

# HEALTHY CHILD CARE

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# WASHINGTON

*EVALUATION REPORT*

*INITIAL IMPLEMENTATION: OCTOBER 2003 – MARCH 2004*

*Prepared for*

*Washington State Department of Health*

*June 2004*

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*Prepared by*

*Organizational Research Services*

*Seattle, Washington*

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# INTRODUCTION

This report was prepared by Organizational Research Services (ORS) to describe the results of an initial implementation of the outcome-based evaluation system developed for the Infant Toddler Initiative of Healthy Child Care Washington (HCCW). HCCW contracted with ORS in September 2002 to design and pilot test an outcome-based evaluation strategy to assess the effectiveness of the Infant and Toddler Initiative. Volunteer consultants from seven Local Health Jurisdictions (LHJs) initially pilot tested the HCCW evaluation in May and June 2003. From October 2003 through March 2004, 26 consultants from 19 LHJs began implementing the evaluation tools. This report describes the following elements of the initial implementation of the evaluation process:

- ♦ Background of HCCW Infant and Toddler Initiative;
- ♦ The Evaluation Plan;
- ♦ Data Collection Tools;
- ♦ Evaluation Findings;
- ♦ Challenges and Lessons Learned;
- ♦ Evaluator Observations; and
- ♦ Conclusions.

# BACKGROUND

Initially conceived by the Washington State Department of Health as part of a small federal grant received in 1995, the goal of Healthy Child Care Washington (HCCW) was to integrate health and safety improvements into child care, early childhood and after-school settings. HCCW has blossomed over the years into a statewide system of partners that envisions a united effort of child care providers, parents, educators, policymakers, advocates, researchers, pediatricians, social service agencies and health professionals to maximize the resources focused on creating healthy and nurturing environments for children. This vibrant initiative to improve the quality of child care for infants and toddlers is the focus of this evaluation report.

The Infant and Toddler Initiative weaves together multiple layers of strategies to enhance the quality of child care provided to infants and toddlers. These include the following strategies:

- ♦ Development of systems at the local and state levels that link health, safety and child care/early childhood programs;
- ♦ Training and technical assistance provided to Child Care Health Consultants in LHJs in skills and standards related to child care quality;
- ♦ Consultation and training provided to child care providers and parents to enhance use of practices that promote health and safety; and
- ♦ Information and referral to parents to assist placement of infants and toddlers in child care settings.

Through these strategies, HCCW impacts the following:

- ♦ State and local partners;
- ♦ Child Care Health Consultants working in the state's 35 Local Health Jurisdictions (LHJs);
- ♦ Child care providers working in centers or homes across the state;
- ♦ Parents with infants and toddlers in child care settings; and
- ♦ Infants and toddlers.

Key partners who carry out these strategies are LHJs, the Washington State Department of Health, Washington State Child Care Resource & Referral Network agencies, Promoting First Relationships-University of Washington Department of Family and Child Nursing, and Pacific Rim Real Time Systems, Inc.

Funding support is provided primarily by the U.S. Department of Health and Human Services, Maternal Child Health and Child Care Bureaus; the Washington State Department of Social and Health Services, Division of Child Care and Early Learning; and the Washington State Department of Health Office of Maternal and Child Health.

# EVALUATION PLAN

Organizational Research Services (ORS) worked closely with HCCW staff, system partners and other contractors to help HCCW create a sustainable, results-oriented evaluation system. The evaluation is designed to move beyond counting outputs, such as the number of consultants trained and the number of child care providers they serve, and instead focuses on the outcomes, or “So what?” questions, such as “What changes occur in the lives of children, families and communities as a result of child care health consultations?” This evaluation system measures the following outcomes:

1. Increase the resources that are available to train child care providers and offer them technical assistance, information and referrals;
2. Expand the use of skills and standards for Child Care Health Consultants;
3. Enhance use of practices by child care providers that promote the social, emotional and physical health and cognitive development of children; and
4. Improve communication between child care providers and parents about child care quality and their children’s development and behavior.

These cascading levels of outcomes are based on a “theory of change” that recognizes that the social, emotional and physical health and cognitive needs of children are embedded in and influenced by systemic factors. These include the parent-child care communication system, the child care center system, the system of support available to child care providers, and the system of institutions and agencies dedicated to improving the care of children. This evaluation addresses each of these levels as a means to improve the quality of child care provided to infants and toddlers. See **Appendix A** for the HCCW Theory of Change and Logic Model.

## DATA COLLECTION TOOLS

Several data collection forms are used for this evaluation: the Encounter Form, the Provider Action Plan, the Consultant Action Plan and the Systems Development Tracking Tool. See **Appendix B** for samples of these forms.

### **Encounter Form**

The Encounter Form collects some data, such as who the Child Care Health Consultants serve, how they contact providers, and what topics they address on each *significant* interaction (encounter) that consultants have with providers or others (e.g., parents). Significant encounters include any consultation held in person or by phone or email or any meeting or training they attended as a system partner or trainer.

## **The Provider Action Plan**

The main purpose of the Provider Action Plan is to document the major issues addressed in consultations with providers, the proposed solutions, and the providers' success in solving the issues after 30 days. This plan highlights the key work performed by consultants – providing assistance to individual child care providers so they can change their environments, their processes or their policies to improve the health and safety of children in child care settings.

Consultants complete the first part of the triplicate form with the provider so that both have input into defining the issue and potential solutions. The provider retains the top copy, or it is mailed to the provider when the consultation is not in-person. Consultants then complete the form after 30 days to determine what changes occurred within the child care setting. Consultants use a standardized set of codes to track topics covered, actions/solutions suggested and progress observed. Training and ongoing technical assistance are provided by HCCW and ORS to ensure the reliability and consistency of code usage. Consultants may also refer to an evaluation handbook developed by ORS to help clarify and guide their use of codes and measure their progress.

## **The Consultant Action Plan**

The Consultant Action Plan documents progress towards increased use of skills and standards by Child Care Health Consultants. The plan is used at each training or significant technical assistance intervention by statewide consultants, including Pacific Rim Real Time Systems, Inc. consultant Jan Gross and Promoting First Relationships-University of Washington Department of Family and Child Nursing consultant Julie Nagel. Similar to the Provider Action Plan, this form is designed to be filled out by the trainer of the consultants after a training or substantial one-on-one consultation. The trainer and the Child Care Health Consultant discuss what changes in practice will result from the information supplied and categorize the topic of the training, which corresponds to state and national lists of core competencies. After a 90-day follow up period, the trainer and consultant gauge the extent to which the training or consultation led to changes in practice. ORS and HCCW selected the 90-day period because consultants often receive training on techniques or information that may not prove to be immediately relevant but will likely be useful when they encounter a situation where the issue addressed in the training or consultation is observed.

## **The Systems Development Tracking Tool**

The Systems Development Tracking Tool is completed quarterly by the Healthy Child Care Washington Advisory Team members from the Washington State Department of Health; Washington State Child Care Resource & Referral Network agencies; Promoting First Relationships-University of Washington Department of Family and Child Nursing; and Pacific Rim Real Time Systems, Inc. Members list each significant system development collaboration involving systems partners in Washington State, such as

coalitions, advisory groups, work groups, coordinating councils or initiatives. For each collaboration, members describe organizations represented, level of collaboration, intended or achieved results, and significant facts that act as barriers or facilitators to the collaboration.

## **Online Data Collection System**

In November 2003, Child Care Health Consultants gained access to the HCCW Data Collection Application (HCCWDC) to report all evaluation and state reporting requirements. HCCWDC has two data entry systems: Data Collection and Activity Tracking. The Data Collection system contains forms for the Child Care Health Consultants to fill out that match their paper forms. The Activity Tracking system captures all activities in a calendar-type system; Child Care Health Consultants enter all activities on a daily or weekly basis and are able to schedule future activities, record completed activities, or edit existing activities.

Most Child Care Health Consultants used the Data Collection system to enter their Encounter Form and Provider Action Plan data. Only nine of the 27 Child Care Health Consultants who participated in the six-month initial implementation of the evaluation used Activity Tracking. However, these nine consultants entered 356 encounters, roughly one-third (30.5%) of the data.

Because the initial release of the Activity Tracking system did not exactly match the Data Collection system forms, data are consistently missing for some variables entered into the Activity Tracking system. For analyzing these data points, those cases were not included as part of the total number of cases. These issues are being addressed through newer versions of the online application and additional training for Child Care Health Consultants on the required data components.

# EVALUATION FINDINGS

The evaluation of the HCCW Infant and Toddler Initiative allows for analyses in a number of areas related to the Infant and Toddler Initiative strategies. Findings will be described for the following:

- ♦ Child Care Health Consultant Activities;
- ♦ Child and Site Referrals;
- ♦ Changes in Child Care Settings; and
- ♦ Changes in Systems Supporting Early Childhood.

## CHILD CARE HEALTH CONSULTANT ACTIVITIES

Child Care Health Consultants engage in activities to achieve the following outcomes:

- ♦ Enhance use of practices by child care providers that promote the social, emotional and physical health and cognitive development of children; and
- ♦ Improve communication between child care providers and parents about child care quality and their children's development and behavior.

