	15	48	19
Care provider role or relationship					
Unlicensed/informal care provider (n=299)					
Grandparent	17	77	-	-	-
Other family†	3	15	-	-	-
Friend/neighbor	2	9	-	-	-
Licensed care provider (n=362)		-			
Site administrator	15	-	.6	28	24
Lead teacher/caregiver	40	-	86	86	43
Assistant teacher/caregiver	16	-	8	27	24
Support staff	3	-	1	6	-
Multiple roles	3	-	3	3	7
Other	1		-	1	2

† "Other family" includes brothers, sisters, aunts, uncles, and cousins

CHILD CARE PROVIDER CONSULTATION ADDITIONAL ANALYSIS

Table 7: Number of consultations and average number and length of time per consultation/follow-up by provider type

	All Sites (n=215)	FFN (n=67)	Family Home (n=62)	Licensed Centers (n=59)	Partial Day Providers (n=16)
Number of consultations	1,950	605	262	939	99
Average number of consultations per site	9	9	4	16	6
Average consultation time per site (minutes)	58	54	67	58	46
Average follow-up time per site (minutes)	27	30	25	27	29

Table 8: Consultations that included at least one subtopic per topic category by provider type

	All Sites (n=215)		FFN (n=67)		Family Home (n=62)		Licensed Centers (n=59)		Partial Day Providers (n=16)	
	#	%	#	%	#	%	#	%	#	%
Growth and development	1,206	62	343	57	141	54	646	69	64	65
Health and safety	453	23	203	34	69	27	154	16	15	15
Nutrition	140	7	53	9	25	10	58	6	1	1
Other†	1,078	55	168	28	67	26	767	82	61	62

† Other subtopics are broken out further in table 11

Table 9: Proportion of all growth and development consultations by growth and development subtopic and provider type

	All Sites (n=215)	FFN (n=67)	Family Home (n=62)	Licensed Centers (n=59)	Partial Day Providers (n=16)
	%	%	%	%	%
Brain development & milestones	12	26	10	6	3
Developmental screening	26	34	45	16	25
Language development	19	24	25	19	8
Mental/behavioral health	18	3	19	23	31
Motor development	13	21	8	11	2
Self-adaptive skills	9	8	3	11	6
Sensory & self-regulation	28	8	6	43	38
Social-emotional development	28	20	17	34	34
Vroom	3	6	3	1	2

Table 10: Proportion of all health and safety consultations by health and safety subtopic and provider type

	All Sites (n=215)	FFN (n=67)	Family Home (n=62)	Licensed Centers (n=59)	Partial Day Providers (n=16)
	%	%	%	%	%
Emergency policies & procedures	12	14	22	3	27
Environmental safety	16	18	7	16	7
Handwashing, diapering, toileting	20	20	3	29	13
Health & safety assessment	6	8	3	2	-
Immunization health records	17	15	14	23	7
Infection/communicable disease prevention	14	4	16	28	13
Medication management	4	3	12	2	13
Oral health	11	21	6	3	-
Physical activity & outdoor time	17	6	22	28	20
Safe sleep	8	5	13	8	-
Toxics	9	17	4	1	7

Table 11: Proportion of all consultations by other subtopic and provider type

	All Sites (n=215)		FFN (n=67)		Family Home (n=62)		Licensed Centers (n=59)		Partial Day Providers (n=16)	
	#	%	#	%	#	%	#	%	#	%
Child-to-caregiver relationship	235	12	42	7	10	4	173	18	4	4
Children with special needs	494	25	2	<1	3	1	450	48	39	39
Classroom curriculum	272	14	-	-	19	7	228	24	22	22
Community resources and referrals	209	11	96	16	12	5	87	9	13	13
Family engagement and interaction	281	14	34	6	29	11	190	20	20	20
Staff/Caregiver health and wellness	125	6	5	1	17	6	95	10	8	8

