Findings from the Survey of Early Head Start Programs: Communities, Programs, and Families

Final Report

December 2006

U.S. Department of Health and Human Services
Administration for Children and Families
Office of Planning, Research and Evaluation

Findings from the Survey of Early Head Start Programs: Communities, Programs, and Families

December 2006

Office of Planning, Research and Evaluation
Administration for Children and Families
Department of Health and Human Services

This report was prepared for the Administration for Children and Families, U.S. Department of Health and Human Services (DHHS), under Contract 233-02-0086 (04) to Mathematica Policy Research, Inc., Princeton, NJ. The contents of this report do not necessarily reflect the views or policies of DHHS, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

ACKNOWLEDGMENTS

We would like to thank the many people who contributed to the successful completion of this study and report. We begin with Ellen Kisker, a former MPR colleague and arguably one of the foremost experts on the Early Head Start program, who began this project and who has remained involved even after leaving MPR. Rachel Chazan-Cohen, Senior Research Analyst, Administration for Children and Families, and Helen Raikes, Society for Research in Child Development consultant, have provided invaluable leadership and vision to shape this effort. Judith Jerald, former Coordinator of Early Head Start, guided formation of the policy questions we tried to answer. Our technical work group members (listed below) were an invaluable resource in commenting on early versions of the survey and site visit protocols. We are grateful also to the program directors and T&TA providers who helped us pretest the survey and candidly gave us suggestions for its improvement. Lillian Sugarman and her staff at Zero To Three hosted two large conference calls to help Early Head Start programs understand the intent of the study and particular survey items. This report would have been impossible without the support and participation of the 660 Early Head Start respondents that so generously spent their time and effort to complete the survey with care and accuracy.

Numerous staff at MPR also played critical roles in the research effort. Leonard Hart and Yuki Focus patiently revised and tested the web survey over the course of months to ensure it ran smoothly and without errors. Rob Samardik and staff at the MPR Survey Operations Center manned the helpline, talking many through the intricacies of the web survey, and conducted follow-up calls to clarify information. Thomas McCall and Anne Bloomenthal skillfully prepared the initial data set and constructed many of the variables. Andrew McGuirk and Bonnie Hart were both instrumental in generating a tremendous number of analyses and tables in a short amount of time. Patricia Seunarine carefully tracked project expenditures. We benefited from an experienced team that conducted site visits to programs, including Barbara Schiff Kennen, Emily Sama Martin, Louisa Tarullo, and Ellen Kisker.

Diane Paulsell and Louisa Tarullo provided valuable insights during the review process. We are especially grateful to Patricia Ciaccio, who skillfully edited the report. Bryan Gustus led its formatting and production, with assistance from Jennifer Baskwell, and a heroic final effort from William Garrett. Any remaining errors or omissions are our own.

Technical Work Group

Jon Korfmacher
Associate Professor
Erikson Institute

Rich Faldowski
Assistant Professor
Medical University of South Carolina

Eduardo Armijo
Research Scientist
University of Washington

Kathleen Hebbeler
Program Manager
SRI International

Tammy Mann
Deputy Director
Zero To Three

Mary Shiffer
Regional Office EHS Liaison
Pennsylvania ACF Regional Office

Jana Gifford
Visiting Lecturer of Early Childhood Education
Arkansas Tech University

Helen Raikes
Professor, Family and Consumer Sciences
University of Nebraska—Lincoln

Susan Sprachman
Senior Fellow
Mathematica Policy Research, Inc.

Diane Paulsell
Senior Researcher
Mathematica Policy Research, Inc.

Beth Green
Vice President and Senior Research Associate
NPC Research, Inc.

Carla Peterson
Associate Professor
Iowa State University

Dr. Mark Swanson
Executive Director
Partners for Inclusive Communities

Kathryn Barnard
Professor Emeritus of Nursing
University of Washington

Rhodanne Schiller
Early Learning Coordinator
Community Development Institute

Lynda Bitner
Regional Office EHS Liaison
Kansas ACF Regional Office

Christine Sciarrino
Assistant to the President for Research
and Professional Studies
The Clayton Foundation

Gloria Murray
Early Head Start Parent

Cheryl Mitchell
Research Professor
University of Vermont

Donna Bryant
Associate Director of FPG and Senior Scientist
University of North Carolina at Chapel Hill

CONTENTS

Chapter		Page
	EXECUTIVE SUMMARY	xix
I	**INTRODUCTION AND BACKGROUND**	1
	BACKGROUND ON EARLY HEAD START	2
	Program Impacts and Implementation	2
	Performance Measures for Head Start Programs Serving Infants and Toddlers	4
	OVERVIEW OF THE SURVEY OF EARLY HEAD START PROGRAMS	5
	GUIDE TO THE REPORT	10
II	**METHODS**	11
	DATA COLLECTION	11
	Survey Design	11
	Survey Administration	12
	Sample Frame and Response Rates	15
	Site Visit Protocol Development	16
	Site Visitor Qualifications and Training	16
	Site Selection and Procedures During the Visits	16
	ANALYTIC APPROACHES	18
	Analysis of Survey Data	18
	Analysis of Site Visit Data	19

Chapter **Page**

III CHARACTERISTICS OF EARLY HEAD START PROGRAMS 21

THE PROGRAM SETTING 21

PROGRAM FUNDING 23

EARLY HEAD START ENROLLMENT 27

EARLY HEAD START FAMILY CHARACTERISTICS 34

Population-Level Demographics 34
Program-Level Demographics 36
Comparison of Program-Level and Population-Level Demographics 39
Family Risk Factors 40
Children with Disabilities 45

KEY POINTS 48

IV EARLY HEAD START PROGRAM SERVICES 51

EARLY HEAD START SERVICE DELIVERY MODELS 51

Program Changes Since Inception 52

STRATEGIES FOR ENGAGING FAMILIES IN EARLY HEAD START SERVICES 54

Retaining Families 55
Parent Involvement 56
Frequency of Home Visits 59
Transitions 60

KEY POINTS 64

V STAFF CHARACTERISTICS AND PROGRAM MANAGEMENT 65

EARLY HEAD START STAFF CHARACTERISTICS 65

Specialists and Coordinators 66
Management Staff 67
Frontline Staff 68
Staff Turnover 70

Chapter **Page**

V *(continued)*

SUPERVISION AND STAFF DEVELOPMENT 73

Supervisory Practices and Support 73
Training Opportunities 74

PROGRAM SYSTEMS TO SUPPORT CONTINUOUS PROGRAM IMPROVEMENT 77

Curricula in Use 77
Use of Screening and Assessment Instruments 78
Parent and Family Assessments 79
Child Care Quality Assessments 79
Management Information Systems (MIS) and Use of Data 80

KEY POINTS 82

VI **PROGRAM PARTNERSHIPS** 85

EARLY HEAD START COMMUNITY PARTNERSHIPS 85

PARTNERSHIPS WITH COMMUNITY CHILD CARE PROVIDERS 86

PARTNERSHIPS WITH PART C PROVIDERS 88

Identifying and Referring Children with Disabilities 90

PARTNERSHIPS WITH HEALTH PROVIDERS 94

PARTNERSHIPS WITH MENTAL HEALTH CARE PROVIDERS 94

OTHER SCREENING AND REFERRAL SERVICES 96

KEY POINTS 98

VII **EARLY HEAD START SUBGROUP FINDINGS** 101

ANALYTIC APPROACH 101

Determining Subgroup Differences 101

Chapter **Page**

VII *(continued)*

COMMUNITY CONTEXT SUBGROUPS 104

Service Area 104
Community Diversity 105

PROGRAM CHARACTERISTICS 106

Program Size 106
Program Service Approach 107
Operates Preschool Head Start 109
Serving Pregnant Women 109
Caregiver Education 110

FAMILY CHARACTERISTICS 110

Demographic and Psychological Risks 111
Teenage Mothers 112
Developmental Concerns 112
Program Diversity 112

SUMMARY OF KEY FINDINGS 113

VIII CROSS-CUTTING THEMES AND DIRECTIONS FOR FUTURE RESEARCH 175

CROSS-CUTTING THEMES 175

DIRECTIONS FOR FUTURE RESEARCH 179

Potential Descriptive Studies 180
Potential Experimental Research 180

REFERENCES 183

APPENDIX A: SURVEY OF EARLY HEAD START PROGRAMS A.1

APPENDIX B: EXPANDED DESCRIPTION OF SURVEY DATA COLLECTION METHODS B.1

APPENDIX C: PILOT TESTS OF PROGRAM RATING SCALES IN EARLY HEAD START SITE VISITS C.1

APPENDIX D: SUPPLEMENTAL WEIGHTED TABLES D.1

TABLES

Table		Page
I.1	EARLY HEAD START PERFORMANCE MEASURES FRAMEWORK, OBJECTIVES, AND MEASURES	7
II.1	DATA SOURCES FOR EARLY HEAD START PROGRAM AND FAMILY CHARACTERISTICS AND PERFORMANCE MEASURES, BY PERFORMANCE OBJECTIVE	13
II.2	RESPONSE RATES BY SURVEY METHOD	15
II.3	CHARACTERISTICS OF PROGRAMS SELECTED FOR SITE VISITS	17
III.1	KEY CHARACTERISTICS OF EARLY HEAD START PROGRAMS	22
III.2	EARLY HEAD START PROGRAM FUNDING	26
III.3	CHARACTERISTICS OF EARLY HEAD START CHILDREN	30
III.4	EARLY HEAD START PROGRAM ENROLLMENT	32
III.5	DEMOGRAPHICS OF EARLY HEAD START FAMILIES: PROGRAM LEVEL	38
III.6	PREVALENCE OF DEMOGRAPHIC AND PSYCHOLOGICAL RISK FACTORS ACROSS PROGRAMS	44
III.7	PREVALENCE OF DEVELOPMENTAL CONCERNS AMONG ALL EARLY HEAD START CHILDREN	48
IV.1	PROGRAM MODELS FOR DELIVERING EARLY HEAD START SERVICES	53
IV.2	EARLY HEAD START PROGRAM SERVICE MODELS AND FREQUENCY OF HOME VISITS	62

Table **Page**

V.1 TYPES OF STAFF IN EARLY HEAD START PROGRAMS 66

V.2 QUALIFICATIONS AND EDUCATION OF EARLY HEAD START STAFF 67

V.3 EARLY HEAD START STAFF TURNOVER 72

V.4 SUPERVISORY PRACTICES AND TRAINING OPPORTUNITIES IN EARLY HEAD START 74

V.5 USE OF CURRICULA, SCREENERS, AND ASSESSMENTS 77

V.6 PARENT/FAMILY ASSESSMENTS IN EARLY HEAD START 79

V.7 EARLY HEAD START PROGRAM EFFORTS TO ENSURE QUALITY OF CHILD CARE 80

V.8 USE OF MANAGEMENT INFORMATION SYSTEMS (MIS) IN EARLY HEAD START 81

VI.1 EARLY HEAD START SERVICE REFERRALS 98

VII.1 EARLY HEAD START PROGRAM SUBGROUPS 102

VII.2 EARLY HEAD START PROGRAM SUBGROUP COMPARISONS: POINT DIFFERENCES REQUIRED FOR EACH EFFECT SIZE 114

VII.3 SUMMARY OF KEY SUBGROUP DIFFERENCES 118

VII.4 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: SERVICE AREA 119

VII.5 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: COMMUNITY DIVERSITY 123

VII.6 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: CHANGE IN COMMUNITY DIVERSITY 127

VII.7 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: PROGRAM SIZE 131

VII.8 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: SERVICE APPROACH 135

Table **Page**

VII.9 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: OPERATING PRESCHOOL HEAD START 139

VII.10 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: SERVING PREGNANT WOMEN 143

VII.11 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: PRIMARY CAREGIVER EDUCATION 147

VII.12 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: FAMILIES WITH DEMOGRAPHIC RISKS 151

VII.13 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: FAMILIES WITH PSYCHOLOGICAL RISKS 155

VII.14 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: PROPORTION OF TEEN MOTHERS 159

VII.15 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: PROPORTION OF CHILDREN WITH DEVELOPMENTAL CONCERNS 163

VII.16 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: MINORITY ENROLLMENT 167

VII.17 EARLY HEAD START PROGRAM CHARACTERISTICS BY SUBGROUP: SERVING NON-ENGLISH SPEAKING FAMILIES 171

FIGURES

Figure		Page
I.1	CONCEPTUAL FRAMEWORK FOR PROGRAMS SERVING INFANTS AND TODDLERS	6
I.2	EARLY HEAD START PROGRAMS, 1996	9
I.3	EARLY HEAD START PROGRAMS, 2005	9
III.1	EARLY HEAD START ACTUAL ENROLLMENT, INCLUDING CHILDREN AND PREGNANT WOMEN	29
III.2	RACE/ETHNICITY OF EARLY HEAD START FAMILIES: POPULATION LEVEL	36
III.3	PRIMARY (NON-ENGLISH) LANGUAGE OF EARLY HEAD START FAMILIES: POPULATION LEVEL	37
III.4	PERCENTAGE OF PROGRAMS SERVING FAMILIES THAT PRIMARILY SPEAK A LANGUAGE OTHER THAN ENGLISH	39
III.5	PREVALENCE OF DEMOGRAPHIC FACTORS ACROSS EARLY HEAD START PROGRAMS: CONCENTRATION OF FAMILIES WITH EACH RISK FACTOR	42
III.6	PREVALENCE OF PSYCHOLOGICAL RISK FACTORS ACROSS EARLY HEAD START PROGRAMS: CONCENTRATION OF FAMILIES WITH EACH RISK FACTOR	43
III.7	PERCENTAGE OF EARLY HEAD START CHILDREN WITH ANY SUSPECTED OR DIAGNOSED DISABILITY, WITHIN PROGRAMS	46
IV.1	EARLY HEAD START PROGRAM MODELS	54

Figure **Page**

IV.2 CHANGES TO EARLY HEAD START PROGRAMS SINCE INCEPTION, AMONG PROGRAMS WITH A CHANGE 55

IV.3 AVERAGE ENROLLMENT TURNOVER, AS A PERCENTAGE OF TOTAL PROGRAM ENROLLMENT 56

IV.4 PERCENTAGE OF PROGRAMS CONDUCTING EACH ACTIVITY TO ENCOURAGE FATHER INVOLVEMENT 60

VI.1 CHARACTERISTICS OF CHILD CARE PARTNERSHIPS, AMONG EARLY HEAD START PROGRAMS WITH FORMAL AGREEMENTS 88

VI.2 CHARACTERISTICS OF PART C PARTNERSHIPS, AMONG EARLY HEAD START PROGRAMS WITH FORMAL AGREEMENTS 90

VI.3 IDENTIFICATION OF AND TREATMENT FOR CHILDREN WITH DISABILITIES 91

VI.4 STAGE OF EVALUATION AND TREATMENT OF DISABILITIES AMONG EARLY HEAD START CHILDREN 92

VI.5 CHARACTERISTICS OF HEALTH CARE PARTNERSHIPS, AMONG EARLY HEAD START PROGRAMS WITH FORMAL AGREEMENTS 94

VI.6 CHARACTERISTICS OF MENTAL HEALTH PARTNERSHIPS, AMONG EARLY HEAD START PROGRAMS WITH FORMAL AGREEMENTS 95

VI.7 PERCENTAGE OF PROGRAMS OFFERING EACH TYPE OF SCREENING 96

BOXES

Box		Page
I.1	EARLY HEAD START IMPACTS	4
III.1	INTEGRATING EARLY HEAD START AND HEAD START PROGRAMS	24
III.2	MANAGING MULTIPLE GRANTS IN EARLY HEAD START	25
III.3	ENROLLMENT CRITERIA IN EARLY HEAD START PROGRAMS	28
III.4	RECRUITING, ENROLLING, AND SERVING PREGNANT WOMEN	31
III.5	EARLY HEAD START FAMILY RECRUITING PRACTICES	33
III.6	RESPECTING FAMILY CULTURE IN EARLY HEAD START PROGRAMS	35
III.7	ADDRESSING FAMILIES' SOCIAL SERVICES NEEDS IN EARLY HEAD START PROGRAMS	41
III.8	HIGH-RISK FAMILIES IN EARLY HEAD START	43
III.9	CHILDREN WITH DISABILITIES IN EARLY HEAD START PROGRAMS	47
IV.1	RETAINING FAMILIES IN EARLY HEAD START	57
IV.2	INVOLVING PARENTS IN EARLY HEAD START DECISION-MAKING AND PROGRAM OPERATIONS	58
IV.3	INVOLVING FATHERS IN EARLY HEAD START	61
IV.4	TRANSITIONS FROM EARLY HEAD START TO PRESCHOOL	63
V.1	PROVIDING EFFECTIVE LEADERSHIP IN EARLY HEAD START PROGRAMS	69

Box **Page**

V.2 CHALLENGES IN HIRING AND RETAINING STAFF IN EARLY HEAD START PROGRAMS 71

V.3 SUPPORTING EARLY HEAD START STAFF WITH REFLECTIVE SUPERVISION 75

V.4 PROVIDING OPPORTUNITIES FOR TRAINING AND STAFF DEVELOPMENT IN EARLY HEAD START PROGRAMS 76

V.5 USING MANAGEMENT INFORMATION SYSTEMS (MIS) IN EARLY HEAD START PROGRAMS 82

VI.1 CHARACTERISTICS OF CHILD CARE PARTNERSHIPS 87

VI.2 WORKING WITH PARTNERS TO ENSURE QUALITY CHILD CARE IN EARLY HEAD START 89

VI.3 POSSIBLE IMPEDIMENTS TO EVALUATING REFERRED CHILDREN 93

EXECUTIVE SUMMARY

Early Head Start is a comprehensive, two-generation federal initiative begun in 1995 and aimed at enhancing the development of infants and toddlers while strengthening families. Designed for low-income pregnant women and for families with infants and toddlers 3 years of age or younger, Early Head Start programs, like preschool Head Start programs, must comply with the Head Start Program Performance Standards—a set of rigorous criteria that are based on best practices identified by a wide range of practitioners and researchers (Administration for Children and Families [ACF] 1996).

As is the case with Head Start, research with a focus on continuous program improvement has been incorporated into Early Head Start from the beginning. When the program began, Congress mandated a rigorous evaluation—the Early Head Start Research and Evaluation Project (EHSREP)—designed to include an implementation study and an impact study to inform program improvement and to assess the program's effects on child and family outcomes.[1] Following that study, ACF is embarking on a series of descriptive studies about Early Head Start. Rapid expansion of the program during the past decade has increased the importance of this research. This report contains information from the Survey of Early Head Start Programs—the first step of this descriptive research. Beyond the need for an updated picture of the Early Head Start program, the Survey of Early Head Start Programs was designed to build on the earlier impact and implementation studies to provide information to support program improvement in Early Head Start.

Five main research questions guided the study:

1. What are the characteristics of Early Head Start programs?

2. Who is served by Early Head Start programs?

3. What services do Early Head Start programs provide?

[1] Throughout this report we reference findings from the national evaluation as the Early Head Start Research and Evaluation Project, or EHSREP. We refer to its specific components as the EHSREP implementation study and the EHSREP impact study.

4. How are Early Head Start programs managed and staffed?

5. Do key program subgroups differ in their characteristics? If so, how?

BACKGROUND ON EARLY HEAD START

Early Head Start programs provide a wide range of services, as mandated in the comprehensive Head Start Program Performance Standards.[2] These include child development services, child care, parenting education, case management, health care and referrals, and family support. In addition to providing many services directly, programs form partnerships with other community service providers as vehicles for delivering some services. To ensure that services are of high quality, the performance standards identify explicitly what programs must do to meet standards (for example, they specify child:adult ratios in child care centers and educational requirements for staff). The standards also define four service delivery options that programs can use based on the unique needs of families: (1) home-based—families receive weekly home visits and at least two group socializations[3] per month, (2) center-based—families receive center-based child care plus other activities, (3) combination—families receive both home visits and center experiences, and (4) locally designed. A program can choose to deliver one option to all families or different combinations to different families, based on the program's determination of the best mix of services for meeting families' needs.[4]

The Early Head Start Research and Evaluation Project

In 1996, after the Administration on Children, Youth and Families (ACYF) funded the first Early Head Start programs, and ACYF along with Mathematica Policy Research, Inc. (MPR), Columbia University's Center for Children and Families at Teachers College and the Early Head Start Consortium, initiated a rigorous, large-scale program evaluation. The study, conducted with 17 Early Head Start programs, included a rigorous impact study (ACYF 1999, 2000a, 2000b, 2002) and an in-depth implementation study (ACYF 2001, 2002). The impact study found that Early Head Start programs had a broad range of effects on child and parent outcomes, both when children were 24 months old and when they were 36 months old (ACYF 2002a). Child outcomes that program participation positively affected included health and cognitive, language, and social-emotional development. Among

[2] We use the term *performance standards* to refer to the statutory regulations that programs must meet (the Head Start Program Performance Standards).

[3] Group socializations are opportunities for parents, their children, and Early Head Start staff to meet in an informal atmosphere. They allow parents to meet both with Early Head Start staff and with other parents to discuss their children's interests, strengths, and needs.

[4] We use the term *service option* to refer to one of the four methods of service delivery outlined in the performance standards. Throughout this report, the terms *program approach(es) to service delivery* and *program model* refer to specific combinations of options programs use to deliver services. Chapter IV is dedicated to a thorough examination of current program approaches to service delivery.

parents, Early Head Start positively affected parenting behaviors, such as supportiveness for children's emotional and literacy development, as well as indicators of self-sufficiency.

Analyses showed that most groups of families benefited from the program. Impacts varied by characteristics of programs, notably their success in implementing the performance standards and their approaches to service delivery.[5] Analysis of program-control differences within subgroups showed that programs fully implementing key elements of the Head Start Program Performance Standards demonstrated the broadest pattern of impacts. All approaches achieved favorable impacts, but programs that provided both home- and center-based services, referred to in that study as "mixed approach" programs, produced a stronger pattern of impacts.[6] A followup of these children in the spring before kindergarten entry found that Early Head Start continued to have positive impacts, mainly in parenting and children's social-emotional development (ACF 2006).

Performance Measures

After the initial results from the EHSREP became available, ACF was in a position to develop performance measures that outlined specific programmatic activities and expected outcomes for children and families (ACF 2003). Much work had already been done for preschool Head Start programs in articulating a comprehensive framework for providing quality services, desired outcomes for children, and the mechanisms by which programs meet these goals. The effort for programs serving infants and toddlers built upon this existing framework (ACF 2003). Specifically, the Performance Measures Framework for Head Start Programs Serving Infants and Toddlers (hereafter "performance measures framework") is based on (1) the Head Start Program Performance Standards, which include the regulations and rules all programs must follow; (2) the Head Start performance measures framework, which identifies mechanisms by which programs will affect preschool children's outcomes; (3) the Statement of the Advisory Committee for Head Start Programs Serving Infants and Toddlers (ACF 1994), which provided guidance in developing the new program; and (4) findings from the EHSREP.

The performance measures framework, which is structured as a pyramid, rests on a foundation of four cornerstones for Early Head Start services articulated by the Advisory Committee for Head Start Programs Serving Infants and Toddlers: (1) staff, (2) child, (3) family, and (4) community. The framework has four layers, with program management at the base supporting a layer representing effective services that in turn bring about positive family and child outcomes and ultimately children's competence (Figure 1). Within each layer of the pyramid, blocks represent objectives that include specific performance measures

[5] The Early Head Start impact study defined three program approaches: home-based, center-based, and mixed (providing both home- and center-based options).

[6] In this study, we further refine the EHSREP definition of mixed approach into "multiple" approach, in which the program primarily offers both home- and center-based services to *different* families, and "combination" approach, in which programs provide home- and center-based services to *all* families.

Figure 1. Conceptual Framework for Programs Serving Infants and Toddlers

representing key program goals. Programs maintain high quality by achieving these objectives and can then offer effective services to children and families. These services bring about positive child and family outcomes that support children's competence, as the top of the pyramid illustrates. The focus of the Survey of Early Head Start Programs is on the two bottom layers of the pyramid: management systems and services.

THE SURVEY OF EARLY HEAD START PROGRAMS

The Survey of Early Head Start Programs study approach and rationale focused on collecting quantitative data on all programs, supplemented in breadth and depth by qualitative information on a smaller subset of programs. The first and primary data source is the survey, which included a comprehensive set of questions on program management and services (Appendix A contains the survey instrument). The second data source is a series of site visits to 17 programs to gather in-depth information about implementation. The goal of the survey was to take a "snapshot in time" to paint a basic picture of all Early Head Start programs. We purposively selected site visit programs to represent a range of characteristics, including ACF region, program size, whether programs serve pregnant women, whether programs serve children through partnerships with child care providers, ubanicity, recent changes in demographics, turnover of program director, and program approach. We

conducted the site visits to help illuminate and explain survey findings and identify potential implementation issues and lessons.

We intended this survey to represent all Early Head Start programs so that descriptions would be generalizable. Because we contacted all operating Early Head Start programs and obtained a response rate of nearly 90 percent, we are able to generalize our findings to the universe of Early Head Start programs.

FINDINGS

Here, we provide a brief summary of our findings in each of the major areas we examined: (1) community and family characteristics, (2) program approaches to service delivery, (3) program management and staffing, (4) program partnerships, and (5) subgroup analyses. We end with a discussion of implications for program planning and future research.

Community and Family Characteristics

- Early Head Start programs are equally likely to be located in urban or rural areas. Many (42 percent) are in areas of increasing cultural diversity.

- Most (69 percent) Early Head Start programs are run by nonprofit community agencies.

- To supplement program services, most (63 percent) Early Head Start programs obtain outside funding in addition to the Early Head Start grant. Thus, the typical program blends funds and responds to funders other than Early Head Start. Programs that do not report receiving outside funds may receive in-kind contributions, but we did not ask about those in the survey.

- About one-third of Early Head Start programs are small, serving 50 or fewer children and pregnant women; nearly three-quarters serve 100 or fewer. A few programs are very large, with enrollment in the hundreds.

- Most (62 percent) Early Head Start children enter the program between birth and age 2 and stay until age 3. About 13 percent of children enter the program during the prenatal period.

- All programs surveyed maintain a waiting list for enrollment of eligible families and prioritize families by their level of need. Most programs are either at enrollment capacity or overenrolled.

- Whites, African Americans, and Hispanics make up most of the Early Head Start population, although many other races/ethnicities are represented. Three-quarters of programs serve some black or Hispanic families. About one-quarter

of families served speak a language other than English; however, these families are distributed across nearly three-quarters of programs.

- Fairly high levels of family risk factors are prevalent across Early Head Start programs, in part because programs prioritize the families with greatest needs for enrollment. Demographic risk factors include unemployment, single parent, and lack of a high school credential. Single parenthood is the most prevalent risk factor, although most programs serve families that have three or more demographic risk factors, and about 20 percent serve a high concentration (more than half of enrollment) of families that have three or more.

- Psychological risk factors include mental health, family violence, or substance use issues. When considering the co-occurrence of risk factors, about 15 percent of programs serve high or very high concentrations (more than half of enrollment) of families with two or more psychological risk factors. Although programs have a lower prevalence of individual risk factors in their enrolled populations when compared with demographic risks, psychological risks can present programs with serious service and management challenges.

- More than three-quarters of Early Head Start programs reported that at least 10 percent of the children they serve have developmental concerns. Nearly one-fifth of programs' enrollments are more than 30 percent children with special needs.

- Across the universe of Early Head Start children, 20 percent of all Early Head Start children have been referred for evaluation of a suspected disability, and many are receiving services (76 percent). Communication disorders and developmental delays are the most common types of developmental concerns among Early Head Start children.

Program Approaches to Service Delivery

- While programs vary greatly in their approaches to service delivery, most use a multiple service delivery model, providing both home- and center-based services. Only a few offer both types of services to all their families (combination approach).

- Although most programs provide all core services to families directly, 28 percent provide some Early Head Start center-based services through community partners.

- Many programs offer home visits more frequently than the performance standards require. Ninety-nine percent of programs providing home-based

services offer them weekly or more often.[7] Among programs providing center-based services though their own centers, nearly half offer home visits twice a year (48 percent), and the remaining 51 percent do so more frequently. Notably, among programs that provide services through partners, 64 percent offer home visits more than twice a year. Among programs that offer family child care services 59 percent offer home visits more often than twice per year.

- Considering frequency of home visits within the research definitions of program approach, 99 percent of home-based only programs offer weekly home visits and 66 percent of center-based only programs offer home visits at least twice a year but less than monthly. In multiple approach programs, 99 percent provide weekly home visits to home-based families, 52 percent offer home visits at least twice a year but less than monthly to center-based families, and 42 percent offer home visits at least monthly along with center care. By definition, combination programs offer *all* families center-based care and home visits at least monthly.

- Most programs (65 percent) have transition plans for all children. Generally, planning begins when a child reaches age 2½.

Program Management and Staffing

- Nearly all programs (95 percent) have directors and managers with BAs or advanced degrees.

- In 47 percent of programs, at least half the home visitors have a BA. Nearly half of all programs report that all home visitors they employ have an AA or higher. More than two-thirds report that at least half their home visitors have an AA or higher.

- Few programs (13 percent) report that all primary caregivers have an AA or higher; for 32 percent, the figure is at least half.

- In 17 percent of programs, at least half of primary caregivers have a BA. All primary caregivers in center-based programs must have a Child Development Associate (CDA) credential or equivalent within one year of hire. Nearly one-third of programs report employing *only* primary caregivers with at least a CDA.

- Few programs (12 percent) lost their director in the year before the survey, and only a handful (5 percent) lost both a director and manager in that period.

[7] Programs could indicate offering home visits that "varied with family needs," a category we consider to represent home visits at or above the required level. We stress that these are home visits that programs offer to families, not necessarily how often the visits are completed.

Turnover rates among primary caregivers and home visitors were higher—between 20 and 24 percent, on average.

- Programs engage in a variety of supervisory activities with staff members to support and guide them. More than 80 percent of programs report using reflective supervision with primary caregivers and home visitors. Two-thirds of the programs that report using reflective supervision receive outside training or assistance to conduct it.

Program Partnerships

- Early Head Start programs are encouraged to develop partnerships with community agencies both to improve the quality of services (such as child care) as well as to ensure proper linkages between families and other providers. Ninety-five percent of programs participate collaborative groups of service providers, and of those, 75 percent hold a leadership position. Ninety-two percent of programs have at least one formal partnership with a community service provider.

- More than 40 percent of programs report having formal child care partnership agreements in place, and 30 percent report serving children through them. Programs that use partnerships for services are more likely to have partnership agreements that include providing payments for services and evaluating quality.

- Nearly all programs have a formal partnership with a Part C provider, and these are an important avenue for ensuring that children receive early intervention services when needed. Only 4 percent of all Early Head Start children with a suspected disability had not yet been referred for further evaluation at the time the survey was conducted.

- About two-thirds of children evaluated for early intervention eligibility are receiving these services. Only 7 percent of those referred are found ineligible for Part C services. Seventeen percent of children referred for evaluation were still awaiting it at the time of the survey. Among referred children, 16 percent had been evaluated and were found eligible for Part C services but were not receiving them at the time of the survey. Children referred for emotional/behavioral or communication disorders were least likely to be receiving services and more likely to be awaiting evaluation.

- About three-quarters of programs have partnerships with health care providers; more than 80 percent have them with mental health providers.

- One-third of programs have formal partnerships with at least one child care, health, and mental health provider.

Program Subgroup Analysis

- By and large, programs differ in mostly expected ways when we examine subgroups of community, program, and family characteristics, and we view this consistency as a validity check on survey responses. For example, programs in urban areas tend to be larger and are more likely to serve minority and high-risk populations, and the reverse is true for rural programs. The subgroups with most marked differences are those related to service area, program size, and program approach.

In this section, we discuss broad themes identified from survey data; in doing so, we review key findings, then suggest potential avenues for future research.

Cross-Cutting Themes

Several cross-cutting themes emerge from a broad examination of the survey findings. In identifying these themes, we pay special attention to areas of concurrence between the survey's quantitative and qualitative data. We highlight connections that indicate key trends and challenges for Early Head Start programs.

Community context, especially urbanicity, is associated to some extent with program services and management.

Program Service Models. Although prevalent in all settings, multiple approach programs are most likely to be found in suburban areas. Urban programs are more likely than suburban and rural ones to follow a center-based approach, while rural programs are most likely to implement a home-based model. Program leaders often mentioned efforts to meet the needs of local families (for example, by making child care available to parents who are working or in school). Program staff also noted such factors as parents' access to transportation, or other limitations in local resources, when choosing a program model.

As we have noted, multiple approach models are most prevalent, more so now than when the program was first implemented. As Early Head Start has become more established, programs may have begun to offer multiple approaches to service delivery to be responsive to the diversity of families and their needs. Programs appear to be individualizing their approaches and this may allow them to provide an optimal mix of services to families, particularly those with high levels of risk factors.

Staffing. Context may also be linked with program staffing, but the patterns in this area are less clear. Suburban programs have home visitors with the highest educational credentials (they are the most likely to employ home visitors with an associate's degree or higher), and rural programs are the least likely to do so. Programs in rural areas with limited labor pools may find it difficult to identify and hire well-qualified staff. Rural programs, perhaps because of their overall smaller size, are also less likely to employ certain types of specialists, including those in male involvement, disability, health care, nutrition, mental health, and literacy.

Programs in diverse communities described making special efforts to recruit and hire staff whose linguistic skills and ethnic background match those of enrolled families. Many programs report changes in the race/ethnicity of the populations they serve. For example, about one-fifth of programs serving Hispanic families indicated that the enrollment of such families has increased substantially over the past five years. Such rapid demographic changes have implications for the kinds of skills and cultural competencies that staff need.

Early Head Start programs work to serve families at high risk.

Families enrolled in Early Head Start present complex combinations of risk factors. Risks include children with identified disabilities, as well as families experiencing numerous simultaneous high risk characteristics and events, any one of which could present challenges to programs in providing services. Further complicating matters, the risk profile for a particular family can change—perhaps rapidly—over time.

Programs that serve many families in acute crisis were more likely to use a multiple service approach, suggesting that flexibility in the choice of approach may be important to serving them effectively. Further, these programs require staff with the skills and resources to cope with hard-to-serve families and deliver Early Head Start services. We might expect to see high rates of staff turnover, however, turnover does not differ across programs serving many high risk versus fewer high risk families. Evidently, programs have found ways to recruit and retain appropriate staff. Given the prevalence of high risk families, and the challenges they present, programs serving many such families may need additional support, staff training, and technical assistance.

Many Early Head Start programs establish strong connections with other service providers, but some links appear to be easier to forge than others.

Many programs have partnerships with Part C agencies, health care providers, and mental health providers. Partnerships for child development services are less common, however, and most programs provide all such services directly. These patterns suggest that Early Head Start programs are especially likely to pursue organizational links that complement their own expertise and that offer the potential to address specific unmet family needs. It is also possible that creating partnerships for disability, health care, or similar services is less complex than establishing links for child development services, because programs with child care partnerships bear substantial responsibility for ensuring that such services meet performance standards requirements. Site visit interviews suggest that some staff view the benefits of building partnerships for child care as seldom worth the time and resources required.

Integration of Early Head Start and Head Start services could also be considered a process of establishing partnerships, though this often occurs within agencies. A large majority of Early Head Start programs operate under the same agency auspices as preschool Head Start programs, but not all these programs offer seamless birth-to-5 services. Although nearly half the Early Head Start programs visited described their intention to integrate their services with preschool Head Start, challenges to creating seamless services remain, including (1) imbalances in enrollment levels between Early Head Start and Head

Start programs, (2) addressing staff perceptions that they cannot learn the skills to work with older or younger children, and (3) the tension between offering continued services and fostering independence of families.

Early Head Start programs face the challenge of adapting to federal and state policies regarding whom they serve and employ.

As a government program in which eligibility is based on income, Early Head Start features program requirements and eligibility criteria with which agencies receiving funding must comply. Under some circumstances, enrollments and transitions can be complicated by eligibility criteria. For instance, during site visits, some programs serving teen parents indicated that such parents are sometimes classified as "over income" because the income of their own parents' is considered in determination of eligibility. Because of changes in family income since their initial enrollment, Early Head Start children ready to transition to preschool may not qualify to continue receiving services through Head Start. In such cases, alternatives for child care and family services must be identified. Early Head Start agencies also take into consideration the eligibility requirements of other programs, such as the Child Care and Development Fund (CCDF). Subsidies from CCDF sometimes help fund child care slots at a partner center, for instance. Changes in parents' eligibility for the subsidies can affect the stability of a child's placement and the overall partnership.

Early Head Start programs are also subject to policies regarding minimum qualifications for staff. In many cases, however, a gap appears to exist between staff qualification requirements and availability of appropriately credentialed applicants. Programs may respond by prioritizing higher qualifications for some positions. For example, one possible reason that home visitors tend to have higher credentials than primary caregivers is programs' intent to have more qualified people in positions that require greater staff independence.

DIRECTIONS FOR FUTURE RESEARCH

The Survey of Early Head Start Programs has examined the two base levels of the performance measures framework—program management and services—and thus offers a substantial foundation for future research. Future studies could build on survey findings by examining the next layer of the framework—child and family outcomes—and benefit practitioners and policymakers both by identifying effective approaches to service delivery and program management and by linking services and management practices to family and child outcomes.

CHAPTER I

INTRODUCTION AND BACKGROUND

Early Head Start is a comprehensive, two-generation federal initiative begun in 1995 and aimed at enhancing the development of infants and toddlers while strengthening families. Designed for low-income pregnant women and families who have infants and toddlers 3 years of age or younger, Early Head Start programs, like preschool Head Start programs, must comply with the Head Start Program Performance Standards—a rigorous set of criteria that are based on best practices identified by a wide range of practitioners and researchers (Administration for Children and Families 1996).

As is the case with Head Start, research with a focus on continuous program improvement has been incorporated into Early Head Start since the inception of the program. At the time the program began, Congress mandated a rigorous evaluation designed to include an implementation study and an impact study to inform program improvement and to assess the program's effects on child and family outcomes—the Early Head Start Research and Evaluation Project (EHSREP).[1] Following that effort, the Administration for Children and Families (ACF) is embarking on a descriptive study of Early Head Start, which has grown from 68 programs in 1995 to nearly 750 nationwide. This report contains information from the first step of this descriptive research effort—the Survey of Early Head Start Programs, which provides information on program management, populations served, and services provided. It also answers the following questions:

1. What are the characteristics of Early Head Start programs?

2. Who is served by Early Head Start programs?

3. What services do Early Head Start programs provide?

4. How are Early Head Start programs managed and staffed?

5. Do key program subgroups differ in their characteristics? If so, how?

---

[1] Throughout this report we reference findings from the national evaluation as the Early Head Start Research and Evaluation Project, or EHSREP. At times, we refer to its specific components as the Early Head Start implementation study and the Early Head Start impact study.

The next section provides a brief description of Early Head Start services, reviews previous research findings, and describes the Performance Measures for Head Start Programs Serving Infants and Toddlers, which provide the basis for the Survey of Early Head Start Programs.

BACKGROUND ON EARLY HEAD START

Early Head Start programs provide a wide range of services, as mandated in the comprehensive Head Start Program Performance Standards.[2] These include child development services, child care, parenting education, case management, health care and referrals, and family support. In addition to providing many services directly, programs also form partnerships with other community service providers as vehicles for providing some services. To ensure that high-quality services are delivered, the performance standards identify explicitly what programs must do to meet standards of quality (for example, they specify child:adult ratios in child care centers and educational requirements for staff providing child care). The standards also define four service delivery options that programs can choose for providing services to families based on their unique needs: (1) a home-based option—families receive weekly home visits and at least two group socializations[3] per month, (2) a center-based option—families receive center-based child care plus other activities, (3) a combination option—families receive both home visits and center experiences, and (4) a locally designed option. A program can choose to deliver one option to all families, or different combinations of these options to different families based on the program's determination of the best mix of services for meeting families' needs.[4]

Program Impacts and Implementation

Early Head Start's focus on continuous program improvement reflects the importance that Head Start has traditionally placed on this aspect of program development. In 1996, after the Administration on Children, Youth and Families (ACYF) funded the first Early Head Start programs, Mathematica Policy Research, Inc. (MPR), together with Columbia University's Center for Children and Families at Teachers College and the Early Head Start Research Consortium, conducted a rigorous, large-scale program evaluation. The intent of this random assignment study of 17 Early Head Start programs was to inform program improvement and assess the effects on child and family outcomes. The EHSREP yielded much valuable information on program implementation (ACYF 1999, 2000a, 2000b, 2002)

[2] We use the term *performance standards* to refer to the statutory regulations that programs must meet (the Head Start Program Performance Standards).

[3] Group socializations are opportunities for parents, their children, and Early Head Start staff to meet in an informal atmosphere. They allow parents to meet both with Early Head Start staff and with other parents to discuss their children's interests, strengths, and needs.

[4] We use the term *service option* to refer to one of the four methods of service delivery outlined in the performance standards. Throughout this report, the terms *program approach(es) to service delivery* and *program model* refer to specific combinations of options programs use to deliver services. Chapter IV is dedicated to a thorough examination of current program approaches to service delivery.

and program impacts (ACYF 2001, 2002) and also stimulated many other scholarly papers, conference presentations, books, and local site-level studies.

The implementation study provided much-needed information on how these first programs began serving families and how services evolved (ACYF 1999, 2000a, 2000b, 2002) and was useful for policy development and technical assistance efforts. That study examined program implementation and demonstrated that 5 of the programs were early implementers (judged to be fully implemented after two years of serving families), while 12 were not. Of these 12, more than half (7 programs) were fully implemented two years later, the remaining 5 did not achieve full implementation within the study period, the first 3 years of serving families. At the outset, the number of programs with home-based, center-based, and mixed (different combinations of home- and center-based) approaches was balanced. After two years, only 2 of the programs were still completely home-based; while 11 had begun providing a mixture of home- and center-based services.

The impact study found that Early Head Start programs had a broad range of positive effects on child and parent outcomes, both when children were 24 months old and when they were 36 months of age (ACYF 2002a). Child outcomes positively affected by program participation included children's health and cognitive, language, and social-emotional development. Among parents, Early Head Start positively affected parenting behaviors, such as supportiveness for children's emotional and literacy development, as well as indicators of self-sufficiency. Impact analyses showed that most groups of families benefited from the program. The evaluation team defined 29 subgroups based on family characteristics at enrollment and program characteristics (for example, race/ethnicity, maternal age, maternal depression, and so on) and found positive impacts for 28 of the 29 subgroups, although the pattern and magnitude of the impacts varied by group. Program impacts varied by characteristics of programs, notably their success in implementing the performance standards and their approaches to service delivery.[5] The embedded implementation study provided a framework for rating the level and timing of program implementation (early, later, and incomplete implementers based upon information gathered on in-depth site visits). Analysis of program-control differences within subgroups showed that programs fully implementing key elements of the Head Start Program Performance Standards in the evaluation period demonstrated the broadest pattern of impacts. All program approaches achieved favorable impacts, but programs that provided both home- and center-based services, referred to as "mixed approach" programs, produced a stronger pattern of impacts. A followup of these children in the spring prior to kindergarten entry found that Early Head Start continued to have positive impacts, mainly in the areas of children's social-emotional development and parenting (ACF 2006). Box I.1 provides further detail about program impacts from EHSREP.

[5] The Early Head Start impact study defined three program approaches: home-based, center-based, or mixed (providing both home- and center-based options).

BOX I.1

EARLY HEAD START IMPACTS

The Early Head Start Research and Evaluation Project was a comprehensive and rigorous study of Early Head Start, beginning at its inception in 1995. Mathematica Policy Research, Inc., along with partners at Columbia University and the Early Head Start Consortium, conducted the impact study, including random assignment of 3,001 families in 17 programs to either Early Head Start or a control group (ACYF 2001, 2002). Families were followed over time, with data collected when children were 14, 24, and 36 months of age, and finally at approximately age 5 (when children were in their prekindergarten year). In addition to direct child assessments, parent information, and videotaped semistructured parent-child interactions, were collected. By the time children were 3 years old, the Early Head Start program group had experienced modest positive impacts across a broad range of child and parent outcomes. Overall, program children performed better on measures of cognition, language, health, and social-emotional functioning compared with control group children. Further, parents in the program group showed more support than control parents for their child's development (emotional, cognitive, and language). The programs had some impacts on self-sufficiency as well: program parents were more likely to be in school or job training. Within 29 subgroups based on family characteristics, such as race/ethnicity and number of risk factors, African American families, those enrolling during pregnancy, and families with a moderate number of demographic risks benefited most from the program, and all subgroups showed some positive impacts, with the exception of children from families with the most risk factors. Programs that fully implemented the Head Start Program Performance Standards and programs that offered both home- and center-based services (termed *mixed approach*) had the largest impacts.

At approximately age 5 (two years after the program ended and children were in their prekindergarten year), the evaluation team once again gathered information from study children and families (ACF 2006). The team found significant favorable impacts of the program on children's social-emotional development, specifically behavior problems and approaches toward learning. There were no impacts on behavior in play with a parent. For language outcomes, we found significantly better receptive vocabulary among Spanish-speaking children, although not native English speakers. There were no impacts on children's academic skills. The Early Head Start program group was also significantly more likely to be in a formal child care program in their prekindergarten year. Among parents, Early Head Start continued to have positive impacts on support for children's learning (including daily reading, home environment, and teaching activities). There was no impact on other parenting behaviors, although there was a decreased risk of maternal depression (a new impact at prekindergarten). Impacts within subgroups continued to show sustained impacts from 36 months, and positive impacts for the highest demographic risk group emerged. Program implementation no longer showed differences in impacts, but program approach did. However, at prekindergarten, home-based rather than mixed approach programs had the strongest impacts.

Performance Measures for Head Start Programs Serving Infants and Toddlers

After the initial results from the EHSREP became available, ACF was in a position to develop performance measures that outlined specific programmatic activities and expected outcomes for children and families (ACF 2003). Much work had already been done for preschool Head Start programs in articulating a comprehensive framework for providing quality services, desired outcomes for children, and the mechanisms by which programs meet these goals. The effort for programs serving infants and toddlers built upon this existing framework (ACF 2003). Specifically, the Performance Measures Framework for Head Start Programs Serving Infants and Toddlers (hereafter "performance measures framework") is based on (1) the Head Start Program Performance Standards, which include

the regulations and rules all programs must follow; (2) the Head Start Performance Measurement Framework, which identifies mechanisms by which programs will affect preschool children's outcomes; (3) the Statement of the Advisory Committee for Head Start Programs Serving Infants and Toddlers (ACF 1994), which provided guidance in developing the new program; and (4) findings from the EHSREP.

MPR guided the process of developing performance measures for Early Head Start (ACF 2003). The process was lengthy and included regular meetings of an internal working group of federal staff, followed by consultation with the Early Head Start Technical Work Group (consisting of experts in the field, including Early Head Start staff and parents) and focus groups with program staff, parents, regional office staff, and technical assistance providers.

What emerged from this process was a conceptual framework for programs serving families with infants and toddlers (Figure 1.1). Structured as a pyramid, the framework rests on a foundation of four cornerstones for Early Head Start services articulated by the Advisory Committee for Head Start Programs Serving Infants and Toddlers: (1) staff, (2) child, (3) family, and (4) community. The framework has four layers, with program management at the base supporting a layer representing effective services that in turn bring about positive family and child outcomes and, ultimately, children's competence. Within each layer of the pyramid, blocks represent objectives that include specific performance measures representing key program goals (Figure I.1 illustrates the pyramid and objectives; Table I.1 lists specific performance measures within each objective). For example, the four objectives of the management systems layer are (1) to support staff to work effectively with parents and children, (2) to create child development environments, (3) to involve parents, and (4) to develop strong community partnerships. Programs maintain high quality by achieving these objectives and can then offer effective services to children and families. The services layer has three key objectives: (1) providing children with individualized services, (2) developing relationships with parents and children, and (3) linking children and families to community services. These services bring about positive child and family outcomes that support children's competence (the ultimate goal, at the top of the pyramid). Our focus in this research is on the two bottom layers of the pyramid: management systems and services. Chapter II describes our approach to operationalizing the performance measures—that is, creating precise statements about how performance measures are being implemented by programs, based on their responses to survey questions.[6]

OVERVIEW OF THE SURVEY OF EARLY HEAD START PROGRAMS

The Survey of Early Head Start programs is the first step in a planned series of descriptive studies about Early Head Start. Rapid expansion of the program over the past decade has increased the importance of this research. Since its inception in 1995, Early

[6] We use the term *performance measures* to refer to specific practices and activities that have been identified to achieve the best outcomes for children. This is distinct from the Head Start Program Performance Standards.

Figure I.1. Conceptual Framework for Programs Serving Infants and Toddlers

Head Start has grown from 68 programs to nearly 750 (figures I.2 and I.3). Beyond the need for an updated picture of the Early Head Start program, the Survey of Early Head Start Programs was designed to build upon the earlier impact and implementation studies to provide information to support program improvement in Early Head Start. As described earlier, child and family outcomes varied by program approach and implementation.

The Survey of Early Head Start Programs study approach and rationale focused on collecting quantitative data on all programs, supplemented in breadth and depth by qualitative information on a smaller subset of programs. The first and primary data source is the survey, which included a comprehensive set of questions on program management and services (Appendix A contains the survey instrument). The second data source is a series of site visits to 17 programs to gather in-depth information about implementation. The goal of the survey was to take a "snapshot in time" and paint a basic picture of all Early Head Start programs. We conducted the site visits to help illuminate and explain survey findings and identify potential implementation issues and lessons.

We developed the survey items to produce clear and quantifiable performance measures in the two foundation layers of the conceptual framework: management systems and services. Operationalizing and measuring these performance indicators sets the stage for later analyses of programs' progress toward and achievement of the desired outcomes shown in the pyramid.

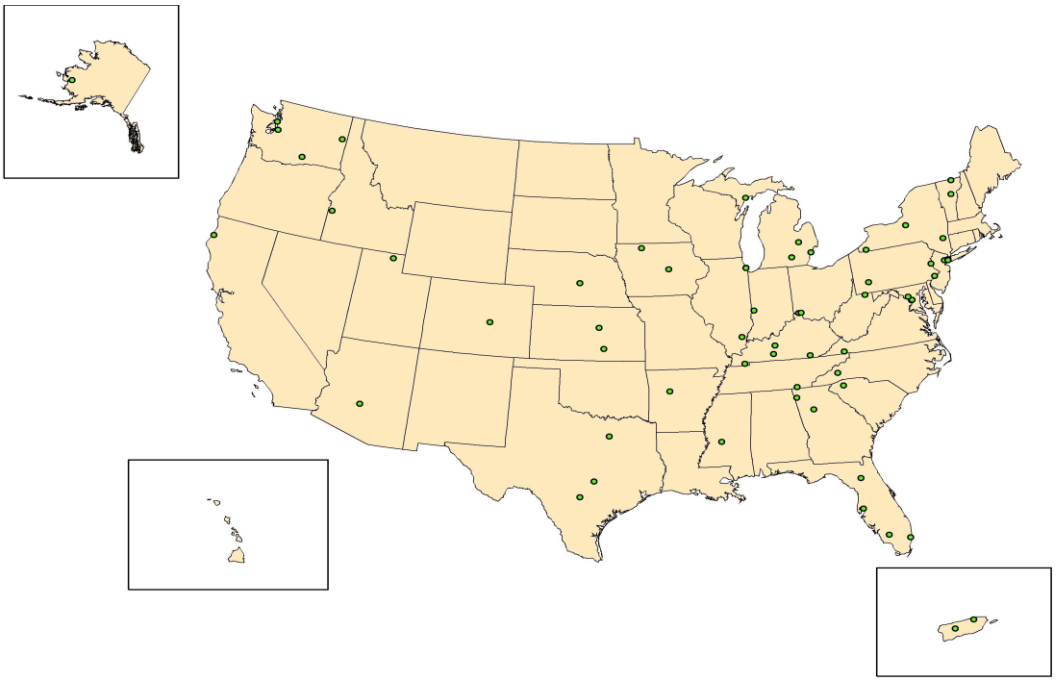
Table I.1. Early Head Start Performance Measures Framework, Objectives, and Measures

Management Systems: Processes for Improvement
Programs are well managed operationally and financially.
Programs design and implement services to be responsive to the needs of families in the community.
Programs conduct self-assessments that are used for continuous improvement.
Management Systems: Support Staff
Programs employ qualified staff with the skills necessary to provide high-quality services.
Programs support ongoing staff development, training, and mentoring.
Programs support staff activities through ongoing reflective supervision.
Programs promote staff retention and continuity.
Management Systems: Relationships with Community Partners
Programs form partnerships with other community programs and organizations to support an integrated community-wide response to the needs of families with young children.
Programs form partnerships and coordinate services with local Part C agencies.
Programs form partnerships and coordinate services with community child care providers to meet the needs of families and enhance the quality of local child care services through the sharing of resources, training, and knowledge.
Programs form partnerships and coordinate services with local health agencies and health care providers to meet the health-related needs of families.
Management Systems: Involving Parents
Parents are involved actively in program planning and decision making.
Programs encourage and support fathers' involvement in program planning, decision making, and activities.
Program Services: Linking to Community Services
Programs work collaboratively with families to identify their goals, strengths, and needed services and offer them opportunities to develop and implement individualized family partnership agreements that take into account other family plans.
Programs link parents with social service agencies to obtain needed services.
Programs link parents with educational and employment agencies to obtain needed services.
Programs link parents with physical and mental health care prevention and treatment services to obtain needed care.
Programs link parents with needed prenatal care and education services.
Programs help parents secure high quality child care in order to work, attend school, or gain employment training.
Programs help parents and children make a smooth transition to Head Start or other preschool programs.

Table I.1 *(continued)*

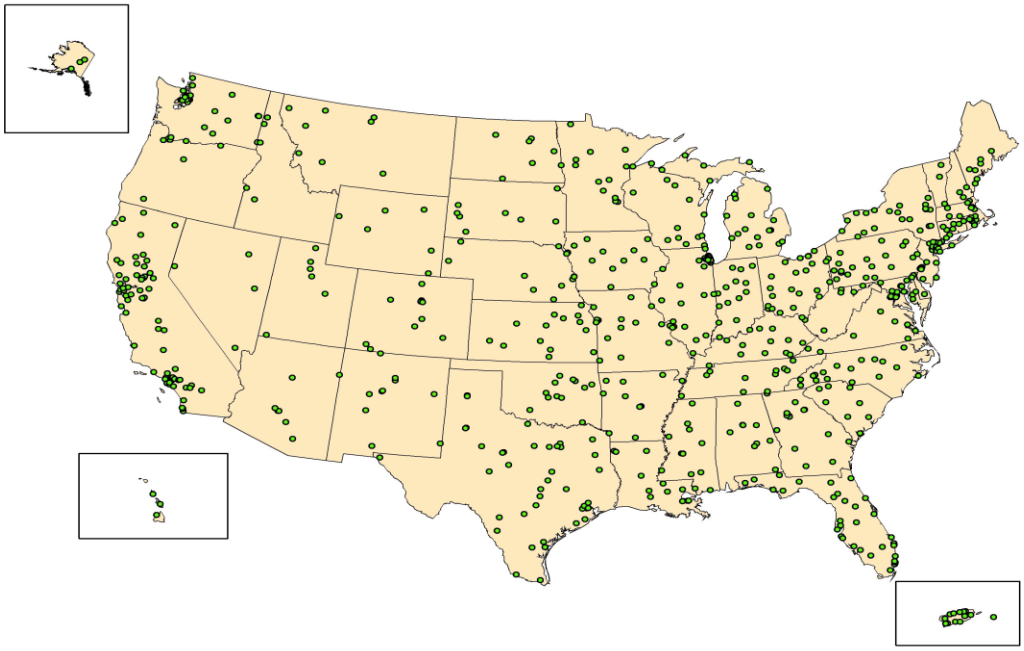
Program Services: Responsive and Caring Relationships with Parents and Children
Staff form respectful and supportive relationships with parents through all aspects of service delivery.
Staff form nurturing relationships with children in group-care settings or during home visits.
Programs support and honor the home cultures and languages of families.
Program Services: Provide Children with Individualized Services
Programs provide developmentally enriching educational environments in group-care settings and developmentally enriching parenting and child development services during home visits and group socializations.
Programs link children with needed medical, dental, and mental health services.
Programs link pregnant women with comprehensive prenatal health care and education.
Programs provide children in group-care settings with meals and snacks that meet their daily nutritional needs, and parents receiving home-based services are given information about meeting their children's nutritional needs.
Programs provide individualized services for parents and children, including children with disabilities.

Figure I.2. Early Head Start Programs, 1996



Source: Program Information Report, 1996.

Figure I.3. Early Head Start Programs, 2005



Source: Program Information Report, 2006.

GUIDE TO THE REPORT

Throughout this report, we present key survey findings and supplement them with qualitative information collected during site visits. Illustrative information from the site visits is highlighted in text boxes. Although by necessity we describe the performance measures framework in a linear fashion, the reality of Early Head Start program operation is dynamic. Elements at the bottom of the pyramid influence those above them, but the same is true in reverse. Changes in needs of families served may result in changes in services that require changes in management. Therefore, we organized the report to provide information in a way that allows the reader to understand the context in which programs operate and the people they serve, how programs provide services, how they are staffed and managed, and how they work with community partners. We also explore differences by program subgroups and sidebar text boxes on special topics in each chapter. The rest of this report is organized as follows:

- Chapter II details the survey and site visit methodologies.
- Chapter III describes programs, their communities, and enrolled families.
- Chapter IV describes program services and ways that programs engage families in them.
- Chapter V outlines programs' management practices, including staff characteristics and training.
- Chapter VI describes program partnerships with community agencies and the services provided through them.
- Chapter VII describes program subgroups and key differences among them.
- Chapter VIII identifies cross-cutting themes, implications, and next steps for research.