Consultants track these activities with the Encounter Form.

During the six-month initial implementation period (October 2003-March 2004) the following occurred:

- ♦ 27 Child Care Health Consultants in 26 Local Health Jurisdictions (LHJs) serving 29 counties documented 1,167 encounters.
- ♦ Of the encounters documented, Child Care Health Consultants served more than
  - ♦ 6,461 staff members at child care facilities serving more than 28,546 children.

See **Table 1** for a full list of Local Health Jurisdictions and the number of encounters documented.<sup>1</sup>

**Table 1: Number and Percentage of Encounters by LHJ (N=1,167)**

<b>LHJ</b>	<b>N</b>	<b>Percent of Responses</b>
Tacoma-Pierce	189	16.2
Chelan-Douglas	150	12.9
Clark	104	8.9
Mason	91	7.8
Asotin	68	5.8
Whitman	64	5.5
Clallam	56	4.8
Skagit	56	4.8
Grant	50	4.3
Bremerton-Kitsap	42	3.6
Yakima	41	3.5
Jefferson	40	3.4
Snohomish	38	3.3
NE Tri	37	3.2
Okanogan	30	2.6
Island	28	2.4
Pacific	19	1.6
Spokane	15	1.3
Walla Walla	15	1.3
Columbia	12	1.0
Garfield	9	0.8
Thurston	5	0.4
Adams	3	0.3
Kittitas	2	0.2
Lewis	2	0.2
Skamania	1	0.1
<b>TOTAL</b>	<b>1167</b>	<b>100.0</b>

<sup>1</sup> Note about the analysis: the data presented in this report should be considered preliminary. As shown in **Table 1** below, the data ranges from one encounter to almost 200 from any given LHJ. In addition, nine LHJs are not represented in the initial implementation data, including Seattle-King County, which would also make up a large percentage of the data. However, because the results are similar to results from last year's pilot test, we could reasonably expect to see similar patterns across the state in future years.

## Types of Providers Served

Child Care Health Consultants serve a variety of providers in a variety of settings:

- ◇ Most encounters occurred with center-based facilities.
  - ◆ 81.0 percent of encounters occurred at center-based facilities.
  - ◆ 19.0 percent occurred at home-based facilities.
- ◇ Child Care Health Consultants serve various types of child care providers.
  - ◆ 70.2 percent of providers were child care centers.
  - ◆ 16.8 percent were licensed home child care.
  - ◆ 10.5 percent were Head Start/Early Head Start programs.

See **Table 2** for a full list of child care providers served by Child Care Health Consultants.

**Table 2: Types of Providers Served by Child Care Health Consultants (N=702)<sup>2</sup>**

Provider Type	N	Percent
Child Care Center	493	70.2
Licensed Home Child Care	118	16.8
Head Start/Early Head Start	74	10.5
Unlicensed Home Child Care	13	1.9
Early Childhood Education and Assistance Program (ECEAP)	2	0.3
FFN-Family, Friend or Neighbor	2	0.3
TOTAL	702	100.0

<sup>2</sup> Note about the data: The N for the types of providers is lower than the total number of encounters for two reasons. First, these data were not captured by many who used the Activity Tracking system. In addition, some encounter types, such as e-mails, trainings and meetings, are often not relevant to this data variable; therefore type of provider was not recorded. A cross tabulation was done of encounter types and provider types to determine applicable data points. Missing data and Not Applicable entries were not included in the cases for analysis of provider types.

- ♦ Most facilities that Child Care Health Consultants work with employ five or fewer total staff members.
  - ♦ More than half (56.3%) of the facilities employ five or fewer individuals.
  - ♦ Almost one-quarter (22.7%) employ from six to 10 individuals.
  - ♦ 12.8 percent employ 11-15 staff members, and 8.2 percent employ 16 or more.
  - ♦ The average number of staff members at sites where encounters took place is 6.4.
  
- ♦ Child Care Health Consultants work most often with facilities that care for 50 or fewer children.
  - ♦ More than half of the facilities served (57.3%) cared for 25 or fewer children.
  - ♦ Almost one-quarter (24.6%) cared for 26 to 50 children.
  - ♦ 11.3 percent served 51 to 75 children, and only 6.9 percent served 76 or more children.
  - ♦ The average number of children at child care facilities served by Child Care Health Consultants is 28.4.

## **Topics Covered During Encounters**

Child Care Health Consultants cover a variety of topics with child care providers through their encounters. The most common topics include the following:

- ♦ Communicable Disease/Contagious Conditions;
- ♦ Health Policies Review/Development;
- ♦ Special Needs/Medical Management;
- ♦ Social Emotional Growth and Development; and
- ♦ Emergency Preparedness.

See **Table 3** for the full list and frequency of priority topics covered during encounters.

**Table 3: Number and Percentage of Topics Addressed by Child Care Health Consultants (N=1,167)\***

Type of Issue	N	Percent of Encounters
Communicable Disease/Contagious Conditions	320	27.4
Health Policies Review/ Development	152	13.0
Special Needs	126	10.8
Social-Emotional Growth & Development	109	9.3
Emergency Preparedness	91	7.8
Physical Growth & Development	90	7.7
Non-Communicable Health	88	7.5
Environmental Health & Food Safety	87	7.5
Feeding Issues	86	7.4
Immunizations	83	7.1
Other	76	6.5
Mandatory Trainings	70	6.0
Nutrition/ Menu Planning	63	5.4
Sleeping Issues	63	5.4
Indoor Safety	60	5.1
Communication with Parents	54	4.6
Brain/Cognitive Development	50	4.3
Staff Health	48	4.1
Oral Health	46	3.9
Diapering	32	2.7
Bonding/Attachment	19	1.6
Family Health	19	1.6
Access to Medical Home	15	1.3
Child Abuse and Neglect	15	1.3
Playground/Outdoor Safety	7	0.6
Access to Dental Home	3	0.3
Health Insurance Access	2	0.2
TOTAL	1874	(See Note)

*\*Percentages may total more than 100 percent since consultants may list up to three primary topic codes per encounter.*

## Variation in Encounter Topics among Counties

While most LHJs followed the general pattern of topic frequency, some Health Consultants covered a higher than average number of specific topics.<sup>3</sup> Some examples of variations include the following:

- ◆ 19.9 percent of encounters within Clark County covered Emergency Preparedness, compared to 7.8 percent overall.
- ◆ The Child Care Health Consultant serving Snohomish County was more likely to cover Feeding Issues (29.2%) and Nutrition and Meal Planning (36.5%) than average, 7.4 percent and 5.4 percent, respectively.
- ◆ Two LHJs, NE Tri Health Department (Ferry, Pend Oreille, and Stevens Counties) and Grant County, were more likely to cover Health Policies Review/Development than average, 32.5 percent and 21.5 percent, respectively, compared to 13.0 percent.
- ◆ Oral Health was a topic more than one-fifth of the time for Columbia County (21.7%) and Okanogan County (22.6%), compared to 3.9 percent on average.
- ◆ Social Emotional Growth and Development was covered in 30.4 percent of encounters in Jefferson County and 19.3 percent of encounters in Skagit County, compared to 9.3 percent overall.

These variations could stem from a variety of factors — consultant expertise or strong interest in a particular topic, a recent training in a specialized area, or a need that may vary from other parts of the state because of regional variables.

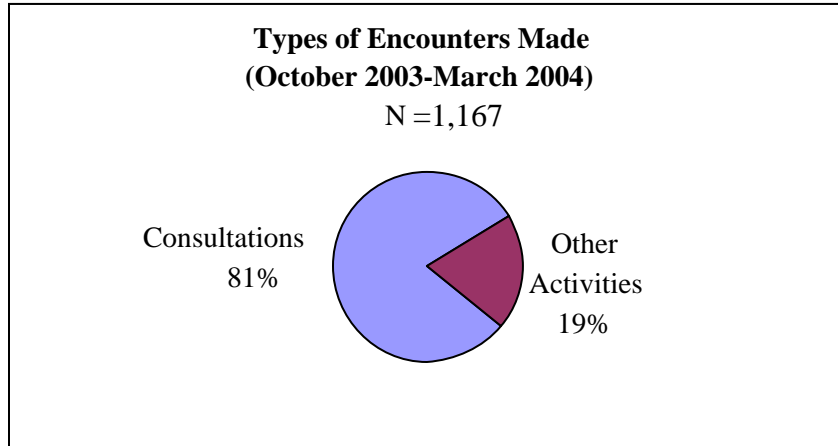
## Types of Encounters

Most encounters by Child Care Health Consultants were consultations.

- ◆ 81.0 percent were consultations, working directly with providers on specific issues or topics.
- ◆ 19.0 percent were other types of activities, including meetings, trainings, mailings and facility assessments.