Table 12: Average consultation time by topic and provider type

	All Sites (n=215)		FFN (n=67)		Family Home (n=62)		Licensed Centers (n=59)		Partial Day Providers (n=16)	
	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up
Growth and development	60	28	58	34	68	28	61	28	49	29
Health and safety	57	22	50	15	59	22	58	24	35	24
Nutrition	66	24	60	-	74	21	68	25	15	-
Other	60	27	56	30	64	30	60	27	50	27

Table 13: Average consultation time by other subtopic and provider type

	All Sites		FFN		Family Home		Licensed Centers		Partial Day Providers	
	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up	Consult-ation	Follow Up
Child-to-caregiver relationship	66	25	61	30	90	19	67	25	53	60
Children with special needs	63	30	83	-	85	38	63	30	54	26
Classroom curriculum	67	25	-	-	77	15	66	27	68	25
Community resources and referrals	51	27	48	30	75	15	53	27	47	32
Family engagement and interaction	60	24	58	-	73	38	58	22	56	23
Staff/Caregiver health and wellness	52	20	57	-	77	19	49	20	32	30

Table 14: Proportion of consultations provided by modality and provider type

	All Sites	FFN	Family Home	Licensed Centers	Partial Day Providers
	%	%	%	%	%
In-person	75	94	87	61	58
Phone	4	0	3	5	16
Email/messaging	12	6	3	18	16
Multiple	9	0	7	16	10

CHILD CARE PROVIDER FOLLOW-UP SURVEY ADDITIONAL ANALYSIS

Table 17. Characteristics of providers completing the child care provider survey

	All Respondents	FFN	Family Home	Licensed Centers
	%	%	%	%
Provider type (n=164)	100	22	32	44
Language in which survey was completed (n=164)				
Amharic	1	6	-	-
Arabic	1	-	2	-
Chinese	9	42	-	-
English	69	36	54	96
Oromo	1	3	-	-
Somali	17	11	44	1
Spanish	2	3	-	3
Actively receiving CCHC services (n=164)†				
Yes	70	100	67	60
No	30	0	33	40
Primary role—licensed (n=128)				
Lead teacher/caregiver	52	-	75	38
Assistant teacher/caregiver	5	-	4	6
Site administrator	43	-	21	57
Relationship to child—FFN (n=36)				
Grandparent	81	81	-	-
Other immediate family	14	14	-	-
Family friend	5	5	-	-

† Actively receiving services means the child care provider was currently engaging with a consultant at the time of the survey as opposed to receiving CCHC services in the past

Table 18. Consultation topics covered by provider type

	All Respondents (n=164)	FFN	Family Home	Licensed Centers
	%	%	%	%
Growth and development	77	92	79	72
Health and safety†	62	75	75	47
Child behavior	66	75	38	82
Family engagement and interaction (licensed only)	34	-	48	43
Child/parent to provider relationship (FFN only)	16	75	-	-
Community resources and referrals	55	92	52	42

† Includes nutrition

Table 19. Provider ranking of the most useful consultation topics

	All Respondents (n=82)	FFN	Family Home	Licensed Centers
First	Health and safety†	Health and safety†	Health and safety†	Child behavior
Second	Growth and development	Growth and development	Growth and development	Growth and development
Third	Child behavior	Child behavior	Family engagement (licensed)	Health and safety†
Fourth	Family engagement (licensed)	Community resources/ referrals	Child behavior	Family engagement (licensed)
Fifth	Community resources/ referrals	Child/parent to provider relationship (FFN only)	Community resources/ referrals	Community resources/ referrals
Sixth	Child/parent to provider relationship (FFN only)			

† Includes nutrition

Table 20: Reported increase in provider knowledge of and ability to apply consultation topics in daily practice