We end each chapter with a summary of key findings. In addition to the information above, the appendixes provide detail on the findings in the main body of the report. Appendix A contains the complete survey instrument; Appendix B describes survey methodology in detail, focusing on how we obtained high response rates. Appendix C provides descriptive information on two instruments piloted during the site visits, including staff reactions to them. Appendix D presents supplemental tables with weighted data.

CHAPTER II

METHODS

For this study, we aimed to collect data from the complete universe of Early Head Start programs funded at the time of the survey and to supplement our quantitative survey data with qualitative information collected during in-depth site visits to a subset of programs. The high response rate we achieved on the survey allows us to generalize our survey findings to all Early Head Start programs. The site visits to a subset of programs provided rich data that helped us interpret the survey findings and develop hypotheses about why programs follow particular management or staffing patterns. In this chapter, we describe our approach to both survey and site visit data collection and analysis.

DATA COLLECTION

In this section, we describe our approaches to data collection, beginning with designing and administering the survey, identifying a sample frame, and calculating response rates. Next we discuss developing site visit protocols, selecting a subset of sites to visit, and conducting the site visits.

Survey Design

The Survey of Early Head Start Programs is intended to supplement and extend the primary administrative data source for Early Head Start programs, the annual Program Information Report (PIR).[1] Thus, we replicate or modify some basic PIR items about program characteristics and families. Items for the survey can also serve as pilots for future revisions of the PIR. One important divergence from the PIR is our use of a common reference period (program status as of January 1, 2005) to capture a "snapshot in time" of program enrollment and service delivery activities. In addition, the survey is the first instrument designed specifically to collect data from programs serving infants and toddlers, so it goes beyond the PIR in asking detailed questions about program management, services,

[1] The PIR is a web-based survey that all Head Start and Early Head Start programs must complete annually. It includes basic administrative data, such as enrollment counts, numbers of children served through service options, and staff education and credentials. Programs may submit their reports at any time between May 15 and August 31. Programs do not use a common date for enrollment counts; rather, they provide end-of-month enrollment for three months (November, February, and April). If a program is not operating in one or more of these months, it reports enrollment for an alternate month.

and staffing specific to these programs. The survey questions focus primarily on community and family characteristics, partnership activities, assessment strategies, and children with disabilities.

In addition to collecting basic information about the characteristics of grantees and enrolled families, we designed our survey to address performance measures contained in the two bottom layers of the performance measures framework described in Chapter I—management systems and services (Figure I.1). We developed survey items to measure implementation of as many of the performance measures as possible in the management systems and services layer. Table II.1 displays the specific performance measures, organized by performance objectives in the conceptual framework (Figure I.1) along with the data sources we used to collect information on the implementation of each measure. (The complete survey is in Appendix A.)

During the survey development process, we consulted with an internal project team consisting of MPR staff, federal staff, and consultants. This team and the Technical Work Group (TWG), whose members represented diverse areas of expertise regarding Early Head Start programs and early childhood education, provided feedback on early versions of the instrument. This group collaborated to develop the survey instrument—a process that, because of the complexity of the domains to be measured, took one year to complete. Appendix B gives a complete description of the survey development process.

Survey Administration

To maximize response rates, we fielded the survey through multiple modes. Because in focus groups Early Head Start staff indicated preference for a web-based interface, we developed both a web and a paper-and-pencil version and gave respondents their choice. We mailed them an individualized login and password for accessing the web version, as well as a copy of the paper-and-pencil version. Data collection ran from February 2005 to early July 2005, with web and paper modes occurring simultaneously.

We used several strategies to encourage high response: a comprehensive series of advance mailings, endorsement letters from federal Head Start officials, informational conference calls hosted by the Early Head Start National Resource Center at Zero To Three, a seven-day-a-week help desk (available by email and toll-free telephone), and periodic reminder emails. We contacted programs that did not complete either self-administered form and invited them to complete a partial interview by telephone.[2]

[2] For the telephone version, we selected the most important questions and asked programs to respond only to this abbreviated set of items in hopes of collecting at least partial data from as many programs as possible. Telephone surveys were completed by trained telephone interviewers who entered data directly into the web survey.

Table II.1. Data Sources for Early Head Start Program and Family Characteristics and Performance Measures, by Performance Objective

Data Element	Data Source: Survey	Data Source: Site Visit
A. Grantee Characteristics		
Program approach	X	
Program size	X	
Program sites	X	
Years in operation		X
B. Characteristics of Families Served		
Enrollment criteria		X
Recruiting approaches		X
Characteristics of families and children served	X	X
Families' needs		X
Enrollment turnover	X	X
C. Management Systems: Processes for Improvement		
Programs comply with Head Start regulations. (Not assessed)		
Programs are well managed operationally and financially.		
– Use of MIS	X	X
– Leadership		X
– Communications	X	X
Programs design and implement services to be responsive to the needs of families in the community.		X
Programs conduct self-assessments that are used for continuous improvement.		X
D. Management Systems: Support Staff		
Programs employ qualified staff with the skills necessary to provide high-quality services.	X	
Programs support ongoing staff development, training, and mentoring.	X	X
Programs support staff activities through ongoing reflective supervision.	X	X
Programs promote staff retention and continuity.		X
E. Management Systems: Relationships with Community Partners		
Programs form partnerships with other community programs and organizations to support an integrated community-wide response to the needs of families with young children.	X	X
Programs form partnerships and coordinate services with local Part C agencies.	X	X
Programs form partnerships and coordinate services with community child care providers to meet the needs of families and enhance the quality of local child care services through the sharing of resources, training, and knowledge.	X	X
Programs form partnerships and coordinate services with local health agencies and health care providers to meet the health-related needs of families.	X	X

Table II.1 *(continued)*

Data Element	Data Source: Survey	Data Source: Site Visit
F. Management Systems: Involving Parents		
Parents are actively involved in program planning and decision making.	X	X
Programs encourage and support fathers' involvement in program planning, decision making, and activities.	X	X
G. Program Services: Linking to Community Services		
Programs work collaboratively with families to identify their goals, strengths, and needed services, and offer them opportunities to develop and implement individualized family partnership agreements that take into account other family plans.		X
Programs link parents with social services agencies to obtain needed services.	X	X
Programs link parents with educational and employment agencies to obtain needed services.	X	
Programs link parents with physical and mental health care prevention and treatment services to obtain needed care.	X	
Programs link parents with needed prenatal care and education services.	X	
Programs help parents secure high-quality child care in order to work, attend school, or gain employment training.		X
Programs help parents and children make a smooth transition to Head Start or other preschool programs.	X	X
H. Program Services: Responsive and Caring Relationships with Parents and Children		
Staff form respectful and supportive relationships with parents through all aspects of service delivery.		X
Staff form nurturing relationships with children in group-care settings or during home visits.		X
Programs support and honor the home cultures and languages of families.		X
I. Program Services: Provide Children with Individualized Services		
Programs provide developmentally enriching educational environments in group-care settings and developmentally enriching parenting and child development services during home visits and group socializations. (Not assessed)		
Programs link children with needed medical, dental, and mental health services.	X	X
Programs link pregnant women with comprehensive prenatal health care and education.	X	X
Programs provide children in group-care settings with meals and snacks that meet their daily nutritional needs, and parents receiving home-based services are given information about meeting their children's nutritional needs. (Not assessed)		
Programs provide individualized services for parents and children, including children with disabilities.	X	X

Sample Frame and Response Rates

Our intention was to take a census of the universe of Early Head Start programs operating in late 2004/early 2005. We developed a sample frame from the most recently available PIR data by extracting grantee and delegate identification numbers, selected program characteristics, and contact information. Using these PIR data, we selected Early Head Start programs (not Head Start) and only those providing services directly, excluding grantees that provided services only through delegates.[3] We refer to all respondents to the survey as "programs." This process resulted in a sample frame of 748 programs.

We obtained a response rate of 89 percent, receiving survey responses from 660 programs.[4] This rate includes partially completed surveys. Respondents clearly preferred the web interface, with nearly two-thirds responding in that way. Twenty percent returned paper copies, and the rest completed the survey by telephone (Table II.2). Appendix B presents a detailed description of our methods for fielding the survey and creating final data files.

Table II.2. Response Rates by Survey Method

	Number of Programs	Percentage of Responding Programs	Percentage of All Programs
Survey Mode			
Web	479	72.6	64.0
Paper	148	22.4	19.8
Telephone	33	5.0	4.4
All Responding Programs	**660**	**100**	**88.2**
Nonrespondents			
Ineligible[a]	7	—	0.9
No contact/refused	81	—	10.8
Total Sample Size (Programs)	**748**		**100**

Source: Survey of Early Head Start Programs and 2004–2005 Program Information Report.

[a]These programs lost their federal Early Head Start grants and discontinued service provision during the field period.

[3] A *grantee* agency is one that receives federal funding to operate an Early Head Start program. A *delegate* is a program that provides Early Head Start services. Some grantees provide Early Head Start services directly; others provide services only indirectly, through delegates.

[4] This figure excludes seven programs that were deemed "ineligible" because they lost their Early Head Start funding at some point during the field period. If we include these seven programs in the denominator, the response rate falls to 88 percent.

Site Visit Protocol Development

We designed our site visits to provide in-depth, rich information about program organization, services, and staff through semistructured interviews with staff and two focus group discussions—one with staff and one with parents. We developed the site visit interview guides using an approach similar to the one we used for the survey. Working from the Early Head Start performance measures framework, we identified areas of interest for in-depth exploration beyond or in addition to what we could learn from the survey alone. We created protocols for specific types of program staff—the director and staff members in five different specialty areas (community partnerships, early childhood education, family involvement, health and disabilities, and home visiting). We discussed a core set of questions with multiple staff members, but each protocol also included specific items relevant to particular specialty areas. We also created separate focus group discussion guides for Early Head Start center teachers, home visitors, and parents. During the development process, we consulted with other MPR staff, our ACF project officer, outside consultants, and TWG members.

Interview topics covered the five major program areas described in the survey but in much greater depth and detail (Table II.1). In addition, we gave special attention to staff views on program leadership, the extent of Early Head Start's integration with Head Start, strategies for serving high-risk families, the use of management information systems and data, and partnership arrangements, especially child care partners.

Site Visitor Qualifications and Training

A team of MPR staff conducted the site visits between October 2005 and early February 2006. These people had extensive experience in conducting site visits, and many had visited Early Head Start programs for other studies. To ensure that all visitors would be well prepared to carry out the interviews and focus groups, MPR conducted a day-long training in September 2005. The session included briefings on the study's background and objectives, a review of the interview protocols, and extensive discussion about the research questions and the intent of specific items. We provided all site visitors with training materials that included descriptions of procedures, suggested talking points to use when contacting programs to set up the visits, copies of the interviews and group discussion guides, and supplementary information on Early Head Start. We also held weekly team meetings to discuss the visits and resolve issues and questions that had come up in the field.

Site Selection and Procedures During the Visits

To ensure that we could address questions of interest, we purposively selected sites to visit based on the following eight characteristics: (1) ACF region, (2) program size, (3) whether the programs served pregnant women, (4) whether they served children through partnerships with community child care providers, (5) urbanicity, (6) whether the programs had experienced recent changes in demographics, (7) whether they had experienced recent turnover in the program director, and (8) program approach. We used data from survey responses to categorize the programs according to these characteristics, then we selected

programs to ensure the greatest diversity possible along each dimension and across combinations of dimensions (Table II.3).[5]

Table II.3. Characteristics of Programs Selected for Site Visits

Characteristic	Number of Programs
Region 1	1
Region 2	2
Region 3	2
Region 4	2
Region 5	2
Region 6	1
Region 7	2
Region 8	2
Region 9	1
Region 10	1
Region 11	1
Serves Fewer than 50 Children and Pregnant Women	6
Serves 50 or More Children and Pregnant Women	11
Serves Pregnant Women	14
Does Not Serve Pregnant Women	3
Has Child Care Partner	11
Does Not Have Child Care Partner	6
Serves Children Through Child Care Partners	5
Does Not Serve Children Through Child Care Partners	12
Urban Area	9
Non-urban Area	8
Change in Enrollee Race/Ethnicity	
Increase in Hispanic enrollment	4
No change/do not have Hispanic enrollment	13
Director Turnover During Past Year	1
Program Approach	
Home-based	4
Center-based	4
Both home- and center-based	9
Sample Size (Programs)	**17**

Source: Survey of Early Head Start Programs.

[5] Before contacting programs, our project officer verified that they were in good standing and notified regions of our intent to contact (unnamed) programs in their area. We guaranteed anonymity to participating programs and therefore offer only very general information about this sample.

We contacted the selected programs and asked the director or a staff person to help us set up interviews with appropriate staff members and recruit teachers, home visitors, and parents to participate in focus groups. Site visits took two days to complete. To increase participation, we gave each program a $20 Barnes and Noble gift card; parents received a $20 incentive for participating in the focus groups.

ANALYTIC APPROACHES

This section provides a brief description of our data preparation procedures and the analysis of survey data. We follow with a description of our approach to coding and analysis of the qualitative data we obtained in site visits.

Analysis of Survey Data

Before beginning analysis, we thoroughly prepared the data obtained from the survey. An advantage of the web survey was that there were some built-in data checks, including restricting the range of responses, and screens that alerted respondents to inconsistent answers.[6,7] We applied variable names and labels to all items and created a program that checked all skip patterns (inserting a logical skip code when items were missing for that reason).

To analyze the data, we computed descriptive statistics such as frequencies and means. We created some key constructs for purposes of aggregating programs (for example, categories to describe program service approaches and demographics of enrollees—described in later chapters). We answer the research questions posed in Chapter I that center on the first two layers of the conceptual framework. These include characteristics of programs, families served, services provided, and program management using descriptive statistics of overall program characteristics. We answer questions about differences among program subgroups by creating categories of programs to compare characteristics across programs.

We intended this survey to represent all Early Head Start programs so that descriptions would be generalizable. Because we contacted all Early Head Start programs in operation and obtained a response rate of nearly 90 percent, we are able to generalize our findings to the universe of Early Head Start programs. For the same reason, we are also able to detect small differences between subgroups. To reduce any potential for nonresponse bias, we computed an adjustment factor based on information we knew about all programs from the PIR. To calculate the weights, we used program size, location in a metropolitan statistical area (MSA), agency size, and agency type. Respondents did not differ from nonrespondents,

[6] For example, one data check was that applicable responses using percentages should total 100.

[7] An example is in Survey Section A (see Appendix A). Total child enrollment is reported in item A4C, and if the number of children reported in item A5D did not match, an alert screen would appear and ask respondents to check their answers. These alert screens were placed strategically and only at key places so as to minimize time and burden on respondents.

except that the latter were more likely to be from an MSA (78 percent versus 65 percent, $p < .05$). We then used this factor as a weight in our analysis to allow projections to the full population versus only the sample that responded. Weighted and unweighted data are nearly identical, and therefore we report unweighted data in the body of the report and include tables of weighted data in Appendix D. We use weighted data for subgroup analyses to avoid the possibility that response rates differ across subgroups (something we cannot assess for nonrespondents, because for those programs we do not have the survey data that we used to create the subgroups). We did however compare responding and nonresponding programs on other characteristics from the PIR, including number of children, pregnant women, and children with disabilities, and found no significant differences between groups.

Analysis of Site Visit Data

To ensure the quality of site visit data, we developed a structured site visit report template and subjected all reports to a quality control review before coding and analysis. We used a qualitative analysis software package, Atlas.ti (Scientific Software Development 2004), to organize and synthesize the large amount of data collected during the site visits. This software enabled research team members to use a structured coding scheme for organizing and categorizing data that are linked to the primary research questions. After the site reports were coded, we used Atlas.ti to conduct searches and retrieve data on our research questions and subtopics. Findings from the qualitative data are presented mainly as general descriptions of common program features; in some cases, we identify particularly interesting or unique features to use as examples. In contrast to the survey findings, our site visit findings are not generalizable to all programs. They do, however, provide rich information on a subset of programs and may provide clues to help us understand better why programs organize themselves differently and how various systems operate.

CHAPTER III

CHARACTERISTICS OF EARLY HEAD START PROGRAMS

Documenting the key characteristics of Early Head Start programs, their communities, and enrolled families is important for understanding how programs operate. This chapter describes the context of Early Head Start programs and the families they serve. We begin by describing the settings in which programs operate—including community factors such as urbanicity, cultural diversity, agency auspices, affiliation with a Head Start program, and funding sources agencies use to provide Early Head Start services. We then describe program enrollment, recruitment practices, and basic demographic characteristics of Early Head Start families, and follow with discussion of specific target populations that programs serve, including the extent to which programs serve high-risk families and children with disabilities. In this chapter, we use findings from survey data in two ways. First, we describe program-level data from the survey of all programs (for example, the percentage of programs serving families with particular attributes). Second, we describe some data at the enrolled population level (the percentage of all Early Head Start families with particular attributes). We use pull-out text boxes to describe program and family characteristics based on site visit data from 17 selected programs.

THE PROGRAM SETTING

Early Head Start programs individualize their services precisely because they serve a broad range of communities, as families in different communities have different needs.

Population Density. Early Head Start operates in a broad range of settings, from rural to urban and suburban. Some agencies operate programs in more than one type of setting, such as one in an urban area, and other satellite or delegate program in an outlying rural area. Early Head Start programs are roughly evenly divided between primarily urban (45 percent) and primarily rural (42 percent) service areas (Table III.1). Ten percent operate in mainly suburban areas. Only a handful (2 percent) operate in service areas with a fairly equal mix of two or more categories.

Table III.1. Key Characteristics of Early Head Start Programs

Characteristic	Percentage of Programs
Program Service Area	
Mainly urban	45.2
Mainly rural	42.0
Mainly suburban	9.5
Mixed	2.3
Other	0.9
Number of Program Centers[a]	
Single	35.8
Multiple	64.2
Community Diversity	
High	18.9
Moderate	41.2
Low	39.9
Diversity Past Five Years	
Increased	42.3
Stayed the same	56.3
Decreased	1.4
Agency Nonprofit Status	
Private nonprofit	68.7
Public agency	28.0
Private for-profit	1.8
Other	1.5
Program Auspices	
Community agency	69.7
School	9.9
Government agency	5.8
Tribal government	4.4
University	3.5
Hospital or health care provider	3.4
Other	3.4
Program Operates Own Preschool Head Start	81.6
Sample Size (Programs)	**461–657[b]**

Source: Survey of Early Head Start Programs.

[a]Does not include family child care or home-based services.

[b]Most questions have sample sizes over 640. Number of Program Centers has a sample size of 461 because it includes only programs that operate an Early Head Start Center.

Number of Centers or Sites. About two-thirds of programs operate multiple Early Head Start centers or sites. Programs usually define their service areas by county lines (67 percent), although some use school districts, zip codes, or neighborhoods (not shown). Some programs (24 percent) report using more than one of these definitions to determine the boundaries of their service area.

Community Diversity. Sixty percent of programs are in areas that programs characterize as being of "moderate" or "high" cultural diversity. We also asked programs to indicate change over the past five years; many programs (42 percent) are also in areas of increasing cultural diversity. Here, we discuss *community* diversity as distinct from *program* diversity—because the families served by Early Head Start may not represent all races and cultures in the service area. Still, community diversity is an important consideration for program individualization, because programs in diverse areas may need to find ways to make services attractive to multiple cultural groups and to serve families that speak languages other than English. Rapid changes in community diversity can place stress on program management and hiring as programs adjust to different family needs and cultures.

Program Auspices. Agency auspices play a role in programs' approaches to management and service delivery, because agencies differ in the resources they have to offer Early Head Start programs as well as in their requirements for program management. Most Early Head Start programs are operated by nonprofit community agencies. The majority (69 percent) of programs have private nonprofit status, and a substantial minority (28 percent) are public agencies. Just 3 percent are operated by for-profit companies. Overall, most Early Head Start programs are operated by community agencies, such as community action agencies, community-based organizations, and faith-based organizations (70 percent). Government agencies or tribal governments account for 10 percent of programs, schools account for 10 percent, and the remaining 10 percent are run by universities, health providers, and other types of agencies.

Integration with Head Start. More than 80 percent of Early Head Start programs are run by grantees that also operate a Head Start program. Information collected through site visits suggests that program integration is an ongoing process and that even when Early Head Start and Head Start operate under the same organization, the two programs may function independently. (Box III.1 describes strategies for integrating Early Head Start and Head Start programs and the challenges in doing so, based on site visit data.)

PROGRAM FUNDING

The Office of Head Start provides grants to grantee agencies that can pass the funding through to delegates, provide Early Head Start services directly, or do both. In addition, federal performance standards require that programs raise 20 percent of total program costs through non-federal funds. Matching contributions can be made either through cash donations or through in-kind products, resources, or services. Both monetary and in-kind contributions can be produced by the grantee or delegate agency itself or through outside sources. Programs cannot require that families pay any fees for participating in Early Head Start.

BOX III.1

INTEGRATING EARLY HEAD START AND HEAD START PROGRAMS

The Office of Head Start has encouraged collaboration between Early Head Start and Head Start programs. Among the potential benefits of integrated programs are smoother transitions for families, stronger relationships between families and program staff over time, enhanced access to community partners and other resources for families, and opportunities for staff members to broaden their expertise in early childhood development (DHHS 2005). We selected programs that vary on their affiliation with a Head Start program for site visits. Directors at more than half the programs visited as part of this study consider their programs to provide seamless services for children aged birth to 5. During site visits, staff describe promising strategies for creating integrated programs as well as challenges they face in doing so.

Staff members described integration strategies focusing on program organization and service delivery to move toward better integration of Early Head Start and Head Start. Specific steps programs have taken include the following:

Reorganizing management and staff. Some programs have changed their organizational structure so that one director is responsible for both Head Start and Early Head Start. This director typically supervises an administrator with overall responsibility for Early Head Start and/or specialists who serve families and staff in both programs.

Creating shared staff training plans and using similar curricula and forms. Several programs report integration strategies such as creating staff training plans that cover both Head Start and Early Head Start, choosing a curriculum that can be shared across the programs with appropriate adaptation, and having common forms and management information systems for both programs.

Combining Policy Councils. Programs working to integrate Early Head Start and Head Start programs often have a single Policy Council for Head Start and Early Head Start. Typically, fewer Early Head Start parents serve on the council, but they sometimes hold leadership positions.

Administering a single federal grant for Early Head Start and Head Start. Some programs have received approval to submit a single federal grant application for both Early Head Start and Head Start funding. Managers say that this helps create a stronger administrative link between the two programs, although budgets must still be tracked separately.

Program staff members also highlighted integration challenges related to differences in program size, comfort with and expertise in serving children of different ages, transitions between Early Head Start and Head Start, and program finances.

Differences in program size. Early Head Start programs typically have a much smaller funded enrollment size than their Head Start counterparts in the same agency. Imbalance in enrollment levels may have implications for sharing specialists across programs, as the larger program is likely to place more demands on staff time. Differences in program size may also make it more difficult for Early Head Start parents to have a strong voice in making decisions that affect both programs if parent representation on the council is proportional.

Need for expertise in serving younger or older children. Managers at some programs receiving site visits noted that moving toward integration meant addressing perceptions among Early Head Start or Head Start staff members that they did not have the skills or capacity necessary to work with children in both age groups. Program leaders must be aware of the important differences in the needs of children in each age group and in the training required for staff working with each group.

Box III.1 *(continued)*

Difficulty transitioning families between Early Head Start and Head Start. Staff at several programs note that problems can arise when families' eligibility must be recertified before they enter Head Start, particularly if a family's income has increased since enrolling in Early Head Start. Another problem is lack of available Head Start slots for children whose birthdays occur mid-year. Some programs continue to serve these children in Early Head Start for the rest of the year.

Segregation of program budgets. A logistical challenge mentioned by managers is the requirement that Early Head Start and Head Start budgets and expenditures be tracked separately, even when the programs share a single grant number, staff, and facilities.

Nearly two-thirds of programs use additional outside funding sources to provide Early Head Start services (Table III.2).[1] Programs use additional funds for an array of purposes, from improving Early Head Start services to offering other services, such as dental screenings, father involvement support, and language and cultural training. However, additional funding sources introduce management challenges for programs, such as contending with reporting requirements for multiple funders and working to sustain funding to continue new services. Box III.2 describes the challenges some programs we visited face in managing multiple grants.

BOX III.2

MANAGING MULTIPLE GRANTS IN EARLY HEAD START

During site visits, we learned about the ways programs pursue and use outside funding sources. Administering more than one grant can be a challenge, because it is necessary to report to more than one funder and difficult to sustain funding for limited-term grant activities. Some of the programs we visited that have additional funding sources mentioned burdensome additional reporting requirements, more complex budgeting issues, and other extra requirements. In addition, new grants often involve initiating new services in the Early Head Start program and hiring new staff, but grant funding is time limited, and continuation funds can be difficult to obtain. Several programs report that sustaining funding over time is a challenge, and another program notes that shifting state budgets make it difficult to predict how child care subsidies will fit into future budgets. Furthermore, programs may not always be able to use outside funding to meet their most pressing needs, because grant funds usually can only be used for certain purposes. For example, one director notes that in the year preceding the site visit, the program had more than enough money for technology services but did not have funds to paint the facility. Despite these challenges, however, program staff feel that the additional service opportunities afforded by extra funding are important enough to merit the added effort.

[1] Survey item wording asked about the *funding* that programs receive from outside sources; some programs only receive in-kind contributions.

Table III.2. Early Head Start Program Funding

Characteristic	Percentage of Programs
Program Funding Sources	
Any outside funding sources	62.5
Funding Sources	
State child care subsidies or block grant	34.2
State government grant	17.7
Private foundation grants	14.9
Fundraising activities	13.1
Fee-for-service reimbursements	8.5
County or municipal government grant	8.2
Part C funds	6.3
Contracts	5.6
Grants provided by businesses	5.3
Other source	6.5
Use of Additional Funding Sources	
Child care	47.7
Improvements to existing Early Head Start services	41.2
Parent activities	26.0
Additional Early Head Start staff	24.1
Staff training or technical assistance	22.9
Additional Early Head Start enrollment slots	15.2
Services for Part C children or families	14.9
New Early Head Start services	8.9
Other use	11.6
Number of Additional Funding Sources	
Programs with no additional sources	37.5
Programs with 1 additional source	31.2
Programs with 2 or 3 additional sources	25.7
Programs with 4 or more additional sources	5.7
Sample Size (Programs)	**415–654[a]**

Source: Survey of Early Head Start Programs.

[a]Most questions have sample sizes over 640. One question has a low sample size because it applied only to certain programs: Use of Additional Funding Sources applies only to the 415 programs that report having any additional funding.

The most common sources of additional funding for Early Head Start programs are state subsidies or local grants. One-third of programs use state child care subsidies, and more than a fourth use state, county, and municipal grants (26 percent). Private funding is another main source of additional funding for one-third of programs and includes foundation grants, individual donations, and grants from businesses. Other federal and outside funding sources, used by 20 percent of programs, include fee-for-service funds, contracts, and Part C funds.

EARLY HEAD START ENROLLMENT

Program enrollment is carefully regulated by the Head Start Program Performance Standards and is part of the core area of Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA). Families with children under age 3, and pregnant women, both with incomes below the poverty line (or whose families are eligible or potentially eligible for public assistance) can be enrolled. Programs may impose additional eligibility requirements. Performance standards also lay out requirements for maintaining waiting lists, prioritizing children for enrollment according to need, and ensuring that enrollment slots are filled. The performance standards also specify that 10 percent of enrollment slots should go to children with disabilities and that 10 percent of enrollment slots may go to families with incomes over the federal poverty threshold. (Box III.3 describes programs' enrollment criteria, using site visit interview data.)

Within the enrollment criteria, local programs have some flexibility in how they prioritize families for enrollment. Programs typically integrate the requirements laid out in ERSEA, any additional local eligibility requirements, and local needs they have identified to design programs that are individualized for their communities into a rating system that give priority to the neediest families.

Program Size. Most Early Head Start programs serve fewer than 100 children, and overall mean actual enrollment for Early Head Start is 84 children and pregnant women.[2] However, the few programs with more than 200 enrollees inflate the average (Figure III.1). Just under one-third of programs serve 50 or fewer pregnant women and children; 41 percent of programs serve between 50 and 100. Very large programs, serving 150 or more children and pregnant women, make up 11 percent of programs, and the remaining 16 percent serve between 101 and 149 children and pregnant women. Altogether, program size varies widely, with enrollment ranging from fewer than 10 to nearly 600 children and pregnant women.

Age of Children. The population of children enrolled in Early Head Start consists mainly of 1- and 2-year-olds. Based on survey data, among all children served by Early Head Start, 31 percent are age 1 and 37 percent are age 2. Babies under age 1 make up about

[2] The survey asked programs to report *actual* enrollment rather than *funded* enrollment as of January 1, 2005.

BOX III.3

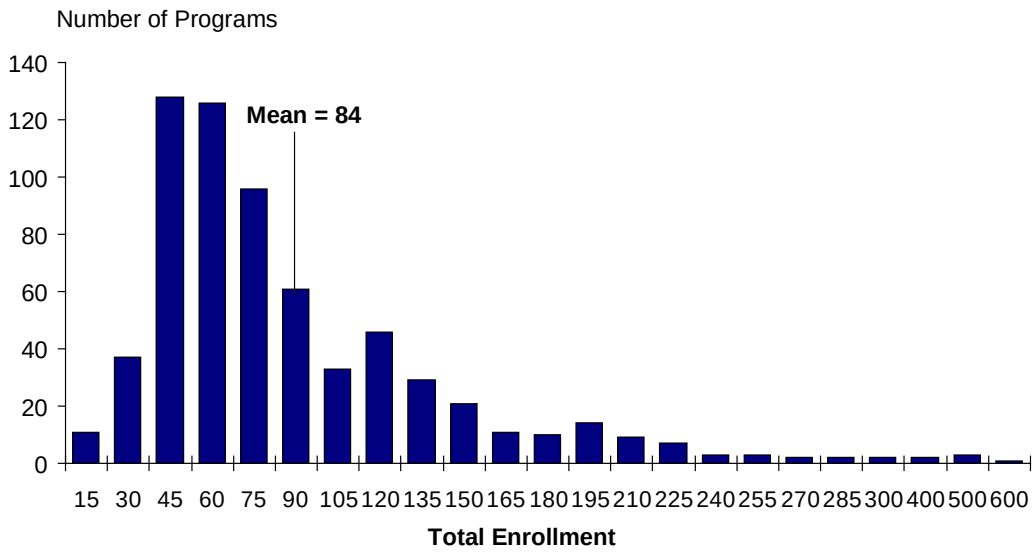
ENROLLMENT CRITERIA IN EARLY HEAD START PROGRAMS

Early Head Start is a voluntary program that is not an entitlement, so programs select enrollees among families that are interested in participating. Federal requirements restrict the service population to families with pregnant women and children up to age 3. Federal poverty guidelines determine families' income eligibility for Early Head Start, although programs may enroll families above the poverty line up to 10 percent of total enrollment. Programs are also required to make at least 10percent of slots available to children with special needs and make efforts to meet that percentage. Grantees or programs may impose more stringent or additional enrollment criteria at their own discretion. Most programs identify more eligible families than the number of slots they have available and therefore maintain a waiting list for enrollment. The federal performance standards require that programs establish waiting lists that rank children according to program criteria for prioritizing families based on community needs. The following data from our site visits describe the programs' experiences selecting and enrolling families.

Among programs participating in the site visits, about half use additional eligibility criteria beyond federal requirements. All but one visited program had a waiting list at the time of the interviews. Additional eligibility requirements typically pertained to family income level or employment status. Several programs impose a full-time work or school requirement on parents seeking center-based care or any Early Head Start services. These and the more stringent income criteria were usually due to requirements for receiving state child care subsidies or other supplemental funding. In addition, one program does not accept children over age 2 at the time of enrollment, because children age out of Early Head Start at age 3, and the staff members feel that families would not benefit from less than a year of services. One program requires that families document that they live in shelters or public housing to be eligible for services. All visited programs keep a list of families waiting for services, although one program had no families on the list at the time of the interview and another had a very small list. A couple of programs have very large waiting lists, and one has twice the number of families on the list as slots available. On average, however, the number of families on waiting lists is about half the number of total enrollment slots.

Almost all Early Head Start programs that participated in site visits use a ranking system to select families for enrollment according to the highest level of need. Early Head Start programs usually maintain a waiting list, but when a slot becomes available, most do not enroll families solely according to length of time on the list. Instead, staff prioritize families for enrollment according to need, so the families with greatest need by local criteria on the waiting list are served first regardless of how long they have been waiting. Programs typically develop a scoring system for applicants, awarding points for family risk factors identified as priorities for the service area. The enrollment prioritization systems that programs use are individualized to the needs of the community. For example, one program uses the results of the community assessment to identify major community needs and worked with its policy council to develop a scoring system based on those needs. Teen parenthood, children with special needs, and particularly low family income or poverty are the priority risk factors cited most frequently by programs we visited. Some programs give families extra enrollment points for single parenthood, current pregnancy, mental health concerns, substance abuse, foster or kinship care, homelessness, not speaking English and other risk factors. Several programs award points for families with a previous history in Early Head Start or Head Start, particularly if the family has another child currently enrolled in Early Head Start. Although these point systems prioritize family needs and risk factors over the family's length of time on the waiting list, some programs do award additional points to families for lengthy periods of time spent waiting for services.

Figure III.1. Early Head Start Actual Enrollment, Including Children and Pregnant Women



Source: Survey of Early Head Start Programs.

Note: Enrollment values on x-axis are increments with the high end of the range reported. Each category is mutually exclusive; for example, the first bar includes programs with up to 15 enrollees.

Sample Size = 648.

22 percent of children served, and most of the remaining children are 3-year-olds (Table III.3). We asked separately about the proportion of children entering the program at various ages and then about age of exit—so the two are not directly comparable but we can get a sense of the flow of children in and out of the program more generally. About 13 percent of children enter the program in the prenatal period, but most enter Early Head Start between birth and age 2 (62 percent). Fewer (19 percent) enter at between 2 and 3 years of age. Conversely, nearly half of enrolled children exit Early Head Start at some point after turning 3 (46 percent), 23 percent exit between ages 2 and 3, and 16 percent exit before age 2. (Survey items are not specific enough to calculate exact age of exit.) Very few pregnant women exit the program before the birth of their child (2 percent).

Considering enrollment from the program standpoint, most programs serve some children across all these ages (as well as pregnant women) and so must provide services appropriate for each age group, including the prenatal period. A few programs serve only or mostly babies under 1 year old (not shown). Almost all programs serve at least some 1- and 2-year-olds, and most serve children primarily of these ages. While most Early Head Start programs serve younger infants and toddlers, a substantial number (about a third of all programs) do not serve 3-year-olds, consistent with the policy that Early Head Start is a 0 to 3 program, with 3-year-olds and older children being served by other programs such as Head

Table III.3. Characteristics of Early Head Start Children

	Percentage of Enrolled Children/ Enrollment Slots
Age of Enrolled Children	
Under 1 Year Old	22.2
1-Year-Olds	31.4
2-Year-Olds	36.8
3-Year-Olds	9.5
4-Year-Olds	0.1
Sample Size (Children)	**46,317**
Pregnant Women	8.2
Age at Program Entry	
Prenatal	12.7
0 to 2 years old	61.5
2 to 3 years old	18.6
Age at Program Exit	
Prenatal	2.1
0 to 2 years old	16.2
2 to 3 years old	23.3
3 or more	46.0
Sample Size (All Enrollment Slots)	**55,570**

Source: Survey of Early Head Start Programs.

Start. Differentials in the concentration of ages across programs may indicate that programs are efficient at transitioning children to other services as they reach age 3.

Although programs are not required to serve pregnant women, they are encouraged to do so, and if they do, they must comply with the performance standards in providing services. Most programs (84 percent) serve pregnant women, although relatively few may be enrolled at any one time and some programs that serve pregnant women may not have any enrolled at a given point in time. Among programs serving pregnant women at the time of the survey, the distribution ranges from just 1 woman (in 9 percent of programs) to 123 (less than 1 percent of programs). These women make up about 10 percent of enrollment in programs serving them. Looking at all Early Head Start enrollment slots, pregnant women fill 8 percent. Programs that serve pregnant women provide basic services as required by the performance standards, but they rarely provide specialized services. For example, of programs serving pregnant women, nearly all provide referrals (98 percent) and prenatal home visits (95 percent); most provide case management services (86 percent) and classes (60 percent). Programs rarely provide other types of services such as transportation, community activities, or doulas—childbirth coaches (all less than 10 percent). Box III.4 describes the unique challenges of serving this group of mothers-to-be and strategies to address them.

BOX III.4

RECRUITING, ENROLLING, AND SERVING PREGNANT WOMEN

In addition to serving families with children aged birth to 3, Early Head Start strives to improve birth outcomes by targeting pregnant women for enrollment. Although programs are not required to serve pregnant women, they are encouraged to do so. The Head Start Program Performance Standards require that programs provide the following services to pregnant women if they do serve them: referrals for comprehensive prenatal and postpartum care, prenatal education on fetal development, and information on the benefits of breastfeeding. Here, we provide findings from both the survey and site visits about enrolling and serving pregnant women and the challenges of serving this population.

Although most programs enroll pregnant women, some programs we visited rarely made special efforts to recruit them. In others, normal recruiting and referral sources (such as doctors' offices, hospitals, Part C providers, and other community providers) are in place to fill slots for pregnant women. One program actively recruits first-time mothers who are immigrants or teenagers, or are in high-risk situations (such as homelessness). Pregnant women from these groups are recruited through high schools, maternity homes, the health department, and peer support programs.

Transitioning to Early Head Start services after childbirth is often easier when families are enrolled in the home-based option. Transitioning from prenatal home visits to center-based services can be more challenging. Home-based programs indicated that transitioning after birth was usually a smooth process, in part because the visiting routine is already established and home visitors simply maintain the mother and child on an existing caseload. Center-based services present more difficulties. Enrolling an infant requires an open slot, adherence to standards about child-staff ratios, and, in some cases, state regulations or child care licensing requirements, all of which can present difficulties in placing an infant. For example, in one site, state child care licensing regulations stipulate a limited range of ages that can be served in a single classroom. As a result, at times infants must wait in home-based services for a center-based opening because staff cannot create a slot for them. Sometimes staff want to create an opening by advancing a child who seemed ready to move on to the next classroom. However, they cannot do so until he or she is old enough, so as not to violate the age range rule in the next classroom. In several other programs, overall low availability of infant slots makes transitions difficult. Transportation is a barrier in one program that cannot transport infants or toddlers without a parent in the vehicle. This rule makes it very difficult for working parents to enroll their children, even though they are the ones most in need of a center-based slot.

Staff at programs we visited described three main challenges in serving pregnant women: (1) women's belief that they did not need services until after the birth of the baby (desiring only a center-based slot); (2) making information seem relevant to experienced mothers who already had other children; and (3) overcoming resistance to receiving services, which is often related to cultural issues. Program staff attempt to address these issues by helping women understand the connection between prenatal care and later child outcomes, providing them with specific information on child development. Staff in some sites reported that teenage mothers are especially resistant to receiving services, in part because of their own developmental stage. Staff try to help mothers bond with babies before the birth and work to break down cultural barriers. Cultural issues cited by programs include language (occasional difficulty hiring bilingual staff), norms about visitors in the home, preferences to bottle-feed rather than breastfeed, and practices that make home visits difficult, such as the Vietnamese custom of secluding the mother and child in the home for two months after birth. Some programs struggle to employ staff who speak families' languages and are familiar with their cultural backgrounds and norms (for example, hiring native Spanish-speaking staff rather than those who learned Spanish in school only).

Program Capacity. Most programs (62 percent) report that the number of children they serve matches their funded enrollment, while 20 percent of programs have more children enrolled than funded slots, and 18 percent have fewer children enrolled than funded slots (Table III.4). The Head Start Program Performance Standards allow programs 30 days to fill a vacancy, so there may be periods when enrollment is lower than the funded level if a few or many children leave at the same time.[3] Temporary underenrollment may be particularly likely in the fall, when many children transition to Head Start. Box III.5 describes some strategies programs use to recruit families to Early Head Start.

Table III.4. Early Head Start Program Enrollment

Characteristics	Percentage of Programs
Enrolled at Funded Enrollment Level	
At funded level	61.7
Above funded level	19.8
Below funded level	18.5
Program Maintains a Waiting List	100.0
Program updated waiting list in past 6 months	95.6
Number of children and pregnant women on waiting list	
0 to 10	17.3
11 to 50	37.7
51 to 100	21.3
100 or more	23.7
Sample Size (Programs)	**583–648**

Source: Survey of Early Head Start Programs.

All programs maintain a waiting list for enrollment, and almost all update it regularly. Waiting lists, which include families with children or pregnant women already deemed eligible for Early Head Start services, are an important strategy to ensure that programs can quickly fill vacant slots when they become available. Just over half the programs report having waiting lists of 50 children or fewer, and three-quarters of programs have waiting lists of fewer than 100 children. However, roughly 15 percent of programs had very small waiting lists, of 10 children or fewer. Ninety-five percent of programs report that they had updated the list during the six-month period before the survey. Waiting lists indicate excess demand for Early Head Start and imply that with additional funding, many programs would be able to serve a larger number of families than they do currently.

[3] Indeed, staff at some programs we visited point out that when a child leaves it can take a few weeks to get another child into the program, because of administrative requirements and the need for the family to adapt its routine. One program we visited reports deliberately enrolling a few extra children when it has funds to cover the slots, so that the program will not appear to be underenrolled if a few children leave unexpectedly.

BOX III.5

EARLY HEAD START FAMILY RECRUITING PRACTICES

During site visit interviews, we explored the practices programs use to recruit families and how they ensure they are reaching those most in need. During our site visits, staff described how the recruitment process works in their programs, and we report that information here.

Almost all the programs we visited report that it is easy for them to fill vacant enrollment slots when they become available, and about half do not recruit aggressively, because they consistently have long waiting lists. The most common ways families learn about the opportunity to enroll in Early Head Start are word of mouth from other enrolled families and referrals from other agencies. Programs reported that positive word of mouth is their most important recruitment tool. A few programs also reported that broader visibility and engagement in the community are important to them, and they achieve these through efforts such as participating in coordinating councils and attending or speaking at community events. In addition, Early Head Start programs accept referrals from other community agencies, such as early intervention programs or disabilities service agencies, public schools, child care providers, health departments and providers, shelters and public housing, social services and child welfare agencies, WIC, mental health agencies, and Head Start programs. Some programs also reported recruiting families by contacting these community agencies when slots were expected to open up (such as in the fall when many Early Head Start children transfer into Head Start or other preschool programs). Many programs we visited place brochures, flyers, or other information about the program in various community locations to attract new applicants, and one program reported attending enrollment days at the local public school to inform families about Early Head Start. A few programs placed ads or announcements in local media or agency bulletins, and a few also report going door to door in target neighborhoods to recruit families.

About half the programs we visited report targeting specific groups for enrollment and making special efforts to recruit and enroll these families. Commonly, programs make special efforts to recruit children with disabilities, as programs are required to make available 10 percent of their slots for children with special needs. A few of the visited programs targeted teen parents, and a couple also targeted homeless families. A few programs we visited set aside a specific number of enrollment slots for pregnant mothers but do not recruit actively to fill these slots. Programs typically identify pregnant mothers from among the families already enrolled in Early Head Start, either through word of mouth or through referrals from WIC or other agencies. None of the visited programs indicated that they target particular racial, ethnic, or cultural groups for enrollment.

The low threshold for income eligibility, as well as requirements for parental employment and program participation, made it difficult for some families to enroll in Early Head Start. Most programs had little difficulty maintaining full enrollment; moreover, more than half the programs we visited complained that they cannot serve all who are in need. One program noted that income eligibility rules are a particular challenge for enrolling teen parents. If a teen is still a dependent, her eligibility assessment must include the income of her own parents; therefore, many do not qualify for Early Head Start.

Site visit interviews highlighted other barriers to enrollment for some potentially eligible families. For example, program options that require a lot of family participation created barriers for some families, particularly for those with limited flexibility because of full-time work or school, lack of transportation, language differences, and hesitation or fear about participating (particularly for undocumented families). One program noted that the waiting list itself is a barrier for families that need care right away.

Programs we visited try to adapt their services and approaches to reduce the barriers to enrollment where possible. For example, one program with stringent eligibility requirements from a state grant is seeking a waiver for Early Head Start families to exempt them from some of the requirements. Another program decided to increase the number of center-based slots it offers because a lot of families have trouble fitting home visits into their schedules. Programs also make adaptations to address cultural or language barriers, such as hiring bilingual staff, bringing in translators, and finding alternative ways to verify income for families without documentation.

EARLY HEAD START FAMILY CHARACTERISTICS

Early Head Start programs serve families from a wide variety of racial and cultural backgrounds. The performance standards do not explicitly require programs to serve families of different races or cultures in their communities. However, the standards do require that programs individualize services to the needs and circumstances of families who live in their service areas and to serve families that are representative of eligible families in the community.

The families that most Early Head Start programs serve vary widely in race/ethnicity and speak many different languages, and this affects program management and staffing. Cultural competence among staff and service delivery approaches that support and honor the home cultures and languages are required by the Head Start Program Performance Standards and are reflected in the performance measures. In programs that serve families from a diverse mix of cultural backgrounds, directors/managers strive to hire staff with cultural backgrounds similar to those of enrolled families and to provide services in a culturally appropriate manner. In this section, we present population-level and program-level survey data on family characteristics separately, then compare the differences between these units of analysis. Box III.6 describes the ways that programs work to ensure they respect the cultures of families they serve.

Population-Level Demographics

Race/Ethnicity. The families served by Early Head Start are diverse in terms of race and ethnicity. The most common racial/ethnic groups among Early Head Start children are white/Caucasian, black/African American, and Hispanic/Latino (Figure III.2). Whites make up the largest proportion of enrolled families (33 percent). African Americans and Hispanics (of any race) make up roughly equal proportions of total enrollment (26 and 25 percent, respectively). Among others, served in much smaller proportions, are American Indian/Alaska Native; Asian, Hawaiian, or Pacific Islander; and biracial or multiracial. We find roughly similar information in the 2004–2005 PIR: 34 percent white, 27 percent black, and 29 percent Hispanic (not shown).

Language. About one-quarter of families served by Early Head Start primarily speak a language other than English. This figure is higher than analogous information in the PIR, where 20 percent of families speak such a language (not shown). Among those speaking a language other than English, Spanish is by far the most common, both in this survey (81 percent; Figure III.3) and in the PIR. There is such variety among the languages spoken by Early Head Start families that no one language apart from Spanish dominates. Three percent of families speak an Asian language, and a similar number speak a European language. The remaining 13 percent speak a variety of other languages, such as Arabic, Vietnamese, Swahili, or native Central and South American languages.

BOX III.6

RESPECTING FAMILY CULTURE IN EARLY HEAD START PROGRAMS

Cultural competence is an important part of the performance measures framework for Early Head Start; programs are expected to understand the cultural differences among families and design their programs to support families' home cultures. The following information from our site visit interviews describes how programs respect home cultures and ensure cultural competence in service delivery.

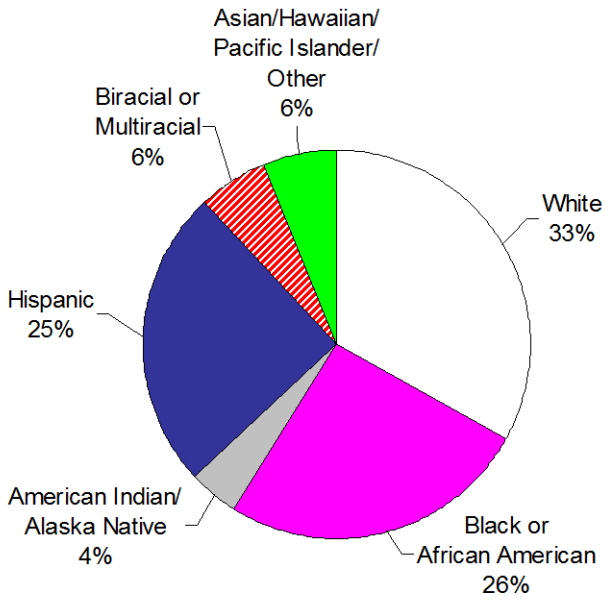
Early Head Start programs we visited emphasize respecting family cultures and traditions, even in less diverse programs. Respecting family culture often means understanding and being sensitive to practices and beliefs from other racial or ethnic groups. Language and communication are the most obvious challenges for programs serving families from diverse cultures, and programs use many strategies to address these and other cultural challenges.

Programs use strategies to ensure culturally competent services, such as hiring staff who are representative of the service population (or at least speak the same languages) and offering diversity or language training to staff. Most programs try to hire culturally representative or bilingual staff, although some said it is not always possible to find enough staff with these qualifications. About half the programs we visited reported offering diversity or language training to staff, as well as encouraging staff to do research or ask parents about their cultural values, traditions, and practices. Programs address language differences in a variety of ways. Some use translators, provide parents with materials in their primary language, or integrate cultural traditions and languages (such as songs or books) into the curriculum and classroom environment. A few programs offer acculturation support services for parents, such as English or literacy courses. Some programs adapt program services (for example, by providing vegetarian meals, not celebrating Christian holidays, celebrating holidays from many cultures, or holding multicultural events).

Programs that encountered differences in cultural childrearing practices are mostly accepting of different practices or take tactful approaches to suggest changing them. Differences in childrearing are related primarily to disciplinary practices (such as spanking) and dietary or nutrition practices (such as mixing rice with infant formula, bottle-feeding to an advanced age, or allowing young children to drink coffee). Program staff generally indicated that they respect cultural or family childrearing practices unless they present a danger to the child or are against the law. However, some programs attempt to influence family practices by using strategies such as sharing positive behavior management techniques and having a nutritionist or nurse explain the health effects of poor nutrition.

Additional challenges for programs related to serving a culturally diverse population include serving families with undocumented immigration status and contending with cultural stigmas against obtaining certain social and health services. Undocumented families presented a significant challenge to several programs. Although immigration status does not bar participation in Early Head Start, it does present challenges in obtaining resources such as employment, housing, bank accounts, health care, and transportation for families. Other problems related to immigration status include a lack of income documentation to determine Early Head Start eligibility and overcoming families' fears and suspicions of being reported to immigration enforcement. Among some cultural groups, programs are also challenged to overcome social stigmas against seeking services related to mental health, disabilities, and domestic violence. Furthermore, families from some cultures are not accustomed to seeking preventive and oral health care, so programs have to work hard to inform families about the importance of these services for the well-being of their family.

Figure III.2. Race/Ethnicity of Early Head Start Families: Population Level



Source: Survey of Early Head Start Programs.

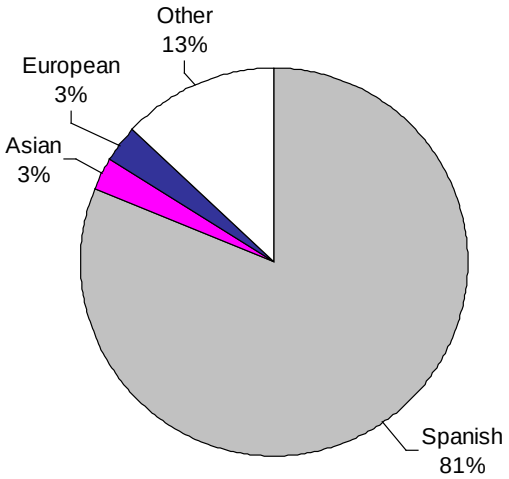
Note: Race/ethnicity information is provided by programs according to the group the family chooses. All race and ethnicity categories are mutually exclusive. Hispanic families of any race are included in one category, and other race categories exclude Hispanic families. Percentages are in the Early Head Start population, not the percentage of programs serving each group.

Sample Size = 55,611.

Program-Level Demographics

Race/Ethnicity. Although a small minority of programs serve one race/ethnicity exclusively, most serve a population that is at least somewhat diverse. Diversity within programs affects program staffing and services, as programs serving multiple races and ethnicities need to provide culturally competent services for all groups. More than 60 percent of Early Head Start programs report serving children or pregnant women from at least four racial/ethnic groups, and almost 20 percent of programs serve as many as six (Table III.5). Few programs serve children and pregnant women of just one specified race/ethnicity: 3 percent of all programs serve only American Indian/Alaska Native, 3 percent only Hispanic (any race), 2 percent only black/African American, and 1 percent only white children and pregnant women. Not unexpectedly, 12 of the 16 programs serving only American Indian or Alaska Native children and pregnant women operate under the American Indian/Alaska Native program branch, which tailors services and program structure to the needs of these cultural groups. Similarly, 7 of the 16 programs serving only Hispanic children and pregnant women are located in Puerto Rico.

Figure III.3. Primary (Non-English) Language of Early Head Start Families: Population Level



Source: Survey of Early Head Start Programs.

Note: Primary language is among only those families speaking a language other than English.

Sample Size = 12,930.

Few programs serve multiple races without one being dominant. About a quarter of Early Head Start programs are dominated by one race/ethnicity (90 percent or more of their service populations) but also serve others: close to half of programs serve a population that is 75 percent or more of one race or ethnicity. The dominant race/ethnicity in these programs is most frequently white or African American, followed by Hispanic or Latino.[4] Two-thirds of the Early Head Start programs operated by the American Indian/Alaska Native branch served 90 percent or more children of this racial category, and many of the other children served are identified as biracial or multiracial.

Among programs serving Hispanic or Latino families, 21 percent report that the number of such families enrolled has increased during the past five years. Changing demographics are important to program management, because as service populations shift,

[4] The survey collected data at the program level, so we had to ask race/ethnicity questions differently from the way we would at an individual level. Programs reported Hispanic enrollees in conjunction with their race (that is, Black/Hispanic or White/Hispanic). When we discuss race and ethnicity, Hispanic ethnicity supersedes race, so white means "White/Non-Hispanic" and black or African American means "Black/Non-Hispanic." Typically, surveys ask the person to identify Hispanic or not and then to select a racial group.

Table III.5. Demographics of Early Head Start Families: Program Level

Characteristics	Percentage of Programs
Programs Serving Multiple Races/Ethnicities	
4 or more races or ethnicities	62.9
6 or more races or ethnicities	18.9
Programs Serving Primarily One Race/Ethnicity	
90 percent or more families of same race/ethnicity	27.2
75 percent or more families of same race/ethnicity	47.9
Families Enrolled in Program[a]	
White/Caucasian (non-Hispanic)	81.7
Black/African American (non-Hispanic)	76.0
Hispanic/Latino, any race	75.1
Biracial/multiracial	70.1
Asian/Hawaiian/Pacific Islander	29.7
American Indian/Alaska Native	26.6
Other race/ethnicity	19.3
Programs Serving Multiple Languages	
2 or more languages	33.6
4 or more languages	8.2
6 or more languages	2.0
Sample Size (Programs)	**646–648**

Source: Survey of Early Head Start Programs.

[a]Race/ethnicity is provided by programs according to the group the family chooses. All race and ethnicity categories are mutually exclusive. Hispanic or Latino families of any race are included in one category, and other race categories exclude families that are Hispanic or Latino.

programs must adapt to ensure that they continue to provide culturally sensitive services (not shown). Among programs serving other than Hispanic racial and ethnic groups, most report that the racial/ethnic composition of their population is unchanged in the past five years.

Language. Most programs serve Spanish-speaking families, although a substantial minority also serve families that speak other languages. Programs serving families that do not speak English must find ways to communicate, usually by hiring bilingual staff, using translators, and translating program materials. Although the Head Start Program Performance Standards do not include specific easily measurable requirements to display cultural competence, they do emphasize that services should be designed to accept and support families' home language and cultural practices, and, where possible, staff should speak the home child's language. It is difficult for some programs to find qualified bilingual staff to meet the needs of these families, especially non-Spanish speakers, and they may not be able to do so if only one or two families speak a particular language. In general,

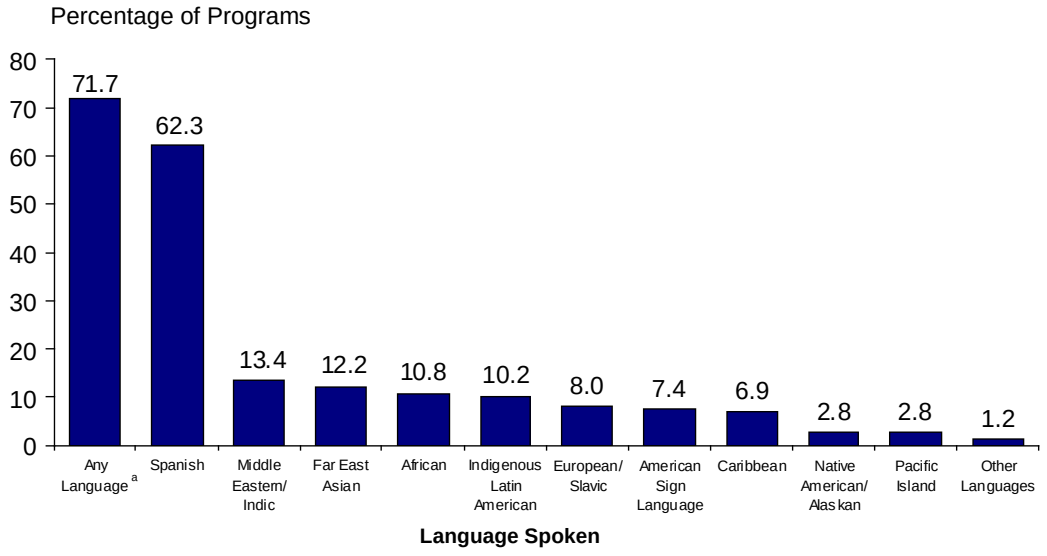
communication is more complicated for programs serving families that speak several different languages rather than just one non-English language.

Almost two-thirds of programs serve at least some Spanish-speaking families, and 40 percent serve families that speak other languages. Other languages spoken by families in at least 10 percent of programs include Middle Eastern languages, such as Arabic or Hindi; East Asian languages, such as Vietnamese or Japanese; African languages, such as Swahili or Wolof; and native Central and South American languages, such as Quechua or Aymara (Figure III.4). Programs often work with more than one language among non-English speakers: 34 percent of programs have two or more languages spoken by different families, and 8 percent have four or more.