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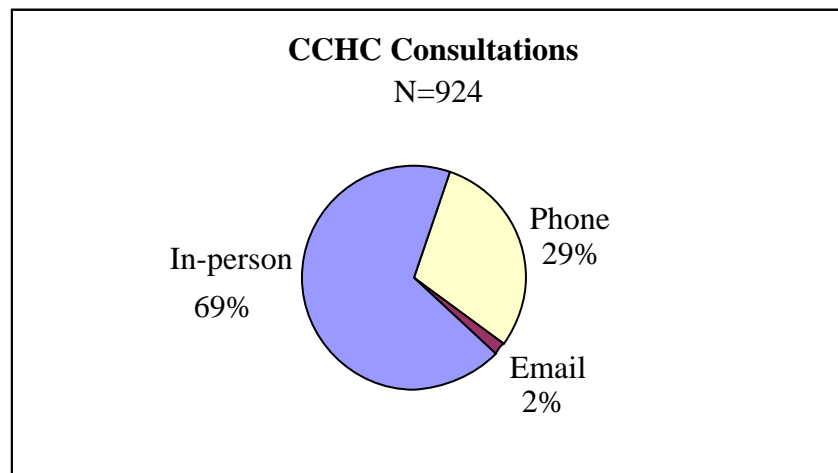
<sup>3</sup> Note about the data: We examined variation in topics covered during encounters to gauge differences across participating LHJs. Percentage results should be viewed with caution because the number of cases from each LHJ varies. However, LHJs with fewer than 20 primary encounter topics covered were not included in this analysis to help mitigate the differential in case size.



**CHILD CARE HEALTH CONSULTANT CONSULTATIONS**

Most consultations documented by Child Care Health Consultants were conducted in person.

- ♦ 68.7 percent were in-person.
- ♦ 29.4 percent were by phone.
- ♦ 1.8 percent were by email.



Consultations were initiated roughly equally by providers or consultants.

- ♦ 40.2 percent of consultations were initiated by providers.
- ♦ 38.0 percent of consultations were initiated by consultants.
- ♦ 17.4 percent of consultations were regularly scheduled meetings.

- ◆ Other consultation initiators included systems partners (3.6%) and “Other” (0.5%).

Consultations varied in length.

- ◆ More than one-third of consultations (37.2%) lasted more than 60 minutes.
- ◆ More than one-quarter (27.3%) lasted 31-60 minutes.
- ◆ About one-fifth (21.3%) took less than 15 minutes.
- ◆ 13.4 percent lasted 16-30 minutes.

These time spans align with the types of consultations provided. About half the consultations are in-person consultations, which are typically more time-consuming than email or phone consultations.

See **Table 4** for the list of the time spent on consulting encounters.

**Table 4: Time Spent on Consulting Encounters<sup>4</sup> (N=924)**

Time Spent	N	Percent of Encounters
Less than 15 minutes	197	21.3
16-30 minutes	124	13.4
31-60 minutes	252	27.3
More than 60 minutes	344	37.2
Missing	7	0.8
Total	924	100.0

Consultants recorded the three priority issues they encouraged providers to address. The most common topics covered during consultations align with the most common topics for all types of encounters:

- ◆ Communicable Disease/Contagious Conditions was a priority issue in almost one-third of the consultations recorded (30.4%).
- ◆ Other frequently discussed topics include the following:
  - ◆ Health Policies Review/Development (14.2%);
  - ◆ Special Needs/Medical Management (9.7%);
  - ◆ Social Emotional Growth and Development (8.8%); and
  - ◆ Emergency Preparedness (8.5%).

<sup>4</sup> Note about the data: Time spent on encounters includes research, preparation, travel and follow-up time.

## OTHER ACTIVITIES

In addition to consultations with child care providers, Child Care Health Consultants hold trainings, participate in meetings with partners, and mail out information on specific topics and conduct facility assessments.

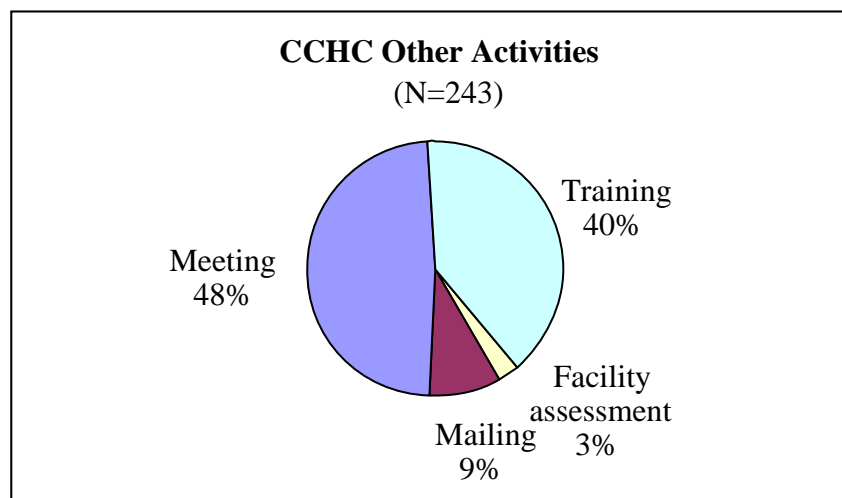
- ◆ 20.8 percent of all encounters were activities other than consultations.
  - ◆ 10.0 percent of the encounters were meetings.
  - ◆ 8.3 percent were trainings.
  - ◆ 1.9 percent were mailings.
  - ◆ 0.6 percent were facility assessments.

See **Table 5** for a full list of the frequency of Child Care Health Consultant activities that were not consultative.

**Table 5: Percentage of Other Types of Encounters (N=1,167)**

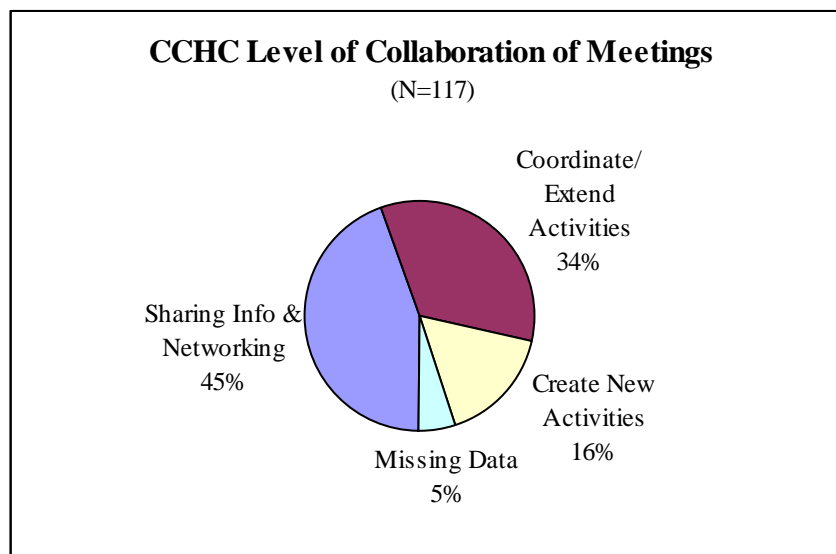
Type of Consultation or Contact	N	Percent of Encounters
<i>Non-Consultative Activities</i>	243	20.8
Meeting	117	10.0
Training	97	8.3
Mail	22	1.9
Facility Assessment	7	0.6

- ◆ The bulk of encounters that were not consultations were meetings (48.1%) and trainings (39.9%).



## Meetings

- ◇ 117 meetings were captured by the Encounter Form.
- ◇ Various system partners and organizations participated in meetings.
  - ◆ **Local Resource & Referral staff members** were involved in 27.4 percent of the meetings.
  - ◆ **LHJs from other counties** were involved in 23.1 percent of the meetings.
  - ◆ **Licensors** were involved in 19.7 percent of the meetings.
  - ◆ **Child Care Providers** and **Head Start/Early Head Start programs** were involved in 17.1 percent of the meetings.
  - ◆ **Internal LHJ departments** or co-workers were involved in 16.2 percent of the meetings.
  - ◆ **Physicians or nurses** were involved in 12.8 percent of the meetings.
  - ◆ **Early Childhood Education organizations** were involved in 9.4 percent of the meetings.
- ◇ Child Care Health Consultants are involved in collaborative efforts in their communities.
  - ◆ 44.4 percent of the meetings involved sharing information and networking.
  - ◆ More than half of all meetings involved higher levels of collaboration, including coordinating or extending existing activities (34.2%) or creating and conducting new activities (16.2%).



- ◇ Primary topics covered in meetings included the following:
  - ◆ Health Policies (14.5%);
  - ◆ Mandatory Trainings (12.8%);
  - ◆ Communicable Disease (12.0%);
  - ◆ Social/Emotional Growth and Development (12.0%); and
  - ◆ “Other” topics (29.1%), such as licensing, participating in advisory groups or meetings related to specific grants, or general networking and sharing of information.
  
- ◇ Meetings were most often initiated by the following:
  - ◆ System Partner (29.9%);
  - ◆ Consultant (26.5%); and
  - ◆ Regularly scheduled meetings (34.2%).
  - ◆ Providers (2.6%) and “Others” (4.3%) rarely scheduled meetings. Three meetings (2.6%) did not show data for who initiated the meeting.
  
- ◇ Child Care Health Consultants generally spent more than 60 minutes on meeting encounters.<sup>5</sup>
  - ◆ Nearly 60 percent (59.8%) lasted more than one hour.
  - ◆ 15.4 percent took 31-60 minutes.
  - ◆ 14.5 percent took 16-30 minutes.
  - ◆ 10.3 percent took 15 minutes or less.