	All Respondents	FFN	Family Home	Licensed Centers
	%	%	%	%
Increased knowledge of consultation topics	99	100	100	97
Increased knowledge of community resources	99	97	100	100
Improved provider-parent conversations	82	59	100	87
Increased use of developmental screening tools/resources	91	91	100	85
Increased ability to identify or use developmentally appropriate activities	61	79	80	37
Increased ability to enhance health and safety	76	85	92	53
Increased ability to support child behaviors†	69	89	70	59

† Includes challenging behavior

APPENDIX I. FOCUS GROUP — KING COUNTY CHILD CARE HEALTH PROGRAM

CHARACTERISTICS

Participating Public Health—Seattle & King County (PHSKC) child care health consultants had been providing consultation services from one to 20 years. Participants provided support related to mental health, infant room care, ECEAP consultation, health screening (vision, healthy growth, health education, child growth and development screening and education), and linkage to resources and referrals. In addition, they reported having expertise in mental health services, including intergenerational trauma, parent-infant psychotherapy and motivational interviewing and reflective practices; child health and safety, including medication management, communicable disease prevention, food allergies, asthma, safe sleep, sanitation, physical activity, nutrition, menu development, and feeding, environmental safety, tooth brushing, infant care, blood borne pathogens; and inclusion, including special needs, child development and growth, and developmental screening. Almost all participants were licensed professionals. Participants indicated that they provided both individual consulting with one child care provider or with teaching teams and group trainings for all child care providers at one site or at multiple sites.

ENGAGEMENT PROCESS

Participants noted that child care providers are connected to the King County Child Care Health Program through contractual obligation with the City of Seattle Department of Education and Early Learning. Child care providers call to connect with child care health consultants when they need their services. When possible, child care health consultants provide services to additional child care providers.

When meeting with a new child care provider, participants indicated that the first step is to build a relationship.

[The consultant] finds out about them, find out where they are at, what they know about the children, and what they want to learn from you.

Participants indicated that they then complete a site assessment and work on goal setting with the child care provider and site director to develop mutual goals for consultation, which typically span a few months or through the end of the school year. The goals and plan of action can be modified.

Some sites where we just…you create a plan, they follow through, and it's set. Other sites we go multiple times – if the teacher can only do 2 steps out of 10 steps, we check in on those.

Participants noted that they connect with child care providers, based on need and desire, building trust and relationship as they meet. At times, they commented that one child care health consultant will bring in another consultant with a different specialty to support a child care provider. For example, a nurse consultant might bring in a mental health consultant to work with a child exhibiting challenging behaviors.

CHILD CARE HEALTH CONSULTATION TOPICS

The PHSKC child care health consultant team includes licensed mental health professionals, nutritionists, and nurses. With this range of expertise, child care health consultants provide support in health topics including physical activity, medication administration, blood borne pathogen review, asthma and allergy training, care plan reviews for children with different chronic medical conditions, breast feeding, and food allergies. They support:

- Providers' sanitation and hygiene practices, including hand washing and cleaning with bleach solution
- Environmental safety such as safe sleep and safe spaces for play, including the safety of the play equipment and toys
- Development of emergency plans such as having evacuation cribs and enough formula for infants for a three day shelter-in-place emergency
- Providing care to children with behavioral challenges and special needs, including helping with social and emotional caregiving in the classroom, managing challenging behavior and childhood trauma, conducting developmental screening, and navigating related conversations with families.

Participants reported facilitating learning through streamlined teaching techniques such as modeling, videos, small and large group trainings, motivational interviewing and reflective conversations with child care providers, psychoeducation, and visual materials with pictures.

CORE ELEMENTS OF CCHC SERVICES

While participants provide a wide range of services to child care providers, there are a few core elements. During their initial meeting with providers, participants said that they communicate that they are a resource to the provider, not an enforcing body. They work to build a positive and trusting relationship and help the child care provider develop relationships with the children in their care. Participants have varied expertise and reported using that expertise to address whatever concern the child care provider has, while ensuring that the child care provider is meeting the Washington Administrative Code (WAC) and licensing requirements in their care.