Comparison of Program-Level and Population-Level Demographics

Language and cultural issues are important for Early Head Start at the national level, not just in particular areas of the country. Most programs serve heterogeneous racial/ethnic groups in addition to those speaking diverse languages. White, African American, and Hispanic children each make up about a third of the entire Early Head Start population but

Figure III.4. Percentage of Programs Serving Families That Primarily Speak a Language Other than English



Source: Survey of Early Head Start Programs.

[a]Programs may serve more than one language, so the sum of each language is not equal to percentage of programs serving different language groups.

Sample Size = 648.

are distributed fairly evenly across more than three-quarters of programs. Although biracial children make up just 6 percent of the total population, they are served by almost three-quarters of programs (Table III.5). Similar patterns are true of American Indian or Alaska Native children and Asian, Hawaiian, or Pacific Islander children as well, but these groups make up small percentages of the total population, and both are served by about a quarter of programs.

A sizable minority (23 percent—not shown) of Early Head Start families primarily speak a language other than English, but most Early Head Start programs (72 percent) serve at least one family that speaks another language. Some programs serve more non-English-speaking families than others, but most must contend with language and associated cultural communication issues with at least some families. Early Head Start's administrative data source, the PIR, supports this finding. According to the PIR, 63 percent of programs serve at least some non-English-speaking families.

Family Risk Factors

Besides providing education services for enrolled children, programs must assess each family's needs and provide or connect families with services to meet them. Because programs prioritize the families with greatest need for enrollment, families served by Early Head Start often have many critical issues for which programs must provide or arrange services. Box III.7 shows examples of needs gleaned from site visits.

All Early Head Start families are "at risk," because Early Head Start serves families with incomes at or near the poverty threshold. Programs often identify additional risk factors, either demographic or psychological. Demographic risk factors typically include single parenthood, teen parenthood, receipt of public assistance, unemployment, or low educational attainment. Psychological risk factors include mental health and substance abuse problems. Other risk factors include living in an unsafe neighborhood and experiencing family violence. As part of the Early Head Start Research and Evaluation Project (EHSREP) impact study, researchers found a high rate of both demographic and psychological risks. Furthermore, the patterns of service use and impacts for children and families varied by level of risk. In terms of demographic risk, the five demographic factors listed above were used to form a cumulative risk index by looking at families with low, medium, and high total number of risks. Families at medium and low risk had the greatest positive program impacts, and although families at high risk did not benefit from Early Head Start at age 3 (ACYF 2002), they did experience positive impacts when children were about age 5 (ACF 2006).

In terms of psychological risks, the EHSREP looked only at maternal depression as a moderating factor. At age 3, at the completion of the program, there was a pattern of positive impacts, particularly on parenting, for families where primary caregivers were depressed at enrollment into the program. The impact study also found that the program had new positive impacts on maternal depression when children were in their prekindergarten year (ACF 2006). Importantly, the program was able to engage families with

BOX III.7

ADDRESSING FAMILIES' SOCIAL SERVICES NEEDS IN EARLY HEAD START PROGRAMS

Early Head Start programs individualize services for the families they serve, so identifying and addressing families' social services needs is an important part of working with families. Understanding family needs also helps programs identify high-risk families and connect them to resources and supports. Programs reported identifying family needs through intake applications, family partnership agreements, ongoing information from home visits or conversations with program staff, staff observations, and general parent needs surveys. Below, we use data from our site visits to identify common family social services needs reported by programs and to describe the challenges programs faced and the strategies they use to address family needs.

According to staff in the Early Head Start programs selected for site visits, the most important family needs include housing, employment, and transportation. Other key needs include health and dental care, child care, mental health services, adult education and training, and parenting skills training. Program staff tended to identify housing, employment, and transportation as the most pressing concerns for families, although other needs such as health and dental care were identified by nearly all programs. Family problems related to housing are also common, including housing quality and affordability, overcrowding, transience, and periodic or long-term homelessness. Employment issues included unemployment, underemployment, and insufficient wages. Transportation is a particular problem in rural counties but was also a concern for a few urban programs; this is an especially important need to address, because it creates barriers to employment and limits participation in most services, including Early Head Start. Many programs reported that mental health services are a need for their families, as well as basic education, literacy, and job training. Several programs, particularly those implementing the home-based option, reported that quality child care is a need. Programs reported that families need support with parenting skills and family violence. Other needs that a few programs mentioned include substance abuse services, supports for young or teen parents, nutrition and food assistance, and financial difficulties such as debt and poverty.

Overcoming families' mistrust was the challenge programs most often mentioned related to meeting family needs. In some cases, the difficulty establishing trust stems from parent suspicions or resistant attitudes; in others, it appears to be related to cultural taboos about acknowledging family problems such as mental health issues or developmental delays. Several programs reported significant difficulties in obtaining services for undocumented families, including eligibility criteria for the services and trust issues for the families. Other challenges included limited availability of services in the community, time constraints for employed parents, and language barriers. About half the managers in programs we visited mentioned stressful working conditions as a barrier to meeting families' needs. Despite programs' efforts to support staff, staff are continually challenged by personal boundary issues, the stress of crisis management, and the lack of immediately evident improvements in family circumstances.

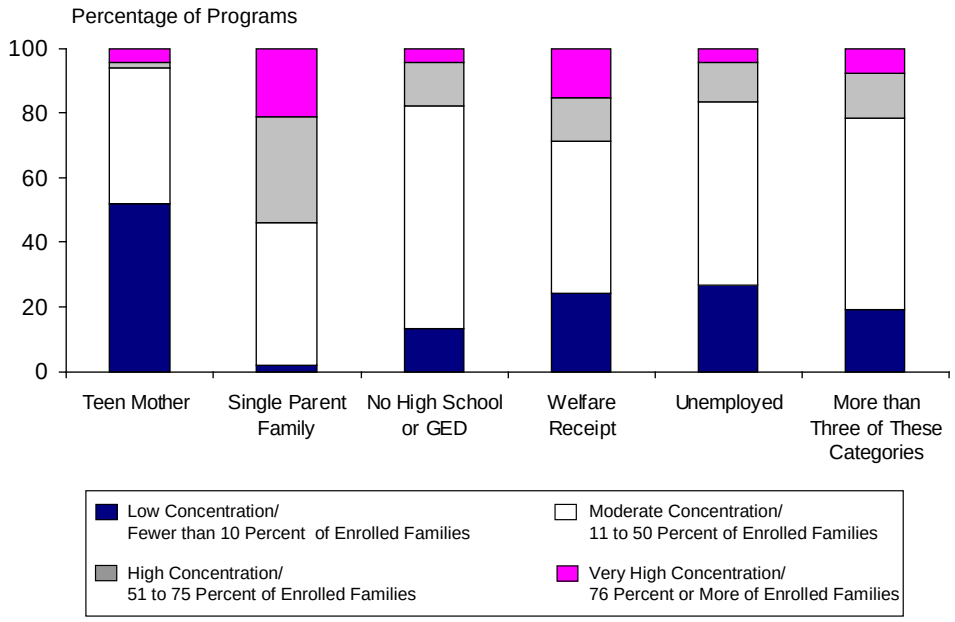
Programs use a variety of strategies to address the challenges they face in meeting family needs, tailored to specific local needs and challenges. In general, program strategies for addressing these challenges included supporting staff in the work they do, informing families about available service options and their benefits, working to link families to needed services, providing services directly at the program, and using program funds to pay for needed services when necessary. Programs often used combinations of these strategies. For example, one program reported problems in connecting families to services because services are limited in the community and service locations are spread out. To address these challenges, the program provides certain services itself and uses program funds to help pay for others. The program also developed a buddy system for families to make appointments together to share transportation. Another program reported that cultural differences make it difficult for some families to recognize needs such as preventive health care and mental health, because those services were not available in many families' home countries. The program offers information to families about the American service delivery system and the cultural expectations related to childrearing. The program respects family cultures but informs families about and encourages them to take advantage of services, for the benefit of both the child and the family.

both demographic and psychological risk factors, although they did leave the program at a higher rate then lower-risk families. As we know, the prevalence of any of these risk factors in the families served by each program influences the services provided, the types of staff hired, and the kinds of partnerships formed and is therefore important to understanding how programs individualize services.

For ease of discussion, we created four mutually exclusive categories that describe the concentration of families with each type (demographic or psychological) of risk factors in a program: low, moderate, high, and very high. A low concentration means that a program serves 10 percent or fewer families with that risk factor, a moderate concentration is between 11 and 50 percent, a high concentration is between 51 and 75 percent, and a very high concentration is 76 percent or higher. The survey data in this section are reported at the program level (figures III.5 and III.6). Box III.8 describes program staff members' views of high-risk families from our site visits.

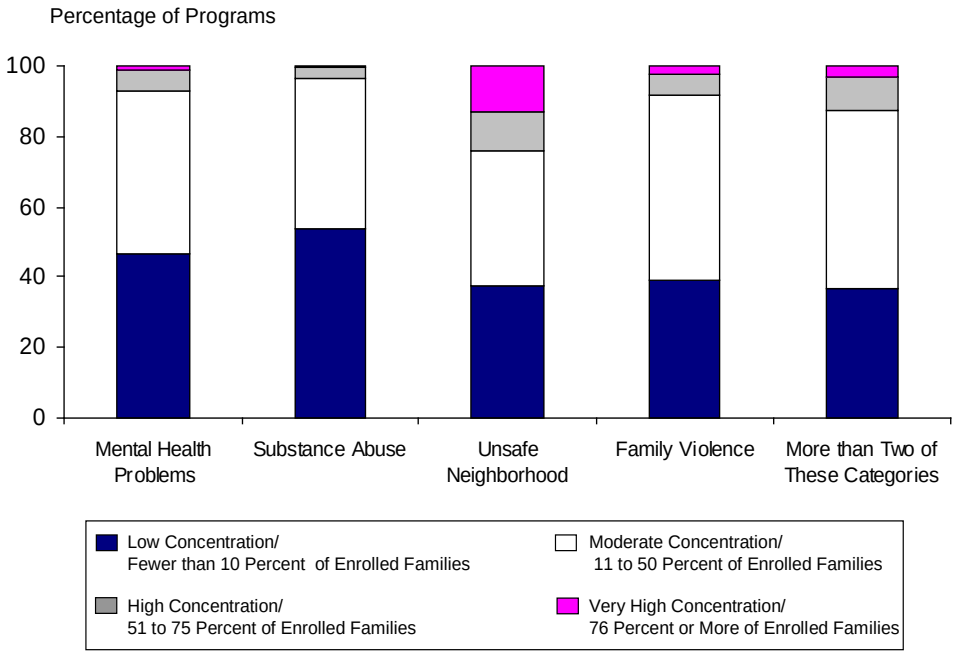
Demographic Risk. Among demographic risk factors described earlier, including single parenthood, teen parent, welfare receipt, unemployment, and low educational attainment, single parenthood is the most prevalent. More than half of Early Head Start

Figure III.5. Prevalence of Demographic Factors Across Early Head Start Programs: Concentration of Families with Each Risk Factor



Source: Survey of Early Head Start Programs.
Sample Size = 634-648.

Figure III.6. Prevalence of Psychological Risk Factors Across Early Head Start Programs: Concentration of Families with Each Risk Factor



Source:Survey of Early Head Start Programs.

Sample Size = 634-638.

BOX III.8

HIGH-RISK FAMILIES IN EARLY HEAD START

Site visit data portray a more complex picture of high-risk families than the survey suggests, with about half the programs we visited indicating that they serve only or primarily high-risk families. Our site visit interviews with program staff suggested that programs generally define high-risk families as those in acute crisis. One program director explained that families move in and out of crisis on a regular basis and experience different risk factors at different times. For example, a family can suddenly become homeless, initiating a crisis period involving several other risk factors such as substance use or depression. Later, the family's risk might be reduced as Early Head Start provides services to resolve these issues. Another director characterized most of the families served as "on the brink" of serious crisis. The challenges and strategies related to working with high-risk families were similar to those described in this chapter for addressing family needs, but staff reported providing them in a more intensive manner for families in crisis.

programs report high or very high proportions of single-parent families in their enrollment; less than 2 percent of programs report low proportions of families with this risk factor (Figure III.5; Table III.6). Low educational attainment occurs at more moderate levels: more than two-thirds of programs serve a moderate proportion of families in which the primary caregiver does not have a high school diploma or a GED. About one-quarter of programs serve moderate to high proportions of families receiving welfare payments. Unemployment is somewhat lower, with more than 80 percent of programs serving low or moderate proportions of unemployed families. Teen mothers make up a low proportion of enrollment in most programs. As some programs specialize in serving this population, concentration within a few programs makes sense. Most programs serve families that have three or more demographic risk factors, and about 20 percent of programs serve a high concentration of such families. Although not all programs serve families with multiple risk factors, all programs serve families that have some risk factors. The co-occurrence of demographic risk factors is to be expected, because individual risk factors can increase the chance of experiencing one of the others (for example, teen parents are more likely to be single, lack a high school credential, and or be unemployed [Maynard 1997]).

Table III.6. Prevalence of Demographic and Psychological Risk Factors Across Programs

	Percentage of Programs				
	Less than 11 Percent of Enrollment	11 to 25 Percent of Enrollment	26 to 50 Percent of Enrollment	51 to 75 Percent of Enrollment	More than 75 Percent of Enrollment
Demographic Risk Factors					
Teen mother	51.5	31.3	11.4	1.8	4.0
Single parent	1.7	9.4	34.9	32.7	21.4
No high school diploma/GED	13.5	33.1	35.8	13.6	4.1
Receive welfare	24.5	23.4	24.1	13.4	14.6
Unemployed/not in school	27.5	26.6	29.7	12.4	3.8
More than 3 demographic risks	19.2	27.9	31.2	14.1	7.6
Psychological Risk Factor					
Mental health problems	46.7	28.5	17.9	5.8	1.1
Substance abuse problems	54.3	30.6	11.8	2.8	0.4
Reside in unsafe neighborhood	37.3	20.6	18.1	10.8	13.3
Experience family violence	39.1	34.5	5.7	5.7	1.7
More than 2 psychological risks	36.6	31.0	19.8	9.6	3.4
Sample Size (Programs)		**634–648**			

Source: Survey of Early Head Start Programs.

Psychological Risk. Psychological risk factors such as those we describe here present difficulties for staff working with families, even if they occur at low frequency. Living in an unsafe neighborhood is the most prevalent psychological risk factor; about one-quarter of programs have high or very high proportions of families living in these conditions (Figure III.6; Table III.6). Programs tend to serve moderate proportions of families experiencing family violence. About half of programs serve relatively low proportions of families with substance abuse or mental health issues; for each of these risk factors, around 5 percent of programs serve high or very high proportions. Relatively low concentrations of mental health concerns are somewhat surprising, given what we learned in the site visits (Box III.8)

and in the EHSREP, where 50 percent of families had depression at baseline, and about one-third had depression when children were 14 and 24 months of age. Mental health issues may prevent them from taking the initiative to apply for the program in the first place or can make ongoing participation difficult, or staff may not recognize mental health problems among parents. When considering the co-occurrence of risk factors, about 15 percent of programs serve high or very high concentrations of families with two or more psychological risk factors.

Children with Disabilities

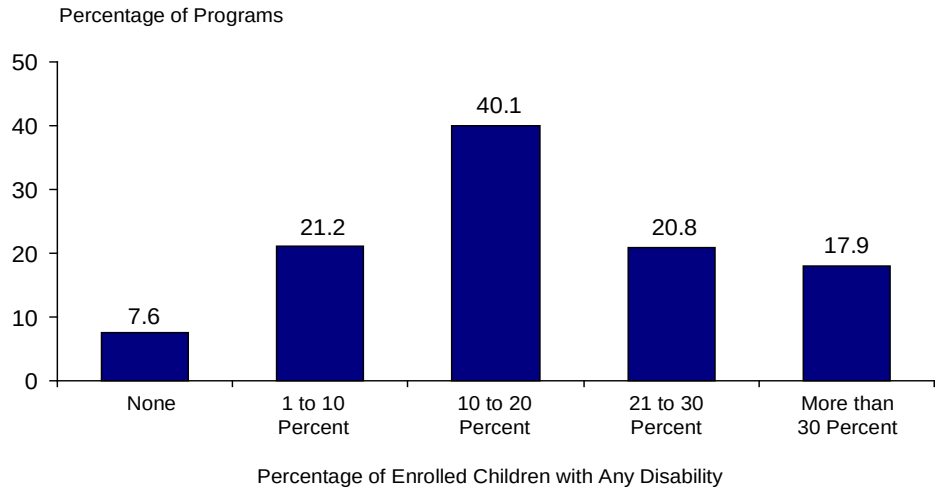
Federal performance standards require that programs make 10 percent of their enrollment slots available to children with special needs. Therefore, the Early Head Start program is an important source of services for young children with disabilities or developmental delays. Indeed, in some communities, Early Head Start is the only infant and toddler program that will accept children with disabilities.[5] Programs are not required to meet the 10 percent enrollment at all times, but they must make demonstrated and ongoing efforts to enroll children with special needs. Because disabilities can be difficult to identify in children under 3, especially infants, the screening and identification process often occurs over a period of time and precedes a formal evaluation by an early intervention provider (Chapter VI details this process).

Program Level. Three-quarters of Early Head Start programs report that at least 10 percent of their total enrollment has developmental concerns, and many programs serve much higher concentrations of children with special needs. Nearly one-fifth of programs have very high concentrations (30 percent or more) of children with developmental concerns, and 5 percent of programs report that at least half their caseloads have been referred for evaluation of a developmental concern. Five percent of programs reported that they did not serve any children with special needs at the time of the survey. A small proportion (2 percent) reported that all the children served have special needs. More typically, programs serve a caseload consisting of 10 to 30 percent of children with identified or suspected special needs. The percentages counted here include children who have been referred for evaluation of a developmental concern but may not yet have been evaluated (Figure III.7).

Prevalence of Developmental Concerns Within the Early Head Start Population. Identifying a disability may entail several stages, the first of which involves talking with the family to verify the observed issues and choose a course of action. It is relatively rare for staff to report having concerns about a child but not yet having referred that child for further evaluation (4 percent, not shown). After conferring with the family, the next step is

[5] Although services for infants and toddlers with special needs are available under Part C of the Individuals with Disabilities Education Act (IDEA), Early Head Start may be the only program of its kind in a given community to accept children with special needs.

Figure III.7. Percentage of Early Head Start Children with Any Suspected or Diagnosed Disability, Within Programs



Source: Survey of Early Head Start Programs.

Note: Sample sizes for disability questions are somewhat smaller as a result of the complexity of the question and fewer completed cases with internally consistent answers. Appendix B describes our approaches to maximize the completeness and accuracy of these data.

Sample Size = 514.

referring the child for evaluation of the concern identified by program staff.[6] Across the universe of Early Head Start children, a fifth have been referred for further evaluation, most commonly as a result of concerns about communication disorders and developmental delays. Before we describe the process of identification in Chapter VI, we here describe the prevalence of disabilities in the population of Early Head Start children. Of the Early Head Start children that have been referred for evaluation of a suspected disability, many are receiving services (76 percent; Table III.7).

Among children who have been referred for evaluation, after accounting for communication (speech or language) disorders in 9 percent of children and developmental delays (such as autism or Down syndrome) in 6 percent, less common concerns include emotional or behavioral issues, physical or orthopedic impairments, sensory impairments (such as blindness or deafness), and others (all less than 2 percent). Box III.9 gives a fuller picture of developmental concerns among Early Head Start children from site visits.

[6] For more information on the identification process, see Chapter VI, Box VI.2.

BOX III.9

CHILDREN WITH DISABILITIES IN EARLY HEAD START PROGRAMS

Serving children with disabilities is part of Early Head Start's mission. Federal performance standards require that Early Head Start programs make 10 percent of their enrollment slots available to children with disabilities, and programs are required to make special efforts to meet this percentage by recruiting children with disabilities and identifying special needs among children already enrolled. The following data from our site visits describe how programs comply.

Some programs have difficulty ensuring that 10 percent of enrolled children are those with special needs, while others have so many children with special needs that they must work hard to keep a mix of special-needs and typically developing children in classrooms. Children with disabilities in the programs we visited range from 3 to about 50 percent of enrollment, with most programs' caseloads at 10 to 20 percent. These percentages change on an ongoing basis as children with special needs are identified.

Some programs have difficulty with having too many or too few children with disabilities. One center-based program whose enrollment of children with disabilities is 50 percent reported it had to stop accepting children with disabilities, because it would no longer be an inclusion program. Early Head Start programs provide inclusive or integrated services to children with and without disabilities rather than have segregated services for children with special needs alone. For some programs, this requires particular effort not to have high percentages of children with disabilities in any one classroom. For example, one program is operated by a disabilities services agency, and about a quarter of the children it serves have special needs. The program reported that it targets children with special needs and does not have difficulty identifying and enrolling them, but staff have to work hard to ensure that Early Head Start classrooms have a mix of typically developing and special-needs children rather than too many children with special needs. Other programs have very small percentages of children with disabilities. Programs identify children with special needs through their own screenings and child assessments conducted regularly in Early Head Start, but they also enroll children with disabilities that have already been identified.

Some programs make special efforts to target families with special-needs children for enrollment, but several programs we visited reported that they do not need to do much active recruiting for these families. Most programs accept referrals from Part C early intervention providers, and some received so many referrals that they could not accept them all.[1] Some grantee agencies also have early intervention or other disability services providers co-located with the Early Head Start program and so do not need to recruit actively. One program is the only early childhood program in the community that serves infants and toddlers with disabilities, so it is able to enroll plenty of children with special needs without actively recruiting. Ongoing screenings and assessments in Early Head Start also uncover special needs among children already enrolled in the program without the need to recruit them specifically. Still, some programs we visited have very low enrollment of children with special needs. Some disabilities are difficult to identify in infants and toddlers because their early stage of development makes it hard to observe delays, and the age of onset of certain developmental milestones ranges widely. One program with a very low enrollment of children with special needs reported that it does not have the facilities or staff expertise to serve children with severe disabilities.

---

[1] These are disability services providers for infants and toddlers with special needs, authorized under Part C of the Individuals with Disabilities Education Act.

Table III.7. Prevalence of Developmental Concerns Among All Early Head Start Children

Characteristic	Percentage of Enrolled Children
Children Who Have Been Referred for Evaluation	20.3
Sample Size (Children)	**41,333**
Among Referred Children	
Eligible for/receiving Part C services or has IFSP	75.6
Specific Concerns Among Children Eligible for Part C Services[a]	
Communication disorder	42.2
Developmental delay	32.4
Emotional or behavioral issues	7.8
Physical or orthopedic impairment	9.1
Sensory impairment	3.0
Health or mental condition	0.8
Other developmental concern	4.6
Sample Size (Children)	**6,335**

Source: Survey of Early Head Start Programs.

[a]These children have been referred for Part C evaluation, have been found eligible, and may be receiving Part C services.

KEY POINTS

- Early Head start programs are equally likely to be located in urban or rural areas. Many are in areas of increasing cultural diversity.

- Most Early Head Start programs are run by nonprofit community agencies.

- Most Early Head Start programs obtain outside funding in addition to the Early Head Start grant funds to supplement program services. Programs that do not report receiving outside funds may receive in-kind contributions, but we did not ask about those in the survey.

- About one-third of Early Head Start programs are small, serving 50 or fewer children and pregnant women; nearly three-quarters of programs serve 100 or fewer. A small number of programs are very large, with enrollment in the hundreds.

- Most Early Head Start children enter the program between birth and age 2 and do not leave until they have reached age 3. About 13 percent of children enter the program during the prenatal period.

- All programs surveyed maintain a waiting list for enrollment of eligible families and prioritize families by their level of need. Most programs are either at enrollment capacity or overenrolled.

- Whites, African Americans, and Hispanics make up the majority of the Early Head Start population, but many other racial/ethnic groups are represented in programs. More than 60 percent of programs serve 4 or more different racial/ethnic groups.

- About one-quarter of families served speak a language other than English; however, they are distributed across nearly three-quarters of programs. Thirty-four percent of programs serve families speaking two or more languages; 8 percent have 4 or more languages represented.

- Fairly high levels of family risk factors are prevalent across Early Head Start programs, in part because programs prioritize the families with greatest need for enrollment. Some programs serve many families with multiple risk factors, and these risk factors present programs with many service and management challenges. About 15 percent of programs report serving families with multiple psychological or demographic risks.

- Three-quarters of Early Head Start programs reported that at least 10 percent of the children they serve have developmental concerns; nearly one-fifth of programs serve concentrations of more than 30 percent children with special needs.

- Communication disorders and developmental delays are the most common types of developmental concerns among Early Head Start children.

- Across the total Early Head Start population, about 20 percent of children have been referred for evaluation, and in about 5 percent of programs, nearly half the children have been referred for evaluation. Among children referred for evaluation, most are receiving services (76 percent).

- Eighty-four percent of programs serve pregnant women, although not all responding programs had any pregnant women enrolled at the time of the survey.

CHAPTER IV

EARLY HEAD START PROGRAM SERVICES

Now that we have described the basic characteristics of programs, and the families and children that they serve, we turn to the services programs actually provide. As we noted in the introductory chapter, Early Head Start programs choose which options (as defined in the Head Start Program Performance Standards) they will use to provide services to families. Programs develop and implement a model of service delivery based on factors that include community needs assessments and the needs of families they serve.

This chapter describes the services programs provide and the strategies they employ to implement them. First, we use survey data to present program models for providing services and explain how these models have changed over time. The second half of the chapter expands on survey findings by using qualitative site visit data to describe the strategies programs use to engage families in Early Head Start services, including their approaches for retaining families, involving parents in the program, and planning for transitions when the program ends.

EARLY HEAD START SERVICE DELIVERY MODELS

The performance standards identify four program service models or "options" from which program can choose to serve individual families: (1) center-based, which can be full- or part-day for four or five days a week, in which child development services are provided in a child care center; (2) home-based, in which families receive weekly home visits and bimonthly group socialization experiences; (3) a combination program incorporating both center-based and home-based services; and (4) a locally designed option (requiring ACF approval).[1] In the EHSREP, the 17 sites were categorized into three program approaches based on services delivered to families: (1) a home-based approach, in which all families received the home-based option; (2) a center-based approach, in which all families received the center-based option; and (3) a mixed approach. Mixed approach programs were those

[1] We use *program approach* as a research term to describe our classifications and analysis of the combinations of options that programs use to deliver services.

that offered families the combination option, or a home-based option to some families and a center-based one to others. In that study, programs changed in their approaches over the study period, with some providing more than one type of service to families, and some adding services above the minimum requirements for a given model. As described in Chapter I, the EHSREP impact study found differential patterns of impacts among program approaches.

Therefore, one of the primary goals of the current survey is to capture and describe the variation in service delivery models across Early Head Start programs that exist today. In the survey, we asked detailed questions about service delivery models to understand, in more depth than is possible through the PIR, the combinations of service delivery models that programs implement. (See Appendix A for the actual survey questions on service delivery models.) Because we group programs into mutually exclusive categories, we can use program approach subgroups to compare and contrast other aspects of programs (see Chapter VII).

Home-based and center-based models that offer those services exclusively are used by 23 and 17 percent of programs, respectively. Home visits are performed by Early Head Start staff and are usually focused on parent-child interactions, modeling appropriate parenting behavior, and generally facilitating activities with parents and children in their home. We distinguish combination programs from multiple approach programs based primarily on the frequency of home visits to *all* families. Combination programs provide center-based care (focused on developmentally appropriate experiences for the child) as well as frequent home-based services that are focused on parent-child interactions to all enrolled families; fewer than 10 percent of programs offer this approach. More than half of programs (51 percent) provide services with a multiple service delivery model (Table IV.1; Figure IV.1). These programs are providing either home-based or center-based services to enrolled families. Use of a multiple model gives programs flexibility to adapt their service delivery approach to meet the individual needs of families and adjust their approach as those needs change.

Our findings about programs' service delivery models are similar to those from the PIR, in which, for the 2004–2005 reporting year, 49 percent of programs offered both home- and center-based options, 24 percent offered only center-based services, 16 percent offered only home-based services, and 8 percent were combination programs. The combination approach offers what seems to be the most intensive intervention and likely requires the highest levels of family participation. We cannot tell from survey data why few programs choose this approach. Perhaps it is difficult to adopt because of the intensity of services or the need for parents to participate in both home- and center-based activities.

Program Changes Since Inception

Sixty-five percent of programs indicated they had made some change to organization or design since the program began (not shown). Among programs that made a change, the

Table IV.1. Program Models for Delivering Early Head Start Services

Program Model	Research Definition: Services Provided by Programs at the Time of the Survey	Number of Programs	Percentage of Programs	Office of Head Start Definition: Program Option Received by Children and Families
Home-based[a]	Home visits offered *at least monthly to all families* (99 percent offered weekly home visits)	114	17.3	Early Head Start services provided to families through the home-based option, including weekly home visits and bimonthly group socializations. Other comprehensive services are also provided.
Center-based[b]	Center-based services and home visits *less than monthly to all families* (98 percent offered visits at least twice a year)	152	23.0	Early Head Start services provided to families with the center-based option, including center care and regular parenting education and family support through two home visits a year. Other comprehensive services offered through the program or referrals.
Combination	Center care plus home visits monthly or more to *all* families	56	8.5	Early Head Start services provided to children through a combination of center-based services based on ratios defined in the Performance Standards.
Multiple options[c]	Programs *primarily* provide home-based services to some families and center-based services to others. A few families may receive both home- and center-based options. Nearly all programs (99 percent) offered weekly home visits to home-based families. Forty-two percent provided combination services to some families.	334	50.6	Children are enrolled in one of the above official Head Start program options, receive services from one of the other program options, and/or move from one program option to another.
Other	Family child care services provided to all families (all offered home visits at least twice a year)	4	0.6	Locally defined program option
Sample Size (Programs)		**660**	**100**	

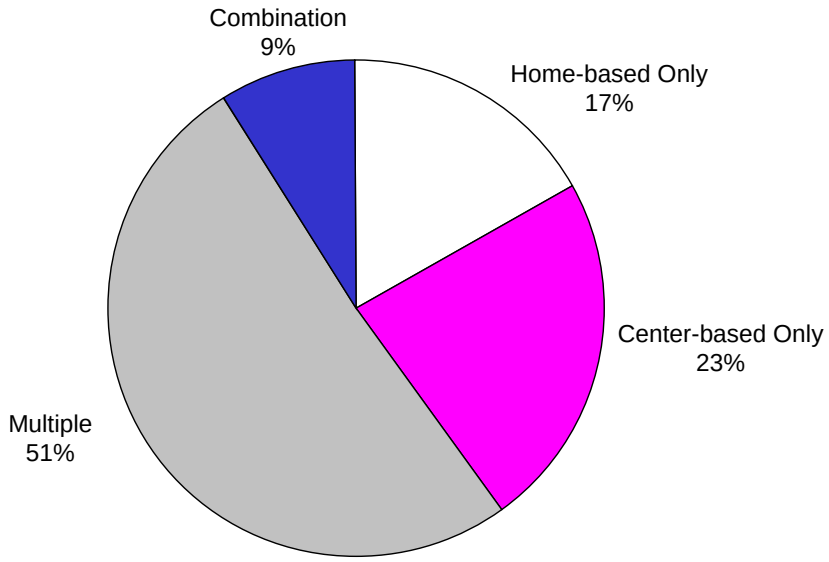
Note: Percentages refer to the *proportion of programs within each service option* that offered home visits at a given frequency.

[a]The Head Start Program Performance Standards require weekly home visit for this program option.

[b]The Head Start Program Performance Standards require twice yearly home visits for this program option. Among programs offering center-based services defined in survey items A4A_C, A4A_E, and A4A_G, 98 percent offered home visits at least twice per year. Among all programs that offered center-based services, including those in A4A_D, A4A_F, and A4A_H, 66 percent offered home visits at least twice per year.

[c]The survey asked about services delivered at one point in time, therefore, we cannot capture the proportions of families that move in and out of different program options. Percentages offering home visits in multiple options programs do not sum to 100 because programs by definition offer more than one option.

Figure IV.1. Early Head Start Program Models



Source: Survey of Early Head Start Programs.

Sample Size: 660 programs.

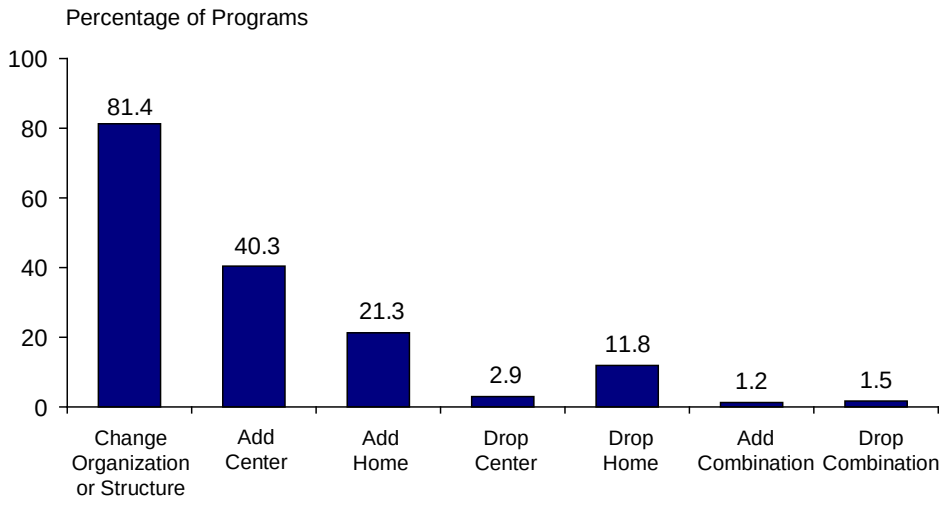
most frequent was to the organizational structure (81 percent; Figure IV.2).[2] Other changes were to design, with 40 percent of programs adding center-based services to their offerings, 21 percent adding home-based services, and 11 percent dropping home-based services. Other changes, including adding or dropping combination models, were infrequent. These findings, coupled with the EHSREP implementation study, suggest that for some time now, programs have been moving to various types of mixed approaches and/or are working to provide center-based services (ACF 2002). The shift could possibly be influenced by welfare reforms that require parents to work or attend school full-time (and thus need child care), or in response to findings from the EHSREP evaluation that the broadest pattern of impacts at age 3 was in mixed approach programs (ACYF 2002), or may reflect the ways that programs strive to individualize services for families.

STRATEGIES FOR ENGAGING FAMILIES IN EARLY HEAD START SERVICES

All programs, regardless of their service delivery models, must find effective strategies to involve families in their services. In the second half of this chapter, we describe the strategies that programs use to engage families and sustain their engagement in the services that they offer.

[2] We are unable to be much more specific about the nature of organizational change, because most respondents selected only this pre-coded response. Those who elaborated on their answers report myriad changes, most frequently adding or dropping family child care or Early Head Start slots.

Figure IV.2. Changes to Early Head Start Programs Since Inception, Among Programs with a Change



Source: Survey of Early Head Start Programs.

Sample Size = 414 programs.

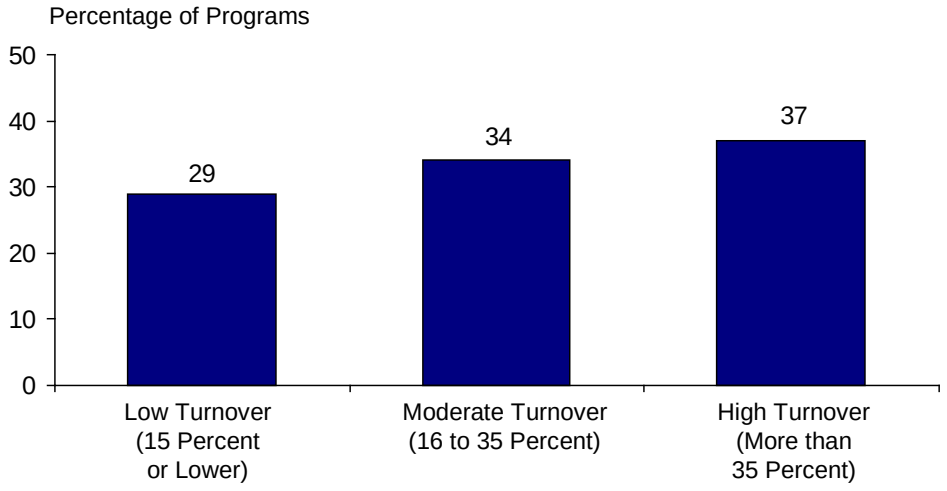
The sections below are organized according to a chronology of families' stages of involvement in program services, starting with enrollment and ending with exit and transition into preschool programs. Because of their qualitative nature, survey data alone provide limited insights into these qualitative topics; therefore, we briefly describe four important issues programs face when engaging families in services and then refer to text boxes using site visit data that contain in-depth examinations of each particular topic. We begin by describing programs' efforts to retain families after they enroll in the program, strategies that promote parent involvement, the frequency of home visits provided to families, and how programs help families and children transition into preschool services after the children age out of Early Head Start.

Retaining Families

To positively affect children's outcomes, Early Head Start must keep families involved and participating. Limiting enrollment turnover among families in the program allows children and families to experience Early Head Start fully and receive its maximum benefits. Families can voluntarily choose to drop out, or programs can decide to drop them from the rolls (usually because of nonparticipation). When programs decide how to handle nonparticipation, they must balance their mission to serve families, funding regulations (subsidy payments usually require children's attendance), and long waiting lists of unserved families.

Enrollment turnover is low to moderate in most Early Head Start programs. We consider turnover (as a proportion of total enrollment) at or below 15 percent to be low, 16 to 35 percent to be moderate, and above 35 percent to be high. On average, across programs, about 34 percent of enrolled families voluntarily withdrew or were dropped by the program in the year before the survey. Although overall enrollment turnover is moderate, the average obscures the distribution (Figure IV.3). Twenty-nine percent of programs had low turnover of enrolled families, and 34 percent had moderate turnover. The remaining 37 percent of programs had high levels. None of these figures include turnover due to normal transition out of Early Head Start when children turn 3 (described in Chapter III). Box IV.1 provides a discussion of this topic, including the types of families who tend to drop out and why they drop out, as well as the strategies programs use to retain them.

Figure IV.3. Average Enrollment Turnover, as a Percentage of Total Program Enrollment



Source: Survey of Early Head Start Programs.

Sample Size = 540 programs.

Parent Involvement

Involving parents in program activities, operations, and decision-making is central to Early Head Start. The performance measures framework reflects the importance the performance standards place on parent involvement in program activities. Although they specifically relate to retaining those families most likely to drop out, the issues here are more generally related to the ways programs work to involve parents. All programs adhere to standards for promoting parent participation, including formation of Policy Councils and

BOX IV.1

RETAINING FAMILIES IN EARLY HEAD START

As part of Early Head Start efforts to positively affect children and families, keeping families involved and fully participating is a key program goal. We use site visit data to describe the types of families who tend to drop out of the program and why they drop out, as well as strategies programs employ to retain families.

In several of the sites we visited, programs report that families who drop out tend to be those at the highest risk and most in need of services. Staff in several sites report that families at highest risk of dropping out are those with multiple risk factors. In addition to being less able to comply with program participation requirements, they are also more likely to move frequently, often suddenly. Common risk factors that tend to go along with dropping out are being a single mother, having substance abuse problems, being in a housing crisis or homeless, having multiple children, and having mental health issues. Families with multiple risk factors may also be hardest to serve effectively; the Early Head Start evaluation showed the most short-term benefits for families at moderate risk and little benefit for those at highest risk (ACYF 2002). However, newer findings at prekindergarten show that positive impacts also emerged for the highest-risk group about two years after the end of the program (ACF 2006).

Challenges to program participation include work schedules, lack of transportation, moving out of the service area, and extended visits to countries of origin. Apart from the highest-risk groups, staff cited several barriers to full participation. Families without access to reliable transportation cannot get children to the program and pick them up when required (especially if programs end early and do not align with parents' work schedules). Weather is a problem, particularly in the winter in one midwestern program. Programs we visited that enroll immigrant families sometimes drop them when they leave for months at a time to visit their home countries. Many of the programs we visited report that a subset of families would, for a variety of these reasons, cycle in and out of the program—enrolling, leaving or being dropped, returning to the waiting list, then reenrolling. When deciding how to handle nonparticipation, programs must balance their mission to serve families, funding regulations (subsidy payments often require children's attendance), and long waiting lists of unserved families. Programs we visited vary in their attendance policies, both in the specificity of the policies and in their enforcement. Although only 7 percent of programs in the survey report saving slots for families who become inactive, many of the programs we visited indicate that they make concerted efforts to contact and reengage families before dropping them from the rolls. A few programs first attempt to change the program option (for example, center-based to home-based) in an effort to retain families. In some programs, slots can be kept open for as long as three or four weeks for families that staff expect will return. In others, slots are filled quickly, in as little as 7 to 10 days. No programs report that the size of the waiting list influences them when deciding whether to drop a noncompliant family.

sending invitations to attend socialization groups. We also have detailed information from site visit interviews about other ways that programs involve parents in activities and decision-making (Box IV.2).

Nearly all programs make special efforts to involve fathers, in keeping with both the performance measures and the special focus that the Office of Head Start has placed on father involvement (ACF 2003b). The level of effort and range of activities is wide; many programs hold special activities to encourage father participation. Ninety-eight percent of programs report including fathers in family events, and 78 percent hold events especially for

BOX IV.2

INVOLVING PARENTS IN EARLY HEAD START DECISION-MAKING AND PROGRAM OPERATIONS

In this text box, we discuss programs' efforts to involve parents in program activities, operations, and decision-making. We also describe parents' impressions of and satisfaction with programs. We base our discussion on interview data from programs selected for site visits. We focus on parent involvement because the performance measures consider their involvement in program activities and planning essential for ensuring program quality. While programs and children benefit from the active involvement of parents, parents themselves also benefit, mainly through increased self-confidence as a parent and an advocate for their child.

Programs are successful at involving parents in program operations and decision-making. All 17 programs selected for site visits had Early Head Start parents involved in the required Policy Council or other parent committees. Such involvement provides opportunities to engage in many activities, including participating in hiring decisions and interviews, making budget and fundraising decisions, making decisions regarding curriculum and child assessments, and generating ideas for program activities. Many programs also involve parents in the community- and self-assessment process, with parents providing written and oral feedback on program activities and needs.

Programs also strive to involve parents in day-to-day program activities, services, and activities for their children. For example, classroom teachers and home visitors often involve parents in the assessment and screening process. Parents also provide input on planned services for their child, particularly if the child has a disability. Parents are encouraged to spend time and/or volunteer in the classroom, assisting with activities, completing administrative tasks, or helping during meals or playtime. They also participate in fundraising and special program events like parties and field trips.

Parents who formally participate in the program and in parent committees benefit from this involvement. For example, in focus groups, some parents suggested that the confidence they gained from involvement with the Policy Council or committees allowed them to focus on accomplishing goals for themselves, such as furthering their education, pursuing a GED, or finding employment. Some programs encourage parent involvement by providing training opportunities to parent committee members. For instance, one program indicates that parents receive training in job interviewing skills. Another offers opportunities for parents to attend conferences, while another pays for the cost of parents to take child care courses to become licensed child care providers. Notably, many programs indicate that several of their current Head Start and Early Head Start staff members are former program parents. Thus, as intended by the framers of Head Start (Zigler and Muenchow 1992), involvement in programs may provide parents a springboard for future employment.

Some programs face challenges in making parents aware of opportunities for involvement and making activities and meetings accessible to working parents. During site visit interviews, parents at one program revealed that they are interested in being more involved in the Policy Council and related parent committees, but they are uncertain about how to become involved. This may reflect the difficulty this program has in drawing awareness to the diversity of opportunities it provides for parent involvement. More commonly, during site visits, programs acknowledged difficulties in getting parents involved in committees because of their competing work schedules and the need to balance work with the demands of parenthood.

Box IV.2 *(continued)*

Programs respond in many ways to challenges in involving parents. For example, during site visit interviews, some programs reported holding meetings in the evenings, paying for child care and mileage, and providing meals to participating parents. In general, programs try to accommodate parent schedules as much as possible. Other programs offer incentives like door prizes, books for children, and points that can be used to purchase items like diapers and formula from the program's pantry. Programs also ensure that materials and activities are available in English and Spanish so that parents feel encouraged to attend. One program also reports having parent committee members recruit new parents, so that parents can hear directly from other parents about the benefits of involvement.

Parents appreciate having relationships and interaction with staff. During focus groups, parents spoke about Early Head Start's emphasis on serving the entire family. This emphasis is shown by programs' efforts at ongoing communication with parents, involving them in home-visiting activities and parent-teacher conferences, and sending home written materials. In particular, having a voice in their children's development and Early Head Start experience is important to families. Many parents we spoke with report satisfaction in their relationship with teachers/home visitors and state that these are people they can trust. They appreciate the respect and concern staff members provide to them and their children. In addition, the general level of support provided by staff to parents for other issues is important to families. For example, one parent described an instance in which her child's teacher called home to check on the child, who had been sick for several days. Another appreciated the support a home visitor provided to her during an ordeal in court.

them (not shown). Programs incorporate other strategies into program practices to encourage father participation, including trying to create father-friendly environments and routinely collecting fathers' contact information (Figure IV.4). Most programs provide staff training on father involvement (86 percent), and nearly 70 percent hire male staff to serve as role models for fathers. Box IV.3 provides detail on the topic of father involvement based on site visit data.

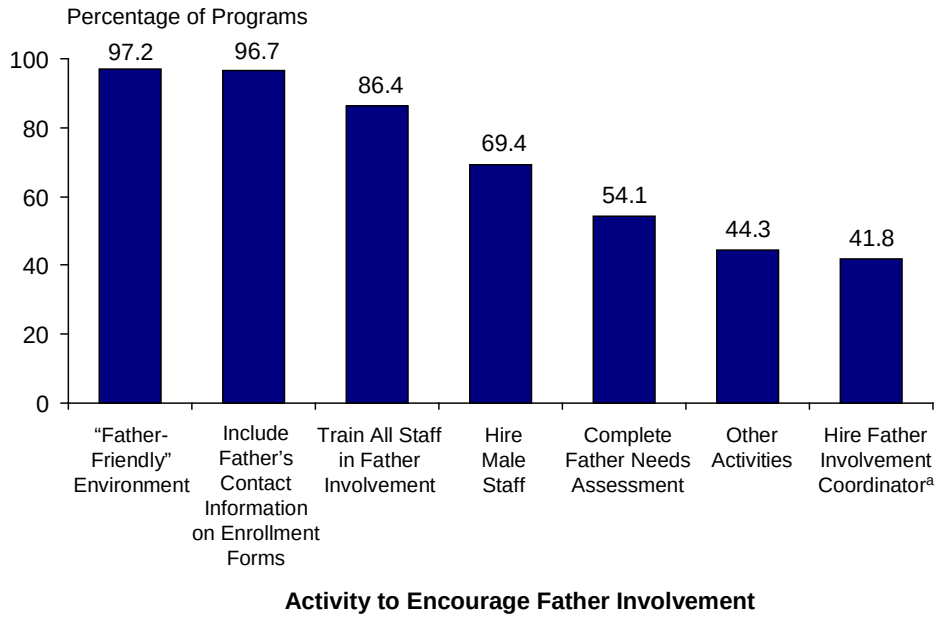
Frequency of Home Visits

We asked programs to indicate the frequency of home visits they offer under each program option they use to deliver Early Head Start services. Table IV.2 shows the percentage of programs that report offering home visits at a frequency that either meets or exceeds the requirements of the performance standards. Very rarely, programs indicated they offer home visits less frequently than required.[3] Ninety-nine percent of programs providing home-based services offer home visits weekly or more often.[4] Among programs

[3] The Head Start Program Performance Standards require weekly home visits in the home-based option and two visits a year in center-based or other options. It is possible that some programs reported the frequency with which they complete, rather than attempt, visits.

[4] Programs could indicate offering home visits that "varied with family needs," a category we consider to represent home visits at or above the required level. We stress that these are home visits that programs offer to families, not necessarily how often the visits are completed.

Figure IV.4. Percentage of Programs Conducting Each Activity to Encourage Father Involvement



Source: Survey of Early Head Start Programs.

[a]Or designate a staff member with at least half-time responsibility for involving fathers.

Sample Size = 599-608 programs.

providing center-based services though their own centers, nearly half offer home visits twice a year (48 percent), and the remaining 51 percent do so more frequently. Notably, among programs that provide services through child care partners, 64 percent offer home visits more often than twice a year. All programs that provide family child care services offer home visits at least twice a year, with 59 percent doing so more frequently.

Transitions

In addition to providing services while children and families are enrolled, programs must help children make a smooth transition from the Early Head Start program to Head Start or another preschool program. A smooth transition is optimal for children's well-being. In recognition of this, one of the performance measures identifies smooth transitions as a key element of Early Head Start services. We have limited survey data about the transition process; however, we know that most programs (65 percent) develop formal transition plans for *all* children leaving Early Head Start. We use data from site visits to describe transition plans, challenges to smooth transitions, and ways that programs address these challenges (Box IV.4).

BOX IV.3

INVOLVING FATHERS IN EARLY HEAD START

Early Head Start has actively supported father involvement, most recently through a demonstration that explored ways to engage dads (Bellotti et al. 2003). Accordingly, in addition to performance measures that call for active parent involvement in Early Head Start (both in decision-making and in participation), one performance measure addresses father involvement—specifically, that programs should encourage and support fathers' involvement in program planning, decision-making, and activities. Site visit data provide information about barriers to father involvement and strategies programs use to overcome them.

Among the 17 programs we visited, all but 2 indicate that they hold special events aimed at involving fathers in the program. The substance of the events varies widely but most often includes activities to appeal to men, such as sporting events (attending baseball games, fishing, or bowling) or picnic/party types of activities (such as "Donuts for Dads" or Fathers' Day parties). Often, picnic/party activities include the entire family.

Father participation in program activities is low to moderate. Despite the efforts that many programs make to appeal to fathers, most programs we visited report limited father participation. Some programs have fathers doing dropoff or pickup of children from centers, and others say that some fathers participate in parent meetings. A few programs we visited indicated that one or more fathers participate in the Policy Council. Some of the challenges and barriers that program staff identify as important are consistent across programs. The leading barrier is fathers' daytime work schedules. Father-mother conflict, domestic violence, and parental attitudes about the mother's role as primary caregiver are also responsible for limited father involvement in several programs. Other factors—incarceration, homelessness, and high-risk behaviors such as drug dealing and substance abuse—are problematic in a few places as well.

Programs employ a range of strategies to address barriers to participation. A few programs address conflicts with fathers' work schedules by scheduling home visits, socializations, or other events in the late afternoon so that fathers can attend. Most programs rely on a range of other strategies, including making centers more father friendly by hanging father-related posters, actively encouraging and positively reinforcing any father participation (such as during dropoff or pickup), and hiring male staff to model caregiving.

To encourage participation at special events, some programs provide door prizes or other gifts, as well as transportation or child care. A couple of programs encourage leadership from fathers by asking involved Early Head Start fathers to bring other fathers with them or by having dads organize events themselves.

Programs provide special training for staff about fathers. One program we visited offers a parent training course for fathers each year (with one meeting a week for six weeks). Other visited programs report they use curricula (such as "24/7 Dad") to inform their staff training and father activities.

Table IV.2. Early Head Start Program Service Models and Frequency of Home Visits

Program Model	Number of Programs	Percentage Offering Home Visits That Meet Standards[a]	Percentage Offering Home Visits That Exceed Standards	Percentage Offering Home Visits at or Above Standards
Home-Based Services	436	95.6	3.0	98.6
Home-Based with Additional Early Head Start Services[b]	55	32.7	21.3	54.0
Own Center with Home Visits	395	48.4	51.1	99.5
Partner Center with Home Visits	104	35.6	64.4	100.0
Family Child Care with Home Visits	56	41.1	58.9	100.0

Source: Survey of Early Head Start Programs.

Note: "Number of programs" includes any program that indicates serving one or more children through each service approach described in the survey. The models presented in this table are items drawn directly from the survey. We asked programs to report children they serve through each model, therefore programs could endorse more than one model.

[a]Head Start Program Performance Standards require home visits weekly in home-based options and home visits twice a year in other options.

[b]For this program approach, we consider programs that offer home visits weekly or more often to meet performance standards.

BOX IV.4

TRANSITIONS FROM EARLY HEAD START TO PRESCHOOL

We focus here on how programs facilitate children's transitions from the Early Head Start program to Head Start or another preschool program. A smooth transition is optimal for children's well-being; in recognition of this, one of the performance measures identifies smooth transitions as a key element of Early Head Start services. Making these transitions seamless is also a requirement of the program performance standards. We use data from site visits to describe transition plans, challenges to smooth transitions, and ways that programs address these challenges.

Of the 17 programs that we visited, 11 report that they develop transition plans for most of their children. We cannot tell from the survey why some children do not receive transition plans, although it may be a result of families' leaving before the children reach the end of their eligibility. As part of the transition process, some programs have group meetings twice a year for parents whose children will be aging out of the program in the following six months. Other programs have individual meetings with parents, usually when the child reaches age 2½. These meetings include a variety of staff members, such as family advocates, teachers, home visitors, and/or education coordinators. At the meetings, they discuss child care options and next steps for both the family and staff.

All Early Head Start programs we visited have formal transition processes for children moving into Head Start programs. Some programs have transition rooms for children between ages 2½ and 3½. These classrooms are geared toward children who are ready to move out of the toddler room but are not yet ready for preschool. The children are exposed to preschool routines, and Head Start teachers visit the transition rooms to become acquainted with the children. Programs that do not have transition rooms introduce the children to Head Start staff, and some make trips to Head Start classrooms to help children become familiar with their new environment.

Programs deal with a variety of challenges transitioning children to preschool. In developing formal transition plans, programs commonly deal with issues of income documentation and age restrictions for children entering Head Start programs. One program described a frustrating situation in which Early Head Start helped parents obtain a better job, but family income then rose above the threshold for Head Start eligibility. In such situations, staff members feel that although parents have made progress, they still need many of the services that Head Start can provide. Some programs offer priority to Early Head Start children for entering the Head Start program; however, because programs are required to serve the neediest families, they cannot always make such accommodations. If an area lacks a preschool Head Start program, the possibility of service gaps increases. Some programs will serve children through age 3 so that they can transfer to Head Start at age 4. Other challenges for transitioning include accessibility of available slots. In rural areas, finding transportation to Head Start programs can be a challenge, and even urban programs report difficulties finding available slots in the right neighborhoods.

Although the transition from Early Head Start to Head Start is not automatic, the children who make the transition most often experience it as a seamless process. The programs we visited try to help children adjust to their new classrooms and teachers, in addition to helping parents adjust to new staff and different procedures. Program staff also help parents by filling out the paperwork, checking on immunizations, and identifying other requirements.

Programs help parents and children make a smooth transition to non-Head Start preschool programs. When families do not qualify for Head Start services, program staff work to find affordable alternative options for them. Programs refer parents to local resources, such as child care resource and referral agencies, and most programs we visited provide parents with guidance on selecting a child care provider. Sometimes staff visit child care centers with parents to help them evaluate the quality of the centers.

KEY POINTS

- Programs vary greatly in their approaches to service delivery but most programs take a multiple approach, providing both home- and center-based services.

- While most programs use a multiple service delivery model, few programs offer both home- and center-based services to all their families (combination approach).

- Many programs, regardless of approach, offer home visits more frequently than the performance standards require. Ninety-nine percent of programs providing home-based services offer them weekly or more often. Among programs providing center-based services through their own centers, nearly half offer home visits twice a year (48 percent), and the remaining 51 percent do so more frequently. Notably, among programs that provide services through partners, 64 percent offer home visits more than twice a year. Among programs that offer family child care services, 59 percent offer home visits more than twice a year.

- Considering frequency of home visits within the research definitions of program approach, 99 percent of home-based only programs offer weekly home visits and 66 percent of center-based only programs offer home visits at least twice a year but less than monthly. In multiple approach programs, 99 percent provide weekly home visits to home-based families, 52 percent offer home visits at least twice a year but less than monthly to center-based families, and 42 percent offer home visits at least monthly along with center care. By definition, combination programs offer *all* families center-based care and home visits at least monthly.

- Programs incorporate many strategies to engage families in the services they offer. They work to keep families who may drop out, and they adopt creative approaches to involving parents in general and fathers in particular.

- Most families have transition plans that start when a child reaches age 2½. Among visited programs, most transitions seem to work smoothly.

CHAPTER V

STAFF CHARACTERISTICS AND PROGRAM MANAGEMENT

Understanding the types of management activities taking place within Early Head Start programs to support the delivery of quality services helps policymakers assess the extent to which programs are achieving key objectives within the performance measures framework. These activities include staff hiring and retention, activities to support staff, use of curricula, and use of data to support continuous program improvement. Because of their critical role in delivering services, this chapter starts with a description of staff qualifications, expertise, and retention in the program. Management activities designed to support staff and enhance their work with children and families, including staff development, training, and supervision are then described. Finally we describe management systems designed to support continuous program improvement, including use of curricula, collection of data, both classroom quality and child functioning, and how this information is used to enhance program practice. Selected topics from the site visits are highlighted in text boxes.

EARLY HEAD START STAFF CHARACTERISTICS

The qualifications of staff and their development are core to the success of early childhood programs and both the Head Start Program Performance Standards and the performance measures framework emphasize employing qualified staff. The current mandate requires that staff working with infants and toddlers obtain a Child Development Associate (CDA) credential or equivalent within one year of hire, and that at least 50 percent of these staff have an associate degree in early childhood education. The pending Head Start reauthorization bill will increase these requirements if passed in its current form.[1] Other important skills include the ability to maintain good relationships with children's families, establish caring relationships with infants and toddlers, provide appropriate developmental experiences, and conduct developmental screenings. Thus, successful service delivery in Early Head Start programs depends on the programs' ability to attract and keep staff with a

[1] The pending Head Start reauthorization bill mandates that by 2008, 50 percent of Head Start teachers have a BA, and that those hired without an AA must earn one within three years of hire.

range of expertise and educational backgrounds. In this section, we describe Early Head Start staff characteristics, how these characteristics differ by types of staff, and the challenges programs experience hiring and keeping qualified staff.