### **Trainings**

- ◇ 97 trainings were documented through the Encounter Forms.
- ◇ More than 998 individuals were trained by Child Care Health Consultants during this period.
- ◇ Various partners participated in trainings.
  - ◆ Child care providers participated in almost half of the documented trainings (49.5%).
  - ◆ Other partners who participated in trainings included the following:
    - Mental Healthcare providers (12.4% of trainings);
    - Out-of-school-time program staff (12.4% of trainings); and
    - Local R&R agency staff (7.2% of trainings).

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<sup>5</sup> Note about the data: Time spent on encounters includes research, preparation, travel and follow-up time.

- ◇ Common topics of trainings included the following:
  - ◆ Special Needs/Medical Management (24.7%);
  - ◆ Non-Communicable Health (22.7%);
  - ◆ Communicable Disease/Contagious Conditions (20.6%); and
  - ◆ Social/Emotional Growth and Development (13.4%).
- ◇ Trainings were often initiated by providers.
  - ◆ 45.4 percent of trainings were initiated by providers.
  - ◆ Consultants initiated trainings about one-fifth of the time (20.6%).
  - ◆ Other initiators included system partners (13.4%), “Other” (5.2%) and regularly scheduled meeting (3.1%). The data did not include the training initiator in twelve cases (12.4%).
- ◇ Most trainings lasted more than sixty minutes.<sup>6</sup>
  - ◆ 73.2 percent of trainings took more than 60 minutes.
  - ◆ Surprisingly, one-fifth (20.6%) of the trainings were recorded as taking less than 15 minutes, possibly because consultants offered a “mini-training” to one or two staff people while they were on-site for other purposes. Future implementation of the evaluation will continue to clarify characteristics of trainings versus consultations.
  - ◆ 5.2 percent of the trainings lasted 31-60 minutes, and only one training (1.0%) lasted 16-30 minutes.

## CHILD AND SITE REFERRALS

Few encounters led to referrals.

- ◇ 12.3 percent of encounters led to referrals for services and resources in the community for individual children.
  - ◆ 143 child referrals were made.
  - ◆ 35.0 percent of child referrals were for primary care.
  - ◆ 11.2 percent of referrals were for the Women, Infants and Children Program (WIC).
  - ◆ 9.1 percent were for a public health nurse.
  - ◆ 7.7 percent were for dental care/oral health, Health Department or emotional/behavior health services.

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<sup>6</sup> Note about the data: Time spent on encounters includes research, preparation, travel and follow-up time.

- ◆ 7.0 percent of referrals were for developmental or vision care.
- ◆ 8.0 percent of encounters led to site referrals.
  - ◆ 93 site referrals were made.
  - ◆ 26.9 percent were referrals to the Division of Child Care and Early Learning (DCCEL).
  - ◆ 23.7 percent were Food Program referrals.
  - ◆ Many site referrals were categorized as “Other” (46.2%). These included referrals to other LHJs, the Washington State Training and Registry System (STARS) website, University of Washington-Promoting First Relationships, the Health Department, or connecting providers with other local providers for resources or expertise.
  - ◆ One site referral (6.5%) was made for the local Resource & Referral Agency and one for Environmental Health.

See **Table 6** for a full list of child referrals.

**Table 6: Percentage of Child Referrals (N=143)**

<b>Child Referral Type</b>	<b>N</b>	<b>Percent of Data</b>
Primary Care	50	35.0
WIC	16	11.2
Public Health Nurse	13	9.1
Dental Care/Oral Health Care	11	7.7
Emotional/Behavior	11	7.7
Health Department	11	7.7
Other	11	7.7
Development	10	7.0
Vision	10	7.0
Child Find	9	6.3
DSHS	9	6.3
Children with Special Health Care Needs	6	4.2
Mental Health	5	3.5
Nutritionist	5	3.5
Speech and Hearing	5	3.5
Communicable Disease	3	2.1
DOH	1	0.7
Environmental Health	1	0.7
Social Worker	1	0.7
Health Educator	0	0.0
TOTAL	142	100.0

As shown in the previous data, Child Care Health Consultants are engaging in a variety of different types of activities and covering a number of important topics during their encounters with providers and systems partners. The next section details the results of some of these activities, in particular their consultations with child care providers.

## **CHANGES IN THE PRACTICE OF CHILD CARE PROVIDERS**

Data gathered from the Provider Action Plan forms address the core outcome: “Enhance use of practices by child care providers that promote the social, emotional and physical health and cognitive abilities of children.” These forms documented the priority issues covered during the consultation session, collected data on the proposed strategies for

addressing these issues and assessed progress made by providers toward these proposed actions.

- ♦ 19 Child Care Health Consultants used the Action Plan forms.
- ♦ 437 consultations resulted in Action Plans.
- ♦ 841 issues were addressed through Action Plans.<sup>7</sup>

See **Table 7** for a full list of lead Local Health Jurisdictions (LHJs)' frequency of action plans completed.

**Table 7: Number and Percentage of Action Plans Completed by LHJ (N=437)**

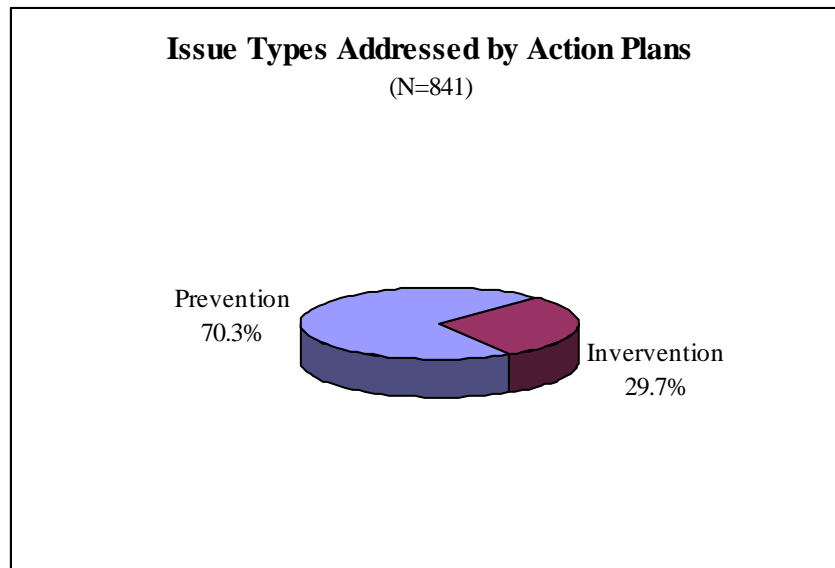
County	N	Percent of Cases
Tacoma-Pierce	171	39.1
Spokane	48	11.0
Clark	46	10.5
Grant	40	9.2
Skagit	34	7.8
Kitsap	31	7.1
UW/King	20	4.5
Yakima	18	4.1
Whitman	14	3.2
Chelan-Douglas	7	1.6
Benton-Franklin	4	0.9
Pacific	2	0.5
Island	2	0.5
TOTAL	437	100.0

<sup>7</sup> Note about the data: This sample is skewed by Tacoma-Pierce County, whose consultants completed more than one-third of the total encounter forms. While the data will always be weighted by metropolitan counties with larger numbers of staff and child care facilities, the results from this initial implementation are not substantially different from last year's pilot test results. Therefore, we would expect similar patterns and results to be seen across the state in future years.

## Issues Addressed by Providers

Most action plans addressed issues of prevention.

- ◇ 70.3 percent addressed prevention issues.
- ◇ 29.7 percent were interventions for existing issues.



Most action plans related to population-level issues.

- ◇ 81.9 percent addressed population issues.
- ◇ 18.1 percent addressed issues related to individuals.

Most consultations dealing with prevention issues also concerned child care populations, while many of the issues of intervention concerned individual children.

Consultants and providers addressed a range of issues through the action planning process.<sup>8</sup>

- ◇ 19.0 percent addressed issues related to Communicable Diseases and Contagious Conditions.
- ◇ 12.1 percent addressed Emergency Preparedness.

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<sup>8</sup> Note about the data: Figures will not match directly between encounter form data and action plan data. The encounter form captures more extensive and different kinds of interactions with Child Care Health Consultants than does the action plan form.

- ♦ 10.7 percent addressed Health Policies Review/Development.
- ♦ 8.8 percent addressed Sleep Issues, particularly SIDS prevention.
- ♦ 6.7 percent addressed Special Needs/Medical Management.

See **Table 8** for a complete listing of the distribution across all 21 issue categories.