There are different core things for different programs, because we are meeting them where they are. If we only have a menu, a few things that won't meet needs in a good way or a respectful way – nursing, mental health, occupational therapy, physical therapy – it's harder to narrow beyond that.

SUCCESSES IN WORKING WITH CHILD CARE PROVIDERS

Participants described successes in working with child care providers. They found success in building a relationship and partnership with child care providers, which led to child care providers being excited to implement what they learn. Participants also found success in the relationships built between the child care provider and the children in their care.

Center with 8 or 9 babies – feeding was not a time for bonding with the children. I worked with the lead teacher on interaction with the babies. She loved seeing the baby return what was served. She then taught other teachers serve and return strategies for feeding the baby to bond with the children.

Mental health consultants found success in leading reflective conversations with child care providers about how to work with children with behavioral issues.

Reflective practice is the idea of helping providers through prompting questions—to help them to be able to reflect on what is going on in front of them and what role they play in the classroom and what the impact of that is on them and their classroom—allowing them a moment to pause. Allow providers to look at and think of their work in a different way—the facilitator asks them to think more deeply and think about them and what role they play in the work and in the environment. There is no time for providers to stop and pause, no one to validate to say, "This is difficult." Think about, what does it mean to sit there, and think what does it mean to work with these children day to day. That process of bringing them to this space and having someone there to facilitate that process.

Participants said that they saw increased change implementation among providers with whom they had a positive relationship.

If good relationship has been built, there is room for support and modeling which empowers the providers. The providers are calmer, [so] there is more interaction with the child, [and] they are calmer…relationship—provider, child, and the consultant.

Participants noted that it is easier for child care providers to implement what they learn when they have support from their administration, including support for additional planning time. They also noted that sites with more financial resources have an easier time implementing changes, even updating basic needs.

Sometimes basic needs aren't met—updating nap mats—that happens faster than the other centers that need to make payroll. Equity at every level—who can access us—sometimes the basic needs are not met.

CHALLENGES IN WORKING WITH CHILD CARE PROVIDERS

Participants stated that they face challenges in supporting child care providers with the children in their care. At times, child care providers are fearful of change and do not want to do something new. Child care providers who are ready to implement change may still lack the resources and tool for that implementation or do not have support from their site directors. Participants noted that there is also turnover among providers.

We're being asked for the help, but it's hard when there is so much teacher turnover and access to teachers and providers.

Some participants reported that there are language and cultural barriers.

How do you share best practice, while upholding the culture of the community. I learn so much from it. I don't want to come into a child care center and come down as someone saying the WACs is the way to be. You can't just go in and ask them to change something, because, for them, it isn't broken. We have to go in and build a relationship, model it, support it, and it takes a long time.

Participants also reported that it is harder to work with child care providers who did not have time or space to care for their own health and wellness throughout the day.

CHANGES IN THE WAY THAT CHILD CARE PROVIDERS WORK WITH CHILDREN AND FAMILIES

Participants indicated that they saw changes in how child care providers work with children, including openness to enrolling children with physical disabilities in their classroom and providing referrals and support.

I noticed one child who didn't speak. I debriefed the teacher right afterwards. I asked questions about that child. I asked to see her file. She had a diagnosis of selective mutism. It was an ongoing conversation…I sent them the appropriate resources. Last I heard, they are taking the child to the Seattle Children's selective autism group. They have been working with the interventions I have suggested. Before, they would force her to talk, but now they understand…are much more compassionate for her.

In addition, participants indicated that child care providers altered their communication practices with children, approaching children with more developmentally appropriate expectations that led to improvements among the children in their care. They also indicated that, since receiving support, child care providers are better equipped to discuss concerns with the child's family.

They made time to work with me—how to have the conversation—normalize, validate their feelings. Stayed present and grounded with them, even if the parent is very reactive about the news—discussed next steps. The conference went well, and parents were receptive to the news. Little by little, they will speak with me and practice in real life to feel more inspired to have these tough conversations.