Specialists and Coordinators

Early Head Start programs employ and have access to a wide range of staff, including primary caregivers and/or home visitors (depending on program model), directors, and specialists, all with knowledge, skills, and experience in a wide array of fields. More than 90 percent of Early Head Start programs employ or have access to a mental health specialist, a disability specialist, and a health care professional or nurse (Table V.1). More than half report having access to a literacy specialist. Less than 20 percent of programs employ or have access to a dietitian or nutritionist. This may be because health specialists/coordinators often oversee services provided to address the nutritional needs of Early Head Start children and families. Nearly two-thirds of programs report having access to a speech or language specialist, perhaps because speech and language impairments are the most common special needs reported for children in Early Head Start. Disability specialists may also provide services for these conditions. Finally, more than half the programs employ staff specifically to support and encourage involvement by fathers, reflecting an emphasis in Early Head Start on support for fathers' involvement in program activities and decision making. Chapter IV provides a more detailed discussion of strategies programs use to involve fathers in program activities.

Table V.1. Types of Staff in Early Head Start Programs

Staff Characteristics	Percentage of Programs
Program Employs or Has Access to	
Mental health specialist	95.5
Disability specialist	92.0
Health care professional or nurse	91.0
Speech or language specialist	64.8
Father or male involvement specialist	57.5
Literacy specialist	56.7
Dietitian or nutritionist	18.9
Any other specialist	27.7
Program Employs	
Home visitors (own)	81.8
Home visitors (partner)	15.8
Primary caregivers (own centers)	82.9
Primary caregivers (partner centers)	33.8
Sample Size (Programs)	**240–652**

Source: Survey of Early Head Start Programs.

Management Staff

Nearly all program directors have a bachelor's or higher degree; 62 percent of programs employ directors with graduate degrees (Table V.2). Eighty-three percent of programs

Table V.2. Qualifications and Education of Early Head Start Staff

Staff Characteristics	Percentage of Programs
Highest Degree Held by Director	
Graduate degree	61.9
Baccalaureate degree	32.9
Associate degree	2.4
GED or high school diploma	2.8
Highest Degree Held by Manager	
Graduate degree	58.9
Baccalaureate degree	36.1
Associate degree	4.1
GED or high school diploma	0.9
Employs **Only** Directors with a Baccalaureate or Graduate Degree	83.3
Employs **Only** Managers with a Baccalaureate or Graduate Degree	50.6
Employs 50 Percent or More Primary Caregivers Who Hold[a]	
Graduate degree	1.1
Baccalaureate degree	15.5
Associate degree	15.5
Child Development Associate credential or equivalent state credential	15.7
Employs **Only** Primary Caregivers with at Least an Associate Degree	13.2
Employs **Only** Primary Caregivers with at Least a Child Development Associate Credential	29.3
Employs 50 Percent or More Home Visitors Who Hold[b]	
Graduate degree	3.8
Baccalaureate degree	46.5
Associate degree	19.0
Child Development Associate credential or equivalent state credential	12.1
Employs **Only** Home Visitors with at Least an Associate Degree	46.7
Employs **Only** Home Visitors with at Least a Child Development Associate Credential	63.3
Sample Size (Programs)	**422–581**

Source: Survey of Early Head Start Programs.

[a]Among programs reporting any caregivers.
[b]Among programs reporting any home visitors.

indicate that they only employ directors with a baccalaureate (BA) or graduate degree.[2] Similarly, half of all programs *only* employ managers with such educational backgrounds. Like directors, more than 90 percent of these staff members have a bachelor's or higher degree. Nearly 60 percent of programs employ at least one manager with a graduate degree.

Management staff members monitor progress toward program goals and oversee implementation of program services. While educational background provides necessary knowledge and expertise to manage and, at times, implement services, other characteristics may also be essential for management staff to be effective in their roles as program leaders. Interviews during site visits provide additional background on the skills and qualities that Early Head Start staff members feel are important for effective leadership (Box V.1).

Frontline Staff

Programs rely on frontline staff working within centers the programs operate, as well as those employed by community partners.[3] Most programs, however, rely on home visitors and primary caregivers employed by the program (82 and 83 percent, respectively). A small minority (16 percent) of the programs that offer home-based services use home visitors employed by community partners. Similarly, one-third of programs report relying on primary caregivers employed through partnerships with child care providers in the community.

Unlike preschool Head Start, where a distinction is made between teacher and assistant teacher in terms of qualifications, for Early Head Start, all direct service classroom care providers are called caregivers. The performance standards do not require primary caregivers in center-based programs to have a BA degree, but at least half must have an associate degree (AA) or higher in early childhood education or a related field. Few programs (13 percent) report that all primary caregivers have an AA or higher; 32 percent indicate that at least half the primary caregivers they employ have an AA or higher degree (Table V.2). All primary caregivers in center-based programs must have a Child Development Associate (CDA) credential or equivalent within one year of hire. Nearly one-third of programs report *only* employing primary caregivers with at least a CDA or higher. Most programs also provide tuition reimbursement for some or all of their primary caregivers and home visitors to support them in securing required educational credentials (discussed later in this chapter). Consequently, many programs employ at least one primary caregiver or home visitor who is without a degree but enrolled in training of some sort (65 and 32 percent, respectively).

[2] A few programs reported on more than one director, possibly because they were describing a director at another site and not just their own, as requested.

[3] Chapter VI provides a detailed discussion of Early Head Start programs' partnerships with other community service providers.

BOX V.1

PROVIDING EFFECTIVE LEADERSHIP IN EARLY HEAD START PROGRAMS

Underlying the performance measures for Early Head Start programs is an expectation that programs employ qualified staff with the skills necessary to provide high-quality services. While the Head Start Program Performance Standards include requirements for staff credentials, other staff characteristics also may be critical for providing high-quality services. In selecting sites for visits, we chose some programs that had experienced a change in director in the past year. In fact, during site visit interviews, Early Head Start staff members rarely focused their discussions of effective leadership traits on credentials or educational background; instead, they focused on personal characteristics as essential for leadership success. In this text box, we discuss staff perceptions of the skills necessary for effective leadership and management staff's attempts to involve staff and parents in decision making.

Frontline and management staff emphasize the ability to motivate and support staff as important skills for effective leadership. During site visits, program directors and other management staff recognized that program leaders have to envision "the bigger picture" while also handling the day-to-day tasks and challenges of their work. Therefore, they must balance an understanding of both daily and long-term requirements and obligations. They also must have a clear vision of the goals for the program. In this process, they must motivate and encourage staff and ensure that they have the tools and materials to effectively carry out their jobs. This requires understanding the inherent challenges of working with low-income families and the difficulties participating families face. To fulfill all these roles, program leaders need strong communication and listening skills, interpersonal and coaching skills, and respect for staff opinion and input.

Program leaders need to have knowledge of child development and Early Head Start regulations, management and decision-making skills, passion for the work, and the ability to support and respect staff. For example, primary caregivers report valuing leaders that relate well to frontline staff, are sympathetic to the demands of their position, and respect and treat them as equals. In particular, primary caregivers emphasize a desire to interact with management staff who seek their opinion and input on policies and procedures and who understand the difficulties associated with their daily work. A similar desire for understanding the challenges of home visiting also emerged during site visits. Other program staff members (such as education coordinators and specialists) underscore the importance of leaders having good communication skills, a willingness to be innovative and try new things, empathy for families and frontline staff, and the ability to maintain staff morale.

In an effort to be inclusive and support staff morale, most programs solicit input from frontline staff on procedural and policy changes. As many of the selected programs report, management staff generally uses this approach to encourage "buy-in" and support of staff members for program changes that directly affect them. Even allowing staff members, during staff meetings, to discuss any changes that have already been decided is seen as a way to encourage their support. It also allows management staff to identify any obstacles to implementation or other ways to approach issues. In addition, several program directors report providing detailed information to staff about proposed and upcoming changes (and the reasons for these changes) to promote the acceptance of such changes. One program reports providing opportunities for staff to contribute suggestions or programmatic ideas throughout the year. Again, program leaders view these activities as a means of effectively leading programs, with the maintenance of staff support perceived as essential to their success and effectiveness.

Programs that do not openly communicate with staff regarding new policies or the rationale for procedural or policy changes have frontline staff members who report greater frustration and feelings of powerlessness. As some staff members at visited programs indicate, it is important for them to have a voice in policy and a clear understanding of any program changes. Some programs also suggest that praise and recognition for frontline staff's ability to adapt to such changes are important in maintaining staff morale.

Home visitors have higher levels of education than primary caregivers on average across programs. Nearly half of all programs report that all home visitors they employ have an AA or higher in early childhood education. More than two-thirds of programs report that at least half their home visitors have an AA or higher. The disparity between education levels of home visitors and primary caregivers suggests that programs may impose a higher standard for the credentials of home visitors than for those of primary caregivers, even though the performance standards contain more stringent education requirements for primary caregivers. One possible explanation for this difference is that the classroom setting is a more supervised environment, while home visiting is a more solitary activity that may require more clinical skills in working with families. Home visitors also need to establish relationships with parents and be able to work effectively with both parents and children. For example, home visitors must be able to communicate effectively and respectfully with parents about sensitive topics and work with families in crisis. Box V.2 describes the ways programs approach hiring qualified staff.

Staff Turnover

Programs strive to hire qualified staff and to keep them. Consistency in staff helps maintain smooth program operations and reduces costs associated with advertising, interviewing, hiring, and training new staff. Furthermore, children and families benefit from consistency when relationships are maintained over time; transitions in front-line staff can be very difficult for families and may at times precipitate termination of participation in the program.

Although Early Head Start programs seek to keep staff, some turnover is to be expected. In the year before the survey, many programs had experienced staff turnover (Table V.3). Depending on the type of staff who leave and the frequency of changes, turnover can have a greater or lesser impact on programs. The loss of management staff is particularly critical, as there may be a resulting disruption in leadership and in smooth program operations. However, the replacement of an ineffective leader with an effective one can have positive effects on a program.

On average, programs report that home visiting staff left at a slightly higher rate than other frontline staff during the year before the survey (24 percent of home visitors, compared to 20 percent of primary caregivers). However, the rate of home visitor turnover varies widely across programs—in that time period, 41 percent of programs had no turnover among home visitors, and 6 percent had all home visitors leave. Sixty-six percent of programs had home visitor turnover at or below 25 percent. Among primary caregivers, an average of 20 percent of those employed directly by Early Head Start left the program in the year before the survey; 17 percent of those employed by community partners left their jobs during the previous year. Again, the rates of turnover vary across programs, with 27 percent of programs reporting no turnover of primary caregivers they employ and 3 percent reporting turnover of all primary caregivers in the past year. Seventy-four percent of programs had turnover at 25 percent or lower. Nearly half the programs (49 percent) report that there has been no turnover among primary caregivers employed by their partners.

BOX V.2

CHALLENGES IN HIRING AND RETAINING STAFF IN EARLY HEAD START PROGRAMS

Overall, Early Head Start programs employ well-qualified frontline staff members despite facing challenges of competing employers offering higher salaries, and shortages of job candidates with early childhood backgrounds and experience working with infants and toddlers. During site visits with selected programs, staff members discussed their experiences hiring and retaining staff.

Many Early Head Start programs have difficulty hiring and retaining qualified frontline staff. During site visit interviews, program staff indicated that compared to other early childhood programs, the requirements for Early Head Start teaching staff are stringent. Because of difficulties identifying qualified applicants, however, programs often must hire staff without the minimum CDA or AA credentials, with the expectation that they will obtain the necessary credentials within a year. Programs also report that qualified staff often feel that the salaries for Early Head Start positions are inadequate, especially when compared to similar positions in the public schools and when considering the emotional commitment the work requires. As some programs report, degreed teachers in Early Head Start often do not receive the same compensation as similar staff in other settings. According to some programs we visited, this compels them to find other ways to make job offers more appealing to potential staff. For example, some programs report offering generous benefit packages to candidates to offset less appealing salaries.

Despite the commitment of staff members to the well-being of children and families that encourages many to join and stay with the program, low salaries continue to contribute to high turnover rates. Difficulty finding staff with an interest in and ability to work with infants and toddlers and the intensive care they require, as opposed to preschool-age children, also contributes to hiring challenges.

A few programs indicate that higher education institutions in rural areas do not offer all the coursework necessary to obtain an appropriate degree in the field. The survey data support this assertion to a certain degree. Compared to programs in mainly suburban and urban areas, rural programs (38 percent) are less likely to employ all home visitors who hold at least an associate degree in early childhood education or a related field (38 percent of rural, compared to 70 percent of suburban and 52 percent of suburban programs). However, similar differences in the degree attainment of primary caregivers did not emerge. Rural programs are also less likely than mainly suburban or urban programs to employ most types of specialists.

Other than educational background, programs emphasize desired experience in their search for qualified frontline staff. For example, many indicate the importance of social service experience, so that staff members are prepared to work with low-income, culturally diverse families who may be in crisis. Cultural competence among staff members is particularly important because of the diversity in cultures and traditions among Early Head Start families. (Chapter III discusses respect for the cultures of families receiving services.) During site visit discussions, programs emphasized the desire to recruit staff members capable of working with families in a nonjudgmental, empathetic manner. Others noted the importance of experience working with young children. As some programs report, frontline staff members need to know how to relate well to children, how children learn, and how programs can contribute to that learning.

A few programs face challenges in hiring bilingual staff. Bilingual staff members, especially those that speak Spanish and English, are in high demand, given the population served by Early Head Start programs. During site visits, some programs emphasize the importance of bilingual staff, as their presence helps build relationships between families and program staff. As these programs point out, the need to use translators during home visits and interactions with families may pose a barrier to establishing greater close communication with parents. In addition, some parents may prefer interacting and communicating with staff sharing the same language and cultural background. In fact, a parent in one visited program notes this preference in home visiting staff. However, as one program points out, it may be a challenge to find bilingual staff with the education and experience to provide high quality services.

Table V.3. Early Head Start Staff Turnover

Staff Characteristics	Number of Programs	Percentage of Programs
Director Left Program in the Past 12 Months	77	11.9
Coordinator or Manager Left Program in the Past 12 Months	185	28.5
Among Programs with Any Management Change, Most Cited Reasons		
Personal reasons	128	61.5
Higher compensation (same field)	69	35.9
Change in job field	68	34.0
Fired or laid off	30	14.8
Other reasons	8	4.4
Staff Turnover in Past 12 Months		**Average Percentage of Staff Leaving Each Year[a]**
Turnover of Home Visitors	422	23.8
Turnover of Primary Caregivers Employed by Program	437	19.8
Turnover of Primary Caregivers Employed by Child Care Partner	121	17.3
Sample Size (Programs	**121–650**	

Source: Survey of Early Head Start Programs.

[a]Calculated within each program as the number of each type of staff leaving divided by total home visitors or total primary caregivers, averaged across all programs with that type of staff.

Relatively few Early Head Start programs (12 percent) lost their director within the previous year. However, a sizable minority of programs (29 percent) report that an Early Head Start coordinator or manager left within the same period. A handful (5 percent—not shown) report that they had lost both their program director and at least one manager. Such transitions in management staff may be particularly troubling for programs because of disruptions in leadership.

Programs report that most staff (managers and frontline) leave the program for personal reasons. More than one-third of programs (36 percent) that lost management staff reported that those staff took higher-paying jobs in the early childhood education field. Programs are challenged to retain credentialed staff members who are often lost to higher-paying jobs in the public school system. Approximately one-third of programs experiencing management turnover indicate that a change in job field was the reason for staff leaving. In most cases, staff left voluntarily, with only 15 percent of programs that lost a manager or director reporting losses due to layoffs or firing.

SUPERVISION AND STAFF DEVELOPMENT

Because of the high toll turnover has on programs and families, and to maintain high-quality services, programs engage in activities to support staff and prevent turnover. Below, we discuss what programs have done to support ongoing staff development, training, and mentoring. In this section, we discuss Early Head Start programs' approaches to supervision and staff support, staff development, and training.

Supervisory Practices and Support

Supervision and support activities help staff meet the demands of their job responsibilities and work effectively with children and families. Supervisory practices include a range of activities, such as reflective supervision, performance appraisals, group case conference sessions, and mentoring. These activities may be conducted individually or in groups. They also may include formal activities, such as individual performance reviews, or less formal activities, such as discussions about how to address the needs of a particular family.

Most Early Head Start programs support staff through ongoing reflective supervision. Reflective supervision is a collaborative learning relationship between the supervisor and supervisee in which staff are encouraged to reflect on the progress of their work with children and families on a regular basis. The process is considered important to ensuring staff quality, retention, and support and is therefore encouraged by its inclusion in the performance measures. Similar numbers of programs report that they engage in this practice with primary caregivers and home visitors (83 and 81 percent of programs, respectively; Table V.4). Two-thirds of programs that do reflective supervision report receiving outside training or assistance to conduct it. Box V.3 provides further details on programs' experiences with reflective supervision. For primary caregivers, 54 percent of programs report that they practice reflective supervision monthly or more often. Slightly more programs (60 percent) indicate they practice reflective supervision monthly or more with home visitors.

Aside from reflective supervision, programs engage in other supervisory activities with staff, including performance appraisals, group case conference sessions, and mentoring. These activities keep management staff abreast of staff performance, the challenges staff face, and potential emerging issues with families. As expected, nearly all programs conduct performance appraisals, almost all conduct group case conference sessions, and a significant proportion assign mentors to less experienced staff. Formal performance reviews provide opportunities for self-assessment and feedback. Assigning experienced staff to mentor junior staff allows programs both to monitor and supervise the activities of less experienced staff and to provide guidance as needed. Case conference sessions can support communication among staff and provide opportunities to brainstorm ways to address challenging problems, particularly in regard to serving high-risk families or families facing particular difficulties.

Table V.4. Supervisory Practices and Training Opportunities in Early Head Start

Supervision and Training	Percentage of Programs
Staff Supervisory Practices	
Conducts performance appraisals for all staff	99.2
Conducts group case conference sessions	92.7
Assigns mentors to less experienced staff	83.6
Conducts reflective supervision with primary caregivers[a]	82.6
Conducts reflective supervision with home visitors[a]	80.9
Received outside training for reflective supervision (among programs that use reflective supervision)	69.4
Staff Development and Training	
Conducts staff training	99.1
Meets with staff individually	98.9
Holds staff meetings	99.5
Observes frontline staff providing services	98.9
Program Provides Tuition Reimbursement for (Some or All)	
Primary caregivers	84.9
Home visitors	79.2
Program Provides Workshop Fees or Other Training Costs for (Some or All)	
Primary caregivers	85.3
Home visitors	86.4
Program Provides Time for Staff Development for (Some or All)	
Primary caregivers	79.6
Home visitors	82.8
Sample Size (Programs)	**398–644**

Source: Survey of Early Head Start Programs.

[a]Reflective supervision is generally considered to be a collaborative learning relationship between the supervisor and supervisee in which staff members are encouraged to reflect on the progress of their work with children and families on a regular basis.

Training Opportunities

Performance standards require programs to provide training to frontline staff and volunteers to help them acquire the skills and knowledge necessary to deliver services effectively. For example, there are annual requirements for training in child safety (CPR, first aid, emergency response, and medicine administration) and child abuse and neglect reporting. However, programs also have flexibility to customize training to address topics of particular interest or need. The content of staff training may therefore vary from program to program and within programs from year to year. Box V.4 provides additional details on the nature of training activities and goals across programs.

BOX V.3

SUPPORTING EARLY HEAD START STAFF WITH REFLECTIVE SUPERVISION

Reflective supervision is a collaborative learning relationship between the supervisor and supervisee in which staff members reflect on the progress of their work with children and families on a regular basis. Programs are expected to make reflective supervision a regular and ongoing process to help frontline staff work with families effectively, to support staff working in stressful circumstances, and to help them find solutions to problems faced in their work with families. Program performance measures emphasize the use of these activities. Accordingly, during site visit interviews, we asked programs to describe their experiences with this practice.

Programs using reflective supervision view it as an opportunity for staff to express their needs and to seek guidance and support for coping with the challenges of working with high-need children and families. Several programs indicate that reflective supervision is often an opportunity for staff to vent frustration, reduce stress, and work toward professional goals. As one program selected for a site visit suggests, the process allows staff members to reflect on their job performance and the difficulties of their position. Two programs also emphasize the importance of staff members' self-awareness and their understanding of how their work affects themselves and others. Reflective supervision allows programs to provide this opportunity to staff. Some programs also suggest that the process helps avoid staff burnout, because it allows staff to discuss issues that are particularly stressful for them. One program notes that when managers listen to staff and support them during this process, staff feel more confident and better able to independently address issues they encounter. Programs we visited use both individual and group meetings for supervision. Group meetings may be led by a manager and individual meetings are held with supervisors (who may be the same person depending on the program).

Some programs are unfamiliar with the term *reflective supervision*, or they believe there is room for improvement in this process for their program. For example, some programs selected for site visits indicate that they do not practice reflective supervision in an organized fashion, in a manner that they are satisfied with, or as frequently as they would like. Finding the time to use this approach with individual staff members is a challenge for several programs. In addition, during interviews, some programs referred to the practice as a less reflective and broad activity than the term implies. For instance, one program reports reviewing classroom teachers' curriculum plans as reflective supervision, rather than discussing personal and classroom goals with teachers. Another defines reflective supervision as having managers model developmentally appropriate practices for teaching staff. Other programs indicate that they do not practice reflective supervision but report engaging in activities that could be classified as taking a reflective approach. Because most programs reported using reflective practices within the survey component (Table V.5), this may indicate some programs' lack of knowledge of terminology.

All Early Head Start programs reported providing opportunities for ongoing staff development and training. In addition to directly providing staff training activities, programs encourage the ongoing professional development of staff by supporting their attendance at conferences, workshops, and classes. For example, 85 percent of programs provide tuition reimbursement for some or all of their primary caregivers, and another 79 percent provide similar reimbursement for their home visitors. Similarly, approximately 85 and 86 percent of programs cover workshop fees or other training costs for some or all of their primary caregivers and home visitors, respectively.

BOX V.4

PROVIDING OPPORTUNITIES FOR TRAINING AND STAFF DEVELOPMENT IN EARLY HEAD START PROGRAMS

The performance measures framework for Early Head Start emphasizes the development of systems that ensure programs are well managed, supportive of staff, and able to effectively meet the needs of participating parents and children. As part of this mandate, programs develop plans and systems to provide staff with training opportunities to support them in performing their job duties and continuing to develop their skills. The nature of training activities, as well as the impetus driving training goals, varies from program to program and from year to year. This variability in approaches to staff training reflects an awareness of and responsivity to program and staff needs. In this text box we discuss programs' training activities, including topics and goals, staff involvement, and participation in national and regional conferences and workshops as seen in site visits.

Training goals and decisions in Early Head Start programs are responsive to staff interests and needs, the needs of participating families, and ongoing self-assessments of program quality. For example, several programs we visited survey teaching staff about their training needs to prioritize areas for training. A handful of programs selected for site visits indicate that the program self-assessment process guides their training plans and goals. During this process, programs report analyzing child and program outcomes; conducting observations of classroom teaching and home visiting practices; and surveying parents, staff, and community partners. Results from the process, therefore, help programs to identify training needs and areas requiring program-wide attention and improvement. Training plans are then crafted based on results from the self-assessment process. Programs also use other tools to guide training activities. For instance, one program indicates that outside initiatives, such as promotion of father involvement, guide their training activities. Other programs emphasize improving staff knowledge on infant and toddler development because, as some staff point out, early childhood coursework does not always focus on this developmental period. Notably, while training areas may be identified for the program as a whole, they also may be identified for individual staff members. For example, programs may focus training on areas important for all staff members to develop (such as the attainment of relevant degrees or knowledge of program curriculum) as well as those that individual staff members are interested in learning more about. Commonly, programs also must comply with state training requirements in health and safety. These requirements generally center on first aid, CPR, child abuse and neglect prevention and reporting, and medicine administration.

Programs vary in how and when they provide training activities and in the staff for whom they provide training. For example, visited programs report providing training opportunities using in-house staff members, outside consultants, or staff at partner agencies. Programs also report providing training at orientation for new staff, as well as at periods throughout the program year for all staff. Similarly, some programs provide all training hours for all staff at the beginning of the program year during pre-service training, while others provide ongoing and in-service training throughout the year. Often, training opportunities are open to staff at child care partners as well. Chapter VI provides further details about the nature of child care partnerships in Early Head Start.

Many programs also emphasize increasing staff members' understanding of program curriculum and the assessment process, knowledge of early child development and developmental milestones, and receipt of necessary teacher credentials. Programs also provide training geared towards developmentally appropriate classroom practices, dealing with parents' mental health and substance abuse issues, building relationships with families, working with special needs children, developing and documenting the goal setting process with families, time management, and culture and language issues. In addition, a handful of programs indicate that it is important for training to be specific to the needs of the program. Typically these programs reference a need to emphasize rural issues (versus urban issues) in mainly rural areas.

Besides providing training opportunities locally, many programs support staff in their attendance at national and regional conferences and workshops. These opportunities may focus on building knowledge among frontline staff or improving the leadership skills of management staff. For example, one program reports providing leadership training for its program director, another program director attended *Coaching for Results* training, and another supports the attendance of its entire management staff at a minimum of one conference annually. Programs also note that they have staff who attend *NAEYC*, local and regional *AEYC* conferences, *WestEd*, and the *Birth To Three Institute*, among other conferences and trainings.

PROGRAM SYSTEMS TO SUPPORT CONTINUOUS PROGRAM IMPROVEMENT

In this section, we report on program activities to support program improvement, including use of specific curricula, screening and assessment tools, and management information systems. The performance standards require programs to screen each child for developmental delays within 45 days of enrollment, and to conduct regular assessments (at least three times a year) to track children's developmental progress. Early Head Start programs are free to select the curricula and screening and assessment tools, they use while providing services.

Curricula in Use

We asked programs to report on the curricula they use in each setting where they provide services (home-based, center-based, or family child care). Programs report using many different curricula in center-based settings, with only a few curricula in use by substantial proportions of programs (Table V.5). Slightly more than three-quarters of

Table V.5. Use of Curricula, Screeners, and Assessments

Curricula and Instruments	Percentage of Programs
Curricula (Center-Based Settings)[a,b]	
Creative Curriculum	75.8
Games to Play with Babies	20.0
Games to Play with Toddlers	20.0
Curricula (Home-Based Settings)[a,c]	
Partners for a Healthy Baby	59.6
Games to Play with Babies	31.3
Games to Play with Toddlers	27.3
Hawaii Early Learning Profile	29.3
Curricula in Family Child Care Settings[a,c]	
Creative Curriculum	82.7
Games to Play with Babies	14.8
Games to Play with Toddlers	14.8
High/Scope	12.4
Screeners[d]	
Ages and Stages	69.5
Ages and Stages Socio-emotional	48.1
Denver II Developmental Screening Test	44.7
Brigance Screening Test	8.7
Assessments[d]	
Creative Curriculum	28.5
Ounce Scale	13.3
High/Scope COR	8.7

Source: Survey of Early Head Start Programs.

[a]Among programs providing this type of service option.
[b]Sample Size = 120.
[c]Sample Size = 99.
[d]Sample Size = 541–601.

programs use the Creative Curriculum (Dodge and Colker 1992) in center-based settings. Other curricula—that are used much less frequently—include Games to Play with Babies and Games to Play with Toddlers (both 20 percent; Silberg 1993). Fifteen percent of programs use the Hawaii Early Learning Profile (Parks 1993), and 15 percent report using an agency-created curriculum (not shown).

Curricula in home-based settings are more evenly distributed across programs than those in center-based settings. The most popular curricula in use by programs that offer home-based services are Partners for a Healthy Baby (60 percent), Games to Play with Babies (31 percent), the Hawaii Early Learning Profile (29 percent), and Games to Play with Toddlers (27 percent).

Among programs that provide family child care services, again most use Creative Curriculum (83 percent), followed by Games to Play with Babies and Games to Play with Toddlers (both 15 percent). Nearly one-fifth use an agency created curriculum.

Use of Screening and Assessment Instruments

Many programs use more than one instrument for initial screening upon program entry. Most programs (70 percent) use the Ages and Stages Questionnaire (Squires et al. 2002). About half the programs use the Ages and Stages Socio-Emotional scale (Squires et al. 1999), and a similar number (45 percent) use the Denver II Developmental Screening Test (Frankenburg and Dodds 1989). A few programs report using other instruments, such as the Brigance Screening Test (Brigance 1991) or another instrument (Table V.5).

Nearly all programs reported using an instrument for ongoing assessment (91 percent). Across programs, many different instruments are used, with only a few programs endorsing any one instrument. The most frequently cited assessment instruments are the Creative Curriculum assessment tools (29 percent), the Ounce Scale (13 percent), and High/Scope COR (9 percent; High/Scope 1999).[4]

Programs use these screening and assessment data in a variety of ways, primarily for lesson plans, either for a class or a specific child (87 percent), referring a child for additional services (79 percent), and planning activities for home visits (74 percent). Other uses that programs report for screening and assessment data are to update individual family partnership agreements (IFSPs; 61 percent), or use assessments in the aggregate to describe child outcomes (42 percent). Ten percent of programs reported other uses of these data.

[4] We hypothesized that there may be a relationship between the type of assessment used and the way programs use their MIS, particularly for individual child progress reports. However, there is little evidence that specific assessments are concentrated within programs that use their MIS in this way. For example, 11 percent of programs that use their MIS for progress reports also use the Creative Curriculum, whereas 9 percent of programs that do not use their MIS in this way also use Creative Curriculum. We see similar small differences when we look at other relatively popular assessments.

Parent and Family Assessments

Nearly three-quarters of programs use some type of parent or family assessment with parents (73 percent; Table V.6). As is the case with some other assessments or instruments, a few parent/family instruments are most likely to be used by programs that conduct such assessments. For example, family partnership agreements are the parent/family assessment that most programs use (80 percent), next most common is an agency created assessment (32 percent), and the Family Needs Scale (10 percent). Programs primarily use parent/family assessment data to support referrals for additional services (93 percent), plan home visit activities (64 percent), and create lesson plans for home visits (49 percent), and update IFSPs (47 percent).

Table V.6. Parent/Family Assessments in Early Head Start

Parent/Family Assessment Instruments and Uses	Percentage of Programs
Family Partnership Agreement	79.5
Agency Created Assessment	31.9
Family Needs Scale	10.4
Use of Parent/Family Assessments	
Refer for additional services	93.3
Plan activities for home visits	64.2
Create lesson plans for home visits	49.3
Update IFSP	46.8
Other	11.0
Sample Size (Programs)	**402-404**

Source: Survey of Early Head Start Programs.

Note: Among 404 programs that use a parent/family assessment.

Child Care Quality Assessments

As described earlier, the performance standards require programs to ensure that child care meets acceptable quality standards. We asked programs to report the quality assessments that they use in each setting where they provide care (centers and family child care). Nearly all programs report using a tool to assess quality in child care settings (92 percent; Table V.7). In center-based settings, two-thirds of programs primarily rely on a well-known child care quality assessment, the Infant Toddler Environment Rating Scale (ITERS; Harms et al. 1990). Only a handful of programs report using any other child care quality assessment, such as the Arnett (1989) or Early Language and Literacy Classroom Observation (ELLCO; Smith 2002; each under 10 percent). Among the few programs providing care through family child care providers, more than half (57 percent) use the Family Day Care Rating Scale (FDCRS; Harms and Clifford 1989); nearly one-third report using another unspecified assessment. After assessing child care quality, nearly all programs

Table V.7. Early Head Start Program Efforts to Ensure Quality of Child Care

Quality Assurance Activities	Percentage of Programs
Conduct Classroom Assessments	92.3
Among Programs That Conduct Assessments, Percentage That Found Improvements Were Needed	93.7
Among Those That Found Needed Improvements, Steps Taken	
Provided staff training	90.7
Developed written improvement plan	75.9
Scheduled follow-up assessment	71.2
Obtained technical assistance	50.3
Terminated partnership	6.0
Improvements to facility/equipment	3.9
Other	3.4
Sample Size (Programs)	**386–456**

Source: Survey of Early Head Start Programs.

found improvements needed to be made, most often by offering staff training, developing written improvement plans, or scheduling a follow-up assessment.

Management Information Systems (MIS) and Use of Data

Nearly 90 percent of Early Head Start programs use an electronic MIS to collect and organize administrative data, most often either the Head Start Family Information System (HSFIS; 34 percent) or Child Plus (37 percent; Table V.8). A handful of programs use other software packages for this purpose (all less than 4 percent), including COPA, Prinis, Access, and locally designed systems. Ten percent of programs report using a combination of software programs to gather and use program data. These systems allow programs to collect data on children and their skills, special needs, and services. For example, programs may collect data on children's attendance and immunizations, health and developmental screening results, service receipt, and referrals. Information on staff (such as type, credentials, and training), participating family demographics, and other information collected at intake are also gathered and stored electronically. These systems enable programs to monitor program activities, enrollment, and quality and are usually the primary resource for meeting reporting requirements such as the PIR. Site visit interviews provide further details on programs' uses of MIS (Box V.5).

Among programs using a computerized MIS, most report satisfaction with their system (Table V.8). One-quarter of programs are very satisfied with their MIS, and half are somewhat satisfied. Among the remaining 25 percent of programs reporting being somewhat or very dissatisfied with their MIS, most cite problems with software as the reason

Table V.8. Use of Management Information Systems (MIS) in Early Head Start

	Number of Programs	Percentage of Programs
Program Uses a Computerized MIS	538	88.3
Type of MIS		
Head Start Family Information System	183	34.2
Child Plus	197	36.8
Access	18	3.4
COPA	19	3.6
Galilleo	7	1.3
Genesis	11	2.1
Prinis	19	3.6
Locally designed	26	4.9
Combination of software	54	10.1
Satisfaction with MIS (Among Programs Using Any)		
Very satisfied	132	24.7
Somewhat satisfied	269	50.3
Somewhat dissatisfied	100	18.7
Very dissatisfied	34	6.4
Reasons for Dissatisfaction with MIS (Among Those Somewhat or Very Dissatisfied)		
Problems with software	76	57.1
Difficult to use	56	42.1
Reports not useful	53	39.9
Lack of technical support or trained staff	20	15.0
MIS does not meet current needs	19	14.3
Sample Size (Programs)	**133–609**	

Source: Survey of Early Head Start Programs.

for their dissatisfaction. Forty-two percent indicate that their MIS is difficult to use, while another 40 percent feel that the reports the MIS generates are not useful. Many programs completing this survey complained that it is difficult to get needed information because their MIS is not adaptable enough or because staff do not know how to use it to report information in a different way from the one to which they are accustomed.[5] Among programs that report being somewhat or very dissatisfied with their MIS, 82 percent use HSFIS and 19 percent use Child Plus (not shown). Small proportions of users of other MIS are also dissatisfied.

[5] These complaints generally were registered during discussion groups of programs that pretested a preliminary version of the survey or in calls to the helpline we established to aid programs in using the web survey.

BOX V.5

USING MANAGEMENT INFORMATION SYSTEMS (MIS) IN EARLY HEAD START PROGRAMS

MIS support programs in their efforts to monitor program activities and compliance with the Head Start Program Performance Standards. During site visit interviews with selected programs, staff described how they use these systems.

Programs use their MIS for program monitoring, generating reports, and tracking participation and service use rates. For example, many programs use the MIS to monitor program participation and service receipt, including attendance rates, completion of home visits and health exams, and receipt of immunizations and screenings. Programs also use their MIS to track enrollment numbers, family characteristics, and children's illnesses and injuries. In addition, programs use these systems to keep track of families that have dropped out of the program or are transitioning into Head Start or another program, the proportion of families with incomes above poverty, and the proportion of children with disabilities. Several programs also use their MIS to record and track families' progress toward family partnership goals. A few programs mention using MIS data to assess father involvement and participation in program activities. Most sites we visited (all but 4 of the 17) use their MIS to compile and provide data for the PIR, the primary annual data collection requirement for programs.

Many programs generate reports with their MIS for instructional planning and to assess training and technical assistance needs. Since programs often maintain records of children's assessments, many report using their MIS as a tool to document and monitor children's status and developmental progress. This information is then used to individualize instruction for children. Some programs also provide child outcomes data generated from the MIS to parents to make them aware of their child's status and to educate them on how to tailor the home environment to meet a child's specific needs. Similar reports can be generated to monitor program-wide performance. In fact, programs report generating program-level data for self-assessment purposes. One program indicates that it is able to identify whether it meets program performance standards for completing screenings, for example. Programs may also use reports to provide program-level data to other interested parties. For example, one program uses its MIS to generate reports for its Policy Council, funders, and executive board. By examining performance at the classroom, center, and program level, programs also are able to identify training opportunities and areas for improvement. For instance, one program indicates that reports from its MIS reveal whether there is a need for better curriculum in certain subjects or whether teachers need more training on how to teach certain subject areas.

Among programs with an MIS, more than 90 percent indicated they use it to generate enrollment lists, reports on the characteristics of Early Head Start families, and on children's immunization status. Fewer (83 percent) use it to generate reports on services provided. MIS are used less often to trace staff training (59 percent), individual child progress (64 percent), or staff characteristics (66 percent).

KEY POINTS

- Nearly all Early Head Start programs have access to a wide array of specialists including mental health, disability, and health care specialists.

- Nearly all programs have directors and managers with BAs or advanced degrees.

- Forty-seven percent of programs have a staff consisting of at least half home visitors with a BA or higher, and 17 percent have a staff consisting of at least half primary caregivers with that credential. Overall, home visitors on average have more education than primary caregivers.

- Sixty-six percent of programs have a staff consisting of at least half home visitors with an AA, and 32 percent have a staff consisting of at least half primary caregivers with that credential.

- Few programs lost their director in the year before the survey, and only a handful lost both a director and manager in that period. Turnover rates among primary caregivers and home visitors were higher—both near 20 percent on average.

- Most programs provide tuition reimbursement for some or all of their primary caregivers and home visitors to support them in securing required educational credentials. Consequently, many programs employ at least one primary caregiver or home visitor who is without a degree but enrolled in training of some sort (65 and 32 percent, respectively).

- Programs we visited report challenges in hiring and keeping frontline staff, primarily because of the educational requirements for Early Head Start teaching staff, the low salaries offered compared to those for similar jobs in the community, and the desire of many candidates to work with preschool-age children rather than infants and toddlers.

- Programs engage in a variety of supervisory activities with staff members to support and guide them. More than 80 percent of programs report using reflective supervision with primary caregivers and home visitors. Of those, more than two-thirds report receiving outside training or assistance to conduct reflective supervision.

- All Early Head Start programs provide opportunities for ongoing staff development and training. Eighty-five percent of programs provide tuition reimbursement for some or all primary caregivers, and 79 percent provide similar reimbursements for home visitors.

- Programs collect large amounts of data on families, staff, services provided, and child functioning. However, not all are aggregating this information for use in continuous program improvement. For instance, 83 percent report using their MIS to generate reports on services provided to children and families, while 64 percent generate reports on individual child progress.

- Ninety percent of programs use an MIS to collect and organize administrative data, most often the HSFIS or Child Plus. About three-quarters of programs using an MIS are somewhat or very satisfied with it. The primary reasons for dissatisfaction are software problems, difficulty using the software, and the inability to generate useful reports.

CHAPTER VI

PROGRAM PARTNERSHIPS

To meet the comprehensive service needs of families as specified in the Head Start Program Performance Standards, Early Head Start programs are encouraged to collaborate with other service providers in their communities. Early Head Start programs typically establish formal (written) or informal partnerships with a variety of community agencies, such as child care providers, health and mental health providers, and social services agencies. The purpose of these partnerships is to promote efficient linkages between Early Head Start families and partner-provided services. In essence, partnerships allow families who enroll in Early Head Start to be linked to social services without the need to seek out each separate service on their own.

Partnership agreements establish a reciprocal relationship between Early Head Start programs and partner agencies. Early Head Start programs can refer enrollees for services (or for evaluation of services needed) and, ideally, will work with the partner agency to coordinate the services and collaboratively monitor families' progress. In some cases, particularly when a child receives early intervention services from a partner agency, interagency cooperation may help to maintain continuity in the services received in both partner and Early Head Start settings. In addition to accessing needed services for Early Head Start families, partnership agreements enable Early Head Start programs to have a wider influence in the community. For instance, partnerships with community child care centers that include provision of training, information, and, possibly, access to materials and additional staff, can help to improve the quality of child care for children not in Early Head Start.

In this chapter, we describe Early Head Start programs' partnerships with a variety of community agencies, most notably child care providers, those offering specialized services for children with disabilities, and providers of basic health and mental health services. We draw primarily on survey data; illustrative examples from site visits are described in text boxes.

EARLY HEAD START COMMUNITY PARTNERSHIPS

Early Head Start programs' success in establishing partnerships with a variety of community agencies is one marker of the place programs hold in their communities. Overall, Early Head Start programs seem to have important roles in their communities. Ninety-five percent of programs participate in a local collaborative group of service

providers; among programs participating in such a group, about three-quarters report they hold a leadership position. Further, many programs have established formal partnerships with key service providers in their communities, specifically child care, health, and mental health providers. The number of actual partnerships varies considerably and is related to community and program features, therefore we report on the number of different types of providers with which programs have formal partnerships. Nearly all programs have at least one formal partnership with a community provider (92 percent).[1] One-third of programs have partnerships with three types (child care, health, and mental health) of providers asked about in the survey. The variety of partnerships may indicate the extent to which programs are integrated in their communities and may facilitate collaboration between and among various providers serving the same families.

PARTNERSHIPS WITH COMMUNITY CHILD CARE PROVIDERS

Early Head Start programs may pursue partnership with child care providers in the community to provide center-based services (Early Head Start slots) to enrolled children. Some center-based programs provide all services directly, others rely on partners to provide some or all of their center-based services. One notable finding from the survey is that formal partnership agreements with child care providers are relatively common. However, as we compare these findings with the ways that programs report serving children (see Chapter IV, Table IV.2), it is apparent that some programs are not using those partnerships for Early Head Start center-based slots at a given time. More than 40 percent of programs report having formal partnership agreements in place with child care providers, but fewer than 30 percent of programs report *serving* children through a child care partner. Possible reasons that some programs do not provide Early Head Start services through existing partners are that (1) the partnerships are with resource and referral agencies, (2) some programs may have what we consider to be "potential partnerships" that, although currently unused, may have been used in the past and will become active again as slots are needed, as funds become available, or if families choose to use the center, or (3) programs may have lapsed partnerships, with an agreement still in place with an inactive partner. Reasons for this may include a center's location not being convenient for current families, or a partnership no longer used due to quality issues and the partner's unwillingness or inability to meet performance standards. Box VI.1 describes features of child care partnerships in greater detail.

Among programs with formal child care partnerships (N = 268), more than 90 percent have agreements to coordinate services, exchange referrals, and share staff training. Nearly as many of the partnership agreements include provisions for technical assistance. Most agreements stipulate quality-of-care issues, such as requiring the partner to adhere to the performance standards, evaluate quality, allow the program to monitor quality, and conduct improvement planning (82 to 89 percent). About 81 percent of agreements include provisions for payments to the partner for child care slots (Figure VI.1).

[1] We omit partnerships with Part C providers because nearly all programs report having them.

BOX VI.1

CHARACTERISTICS OF CHILD CARE PARTNERSHIPS

Early Head Start performance measures call for partnerships with child care providers to help expand the services programs can offer to Early Head Start families and to enhance the quality of child care available in Early Head Start communities. Site visits to Early Head Start programs offered an opportunity to explore the reasons some programs establish child care partnerships, especially for center-based placements; the structure of those partnerships; and the factors that can make partnerships difficult to establish or sustain. We specifically selected some programs that offered services through child care partners and other programs that had inactive partnerships for site visits. Here we present more information gathered in site visits.

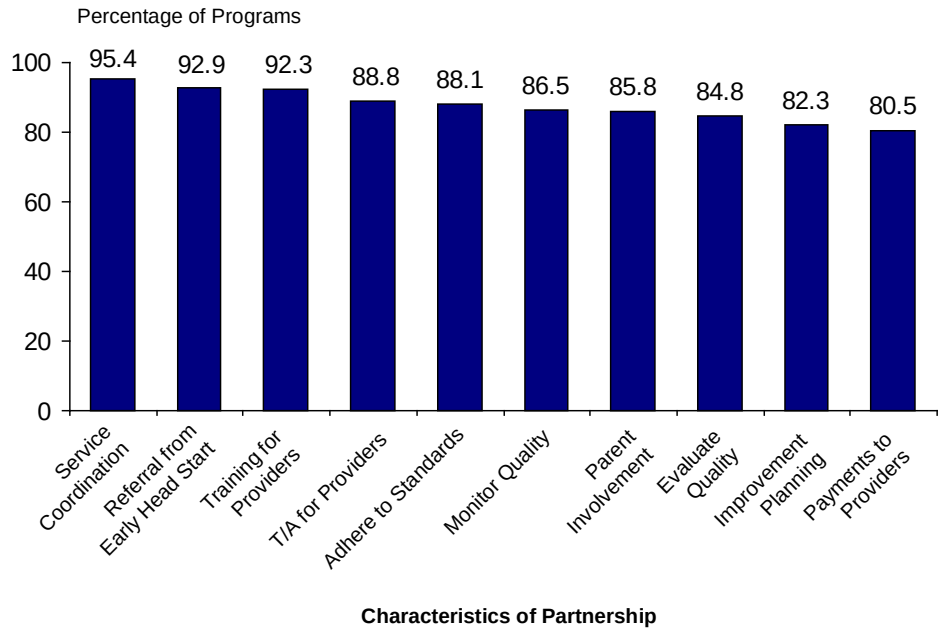
Programs' motivations for establishing child care partnerships, according to staff interviews, include making center-based care available to families in home-based programs, increasing the capacity of center-based programs, and helping other child care providers improve the quality of their services. Staff at some home-based programs (where formal child care partnerships are most prevalent) note that establishing partnerships is important for helping parents access child care when they are working or in school. Several center-based programs partner with other child care providers to provide additional center capacity or to extend the hours that care is available, bridging the time between the end of the Early Head Start day and the end of parents' work days. Finally, staff at a few programs specifically mentioned an interest in helping other providers achieve a higher standard of care. The director of one program notes quality improvement as a primary motivation for establishing a partnership with a private center operating under the same agency auspice.

Staff members describe child care partnerships structured around such activities as financial support, joint staffing, and training or technical assistance. Some programs pay for slots in a partner center or make payments to the partner to enhance the salaries or benefits of teachers working with Early Head Start children. In one program we visited, the Early Head Start agency directly hires and supervises staff working in partner centers. Under some partnerships, Early Head Start specialists provide services to children and families in the partner centers, sometimes only to Early Head Start children and less commonly to non-Early Head Start children as well. Many partnership agreements also include provisions for specialists and managers to provide training and technical assistance on a variety of topics to partner agencies and their staffs. Another common aspect of partnerships is quality monitoring of partner centers, with programs typically using procedures similar to those used for their own in-house monitoring. Depending on the partnership arrangement, monitoring may focus on the partner's entire facility or on just those classrooms where Early Head Start children are present.

Staff members note the challenges of establishing or maintaining partnerships, ranging from partner agencies' difficulty meeting standards to financial and logistical coordination. During site visits, staff at several programs shared examples of collaborations that broke down because partners—both centers and family child care providers—were unable to meet the quality standards required of Early Head Start providers. Programs also encounter problems with the reliability of funding for placements. For example, a partnership based on the assumption that parents will be eligible for child care subsidies (to help pay for care at a partner center) is vulnerable to the possibility that parents will lose their eligibility for subsidies or may move in and out of eligibility. One program we visited had opted to reduce slots with partners and open its own center because of this problem. Staff mentioned other financial issues, such as managing differences in the compensation levels of Early Head Start and non-Early Head Start teachers in the same center or classroom, and logistical challenges, such as coordinating training schedules for Early Head Start and partner staff.

Finally, staff in at least one program note that the amount of effort required to establish and support a partnership can seem high relative to the number of children they can actually serve through it. The level of coordination and technical assistance required to operate a successful partnership may be the same whether the partner serves only a few individuals or several classrooms of Early Head Start children.

Figure VI.1. Characteristics of Child Care Partnerships, Among Early Head Start Programs with Formal Agreements



Source: Survey of Early Head Start Programs.

Sample Size = 251-261 programs.

Beyond serving individual children and families, Early Head Start also strives to improve the availability of services for infants and toddlers in the wider community, in part through improving the quality of child care. Frequently, programs open training to all staff at partner centers, even those not directly serving Early Head Start children. The performance measures specify that Early Head Start programs assist families in obtaining high-quality child care, and programs do so in a variety of ways. Box VI.2 describes the ways that programs interpret their responsibility to help families find non-Early Head Start child care and how they ensure this care is of sufficiently high quality.

PARTNERSHIPS WITH PART C PROVIDERS

Part C of the Individuals with Disabilities Education Act is a federal grant program that helps states operate a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through 2 years, and their families. Partnerships between Early Head Start programs and Part C agencies are particularly salient, not only because performance measures recommend linkages and coordination between them, but also because Early Head Start begins as children are at ages when early intervention may be most effective. As we note elsewhere, the performance standards require Early Head Start programs to make 10 percent of slots available for children with

BOX VI.2

WORKING WITH PARTNERS TO ENSURE QUALITY CHILD CARE IN EARLY HEAD START

Early Head Start is charged with enhancing the quality of child care in communities through two performance measures: "Enhance the quality of local child care services through the sharing of resources, training, and knowledge" and "Help parents secure high-quality child care in order to work, attend school, or gain employment training."

The survey provided information on the prevalence of formal child care partnerships and use of them to provide Early Head Start center-based services, a topic discussed in greater detail in this chapter. We learned that more than 40 percent of programs have formal partnerships with child care providers, although not all programs use them for Early Head Start slots. We use site visit data to elaborate on these findings and to better understand how programs ensure quality child care in partner centers. The rest of the text box presents site visit data.

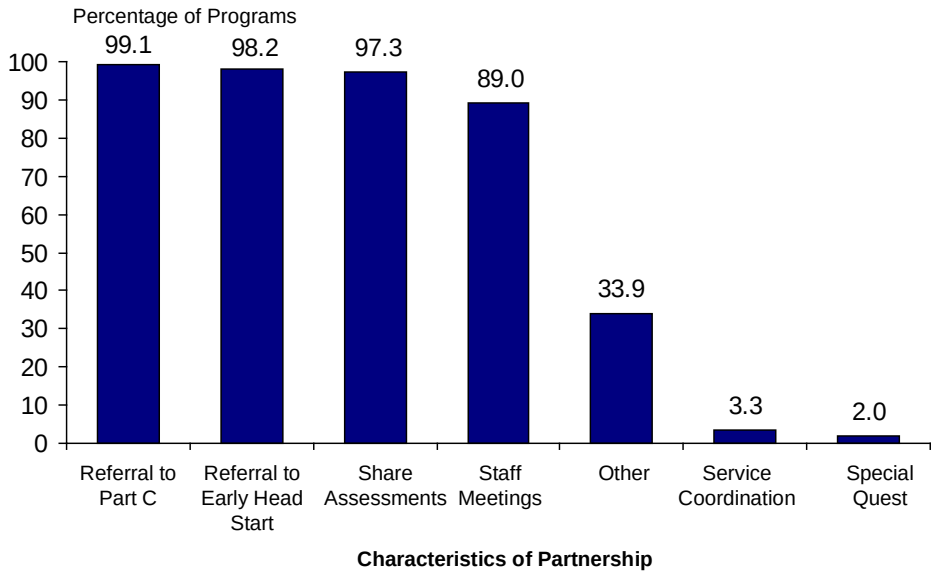
Programs that offer center-based care monitor quality closely, whether the care is offered directly by the program or by a partner. Programs use a variety of methods of quality assurance in child care centers, generally including regular classroom observation, provider training, and use of standardized assessments. A few programs we visited feel that Early Head Start has improved the quality of care available, even outside of the program, through its monitoring and technical assistance activities. Chapter V discusses child care quality assessments in greater detail based on survey findings.

Few programs make direct referrals to child care providers who are not formal community partners. Several programs have partnerships with local child care resource and referral agencies (CCR&Rs) and refer families there to access child care. Few of the visited programs track the use of child care not provided by Early Head Start or their community child care partners, although one program has begun to do so because the question appeared on the PIR last year. To determine whether a provider is meeting sufficient quality standards, this program requires regular staff training (that the program provides), holds annual health and safety screening, conducts classroom observations using the ITERS, and drops in for unannounced visits to observe informally. Staff members in many programs know about other child care arrangements that families use, even if the program does not formally track their use.

disabilities. Coordination with Part C agencies is one way to reach children with special needs. Using survey data primarily, we describe the prevalence and use of these partnerships.

Nearly all Early Head Start programs have a formal partnership with at least one Part C provider, reflecting the program's strong emphasis on early identification and treatment of developmental problems. Partnership agreements with Part C providers include three basic elements: referrals to and from each program, sharing assessment results, and holding staff meetings (89 to 99 percent for each). Although a third of programs report other features, these vary widely. Three percent of programs include service coordination in their partnerships, and two percent are SpecialQuest participants (Figure VI.2). SpecialQuest is a program developed by the Hilton Foundation as part of the Hilton/Early Head Start Training Program. These trainings are specifically designed to increase Early Head Start and Migrant and Seasonal Head Start capacity to provide excellent services to infants/toddlers with disabilities and their families.

Figure VI.2. Characteristics of Part C Partnerships, Among Early Head Start Programs with Formal Agreements



Source: Survey of Early Head Start Programs.

Sample Size = 407-569 programs.

Identifying and Referring Children with Disabilities

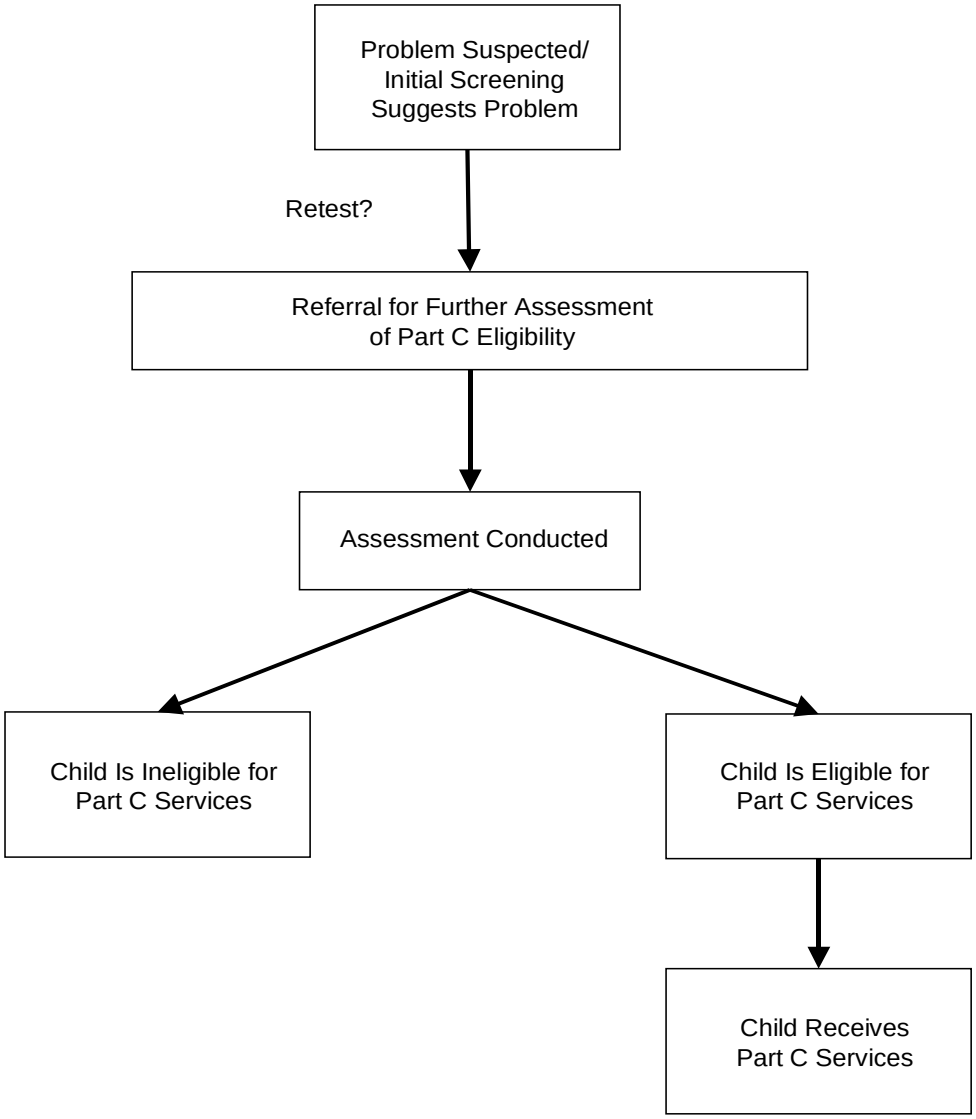
The process of identifying children with disabilities occurs in stages, with several steps required for children to receive services from early intervention partners. The steps involved are (1) suspect a disability and share this concern with the family, (2) refer for further assessment, (3) conduct the assessment, and (4) provide services to those eligible (Figure VI.3). We rely on survey data to describe these stages and report these data based upon average proportions of children within programs at each stage.[2]

The first step occurs when staff suspect, or an initial screening indicates, a problem. Programs are mandated to conduct an initial developmental screening within 45 days of enrollment. The average proportion of children about whom staff have a concern warranting further evaluation and referral is 21 percent. (Not all children referred may have

[2] For each program, we calculated the relevant proportion within each program (*i*) and then calculated the mean across them. For example, the average proportion of Early Head Start children with suspected disabilities is

$$\frac{\sum_{i=1}^{n}\left[\frac{\textit{Children referred for evaluation in program}_i}{\textit{All children in program}_i}\right]}{\textit{N programs}}$$

Figure VI.3. Identification of and Treatment for Children with Disabilities

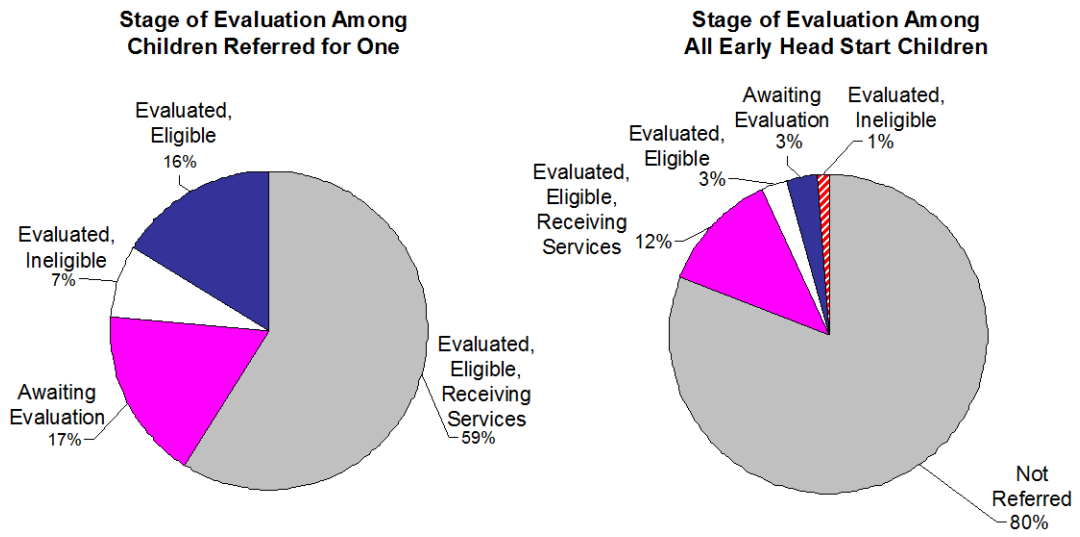


a problem serious enough to warrant special services or meet the eligibility requirements for Part C.)