**Table 8: Percentage of Action Plan Issues Addressing Specific Topics (N=841)<sup>9</sup>**

<b>Issue</b>	<b>N</b>	<b>Percent of Issues Addressed in Consultations</b>
Communicable Diseases & Contagious Conditions	160	19.0
Emergency Preparedness	102	12.1
Health Policies Review/Development	90	10.7
Sleep Issues	74	8.8
Environmental Health & Food Safety	61	7.3
Special Needs/Medical Management Issues	56	6.7
Social/Emotional Growth & Development	39	4.6
Indoor Safety	37	4.4
Physical Growth and Development	36	4.3
Nutrition/Menu Planning	25	3.0
Immunizations	23	2.7
Staff Health	22	2.6
Brain/Cognitive Growth and Development	21	2.5
Other	19	2.3
Diapering	14	1.7
Feeding Issues	14	1.7
Oral Health	14	1.7
Non-Communicable Health	8	1.0
Communication with Parents	6	0.7
Family Health	6	0.7
Bonding/Attachment	5	0.6
Mandated Trainings	5	0.6
Playground Safety/Outdoor	2	0.2
Access to a Medical Home	1	0.1
Child Abuse and Neglect	1	0.1
Access to a Dental Home	0	0.0
Health Insurance Access	0	0.0
<b>TOTAL</b>	<b>841</b>	<b>100.0</b>

<sup>9</sup> Note about the data: While Child Care Health Consultants and providers could address up to three issues per action plan, they were asked to choose one topic per issue. The unit of analysis for the Action Plan data is by issue, not Action Plan. Therefore, the total number of cases analyzed in this section will be the number of issues addressed (N=841) rather than the number of Action Plans completed (N=437).

## Variation in Topics Addressed across Counties

As with the Encounter Form data, variation occurs in how often individual Child Care Health Consultants address particular topics.<sup>10</sup>

- ◇ 80.0 percent of the issues addressed by a nurse consultant from the University of Washington-Promoting First Relationships team were related to Bonding and Attachment and 68.0 percent were related to Social Emotional Growth and Development, compared to 0.6 percent and 4.6 percent, respectively, overall.
- ◇ More than one-quarter (28.3%) of the issues identified for action plans by the Skagit County Child Care Health Consultants related to Special Needs, compared to 6.7 percent overall.
- ◇ Grant County's Child Care Health Consultant primarily addressed issues of Communicable Disease (33.3%) and Health Policies (30.0%) in action plans with providers, compared to 19.0 percent and 10.7 percent, respectively, overall.
- ◇ About one-quarter of the issues addressed in Yakima County (25.0%) and Clark County (23.6%) dealt with Emergency Preparedness, compared to 12.1 percent overall.
- ◇ More than one-fifth (22.5%) of issues addressed in Kitsap County related to Environmental Health and Food Safety, compared to 7.3 percent overall.

As noted previously, these variations could stem from a variety of factors — consultant expertise and interest in a particular topic, a recent training in a specialized area or a need that may vary from other parts of the state because of regional variables.

## Suggested Actions for Providers

After discussing the current issues and problems with child care providers, Child Care Health Consultants and the providers determine specific actions to address the issues of concern. After 30 days, the Child Care Health Consultant contacts the provider to discuss progress made on these issues. These changes could relate to knowledge, attitude, skills, behavior, environmental conditions, child health, community connections, policy, and other changes in individuals or the organization.

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<sup>10</sup> Note about the data: Variation in topics covered as issues for the Action Plans was examined to gauge differences across participating LHJs. Percentage results should be viewed with caution because the number of cases from each LHJ varies. However, LHJs with fewer than 20 action plan issues were not included in this analysis to mitigate the differential in case size.

Child Care Health Consultants suggested a variety of actions to providers.

- ◊ Knowledge changes were suggested for more than two-thirds of the identified issues.
- ◊ Behavior changes were suggested more than one-third of the time.
- ◊ Policy changes were suggested more than one-quarter of the time.
- ◊ Communication with parents was suggested more than one-fifth of the time.

See **Table 9** for a full list of types of proposed actions.

**Table 9: Percentage of Types of Proposed Actions (n=841)**

Action/Change	N	Percent of Consultations*
Knowledge/Awareness Change	564	67.1
Behavior/Practice Change	289	34.4
Policy Change	218	25.9
Communication with Parent	190	22.6
Environmental Change	160	19.0
Communication with Healthcare Professional	44	5.2
Access to Community Resources	25	3.0
Communication with Other	18	2.1
TOTAL	841	(See Note)

*\*Proposed actions will add up to more than 100 percent because Child Care Health Consultants note all relevant suggested actions. Any given issue can have multiple action/solution codes.*

## Types of Changes Observed

In addition to determining a level of progress, Child Care Health Consultants note which type of changes they are seeing at child care settings.

- ◊ Changes are occurring among child care providers.
  - ◆ Knowledge changes were observed in more than one-third of the action plan issue areas.
  - ◆ Child care staff changed their behavior for nearly one-third of the identified issues.
  - ◆ Policy changes occurred for 17 percent of the action plan issues.

See **Table 10** for a full list of changes among child care providers.

**Table 10: Percentage of Changes among Child Care Providers (N=841)**

<b>Progress/Changes among Child Care Providers</b>	<b>N</b>	<b>Percent of Consultations*</b>
Knowledge/Awareness Change in Provider	324	38.5
Behavior Change in Provider	253	30.1
Policy Change at Child Care Facility	145	17.2
Environmental Change	118	14.0
Increased/Better Communication between Provider and Parent(s)	84	10.0
Access of Resources by Provider/Staff	18	2.1
<b>TOTAL</b>	<b>942</b>	<b>(See Note)</b>

*\*Percentages may equal more than 100 percent because multiple changes can be observed for any given issue.*

- ◆ Some changes are being seen among parents who use those child care facilities in which Child Care Health Consultants have provided consultation.
  - ◆ Knowledge changes in parents were identified in 11 percent of the action plan issues.
  - ◆ Parents changed behavior or accessed community resources for 3 percent of the action plan issues.
  - ◆ Percentages of parents who made changes based on action plans are low. However, since the primary work of Child Care Health Consultants is with providers, it is not surprising these figures are lower than are those for providers.

See **Table 11** for a full list of changes among parents.

**Table 11: Percentage of Changes in Evidence among Parents (N=841)**

<b>Progress/Change in Parent(s)</b>	<b>N</b>	<b>Percent of Issues*</b>
Knowledge/Awareness Change in Parent	93	11.1
Behavior Change in Parent	26	3.1
Access of Community Resources for Parent	12	1.4
<b>TOTAL</b>	<b>131</b>	<b>15.6</b>

*\*Percentages may equal more than 100 percent because multiple changes can be observed for any given issue.*

- ◆ Child Care Health Consultants observe changes among children with whom providers they consult with work.
  - ◆ Knowledge and behavior changes in children were identified in 3 percent of the action plan issues.
  - ◆ Evidence showed improved health of an individual child based on the implementation of suggested actions.

- ◆ Because most issues covered in the Action Plans addressed prevention issues rather than interventions, it is not surprising there were few changes that demonstrated improved health of individual children or a child population. Changes in health are counted only when an individual condition changes, not when a change in conditions at a child care facility decreases the likelihood of health issues.

See **Table 12** for a full list of changes among children.

**Table 12: Percentage of Changes among Children (N=841)**

<b>Progress/Change in Child</b>	<b>N</b>	<b>Percent of Consultations*</b>
Knowledge/Awareness Change in Child	25	3.0
Behavior Change in Child	25	3.0
Improved Health of Individual Child	18	2.1
Access of Community Resources for Child	11	1.3
Improved Health of Child Population Center wide	4	0.5
<b>TOTAL</b>	<b>83</b>	<b>9.9</b>

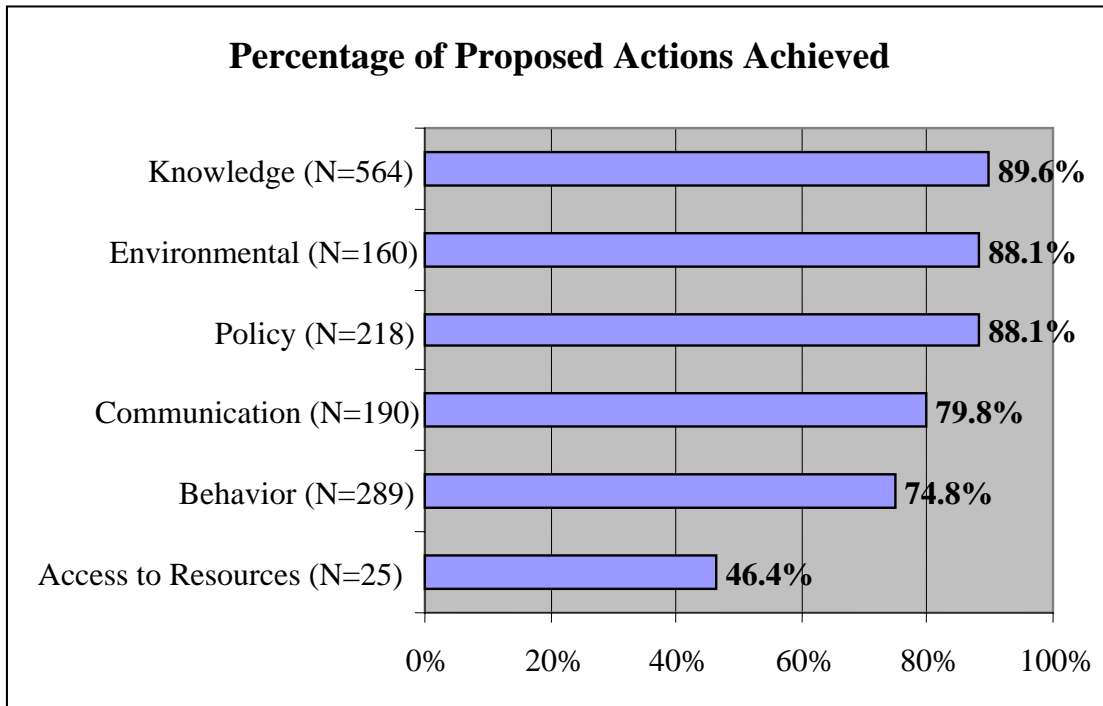
*\*Percentages may equal more than 100 percent because multiple changes can be observed for any given issue.*

In addition to seeing whether specific types of changes were made, it is possible to see if providers, parents and/or children made the kinds of changes specifically suggested by the Child Care Health Consultant for an action plan issue.<sup>11</sup>

- ◆ In consultations in which knowledge and awareness changes were proposed, evidence of this type of change occurred 89.6 percent of the time.
- ◆ In consultations in which behavioral changes were proposed, evidence showed behavior changes occurred 74.8 percent of the time.
- ◆ In consultations in which policy changes were proposed, evidence showed policy changes occurred 88.3 percent of the time.
- ◆ In consultations in which environmental changes were proposed, evidence showed environmental changes occurred 88.1 percent of the time.
- ◆ In 79.8 percent of consultations in which improved communication between parents and providers was proposed, providers demonstrated evidence of improved communication.

<sup>11</sup> Note about the data: Figures for “proposed actions achieved” include changes made by providers, parents and/or children.

- ◊ In consultations in which it was suggested that providers, parents or children access community resources, evidence showed that resources were accessed 46.4 percent of the time.



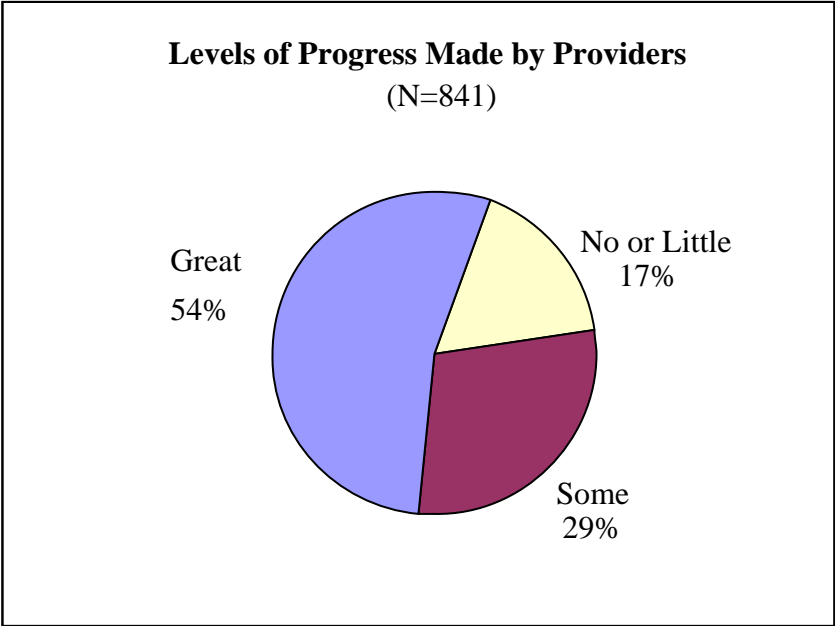
## Levels of Progress Made by Providers

Providers are making significant progress on specific issues.

- ◊ Consultants reported an average progress level of 2.37, on a scale of “1” equals no or little progress, “2” equals some progress and “3” equals great progress.<sup>12</sup>
- ◊ In the majority of consultations (82.8%), at least some progress toward addressing priority issues at child care centers and homes was achieved.<sup>13</sup>
- ◊ “Great progress” occurred as a result of the consultations in more than half (53.7%) of the centers and homes.

<sup>12</sup> Note about the data: Consultants are advised to determine progress based on a set of criteria of types of changes that indicate “Some” or “Great” progress rather than determining progress by how well an individual provider does the suggested action. For example, behavior changes are always considered “Great” change, while knowledge changes are always considered “Some” change, anticipating that changes in knowledge should lead to changes in behavior, policy or other areas. This is meant to allow for greater reliability across the data. Consultants use a codebook developed by ORS to guide them.

<sup>13</sup> Note about the data: “No” or “Little Progress” was also entered in cases where child care facilities went out of business or the particular staff person with whom the issue related was no longer employed by the facility. Therefore, the percentage of “No” or “Little” progress may also contain cases in which “Not Applicable” or “Unable to Determine” may have been more appropriate.



Clearly, Child Care Health Consultants are having positive impacts on child care providers, children and families. The consultations are resulting in changes in knowledge, behavior, policies, environments and communication. HCCW supports this work by making changes within the systems that support Child Care Health Consultants and early childhood.

# CHANGES IN SYSTEMS SUPPORTING EARLY CHILDHOOD

To create meaningful and lasting changes in the health and safety of infants and toddlers and their families, changes must occur in the systems that support them. The system-level outcome in the HCCW initiative is as follows:

- ◆ Development of systems at the local and state levels that link health, safety and child care/early childhood programs.

We selected six specific indicators for this outcome:

- ◆ Better coordinated and integrated training system that reflects best practices for Child Care Health Consultants;
- ◆ Increased modes of communication among system partners;
- ◆ Increased stability of funding;
- ◆ Increased amount of funds for HCCW;
- ◆ Increased number of sources of funding for HCCW; and
- ◆ Maintain infrastructure that responds to HCCW growth and expansion.

The following section details the evaluation findings in these areas.

## **Changes in Child Care Health Consultants' Practice**

Child Care Health Consultants are supported in their work through professional development and technical assistance by two statewide consulting groups, Pacific Rim Real Time Systems, Inc. (Jan Gross, Lead Consultant), and Promoting First Relationships-University of Washington Department of Family and Child Nursing (Jean Kelly, Director and Julie Nagel, Lead Consultant). These consultants work one-on-one with Child Care Health Consultants to improve their skills in core competencies related to their work with child care providers. The state consultants and the Child Care Health Consultants use the Consultant Action Plan form to collect data on the consultants' progress toward improving their skills in particular areas.

- ◆ During the initial implementation period, the state consultants completed 36 Action Plans with 29 Child Care Health Consultants from 27 counties across the state.
- ◆ Through this process, Child Care Health Consultants addressed 66 skills or core competencies.

- ♦ A large percentage of the core competencies addressed related to Social Emotional Development (34.8%) and Bonding/Attachment (16.7%). This is likely because of the emphasis on these areas in the Promoting First Relationships curriculum.
- ♦ Other topics more typically addressed included Consultations Skills (15.2%) and Training Skills (10.6%).
- ♦ On average, progress was made in 81.9 percent of the issues addressed. Great progress was made for 25.8 percent of the issues.<sup>14</sup>

Through this technical assistance, HCCW is able to expand the use of skills and standards for Child Care Health Consultants.

See **Table 13** for a full list of competencies addressed.

**Table 13: Core Competency Skills Addressed and Progress Made by Child Care Health Consultants**

<b>Training Topic</b>	<b>N</b>	<b>Percentage of Areas Addressed</b>	<b>Average Progress *</b>
Social/Emotional Development	23	34.8	2.13
Bonding/Attachment	11	16.7	2.27
Consultation Skills	10	15.2	1.80
Training Skills	7	10.6	2.00
Curriculum Development	5	7.6	1.80
Meeting with Child Care Partners	3	4.5	1.67
Health Policies Review/Development	2	3.0	2.00
Insurance for Children	2	3.0	2.50
Medical Home	2	3.0	2.50
Children with Special Needs	1	1.5	3.00
<b>TOTAL</b>	<b>66</b>	<b>100.0</b>	<b>2.08</b>

\*1=No/little Progress; 2=Some Progress; 3=Great Progress

## **Communication with System Partners**

<sup>14</sup> Note about the data: While a codebook delineating specific action/solution codes, progress codes and guidelines for determining levels of progress was created for the Provider Action Plan after the 2003 pilot test, this process will not begin until July 2004 for the Consultant Action Plan. Therefore, a greater degree of variability occurred in how levels of progress were determined, even within issues addressed by individual state consultants. The average level of progress data should be viewed with caution.

HCCW and the Child Care Health Consultants are engaging in substantial collaborations with early childhood systems partners. Through these efforts, they are keeping health and child care issues “at the table” for many major early childhood initiatives.