Among all enrolled children, about four percent have not yet been referred for further evaluation, although programs had concerns about them. When a problem is suspected, programs may choose to wait and reassess the child before referring the child to Part C, in case the child was having an "off day." We note that the average may be misleading, as nearly half (45 percent) of the programs report there are no children they suspect have a problem but have not yet referred. Among programs that report at least one child awaiting referral, the range is between 1 and 43 children, although most report no more than 5.

When a suspected problem reaches a given threshold of severity (this may differ across programs), the child will be referred to a partner for further evaluation. On average, across programs, 17 percent of children who have been referred for evaluation are still awaiting it (Figure VI.4). We are particularly interested in this group, because the percentage indicates that children who may need services are not receiving them (Box VI.3).

Figure VI.4. Stage of Evaluation and Treatment of Disabilities Among Early Head Start Children



Source: Survey of Early Head Start Programs.

Note: The chart on the right includes the total children served by programs with non-missing data on the relevant questions.

Sample Size = 8,375 children for the pie chart on the left and 41,333 children for the pie chart on the right.

BOX VI.3

POSSIBLE IMPEDIMENTS TO EVALUATING REFERRED CHILDREN

During site visits, we explored some possible reasons that children may be "stuck" after being referred for evaluation, but not yet having been evaluated. The two primary explanations are (1) parent reluctance to follow through with the evaluations and (2) lack of resources. Most commonly, reluctance is based on concerns about labeling the child as having special needs or denial that the child has any problems. These attitudes may be reinforced at times by physicians who are willing to wait and see whether children outgrow the problem. Cultural barriers may also be behind parental reluctance to seek treatment for their children. Resource issues include lack of adequate transportation for parents to take children to appointments, long delays before Part C staff conduct evaluations (providers have 45 days to complete their assessment), and low availability of specialized services (such as speech/language) or the home-based therapies that parents prefer.

Children who are ineligible do not have disabilities severe enough to receive Part C services. On average, few children (7 percent) who are evaluated are found to be ineligible for Part C services, indicating that program staff rarely make inappropriate referrals. Eligibility requirements vary by state, so a child may meet the threshold for services in one state and not in another.

Two-thirds of the children evaluated by Part C and found eligible receive the services they need from Part C partners. However, a few (16 percent, on average), although eligible, are not receiving services. This gap may be a result of limited access to certain services or delays in accessing services.

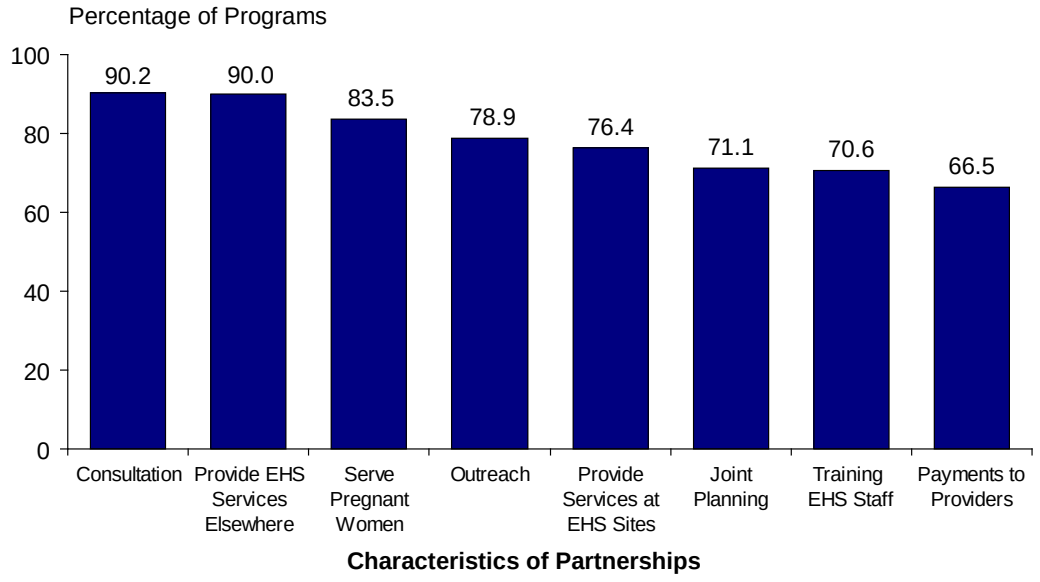
Children referred for emotional/behavioral or communication concerns were least likely to be receiving services. We asked programs to report the stage of evaluation for each child by his or her primary concern (emotional/behavioral, communication, developmental delay, sensory impairment, physical/orthopedic impairment, or other impairments). On average across programs, about 75 percent of children referred for concerns other than emotional/behavioral or communication had been evaluated, were found eligible, and were receiving services. In comparison, only 47 percent of children referred for emotional/ behavioral and 62 percent referred for communication disorders were receiving Part C services. Children referred for emotional/behavioral disorders were most likely to be awaiting evaluation—on average, 30 percent referred for evaluation had not yet been evaluated, more than twice as high as the proportions of children referred for other disorders (ranging from 10 to 14 percent of referred children across programs). Fear of social stigma may be a factor in keeping these children from formal evaluation and/or Part C programs may have fewer assessments or less expertise in diagnosing problems in these areas at such young ages. Children referred for communication disorders were slightly more likely to be awaiting evaluation (19 percent, on average).

PARTNERSHIPS WITH HEALTH PROVIDERS

An important aspect of the comprehensive services mandated by the performance standards, as well as the performance measures, is to ensure appropriate linkages between families and community health services. In the health care field, this is generally referred to as ensuring that children have a "medical home." To prevent families from having treatment only for acute care or emergencies, Early Head Start strives to link them with health care providers for well-baby checkups, immunizations, and routine care. Programs also try to help families see the value of seeking routine preventive care even when their child is well.

Just over three-quarters of programs have partnerships with health care providers; the provisions of these agreements do not vary greatly across programs. Most include consultation and services for pregnant women; services are more likely to be provided off-site than at the Early Head Start program. Two-thirds include provisions to pay providers for health care services (Figure VI.5).

Figure VI.5. Characteristics of Health Care Partnerships, Among Early Head Start Programs with Formal Agreements



Source: Survey of Early Head Start Programs.

Sample Size = 445-525 programs.

PARTNERSHIPS WITH MENTAL HEALTH CARE PROVIDERS

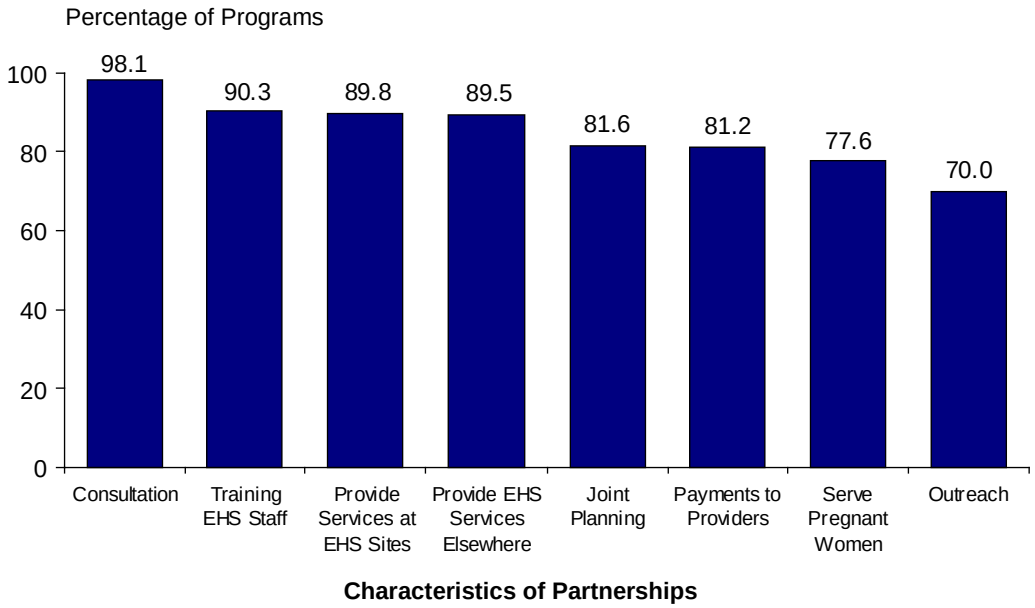
Because of the high rate of mental health and substance use issues in populations served by Early Head Start (ACYF 2002; Knitzer and Yoshikawa 1997), identifying mental health

needs and accessing treatment for children or their families is another area in which partnerships are key. Apart from parents and adult family members who may struggle with chronic mental health issues, infant mental health is also an important component of Early Head Start services. Infants and toddlers experience the gamut of emotions, and healthy development requires them to gradually take on more of the responsibility to regulate their interactions, attention, and behavior. To support positive emotional and social development, adults must understand their role in facilitating children's capacity to regulate their emotions, explore their environments, and communicate with adults (Zero To Three 2001).

Among programs with formal mental health partnerships, nearly all agreements include consultation (98 percent, Figure VI.6). Other common features of these partnerships are providing training for Early Head Start staff and providing services at Early Head Start programs or elsewhere (all 90 percent).

More than 80 percent of programs have formal partnerships with mental health providers. Nearly all (92 percent; Figure VI.7) programs screen for mental health problems, and 98 percent provide referrals. Services may be provided at the program site, either

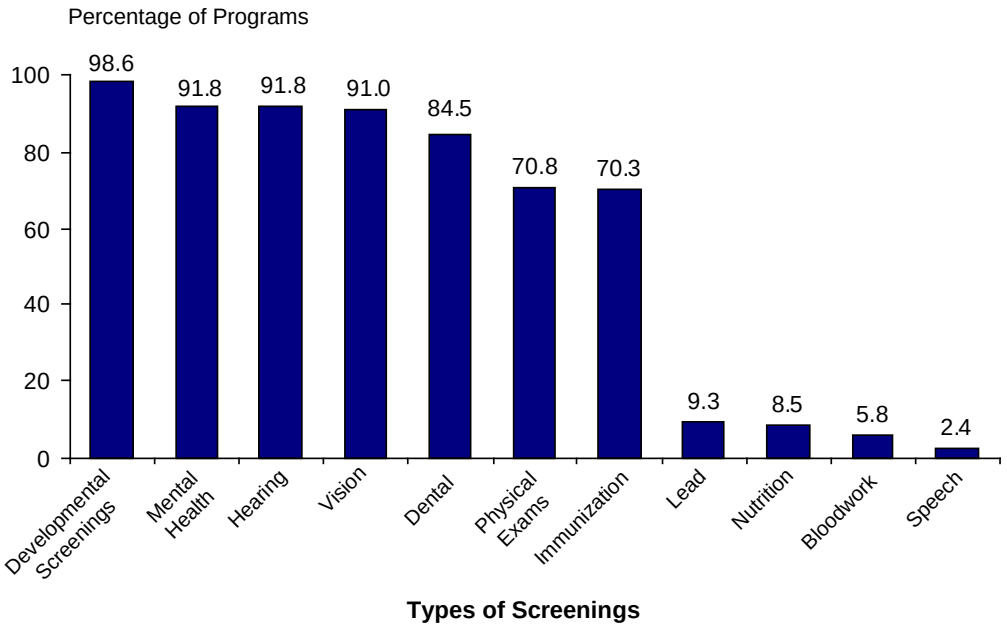
Figure VI.6. Characteristics of Mental Health Partnerships, Among Early Head Start Programs with Formal Agreements



Source: Survey of Early Head Start Programs.

Sample Size = 445-525 programs.

Figure VI.7. Percentage of Programs Offering Each Type of Screening



Source: Survey of Early Head Start Programs.

Sample Size = 572-597 programs.

through partners or their own staff members, or elsewhere, such as at the provider's office. Programs reported the proportion of enrolled families that receive mental health services at the program, referrals, or both places. The overlap among programs is high, but 70 percent of programs report that at least some families received services only at the Early Head Start program. Eighty-one percent report that at least some families receive services only through referrals, and 79 percent of programs report at least some families receive service both at the program and through referrals (not shown).

OTHER SCREENING AND REFERRAL SERVICES

Early Head Start programs play a key role in identifying health and mental health needs of families and getting them needed services. Programs can conduct screenings themselves or use consultants or community partners. Almost all programs (99 percent) report conducting developmental screenings—as expected due to performance standards requirements for ongoing assessment (see Chapter V). Most programs offer mental health, hearing, and vision screenings (all more than 90 percent), while dental screenings are offered by 85 percent of programs. Physical examinations and immunizations are offered by 70 percent of programs. Although not specifically asked, programs wrote in about other

screenings they offer. About 15 percent of programs report providing lead, 9 percent nutrition, and 2 percent speech screenings (Figure VI.6).

When looking to fulfill the needs of families, programs can provide services themselves within the program using Early Head Start staff, by forging connections with community partners to provide services either on- or off-site, or by referring children and families to other community agencies with whom they do not have formal partnership agreements. We asked about the types of services for which programs provide referrals and found that most programs provide referrals for myriad services. Most infrequent service referrals are for English language learners (81 percent), transportation assistance (84 percent) and child care (87 percent; Table V.1). About 90 percent or more of programs report referring families for other services such as emergency assistance, disability services, or employment assistance. Although we cannot tell which specific services are provided by programs or through their partners, partnerships are most common for health, mental health, and disability providers, for each, more than 80 percent of programs have formal partnerships with some or all such providers. Least common are partnerships with legal, financial counseling or transportation providers (Table VI.1).

Table VI.1. Early Head Start Service Referrals

Type of Referral	Percentage of Programs	Partnerships with Some or All Providers[a]
Child Care	87.3	54.5
Health Care	99.0	78.2
Prenatal Care	95.6	66.2
Mental Health Care	98.1	83.7
Transportation Assistance	84.3	38.8
Disability Services	98.8	93.6
Employment Assistance	96.8	55.2
Emergency Assistance	98.3	46.2
Education or Job Training	97.5	58.5
Drug or Alcohol Abuse	93.9	46.1
Legal Assistance	90.4	29.2
Housing Assistance	98.2	46.2
Financial Counseling	88.5	37.3
Family Literacy	94.4	62.0
English Language Learner	80.6	52.1
Other	16.9	--
Sample Size (Programs)	**562–598**	**440–576**

Source: Survey of Early Head Start Programs.

[a]Among programs that make such referrals.

KEY POINTS

- Ninety-five percent of programs participate in a local collaborative of service providers; of those, 75 percent hold leadership positions.

- Ninety-two percent of programs have at least one formal partnership with a community provider, and about one-third have a partnership with a child care, health, and mental health provider.

- More than 40 percent of programs report having formal child care partnership agreements in place, and 30 percent of programs report serving children through them.

- Among programs with child care partnerships, more than 90 percent have agreements to coordinate services, exchange referrals, and share staff training. Nearly as many of the partnership agreements include provisions for technical assistance.

- Nearly all programs have a formal partnership with a Part C provider, an important avenue for early intervention. Only 4 percent of all Early Head Start children have a suspected disability but have not yet been referred for further evaluation.

- About 60 percent of children evaluated for services are receiving them. Only 6 percent of those referred are found ineligible for Part C services. Seventeen percent of children who have been referred for evaluation were still awaiting evaluation at the time of the survey. Among referred children 16 percent had been evaluated and found eligible for Part C services, but were not receiving them at the time of the survey. Children referred for emotional/behavioral or communication disorders were least likely to be receiving services and more likely to be awaiting evaluation.

- About three-quarters of programs have partnerships with health care providers and more than 80 percent have partnerships with mental health providers. Many programs provide services at their facility and through referrals.

- Relatively few programs offer screenings for speech, blood work, nutrition, or lead. About 70 percent of programs offer physical examinations or immunization screenings. Eighty-five percent offer dental examinations.

- Nearly all programs offer developmental, mental health, hearing and vision screenings.

- Ninety percent or more of programs refer for myriad services such as emergency assistance, disability services, or employment assistance. Fewer, but still substantial proportions, refer for transportation assistance and child care.

- Among programs providing referrals the proportion reporting formal partnerships with some or all providers is much more variable. Most common are health, mental health and disability partnerships; least common are legal, financial, or transportation provider partnerships.

CHAPTER VII

EARLY HEAD START SUBGROUP FINDINGS

Thus far, we have examined survey data for what they can tell us about the total population of Early Head Start programs. Yet programs differ from one another. For example, a subgroup of programs operating in urban areas may be very different from those providing services in rural areas. In this chapter, we examine how subgroups differ on key characteristics, as comparing subgroups may suggest areas for planning and future research. For example, if subgroups have meaningfully different profiles, providers of training and technical assistance might plan and target support according to the varying needs that must be met. A logical next step would be to conduct research aimed specifically at understanding potential linkages between characteristics and child outcomes. This chapter describes our analytic approach to subgroup analysis, as well as differences across subgroups in their community, program, and family characteristics.

ANALYTIC APPROACH

Using survey data, we categorized programs into mutually exclusive subgroups for comparison. We then compiled variables spanning community, program, and family characteristics of interest and examined them by subgroup. This section describes the subgroups we defined and how we analyzed the data.

We generated 14 subgroups that fall into three broad categories: (1) community (service area, diversity, and change in diversity), (2) program (size, approach, Head Start affiliation, serving pregnant women, and primary caregiver education), and (3) family characteristics (demographic and psychological risks, racial/ethnic and language diversity, teenage mothers, and developmental concerns). See Table VII.1.

Determining Subgroup Differences

First, we must calculate and compare differences, and decide what size difference is large enough to be meaningful. In a study with an experimental design, or a descriptive study in which only a sample of programs are included, we would use inferential statistics to

Table VII.1. Early Head Start Program Subgroups

Category	Subgroups
Community Characteristics	
Service Area	Urban (N = 290; 45.2 percent) Suburban (N = 61; 9.5 percent) Rural (N = 269; 42.0 percent)
Community Diversity	High: Rated by Survey Respondents (N = 123; 18.9 percent) Lower: Rated by Survey Respondents (N = 527; 81.1 percent)
Change in Diversity (Past Five Years)	Increasing: Rated by Survey Respondents (N = 273; 42.3 percent) Stable/Decreasing: Rated by Survey Respondents (N = 372; 57.7 percent)
Program Characteristics	
Program Size	Small: Fewer than 50 Families (N = 209; 31.7 percent) Medium: 51 to 100 Families (N = 271; 41.1 percent) Large: 101 to 150 Families (N = 108; 16.4 percent) Very Large: More than 150 Families (N = 72; 10.9 percent)
Program Approach	Home-Based (N = 114; 17.3 percent) Center-Based (N = 152; 23.0 percent) Multiple (N = 334; 50.6 percent) Combination (N = 56; 8.5 percent)
Preschool Head Start Affiliation	Head Start: (N = 532; 81.6 percent) No Head Start: (N = 120; 18.4 percent)
Pregnant Women	Serve Pregnant Women (N = 551; 84.5 percent) Do Not Serve Pregnant Women (N = 101; 15.5 percent)
Primary Caregiver Education	High Education: 50 Percent or More Primary Caregivers Have BA or More (N = 83; 17.6 percent) Lower Education: Less than 50 Percent Primary Caregivers Have BA (N = 388; 82.4 percent)
Family Characteristics	
Demographic Risk	High: More than 25 Percent Enrollment with 3 or More Risks (N = 335; 52.8 percent) Lower: 25 Percent or Less Enrollment with 3 or More Risks (N = 299; 47.2 percent)
Psychological Risk	High: More than 25 Percent Enrollment with 2 or More Risks (N = 207; 32.6 percent) Lower: 25 Percent or Less Enrollment with 2 or More Risks (N = 429; 67.5 percent)
Enrollee Diversity	High: 50 Percent or More Racial/Ethnic Minorities (N = 439; 68.0 percent) Lower: Less than 50 Percent Racial/Ethnic Minorities (N = 207; 32.0 percent)

Table VII.1 *(continued)*

Category	Subgroups
Language Diversity	High: 25 Percent or More Non-English Speakers (N = 199; 43.0 percent) Lower: Less than 25 Percent Non-English Speakers (N = 264; 57.0 percent)
Teenage Mothers	High: 10 Percent or More of Enrollment (N = 314; 48.5 percent) Lower: Less than 10 Percent of Enrollment (N = 334; 51.5 percent)
Developmental Concerns	High: 20 Percent or More of Enrollment (N = 276; 45.3 percent) Lower: Less than 20 Percent of Enrollment (N = 334; 54.8 percent)

determine the significance of differences, based on the probability of achieving a difference of a given size by chance alone. Because this study covered the universe of Early Head Start programs, differences between subgroups of programs are real differences, rather than estimates, and no test of statistical significance is needed. To standardize differences between subgroups, we calculated effect size units to compare subgroups on key characteristics.

An effect size is a statistic that presents differences between means as a standard unit—a fraction of a standard deviation. Effect sizes are calculated as the difference between means divided by the population standard deviation for a given characteristic. In subgroups with only two levels, the effect size is the difference in their means, expressed as a fraction of a standard deviation. For subgroups with more than two levels, we present the *maximum* effect size.[1] However, because large differences in subgroup means can fall between the highest and lowest values, we provide a reference table that shows the point differences needed to reach effect sizes of different magnitudes (Table VII.2).

We created tables listing key community, program, and enrollee characteristics, by program subgroups. The tables present means within subgroups on a given characteristic, differences between means, and effect sizes. Because the tables are long, they are placed at the end of the chapter for the reader's convenience. Table VII.3 presents a summary of differences by key program subgroups. The complete set of tables follows. In the text, we discuss differences in the relative prevalence of characteristics across subgroups, but again, for ease of reading, we do not report means, differences, or effect sizes in the text. Because effect sizes are descriptive statistics without probabilities (p-values) associated with them, we need a guideline for deciding what size differences are practically meaningful. Therefore, for this exploratory work we highlighted differences in the text with an effect size of 0.2 or higher. We note differences of at least 0.1 if they are part of a larger pattern of differences.

[1] We calculated effect sizes in multilevel subgroups by subtracting the smallest mean from the largest across subgroup levels and dividing by the population standard deviation of each characteristic.

Although such an analysis has benefits, it also has some limitations. Many subgroups we defined are highly intercorrelated, and some subgroups and individual characteristics have small sample sizes. In addition, all the analyses presented in this chapter are descriptive; large effect sizes indicate a relationship among variables, but they do not imply causality or the direction of the relationship.

COMMUNITY CONTEXT SUBGROUPS

As detailed in Chapter III, Early Head Start programs function within the context of their communities. Therefore, we expect that community context is related to other program features, such as program auspices, program size, employee education, and population served. In the sections that follow, we describe findings for subgroups according to community characteristics defined by service area, diversity of the community, and recent change in diversity.

Service Area (Table VII.4)

In Chapter III we divided the areas programs serve into three broad categories: urban, rural, and suburban. Programs are about evenly distributed across urban (45 percent) and rural (42 percent) areas. About 10 percent of programs are located in suburban areas, and the rest are in mixed areas. Because cultural populations in the United States vary across urban, rural, and suburban areas, it is perhaps not surprising that programs in each type of service area also differ in their degree of cultural diversity. Although suburban programs make up only a small proportion of all Early Head Start programs, they are the most diverse and are increasing in diversity relative to rural programs. Urban programs are also much more culturally diverse than rural programs and have increased in diversity in recent years.

Urban and suburban programs are more likely than rural ones to operate under the auspices of a community agency. Rural programs are the most likely to have tribal government auspices. Both urban and rural programs are more likely than those in suburban areas to be housed in university settings.

In terms of enrollment, there are fewer differences than might be expected between urban and rural programs. The main differences are between suburban and rural programs, with suburban more likely to be of medium size (enrollment of 51 to 100 children and pregnant women) and rural the most likely to be small.

Suburban programs seem to have greater community resources. They are the most likely to receive a variety of forms of outside funding. In some cases, suburban programs also differ from urban programs (such as in fundraising), but for the most part, the trend is for suburban programs to be the most likely to have various types of funding, followed by urban, and then rural (although urban-rural differences are small). An exception is that rural programs are more likely than the others to receive Part C (early intervention) funds. This could be because rural areas have fewer service providers, so agencies operating Early Head Start programs provide a wider variety of services.

Overall, most programs follow a multiple approach, with only somewhat higher prevalence of this approach for suburban programs. Rural programs are the most likely to follow a home-based model and urban programs a center-based one. This choice of model may be related in part to families' access to transportation and their geographic distance from the program. In rural areas, families may not be able to take children to an Early Head Start center far from home, especially if public transportation is not available. In contrast, urban programs may be located closer to where families live and may be more accessible by public transportation. Suburban programs are more likely than rural ones to have access to different types of specialists. Specifically, they are likely to have specialists in male involvement, disability, health care, nutrition, mental health, and literacy. Urban programs follow closely behind suburban ones in their access to specialists; again, the trend is for suburban programs to have the highest probability, followed by urban and then rural ones.

Staff education differs by service area, although only for home visitors. Suburban programs have a greater probability than urban and rural programs of employing home visitors with an AA or higher. Rural programs are least likely to have staff with this level of education, although they are more likely to have a home-based program model in which these staff would be employed. Despite having overall better-educated staff, programs in suburban areas have higher rates than urban and rural programs of staff turnover for home visitors. Urban programs have the lowest rates of caregiver turnover compared to other program types.

There are few differences in partnerships by service area, except that rural programs are the most likely to have Part C and health care partnerships. This is consistent with the finding that rural programs are the most likely to receive Part C funding, and may indicate the importance of linking rural families to services.

Enrollee characteristics differ in expected ways by service area. Rural areas have lower minority enrollment than urban and suburban programs. Similarly, rural programs are far less likely than the other two groups to serve families whose primary language is other than English. Enrollee risks tend to be more elevated in urban programs than in rural ones. In general, urban and suburban programs serve families with more demographic risks than do rural programs. Most large differences between urban and rural programs are among single parents, mothers who receive welfare, and teen mothers, all of whom are more prevalent in urban programs. Suburban programs have a higher prevalence than rural ones of families lacking a high school credential and having multiple demographic risks. Psychological risk factors are concentrated in urban programs, which have the highest prevalence of unsafe neighborhoods and multiple risk factors. The exception is that substance abuse is far more common in rural programs (although the overall number of any programs serving *many* families with substance abuse issues is small).

Community Diversity (Tables VII.5 and VII.6)

We measured community diversity based on survey respondents' ratings of the diversity of their service areas, and change over the past five years. Eighty percent of programs rate their community diversity as moderate or low; 20 percent rate it as high. However,

42 percent of programs report diversity has increased in the past five years; 56 percent report no change.

There are few differences between programs that operate in areas rated high in cultural diversity, or as increasing in diversity, except in expected ways. For example, programs with high or increasing community diversity are more likely to be in urban or suburban areas and to have higher prevalence of some risks associated with urban settings, such as many families receiving welfare and living in unsafe neighborhoods. As would be expected, these programs serve high proportions of racial/ethnic and language minority groups. Programs with high community diversity also have more management turnover than programs in communities that are less diverse.

PROGRAM CHARACTERISTICS

In this section, we describe subgroups based on program characteristics, including size, affiliation with a Head Start program, serving pregnant women, staff education, and approach to service delivery.

Program Size (Table VII.7)

We characterized programs by the size of their enrollment of children and pregnant women, creating four groups of small (32 percent), medium (41 percent), large (16 percent), and very large (11 percent) programs. In terms of community characteristics, very large programs are most likely to be in urban areas, and small programs are most likely to be in rural ones. Suburban programs fall between these extremes and are most likely to be of medium size. Similarly, larger programs tend to be in areas of at least moderate and increasing community diversity. Small programs tend to be in low-diversity areas that have not changed in recent years.

Program characteristics vary by size in that larger programs are most likely to operate out of community agencies and universities and least likely out of schools. Small programs are the most likely to have tribal government auspices. School auspices are most prevalent in small and medium-sized programs. Larger programs tend to operate in multiple sites, whereas small programs in a single site, as would be expected. Very large programs are most likely to be affiliated with a preschool Head Start. The picture is mixed when we look at types of funding programs receive; however, large and very large programs tend to be more likely than small and medium-sized programs to receive almost every type of funding. Large and very large programs are also the most likely to have a management information system (MIS).

In terms of program approach, small and medium-sized programs are most likely to have a home-based approach. Both the small and the very largest programs are most likely to be center-based. Although combination models are relatively rare, small programs are more likely to use a combination approach and least likely to use a multiple option. Small programs are most likely to choose a single program approach (center, home, or combination), while larger programs, with more staff and perhaps greater diversity of family

needs, are more likely to choose more than one option (multiple approach). Larger programs tend to have greater access to specialists than medium-sized or small programs. There are especially large differences between larger and smaller programs in having male involvement specialists, nurses, and dietitians; again, these differences are to be expected given the greater resources of larger programs overall. Large programs are likely to be more complex than smaller ones, perhaps because of economies of scale that make specialists affordable. Small and medium-sized programs have the highest levels of staff education for primary caregivers and home visitors, as well as the highest rates of employee turnover (although with smaller numbers of staff, having just a few employees leave could result in a large rate of turnover). Small programs are least likely to have had turnover of the director in the previous year. Very large programs have the greatest likelihood of formal partnership with each type of provider—Part C, child care, mental and health care providers—relative to all other groups. However, the smallest programs have the highest average number of Head Start program partnerships for transitions—more than twice as many as very large programs.

Very large programs have the highest concentration of racial/ethnic minorities and people who speak languages other than English. This association may be related to the somewhat higher prevalence of very large programs in urban areas, which also have more minority residents. There is a mixed pattern of specific risks; in general, however, these are most prevalent in larger programs. Among demographic risks, large programs have the most prevalence of low enrollee education, and very large programs encounter the highest unemployment. Although the profile of individual demographic risk factors varies by program size, the difference in percentage of enrolled population at the highest risk levels (more than risk factors) does not differ by program size. All psychological risk factors, including unsafe neighborhoods, family violence, and substance use, are most prevalent in very large programs, except for mental health problems, which are most prevalent in large programs. Similarly, very large programs, on average, have the highest percentage of families with more than two psychological risk factors.

Program Service Approach (Table VII.8)

Chapter IV describes the way we characterize program models (center-based, home-based, multiple, and combination), based on services provided, with the multiple approach most prevalent. As noted earlier, center-based programs are most likely to be in urban areas; conversely, home-based programs are most likely to be in rural ones. Multiple and combination approach programs are evenly distributed across service areas. Home-based programs are most likely to be in areas of low diversity and least likely to be in those of moderate cultural diversity.

In terms of program characteristics, combination programs are the most likely to be in community agencies, and multiple programs least likely—note, however, that there are not many combination programs. Although few programs overall do so, center-based programs are most likely to have government agency auspices and multiple programs to have school auspices. Home-based programs are by far the most likely to operate in a single site, while combination programs are most likely to have multiple sites, followed closely by center-based and multiple programs. As we describe under the program size subgroups, small

programs are the most likely to be combination models and the least likely to be multiple. Multiple programs are the most likely to be large or very large. Combination programs are also the most likely to operate a Head Start program; home-based are the least likely.

In general, home-based programs have lower receipt of outside funding (perhaps related to their overall smaller size). Center-based programs are the most likely to have state child care subsidies, fee-for-service, and funds from individual fundraising contributions. Programs with center-based services may use these additional funding sources to supplement Early Head Start funds to cover the cost of full-day center-based child care. Combination programs are the most likely to have other, rarer, funding sources, including contracts, grants from businesses, and other sources.

Multiple approach and center-based programs are most likely to have an MIS, in part perhaps because they also tend to be larger. Center-based programs are most likely to use these systems for producing reports on services or on individual progress.

Combination programs have access to the most specialists, including mental health, disability, literacy, speech, and health care specialists. Multiple programs have the most likelihood of a male involvement specialist, and they follow closely behind combination programs in access to mental health, disability, and health care specialists relative to home- or center-based programs. Home-based programs are least likely to have access to specialists. Combination programs and those offering a wider range of service options may need more specialists to implement these services.

Multiple approach programs have the highest likelihood of only having primary caregivers and home visitors with an AA. However, staff education among other program models is difficult to interpret, because a few programs that offered only home services also reported on education and turnover of primary caregivers; similarly, a few programs offering only center-based services reported on home visitors. Therefore, home visitor education is highest in center-based programs and primary caregiver highest in home-based programs. Home-based programs have highest rates of turnover among home visitors, although this is also a function of program approach. Multiple programs have the highest levels of management turnover and combination programs the lowest.

Center- and home-based programs are most likely to have formal partnerships with child care partners, depending on which definition of program model we use (direct services only or direct and partner-provided services). Center-based programs are most likely to have partnerships with health and mental health providers. All program models have a high likelihood of having formal Part C partnerships. Otherwise, home-based programs have the least likelihood of formal partnerships with health or mental health agencies.

Among enrollee characteristics, center-based programs have the highest prevalence of minority enrollment and home-based the lowest. This is consistent with the tendency of center-based programs to be in areas with high and increasing diversity. Combination programs are the most likely to serve families that speak a language other than English. Enrollee turnover is highest among home-based programs and lowest among center-based

ones. Combination programs are more likely than the other models to have children enter the program at older ages (2 to 3 years).

Patterns of enrollee risk vary in expected ways by program approach, particularly when keeping in mind the needs these risk factors represent. For demographic risks, home-based programs are the most likely to serve families receiving welfare and those with an unemployed primary caregiver and the least likely to serve teens. Center-based programs tend to have more single and employed parents, who likely need child care. Combination programs tend to serve families without high school credentials and teen mothers. Multiple programs have the highest levels of multiple demographic risks. They also have the highest levels of many individual psychological risk factors as well as multiple psychological risks among program approaches. Multiple approach programs have higher prevalence of unsafe neighborhoods, family violence, and multiple psychological risks than the other models. Mental health problems have highest prevalence in combination and home-based programs.

Operates Preschool Head Start (Table VII.9)

Most Early Head Start programs also have an affiliation with a preschool Head Start program (82 percent). Programs that are part of agencies that also operate a preschool Head Start do not differ in community characteristics from programs that do not have such an affiliation. They are just as likely to be in urban or rural areas and areas of higher or lower diversity. Programs with a preschool Head Start are much more likely than programs without one to operate under community agency auspices. Conversely, programs without a Head Start affiliation are more likely than those with one to operate under the auspices of a university. Programs with a Head Start affiliation are more likely to have multiple sites and to have an MIS. However, they are less likely to receive some types of outside funding. In their service approaches, programs with a preschool Head Start are less likely to be home-based, but, differences are small.

In general, Head Start affiliated programs have access to more specialists overall. They particularly tend to have mental health, literacy, and speech/language specialists more so than other programs. Programs with a Head Start affiliation have lower staff turnover (both management and primary caregivers) and a higher likelihood of community partnerships with health and mental health providers. Not surprisingly, they have formal agreements with more preschool Head Start programs than do programs without such an affiliation. There are few differences in enrollment characteristics, although enrollment turnover is lower in affiliated programs. Head Start-affiliated programs serve fewer families with psychological and demographic risks, especially family violence than other programs. However, they serve more families with substance abuse issues than do those without Head Start affiliation.

Serving Pregnant Women (Table VII.10)

As we describe in Chapter III, 84 percent of programs serve pregnant women. Here we find that programs serving pregnant women do not differ in community characteristics from programs that do not serve them, although programs report increasing diversity in recent years. There are a few differences among program characteristics in that programs that serve

pregnant women tend to be large or very large, but they are less likely than programs that do not serve pregnant women to have an affiliation with a preschool Head Start. Perhaps because programs serve pregnant women in their homes, they are more likely to use a home-based or a multiple approach. Programs that do not serve pregnant women are more likely than programs that do to use a center-based or combination model. Programs that serve pregnant women have greater access to all specialists, but in particular to specialists in male involvement, disability specialists, and nurses. Programs that serve pregnant women have higher primary caregiver education, but lower home visitor education than other programs. They are most likely however, to employ only primary caregivers and home visitors with at least an AA. They are also more likely to serve families that speak languages other than English. Finally, families in programs that serve pregnant women are twice as likely to have high numbers of demographic and psychological risks.

Caregiver Education (Table VII.11)

The performance standards require that at least half of primary caregivers hold an AA. Here we applied a higher standard to measure very high staff education—programs in which at least half their primary caregivers hold a BA (a relatively small group of 83 programs). We find that "high staff education" programs do not differ in community characteristics from programs with lower levels of staff education. In terms of program characteristics, high staff education programs are more likely to have a single site, be affiliated with a university, and be smaller than programs with lower staff education. Programs high in staff education are less likely to have an MIS, and less likely to use it for information on services when they do have one. These programs also tend to pursue a multiple approach and are less likely to use center-based or combination approaches. Obviously, these programs have higher overall staff education in the various ways we define it. They tend to have lower management and frontline staff turnover than programs with lower staff education. All high staff education programs have Part C partnerships, but they are less likely than programs with lower levels of staff education to have formal partnerships with health or mental health care providers. Minority enrollment tends to be lower in programs with higher staff education. Demographic risk factors are multiple, with single parents lower in prevalence among high staff education programs but higher in welfare receipt and unemployment. There are no differences in terms of psychological risk factors.

FAMILY CHARACTERISTICS

As we have stressed throughout this report, programs must, as a first step to being effective, adapt their services to meet family needs. Clearly, family characteristics are highly correlated with community characteristics. Although these analyses do not allow conclusions about the direction of influence among these factors, it is logical to think of programs as operating in and reacting to the context of families and the communities they serve. Head Start programs target those most in need and serve many families with numerous risk factors. Next we describe programs with high concentrations of families with two different types of multiple risk factors (demographic and psychological), then programs with many teenage mothers, and then those that serve many children with suspected or

diagnosed developmental concerns. Finally, we describe programs with high concentrations of minority families.

Demographic and Psychological Risks (Tables VII.12 and VII.13)

Programs rated their enrollment population on the proportions they serve with each of five demographic risks: (1) single parents, (2) receiving welfare, (3) primary caregivers without a high school credential, (4) primary caregivers unemployed/not in school, and (5) teenage mothers. Programs in the high-risk group are those that serve a majority of enrollees with three or more of these risks. We refer to these programs as "serving high-risk enrollees" and to the rest as "serving lower-risk enrollees." Programs serving enrollees with high demographic risks do not differ in community characteristics except that they are in areas of increasing diversity and are less likely to be in rural settings. They are more likely to be associated with school systems and universities and less likely to be in community agencies. Programs with high-risk enrollees have greater access to several types of specialists, including male involvement, disability, literacy speech/language, and health care specialists. They are less likely to have an MIS or to use it for reports on service or individual progress.

Programs serving high demographic risk families are more likely to pursue a multiple approach, and least likely to have only center-based services. They are more likely to have had turnover of management-level staff in the previous year. In terms of family characteristics, on average, they have a higher percentage of minority families, and, not surprisingly, they tend to have higher levels of each individual demographic, as well as psychological, risks (described below).

The profile of programs serving many enrollees with high levels of psychological risks is similar to that of programs serving high levels of families with demographic risks. As in our approach to demographic risks, we classified programs as serving enrollees at high psychological risk if at least half their enrollment had two of the following: (1) unsafe neighborhood, (2) family violence, (3) mental health problems, and (4) substance abuse. Programs serving enrollees with high psychological risk differ in a few ways from those serving lower-risk families. They are more likely to be in urban settings (although diversity does not differ). Program characteristics include lower likelihood of community agency auspices and higher of school auspices, between high- and lower-risk programs, respectively. Programs with high-risk enrollees are much more likely than those with lower-risk enrollees to have very large enrollments (and less likely to be small). They are more likely to pursue a multiple service approach, and less so to have a single service option (home- or center-based). Programs with high risk enrollees are less likely to be affiliated with a preschool Head Start. They have higher primary caregiver education, although not home visitor and they tend to have mental health specialists but are less likely to have speech/language specialists. Enrollee characteristics differ in expected ways, with programs serving high-risk enrollees having higher minority enrollment, as well much higher prevalence of all types of demographic and individual psychological risks.

Teenage Mothers (Table VII.14)

Teen mothers are not present in high concentrations across program enrollment; in about half of programs, they make up at least 10 percent of enrollment; in the other half, the figure is less than 10 percent. Programs with a higher prevalence of teen mothers differ very little from programs with a lower one. There are no community-level differences. Programs with many teenage mothers receive more government grants and Part C funding, but there are few other programmatic differences. They are less likely to be home-based, and tend to have somewhat lower staff education. As would be expected, programs with many teenage mothers also have higher levels of certain risks, including single parents and parents without a high school credential. They also have higher levels of family violence and mental health problems.

Developmental Concerns (Table VII.15)

As we describe in Chapter III, programs must set aside 10 percent of their enrollment slots for children with disabilities. Here, we examine programs that report 20 percent or more of their enrollment as having disabilities (38 percent) relative to programs with a lower prevalence. We find very few differences in programs that enroll a substantial proportion of children with developmental concerns relative to programs with lower such enrollment. Among programs with high levels of developmental concerns, we find that although they are equally likely to have a formal Part C partnership, they are somewhat more likely to have staff meetings as a part of that agreement. Staff have higher levels of education both among primary caregivers and home visitors. Enrollee characteristics of programs with high levels of children with disabilities include lower prevalence of blacks and minorities; enrollment turnover is also higher in these programs.

Program Diversity (Tables VII.16 and VII.17)

We considered several family characteristics that we describe under the rubric of diversity. These include racial/ethnic minority enrollment and speaking a primary language other than English. Race/ethnicity and primary language are highly correlated, and the profiles of programs serving many families that are racial/ethnic minorities or that speak languages other than English are similar. Programs with racial/ethnic minorities making up at least half their enrollment are "high-minority," whereas those with fewer are "lower minority."

High-minority programs differ from lower-minority programs in community context. Specifically, they are more likely to be in urban communities, and in neighborhoods with moderate to high and increasing cultural diversity.

High- and lower-minority programs also differ in auspices, in that high-minority programs are less likely to be in community agencies and more likely to be tribal government settings. However, they are also more likely to have very large program enrollment. High minority programs are less likely to have an MIS but are more likely to use one for tracking individual progress. These programs are less likely than lower-minority ones to use home-based or multiple approaches and more likely to use center-based or combination ones. In

terms of staff turnover, high-minority programs have lower primary caregiver turnover, but higher management-level turnover. They also have less access to literacy specialists and have lower staff education. Partnerships with Part C providers are lower, but partnerships with health care providers (important for this population) are higher in high-minority programs. As expected, enrollee characteristics differ in that high-minority programs serve more non-English speakers and have increased prevalence of several demographic and psychological risk factors, such as single parent, lack of a high school credential, teen mother, unsafe neighborhood, family violence, and multiple psychological risks. Conversely, high-minority programs are lower on several risk factors as well, including employment and mental health problems.

Characteristics of programs that serve a substantial proportion of non-English-speaking enrollees (defined here as at least 25 percent of enrollment) have only a few notable differences from those serving fewer, mostly concentrated within community and family characteristics. These programs are more likely to be in urban and suburban communities than in rural ones, and to have a greater number of preschool Head Start programs in the community (also related to service area, as reported earlier). Compared with programs that have fewer non-English-speaking enrollees, programs with many non-English speakers are less likely to have an MIS, more likely to use a combination approach, and less likely to use a center-based one. Programs with many non-English speakers have lower primary caregiver turnover, and are mixed in staff education (more likely to have highly educated primary caregivers but less likely to have similarly educated home visitors) relative to their counterparts. Part C and mental health provider partnerships have lower prevalence in non-English programs; other partnerships do not differ between groups. As with race/ethnicity, programs with greater proportions of non-English speakers are also more likely to have high levels of racial/ethnic minorities. Patterns of risks are mixed, with lower levels of single parents but increased prevalence of primary caregivers without a high school credential, family violence, and unsafe neighborhoods.

SUMMARY OF KEY FINDINGS

Here, we present as a quick reference a synopsis of program characteristics within key subgroups we studied (Table VII.3). By and large, we find that programs differ in mostly expected ways when we examine subgroups of community, program, and family characteristics, and we view this consistency as a validity check on survey responses. The subgroups with the most marked differences are those related to service area, program size, and program approach, and these are summarized below. For example, urban and suburban programs differ in similar ways as larger and small programs. Among other subgroups we studied, there are few other differences, except in expected directions, that are based on the remaining program and enrollee characteristics.

Table VII.2. Early Head Start Program Subgroup Comparisons: Point Differences Required for Each Effect Size

	Effect Size			
	0.1	0.2	0.3	0.4
Community Characteristics				
Service Area				
Mainly urban	5.0	10.0	15.0	20.0
Mainly rural	4.9	9.8	14.8	19.7
Mainly suburban	3.0	5.9	8.9	11.8
Mixed	1.5	3.0	4.6	6.1
Other	0.9	1.9	2.8	3.8
Community Diversity				
High	3.9	7.8	11.8	15.7
Moderate	4.9	9.9	14.8	19.7
Low	4.9	9.8	14.7	19.6
Diversity Past Five Years				
Increased	4.9	9.9	14.8	19.8
Stayed the same	5.0	9.9	14.9	19.9
Decreased	1.2	2.3	3.5	4.7
Program Characteristics				
Program Auspice				
Community agency	4.6	9.2	13.8	18.4
Government agency	2.3	4.7	7.0	9.3
Tribal government	2.0	4.1	6.1	8.1
School	3.0	6.0	8.9	11.9
University	1.8	3.7	5.5	7.4
Hospital or health care provider	1.8	3.6	5.4	7.2
Other	1.8	3.6	5.5	7.3
Number of Sites				
Single	4.8	9.6	14.4	19.2
Multiple	4.8	9.6	14.4	19.2
Enrollment (Number of Children and Pregnant Women)				
50 or fewer	4.7	9.3	14.0	18.7
51 to 100	4.9	9.8	14.7	19.6
101 to 150	3.7	7.4	11.1	14.9
151 or more	3.2	6.3	9.5	12.6
Operates Own Preschool Head Start	3.9	7.7	11.6	15.5
Outside Funding Sources				
State child care subsidies/ block grant	4.8	9.5	14.3	19.0
State government grant	3.8	7.6	11.4	15.2
Private foundation grants	3.6	7.1	10.7	14.3
Fundraising activities	3.4	6.7	10.1	13.5

Table VII.2 *(continued)*

Characteristics	Effect Size 0.1	0.2	0.3	0.4
Fee-for-service reimbursements	2.8	5.6	8.4	11.2
County/municipal government grant	2.7	5.5	8.2	11.0
Part C funds	2.4	4.8	7.3	9.7
Contracts	2.3	4.6	6.9	9.3
Grants provided by businesses	2.2	4.5	6.7	9.0
Other source	2.5	4.9	7.4	9.9
Has an MIS	3.2	6.4	9.6	12.8
Uses MIS for Reports on Services (Among Programs Using an MIS)	3.7	7.4	11.2	14.9
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	4.8	9.6	14.4	19.2
Overall Program Approach				
Home-based	3.8	7.5	11.3	15.1
Center-based	4.2	8.4	12.7	16.9
Multiple	5.0	10.0	15.0	20.0
Combination	2.8	5.7	8.5	11.3
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	5.0	9.9	14.9	19.8
Mental health specialist	2.1	4.2	6.2	8.3
Disability specialist	2.7	5.4	8.2	10.9
Literacy specialist	5.0	9.9	14.9	19.8
Speech or language specialist	4.8	9.6	14.3	19.1
Heath care professional or nurse	2.9	5.7	8.6	11.5
Other specialist	4.5	9.0	13.5	18.0
Dietitian or nutritionist	3.9	7.8	11.7	15.6
Employs **Only** Primary Caregivers with at Least an AA	3.4	6.8	10.1	13.5
Employs **Only** Home Visitors with at Least an AA	5.0	10.0	15.0	20.0
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	3.0	6.1	9.1	12.2

Table VII.2 *(continued)*

Characteristics	Effect Size 0.1	0.2	0.3	0.4
Lost Director or Manager in Past 12 Months	4.8	9.6	14.4	19.2
Rate of Employee Turnover				
Caregivers employed by program	2.3	4.5	6.8	9.0
Home visitors	2.9	5.7	8.6	11.4
Program Partnerships				
Has Formal Agreement with Part C Partner	1.8	3.6	5.4	7.2
Part C Partnership Features				
Referrals to Part C	0.9	1.9	2.8	3.7
Referrals to Early Head Start	1.3	2.6	4.0	5.3
Share assessments	1.6	3.3	4.9	6.5
Staff meetings	3.1	6.3	9.4	12.6
Has Formal Agreement with Child Care Partner	4.9	9.9	14.8	19.8
Has Formal Agreement with Health Care Provider	4.2	8.4	12.5	16.7
Has Formal Agreement with Mental Health Care Provider	3.7	7.5	11.2	15.0
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	0.7	1.4	2.1	2.8
Family Characteristics				
Average Enrollment Turnover	3.0	6.0	8.9	11.9
Program Enrollment				
Mostly white	4.6	9.2	13.8	18.4
Mostly black	4.2	8.5	12.7	17.0
Mostly Hispanic	3.9	7.7	11.6	15.5
Mostly minority	4.6	9.3	13.9	18.6
Serves Any Families Speaking Primary Language Other than English	4.5	9.0	13.5	18.0
Age at Program Entry				
Prenatal	1.5	3.1	4.6	6.2
0 to 2 years old	2.0	3.9	5.9	7.9
2 to 3 years old	1.6	3.2	4.8	6.4

Table VII.2 *(continued)*

Characteristics	Effect Size 0.1	0.2	0.3	0.4
Primarily Serves Families with the Following Demographic Risk Factors:				
Single parent	5.0	10.0	15.0	20.0
Receiving welfare payments	4.5	8.9	13.4	17.8
Primary caregiver does not have diploma/GED	3.8	7.6	11.3	15.1
Primary caregiver unemployed or not in school	3.6	7.3	10.9	14.5
Teen mother	2.3	4.6	7.0	9.3
More than three risk factors (above)	4.1	8.1	12.2	16.3
Primarily Serves Families with the Following Psychological Risk Factors:				
Unsafe neighborhood	4.2	8.4	12.7	16.9
Experience family violence	2.6	5.2	7.8	10.3
Mental health problems	2.5	5.0	7.4	9.9
Substance abuse	1.7	3.5	5.2	7.0
More than two risk factors (above)	3.3	6.6	9.9	13.2

Source: Survey of Early Head Start Programs.

[a]We calculated point differences needed for each effect size with the same equation we used to calculate actual effect size, this time solving for the point difference needed to achieve particular effect sizes:

$$ES_i = \frac{X}{\sigma_X},$$

where ES_i is an effect size of value *i*, X is the point difference between subgroup means, and σ_X is the population standard deviation for a given characteristic, *x*.

Table VII.3. Summary of Key Subgroup Differences

	Service Area			Program Size		Program Approach			
Characteristics	Urban	Suburban	Rural	Small	Large	Home-Based	Center-Based	Multiple	Combination
Community Characteristics									
Urban				–		–	+	+	+
Rural				+		+	–	+	+
High/Increasing Diversity	+	+	–	–	+				
Program Characteristics									
Community Agency Auspice	+	+	–	–				–	+
School Auspice	–	+		+		+	+	+	–
Multiple Sites				–	+	–	+	+	+
Large Enrollment						–		+	+
Operates Preschool Head Start						–	+	+	+
Several Funding Sources	–	+	–	–	+	–	+	+	+
Home-Based Approach	–		+	+					
Center-Based Approach	+	+	–	+	–				
Multiple Approach	–	+		–	+				
Combination Approach				+					
Access To Specialists	+	+	–	–	+	–	+	+	+
High Staff Education	+	+	–	+	–	+	+	+	–
High Primary Caregiver Turnover	–	+		+	–				
High Home Visitor Turnover	–	+				+	–	+	+
Family Characteristics									
High Demographic Risk			–					+	–
High Psychological Risk	+			–	–	–		+	
High Minority	+	+	–	–		–	+	+	+
Serve Non-English Speakers	+	+	–	–	+		–		+

Source: Survey of Early Head Start programs.

Note: For brevity, we have collapsed levels of program size subgroups and of some key characteristics. In the case of program size subgroups, +/-- indicates a difference with effect size at least 0.2 relative to the category with the highest or lowest prevalence, whether or not that category is shown (for example, "large" programs may differ at this level on a given characteristic from "medium" programs although medium is a level not shown.

+ = Subgroup is more likely to have a characteristic (0.2 effect size or higher).

– = Subgroup is less likely to have a characteristic (0.2 effect size or higher).

Blank cells indicate no difference (effect size less than 0.2).

Table VII.4. Early Head Start Program Characteristics by Subgroup: Service Area[a]

Characteristics	Subgroup Levels: Percentage of Programs				
	Urban (N = 290)	Suburban (N = 61)	Rural (N = 269)	Difference	Effect Size[b]
Community Characteristics					
Service Area					
Mainly urban	—	—	—	—	—
Mainly rural	—	—	—	—	—
Mainly suburban	—	—	—	—	—
Mixed	—	—	—	—	—
Community Diversity					
High	29.4	32.3	5.5	26.8	0.7
Moderate	45.9	48.2	33.3	14.9	0.3
Low	24.7	19.5	61.2	41.7	0.9
Diversity Past Five Years					
Increased	48.9	57.7	30.9	26.8	0.5
Stayed the same	49.2	40.6	68.4	27.8	0.6
Decreased	2.0	1.7	0.8	1.2	0.1
Program Characteristics					
Program Auspice					
Community agency	72.3	79.0	66.1	12.9	0.3
Government agency	6.0	4.6	5.6	1.4	0.1
Tribal government	0.7	0.0	7.9	7.9	0.4
School	8.1	12.8	10.9	4.7	0.2
University	4.9	0.0	3.3	4.9	0.3
Hospital or health care provider	4.2	1.7	2.9	2.5	0.1
Other	3.9	2.0	3.4	1.9	0.1
Number of Sites					
Single	36.9	32.5	36.8	4.4	0.1
Multiple	63.1	67.5	63.2	4.4	0.1
Program Enrollment (Number of Children and Pregnant Women)					
50 or fewer	29.8	24.9	37.3	12.4	0.3
51 to 100	40.7	51.2	37.9	13.3	0.3
101 to 150	16.9	17.3	15.2	2.1	0.1
More than 150	12.7	6.7	9.6	6.0	0.2
Operates Own Preschool Head Start	79.7	81.8	83.5	3.8	0.1

Table VII.4 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Urban (N = 290)	Suburban (N = 61)	Rural (N = 269)	Difference	Effect Size[b]
Outside Funding Sources					
State child care subsidies/block grant	37.5	46.3	27.7	18.6	0.4
State government grant	15.0	18.3	18.4	3.4	0.1
Private foundation grants	17.5	14.2	11.2	6.3	0.2
Fundraising activities	12.1	19.2	12.1	7.1	0.2
Fee-for-service reimbursements	8.4	7.1	7.6	1.3	0.0
County/municipal government grant	9.9	13.3	4.8	8.5	0.3
Part C funds	3.7	1.7	9.1	7.4	0.3
Contracts	6.9	7.4	4.3	3.1	0.1
Grants provided by businesses	5.1	8.5	4.5	4.0	0.2
Other source	6.3	5.6	6.8	1.2	0.0
Has an MIS	86.5	89.9	90.2	3.7	0.1
Uses MIS for Reports on Services (Among Programs Using an MIS)	83.6	84.2	82.7	1.5	0.0
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	65.8	62.7	63.5	3.1	0.1
Program Approach					
Home-based	12.3	17.6	22.4	10.1	0.3
Center-based	30.1	17.8	17.5	12.6	0.3
Multiple	48.1	57.9	50.8	9.8	0.2
Combination	9.1	4.8	8.6	4.3	0.2
Staff Characteristics					
Program Employs or Has Access to:					
Male involvement specialist	59.5	69.0	51.3	17.7	0.4
Mental health specialist	96.8	98.0	92.8	5.2	0.3
Disability specialist	93.1	98.0	88.5	9.5	0.3
Literacy specialist	57.0	63.2	54.8	8.4	0.2
Speech or language specialist	63.5	68.5	65.9	5.0	0.1
Heath care professional or nurse	93.6	95.1	87.5	7.6	0.3
Other specialist	29.5	33.6	24.7	8.9	0.2
Dietitian or nutritionist	20.2	26.0	16.2	9.8	0.3

Table VII.4 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Urban (N = 290)	Suburban (N = 61)	Rural (N = 269)	Difference	Effect Size[b]
Employs **Only** Primary Caregivers with at Least an AA	12.0	11.8	13.7	1.9	0.1
Employs **Only** Home Visitors with at Least an AA	51.5	70.2	38.0	32.2	0.6
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	8.5	11.3	11.3	2.8	0.1
Lost Director or Manager in Past 12 Months	38.6	31.2	32.6	7.4	0.2
Rate of Employee Turnover					
Caregivers employed by program	18.3	21.7	21.6	3.4	0.2
Home visitors	22.8	27.7	23.7	4.9	0.2
Program Partnerships					
Has Formal Agreement with Part C Partner	95.2	96.8	98.8	3.6	0.2
Has Formal Agreement with Child Care Partner	44.9	41.4	38.2	6.7	0.1
Has Formal Agreement with Health Care Provider	76.1	73.9	80.4	6.5	0.2
Has Formal Agreement with Mental Health Care Provider	84.0	82.2	84.2	2.0	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	3.2	2.1	1.8	1.4	0.2
Family Characteristics					
Average Enrollment Turnover	33.7	36.4	33.9	2.7	0.1
Program Enrollment					
Mostly white	11.3	18.2	55.5	44.2	1.0
Mostly black	37.8	13.4	10.4	27.4	0.6
Mostly Hispanic	23.1	21.4	11.8	11.3	0.3
Mostly minority	87.7	78.7	44.1	43.6	0.9
Serve Any Families Speaking Primary Language Other than English	80.2	90.3	58.5	31.8	0.7

Table VII.4 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Urban (N = 290)	Suburban (N = 61)	Rural (N = 269)	Difference	Effect Size[b]
Programs Primarily Serving Families with Demographic Risk Factors:					
Single parent	65.9	59.7	39.0	26.9	0.5
Receiving welfare payments	32.1	22.7	21.2	10.9	0.2
Primary caregiver does not have diploma/GED	20.7	22.7	13.1	9.6	0.3
Primary caregiver unemployed or not in school	14.1	15.8	17.0	2.9	0.1
Teen mother	8.1	3.3	3.8	4.8	0.2
More than three risk factors (above)	23.4	27.7	18.3	9.4	0.2
Programs Primarily Serving Families with Psychological Risk Factors:					
Unsafe neighborhood	38.2	18.0	8.0	30.2	0.7
Experience family violence	9.3	5.4	5.2	4.1	0.2
Mental health problems	7.2	5.0	6.9	2.2	0.1
Substance abuse	1.4	0.0	5.5	5.5	0.3
More than two risk factors (above)	16.1	11.8	8.8	7.3	0.2
Sample Size (Programs)	**103–290**	**23–61**	**72–269**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We excluded the few programs that characterized their area as “mixed” or “other.”