- ◇ Child Care Health Consultants documented 117 meetings with systems partners, including local Resource & Referral agencies, Local Health Jurisdictions from other counties, licensors, providers, Head Start/Early Head Start programs, physicians and nurses, and early childhood education organizations. Meeting topics included Health Policy Review/Development, Mandatory Trainings, Communicable Disease, and Social Emotional Growth and Development.
- ◇ HCCW partners support the efforts to develop systems at all levels that link health, safety and child care/early childhood systems. Partners include the following:
  - ◆ Lorrie Grevstad, Washington State Department of Health Office of Maternal and Child Health;
  - ◆ Elizabeth Bonbright-Thompson, Washington State Child Care Resource & Referral Network;
  - ◆ Jean Kelly, Promoting First Relationships-University of Washington Department of Family and Child Nursing; and
  - ◆ Jan Gross, Pacific Rim Real Time Systems, Inc.
- ◇ HCCW partners worked with more than 50 organizations comprised of many local, state and federal partners. Some of these groups include the following:
  - ◆ Better Baby Care Campaign;
  - ◆ BUILD Initiative;
  - ◆ Child Care Coordinating Committee;
  - ◆ Child Care Works;
  - ◆ CHILD (Children’s Health Immunizations Linkage and Development) Profile;
  - ◆ CHEF (Comprehensive Health Education Foundation);
  - ◆ Early Childhood Education Campaign;
  - ◆ Every Child Matters;
  - ◆ First Steps;
  - ◆ Foundation for Early Learning;
  - ◆ Office of the State Superintendent for Public Instruction;
  - ◆ Project TEACH; and
  - ◆ WA-PEN (Washington Association of Parent Educators Network).

See **Appendix C** for a full table of collaborations.

- ♦ Frequently, multiple members of the HCCW Advisory Group are involved in the same collaborations. In these cases, they are able to share HCCW concepts from differing perspectives and areas of expertise: community-based organization and child care, state agency and health, university and social/emotional growth and development/infant mental health, and the perspective of the practicing public health nurses.
- ♦ These collaborations have achieved or are working toward a number of results.
  - ♦ ***Inclusion of health and child care issues in early childhood initiatives, projects and groups***, including the following:
    - Advisory Group for Early Learning Benchmarks;
    - Annual Western Region Head Start and Early Childhood Education and Assistance Program (ECEAP) Conference;
    - Center on Human Development and Disability Early Intervention Task Force;
    - Child Care Coordinating Committee;
    - Head Start State Collaboration Project Advisory Committee;
    - Head Start Summer Institute for Head Start, Early Head Start and ECEAP staff;
    - Internal Department of Health Teams;
    - Kids Get Care Collaboration;
    - Office of Superintendent of Public Instruction (OSPI) Early Childhood Program; and
    - Washington BUILD Initiative.
  - ♦ ***Efforts to coordinate early childhood efforts***
    - Connections have been developed between HCCW, Early Childhood Comprehensive Systems (ECCS) Grant and the Oral Health Systems Grant.
    - HCCW evaluation findings helped form new contract work with a CDC (Center for Disease Control) on nutrition and physical activity.
    - Integrating Better Baby Care Campaign with DCCEL (Division of Child Care Early Learning) Consumer Education Campaign.
    - Meeting hosted by Governor's Policy Office to coordinate early childhood initiatives with all lead entities.

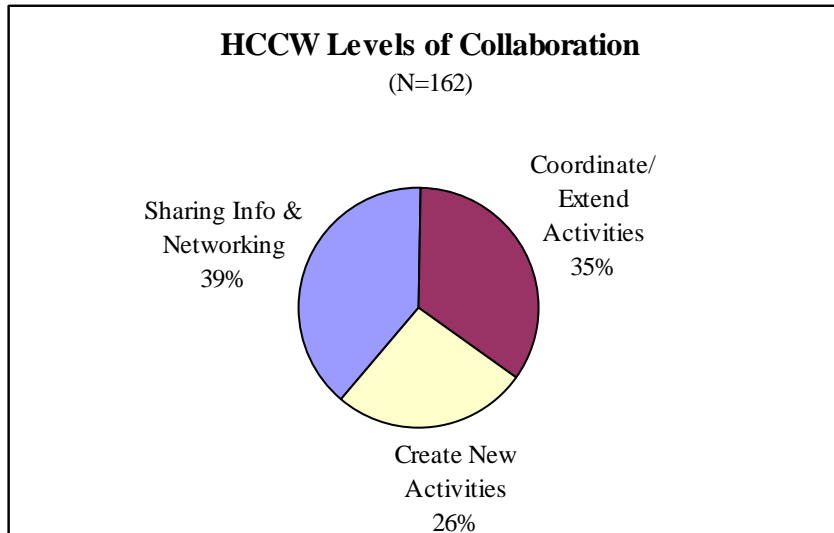
- Statewide retreat and meetings to redefine Sequenced Transition to Education in the Public Schools (STEPS) to provide resources for the field without duplicating other statewide early childhood efforts.
- Mapping of systems in early childhood and after-school systems to examine how systems currently exist and inter-relate.
- Tacoma/Pierce County Creating School Linkages Forum brought together early learning, K-12 and higher education communities to forge new partnerships on behalf of school readiness.
- Exploration of critical topics for cross-training of licensors, Resource & Referral staff and Child Care Health Consultants.
- ◆ ***Impacting policy and fiscal investments in child care and early learning programs nationally and at state and local levels***
  - League of Education Voters included pre-K in the Education Trust Fund Initiative proposal.
  - National Child Care Resource & Referral Association Public Policy Committee successfully placed significant language in key policy measures and secured ongoing funding for Child Care Aware.
  - A collaboration of statewide groups held a Governor's Candidate Forum so candidates could present their views on early childhood issues and respond to questions from the field. Partners included the Washington Resource & Referral Network; Washington Association for the Education of Young Children (WAEYC); Head Start/ECEAP Association; School's Out Washington; and 250 Head and ECEAP teachers, parents and directors from around the state.
  - Every Child Matters Coalition is working to get individuals who care about children registered to vote. Partners include Washington Resource & Referral Network, WAEYC, Head Start/ECEAP Association, School's Out Washington, Children's Alliance, Catholic Charities, Welfare Rights Organizing Council (WROC) and others.
  - Presentation to Seattle Families and Education Levy Citizen's Advisory Council regarding inclusion of policies and funding priorities that nurture and support early care and education issues.
- ◆ ***Creating materials to share information***
  - Development of Neurons to Neighborhood pamphlet for the Seattle/King County School Readiness Initiative.
  - Development of white paper on child care subsidies with concrete recommendations for action.
  - Development of CDC Grant curriculum for Child Care Health Consultants on reducing sedentary behaviors.

◆ *Developing new funding sources*

Broad-based group developed a grant to prevent child abuse and neglect through caregiver training. Partners included Resource & Referral Network, Washington Council for Prevention of Child Abuse and Neglect (WCPCAN), DOH, DCCEL, WA-PEN and the Infant Toddler Early Intervention Program (ITEIP).

- ◆ Certain factors and conditions facilitate collaborative work.
  - ◆ By participating in various groups and committees, HCCW is receiving support from diverse partners, including OSPI.
  - ◆ The current strong focus on early childhood and school readiness locally (e.g., development of County School Readiness Action Agendas) and statewide (e.g., BUILD Initiative, ECCS) is providing opportunities to show connections between health and school readiness and education agendas.
  - ◆ Many committed individuals and groups are working in the area of early childhood.
  - ◆ Engagement with diverse partners allows exposure to other groups and key policy makers and funders.
  - ◆ Internally, the Office of Maternal and Child Health is undergoing a Five-Year Needs Assessment process, which requires deliberate thinking and planning and also provides opportunities to coordinate across programs.
- ◆ Barriers exist that can present challenges to collaborative efforts.
  - ◆ Lack of time and workload issues
    - Participation in various groups can be time-consuming for partners on top of already tight schedules.
    - Work may move slowly due to less time for collaboration partners to complete new projects in addition to existing job responsibilities.
  - ◆ Infrequent meetings
    - While time for meetings is always an issue, meetings that are rare or infrequent may stymie progress on collaborative goals.
  - ◆ Lack of resources to support collaborative efforts
    - Many collaborations, including BUILD and the State Infant-Toddler Initiative, lack funding to support the work performed by various partners.
    - The time taken for meetings and related work and travel can make partnering costly to individuals and organizations.
    - Inconsistencies in annual funding from HCCW to contractors make long-term planning difficult.

- ◆ Many stakeholders and the public do not readily see the connection between health and school readiness.
- ◆ Challenges related to multiple early childhood efforts currently underway.
  - It can be difficult to understand how various efforts could most efficiently and effectively intersect while each effort still meets its individually stated agendas, goals, and outcomes.
  - With limited resources and funding, turf issues can emerge across organizations.
  - Needs and priorities can vary across groups within the state and nationally, making consensus or goal-setting more challenging.
- ◆ Unclear direction or leadership for collaboration.
  - In a few cases, collaborative efforts have been stifled or slowed by unclear direction or poor leadership. For example, the Governor's Policy Office hosted a meeting with all lead entities with systemic initiatives to clarify roles and responsibilities and define overlap. However, unclear direction and leadership have led to unfinished tasks and frustration.
- ◆ The collaborations by HCCW Advisory Team members and the Child Care Health Consultants have been substantial.
  - ◆ More than one-quarter of all meetings and collaborations (26.1%) have sparked initiation or inaction of new activities.
  - ◆ More than one-third (34.8%) helped HCCW coordinate or extend existing activities.
  - ◆ More than one-third (39.1%) involved sharing information and networking.