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.5. Early Head Start Program Characteristics by Subgroup: Community Diversity[a]

Characteristics	Subgroup Levels: Percentage of Programs: High Community Diversity (N = 123)	Lower Community Diversity (N = 527)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	71.6	40.2	31.4	0.6
Mainly rural	11.9	47.7	35.8	0.7
Mainly suburban	16.5	8.1	8.4	0.3
Mixed	0.0	2.9	2.9	0.2
Other	0.0	1.1	1.1	0.1
Community Diversity				
High	—	—	—	—
Moderate	—	—	—	—
Low	—	—	—	—
Diversity Past Five Years				
Increased	71.6	35.6	36.0	0.7
Stayed the same	27.6	62.9	35.3	0.7
Decreased	0.9	1.5	0.6	0.1
Program Characteristics				
Program Auspice				
Community agency	74.5	69.4	5.1	0.1
Government agency	3.2	6.1	2.9	0.1
Tribal government	0.7	4.9	4.2	0.2
School	9.9	9.8	0.1	0.0
University	3.2	3.7	0.5	0.0
Hospital or health care provider	2.3	3.4	1.1	0.1
Other	6.2	2.9	3.3	0.2
Number of Sites				
Single	35.5	35.9	0.4	0.0
Multiple	64.5	64.1	0.4	0.0
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	30.8	32.4	1.6	0.0
51 to 100	43.0	39.9	3.1	0.1
101 to 150	15.7	16.6	0.9	0.0
More than 150	10.5	11.2	0.7	0.0
Operates Own Preschool Head Start	80.5	82.1	1.6	0.0

Table VII.5 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Community Diversity (N = 123)	Lower Community Diversity (N = 527)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	38.2	33.7	4.5	0.1
State government grant	18.4	17.4	1.0	0.0
Private foundation grants	18.2	14.4	3.8	0.1
Fundraising activities	14.7	12.9	1.8	0.1
Fee-for-service reimbursements	9.5	8.3	1.2	0.0
County/municipal government grant	14.5	6.6	7.9	0.3
Part C funds	5.1	6.4	1.3	0.1
Contracts	6.2	5.7	0.5	0.0
Grants provided by businesses	6.2	5.0	1.2	0.1
Other source	8.4	5.8	2.6	0.1
Has an MIS	87.0	88.6	1.6	0.0
Uses MIS for Reports on Services (Among Programs Using an MIS)	83.3	83.3	0.0	0.0
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	68.8	63.4	5.4	0.1
Program Approach				
Home-based	18.8	17.1	1.7	0.0
Center-based	22.0	23.6	1.6	0.0
Multiple	50.8	50.2	0.6	0.0
Combination	8.4	8.4	0.0	0.0
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	58.3	56.8	1.5	0.0
Mental health specialist	96.3	95.3	1.0	0.0
Disability specialist	93.0	91.7	1.3	0.0
Literacy specialist	55.0	57.2	2.2	0.0
Speech or language specialist	65.6	64.6	1.0	0.0
Heath care professional or nurse	95.0	89.9	5.1	0.2
Other specialist	26.6	28.2	1.6	0.0
Dietitian or nutritionist	21.1	18.2	2.9	0.1
Employs **Only** Primary Caregivers with at Least an AA	12.3	13.4	1.1	0.0

Table VII.5 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Community Diversity (N = 123)	Lower Community Diversity (N = 527)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	47.8	46.4	1.4	0.0
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	6.9	11.1	4.2	0.1
Lost Director or Manager in Past 12 Months	46.2	33.2	13.0	0.3
Rate of Employee Turnover				
Caregivers employed by program	16.5	20.5	4.0	0.2
Home visitors	21.9	24.3	2.4	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	93.8	97.3	3.5	0.2
Has Formal Agreement with Child Care Partner	43.2	41.7	1.5	0.0
Has Formal Agreement with Health Care Provider	78.2	77.2	1.0	0.0
Has Formal Agreement with Mental Health Care Provider	85.0	82.8	2.2	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	4.5	2.1	1.6	0.3
Family Characteristics				
Average Enrollment Turnover	36.9	33.1	3.8	0.1
Program Enrollment				
Mostly white	7.8	35.9	28.1	0.6
Mostly black	18.8	24.8	6.0	0.1
Mostly Hispanic	33.0	14.8	18.2	0.5
Mostly minority	92.2	63.0	29.2	0.6
Serve Any Families Speaking Primary Language Other than English	93.5	67.5	26.0	0.6

Table VII.5 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Community Diversity (N = 123)	Lower Community Diversity (N = 527)	Difference	Effect Size[b]
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	54.9	53.4	1.5	0.0
Receiving welfare payments	36.4	25.4	11.0	0.2
Primary caregiver does not have diploma/GED	26.0	15.5	10.5	0.3
Primary caregiver unemployed or not in school	12.9	16.5	3.6	0.1
Teen mother	7.3	5.4	1.9	0.1
More than three risk factors (above)	25.1	20.2	4.9	0.1
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	33.9	20.9	13.0	0.3
Experience family violence	7.4	7.3	0.1	0.0
Mental health problems	6.5	6.7	0.2	0.0
Substance abuse	1.6	3.4	1.8	0.1
More than two risk factors (above)	14.5	12.0	2.5	0.1
Sample Size (Programs)	**46–123**	**158–527**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]High-diversity programs are those in communities characterized as such by respondents.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.6. Early Head Start Program Characteristics by Subgroup: Change in Community Diversity[a]

Characteristics	Subgroup Levels: Percentage of Programs — Increasing Diversity (N = 273)	Stable/ Decreasing Diversity (N = 372)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	53.3	40.7	12.6	0.3
Mainly rural	30.0	48.9	18.9	0.4
Mainly suburban	13.4	7.1	6.3	0.2
Mixed	2.6	2.2	0.4	0.0
Other	0.7	1.1	0.4	0.0
Community Diversity				
High	32.0	9.4	22.6	0.6
Moderate	50.5	35.4	15.1	0.3
Low	17.6	55.3	37.7	0.8
Diversity Past Five Years				
Increased	—	—	—	—
Stayed the same	—	—	—	—
Decreased	—	—	—	—
Program Characteristics				
Program Auspice				
Community agency	73.9	67.8	6.1	0.1
Government agency	4.8	6.2	1.4	0.1
Tribal government	1.4	5.8	4.4	0.2
School	10.2	9.4	0.8	0.0
University	4.0	3.3	0.7	0.0
Hospital or health care provider	2.6	3.7	1.1	0.1
Other	3.1	3.8	0.7	0.0
Number of Sites				
Single	32.8	38.1	5.3	0.1
Multiple	67.2	61.9	5.3	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	26.5	36.3	9.8	0.2
51 to 100	43.5	38.0	5.5	0.1
101 to 150	18.0	15.2	2.8	0.1
More than 150	12.1	10.5	1.6	0.1
Operates Own Preschool Head Start	83.3	80.4	2.9	0.1

Table VII.6 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs — Increasing Diversity (N =273)	Stable/ Decreasing Diversity (N =372)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	40.0	30.7	9.3	0.2
State government grant	19.4	16.3	3.1	0.1
Private foundation grants	15.6	14.6	1.0	0.0
Fundraising activities	16.2	11.2	5.0	0.1
Fee-for-service reimbursements	9.7	7.8	1.9	0.1
County/municipal government grant	8.4	7.9	0.5	0.0
Part C funds	7.6	5.2	2.4	0.1
Contracts	7.1	4.9	2.2	0.1
Grants provided by businesses	5.7	5.0	0.7	0.0
Other source	5.6	6.9	1.3	0.1
Has an MIS	87.3	89.3	2.0	0.1
Uses MIS for Reports on Services (Among Programs Using an MIS)	83.4	83.7	0.3	0.0
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	67.7	62.1	5.6	0.1
Program Approach				
Home-based	18.2	16.7	1.5	0.0
Center-based	24.1	23.0	1.1	0.0
Multiple	49.8	50.7	0.9	0.0
Combination	7.6	8.8	1.2	0.0
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	59.5	55.2	4.3	0.1
Mental health specialist	96.7	94.5	2.2	0.1
Disability specialist	93.7	90.4	3.3	0.1
Literacy specialist	58.3	55.1	3.2	0.1
Speech or language specialist	62.3	67.0	4.7	0.1
Heath care professional or nurse	92.5	89.6	2.9	0.1
Other specialist	27.4	27.6	0.2	0.0
Dietitian or nutritionist	20.3	17.7	2.6	0.1
Employs **Only** Primary Caregivers with at Least an AA	12.8	13.8	1.0	0.0

Table VII.6 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Increasing Diversity (N =273)	Stable/ Decreasing Diversity (N =372)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	46.5	46.6	0.1	0.0
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	9.1	11.4	2.4	0.1
Lost Director or Manager in Past 12 Months	37.9	34.0	3.9	0.1
Rate of Employee Turnover				
Caregivers employed by program	19.4	20.0	0.6	0.0
Home visitors	25.9	22.1	3.8	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	96.0	97.1	1.1	0.1
Has Formal Agreement with Child Care Partner	42.6	41.0	1.6	0.0
Has Formal Agreement with Health Care Provider	77.2	77.5	0.3	0.0
Has Formal Agreement with Mental Health Care Provider	81.2	84.4	3.2	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.5	2.6	0.1	0.0
Family Characteristics				
Average Enrollment Turnover	33.3	34.0	0.7	0.0
Program Enrollment				
Mostly white	26.1	33.9	7.8	0.2
Mostly black	27.1	21.1	6.0	0.1
Mostly Hispanic	14.5	21.3	6.8	0.2
Mostly minority	73.2	65.1	8.1	0.2
Serve Any Families Speaking Primary Language Other than English	83.7	64.2	19.5	0.4

Table VII.6 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Increasing Diversity (N =273)	Stable/ Decreasing Diversity (N =372)	Difference	Effect Size[b]
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	56.8	51.8	5.0	0.1
Receiving welfare payments	31.1	25.0	6.1	0.1
Primary caregiver does not have diploma/GED	20.3	15.3	5.0	0.1
Primary caregiver unemployed or not in school	16.0	16.0	0.0	0.0
Teen mother	5.1	6.1	1.0	0.0
More than three risk factors (above)	25.7	17.8	7.9	0.2
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	27.4	20.2	7.2	0.2
Experience family violence	7.3	7.2	0.1	0.0
Mental health problems	7.6	5.6	2.0	0.1
Substance abuse	2.9	2.9	0.0	0.0
More than two risk factors (above)	12.2	12.6	0.4	0.0
Sample Size (Programs)	**90–273**	**112–372**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]Program respondents reported how their community's diversity has changed over the past five years.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.7. Early Head Start Program Characteristics by Subgroup: Program Size[a]

Characteristics	Subgroup Levels: Percentage of Programs					
	Small (N = 209)	Medium (N = 271)	Large (N = 108)	Very Large (N = 72)	Difference	Effect Size[b]
Community Characteristics						
Service Area						
Mainly urban	42.6	46.3	47.7	52.8	10.2	0.2
Mainly rural	47.5	38.5	38.3	35.5	12.0	0.2
Mainly suburban	7.5	12.2	10.2	5.9	6.3	0.2
Mixed	1.5	1.9	3.0	5.9	4.4	0.3
Other	1.0	1.1	0.9	0.0	1.1	0.1
Community Diversity						
High	18.2	20.1	18.1	18.1	2.0	0.1
Moderate	35.1	40.9	46.4	56.1	21.0	0.4
Low	46.7	39.0	35.5	25.8	20.9	0.4
Diversity Past Five Years						
Increased	34.9	45.8	46.6	45.9	11.7	0.2
Stayed the same	63.6	53.1	51.7	52.7	11.9	0.2
Decreased	1.5	1.2	1.7	1.4	0.5	0.0
Program Characteristics						
Program Auspice						
Community agency	64.5	71.7	73.1	74.3	9.8	0.2
Government agency	5.8	5.2	7.5	5.4	2.3	0.1
Tribal government	7.8	3.0	2.7	1.2	6.6	0.3
School	10.4	12.4	6.3	4.0	8.4	0.3
University	3.3	3.4	3.6	4.4	1.1	0.1
Hospital or health care provider	2.3	3.7	2.9	5.4	3.1	0.2
Other	5.8	0.8	3.9	5.4	5.0	0.3
Number of Sites						
Single	57.6	34.2	19.1	14.9	42.7	0.9
Multiple	42.4	65.8	81.0	85.1	42.7	0.9
Program Enrollment (Number of Children and Pregnant Women)						
50 or fewer	—	—	—	—	—	—
51 to 100	—	—	—	—	—	—
101 to 150	—	—	—	—	—	—
More than 150	—	—	—	—	—	—
Operates Own Preschool Head Start	83.8	77.6	82.5	90.1	12.5	0.3

Table VII.7 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs — Small (N = 209)	Medium (N = 271)	Large (N = 108)	Very Large (N = 72)	Difference	Effect Size[b]
Outside Funding Sources						
State child care subsidies/ block grant	30.4	30.9	45.0	42.0	14.6	0.3
State government grant	14.6	16.6	21.1	23.8	9.2	0.2
Private foundation grants	9.8	15.3	23.4	15.8	13.6	0.4
Fundraising activities	12.4	15.7	7.7	12.8	8.0	0.2
Fee-for-service reimbursements	7.3	9.7	10.8	4.4	6.4	0.2
County/municipal government grant	7.5	8.1	7.8	11.6	4.1	0.1
Part C funds	6.0	4.6	11.1	5.6	6.5	0.3
Contracts	7.1	5.2	3.9	5.8	3.2	0.1
Grants provided by businesses	1.9	7.0	7.6	6.0	5.7	0.3
Other source	8.2	5.2	6.8	6.0	3.0	0.1
Has an MIS	82.6	89.7	92.4	93.8	11.2	0.3
Uses MIS for Reports on Services (Among Programs Using an MIS)	85.1	81.7	85.0	83.1	3.4	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	64.3	63.4	64.5	67.8	4.4	0.1
Program Approach						
Home-based	23.7	17.8	9.6	6.9	16.8	0.4
Center-based	31.7	19.2	16.9	22.5	14.8	0.4
Multiple	31.7	56.7	63.6	61.3	31.9	0.6
Combination	12.9	5.9	8.9	6.9	7.0	0.2
Staff Characteristics						
Program Employs or Has Access to:						
Male involvement specialist	45.6	57.7	68.7	62.4	23.1	0.5
Mental health specialist	92.3	96.1	97.4	97.7	5.4	0.3
Disability specialist	87.5	93.7	92.0	95.8	8.3	0.3
Literacy specialist	50.7	59.0	58.8	59.6	8.9	0.2
Speech or language specialist	67.9	64.6	65.0	58.4	9.5	0.2
Heath care professional or nurse	86.0	92.0	91.1	98.2	12.2	0.4
Other specialist	22.3	25.6	37.4	33.0	15.1	0.3
Dietitian or nutritionist	13.2	22.0	16.7	23.8	10.6	0.3
Employs **Only** Primary Caregivers with at Least an AA	16.5	13.4	8.4	11.0	8.1	0.2

Table VII.7 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Small (N = 209)	Medium (N = 271)	Large (N = 108)	Very Large (N = 72)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	47.8	51.0	43.0	32.7	18.3	0.4
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	16.4	10.2	5.0	7.7	11.4	0.4
Lost Director or Manager in Past 12 Months	29.4	38.0	35.7	44.0	14.6	0.3
Rate of Employee Turnover						
Caregivers employed by program	21.2	20.7	16.8	17.3	4.4	0.2
Home visitors	22.7	26.0	22.6	21.3	4.7	0.2
Program Partnerships						
Has Formal Agreement with Part C Partner	96.2	95.5	98.2	100.0	4.5	0.2
Has Formal Agreement with Child Care Partner	33.7	40.9	52.3	54.9	21.2	0.4
Has Formal Agreement with Health Care Provider	76.6	78.7	69.9	87.2	17.3	0.4
Has Formal Agreement with Mental Health Care Provider	82.7	82.2	80.1	92.8	12.7	0.3
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	4.4	1.8	2.5	1.6	2.8	0.4
Family Characteristics						
Average Enrollment Turnover	34.9	35.3	32.3	30.5	4.8	0.2
Program Enrollment						
Mostly white	31.3	31.7	32.9	21.0	11.9	0.3
Mostly black	25.2	19.7	27.0	28.0	8.3	0.2
Mostly Hispanic	14.8	20.1	15.0	27.1	12.3	0.3
Mostly minority	68.2	66.4	67.2	79.0	12.6	0.3
Serve Any Families Speaking Primary Language Other than English	57.8	75.8	79.9	87.6	29.8	0.7

Table VII.7 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Small (N = 209)	Medium (N = 271)	Large (N = 108)	Very Large (N = 72)	Difference	Effect Size[b]
Programs Primarily Serving Families with Demographic Risk Factors:						
Single parent	54.2	51.9	51.0	57.6	6.6	0.1
Receiving welfare payments	28.6	25.8	29.7	25.1	4.6	0.1
Primary caregiver does not have diploma/GED	16.4	17.8	21.5	11.4	10.1	0.3
Primary caregiver unemployed or not in school	11.4	18.2	11.8	23.7	12.3	0.3
Teen mother	5.9	6.0	5.0	5.3	1.0	0.0
More than three risk factors (above)	19.0	20.6	24.8	21.3	5.8	0.1
Programs Primarily Serving Families with Psychological Risk Factors:						
Unsafe neighborhood	16.7	22.9	22.7	43.2	26.5	0.6
Experience family violence	4.7	9.8	2.7	11.6	8.9	0.3
Mental health problems	4.3	7.4	9.0	6.8	4.7	0.2
Substance abuse	1.8	2.6	4.5	6.7	4.9	0.3
More than two risk factors (above)	8.0	14.7	7.6	24.3	16.7	0.5
Sample Size (Programs)	**55–209**	**101–271**	**34–108**	**14–72**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We defined small programs as those with fewer than 50 enrollees, medium as those with 50 to 100, large with 101 to 150, and very large as those with more than 150 enrollees.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.8. Early Head Start Program Characteristics by Subgroup: Service Approach[a]

	Subgroup Levels					
	Percentage of Programs					
Characteristics	Home-Based (N = 114)	Center-Based (N = 152)	Multiple (N = 334)	Combination (N = 56)	Difference	Effect Size[a]
Community Characteristics						
Service Area						
Mainly urban	33.4	58.9	44.1	49.1	25.5	0.5
Mainly rural	54.0	30.5	41.4	41.4	23.5	0.5
Mainly suburban	10.0	7.3	11.1	5.5	5.6	0.2
Mixed	1.9	2.0	2.5	4.0	2.1	0.1
Other	0.8	1.3	0.9	0.0	1.3	0.1
Community Diversity						
High	20.5	17.9	19.2	19.0	2.6	0.1
Moderate	30.9	46.2	42.8	41.5	15.3	0.3
Low	48.6	35.9	38.0	39.5	12.7	0.3
Diversity Past Five Years						
Increased	44.6	43.6	42.0	38.7	5.9	0.1
Stayed the same	54.6	55.0	56.2	61.3	6.7	0.1
Decreased	0.8	1.4	1.8	0.0	1.8	0.2
Program Characteristics						
Program Auspice						
Community agency	71.2	71.3	67.5	80.5	13.0	0.3
Government agency	7.0	7.5	5.4	1.7	5.8	0.2
Tribal government	3.4	4.6	3.8	6.9	3.5	0.2
School	8.7	10.0	11.3	1.7	9.6	0.3
University	2.7	2.6	4.5	1.8	2.7	0.1
Hospital or health care provider	3.4	1.3	4.5	2.0	3.2	0.2
Other	3.6	2.8	3.1	5.4	2.6	0.1
Number of Sites						
Single	63.9	36.0	37.7	1.9	42.0	0.9
Multiple	36.1	64.0	62.3	78.1	42.0	0.9
Program Enrollment (Number of Children and Pregnant Women)						
50 or fewer	44.3	43.8	20.2	47.2	27.0	0.6
51 to 100	42.0	33.4	45.4	27.3	18.1	0.4
101 to 150	9.2	12.0	20.8	16.8	11.6	0.3
More than 150	4.5	10.8	13.6	8.8	9.1	0.3
Operates Own Preschool Head Start	75.9	84.8	80.7	90.7	14.8	0.4

Table VII.8 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Home-Based (N = 114)	Center-Based (N = 152)	Multiple (N = 334)	Combination (N = 56)	Difference	Effect Size[a]
Outside Funding Sources						
State child care subsidies/ block grant	6.1	42.3	39.9	39.2	36.2	0.8
State government grant	13.0	18.2	19.6	14.2	6.6	0.2
Private foundation grants	17.0	13.2	14.3	18.2	5.0	0.1
Fundraising activities	9.7	15.2	12.6	14.7	5.5	0.2
Fee-for-service reimbursements	2.5	11.9	8.7	11.5	9.4	0.3
County/municipal government grant	6.5	7.0	9.3	9.4	2.9	0.1
Part C funds	5.3	4.0	7.6	6.5	3.6	0.1
Contracts	1.9	8.6	5.1	9.4	7.5	0.3
Grants provided by businesses	5.2	1.5	5.6	14.2	12.7	0.6
Other source	7.3	4.7	6.7	9.6	4.9	0.2
Has an MIS	86.3	89.9	88.9	84.4	5.5	0.2
Uses MIS for Reports on Services (Among Programs Using an MIS)	72.2	81.9	88.7	80.5	8.2	0.2
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	55.6	59.8	79.8	65.9	24.2	0.5
Direct Program Approach						
Home-based	100.0	0.0	14.5	0.0	100.0	2.3
Center-based	0.0	85.7	0.3	0.0	85.7	2.1
Multiple	0.0	0.0	84.9	0.0	84.9	1.7
Combination	0.0	0.0	0.3	100.0	100.0	3.5
Staff Characteristics						
Program Employs or Has Access to:						
Male involvement specialist	49.0	54.0	60.8	58.6	11.8	0.2
Mental health specialist	91.7	94.7	96.7	97.4	5.7	0.3
Disability specialist	88.7	90.5	92.7	96.9	8.2	0.3
Literacy specialist	46.6	57.4	58.2	65.4	18.8	0.4
Speech or language specialist	50.6	69.3	65.3	73.7	23.1	0.5
Heath care professional or nurse	90.0	86.8	91.9	97.0	10.2	0.4
Other specialist	30.6	27.5	26.2	27.0	4.4	0.1
Dietitian or nutritionist	19.7	17.3	20.4	13.1	7.3	0.2
Employs **Only** Primary Caregivers with at Least an AA[b]	24.8	9.2	16.7	0.0	24.8	0.7

Table VII.8 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Home-Based (N = 114)	Center-Based (N = 152)	Multiple (N = 334)	Combination (N = 56)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA[b]	43.3	61.0	47.1	35.5	25.5	0.5
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	5.9	8.4	11.2	0.0	11.2	0.4
Lost Director or Manager in Past 12 Months	35.4	30.2	39.8	25.8	14.0	0.3
Rate of Employee Turnover[b]						
Caregivers employed by program	20.2	19.3	19.8	21.8	2.5	0.1
Home visitors	27.2	11.8	24.2	20.8	15.4	0.5
Program Partnerships						
Has Formal Agreement with Part C Partner	97.9	95.7	96.7	95.8	2.2	0.1
Has Formal Agreement with Child Care Partner	23.3	48.6	46.3	38.5	25.3	0.5
Has Formal Agreement with Health Care Provider	70.3	86.6	75.7	79.3	16.3	0.4
Has Formal Agreement with Mental Health Care Provider	74.2	90.5	81.9	88.3	16.3	0.4
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	1.5	2.5	2.1	9.5	8.0	1.1
Family Characteristics						
Average Enrollment Turnover	42.0	26.9	33.9	37.7	15.1	0.5
Program Enrollment						
Mostly white	49.9	11.4	35.6	14.8	38.5	0.8
Mostly black	8.9	44.9	17.9	30.0	36.0	0.8
Mostly Hispanic	18.0	23.0	16.7	15.1	7.9	0.2
Mostly minority	49.3	87.9	63.2	85.2	38.6	0.8
Serve Any Families Speaking Primary Language Other than English	72.2	66.5	73.8	75.4	8.9	0.2
Age at Program Entry						
Prenatal	14.2	13.9	13.6	12.6	1.6	0.1
0 to 2 years old	68.7	66.5	67.1	63.6	5.1	0.3
2 to 3 years old	17.3	17.9	19.6	22.3	5.0	0.3

Table VII.8 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Home-Based (N = 114)	Center-Based (N = 152)	Multiple (N = 334)	Combination (N = 56)	Difference	Effect Size[a]
Programs Primarily Serving Families with Demographic Risk Factors:						
Single parent	32.0	71.0	50.2	62.3	39.0	0.8
Receiving welfare payments	30.6	23.2	30.0	15.9	14.7	0.3
Primary caregiver does not have diploma/GED	18.4	17.0	16.4	21.3	4.9	0.1
Primary caregiver unemployed or not in school	21.9	3.8	20.5	5.6	18.1	0.5
Teen mother	0.9	7.3	5.5	10.6	9.7	0.4
More than three risk factors (above)	19.9	15.7	24.0	14.1	9.9	0.2
Programs Primarily Serving Families with Psychological Risk Factors:						
Unsafe neighborhood	19.6	22.1	25.9	18.3	7.6	0.2
Experience family violence	6.1	3.9	9.5	5.4	5.6	0.2
Mental health problems	8.0	0.7	8.3	8.8	8.1	0.3
Substance abuse	1.7	2.6	3.8	1.7	2.1	0.1
More than two risk factors (above)	7.8	8.5	16.0	10.8	8.2	0.2
Sample Size (Programs)	**9–114**	**25–152**	**108–334**	**9–56**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

[b]A small number of home-only programs (six programs) reported primary caregiver turnover in the past year. Similarly, a small number of center-only programs (seven programs) reported home visitor turnover.

Table VII.9. Early Head Start Program Characteristics by Subgroup: Operating Preschool Head Start

Characteristics	Subgroup Levels: Percentage of Programs: Operates Preschool Head Start (N = 532)	Does Not Operate Preschool Head Start (N = 120)	Difference	Effect Size[a]
Community Characteristics				
Service Area				
Mainly urban	44.7	50.7	6.0	0.1
Mainly rural	42.1	37.1	5.0	0.1
Mainly suburban	9.7	9.6	0.1	0.0
Mixed	2.5	1.7	0.8	0.1
Other	0.9	0.9	0.0	0.0
Community Diversity				
High	18.6	20.2	1.6	0.0
Moderate	42.2	39.4	2.8	0.1
Low	39.3	40.4	1.1	0.0
Diversity Past Five Years				
Increased	43.5	38.8	4.7	0.1
Stayed the same	55.2	59.6	4.4	0.1
Decreased	1.3	1.6	0.3	0.0
Program Characteristics				
Program Auspice				
Community agency	73.7	54.4	19.3	0.4
Government agency	5.2	8.2	3.0	0.1
Tribal government	4.4	3.2	1.2	0.1
School	9.5	9.9	0.4	0.0
University	2.1	10.2	8.1	0.4
Hospital or health care provider	1.7	10.8	9.1	0.5
Other	3.5	3.3	0.2	0.0
Number of Sites				
Single	33.0	51.1	18.1	0.4
Multiple	67.0	48.9	18.1	0.4
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	32.7	28.4	4.3	0.1
51 to 100	38.4	49.7	11.3	0.2
101 to 150	16.7	15.9	0.8	0.0
More than 150	12.2	6.0	6.2	0.2
Operates Own Preschool Head Start	—	—	—	—

Table VII.9 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Operates Preschool Head Start (N = 532)	Does Not Operate Preschool Head Start (N = 120)	Difference	Effect Size[a]
Outside Funding Sources				
State child care subsidies/ block grant	35.6	29.9	5.7	0.1
State government grant	16.7	22.2	5.5	0.1
Private foundation grants	12.8	25.3	12.5	0.4
Fundraising activities	12.5	16.3	3.8	0.1
Fee-for-service reimbursements	8.8	6.9	1.9	0.1
County/municipal government grant	6.5	15.8	9.3	0.3
Part C funds	6.3	6.2	0.1	0.0
Contracts	5.8	5.5	0.3	0.0
Grants provided by businesses	4.4	10.0	5.6	0.2
Other source	5.9	8.9	3.0	0.1
Has an MIS	89.6	82.7	6.9	0.2
Uses MIS for Reports on Services (Among Programs Using an MIS)	84.1	79.6	4.5	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	65.3	59.1	6.2	0.1
Program Approach				
Home-based	16.1	22.9	6.8	0.2
Center-based	24.2	19.4	4.8	0.1
Multiple	49.8	53.5	3.7	0.1
Combination	9.1	4.2	4.9	0.2
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	57.4	54.0	3.4	0.1
Mental health specialist	96.3	91.5	4.8	0.2
Disability specialist	92.6	88.7	3.9	0.1
Literacy specialist	61.2	36.6	24.8	0.5
Speech or language specialist	67.8	50.1	17.7	0.4
Heath care professional or nurse	90.4	93.2	2.8	0.1
Other specialist	29.0	23.1	5.9	0.1
Dietitian or nutritionist	17.9	23.5	5.4	0.1

Table VII.9 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Operates Preschool Head Start (N = 532)	Does Not Operate Preschool Head Start (N = 120)	Difference	Effect Size[a]
Employs **Only** Primary Caregivers with at Least an AA	14.1	8.6	5.5	0.2
Employs **Only** Home Visitors with at Least an AA	47.6	43.0	4.6	0.1
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	11.0	7.1	3.9	0.1
Lost Director or Manager in Past 12 Months	31.4	53.9	22.5	0.5
Rate of Employee Turnover				
Caregivers employed by program	19.1	23.8	4.7	0.2
Home visitors	24.4	22.0	2.4	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	96.7	96.4	0.3	0.0
Has Formal Agreement with Child Care Partner	41.8	41.9	0.1	0.0
Has Formal Agreement with Health Care Provider	78.6	71.6	7.0	0.2
Has Formal Agreement with Mental Health Care Provider	84.5	76.9	7.6	0.2
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	3.4	1.8	1.6	0.2
Family Characteristics				
Average Enrollment Turnover	32.8	37.5	4.7	0.2
Program Enrollment				
Mostly white	31.9	25.4	6.5	0.1
Mostly black	21.7	31.8	10.1	0.2
Mostly Hispanic	18.5	16.1	2.4	0.1
Mostly minority	66.9	74.6	7.7	0.2
Serve Any Families Speaking Primary Language Other than English	71.4	74.1	2.7	0.1

Table VII.9 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Operates Preschool Head Start (N = 532)	Does Not Operate Preschool Head Start (N = 120)	Difference	Effect Size[a]
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	52.5	58.7	6.2	0.1
Receiving welfare payments	26.5	32.5	6.0	0.1
Primary caregiver does not have diploma/GED	15.8	24.9	9.1	0.2
Primary caregiver unemployed or not in school	14.5	21.8	7.3	0.2
Teen mother	5.2	8.4	3.2	0.1
More than three risk factors (above)	19.8	26.7	6.9	0.2
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	21.9	29.5	7.6	0.2
Experience family violence	5.5	15.0	9.5	0.4
Mental health problems	5.9	10.0	4.1	0.2
Substance abuse	3.5	1.7	1.8	0.1
More than two risk factors (above)	11.6	17.1	5.5	0.2
Sample Size (Programs)	**387–532**	**73–120**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.10. Early Head Start Program Characteristics by Subgroup: Serving Pregnant Women

Characteristics	Subgroup Levels: Percentage of Programs: Serving Pregnant Women (N = 551)	Not Serving Pregnant Women (N = 101)	Difference	Effect Size[a]
Community Characteristics				
Service Area				
Mainly urban	46.7	42.6	4.1	0.1
Mainly rural	40.3	45.2	4.9	0.1
Mainly suburban	9.5	10.2	0.7	0.0
Mixed	2.7	1.0	1.7	0.1
Other	0.9	1.0	0.1	0.0
Community Diversity				
High	19.5	15.5	4.0	0.1
Moderate	41.8	41.7	0.1	0.0
Low	38.7	42.8	4.1	0.1
Diversity Past Five Years				
Increased	43.8	35.9	7.9	0.2
Stayed the same	54.8	63.0	8.2	0.2
Decreased	1.5	1.1	0.4	0.0
Program Characteristics				
Program Auspice				
Community agency	69.5	70.3	0.8	0.0
Government agency	6.0	5.1	0.9	0.0
Tribal government	3.3	9.6	6.3	0.3
School	10.4	7.1	3.3	0.1
University	3.6	3.0	0.6	0.0
Hospital or health care provider	3.4	2.9	0.5	0.0
Other	3.7	2.0	1.7	0.1
Number of Sites				
Single	35.5	39.7	4.2	0.1
Multiple	64.5	60.3	4.2	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	28.2	53.3	25.1	0.5
51 to 100	40.3	38.6	1.7	0.0
101 to 150	18.8	5.3	13.5	0.4
More than 150	12.7	2.8	9.9	0.3
Operates Own Preschool Head Start	80.2	88.8	8.6	0.2

Table VII.10 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Serving Pregnant Women (N = 551)	Not Serving Pregnant Women (N = 101)	Difference	Effect Size[a]
Outside Funding Sources				
State child care subsidies/ block grant	32.5	44.0	11.5	0.2
State government grant	17.1	20.9	3.8	0.1
Private foundation grants	15.1	12.1	3.0	0.1
Fundraising activities	13.4	9.2	4.2	0.1
Fee-for-service reimbursements	8.3	9.2	0.9	0.0
County/municipal government grant	8.5	7.2	1.3	0.0
Part C funds	6.4	5.6	0.8	0.0
Contracts	4.6	10.9	6.3	0.3
Grants provided by businesses	5.8	3.0	2.8	0.1
Other source	6.4	7.3	0.9	0.0
Has an MIS	88.2	89.4	1.2	0.0
Uses MIS for Reports on Services (Among Programs Using an MIS)	83.5	82.9	0.6	0.0
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	63.4	68.3	4.9	0.1
Program Approach				
Home-based	18.7	8.8	9.9	0.3
Center-based	19.7	39.9	20.2	0.5
Multiple	53.9	32.2	21.7	0.4
Combination	7.1	18.2	11.1	0.4
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	60.0	42.9	17.1	0.3
Mental health specialist	95.8	93.6	2.2	0.1
Disability specialist	93.4	83.0	10.4	0.4
Literacy specialist	57.0	53.2	3.8	0.1
Speech or language specialist	65.4	58.4	7.0	0.1
Heath care professional or nurse	92.6	80.1	12.5	0.4
Other specialist	28.9	24.3	4.6	0.1
Dietitian or nutritionist	19.4	15.1	4.3	0.1

Table VII.10 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Serving Pregnant Women (N = 551)	Not Serving Pregnant Women (N = 101)	Difference	Effect Size[a]
Employs **Only** Primary Caregivers with at Least an AA	14.2	8.6	5.6	0.2
Employs **Only** Home Visitors with at Least an AA	45.9	52.5	6.6	0.1
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	11.1	5.2	5.9	0.2
Lost Director or Manager in Past 12 Months	36.5	30.9	5.6	0.1
Rate of Employee Turnover				
Caregivers employed by program	19.3	20.9	1.6	0.1
Home visitors	24.0	22.2	1.8	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	96.8	95.5	1.3	0.1
Has Formal Agreement with Child Care Partner	41.9	43.5	1.6	0.0
Has Formal Agreement with Health Care Provider	77.3	78.6	1.3	0.0
Has Formal Agreement with Mental Health Care Provider	82.7	85.7	3.0	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.6	3.1	0.5	0.1
Family Characteristics				
Average Enrollment Turnover	33.6	37.0	3.4	0.1
Program Enrollment				
Mostly white	31.9	23.8	8.1	0.2
Mostly black	23.1	25.1	2.0	0.0
Mostly Hispanic	17.7	21.3	3.6	0.1
Mostly minority	67.2	75.2	8.0	0.2
Serve Any Families Speaking Primary Language Other than English	74.2	60.0	14.2	0.3

Table VII.10 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Serving Pregnant Women (N = 551)	Not Serving Pregnant Women (N = 101)	Difference	Effect Size[a]
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	52.0	57.8	5.8	0.1
Receiving welfare payments	28.0	21.6	6.4	0.1
Primary caregiver does not have diploma/GED	17.5	14.4	3.1	0.1
Primary caregiver unemployed or not in school	16.1	12.2	3.9	0.1
Teen mother	6.1	2.0	4.1	0.2
More than three risk factors (above)	22.6	11.2	11.4	0.3
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	24.6	14.1	10.5	0.2
Experience family violence	7.7	4.0	3.7	0.1
Mental health problems	7.0	4.9	2.1	0.1
Substance abuse	3.6	1.0	2.6	0.1
More than two risk factors (above)	13.4	6.9	6.5	0.2
Sample Size (Programs)	**170–551**	**33–101**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.11. Early Head Start Program Characteristics by Subgroup: Primary Caregiver Education[a]

Characteristics	Subgroup Levels: Percentage of Programs			
	High Education (N = 83)	Lower Education (N = 388)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	43.0	48.4	5.4	0.1
Mainly rural	40.0	38.1	1.9	0.0
Mainly suburban	13.6	10.4	3.2	0.1
Mixed	2.3	2.1	0.2	0.0
Other	1.1	1.0	0.1	0.0
Community Diversity				
High	20.8	19.2	1.6	0.0
Moderate	41.1	42.6	1.5	0.0
Low	38.2	38.2	0.0	0.0
Diversity Past Five Years				
Increased	48.1	42.7	5.4	0.1
Stayed the same	49.5	55.8	6.3	0.1
Decreased	2.4	1.5	0.9	0.1
Program Characteristics				
Program Auspice				
Community agency	69.2	70.3	1.1	0.0
Government agency	8.2	5.2	3.0	0.1
Tribal government	3.5	4.8	1.3	0.1
School	10.7	10.0	0.7	0.0
University	5.9	2.6	3.3	0.2
Hospital or health care provider	1.2	3.1	1.9	0.1
Other	1.3	4.0	2.7	0.1
Number of Sites				
Single	45.4	33.6	11.8	0.2
Multiple	54.6	66.4	11.8	0.2
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	33.2	29.6	3.6	0.1
51 to 100	46.0	38.9	7.1	0.1
101 to 150	14.6	18.6	4.0	0.1
More than 150	6.2	13.0	6.8	0.2
Program Operates Own Preschool Head Start	88.0	82.3	5.7	0.1

Table VII.11 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Education (N = 83)	Lower Education (N = 388)	Difference	Effect Size[b]
Program Outside Funding Sources				
State child care subsidies/ block grant	38.3	40.9	2.6	0.1
State government grant	20.3	18.5	1.8	0.0
Private foundation grants	13.7	13.6	0.1	0.0
Fundraising activities	13.4	14.6	1.2	0.0
Fee-for-service reimbursements	11.3	9.2	2.1	0.1
County/municipal government grant	10.5	8.5	2.0	0.1
Part C funds	3.6	6.2	2.6	0.1
Contracts	7.9	5.6	2.3	0.1
Grants provided by businesses	2.5	6.3	3.8	0.2
Other source	10.4	5.2	5.2	0.2
Has an MIS	84.1	89.3	5.2	0.2
Uses MIS for Reports on Services (Among Programs Using an MIS)	77.3	85.3	8.0	0.2
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	65.2	67.4	2.2	0.0
Program Approach				
Home-based	4.7	4.2	0.5	0.0
Center-based	13.7	29.2	15.5	0.4
Multiple	77.6	53.6	24.0	0.5
Combination	3.9	12.5	8.6	0.3
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	56.1	59.7	3.6	0.1
Mental health specialist	96.5	94.9	1.6	0.1
Disability specialist	91.3	93.1	1.8	0.1
Literacy specialist	65.7	56.7	9.0	0.2
Speech or language specialist	72.3	67.4	4.9	0.1
Heath care professional or nurse	92.8	91.3	1.5	0.1
Other specialist	21.5	30.3	8.8	0.2
Dietitian or nutritionist	20.3	18.9	1.4	0.0
Employs **Only** Primary Caregivers with at Least an AA	52.3	4.9	47.4	1.4

Table VII.11 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Education (N = 83)	Lower Education (N = 388)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	56.6	45.6	11.0	0.2
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	34.6	3.8	30.8	1.0
Lost Director or Manager in Past 12 Months	26.9	37.5	10.6	0.2
Rate of Employee Turnover				
Caregivers employed by program	17.9	20.2	2.3	0.1
Home visitors	16.3	26.1	9.8	0.3
Program Partnerships				
Has Formal Agreement with Part C Partner	100.0	95.9	4.1	0.2
Has Formal Agreement with Child Care Partner	33.8	41.1	7.3	0.1
Has Formal Agreement with Health Care Provider	70.6	80.5	9.9	0.2
Has Formal Agreement with Mental Health Care Provider	79.3	85.3	6.0	0.2
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	1.6	2.8	1.2	0.2
Family Characteristics				
Average Enrollment Turnover	32.9	32.4	0.5	0.0
Program Enrollment				
Mostly white	38.5	23.5	15.0	0.3
Mostly black	14.9	29.3	14.4	0.3
Mostly Hispanic	21.1	16.9	4.2	0.1
Mostly minority	60.3	75.7	15.4	0.3
Serve Any Families Speaking Primary Language Other than English	73.7	73.8	0.1	0.0
Programs Primarily Serving Families with the Following Demographic Risk Factors:				
Single parent	41.3	62.7	21.4	0.4
Receiving welfare payments	35.3	26.0	9.3	0.2

Table VII.11 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Education (N = 83)	Lower Education (N = 388)	Difference	Effect Size[b]
Primary caregiver does not have diploma/GED	13.4	19.0	5.6	0.1
Primary caregiver unemployed or not in school	22.6	11.8	10.8	0.3
Teen mother	8.6	7.1	1.5	0.1
More than three risk factors (above)	23.1	22.0	1.1	0.0
Programs Primarily Serving Families with the Following Psychological Risk Factors:				
Unsafe neighborhood	20.8	24.0	3.2	0.1
Experience family violence	4.8	7.8	3.0	0.1
Mental health problems	4.7	6.2	1.5	0.1
Substance abuse	3.6	3.0	0.6	0.0
More than two risk factors (above)	12.2	13.4	1.2	0.0
Sample Size (Programs)	**24–83**	**134–388**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]Higher education is defined as programs with 50 percent or more of their primary caregivers holding a bachelor's degree or higher.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.12. Early Head Start Program Characteristics by Subgroup: Families with Demographic Risks[a]

Characteristics	Subgroup Levels: Percentage of Programs			
	High Risk (N = 137)	Lower Risk (N = 497)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	50.2	44.8	5.4	0.1
Mainly rural	35.0	43.3	8.3	0.2
Mainly suburban	12.5	8.9	3.6	0.1
Mixed	2.3	2.5	0.2	0.0
Other	0.0	0.6	0.6	0.1
Community Diversity				
High	22.5	18.3	4.2	0.1
Moderate	42.4	40.9	1.5	0.0
Low	35.1	40.8	5.7	0.1
Diversity Past Five Years				
Increased	51.5	39.3	12.2	0.2
Stayed the same	47.1	59.3	12.2	0.2
Decreased	1.4	1.4	0.0	0.0
Program Characteristics				
Program Auspice				
Community agency	60.9	73.0	12.1	0.3
Government agency	6.8	5.4	1.4	0.1
Tribal government	2.2	4.9	2.7	0.1
School	14.6	8.4	6.2	0.2
University	6.8	2.4	4.4	0.2
Hospital or health care provider	0.7	3.6	2.9	0.2
Other	8.2	2.3	5.9	0.3
Number of Sites				
Single	39.8	34.3	5.5	0.1
Multiple	60.2	65.7	5.5	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	29.1	32.7	3.6	0.1
51 to 100	39.8	40.9	1.1	0.0
101 to 150	19.6	15.5	4.1	0.1
More than 150	11.4	10.9	0.5	0.0
Operates Own Preschool Head Start	76.9	83.3	6.4	0.2

Table VII.12 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Risk (N = 137)	Lower Risk (N = 497)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	29.2	36.3	7.1	0.1
State government grant	16.8	16.9	0.1	0.0
Private foundation grants	14.5	14.7	0.2	0.0
Fundraising activities	15.5	12.4	3.1	0.1
Fee-for-service reimbursements	8.6	8.6	0.0	0.0
County/municipal government grant	10.1	7.8	2.3	0.1
Part C funds	6.8	6.4	0.4	0.0
Contracts	5.5	5.6	0.1	0.0
Grants provided by businesses	4.9	5.1	0.2	0.0
Other source	9.2	6.0	3.2	0.1
Has an MIS	88.6	87.8	0.8	0.0
Uses MIS for Reports on Services (Among Programs Using an MIS)	77.9	84.7	6.8	0.2
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	61.1	64.9	3.8	0.1
Program Approach				
Home-based	16.3	17.7	1.4	0.0
Center-based	17.5	24.6	7.1	0.2
Multiple	58.0	48.4	9.6	0.2
Combination	5.9	9.2	3.3	0.1
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	62.6	55.0	7.6	0.2
Mental health specialist	97.9	94.9	3.0	0.1
Disability specialist	96.9	90.5	6.4	0.2
Literacy specialist	64.1	53.8	10.3	0.2
Speech or language specialist	70.7	63.1	7.6	0.2
Heath care professional or nurse	94.7	89.5	5.2	0.2
Other specialist	29.9	27.2	2.7	0.1
Dietitian or nutritionist	21.0	18.1	2.9	0.1
Employs **Only** Primary Caregivers with at Least an AA	15.3	12.7	2.6	0.1

Table VII.12 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Risk (N = 137)	Lower Risk (N = 497)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	46.6	47.3	0.7	0.0
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	10.5	10.5	0.0	0.0
Lost Director or Manager in Past 12 Months	42.0	33.8	8.2	0.2
Rate of Employee Turnover				
Caregivers employed by program	19.7	19.9	0.2	0.0
Home visitors	25.9	23.2	2.7	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	96.1	96.7	0.6	0.0
Has Formal Agreement with Child Care Partner	41.6	42.6	1.0	0.0
Has Formal Agreement with Health Care Provider	78.0	77.9	0.1	0.0
Has Formal Agreement with Mental Health Care Provider	79.7	84.6	4.9	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.6	2.7	0.1	0.0
Family Characteristics				
Average Enrollment Turnover	34.7	33.3	1.4	0.0
Program Enrollment				
Mostly white	24.6	32.1	7.5	0.2
Mostly black	28.4	22.1	6.3	0.1
Mostly Hispanic	20.6	18.2	2.4	0.1
Mostly minority	74.6	67.1	7.5	0.2
Serve Any Families Speaking Primary Language Other than English	78.2	70.7	7.5	0.2
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	77.4	47.2	30.2	0.6
Receiving welfare payments	59.1	19.0	40.1	0.9

Table VII.12 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs — High Risk (N = 137)	Lower Risk (N = 497)	Difference	Effect Size[b]
Primary caregiver does not have diploma/GED	40.2	11.4	28.8	0.8
Primary caregiver unemployed or not in school	37.6	10.1	27.5	0.8
Teen mother	17.1	2.8	14.3	0.6
More than three risk factors (above)	—	—	—	—
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	38.4	18.5	19.9	0.5
Experience family violence	18.2	4.3	13.9	0.5
Mental health problems	11.6	5.3	6.3	0.3
Substance abuse	5.7	2.2	3.5	0.2
More than two risk factors (above)	32.2	7.0	25.2	0.8
Sample Size (Programs)	**49–137**	**149–497**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]Programs that reported having more than 50 percent of their enrolled families with three or more demographic risks (teen mother, single parent family, primary caregiver does not have diploma/GED, primary caregiver unemployed or not in school, or receiving welfare payments).

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.13. Early Head Start Program Characteristics by Subgroup: Families with Psychological Risks[a]

Characteristics	Subgroup Levels: Percentage of Programs			
	High Risk (N = 81)	Lower Risk (N = 555)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	58.6	44.1	14.5	0.3
Mainly rural	28.5	42.9	14.4	0.3
Mainly suburban	9.0	9.9	0.9	0.0
Mixed	3.9	2.0	1.9	0.1
Other	0.0	1.1	1.1	0.1
Community Diversity				
High	22.1	18.7	3.4	0.1
Moderate	45.8	41.3	4.5	0.1
Low	32.1	40.0	7.9	0.2
Diversity Past Five Years				
Increased	41.7	42.5	0.8	0.0
Stayed the same	58.3	56.1	2.2	0.0
Decreased	0.0	1.4	1.4	0.1
Program Characteristics				
Program Auspice				
Community agency	59.5	71.8	12.3	0.3
Government agency	2.5	6.0	3.5	0.1
Tribal government	4.8	4.1	0.7	0.0
School	11.9	9.5	2.4	0.1
University	7.6	2.9	4.7	0.3
Hospital or health care provider	5.2	3.0	2.2	0.1
Other	8.6	2.8	5.8	0.3
Number of Sites				
Single	38.7	35.5	3.2	0.1
Multiple	61.3	64.6	3.3	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	20.6	32.9	12.3	0.3
51 to 100	47.6	39.4	8.2	0.2
101 to 150	10.0	17.8	7.8	0.2
More than 150	21.8	9.9	11.9	0.4
Operates Own Preschool Head Start	75.3	82.6	7.3	0.2

Table VII.13 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs — High Risk (N = 81)	Lower Risk (N = 555)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	31.1	35.3	4.2	0.1
State government grant	17.1	18.0	0.9	0.0
Private foundation grants	18.4	14.0	4.4	0.1
Fundraising activities	12.8	13.0	0.2	0.0
Fee-for-service reimbursements	6.6	8.3	1.7	0.1
County/municipal government grant	10.6	7.7	2.9	0.1
Part C funds	9.1	5.9	3.2	0.1
Contracts	4.2	5.3	1.1	0.0
Grants provided by businesses	5.5	5.2	0.3	0.0
Other source	12.1	5.8	6.3	0.3
Has an MIS	88.0	88.2	0.2	0.0
Uses MIS for Reports on Services (Among Programs Using an MIS)	79.0	84.1	5.1	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	62.9	64.2	1.3	0.0
Program Approach				
Home-based	10.8	17.6	6.8	0.2
Center-based	15.8	24.0	8.2	0.2
Multiple	64.7	49.3	15.4	0.3
Combination	7.6	8.8	1.2	0.0
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	52.1	58.1	6.0	0.1
Mental health specialist	100.0	94.8	5.2	0.3
Disability specialist	94.1	91.8	2.3	0.1
Literacy specialist	52.7	57.6	4.9	0.1
Speech or language specialist	52.9	66.6	13.7	0.3
Heath care professional or nurse	91.9	90.9	1.0	0.0
Other specialist	30.6	27.1	3.5	0.1
Dietitian or nutritionist	24.5	17.9	6.6	0.2
Employs **Only** Primary Caregivers with at Least an AA	17.8	12.3	5.5	0.2

Table VII.13 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Risk (N = 81)	Lower Risk (N = 555)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	43.6	46.6	3.0	0.1
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	11.1	10.0	1.1	0.0
Lost Director or Manager in Past 12 Months	37.3	35.9	1.4	0.0
Rate of Employee Turnover				
Caregivers employed by program	22.3	19.3	3.0	0.1
Home visitors	21.8	24.5	2.7	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	95.7	96.7	1.0	0.1
Has Formal Agreement with Child Care Partner	39.4	42.3	2.9	0.1
Has Formal Agreement with Health Care Provider	77.6	77.2	0.4	0.0
Has Formal Agreement with Mental Health Care Provider	79.0	84.0	5.0	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.0	2.8	0.8	0.1
Family Characteristics				
Average Enrollment Turnover	33.5	33.8	0.3	0.0
Program Enrollment				
Mostly white	18.9	31.9	13.0	0.3
Mostly black	27.7	22.8	4.9	0.1
Mostly Hispanic	22.6	17.9	4.7	0.1
Mostly minority	81.1	67.2	13.9	0.3
Serve Any Families Speaking Primary Language Other than English	77.0	71.9	5.1	0.1
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	67.0	51.9	15.1	0.3
Receiving welfare payments	46.8	25.0	21.8	0.5
Primary caregiver does not have diploma/GED	30.9	15.9	15.0	0.4

Table VII.13 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs — High Risk (N = 81)	Lower Risk (N = 555)	Difference	Effect Size[b]
Primary caregiver unemployed or not in school	32.0	13.5	18.5	0.5
Teen mother	14.4	4.7	9.7	0.4
More than three risk factors (above)	53.8	16.3	37.5	0.9
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	69.0	17.0	52.0	1.2
Experience family violence	44.7	1.9	42.8	1.7
Mental health problems	27.9	3.7	24.2	1.0
Substance abuse	13.2	1.8	11.4	0.7
More than two risk factors (above)	—	—	—	—
Sample Size (Programs)	**28–81**	**169–555**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]Programs that reported having more than 50 percent of their enrolled families with two or more psychological risks (mental health problems, substance abuse, residing in an unsafe neighborhood, or experiencing family violence) make up the high-risk subgroup.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.14. Early Head Start Program Characteristics by Subgroup: Proportion of Teen Mothers[a]

Characteristics	Subgroup Levels: Percentage of Programs: High Proportion Teen Mothers (N = 314)	Lower Proportion Teen Mothers (N = 334)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	46.4	45.4	1.0	0.0
Mainly rural	41.5	40.7	0.8	0.0
Mainly suburban	8.8	10.7	1.9	0.1
Mixed	2.3	2.5	0.2	0.0
Other	1.0	0.8	0.2	0.0
Community Diversity				
High	18.8	18.8	0.0	0.0
Moderate	40.1	42.6	2.5	0.1
Low	41.1	38.6	2.5	0.1
Diversity Past Five Years				
Increased	42.2	42.2	0.0	0.0
Stayed the same	56.5	56.6	0.1	0.0
Decreased	1.3	1.2	0.1	0.0
Program Characteristics				
Program Auspice				
Community agency	66.1	73.9	7.8	0.2
Government agency	5.8	5.4	0.4	0.0
Tribal government	5.3	3.2	2.1	0.1
School	11.7	8.0	3.7	0.1
University	3.2	4.0	0.8	0.0
Hospital or health care provider	3.7	2.8	0.9	0.1
Other	4.2	2.8	1.4	0.1
Number of Sites				
Single	33.3	38.8	5.5	0.1
Multiple	66.7	61.2	5.5	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	29.9	34.3	4.4	0.1
51 to 100	38.4	41.4	3.0	0.1
101 to 150	19.3	14.1	5.2	0.1
More than 150	12.4	10.2	2.2	0.1
Operates Own Preschool Head Start	79.5	83.5	4.0	0.1

Table VII.14 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Proportion Teen Mothers (N = 314)	Lower Proportion Teen Mothers (N = 334)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	33.8	35.4	1.6	0.0
State government grant	21.2	14.7	6.5	0.2
Private foundation grants	14.2	15.4	1.2	0.0
Fundraising activities	13.6	12.5	1.1	0.0
Fee-for-service reimbursements	7.5	8.8	1.3	0.0
County/municipal government grant	10.9	5.1	5.8	0.2
Part C funds	8.1	4.7	3.4	0.1
Contracts	5.2	5.7	0.5	0.0
Grants provided by businesses	6.6	4.1	2.5	0.1
Other source	5.8	7.1	1.3	0.1
Has an MIS	88.0	88.9	0.9	0.0
Uses MIS for Reports on Services (Among Programs Using an MIS)	82.2	84.6	2.4	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	64.0	64.3	0.3	0.0
Program Approach				
Home-based	14.7	19.1	4.4	0.1
Center-based	22.7	23.9	1.2	0.0
Multiple	51.8	49.6	2.2	0.0
Combination	10.1	6.9	3.2	0.1
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	56.8	57.5	0.7	0.0
Mental health specialist	95.4	95.5	0.1	0.0
Disability specialist	92.1	92.1	0.0	0.0
Literacy specialist	59.0	54.1	4.9	0.1
Speech or language specialist	68.9	60.8	8.1	0.2
Heath care professional or nurse	93.0	89.1	3.9	0.1
Other specialist	29.2	25.5	3.7	0.1
Dietitian or nutritionist	19.2	18.7	0.5	0.0
Employs **Only** Primary Caregivers with at Least an AA	10.9	15.6	4.7	0.1

Table VII.14 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Proportion Teen Mothers (N = 314)	Lower Proportion Teen Mothers (N = 334)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	44.1	49.0	4.9	0.1
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	7.6	13.5	5.9	0.2
Lost Director or Manager in Past 12 Months	33.5	37.5	4.0	0.1
Rate of Employee Turnover				
Caregivers employed by program	18.7	20.3	1.6	0.1
Home visitors	24.3	23.7	0.6	0.0
Program Partnerships				
Has Formal Agreement with Part C Partner	97.0	96.6	0.4	0.0
Has Formal Agreement with Child Care Partner	42.5	41.8	0.7	0.0
Has Formal Agreement with Health Care Provider	78.1	77.0	1.1	0.0
Has Formal Agreement with Mental Health Care Provider	82.2	84.5	2.3	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.4	2.9	0.5	0.1
Family Characteristics				
Average Enrollment Turnover	33.9	33.2	0.7	0.0
Program Enrollment				
Mostly white	29.9	31.5	1.6	0.0
Mostly black	24.0	22.4	1.6	0.0
Mostly Hispanic	16.8	20.0	3.2	0.1
Mostly minority	69.5	67.6	1.9	0.0
Serve Any Families Speaking Primary Language Other than English	70.7	73.3	2.6	0.1

Table VII.14 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Proportion Teen Mothers (N = 314)	Lower Proportion Teen Mothers (N = 334)	Difference	Effect Size[b]
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	62.6	45.2	17.4	0.3
Receiving welfare payments	29.2	25.7	3.5	0.1
Primary caregiver does not have diploma/GED	22.1	12.9	9.2	0.2
Primary caregiver unemployed or not in school	13.7	17.6	3.9	0.1
Teen mother	—	—	—	—
More than three risk factors (above)	23.7	18.3	5.4	0.1
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	25.3	21.4	3.9	0.1
Experience family violence	10.3	4.2	6.1	0.2
Mental health problems	9.0	4.2	4.8	0.2
Substance abuse	3.8	2.3	1.5	0.1
More than two risk factors (above)	14.8	10.1	4.7	0.1
Sample Size (Programs)	**110–314**	**92–334**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We defined programs with high proportions of teen mothers as those with teen mothers making up more than 10 percent of their enrollment.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.15. Early Head Start Program Characteristics by Subgroup: Proportion of Children with Developmental Concerns

	Subgroup Levels			
	Percentage of Programs			
Characteristics	High Level Children with Developmental Concerns[a] (N = 276)	Lower Level Children with Developmental Concerns (N = 334)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	43.5	46.9	3.4	0.1
Mainly rural	42.0	41.4	0.6	0.0
Mainly suburban	10.8	9.1	1.7	0.1
Mixed	3.0	1.5	1.5	0.1
Other	0.7	1.2	0.5	0.1
Community Diversity				
High	17.5	20.0	2.5	0.1
Moderate	44.8	38.3	6.5	0.1
Low	37.8	41.6	3.8	0.1
Diversity Past Five Years				
Increased	44.9	40.2	4.7	0.1
Stayed the same	54.4	58.0	3.6	0.1
Decreased	0.7	1.8	1.1	0.1
Program Characteristics				
Program Auspice				
Community agency	70.4	69.1	1.3	0.0
Government agency	5.5	5.4	0.1	0.0
Tribal government	3.9	5.0	1.1	0.1
School	9.2	11.2	1.9	0.1
University	4.1	3.0	1.1	0.1
Hospital or health care provider	4.3	2.4	1.9	0.1
Other	2.6	4.0	1.4	0.1
Number of Sites				
Single	35.6	37.0	1.4	0.0
Multiple	64.5	63.0	1.5	0.0
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	32.3	29.9	2.4	0.1
51 to 100	39.4	41.2	1.8	0.0
101 to 150	18.0	15.9	2.1	0.1
More than 150	10.3	13.0	2.7	0.1
Operates Own Preschool Head Start	79.8	83.4	3.6	0.1

Table VII.15 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Level Children with Developmental Concerns[a] (N = 276)	Lower Level Children with Developmental Concerns (N = 334)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	31.4	34.7	3.3	0.1
State government grant	17.1	17.9	0.8	0.0
Private foundation grants	15.4	14.9	0.5	0.0
Fundraising activities	13.8	13.3	0.5	0.0
Fee-for-service reimbursements	6.0	8.4	2.4	0.1
County/municipal government grant	7.1	8.2	1.1	0.0
Part C funds	8.0	5.1	2.9	0.1
Contracts	4.2	5.1	0.9	0.0
Grants provided by businesses	4.6	5.5	0.9	0.0
Other source	5.3	7.3	2.0	0.1
Has an MIS	86.2	90.3	4.1	0.1
Uses MIS for Reports on Services (Among Programs Using an MIS)	83.3	83.3	0.0	0.0
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	59.0	67.3	8.3	0.2
Program Approach				
Home-based	19.4	16.1	3.3	0.1
Center-based	19.5	23.5	4.0	0.1
Multiple	53.3	52.0	1.3	0.0
Combination	7.7	7.2	0.5	0.0
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	55.5	58.9	3.4	0.1
Mental health specialist	95.3	95.6	0.3	0.0
Disability specialist	93.1	92.0	1.1	0.0
Literacy specialist	55.5	58.7	3.2	0.1
Speech or language specialist	64.1	65.8	1.7	0.0
Heath care professional or nurse	90.9	90.9	0.0	0.0
Other specialist	25.3	27.7	2.4	0.1
Dietitian or nutritionist	21.3	17.9	3.4	0.1
Employs **Only** Primary Caregivers with AA	16.7	10.3	6.4	0.2

Table VII.15 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Level Children with Developmental Concerns[a] (N = 276)	Lower Level Children with Developmental Concerns (N = 334)	Difference	Effect Size[b]
Employs **Only** Home Visitors with AA	51.0	42.9	8.1	0.2
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	14.5	6.9	7.6	0.3
Lost Director or Manager in Past 12 Months	31.9	38.4	6.5	0.1
Rate of Employee Turnover				
Caregivers employed by program	21.0	18.0	3.0	0.1
Home visitors	23.5	23.9	0.4	0.0
Program Partnerships				
Has Formal Agreement with Part C Partner	96.9	96.8	0.1	0.0
Part C Partnership Features				
Referrals to Part C	99.6	98.6	1.0	0.1
Referrals to Early Head Start	98.8	97.6	1.2	0.1
Share assessments	97.0	97.2	0.2	0.0
Staff meetings	91.7	86.8	4.9	0.2
Has Formal Agreement with Child Care Partner	41.5	41.3	0.2	0.0
Has Formal Agreement with Health Care Provider	74.8	79.0	4.2	0.1
Has Formal Agreement with Mental Health Care Provider	82.4	84.7	2.3	0.1
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.3	2.8	0.5	0.1
Family Characteristics				
Average Enrollment Turnover	36.2	31.3	4.9	0.2
Program Enrollment				
Mostly white	34.4	27.6	6.8	0.1
Mostly black	17.3	27.2	9.9	0.2
Mostly Hispanic	19.1	16.9	2.2	0.1
Mostly minority	64.5	71.8	7.3	0.2

Table VII.15 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: High Level Children with Developmental Concerns[a] (N = 276)	Lower Level Children with Developmental Concerns (N = 334)	Difference	Effect Size[b]
Serve Any Families Speaking Primary Language Other than English	76.0	71.5	4.5	0.1
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	50.5	56.1	5.6	0.1
Receiving welfare payments	26.9	29.0	2.1	0.0
Primary caregiver does not have diploma/GED	16.7	17.8	1.1	0.0
Primary caregiver unemployed or not in school	18.8	14.1	4.7	0.1
Teen mother	4.4	7.0	2.6	0.1
More than three risk factors (above)	21.5	21.6	0.1	0.0
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	24.5	23.7	0.8	0.0
Experience family violence	8.2	6.5	1.7	0.1
Mental health problems	7.1	5.7	1.4	0.1
Substance abuse	3.1	3.0	0.1	0.0
More than two risk factors (above)	14.3	11.3	3.0	0.1
Sample Size (Programs)	**84–276**	**104–334**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]Programs that have more than 20 percent of enrolled children with suspected or diagnosed disabilities make up the "high level of children with developmental concerns" subgroup. Those with fewer than 20 percent are the "lower level of developmental concerns" subgroup.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.16. Early Head Start Program Characteristics by Subgroup: Minority Enrollment[a]

Characteristics	Subgroup Levels: Percentage of Programs: Primarily Minority (N = 439)	Primarily Nonminority (N = 207)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	59.2	18.0	41.2	0.8
Mainly rural	26.5	72.5	46.0	0.9
Mainly suburban	11.1	6.5	4.6	0.2
Mixed	2.0	2.6	0.6	0.0
Other	1.1	0.5	0.7	0.1
Community Diversity				
High	25.9	4.8	21.1	0.5
Moderate	47.3	28.1	19.2	0.4
Low	26.9	67.1	40.2	0.8
Diversity Past Five Years				
Increased	44.8	35.6	9.2	0.2
Stayed the same	53.4	63.9	10.5	0.2
Decreased	1.8	0.5	1.3	0.1
Program Characteristics				
Program Auspice				
Community agency	65.5	78.8	13.3	0.3
Government agency	5.9	5.4	0.5	0.0
Tribal government	6.0	0.4	5.6	0.3
School	10.8	7.8	3.0	0.1
University	4.4	1.9	2.5	0.1
Hospital or health care provider	3.6	2.8	0.8	0.0
Other	3.8	2.8	1.0	0.1
Number of Sites				
Single	37.9	30.8	7.2	0.1
Multiple	62.1	69.3	7.2	0.1
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	32.0	32.4	0.4	0.0
51 to 100	39.0	43.0	4.0	0.1
101 to 150	16.2	17.2	1.0	0.0
More than 150	12.8	7.4	5.4	0.2
Operates Own Preschool Head Start	79.8	85.2	5.3	0.1

Table VII.16 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Primarily Minority (N = 439)	Primarily Nonminority (N = 207)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	34.6	35.2	0.6	0.0
State government grant	15.4	22.7	7.3	0.2
Private foundation grants	16.2	12.9	3.3	0.1
Fundraising activities	14.2	10.3	3.9	0.1
Fee-for-service reimbursements	7.7	10.0	2.3	0.1
County/municipal government grant	9.1	6.4	2.7	0.1
Part C funds	5.9	7.3	1.4	0.1
Contracts	6.9	3.0	3.9	0.2
Grants provided by businesses	5.5	5.3	0.2	0.0
Other source	7.3	4.9	2.4	0.1
Has an MIS	85.7	94.0	8.3	0.3
Uses MIS for Reports on Services (Among Programs Using an MIS)	85.0	80.3	4.7	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	69.1	55.2	13.9	0.3
Program Approach				
Home-based	12.3	27.7	15.4	0.4
Center-based	30.0	9.0	21.0	0.5
Multiple	46.4	58.9	12.5	0.2
Combination	10.5	4.0	6.5	0.2
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	59.3	52.5	6.8	0.1
Mental health specialist	96.4	93.4	3.0	0.1
Disability specialist	92.5	90.5	2.0	0.1
Literacy specialist	54.1	61.8	7.7	0.2
Speech or language specialist	64.8	66.1	1.3	0.0
Heath care professional or nurse	91.9	89.4	2.5	0.1
Other specialist	29.8	23.8	6.0	0.1
Dietitian or nutritionist	18.0	20.3	2.3	0.1
Employs **Only** Primary Caregivers with at Least an AA	12.1	14.8	2.7	0.1

Table VII.16 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Primarily Minority (N = 439)	Primarily Nonminority (N = 207)	Difference	Effect Size[b]
Employs **Only** Home Visitors with at Least an AA	45.7	48.7	3.0	0.1
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	7.3	15.9	8.6	0.3
Lost Director or Manager in Past 12 Months	38.0	30.7	7.3	0.2
Rate of Employee Turnover				
Caregivers employed by program	18.3	22.8	4.5	0.2
Home visitors	23.7	24.3	0.6	0.0
Program Partnerships				
Has Formal Agreement with Part C Partner	95.7	98.5	2.8	0.2
Has Formal Agreement with Child Care Partner	43.0	39.9	3.1	0.1
Has Formal Agreement with Health Care Provider	80.6	70.8	9.8	0.2
Has Formal Agreement with Mental Health Care Provider	83.3	83.3	0.0	0.0
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	2.7	2.4	0.3	0.0
Family Characteristics				
Average Enrollment Turnover	32.4	36.1	3.7	0.1
Program Enrollment				
Mostly white	0.0	97.1	97.1	2.1
Mostly black	34.5	0.0	34.5	0.8
Mostly Hispanic	26.7	0.0	26.7	0.7
Mostly minority	—	—	—	—
Serve Any Families Speaking Primary Language Other than English	78.8	57.4	21.4	0.5
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	60.9	38.5	22.4	0.4
Receiving welfare payments	28.6	24.2	4.4	0.1

Table VII.16 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Primarily Minority (N = 439)	Primarily Nonminority (N = 207)	Difference	Effect Size[b]
Primary caregiver does not have diploma/GED	21.3	9.1	12.2	0.3
Primary caregiver unemployed or not in school	12.7	21.5	8.8	0.2
Teen mother	7.4	2.5	4.9	0.2
More than three risk factors (above)	22.7	16.8	5.9	0.1
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	31.9	4.3	27.6	0.7
Experience family violence	9.2	3.2	6.0	0.2
Mental health problems	5.3	9.4	4.1	0.2
Substance abuse	2.7	3.8	1.0	0.1
More than two risk factors (above)	14.7	7.4	7.3	0.2
Sample Size (Programs)	**155–439**	**48–207**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We defined programs with more than 50 percent racial/ethnic minority enrollment as the "primarily minority" subgroup.

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

Table VII.17. Early Head Start Program Characteristics by Subgroup: Serving Non-English Speaking Families[a]

Characteristics	Subgroup Levels: Percentage of Programs: Many Non-English-Speaking (N = 199)	Fewer Non-English-Speaking (N = 264)	Difference	Effect Size[b]
Community Characteristics				
Service Area				
Mainly urban	62.9	42.5	20.4	0.4
Mainly rural	17.5	44.6	27.1	0.6
Mainly suburban	15.5	9.8	5.7	0.2
Mixed	2.6	2.4	0.2	0.0
Other	1.5	0.7	0.8	0.1
Community Diversity				
High	41.1	12.2	28.9	0.7
Moderate	37.0	54.0	17.0	0.3
Low	21.8	33.8	12.0	0.2
Diversity Past Five Years				
Increased	52.3	46.9	5.4	0.1
Stayed the same	45.2	51.6	6.4	0.1
Decreased	2.5	1.5	1.0	0.1
Program Characteristics				
Program Auspice				
Community agency	69.8	73.5	3.7	0.1
Government agency	5.9	4.7	1.2	0.1
Tribal government	2.4	1.5	0.9	0.0
School	12.2	9.6	2.6	0.1
University	3.1	4.6	1.5	0.1
Hospital or health care provider	4.1	2.2	1.9	0.1
Other	2.7	3.8	1.1	0.1
Number of Sites				
Single	32.4	33.8	1.4	0.0
Multiple	67.6	66.2	1.4	0.0
Program Enrollment (Number of Children and Pregnant Women)				
50 or fewer	25.6	25.6	0.0	0.0
51 to 100	44.4	41.1	3.3	0.1
101 to 150	14.3	21.1	6.8	0.2
More than 150	15.7	12.3	3.4	0.1
Operates Own Preschool Head Start	81.9	80.5	1.4	0.0

Table VII.17 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Many Non-English-Speaking (N = 199)	Fewer Non-English-Speaking (N = 264)	Difference	Effect Size[b]
Outside Funding Sources				
State child care subsidies/ block grant	32.4	40.6	8.2	0.2
State government grant	15.2	19.6	4.4	0.1
Private foundation grants	17.4	18.6	1.2	0.0
Fundraising activities	13.1	16.1	3.0	0.1
Fee-for-service reimbursements	6.8	10.7	3.9	0.1
County/municipal government grant	11.7	7.5	4.2	0.2
Part C funds	5.2	6.2	1.0	0.0
Contracts	4.8	6.2	1.4	0.1
Grants provided by businesses	5.8	6.7	0.9	0.0
Other source	6.3	5.8	0.5	0.0
Has an MIS	82.4	92.5	10.1	0.3
Uses MIS for Reports on Services (Among Programs Using an MIS)	80.8	82.8	2.0	0.1
Uses MIS for Individual Progress Reports (Among Programs Using an MIS)	63.0	65.5	2.5	0.1
Program Approach				
Home-based	19.3	15.0	4.3	0.1
Center-based	15.7	26.2	10.5	0.2
Multiple	52.6	52.1	0.5	0.0
Combination	11.8	6.3	5.5	0.2
Staff Characteristics				
Program Employs or Has Access to:				
Male involvement specialist	54.3	60.8	6.5	0.1
Mental health specialist	96.6	94.8	1.8	0.1
Disability specialist	93.0	93.3	0.3	0.0
Literacy specialist	56.4	55.8	0.6	0.0
Speech or language specialist	62.8	63.7	0.9	0.0
Health care professional or nurse	93.6	89.8	3.8	0.1
Other specialist	27.3	33.8	6.5	0.1
Dietitian or nutritionist	24.0	14.9	9.1	0.2
Employs **Only** Primary Caregivers with at Least an AA	14.8	9.3	5.5	0.2
Employs **Only** Home Visitors with at Least an AA	39.7	54.0	14.3	0.3

Table VII.17 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Many Non-English-Speaking (N = 199)	Fewer Non-English-Speaking (N = 264)	Difference	Effect Size[b]
Employs **Only** Primary Caregivers and Home Visitors with at Least an AA	6.9	9.2	2.3	0.1
Lost Director or Manager in Past 12 Months	37.8	39.6	1.8	0.0
Rate of Employee Turnover				
Caregivers employed by program	16.4	22.0	5.6	0.2
Home visitors	25.4	22.3	3.1	0.1
Program Partnerships				
Has Formal Agreement with Part C Partner	93.8	98.0	4.2	0.2
Has Formal Agreement with Child Care Partner	41.4	42.5	1.1	0.0
Has Formal Agreement with Health Care Provider	77.6	78.2	0.6	0.0
Has Formal Agreement with Mental Health Care Provider	78.4	87.7	9.3	0.2
Number of Preschool Head Start Programs with Formal Agreement to Coordinate Transition Services	3.4	2.0	1.4	0.2
Family Characteristics				
Average Enrollment Turnover	37.3	34.3	3.0	0.1
Program Enrollment				
Mostly white	4.0	38.8	34.8	0.8
Mostly black	10.7	29.9	19.2	0.5
Mostly Hispanic	43.5	7.4	36.1	0.9
Mostly minority	95.0	59.7	35.3	0.8
Serve Any Families Speaking Primary Language Other than English	—	—	—	—
Programs Primarily Serving Families with Demographic Risk Factors:				
Single parent	46.6	60.3	13.7	0.3
Receiving welfare payments	25.6	28.4	2.8	0.1
Primary caregiver does not have diploma/GED	28.3	12.6	15.7	0.4

Table VII.17 *(continued)*

Characteristics	Subgroup Levels: Percentage of Programs: Many Non-English-Speaking (N = 199)	Fewer Non-English-Speaking (N = 264)	Difference	Effect Size[b]
Primary caregiver unemployed or not in school	15.1	15.9	0.8	0.0
Teen mother	5.5	4.7	0.8	0.0
More than three risk factors (above)	22.3	23.0	0.7	0.0
Programs Primarily Serving Families with Psychological Risk Factors:				
Unsafe neighborhood	33.7	22.0	11.7	0.3
Experience family violence	10.1	5.4	4.7	0.2
Mental health problems	6.0	6.7	0.7	0.0
Substance abuse	1.5	3.4	1.9	0.1
More than two risk factors (above)	16.2	11.3	4.9	0.1
Sample Size (Programs)	**68–199**	**84–264**		

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse.

[a]We defined programs serving more than 25 percent of enrollees with a primary language other than English as “many non-English-speaking.”

[b]We calculated effect sizes by taking the absolute value of the difference between means and dividing by the population standard deviation. For subgroups with more than two levels, we calculated the difference between the maximum and minimum means and divided by the population standard deviation.

CHAPTER VIII

CROSS-CUTTING THEMES AND DIRECTIONS FOR FUTURE RESEARCH

Previous chapters have described the extensive information that the Survey of Early Head Start Programs provides on fundamental aspects of the program—including characteristics of communities and families, services, management and staffing, and partnerships. The survey builds upon existing data from the Program Information Report, offering detailed quantitative and qualitative data on program operations and enrollment. It also highlights the wide range of services and experiences among current Early Head Start programs and offers a baseline for future inquiries on their operation and context.

In this chapter, we propose broad themes identified from survey data; in doing so, we review some of the key findings presented in previous chapters. We then suggest potential avenues for future research.

CROSS-CUTTING THEMES

Several cross-cutting themes emerge from a broad examination of the survey findings. In identifying these themes, we pay special attention to areas of concurrence between the survey's quantitative and qualitative data. We highlight connections that indicate key trends and challenges for Early Head Start programs.

- Community context, especially urbanicity, is associated to some extent with program services and management.

Survey data support the notion that program approaches and service offerings are associated with community context. As noted in Chapter VII, urban programs are more likely than suburban and rural ones to follow a center-based approach, while rural programs are most likely to implement a home-based model. Multiple approach programs make up about half of programs in each service area but are most prevalent in suburban areas. On the other hand, combination programs are low in prevalence overall, but are least likely to be in a suburban setting. In describing their reasons for choosing a particular approach, program leaders often mentioned efforts to meet the needs of local families (for example, by making child care available to parents who are working or in school). Program staff also noted such factors as parents' access to transportation, or other limitations in local resources,

when choosing a program model. Affiliation with a preschool Head Start program may also be a factor in choice of model; rural programs are most likely to be affiliated with a preschool Head Start program, but differences among programs across areas are not large.

Context also may be linked with program staffing, but the patterns in this area are less clear. Suburban programs seem most resource rich in general. They are the most likely to employ home visitors with an associate's or higher degree, and they have the most access to specialists. Conversely, rural programs are the least likely to have these attributes. We caution that the suburban subgroup is made up of a small number of programs, and differences may be exaggerated as a result. However, it is also possible that programs in rural areas with limited labor pools find it more difficult to identify and hire well-qualified staff, and may have less access to specialists. The distinction between rural and other programs is not consistent across all types of staff, however; there is no notable difference in the credentials of primary caregivers in rural or urban programs.

Community demographics and patterns of family and community risk factors may be additional influences on hiring decisions. For example, programs in increasingly diverse communities tend to serve more racial/ethnic and language minority families. During site visits, managers of programs in such areas described their efforts to recruit and hire staff whose linguistic skills and ethnic background match those enrolled families.

These survey findings—that small, home-based, and rural programs have the least access to highly educated staff or specialists compared with larger, urban, multiple approach programs, may have implications for T/TA. Targeted T/TA and perhaps additional resources for small, home-based, rural programs may be warranted to support their efforts to hire and retain qualified staff.

- Early Head Start program work to serve families at high risk.

Families enrolled in Early Head Start present complex combinations of risk factors. Risks include children with identified disabilities, as well as families experiencing numerous simultaneous high risk characteristics and events, any one of which could present challenges to programs in providing services. Further complicating matters, the risk profile for a particular family can change—perhaps rapidly—over time.

Programs that serve many families in acute crisis were more likely to use a multiple service approach, suggesting that flexibility in the choice of approach may be important to serving them effectively. Further, these programs require staff with the skills and resources to cope with hard-to-serve families and deliver Early Head Start services. We might expect to see high rates of staff turnover, but found it does not differ across programs serving many high risk versus fewer high risk families. As described in Chapter VII, programs whose enrollment is characterized by many families with high psychological risks are more likely than other programs to employ mental health specialists. Evidently, programs have found ways to recruit and retain appropriate staff. However, given the prevalence of high risk families and the challenges they present, programs serving many such families may need continued and additional support, staff training, and technical assistance.

- Early Head Start programs are not static—as a group and individually, they change the mix of services they provide. They also experience transitions in staff and management structure, as well as in the characteristics of the families they serve.

Survey data provide some insight not only on Early Head Start programs' current circumstances, but also on how they have changed. As noted in Chapter IV, about two-thirds of programs indicated they had made some change to program organization or program design since they began. Programs most often altered their organizational structure, but changes to program design were also frequent, with two-fifths of programs adding center-based services to their offerings, one-fifth adding home-based services, and one-tenth dropping home-based services. Such changes could be due to a variety of factors, including needs expressed by families, welfare reforms requiring families to work or attend school full-time, findings from the EHSREP evaluation that multiple approach programs had the broadest pattern of impacts, or a continued focus on individualizing and customizing services as programs mature. The movement toward multiple approaches observed in the EHSREP seems to have been maintained. This may be a response by programs to be able to flexibly meet the changing needs of families.

As with many providers of early childhood education, staffing changes and turnover are a common feature of Early Head Start programs. As noted in Chapter V, turnover at the director level is infrequent, with just over 1 in 10 programs experiencing a change in directors during the past year. However, turnover among frontline staff is higher: programs reported that about a quarter of all home visitors left their positions in the past year, and about one-fifth of all primary caregivers. (Compared with average staff turnover in early childhood programs, these rates might be considered moderate. According to state-level data compiled by the Center for the Child Care Workforce [2004], turnover rates among frontline early childhood staff typically range between 25 and 40 percent). However, staff transitions plainly create challenges for program directors and managers and have implications for the ability of children and families' to form close relationships with staff.

Some programs operating in communities experiencing demographic shifts also report changes in the race/ethnicity of the populations they serve. For example, about one-fifth of programs serving Hispanic families indicated that the number of such families has increased substantially over the past five years. Such demographic changes have implications for the kinds of skills and cultural competencies that staff need.

- Many Early Head Start programs establish strong connections with other service providers, but some links appear to be easier to forge than others.

The Survey of Early Head Start Programs explores in detail the characteristics of program partnerships with other agencies, as well as the successes and challenges programs have experienced in developing such connections. Many programs have partnerships with Part C agencies, health care providers, and mental health providers. Partnerships for child development services are less common, however, and most programs provide all the services they offer directly. These patterns suggest that Early Head Start programs are especially

likely to pursue organizational links that complement their own expertise and that offer the potential to address specific unmet family needs. It is also possible that creating partnerships for disability, health care, or similar services is a less complex process than establishing links for child development services, because programs with child care partnerships bear substantial responsibility for ensuring that such services meet performance standards. Interviews during site visits suggest that some staff feel the benefits of building partnerships for child care are not always worth the time and resources required.

Integration of Early Head Start and Head Start services could also be considered a process of establishing partnerships, though this often occurs within agencies. As with child care partnerships, programs appear to experience a mixed pattern of successes and challenges in creating connections. As described in Chapter III, a large majority of Early Head Start programs operate under the same agency auspices as preschool Head Start programs, but not all these programs offer seamless birth-to-5 services. Leaders of nearly half the Early Head Start programs receiving site visits cited their intention to integrate their services with preschool Head Start programs and described the progress they have made toward doing so. However, challenges to creating seamless services remain, such as (1) imbalances in enrollment levels between Early Head Start and Head Start programs, (2) addressing staff perceptions that they cannot learn the skills to work with older or younger children, and (3) the tension between offering continued services, birth through age 5, and fostering independence of families as well as serving more families.

- Early Head Start programs face the challenge of adapting to federal and state policies regarding whom they serve and employ.

As a means-tested (eligibility dependent upon income) government program, Early Head Start features requirements and eligibility criteria with which agencies receiving funding must comply. These requirements help ensure that the program maintains quality services and that it reaches those families who need its assistance most. However, policies at the federal and state levels also create challenges for Early Head Start programs as they try to provide continuous services and recruit and employ qualified staff.

Enrollments and transitions can be complicated by eligibility criteria under some circumstances. For instance, during site visits, some programs serving teen parents indicated that such parents are sometimes classified as "over income" because the income of their own parents' is considered in determination of eligibility. Early Head Start children ready to transition to preschool may not qualify to continue receiving services through Head Start because of changes in family income since their initial enrollment. In such cases, alternatives for child care and family services must be identified. Early Head Start agencies also take into consideration the eligibility requirements of other programs, such as the Child Care and Development Fund (CCDF). Subsidies provided with CCDF funds sometimes help fund child care slots at a partner center, for instance. Changes in parents' eligibility for the subsidies can affect the stability of a child's placement and the overall partnership.

Early Head Start programs are also subject to policies regarding minimum qualifications for staff. In many cases, however, a gap appears to exist between staff qualification

requirements and availability of appropriately credentialed applicants. Programs may respond by prioritizing higher educational qualifications for some positions. For example, one possible reason that home visitors tend to have higher credentials than primary caregivers is programs' intent to have more qualified people in positions that require greater staff independence. Programs may also respond to these requirements by investing resources to establish clear pathways for staff to enhance their credentials within the grace period defined under Head Start Program Performance Standards.

- Most Early Head Start programs have an MIS and many are using it to aggregate and track data at the program and individual levels.

Early Head Start programs have been encouraged to use data to improve service delivery for families and to target areas for staff training and support improvement efforts. Most programs have an MIS (88 percent) and of those about three-quarters are satisfied with its performance. Of the one-quarter of MIS users who are not satisfied, many (40 percent) find that the reports generated by the MIS are not useful. Without useful reports, programs will have little incentive to use their MIS in new ways, such as for tracking progress and targeting staff training.

Most MIS can generate basic reports, such as enrollment lists; fewer are useful for tracking ongoing child assessment information or staff training and characteristics—something that may be beneficial for programs to target services and training. The main challenges programs have with MIS are software problems (57 percent), difficulty of use (42 percent), and limited usefulness of reports (40 percent). Efforts to help programs install, use, and troubleshoot MIS may help them make greater use of the data they collect.

DIRECTIONS FOR FUTURE RESEARCH

Having provided a national snapshot in time of the two base levels of the performance measures framework—program management and services—the Survey of Early Head Start Programs offers a substantial foundation for research. It will be important to take periodic snapshots to chart changes in program implementation. In addition, future studies could build on survey findings by examining the next layer of the framework: child and family outcomes. These potential studies could benefit practitioners and policymakers by identifying effective approaches to service delivery and program management and by linking services and management practices to family and child outcomes. Below, we describe several possible purposes and questions such research might address. These questions touch on key elements of the performance measures framework, including community context, management systems, services, and outcomes for children and families.

We organize possible future research studies into two primary categories: descriptive and experimental. Both types are useful, but for different purposes. The advantage of a descriptive study is that it allows examination of many program features to get an in-depth understanding (in this case, nationally representative) of the program and its operations. Correlations between program characteristics and outcomes do not enable us to establish causality between a given characteristic or practice and outcomes, but a study of this type can

suggest likely pathways of relations for further research and avenues for training and technical assistance. An experimental study, on the other hand, is necessarily narrower in focus but allows a rigorous examination of the ways that particular program elements affect child and family outcomes. Unlike a descriptive study, a study using an experimental design with random assignment would allow conclusions about causal relationships between program characteristics or practices and participant outcomes.

Potential Descriptive Studies

Several of the research questions proposed below suggest the use of child and family outcome data, and the comparison of outcomes across programs taking different approaches to management and service delivery. Outcome data could be gathered through a descriptive longitudinal study similar to the Head Start Family and Child Experiences Survey (FACES). FACES gathers comprehensive data on the cognitive and social-emotional development of Head Start children through direct child assessments in multiple domains; observations of Head Start classrooms; and interviews with Head Start parents, teachers, and administrators (ACF 2003). In addition, FACES examines the characteristics of families; the quality of Head Start classrooms; and the qualifications and credentials, of Head Start teachers and other program staff as well as their views toward preschool education. The design and structure of the FACES study is a model that Early Head Start may want to build upon in future research.

Much like the FACES study described above, data from successive cohorts of Early Head Start children could answer questions such as these: What are the developmental skills of Early Head Start children when they enter the program? What is the quality of their Early Head Start classrooms as early learning environments, and what specific program approaches are being used? How do programs vary in how they reach full implementation of the comprehensive Head Start Program Performance Standards? What are the characteristics and qualifications of Early Head Start teachers, and how do they relate to children's outcomes? Do the data suggest a potential relationship of classroom quality, program approach, and overall program implementation to children's outcomes? What is the best way to characterize management structures and practices of Early Head Start programs? Are particular structures and practices linked to staff consistency and effectiveness? How can the quality of leadership at various levels within a program be described and assessed? Does leadership quality relate to staff turnover rates, qualifications, and effectiveness?

Potential Experimental Research

As mentioned above, experimental and descriptive approaches can complement one another in answering research questions. One way to determine the actual effect (impact) of a particular program element or service on child and family outcomes is to identify important potential elements, then randomly assign programs to them (for example, different levels of training and technical assistance for staff). Researchers then would estimate the impacts of the strategies on service quality and children's outcomes. With an experimental design, researchers could establish clear causal links between these different

program conditions and children's outcomes. Further, a carefully designed experimental study or studies could address the extent to which variations in child outcomes are accounted for by the interaction between program and family/child characteristics. In other words, an experimental study could answer the question "What works best for whom?" Therefore, the Office of Head Start and training and technical assistance providers would be able to provide clear guidance to programs about which strategies have evidence of effectiveness, and for which families.

Clearly, the topics suggested here represent only an initial set of possibilities for future research. As the Early Head Start program continues to develop, practitioners, policymakers, and researchers will no doubt identify additional ways in which this study can inform efforts to understand and improve the program for the benefit of its participants.

REFERENCES

Administration for Children and Families. "Preliminary Findings from the Early Head Start Prekindergarten Followup." Early Head Start and Research and Evaluation Project report. Washington, DC: DHHS, April 2006.

Administration for Children and Families. *Head Start FACES (2000): A Whole-Child Perspective on Program Performance.* Washington, DC: DHHS, 2003.

Administration for Children and Families. "Program Performance Measures for Head Start Programs Serving Infants and Toddlers." Washington, DC: DHHS, 2003.

Administration for Children and Families. "Head Start Program Performance Standards." Final rule cited in *Federal Register,* November 5, 1996. [www.acf.hhs.gov/programs/hsb/performance].

Administration for Children and Families. "Statement of the Advisory Committee on Services for Families with Infants and Toddlers." Washington, DC: DHHS, 1994. [www.bmcc.edu/Headstart/Advse.Commtte/index.html].

Administration on Children, Youth and Families. *Dedicated to Dads: Lessons from the Early Head Start Fatherhood Demonstration.* Washington, DC: DHHS, 2003.

Administration on Children, Youth and Families. *Pathways to Quality and Full Implementation in Early Head Start.* Washington, DC: DHHS, 2002a.

Administration on Children, Youth and Families. *Building Their Futures: How Early Head Start Programs Are Enhancing the Lives of Infants and Toddlers in Low Income Families.* Summary Report. Washington, DC: DHHS, 2001.

Administration on Children, Youth and Families. *Leading the Way: Characteristics and Early Experiences of Selected First-Wave Early Head Start Programs. Executive Summary.* Washington, DC: DHHS, 2000a.

Administration on Children, Youth and Families. *Leading the Way: Characteristics and Early Experiences of Selected First-Wave Early Head Start Programs. Volume 3: Program Implementation.* Washington, DC: DHHS, 2000b.

Administration on Children, Youth and Families. *Leading the Way: Characteristics and Early Experiences of Selected First-Wave Head Start Programs. Volume 1: Cross-Site Perspectives.* Washington, DC: DHHS, 1999a.

Administration on Children, Youth and Families. *Leading the Way: Characteristics and Early Experiences of Selected First-Wave Early Head Start Programs. Volume 2: Program Profiles.* Washington, DC: DHHS, 1999b.

Arnett, Jeffrey. "Caregivers in Day Care Centers: Does Training Matter?" *Journal of Applied Developmental Psychology,* vol. 10, 1989, pp. 541–552.

Brigance, Albert H. "Brigance Diagnostic Inventory of Early Development, Revised (BDIED-R)." North Billerica, MA: Curriculum Associates, 1991.

Center for the Child Care Workforce. "Current Data on the Salaries and Benefits of the U.S. Early Childhood Education Workforce." Washington, DC: CCCW, June 2004.

Dodge, Diane Trister, and Laura J. Colker. "Creative Curriculum for Early Childhood." Washington, DC: Teaching Strategies, 1992.

Frankenburg, William K., and J.B. Dodds. "Denver II Development Screening Test (DDST-II)." Denver: Denver Developmental Materials, Inc., 1989.

Harms, Thelma, and Richard M. Clifford. "Family Day Care Rating Scale (FDCRS)." New York: Teachers College Press, 1989.

Harms, Thelma, Debby Cryer, Richard M. Clifford, and Frank Porter. "Infant/Toddler Environment Rating Scale (ITERS)." New York: Teachers College Press, 1990.

High/Scope Education Research Foundation. "High/Scope Child Observation Record (COR) for Ages 2 1/2 – 6." Ypsilanti, MI: High/Scope Press, 1999.

Lambert, R.G., M. Abbott-Shim, and C. Oxford-Wright. *Policy and Program Management Inventory: Teachers Version.* Georgia State University, 2001. [education.uncc.edu/qrc/teacher%20version.pdf]. Accessed September 28, 2006.

Love, John M., Ellen Eliason Kisker, Christine M. Ross, Peter Z. Schochet, Jeanne Brooks-Gunn, Diane Paulsell, Kimberly Boller, Jill Constantine, Cheri Vogel, Alison Sidle Fuligni, and Christy Brady-Smith. "Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start. Vol. I: Final Technical Report." Princeton, NJ: Mathematica Policy Research, Inc., June 2002.

Maynard, Rebecca. *Kids Having Kids.* New York: Robin Hood Foundation, 1996.

Parks, Stephanie. "Hawaii Early Learning Profile (HELP)." Palo Alto, CA: VORT Corporation, 1997.

Scientific Software Development. *Atlas.ti: Visual Qualitative Data Analysis Management Model Building in Education Research and Business.* Berlin: Scientific Software Development, 2004.

Silberg, Jackie. *Games to Play with Babies.* Beltsville, MD: Gryphon House, Inc., 1993a.

Silberg, Jackie. *Games to Play with Toddlers.* Beltsville, MD: Gryphon House, Inc., 1993b.

Smith, Miriam W. "User's Guide to the Early Language and Literacy Classroom Observation Toolkit. Research Edition (ELLCO)." Baltimore, MD: Paul H. Brooks, 2002.

Squires, Jane, Diane Bricker, and Elizabeth Twombly. "Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)." Baltimore, MD: Paul H. Brookes Publishing Co., 2002.

Squires, Jane, LaWanda Potter, and Diane Bricker. "Ages and Stages Questionnaires (ASQ)." Baltimore, MD: Paul H. Brookes Publishing Company, 1999.

Yoshikawa, H., and J. Knitzer. *Lessons from the Field: Head Start Mental Health Challenges to Meet Changing Needs.* New York: Columbia University, Mailman School of Public Health, National Center for Children in Poverty and American Orthospsychiatric Association, 1997.

Zero To Three Infant Mental Health Task Force. *Definition of Infant Mental Health.* Washington, DC: Zero To Three, December 2001. [www.zerotothree.org/imh/definition.html]. Accessed July 24, 2006.

Appendix A

Survey of Early Head Start Programs

OMB NO. 0970-0008
APPROVAL EXPIRES: 12/31/2007

MPR Reference No.: 6028-004

MATHEMATICA
Policy Research, Inc.

Survey of Early Head Start Programs

January 2005

MPR ID #: |___|___|___|___|___|___|___|___|

GRANT # AND DELEGATE: |___|___|___|___|___|___|___|___|-|___|___|___|

Early Head Start Program:_____

Mailing Address:_____

Location Address:_____

Telephone Number: (|___|___|___|)-|___|___|___|-|___|___|___|___|
Area Code Number

Fax Number: (|___|___|___|)-|___|___|___|-|___|___|___|___|
Area Code Number

Director's Name:_____

E-mail Address:_____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0992-0008. The time required to complete this information collection is estimated to average 180 minutes per respondent, including the time to review instructions, gather the data needed, and complete and review the information collected. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, DC 20202. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: U.S. Department of Education, Institute of Education Sciences, 555 New Jersey Avenue, NW, Washington, DC 20208.

Prepared by Mathematica Policy Research, Inc.

PURPOSE OF THE STUDY

The Administration for Children and Families (ACF) has funded Mathematica Policy Research (MPR), a nationally recognized social policy research company to gather information from all Early Head Start programs. ACF is interested in programs' management practices and program services to inform planning for training and technical assistance as well as for future research. MPR brings to this task experience from conducting the EHS Research and Evaluation Project, which found a broad range of impacts on child development and parent outcomes as well as great variation in service delivery patterns and rates of implementation.

This is the first survey expressly designed for Early Head Start programs and is being sent to all EHS program directors nationwide. In addition, MPR staff will visit 25 programs to gather more in-depth information about these topics. You may recognize some of the questions in the survey as being the same or similar to those that appear on the Program Information Report (PIR). We have tried to keep duplication to a minimum, but some duplication is necessary.

Unlike the PIR, the information you provide in the survey will **not** be used for accountability purposes. We will **not** report on individual programs but will report findings in aggregate statistical form (such as "X% of programs offered center-based services" and further, those programs that offered center-based services also had Y characteristics). Information you provide will be treated in a confidential manner to the extent allowable by law.

We appreciate your help! After completing the survey, we will send you a $20 Barnes & Noble gift certificate.

INSTRUCTIONS

Please review the Early Head Start program information listed on the front cover. Cross out errors and enter the correct or missing information.

The questionnaire is divided into five sections:

A. PROGRAM CHARACTERISTICS AND ENROLLMENT

B. FAMILY CHARACTERISTICS AND INVOLVEMENT

C. STAFF CHARACTERISTICS

D. COMMUNITY PARTNERSHIPS

E. PROGRAM IMPROVEMENT ACTIVITIES

- Mark each response box with an "X." If a question has a line to write an answer, write your answer in the space provided.
- For questions that require a numeric or percentage response, write the numbers in the boxes provided, recording "zeros" to the left for space unused. For example, 25 should be recorded as |_0_|_2_|_5_|.
- Return the completed questionnaire in the envelope provided. Please keep a copy for your records.
- If you have any questions, contact Mathematica Policy Research, Inc. (1-888-633-8329).

SCREENER

This survey has been specifically designed to help ACF gain a better understanding of how Early Head Start programs deliver services to families and children. You will notice in a few places that the survey asks questions that are similar to those on the Program Information Report (PIR). However, many of these questions have been refined to reflect the services offered to infants and toddlers, or substantially elaborated to gather information specific to Early Head Start programs.

S1. Do you currently provide Early Head Start services to families?

1 ☐ Yes → **GO TO A1**

0 ☐ No

S1A. When did you stop providing Early Head Start services?

|___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

GO TO E32, PAGE 34

A. PROGRAM CHARACTERISTICS AND ENROLLMENT

A1. Which of the following best describes your agency?

MARK ONLY ONE

1 ☐ A private for-profit
2 ☐ A private not-for-profit
3 ☐ A public agency
4 ☐ Something else *(Specify)*

_____

A1A. Which of the following phrases best describes your agency?

MARK ONLY ONE

1 ☐ A Community Action Agency (CAA/CAP)
2 ☐ A community-based organization (CBO)
3 ☐ A public or private school system
4 ☐ A government agency
5 ☐ A tribal government or consortium
6 ☐ A hospital
7 ☐ A health care provider or agency
8 ☐ A university
9 ☐ A faith-based organization
10 ☐ Something else *(Specify)*

_____

A2. Apart from any Early Head Start grants from the Administration on Children, Youth and Families that you may receive, do you receive funding for Early Head Start services from any of the following sources?

MARK YES OR NO FOR EACH

		Yes	No
a.	A state government grant	1 ☐	0 ☐
			0 ☐
c.	A county or municipal government grant	1 ☐	0 ☐
d.	One or more private foundation grants	1 ☐	0 ☐
e.	Grants provided by businesses	1 ☐	0 ☐
f.	Fundraising activities	1 ☐	0 ☐
g.	Part C funds	1 ☐	0 ☐
h.	Contracts	1 ☐	0 ☐
i.	Fee-for-service reimbursements	1 ☐	0 ☐
j.	Some other source *(Specify)* _____	1 ☐	0 ☐

A2A. How does your Early Head Start program receive state child care subsidies?

MARK ALL THAT APPLY

1 ☐ Individual child payment
2 ☐ Grant directly from the state program
3 ☐ Some other subsidy *(Specify)*

_____

A3. What do these funding sources pay for?

MARK ALL THAT APPLY

1 ☐ Additional Early Head Start enrollment slots
2 ☐ New Early Head Start services
3 ☐ Improvements to existing Early Head Start services
4 ☐ Additional Early Head Start staff
5 ☐ Staff training or technical assistance
6 ☐ Services for Part C children or families
7 ☐ Parent activities
8 ☐ Child care
9 ☐ Some other use *(Specify)*

_____

n.a. ☐ Not applicable

A3A. How many slots?

|___|___| NUMBER OF SLOTS

A4. As of January 1, 2005, how many pregnant women were enrolled in your Early Head Start program and received Early Head Start services such as classes or home visits?

|___|,|___|___|___| NUMBER OF PREGNANT WOMEN

0 ☐ None

A4A. We would like to understand the way your Early Head Start program plans services to best meet the needs of enrolled families. Some programs may use several service categories to account for all enrolled children. Using the categories below, report each child only once in the category that best describes his or her service mix.

As of January 1, 2005, what is the actual enrollment of children, not including pregnant women, in your Early Head Start program served through the following program options:

COUNT CHILD IN ONLY ONE CATEGORY.

	A4A.		If number of children recorded in A4A: A4B.
	Not Applicable	**Number of Early Head Start Children**	**How often are home visits completed per family, on average?**
a. Home-based services, in which Early Head Start services are provided primarily in the child's home	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Something else *(Specify)* _____
b. Home-based services, plus Early Head Start services such as center-based care, family child care, respite care, or similar service options	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Something else *(Specify)* _____
c. Centers you operate, in which Early Head Start services are provided primarily in a child development center but also include home visits	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Something else *(Specify)* _____
d. Centers you operate, in which Early Head Start services are provided primarily in a child development center and **do not** include home visits	n.a. ☐	|___|___|___|	
e. Centers you partner with, in which Early Head Start services are provided primarily in a child development center but also include home visits	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Something else *(Specify)* _____
f. Centers you partner with, in which Early Head Start services are provided primarily in a child development center and **do not** include home visits	n.a. ☐	|___|___|___|	
g. Family child care, in which Early Head Start services are provided primarily in a family child care home but also include home visits	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Something else *(Specify)* _____
h. Family child care, in which Early Head Start services are provided primarily in a family child care home and **do not** include home visits	n.a. ☐	|___|___|___|	
i. Some other program option *(Specify)* _____	n.a. ☐	|___|___|___| **GO TO A4B**	1 ☐ Once a year 2 ☐ Twice a year 3 ☐ Less than once a month 4 ☐ Monthly 5 ☐ Weekly 6 ☐ Varies with family needs 7 ☐ Do not have home visits 8 ☐ Something else *(Specify)* _____

A4C. **TOTAL NUMBER OF CHILDREN (SUM OF A4Aa a to A4Ai)** |___|___|___|,|___|___|___|

A4D. **TOTAL NUMBER OF CHILDREN AND PREGNANT WOMEN (SUM OF A4 + A4C)** |___|___|___|,|___|___|___|

A5. Is the number of children and pregnant women in question A4D, Page 2, the actual enrollment for your Early Head Start Program?

1 ☐ Yes

0 ☐ No → **GO BACK AND CORRECT NUMBERS IN A4 and A4A**

A5A. Is the number of children and pregnant women in question A4D, Page 2, the typical enrollment for your Early Head Start Program?

1 ☐ Yes

0 ☐ No, the number is higher than typical

2 ☐ No, the number is lower than typical

A5B. Is the number of children and pregnant women in question A4D, Page 2, the funded enrollment for your Early Head Start Program?

1 ☐ Yes

0 ☐ No, the number is higher than funded

2 ☐ No, the number is lower than funded

A5C. How many of the total children in question A4C, Page 2, who are currently enrolled in your Early Head Start program are . . .

	Number of Early Head Start Children	None
a. Under 1 year old.....	|__|__|__|	0 ☐
b. 1 year old	|__|__|__|	0 ☐
c. 2 years old.....	|__|__|__|	0 ☐
d. 3 years old.....	|__|__|__|	0 ☐
e. 4 years old or older.....	|__|__|__|	0 ☐

A5D. SUM OF A5C (a to e): |__\|__\|__\|,|__\|__\|__\|

A5E. DOES THE SUM IN QUESTION A5D EQUAL THE SUM IN QUESTION A4C, Page 2?

1 ☐ Yes

0 ☐ No → **GO BACK AND CORRECT NUMBERS IN QUESTIONS A5C OR A4A, PAGE 2**

A6. On average, what percentage of all your program families enter Early Head Start . . .

a. Before child's birth?..... |__\|__\|__\| %

b. When child is 0-2 years old? ..... |__\|__\|__\| %

c. When child is 2-3 years old? ..... |__\|__\|__\| %

A7. On average, what percentage of all your Early Head Start program families leave Early Head Start . . .

a. At or before child's birth? ..... |__\|__\|__\| %

b. When child is 0-2 years old? ..... |__\|__\|__\| %

c. When child is 2-3 years old? ..... |__\|__\|__\| %

d. When child is over 3 years old? ..... |__\|__\|__\| %

A8. At any time during the past 12 months, how many children stopped attending your Early Head Start program for the following reasons? Do not count children who re-enroll.

ESTIMATE IF NECESSARY.

	NUMBER OF CHILDREN
a. Dropped out or withdrawn	|__|__|__|
b. Terminated by the Early Head Start program, no longer qualify, lack of participation.....	|__|__|__|
c. Became inactive but slots saved	|__|__|__|
d. No children stopped attending.....	0 ☐ → **GO TO A10, PAGE 4**

A9. Of the spaces left open by those who left your Early Head Start program, how many were filled by children and pregnant women during the past 12 months?

|___|___|___| CHILDREN AND PREGNANT WOMEN

A10. When was the last time you updated your waiting list?

MARK ONLY ONE

1 ☐ In the past 0 - 3 months

2 ☐ In the past 4 - 6 months

3 ☐ In the past 7 - 12 months

4 ☐ More than 12 months ago

0 ☐ None – Do not have waiting list

d ☐ Don't know

A11. How many children and pregnant women are currently on your waiting list?

|___|___|___| NUMBER OF CHILDREN AND PREGNANT WOMEN

0 ☐ None

d ☐ Don't know

A12. Of all the children who have ever enrolled in Early Head Start, what percent remain in your Early Head Start program until they are no longer age eligible?

|___|___|___| PERCENT OF CHILDREN REMAIN UNTIL NO LONGER AGE ELIGIBLE

0 ☐ None

A13. Of those children who remain until they are no longer age eligible, for what percentage, on average, are you able to develop transition plans?

|___|___|___| PERCENT OF CHILDREN WITH TRANSITION PLANS

0 ☐ None

A14. On average, what percentage of children in your Early Head Start program transition into preschool Head Start?

|___|___|___| PERCENT TRANSITION TO HEAD START PROGRAM

A15. On average, what percentage of children in your Early Head Start program transition into a non-Head Start preschool program?

|___|___|___| PERCENT TRANSITION TO NON-HEAD START PROGRAM

A16. Does your agency operate a Preschool Head Start Program?

1 ☐ Yes

0 ☐ No → **GO TO B2, PAGE 5**

A17. As of January 1, 2005, how many children were enrolled in your Preschool Head Start program?

|___|___|,|___|___|___| NUMBER OF CHILDREN ENROLLED

A18. What percentage of the children enrolled by your Preschool Head Start program are . . .

PERCENT

|___|___|___| 3 YEARS OLD?

|___|___|___| 4 YEARS OLD?

|___|___|___| 5 YEARS OLD?

B1. NOT IN PAPER VERSION.

B2. How many of the total number of children and pregnant women enrolled in your Early Head Start program are from the following racial or ethnic groups?

- *Please count children and pregnant women by the individual ethnicity or race that the family chooses.*

	B2.		B2A.
	Number of Early Head Start Children and Pregnant Women	**Program Does Not Track This Information**	**Over the past 5 years, has the number of children and pregnant women from this racial or ethnic group increased substantially, remained about the same, or decreased substantially?**
			3 ☐ INCREASED SUBSTANTIALLY 1 ☐ DECREASED SUBSTANTIALLY
b. Asian.....	|___|___|___| 0 ☐ None	d ☐	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
			3 ☐ INCREASED SUBSTANTIALLY
d. Black/Hispanic	|___|___|___| 0 ☐ None	d ☐	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
			3 ☐ INCREASED SUBSTANTIALLY
f. White	|___|___|___| 0 ☐ None	d ☐	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
			3 ☐ INCREASED SUBSTANTIALLY
h. Biracial or multi-racial	|___|___|___| 0 ☐ None	d ☐	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
			3 ☐ INCREASED SUBSTANTIALLY

B3. Do any of the children and pregnant women served by your Early Head Start program speak a language other than English as their primary language at home?

1 ☐ Yes

0 ☐ No → **GO TO B4, PAGE 7**

B3A. Of the children and pregnant women who speak a primary language other than English, in the home, what number speak the following?

	B3A. MARK ALL THAT APPLY	B3B. Over the past 5 years, has the number of children and pregnant women speaking this language, increased substantially, remained about the same, or decreased substantially?
		3 ☐ INCREASED SUBSTANTIALLY
b. Native Central American, South American and Mexican Languages (e.g., Mexican, Quichean)	|__|__|__| NUMBER OF CHILDREN AND PREGNANT WOMEN 0 ☐ None	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
		3 ☐ INCREASED SUBSTANTIALLY
d. Middle Eastern and Indic languages (e.g., Arabic, Hindi)	|__|__|__| NUMBER OF CHILDREN AND PREGNANT WOMEN 0 ☐ None	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
		3 ☐ INCREASED SUBSTANTIALLY
f. Native North American or Alaska Native languages....	|__|__|__| NUMBER OF CHILDREN AND PREGNANT WOMEN 0 ☐ None	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
		3 ☐ INCREASED SUBSTANTIALLY
h. European and Slavic languages (e.g., Italian, Croatian).....	|__|__|__| NUMBER OF CHILDREN AND PREGNANT WOMEN 0 ☐ None	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
		3 ☐ INCREASED SUBSTANTIALLY
j. American Sign Language	|__|__|__| NUMBER OF CHILDREN AND PREGNANT WOMEN 0 ☐ None	3 ☐ INCREASED SUBSTANTIALLY 2 ☐ REMAINED ABOUT THE SAME 1 ☐ DECREASED SUBSTANTIALLY
		3 ☐ INCREASED SUBSTANTIALLY

B4. Early Head Start programs face many challenges in serving high need or high risk families. We would like to know more about the needs of the enrolled families you serve and how many of them have high needs or are at high risk. Rather than collecting specific information to provide exact figures, please provide your *best estimate* of the proportion of families who fit each of the following categories:

- *Families may fall into more than one category.*

	Percentage of Families
	1 ☐ ≤ 10 percent
B4B. Single parent family (primary caregiver of child not married or living with a partner)....	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
B4D. Anyone in family receives welfare payments (cash assistance or TANF).....	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
B4F. Considering the five categories above, what proportion of families enrolled in your Early Head Start program have more than three of these characteristics?	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more

B5. Thinking about enrolled families, what percentage of families have the following characteristics:

- *Families may fall into more than one category.*
- *Please provide your best estimate.*

	Percentage of Families
	1 ☐ ≤ 10 percent
B5B. Substance abuse	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
B5D. Experience family violence	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more
	1 ☐ ≤ 10 percent 2 ☐ 11 to 25 percent 3 ☐ 26 to 50 percent 4 ☐ 51 to 75 percent 5 ☐ 76 percent or more

B6. What is the number of children actually enrolled in your Early Head Start program who have developmental concerns but who have not been referred or evaluated? Perhaps these children are being monitored by staff members to determine the need for referral or perhaps the families are in the process of deciding whether to pursue formal assessment.

|___|___|___| NUMBER OF CHILDREN

0 ☐ None

B6A. Many Early Head Start children have developmental concerns that require some level of assessment and intervention. The process leading to intervention can include the building of awareness, planning with families, referral for evaluation, and then possible referral for intervention services. Please record the number of children with each developmental concern and indicate where they are in this process. Please ONLY report the PRIMARY concern for each child. Thus, each child should be included in only one row.

ESTIMATE IF NECESSARY.