## Budgets and Staffing

Another part of system level development is acquisition of stable funding and maintaining adequate staff to administer programs.

In March 2004, Local Health Jurisdictions (LHJs) completed survey gathering information about whether, and to what extent, LHJs subsidize their Healthy Child Care Washington Infant/Toddler program. Thirty-six individuals responded from 33 LHJs.<sup>15</sup>

Most HCCW Infant/Toddler funding covers the equivalent of half the salary of a full-time public health nurse.

- ♦ The average FTE allocation covered by HCCW Infant/Toddler Funding is 0.39.
- ♦ The minimum FTE listed was 0.04, and the highest FTE was 0.88.
- ♦ The most common response was 0.5 FTE.

More than half of the LHJs had small amounts of FTE supporting Child Care Health Consultant work, generally clerical or administrative support.

- ♦ 58.3 percent of the respondents had other FTEs supporting Child Care Health Consultant work, most often for administrative or clerical support. In some counties, such as Pierce and King, multiple public health nurse FTEs support the work.

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<sup>15</sup> Three counties had more than one respondent; however, responses by different individuals from the same county varied. For the analysis, both responses for a county are included.

- ♦ The most common response to the amount of FTEs supporting Child Care Health Consultant work was 0.1 FTE, which was also the median. The average was 1.3, a number that was skewed high due to 16.12 FTEs at King County and 1.95 FTEs at Tacoma-Pierce.

Most LHJs do not use MCH Block Grant funding for Child Care Health Consultant work.

- ♦ Only four of the respondents (11.1%) said they used Maternal and Child Health (MCH) Block Grant funding for Child Care Health Consultant work.
- ♦ Of those who did, the amount of block grant money ranged from \$200 to \$6,000 to \$74,410. (One respondent who replied “yes” did not supply a figure.)

More than half the responding LHJs use local funding to support salaries.

- ♦ 52.8 percent of the respondents used local funding for Child Care Health Consultant work.
- ♦ The amounts used from local funding ranged from \$262.54 to \$812,106. The local funding was generally allocated for salaries.

About one-quarter of the responding LHJs use other funding for Child Care Health Consultant work, usually to cover the costs of supplies, trainings and salaries.

- ♦ 27.8 percent of the respondents stated they used other funding for Child Care Health Consultant work.
- ♦ For those who used “other” funding, amounts ranged from \$2,000 to more than one million dollars. This money was typically used for supplies, FTEs and other costs not covered by other funding sources.
- ♦ Other funding included contracts from cities or providers and County General Fund contributions.

Comments from responding LHJs suggest there is greater need for these services than current funding levels provide in some counties, particularly rural areas that have fewer resources than larger metropolitan areas. LHJs also cited the value of providing prevention services to avoid more costly interventions.

Clearly, Child Care Health Consultants are accomplishing a great deal in the field, despite scarce resources. The data from this survey also suggests that there are opportunities for most LHJs to explore increased sources and amounts of funding to support this work.

# CHALLENGES AND LESSONS LEARNED

ORS worked closely with the HCCW Team and local Child Care Health Consultants to design and test the evaluation described in this report. Through this initial evaluation implementation process, a number of challenges and lessons learned have been identified.

## **Data Collection Issues**

A variety of challenges related to data collection efforts impacted the amount of data available for analyses. These included participation rates, questions regarding contractual requirements and data reporting redundancies. More detailed explanations of these issues can be found in **Appendix D**. These issues are being addressed through additional training, new language in the 2004-05 HCCW Statement of Work, and efforts to decrease redundancies in reporting requirements.

## **Online Data Collection System Issues**

Several issues with the new online data collection system also affected data collection efforts.

Early difficulties in using the online data collection system seemed to affect participation by some Child Care Health Consultants. In a few cases, consultants entered one or two forms in October and never used the system again.

Inability to see who was entering data prevented ORS and HCCW staff from addressing data entry and data collection issues early on. Since we did not know who was, or was not, entering Encounter Form and Provider Action Plan data, we were unable to follow up with individual LHJs or Child Care Health Consultants to encourage them to participate and support their efforts in the evaluation.

Several LHJs already have online systems into which Child Care Health Consultants are required to enter their activities, and these consultants are reluctant to duplicate their work. Efforts to coordinate data collection from existing systems have not progressed beyond initial conversations, but future integration will allow for more comprehensive data for reporting.

## **Data Reporting Redundancies**

Currently, all LHJs are responsible for completing the Encounter Form, which documents specific types of activities (consultations, meetings, trainings and facility assessments) for HCCW. They are also required to complete the Basic Monthly Report, which documents cumulative monthly activities for federal reporting, including the activities captured on the Encounter Form. Duplication in the type of information requested has frustrated some Child Care Health Consultants, who are expected to enter the same information multiple times. Efforts are underway to streamline the requirements.

## **Topic Code Updates**

Topic codes were initially determined by a core group of HCCW team members and Child Care Health Consultants. During the six-month initial implementation of the evaluation, all forms were reviewed for cases in which Child Care Health Consultants chose “Other” as the topic area. In many cases, the “Other” topic conformed to an existing topic code. However, a few topics arose consistently enough to add a new topic code. A new topic code is also being added to evaluate a CDC grant focused on decreasing sedentary behaviors. The following two topic codes will be added for next year:

- ◊ Physical Activity (PA): Consultation/training/technical assistance on increasing physical activity and decreasing screen time (resources, policy, environmental changes); and
- ◊ Staff Resources (SR): Consultation/materials for professional development of staff members support for educational pursuits, information on legislative updates.

In addition, wording was added to the Brain/Cognitive Growth and Development topic to capture Child Care Health Consultant work related to curricula to enhance brain and cognitive development.

## **Data Collection on Consultations with Child Care Health Consultants**

Changes in funding affected the nature of the consulting that Jan Gross of Pacific Rim Real Time Systems, Inc., provided to Child Care Health Consultants over the past six months. While still providing substantial technical assistance, her consulting tended to occur at regional meetings or via phone and email, formats which did not lend themselves as well to the Consultant Action Plan form. Therefore, much of her work this year to support Child Care Health Consultants in their attainment of skills and core competencies was not captured. This problem is being remedied with a new tool that will allow Jan to report which core competencies and skills she addresses monthly with Child Care Health Consultants. Discussions are also underway to develop new methods to incorporate the

Consultant Action Plan into her current mode of consulting. We anticipate better and more complete data on this strand of the HCCW strategy next year.

## EVALUATOR OBSERVATIONS

The Healthy Child Care Washington Child Care Health Consultants are making a difference in the health and safety of children in child care settings. The initial implementation process was successful in collecting useful data on all of the outcomes identified and went even further to document changes in children's health attributable to the work of Child Care Health Consultants. With the changes in data collection implemented and all Child Care Health Consultants active in data collection, we fully expect to continue generating more useful information. We intend for these data to contribute to improving the work of HCCW and documenting the positive changes that are occurring in child care settings across the state.

One identified area of possible need is increased focus with child care providers on the concept of Medical Home. While most Child Care Health Consultants cover a breadth of topics through their consultations with child care providers and systems partners, Access to Medical Home and Access to Health Insurance receive a noticeable lack of attention. Since these topics are high priorities within Department of Health initiatives, it is worth noting the low frequency of these topics in the interactions between Child Care Health Consultants, providers and systems partners.

One other area to monitor could be suggested actions and referrals to access community resources. In both the encounter form data and provider action plan data, these actions are rarely suggested. One possible reason is that Child Care Health Consultants are often able to serve in multiple capacities, negating the need for outside assistance. In some cases, a rural area may have few outside resources to be referred to. In addition, in the Action Plan data, cases in which accessing resources was suggested (only 25 times) had the lowest percentage of follow-through (46.4%). While the small number of cases means this data should be viewed with caution, this lack of follow-through could still be worth monitoring.

One positive emerging trend is the significant amount of systems building that is occurring among HCCW partners, who are interacting collaboratively to develop systems that support healthy and safe child care/early childhood programs. Through their involvement in various initiatives, work groups and other collaborations, HCCW is keeping health and child care issues at the forefront of state and local efforts to focus on early childhood.

# CONCLUSIONS

While this initial implementation of the evaluation measured activities and changes in only some child care settings and the work of only a sample of Child Care Health Consultants and system partners, the evidence shows the Infant and Toddler Initiative of Healthy Child Care Washington is resulting in desired outcomes.

- ♦ Child care providers are being offered technical assistance, information and needed referrals.
- ♦ Child Care Health Consultants are increasing their own skills and core competencies through the efforts of state consultants who provide them technical assistance.
- ♦ Child care providers are increasing their use of practices that promote the social, emotional and physical health and cognitive development of children.
- ♦ Communication is improving between child care providers and parents.

With full implementation of the evaluation efforts, we expect to be able to assess where, and in what ways, the program is having its greatest impacts, and gain additional insights for program improvement.

Full implementation of the evaluation tools and reporting will begin with all state-funded Child Care Health Consultants at the 35 LHJs beginning July 1, 2005. Trainings for all LHJs will be held to orient Child Care Health Consultants to their evaluation and contractual requirements, the evaluation data collection tools, the online data collection system and the coding protocol.