List of Developmental Concerns	Not Applicable	PLEASE REPORT THE PRIMARY DEVELOPMENTAL CONCERN FOR EACH CHILD ONLY ONCE			
		Number of Children Early Head Start Referred for or Awaiting Part C Evaluation	Number of Children Evaluated But Not Eligible for Part C Services	Number of Children Evaluated and Eligible for Part C Services	Number of Children with IFSP or Receiving Part C Services
					___ ___ ___
b. A communication disorder such as a speech or language impairment.....	n.a. ☐ **GO TO B6Ac**	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None
					___ ___ ___
d. A sensory impairment (including deafness or blindness).....	n.a. ☐ **GO TO B6Ae**	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None
					___ ___ ___
f. Other developmental concerns *(Specify)* ..... _____	n.a. ☐ **GO TO B7**	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None	|___|___|___| 0 ☐ None

B7. Does your Early Head Start program involve parents or guardians in any of the following ways:

MARK YES OR NO FOR EACH

	Yes	No	NA	B7A. IF MARKED "YES": How many parents are involved?
				|___|___|___|
b. Combined Early Head Start and Head Start Policy Council.....	1 ☐	0 ☐	n.a. ☐	|___|___|___|
				|___|___|___|
d. Making improvements in the facilities	1 ☐	0 ☐	n.a. ☐	|___|___|___|
				|___|___|___|
f. Some other way *(Specify)* ..... _____	1 ☐	0 ☐	n.a. ☐	|___|___|___|

B7B. Do you offer any of the following services to pregnant women?

	B7B.	B7C. How frequently are these offered?
b. Prenatal home visits	1 ☐ Yes → 0 ☐ No n.a. ☐ Not Applicable	|__|__| Times per month
d. Classes.....	1 ☐ Yes → 0 ☐ No n.a. ☐ Not Applicable	|__|__| Times per month
	→	|__|__| Times per month

B8. Do you offer any of the following services to children and families?

	B8.	B8A. How frequently are these offered?
	→	
b. Events for the entire family	1 ☐ Yes → 0 ☐ No n.a. ☐ Not Applicable	|__|__| Times per year
	→	
d. Parent training or workshops on subjects such as employment, job training, ELL (English Language Learner), or financial counseling	1 ☐ Yes → 0 ☐ No n.a. ☐ Not Applicable	|__|__| Times per year
	→	

B9. Has your program made a commitment to being father friendly by:

MARK YES OR NO FOR EACH

	Yes	No
b. Hiring male staff	1 ☐	0 ☐
d. Ensuring the décor includes pictures of fathers and is otherwise father friendly	1 ☐	0 ☐
f. Completing a father involvement needs assessment	1 ☐	0 ☐

B10. Which types of activities does your Early Head Start program do to involve fathers or father figures?

MARK YES OR NO FOR EACH

	Yes	No	B10A. IF MARKED "YES": On average, what percentage of fathers participate?
b. Host events for the entire family that include fathers	1 ☐	0 ☐	|__|__|__| %
d. FOR HOME-BASED FAMILIES: make a special effort to include fathers in home visits or group socialization activities	1 ☐	0 ☐	|__|__|__| %

The next series of questions ask about the types of staff you employ, their education, and staff development activities.

C1. How many of the following frontline staff does your program employ to provide Early Head Start services?

C1A. How many of the following frontline staff do your community partners employ to provide Early Head Start services?

- *Please count each person only once. Choose the category that best describes his or her role.*
- *If you don't have staff in a particular category, mark "not applicable."*
- *Include staff that work part-time as well as those that work full-time.*

	C1. Number Employed by your Early Head Start Program	C1A. Number Employed by your Community Partner(s) to Provide Early Head Start Services ESTIMATE IF NECESSARY.
		|__|__|__|
b. **Floaters or Rovers:** All staff who are not assigned to specific classrooms but work where needed in caring for children	|__|__|__| n.a. ☐ Not applicable	|__|__|__| n.a. ☐ Not applicable
		|__|__|__|
d. **Family Child Care Providers:** Include all family child care providers and their assistants.	|__|__|__| n.a. ☐ Not applicable	|__|__|__| n.a. ☐ Not applicable
		|__|__|__|
f. **Coordinators or managers**	|__|__|__| n.a. ☐ Not applicable	|__|__|__| n.a. ☐ Not applicable
		|__|__|__|
h. **Other frontline staff** *(Specify)* ..... _____	|__|__|__| n.a. ☐ Not applicable	|__|__|__| n.a. ☐ Not applicable
		|__|__|__|

C1B. Do you employ or have access to the following services?

_____

C2. For each manager in your Early Head Start program, please specify the highest educational degree completed. Do any of your managers hold a . . .

- "*A manager is a staff member who has overall responsibility for the Early Head Start program or a key role in managing the Early Head Start program.*

C2A. Please specify the number of mangers who hold each degree.

		(1) Number of Early Head Start Program Directors	(2) Number of Child Development Education Coordinators or Managers	(3) Number of Health Services Coordinators or Managers	(4) Number of Family and Community Partnerships Coordinators or Managers	(5) Number of Family Services Coordinators or Managers
	→					|__|__|__|
b. Associate of Arts degree?	1 ☐ Yes →	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
	0 ☐ None GO TO C2c					
	→					|__|__|__|
d. Graduate degree?	1 ☐ Yes →	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
	0 ☐ None					

The next question is about your child development staff. By child development staff, we mean staff members who provide or coordinate child development services, including primary caregivers, floaters or rovers, home visitors, family child care providers, child development supervisors, and home-based supervisors.

C3. Please mark the number of child development staff employed by your Early Head Start program who hold credentials in the following areas. Count each person only once by the highest degree held.

C3A. Please specify the number who hold a degree.

		(1) Number of Primary Caregivers	(2) Number of Floaters or Rovers	(3) Number of Home Visitors	(4) Number of Family Child Care Providers	(5) Number of Child Development Supervisors	(6) Number of Home-Based Supervisors
	→						|__|__|__|
b. A Baccalaureate degree in Early Childhood Education or a related field	1 ☐ Yes →	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
	0 ☐ No → GO TO C3c						
	→						|__|__|__|
d. Child Development Associate (CDA) credential	1 ☐ Yes →	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
	0 ☐ No → GO TO C3e						
	→						|__|__|__|
f. Of the number of staff who do not have degrees, how many are enrolled in an Early Childhood Education or related degree program at an accredited institution of higher education	0 ☐ None	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
							|__|__|__|
h. Of the number of staff who do not have degrees, how many are enrolled in a course of early childhood training from some other organization (***not*** an accredited college or university) that leads toward a state infant-toddler credential, the CDA, a family child care certificate, or other credential recognized in your state	0 ☐ None	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|

C4. How many primary caregivers employed by your Early Head Start program left your Early Head Start program during the past 12 months? Please do not include floaters or rovers, home visitors, or family child care providers.

|___|___| NUMBER OF PRIMARY CAREGIVERS

d ☐ Don't know

n..a ☐ Early Head Start program does not have center-based program

C5. How many primary caregivers employed by your community child care partners to provide Early Head Start services left their jobs during the past 12 months?

|___|___| NUMBER OF PRIMARY CAREGIVERS

d ☐ Don't know

n.a. ☐ Early Head Start program does not have center-based program

C6. Has the Early Head Start director or have any coordinators or managers left your Early Head Start program during the past 12 months?

MARK ALL THAT APPLY

1 ☐ Yes, the Early Head Start director

2 ☐ Yes, Early Head Start coordinators or managers |___|___| NUMBER OF EARLY HEAD START COORDINATORS OR MANAGERS WHO LEFT

0 ☐ No → **GO TO C8**

C7. Of the Early Head Start director or managers who left the Early Head Start program, did any leave for the following reasons?

MARK YES, NO, OR DON'T KNOW FOR EACH

	Yes	No	Don't Know
b. For a change in job field	1 ☐	0 ☐	d ☐
d. For personal reasons	1 ☐	0 ☐	d ☐

C8. How many <u>home visitors</u> left your Early Head Start program during the past 12 months? Do not include other staff.

|___|___| NUMBER OF HOME VISITORS

0 ☐ None

d ☐ Don't know

n.a. ☐ Early Head Start program does not have home visits

For each category of staff, please indicate the level of educational benefits you provide. Does your Early Head Start program or grantee agency provide any of the following:

	a. Primary Caregivers	b. Home Visitors
C9. Tuition reimbursement for relevant college courses	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable
C10. Workshop fees or other costs for outside training	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable
C11. Staff time during work hours for staff development activities such as attending courses or workshops	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable	1 ☐ Sometimes/depends 2 ☐ Yes for some 3 ☐ Yes for all 0 ☐ No n.a. ☐ Not applicable

C12. Mark how often your managers or staff supervisors do the following staff development activities.

MARK ONE FOR EACH

	Never	Times per Year	As Needed	Don't Know
				d ☐
b. Formally assign mentors to less experienced staff	0 ☐	|___|___|	1 ☐	d ☐
				d ☐
d. Conduct group case conference sessions	0 ☐	|___|___|	1 ☐	d ☐
				d ☐
f. Conduct staff training	0 ☐	|___|___|	1 ☐	d ☐
g. Observe frontline staff at work or providing services	0 ☐	|___|___|	1 ☐	d ☐
				d ☐
				d ☐

C13. Did you receive outside training and consultation for reflective supervision?

1 ☐ Yes

0 ☐ No

D1. Please indicate how your Early Head Start program defines the community it serves.

MARK ALL THAT APPLY

1 ☐ County or counties

2 ☐ School district

3 ☐ Zip code

4 ☐ Neighborhoods

5 ☐ Something else *(Specify)*

_____

_____

D1A. Please list the zip codes included in your program's catchment area:

|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|
|__|__|__|__|__|	|__|__|__|__|__|

D1B. What percentage of families enrolled in your Early Head Start program live in the following areas?

a. Urban ..... |___|___|___| %

b. Rural ..... |___|___|___| %

c. Suburban ..... |___|___|___| %

d. Something else *(Specify)* ..... |___|___|___| %

_____

_____

MUST TOTAL |**1**|**0**|**0**| %

D2. Please mark the category that best describes how much of a problem each of these are for the neighborhoods your program serves. Most of the families served by this program come from neighborhoods that . . .

- *Please provide your best estimate.*

MARK ONE FOR EACH

	D2. HIGH	D2. MODERATE	D2. LOW	D2A. In the past five years has . . .
				Crime . . .
b. Have unemployment rates that are	3 ☐	2 ☐	1 ☐	**Unemployment . . .** 3 ☐ Gone up, 2 ☐ Stayed about the same, or 1 ☐ Gone down? d ☐ Don't know
				Mobility . . . 3 ☐ Gone up, 2 ☐ Stayed about the same, or 1 ☐ Gone down? d ☐ Don't know

D2B. Most families served by this program come from neighborhoods that are . . .

3 ☐ Highly diverse (have multiple racial or ethnic groups),

2 ☐ Somewhat diverse, or

1 ☐ Not very diverse?

D2C. In the past five years, these neighborhoods have become . . .

3 ☐ More diverse,

2 ☐ Stayed about the same, or

1 ☐ Less diverse?

D3. Not including the preschool Head Start program you operate, how many preschool Head Start programs are in your community?

|___|___| NUMBER OF PRESCHOOL HEAD START PROGRAMS

0 ☐ None → **GO TO D5, PAGE 20**

D4. Of the preschool Head Start programs in your community, with how many do you have a formal agreement to coordinate transition services for children and families?

|___|___| NUMBER OF PRESCHOOL HEAD START PROGRAMS

0 ☐ No preschool Head Start programs in community

n ☐ Agency operates its own preschool Head Start program

D5. Does your Early Head Start program belong to or participate in any local collaborative groups of service providers or other community agencies?

0 ☐ No
d ☐ Don't know
n.a. ☐ Not applicable

→ **GO TO D7**

D5A. How many groups?

|___|___|___| GROUPS

D6. Do any of your staff have leadership roles in these collaboratives?

1 ☐ Yes
0 ☐ No
d ☐ Don't know
n.a. ☐ Not applicable

D7. Does your Early Head Start program have a formal collaborative agreement with at least one local Part C agency?

- "A Part C agency is one designated by Part C of the Individuals with Disabilities Education Act Amendments to be responsible for ensuring that services are provided to all children with disabilities from birth to age 3.

1 ☐ Yes
0 ☐ No
d ☐ Don't know
n.a. ☐ Not applicable

→ **GO TO D9, PAGE 21**

D8. Do your formal agreements include any of the following?

MARK ONE FOR EACH

	Yes	No	Don't Know	Not Applicable
				n.a. ☐
b. Part C referrals to Early Head Start	1 ☐	0 ☐	d ☐	n.a. ☐
				n.a. ☐
d. Sharing assessment results	1 ☐	0 ☐	d ☐	n.a. ☐
				n.a. ☐

D9. Does your Early Head Start program have any formal written partnership agreements with child care providers?

0 ☐ No
d ☐ Don't know → **GO TO D12**

|___|___|___| PROVIDERS

D11. Do your formal written partnership agreements with child care providers include the following services?

	MARK ONE ON EACH		
	Yes	**No**	**Not Applicable**
			n.a. ☐
b. Staff training for child care providers	1 ☐	0 ☐	n.a. ☐
			n.a. ☐
d. Coordination of Early Head Start and child care services	1 ☐	0 ☐	n.a. ☐
			n.a. ☐
f. Child care quality improvement planning	1 ☐	0 ☐	n.a. ☐
			n.a. ☐
h. Adherence to the Performance Standards	1 ☐	0 ☐	n.a. ☐
			n.a. ☐
j. Parent involvement activities	1 ☐	0 ☐	n.a. ☐

D12. Does your Early Head Start program have any formal written partnership agreements with health care providers?

1 ☐ Yes
0 ☐ No
d ☐ Don't know → **GO TO D14, PAGE 22**

D12A. How many providers?

|___|___|___| PROVIDERS

D13. Do your formal written partnership agreements with health care providers include the following?

MARK ONE FOR EACH LINE

	Yes	No	Don't Know	Not Applicable
b. Training for Early Head Start staff	1 ☐	0 ☐	d ☐	n.a. ☐
d. Provision of services to Early Head Start children and families at other locations (referrals)	1 ☐	0 ☐	d ☐	n.a. ☐
f. Joint planning	1 ☐	0 ☐	d ☐	n.a. ☐
h. Outreach	1 ☐	0 ☐	d ☐	n.a. ☐

D14. Does your Early Head Start program have any formal written partnership agreements with mental health providers?

0 ☐ No
d ☐ Don't know
→ **GO TO D16**

|___|___|___| PROVIDERS

D15. Do your formal written partnership agreements with mental health providers include the following?

MARK ONE FOR EACH LINE

	Yes	No	Don't Know	Not Applicable
				n.a. ☐
b. Training for Early Head Start staff	1 ☐	0 ☐	d ☐	n.a. ☐
				n.a. ☐
d. Provision of services to Early Head Start children and families at other locations (referrals)	1 ☐	0 ☐	d ☐	n.a. ☐
				n.a. ☐
f. Joint planning	1 ☐	0 ☐	d ☐	n.a. ☐
				n.a. ☐
h. Outreach	1 ☐	0 ☐	d ☐	n.a. ☐

D16. Do you offer health screenings or referrals for health screenings to children enrolled in your Early Head Start program?

1 ☐ Yes
0 ☐ No → **GO TO D18, PAGE 24**

D17. What kinds of health screenings do you offer?

		D17A. **Where do the screenings happen? Do they happen at the Early Head Start program facility with professionals coming in from outside, at a provider or physician's office, at both the program <u>and</u> a provider's office, or at the child's home?**
a. Hearing	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17b**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
b. Vision	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17c**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
c. Immunization	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17d**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
d. Physical exams	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17e**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
e. Developmental Screening	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17f**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
f. Mental Health	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17g**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
g. Dental Health	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D17h**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home
h. Some other health screening *(Specify)* _____ _____ _____	1 ☐ Yes → **GO TO D17A** 0 ☐ No → **GO TO D18, PAGE 24**	1 ☐ At the Early Head Start program facility 2 ☐ Provider's office 3 ☐ Both 4 ☐ At child's home

D18. What types of mental health services does your Early Head Start program offer?

MARK ALL THAT APPLY

1 ☐ Mental health screenings

2 ☐ Mental health assessments

3 ☐ Family therapy

4 ☐ Care coordination

5 ☐ Staff consultation

6 ☐ Something else *(Specify)*

_____

0 ☐ None

D19. Does your Early Head Start program refer children and their families for mental health services?

1 ☐ Yes

0 ☐ No → **GO TO D21**

D20. <u>On average</u>, what percentage of enrolled families receive mental health services?

At the Early Head Start program only ..... |___|___|___| %

Through a referral only ..... |___|___|___| %

Both at the Early Head Start program and through referral ..... |___|___|___| %

D21. For what kinds of services do you refer your Early Head Start program's families or children to community agencies?

	MARK YES OR NO FOR EACH		IF D21 MARKED "YES": D21A. With what proportion of agencies does your Early Head Start program have formal agreements?		
	Yes	No	All	Some	None
					0 ☐
b. Health care	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
d. Mental health care	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
f. Disability services	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
h. Employment assistance	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
j. Drug or alcohol abuse	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
l. Housing assistance	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
n. Family literacy	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
					0 ☐
p. Some other service *(Specify)* _____	1 ☐	0 ☐	2 ☐	1 ☐	0 ☐
		0 ☐			

E. PROGRAM ACTIVITIES

E1. Since your Early Head Start program started, have there been any changes in your overall organizational or Early Head Start program design?

1 ☐ Yes
0 ☐ No
d ☐ Don't know
n.a. ☐ Not applicable

→ **GO TO E3**

E2. What kind of changes have there been in your Early Head Start program?

MARK ALL THAT APPLY

1 ☐ Changes to organization chart or structure
2 ☐ Added center-based services
3 ☐ Added home-based services
4 ☐ Dropped center-based services
5 ☐ Dropped home-based services
6 ☐ Some other change *(Specify)*

_____

_____

E3. Does your Early Head Start program use a computerized management information system (MIS)?

1 ☐ Yes
0 ☐ No → **GO TO E8, PAGE 27**

E4. What computerized MIS does your Early Head Start program use?

MARK ALL THAT APPLY

1 ☐ Head Start Family Information System (HSFIS)
2 ☐ Child Plus
3 ☐ Combination of software *(Specify)*

_____

_____

4 ☐ Something else *(Specify)*

_____

_____

E5. How satisfied are you with the MIS your Early Head Start program uses?

1 ☐ Very satisfied
2 ☐ Somewhat satisfied

→ **GO TO E7, PAGE 27**

3 ☐ Somewhat dissatisfied
4 ☐ Very dissatisfied

E6. Why are you dissatisfied with the MIS your Early Head Start program uses?

MARK ALL THAT APPLY

1 ☐ MIS is difficult to use

2 ☐ Reports are not useful

3 ☐ Problems with software

4 ☐ Something else *(Specify)*

_____

E7. Which of the following reports can be generated from your Early Head Start program's MIS?

	MARK YES OR NO FOR EACH	
	Yes	**No**
b. Reports on characteristics of Early Head Start program families.....	1 ☐	0 ☐
		0 ☐
d. Reports on child's health/immunization status	1 ☐	0 ☐
		0 ☐
f. Reports on staff training/in-service.....	1 ☐	0 ☐
		0 ☐
h. Something else *(Specify)*..... _____	1 ☐	0 ☐

E8. How many Early Head Start centers does your program operate? Please do not include family child care homes or home-based services.

|___|___| NUMBER OF EARLY HEAD START CENTERS

0 ☐ Do not operate Early Head Start centers → **GO TO E15, PAGE 29**

E8A. Does your Early Head Start program follow a specific curriculum in centers?

1 ☐ Yes, one curriculum

2 ☐ Yes, draws on multiple curricula

0 ☐ No → **GO TO E10**

E9. What curriculum or curricula (does/do) your Early Head Start program use in centers to provide Early Head Start services for children?

Please include center-based services provided by your partner(s).

MARK ALL THAT APPLY

1 ☐ Agency-created curriculum

2 ☐ Assessment, Evaluation and Programming System (AEPS)

3 ☐ Beautiful Beginnings

4 ☐ Creative Curriculum

5 ☐ Early Learning Accomplishments Profile

6 ☐ Emotional Beginnings

7 ☐ Games to Play with Babies

8 ☐ Games to Play with Toddlers

9 ☐ Hawaii Early Learning Profile

10 ☐ High/Scope

11 ☐ Learning Activities for Infants

12 ☐ Montessori

13 ☐ Ones and Twos

14 ☐ Partners as Primary Caregivers

15 ☐ Partners in Learning

16 ☐ Playtime Learning Games for Young Children

17 ☐ Resources for Infant Educators

18 ☐ Talking to Your Baby

19 ☐ The Anti-Bias Curriculum

20 ☐ Another curricula *(Specify)*

_____

_____

E10. Do you conduct any classroom or child care quality assessments in your Early Head Start centers or centers of your Early Head Start partners?

- By assessments, we mean evaluation tools that measure primary caregiver-child interaction, classroom arrangement, or other indicators of quality of care.

1 ☐ Yes

0 ☐ No → **GO TO E14, PAGE 29**

E11. What are the most important classroom or child care quality assessments you use in your Early Head Start center-based child care settings?

MARK ALL THAT APPLY

1 ☐ ITERS (Infant/Toddler Environment Rating Scale)

2 ☐ ARNETT

3 ☐ ELLCO (Early Language and Literacy Classroom Observation)

4 ☐ CCOS (Child Caregiver Observation Scale)

5 ☐ Another assessment *(Specify)*

_____

E12. Based on an assessment of a center-based child care, have you ever determined that improvements were needed?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

→ **GO TO E14, Page 29**

E13. The last time an assessment indicated the need for improvement, what steps did you take?

MARK ALL THAT APPLY

1 ☐ Developed written improvement plan

2 ☐ Scheduled follow-up assessment

3 ☐ Provided staff training

4 ☐ Obtained technical assistance

5 ☐ Terminated partnership

6 ☐ Something else *(Specify)*

_____

E14. What is the usual child-adult ratio in your Early Head Start program's center for children in different age groups listed below?

E14A. What is the usual child-adult ratio for your community partners' centers for children in different age groups listed below?

	E14. For Early Head Start Program Center		E14A. For Community Partners' Center	
	Number of Children per Adult	Not Applicable	Number of Children per Adult	Not Applicable
				n.a. ☐
b. 1 year old	|___|___|	n.a. ☐	|___|___|	n.a. ☐
				n.a. ☐
d. 3 years old	|___|___|	n.a. ☐	|___|___|	n.a. ☐
				n.a. ☐

E15. Do you follow a specific curriculum when providing child care services in a family child care setting?

1 ☐ Yes, one curriculum

2 ☐ Yes, draw on multiple curricula

0 ☐ No → **GO TO E17, PAGE 30**

3 ☐ Do not have family child care services → **GO TO E22, PAGE 32**

E16. What curriculum or curricula (does/do) your family child care use to provide Early Head Start services?

MARK ALL THAT APPLY

1 ☐ Agency-created curriculum
2 ☐ Assessment, Evaluation, and Programming System (AEPS)
3 ☐ Beautiful Beginnings
4 ☐ Creative Curriculum
5 ☐ Early Learning Accomplishments Profile
6 ☐ Emotional Beginnings
7 ☐ Games to Play with Babies
8 ☐ Games to Play with Toddlers
9 ☐ Hawaii Early Learning Profile
10 ☐ Healthy Families America
11 ☐ High/Scope
12 ☐ HIPPY
13 ☐ Learning Activities for Infants
14 ☐ Montessori
15 ☐ Ones and Twos
16 ☐ Partners as Primary Caregivers
17 ☐ Partners in Learning
18 ☐ Playtime Learning Games for Young Children
19 ☐ Resources for Infant Educators
20 ☐ Talking to Your Baby
21 ☐ The Anti-Bias Curriculum
22 ☐ Another curriculum *(Specify)*

_____

E17. Do you conduct any assessments of child care quality in family child care?

1 ☐ Yes
0 ☐ No → **GO TO E21, PAGE 31**

E18. What child care quality assessments are used in your family child care settings?

MARK ALL THAT APPLY

1 ☐ FDCRS (Family Day Care Rating Scale)
2 ☐ ARNETT
3 ☐ ELLCO (Early Language and Literacy Classroom Observation)
4 ☐ CCOS (Child Caregiver Observation Scale)
5 ☐ Another assessment *(Specify)*

_____

E19. Based on an assessment of family child care, have you ever determined that improvements were needed?

1 ☐ Yes

0 ☐ No → **GO TO E21**

E20. The last time an assessment indicated the need for improvement, what steps did you take?

MARK ALL THAT APPLY

1 ☐ Developed a written improvement plan

2 ☐ Scheduled follow-up assessment

3 ☐ Provided staff training

4 ☐ Obtained technical assistance

5 ☐ Terminate partnership

6 ☐ Something else *(Specify)*

_____

E21. What is the usual child-adult ratio in your family child care for Early Head Start children who are in different age groups?

	Number of Children per Adult for Family Childcare	No Children in Age Group
		n.a. ☐
b. 1 year old.....	|___|___|	n.a. ☐
		n.a. ☐
d. 3 years old.....	|___|___|	n.a. ☐
		n.a. ☐

E22. What curriculum or curricula (does/do) your Early Head Start program use in your home-visit services?

MARK ALL THAT APPLY

0 ☐ Does not provide home-based services → **GO TO E23**

1 ☐ Agency-created curriculum

2 ☐ Beautiful Beginnings

3 ☐ Early Learning Accomplishments Profile

4 ☐ Games to Play with Babies

5 ☐ Games to Play with Toddlers

6 ☐ Hawaii Early Learning Profile

7 ☐ Healthy Families America

8 ☐ HIPPY

9 ☐ Learning Activities for Infants

10 ☐ Ones and Twos

11 ☐ Parents as Primary Caregivers

12 ☐ Partners for a Healthy Baby

13 ☐ Partners in Learning

14 ☐ Partners in Parenting Education

15 ☐ Playtime Learning Games for Young Children

16 ☐ Early Head Start Program for Infant/ Toddler Caregivers

17 ☐ Resources for Infant Educators

18 ☐ Talking to Your Baby

19 ☐ Another curriculum *(Specify)*

_____

The next questions are about screening and assessing children and families.

- **Screening:** To identify concerns regarding a child's developmental, sensory, behavioral, motor, language, cognitive, perceptual, and emotional skills that might require a further formal evaluation.
- **Assessment:** Ongoing procedures used by appropriate personnel throughout the period of a child's eligibility to (1) identify strengths, needs and services appropriate to meet those needs; and (2) to identify resources, priorities, and concerns of family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child.

E23. What are the most important child screening tools that you use with children?

MARK ALL THAT APPLY

0 ☐ Does not use

1 ☐ Ages and Stages Questionnaires (ASQ)

2 ☐ Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)

3 ☐ Battelle Developmental Screening Test

4 ☐ Brigance Screening Test

5 ☐ Denver II Developmental Screening Test (DDST II)

6 ☐ EAS Temperament Survey for Children

7 ☐ Peabody Picture Vocabulary Test (PPVT or TVIP-Spanish Version)

8 ☐ Another screening *(Specify)*

_____

E23A. What are the most important child assessment tools that you use with children?

MARK ALL THAT APPLY

0 ☐ Does not use → **GO TO E25, PAGE 33**
1 ☐ Agency-Created Screening Assessment
2 ☐ Achenbach Child Behavior Checklist (CBCL)
3 ☐ Bayley Behavior Rating Scale (BRS)
4 ☐ Bayley Mental Development Index (MDI)
5 ☐ Creative Curriculum Tools
6 ☐ High Scope COR
7 ☐ Infant Toddler Developmental Assessment
8 ☐ The Ounce Scale
9 ☐ Infant Toddler Social Emotional Assessment and Brief Infant Toddler Social Emotional Assessment (ITSEA.BITSEA)
10 ☐ Leiter International Performance Scale Revised (Leiter-R)
11 ☐ Macarthur Communicative Development Inventories (CDI)
12 ☐ Mullen Scales of Early Learning
13 ☐ Preschool Language Scale (PLS-3)
14 ☐ Receptive/Expressive Emergent Language Test-2nd Ed (REEL-2)
15 ☐ Temperament and Atypical Behavior Scale (TABS)
16 ☐ Vineland Adaptive Behavior Scales (VABS)
17 ☐ Vineland Social-Emotional Early Childhood Scales (Vineland SEEC)
18 ☐ Woodcock Johnson
19 ☐ Another assessment tool *(Specify)*

_____

E24. How do you use the child assessments listed in question E23A, to individualize services for children?

MARK ALL THAT APPLY

1 ☐ Use to create lesson plans for classrooms or specified child
2 ☐ Use to plan activities for home visits
3 ☐ Use to update or amend IFSP
4 ☐ Use for referrals for additional services
5 ☐ Aggregate to describe child outcomes
6 ☐ Another purpose *(Specify)*

_____

E25. Do you administer any parent or family assessments to parents of children in Early Head Start?

1 ☐ Yes
0 ☐ No → **GO TO E28**

E26. What parent or family assessments are most important for your Early Head Start program?

MARK ALL THAT APPLY

0 ☐ Does not use → **GO TO E28**
1 ☐ Agency-Created Assessment
2 ☐ Adult-Adolescent Parenting Inventory
3 ☐ Beck Depression Inventory
4 ☐ CES-D Depression Scale
5 ☐ Child Abuse Potential Inventory (CAP)
6 ☐ Family Needs Scale
7 ☐ Family Partnership Agreement
8 ☐ Family Support Scale (FSS)
9 ☐ Home Observation for Measurement of the Environment (HOME)
10 ☐ Infant-Toddler and Family Instrument
11 ☐ Kempe Family Stress Inventory
12 ☐ Knowledge of Infant Development Inventory (KIDI)
13 ☐ Parenting Stress Index
14 ☐ Partners in Parenting Education (PIPE)
15 ☐ Parents as Primary Caregivers Parent Survey
16 ☐ Another parenting or family assessment *(Specify)*

_____

E27. How do you use parent or family assessments listed in question E26?

1 ☐ Use to create lesson plans for home visits
2 ☐ Use to plan activities for home visits
3 ☐ Use to update or amend IFSP
4 ☐ Use for referrals for additional services
5 ☐ Something else *(Specify)*

_____

E28. Overall, how much time did it take to complete this survey? Please include any time required in looking up information or generating reports.

|___|___| HOURS |___|___| MINUTES

E29. How much of the time recorded above was spent on looking up information or generating reports?

|___|___| HOURS |___|___| MINUTES

E30. How many staff members were involved in completing the survey?

|___|___| NUMBER OF STAFF

We are interested in the mix of Early Head Start services offered to families.

E31. If the program options listed at the beginning of the survey (A4A, Page 2) do not adequately describe the Early Head Start services your program provides, record your program service options below.

_____

_____

_____

_____

E32. Please provide the following information about the person primarily responsible for completing this form.

Name:_____

Phone Number: (|___|___|___|)-|___|___|___|-|___|___|___|___|
Area Code

Fax Number: (|___|___|___|)-|___|___|___|-|___|___|___|___|
Area Code

Email Address:_____

END. MPR appreciates you taking the time to complete the survey. Your responses are crucial for research about Early Head Start programs. We anticipate that a report describing the survey findings will be completed by (DATE).

Thank you for participating in this important study. We will be sending your $20 Barnes & Noble gift certificate in the next few weeks.

Please confirm mailing address for sending the $20 Barnes & Noble gift certificate.

EARLY HEAD START PROGRAM NAME:_____

DIRECTOR'S NAME:_____

MAILING ADDRESS:_____

CITY, STATE, ZIP:_____

☐ SAME AS MAILING LABEL

RETURN ADDRESS:

MAIL TO:

MATHEMATICA POLICY RESEARCH, INC. (6028)

P.O. BOX 2393

PRINCETON, NJ 08543-9809

Intentionally Blank

APPENDIX B

EXPANDED DESCRIPTION OF SURVEY DATA COLLECTION METHODS

Chapter II presents a streamlined description of the survey data collection process. Because the process was complex, lengthy, and, ultimately, very successful in achieving high response rates, here we present a much more detailed description of the procedures we employed. We describe specific components of the survey work, including (1) development of item content, (2) web survey development, and (3) data collection procedures. We conclude with implications for practice.

DEVELOPMENT OF ITEM CONTENT

The survey instrument was designed to accomplish the research objectives described in Chapter I. Working from the Early Head Start performance measures pyramid, we developed survey items that would address as many areas as possible within the conceptual model (Figure I.1). We also replicated or modified some items from the primary administrative data source for Early Head Start programs, the Program Information Report (PIR).[1] We vetted earlier versions of the instrument with staff from MPR, our project officer, and outside consultants and Technical Working Group (TWG) members who represented broad expertise in the Early Head Start program. This group worked together to develop the survey instrument, a process that took more than a year due to the complexity of the domains to be measured.

After we had a working survey document, we gave it to program directors and Early Head Start technical assistance providers for their reactions. This took place in focus groups held at the 2004 Birth To Three Institute, the primary annual training conference for Early Head Start program staff. With the assistance of ZERO TO THREE, the conference host organization, we were able to access lists of conference registrants and their job titles before the conference. We invited 15 program directors and 12 training and technical assistance (T/TA) staff to participate in one of four focus groups during a scheduled break in the

[1] The PIR is an annual survey that all Early Head Start and Head Start programs complete. It is the primary national administrative data source for the Early Head Start and Head Start programs.

conference. We asked program directors and T/TA staff to complete a paper-and-pencil copy of the survey and then to discuss the clarity of the questions, whether programs were likely to have access to requested information, preferred mode of data collection, and any other comments and impressions they had. Focus group participants were forthright with their comments and were unanimous that a web-based survey was strongly preferred, followed by mail. A telephone survey was least desirable. Two themes that emerged from these groups were that (1) they appreciated the opportunity to be able to showcase the services Early Head Start provides to families, and (2) they were concerned that the survey would duplicate effort by too closely resembling PIR information that programs already had to provide.

We revised the survey based on focus group suggestions and pretested the revised version with nine Early Head Start program directors. They completed a hard-copy version of the survey, then participated in a debriefing telephone call. In the end, we created a survey with five sections that would take approximately 70 minutes to complete.

As we discuss in detail in the body of this report, the survey collected information on program characteristics, including program service approaches, family characteristics and involvement, staff characteristics, community partnerships, and program improvement activities.

WEB SURVEY DEVELOPMENT

After the items were finalized, we began constructing the web survey. The programming language we used (BLAISE) is attractive and user-friendly, containing easily understood instructions. The web version of the survey replicated, to the extent possible, the paper version. Its primary limitation was that it was not possible to keep some item structures that were in the paper copy (for example, item tables and grids could not be represented).

We maximized responses to the web survey by limiting use of survey features that require completed answers to move to the next item and providing as much clarifying information as possible. Because respondents were unlikely to complete the survey in one session, we allowed them to log in and out at will, saved data automatically, and skipped reentering respondents to the next unanswered question. We also made every accommodation we could to decrease the time needed to complete the instrument online. Those accommodations included using a minimum number of "data check" pop-up screens, allowing respondents to "click through" the entire instrument without entering any data (many opted to preview the items in this way), and giving respondents the ability to proceed through a data check screen even if the data were not changed as prompted.[2] To ensure the cleanest data possible, we provided assistance and clarification by including a link for frequently asked questions (FAQs) on each page of the web survey, as well as an email link to a help desk. Some of the FAQs were constant through the survey, and some were

[2] We discuss our data checking and cleaning procedures in the "Data Cleaning Procedures" section.

specific to items asked in a particular section. Finally, we ordered the survey sections from most to least important, being mindful of the time required to complete all items. Our hope was that even incomplete survey responses would cover the most critical questions before stopping. After extensive pretesting of skip patterns, item wording, and content, we put the instrument online in early February 2005.

Data Collection Procedures

The survey was introduced in an advance email announcing the study. This email, written by the then Associate Commissioner of the Head Start Bureau, explained the study's objectives and encouraged all programs to participate. At the same time, a packet was sent via Federal Express to each program director at the 748 Early Head Start sites providing services to children and families (our sample frame). The packet included a cover letter from the MPR project and survey directors, an endorsement letter from the ACF project officer, a hard-copy survey, a colored flyer with individual login and password information, and a business reply envelope. The cover letter explained the purpose of the study, provided an offer of assistance from our toll-free helpline, and reiterated the voluntary nature of the study—and that identities and responses of all participants would be kept confidential. The business reply envelope gave programs the option to complete the paper survey and return it by mail. Programs received a $20 Barnes & Noble gift card and a certificate of completion for participation in the survey.

With assistance from ZERO TO THREE as host, we held two question-and-answer conference calls approximately four weeks into data collection. Nearly 100 program directors, regional office staff, and T/TA providers participated in the two calls. MPR project and survey directors, the ACF project officer, and ZERO TO THREE staff participated in the calls. In the calls, the project officer described the background of the survey questions and research objectives. The project director explained the process of survey development and explained particularly complex survey items and answered questions about them. The survey director provided helpful hints about negotiating the web survey. Many good questions were raised in these calls, some of which were subsequently addressed in the FAQ sections of the survey.

Throughout the field period, we kept close watch on responses and prepared many reports that would be generated from the survey database automatically either daily or weekly. During the eighth week of data collection, the MPR Survey Operations Center (SOC) began making reminder calls to all program directors who had not yet responded by mail or web. The MPR survey director trained approximately six telephone interviewers to cover the calls Monday through Friday, 9:00 A.M. to 8:00 P.M. E.S.T. and six hours each day on Saturday and Sunday. During this time, we also sent periodic reminder emails to programs that had not responded or that had incomplete surveys.

We developed a tracking database to manage reminder mailings, keep track of the mode in which the survey was completed, and monitor the progress of cases being conducted from the SOC. Throughout the data collection period, we used the database to monitor the progress of cases and generate reports for managing data collection. The database allowed us to issue the Barnes & Noble cards to programs that completed the survey. We also

designed and mailed a frame-ready certificate of participation personalized for each Early Head Start program.

We developed a call-back plan to recover incomplete or missing data. Recognizing that the survey was too long to complete by telephone, we identified a series of "critical questions" for a case to be considered partially complete. Programs that had responded at all or that had omitted answers to these critical questions were targeted for reminder telephone followup. Approximately 10 weeks into data collection, MPR created a preliminary file to identify any missing information on critical questions. Trained quality control clerks contacted program directors by telephone and email and faxed them abbreviated surveys to directly collect responses to these critical questions. The quality control clerks also contacted any programs returning hard-copy surveys with inconsistent or missing data.

Data Cleaning Procedures

We took steps to ensure that data collected via the web and other modes were equivalent. One key limitation of BLAISE for the web is that it cannot support tables—therefore, some items (particularly the B6 series—see Appendix A) presented on the web looked different than those in the paper copy. On the web, each item had to be asked separately, with subquestions embedded as separate screens. For example, a screener question would ask if there were any children with emotional or behavioral disorders. If the respondent answered yes, then subsequent questions would ask about referrals and eligibility status. Presenting the item in this way, rather than as a grid (as in the paper copy), may have elicited different responses. We assessed whether responses varied by mode by creating a series of flags to categorize types of problematic responses to these items (such as skipped questions, illogical answers, and so forth) and noted that problems were somewhat more prevalent in web respondents. To correct any possible unintended bias toward error among web respondents, we called back any program that was flagged to have any of several types of problematic answers. Any differences in the information retrieved through the callback were corrected in the database by quality control clerks. There were no other items that presented challenges beyond those normally associated with preparing data. The final data file was prepared for analysis (variable names and labels applied, values formatted, logical skips coded, and so on).

Results and Implications

This combination of careful survey development and proactive, continuing support and assistance with responses resulted in a very high response rate, not only for surveys of this type, but for any survey: 89 percent of eligible programs responded. This high response was in spite of a variety of factors, including length and complexity of the survey, that would ordinarily work against good response. In addition to the overall high response rate, we found that nearly two-thirds of programs responded via the web-based option, much more than is typical for web-based surveys. In addition to the implications for good survey practices and consistent followup, it appears that, at least in programs like Early Head Start, a web-based approach may be a successful way to reach programs.

APPENDIX C

PILOT TESTS OF PROGRAM RATING SCALES IN EARLY HEAD START SITE VISITS

The purpose of the site visits was twofold. They (1) provided in-depth information to augment survey findings, and (2) pilot-tested measures that might be useful in future research or by programs themselves as part of their self-assessments. We selected two instruments—an implementation rating scale and a work climate survey—for use in the site visits, and we describe their content and basic psychometric properties here. We stress that the sample sizes are quite small, and psychometrics should be interpreted with this in mind.

IMPLEMENTATION RATING SCALE

We adapted a checklist of program implementation ratings developed as part of the Early Head Start evaluation (ACYF 2000a). The implementation rating scale identified specific criteria for determining the degree to which programs implemented each of five program areas. These are based on the Head Start Program Performance Standards and linked to the performance measures framework. They represent cornerstones that underlie the entire Early Head Start program model; see Chapter I, Figure I.1. The cornerstones are child development, family development, staff development, community building development, and management systems and procedures (Table C.1). Site visitors asked program directors to complete the checklists, then reviewed the answers with them as part of the closing interview.

Within each of the cornerstones were listed specific items to be rated on a scale from minimal implementation (level 1) to enhanced implementation (level 5). Each point was anchored with concrete descriptions of program features necessary to achieve a given implementation level.

RATING RESULTS

We considered ratings on individual elements between levels 1 through 3 (assigned by program directors) to have reached partial implementation and elements directors rated at levels 4 or 5 to have reached full implementation for that element (Table C.2).

Table C.1. Program Elements Included in the Early Head Start Implementation Rating Scales

Program Component	Program Element
Child Development and Health	Frequency of child development services
	Developmental assessments
	Follow-up services for children with disabilities
	Health services
	Child care
	Parent involvement in child development services
	Individualization of services
	Group socializations (for home-based and mixed approach programs)
Family Development	Individualized family partnership agreements
	Availability of services
	Frequency of regular family development services
	Parent involvement
Community Building	Collaborative relationships
	Advisory committees
	Transition plans
Staff Development	Supervision
	Training
	Turnover
	Compensation
	Morale
Management Systems	Policy council
	Communication systems
	Goals, objectives, and plans
	Self-assessment
	Community needs assessment

Table C.2. Early Head Start Implementation Rating Scale Levels

Level		Definition
	Partial Implementation	
1	Minimal Implementation	Program shows little or no evidence of effort to implement the relevant program element.
2	Low-Level Implementation	Program has made some effort to implement the relevant program element.
3	Moderate Implementation	Program has implemented some aspects of the relevant program element.
	Full Implementation[a]	
4	Full Implementation	Program has substantially implemented the relevant program element.
5	Enhanced Implementation	Program has exceeded expectations for implementing the relevant program element.

[a]The term "full implementation" is a research term to reflect our judgment that a program had achieved a rating of 4 or 5. We recognize that programs not "fully" implemented were nevertheless often implementing many features of the performance standards. In addition, even when rated as "fully" implemented, programs may have been striving to do more and be involved in continuous improvement activities.

We used criteria developed from the evaluation study (ACYF 2002a) to identify programs at different levels of implementation, but our main purpose was to examine how the instrument performed on this small sample of 17 programs. The rating scales were originally developed for use by site visitors on in-depth visits to programs. Here, our interest is to see what we can learn from self report. For each site, we calculated implementation ratings for each of the five cornerstones and for overall implementation. We stress that individual element ratings were based on directors' responses; we assigned composite (cornerstone and overall) ratings using a set of rules that we define below.

Most visited programs are fully implemented in one or more of the cornerstone areas. Within the child development cornerstone, programs range from low-level implementation to enhanced implementation. Programs are most successful at fully implementing the community building cornerstone (88 percent), and 82 percent of visited programs reached full implementation for management systems and procedures. Most programs (76 percent) have fully implemented the child development cornerstone. Similarly, the majority of programs (65 percent) reached full implementation for the family development cornerstone. Just more than half of the programs (59 percent) reached full implementation for the staff development cornerstone.

To assess overall implementation, we followed these guidelines:[1]

- ***Low-Level Implementation:*** Programs that reached only a low level of implementation had achieved moderate implementation in only one or two program areas. Other programs areas are poorly or minimally implemented.
- ***Moderate Implementation:*** Programs are fully implemented in a few program areas and moderately implemented in the other areas, moderately implemented in all areas, moderately implemented in most areas with low-level implementation in one area, or fully implemented in every area except child development and health services.
- ***Full Implementation:*** Programs that are fully implemented overall were rated as fully implemented in most of the five component areas.
- ***Enhanced Implementation:*** Programs with full implementation in all areas and that exceed the standards in some of the component areas demonstrate enhanced implementation.

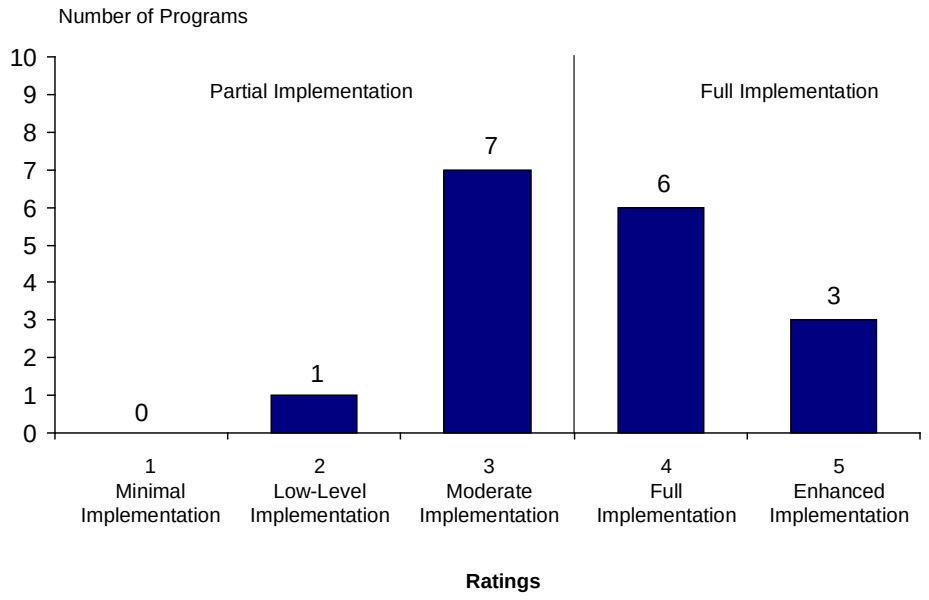
Visited programs range from low to enhanced implementation. We assigned programs overall ratings on a case-by-case basis by assessing the ratings for each of the five categories. Just over half (nine programs, or 53 percent) of the visited programs reached full implementation, and, of the fully implemented programs, three have enhanced overall implementation. We rated only one program as having low-level implementation. This program reached moderate to full implementation on all of the five categories *except* the child development cornerstone. Less than half of visited programs (41 percent) were moderately implemented. Although these programs were not fully implemented, they all have moderate to full implementation in the child development category. Figure C.1 illustrates the range of implementation among the 17 sites.

PROGRAM DIRECTOR IMPRESSIONS

In our reviews of implementation ratings that program directors gave their own programs, many expressed positive opinions about the implementation rating scale. Positive comments included finding most of the descriptors for each rating anchor to be clear and easy to understand. More critical comments about the scale included some confusion about how to rate particular areas when they met some but not all of the requirements for a given rating. A few directors requested clarification about "family development services" and examples of these services. Some program directors were displeased that they met the standards but still could not meet the highest implementation rating (enhanced implementation often goes beyond the performance standards). Most directors, despite finding the instrument interesting and thought provoking, did not indicate that they would

[1] These guidelines were developed by the December 2002 Pathways to Quality and Full Implementation in Early Head Start Programs study.

Figure C.1. Early Head Start Overall Implementation Ratings



Source: Survey of Early Head Start site visits.

Sample size = 17 programs.

use it for program assessment or improvement activities (or, if so, only as part of a much larger process). By and large, directors are satisfied with the instruments they currently use and are not interested in making changes to them.

RELATIONSHIP OF IMPLEMENTATION RATINGS TO SURVEY DATA

We examined survey data between fully implemented and partially implemented programs, based on their self rating. This analysis is very preliminary and based on only a small number of programs. In general, we found no differences in the type of community served, but we did find a few differences in program and family features (not shown). Specifically, fully implemented programs are more likely to have a combination model than partially implemented programs. They are also less likely to have management turnover, although they tend to have high enrollee turnover and to serve enrollees with lower levels of risk than partially implemented programs.

WORK CLIMATE SURVEYS

Work climate surveys were adapted from the Support Subscale of the Policy and Program Management Inventory (Lambert et al. 2001) and were intended to be a quick and easy way to identify areas of concern for staff in the workplace. We created a version of the

survey for teachers and a parallel one for home visitors. The primary difference between the instruments is wording specific to "classroom" or "home visit." During discussion groups with teachers and/or home visitors, site visitors asked the group to complete the relevant instrument. Our aim here is to describe the internal consistency reliability of the scales and to provide basic descriptive summary scores for each program and overall. We conducted analyses separately for each group (teachers and home visitors). The same caution about small sample sizes applies here as well, because each site had multiple teachers or home visitors, the total number of completed surveys was 56 teacher surveys and 36 home visitor surveys among the 17 programs.

The surveys were brief (17 and 18 items for teachers and home visitors, respectively) and asked for ratings of agreement with statements on a five-point scale from 1 (strongly disagree) to 5 (strongly agree). All items were worded so that higher ratings indicate more positive impressions of the work climate.

ANALYTIC PROCESS

Before calculating total scores for individuals and then for sites, we ensured that each item contributed to the quality of the overall rating. We assessed internal consistency by calculating an overall alpha for all survey items. The standardized alphas for both teacher and home visitor surveys were very high (.97 for all 17 items on the teacher survey and .96 for 18 items on the home visitor survey). We created total scores by summing all items in the scale, then calculating total scores for teachers and for home visitors and averages within programs.

DESCRIPTIVE STATISTICS

Next we present overall means and standard deviations for all teacher and home visitor survey items, on the individual level, and the average site score (Tables C.3 through C.6).

STAFF IMPRESSIONS OF THE WORK CLIMATE SURVEYS

Staff generally found the surveys easy to use and took little time to complete them. Many seemed to think the surveys could be useful for program self-assessment. Specifically, home visitors were most enthusiastic about the instrument and found it useful because it easily illustrated problem areas. On a few occasions, however, staff said the questions were too specific and did not capture their overall feelings about the program, and that honest individual ratings could give the mistaken overall impression that they were unhappy in their jobs. We subsequently added an open-ended question to ask about overall job satisfaction and whether the ratings accurately reflected their feelings about their job. In general, staff who liked the work climate survey liked it because it provided an opportunity to think about a variety of situations.

Because of the low variability in work climate ratings across sites, we are unable to examine survey responses in light of these ratings.

Table C.3. Overall Teacher Work Climate Survey Ratings

Survey Item	Mean	Standard Deviation
Helps teachers feel good about their jobs	3.7	1.3
Promotes teamwork among teachers	3.8	1.2
Helps teachers feel that they are part of a team	3.6	1.3
Ensures that teachers do not feel isolated	3.5	1.2
Provides enough assistance to teachers in the classroom	3.4	1.2
Provides orientation to new teachers	4.0	1.1
Helps new teachers adjust to the classroom	3.7	1.2
Knows what teachers deal with in the classroom	3.2	1.2
Has timely delivery of materials for use in classrooms	3.4	1.3
Provides opportunities for teachers to identify their strengths and weakness	3.5	1.1
Provides an atmosphere that is free from destructive gossip	3.3	1.4
Provides freedom for teachers to create their own unique classrooms	4.0	1.1
Has clear guidelines for ordering classroom materials efficiently	3.4	1.3
Provides appropriate and supportive supervision	3.6	1.2
Allows teachers input into planning curriculum	3.9	1.1
Helps teachers to work effectively with children with disabilities	3.9	1.3
Provides useful professional development training	3.9	1.3
Average Site Score	**3.6**	**0.9**

Sample size = 56 teachers.

Table C.4. Average Teacher Work Climate Scores, by Program

Site	Average Site Score
S01	4.3
S02	4.6
S04	3.8
S05	4.2
S06	2.4
S09	1.7
S10	3.8
S11	3.4
S12	4.8
S13	4.5
S16	3.4
S17	3.1

Note: Not all sites employ teachers.

Table C.5. Overall Home Visitor Work Climate Survey Ratings

Survey Item	Mean	Standard Deviation
Helps home visitors feel good about their jobs	4.3	0.8
Promotes teamwork among home visitors	4.3	1.0
Helps home visitors feel that they are part of a team	4.2	1.0
Ensures that home visitors do not feel isolated	4.0	1.1
Provides enough assistance to home visitors	4.0	1.1
Provides orientation to new home visitors	4.1	1.1
Helps new home visitors adjust to their jobs	4.0	1.1
Knows what home visitors deal with in working with families	4.0	1.1
Has timely delivery of materials for use in home visits	4.1	1.0
Provides opportunities for home visitors to identify their strengths and weaknesses	4.2	0.9
Provides an atmosphere that is free from destructive gossip	3.8	1.1
Provides freedom for home visitors to create their own approaches to working with families	4.5	0.8
Has clear guidelines for ordering home visiting materials efficiently	3.8	1.2
Provides appropriate and supportive supervision	4.1	1.1
Allows home visitors input into planning home visit activities	4.6	0.8
Helps home visitors to work effectively with children with disabilities	4.2	0.8
Provides useful professional development training	4.1	1.0
Enables home visitors to access services outside of Early Head Start for families who need them	4.5	0.6
Average Site Score	**4.1**	**0.7**

Sample size = 36 home visitors.

Table C.6. Average Home Visitor Work Climate Scores, by Program

Site	Average Site Score
S03	4.3
S05	3.3
S06	2.7
S07	4.8
S08	4.0
S12	4.6
S14	4.2
S15	4.3
S17	2.9

Note: Not all sites employ home visitors.

Appendix D

Supplemental Weighted Tables

Chapter III Weighted Tables

Table D.1. Key Characteristics of Early Head Start Programs

Characteristic	Percentage of Programs
Program Service Area	
Mainly urban	46.1
Mainly rural	41.0
Mainly suburban	9.7
Mixed	2.4
Other	0.9
Number of Program Centers[a]	
Single	36.0
Multiple	64.0
Community Diversity	
High	19.0
Moderate	41.6
Low	39.4
Diversity Past Five Years	
Increased	42.4
Stayed the same	56.2
Decreased	1.4
Agency Non-Profit Status	
Private non-profit	69.0
Public agency	27.7
Private for-profit	1.8
Other	1.6
Program Auspice	
Community agency	69.9
School	9.8
Government agency	5.8
Tribal government	4.3
University	3.5
Hospital or health care provider	3.3
Other	3.4
Program Operates Own Preschool Head Start	81.8
Sample Size (Programs)	**461–657[b]**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Does not include family child care or home-based services.

[b]Most questions have sample sizes over 640. Number of Program Centers has a sample size of 461 because it only includes programs that operate an Early Head Start Center.

Table D.2. Early Head Start Program Funding

Characteristic	Percentage of Programs
Program Funding Sources	
Any outside funding sources	62.5
Funding Sources	
State child care subsidies or block grant	34.3
State government grant	17.5
Private foundation grants	15.0
Fundraising activities	13.0
Fee for service reimbursements	8.5
County or municipal government grant	8.2
Part C funds	6.2
Contracts	5.7
Grants provided by businesses	5.3
Other source	6.5
Use of Additional Funding Sources	
Child care	47.8
Improvements to existing Early Head Start services	41.0
Parent activities	26.1
Additional Early Head Start staff	23.9
Staff training or technical assistance	22.8
Additional Early Head Start enrollment slots	15.1
Services for Part C children or families	14.6
New Early Head Start services	8.9
Other use	11.7
Number of Additional Funding Sources	
Programs with no additional sources	37.6
Programs with 1 additional source	30.9
Programs with 2 or 3 additional sources	25.9
Programs with 4 or more additional sources	5.7
Sample Size (Programs)	**415–654[a]**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Most questions have sample sizes over 640. One question has a low sample size because it only applied to certain programs: Use of Additional Funding Sources only applies to the 415 programs that report having any additional funding.

Table D.3. Early Head Start Program Enrollment

Characteristics	Percentage of Programs
Number of Children and Pregnant Women Enrolled	
50 or fewer	32.0
51 to 100	40.3
101 to 149	16.5
150 or more	11.2
Enrolled at Funded Enrollment Level	
At funded level	62.0
Above funded level	19.8
Below funded level	18.2
Program Maintains a Waiting List	100.0
Program updated waiting list in past 6 months	95.6
Number of children and pregnant women on waiting list	
0 to10	17.4
11 to 50	37.6
51 to100	21.2
100 or more	23.9
Sample Size (Programs)	**583–660**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

Table D.4. Characteristics of Early Head Start Children

	Percentage of Enrolled Children
Age of Enrolled Children	
Under 1 Year Old	22.2
1-Year-Olds	31.4
2-Year-Olds	36.8
3-Year-Olds	9.5
4-Year-Olds	0.1
Age at Program Entry	
Prenatal	12.7
0 to 2 years old	61.6
2 to 3 years old	18.6
Age at Program Exit	
Prenatal	2.1
0 to 2 years old	16.2
2 to 3 years old	23.3
3 or more	46.0
Sample Size (Children)	**46,317**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

Table D.5. Demographics of Early Head Start Families: Program Level

Characteristics	Percentage of Programs
Programs Serving Multiple Races/Ethnicities	
4 or more races or ethnicities	62.8
6 or more races or ethnicities	18.9
Programs Serving Primarily One Race/Ethnicity	
90 percent or more families of same race/ethnicity	26.3
75 percent or more families of same race/ethnicity	47.1
Families Enrolled in Program[a]	
White/Caucasian (non-Hispanic)	81.5
Black/African American (non-Hispanic)	76.2
Hispanic/Latino, any race	75.2
Biracial/multiracial	70.1
Asian/Hawaiian/Pacific Islander	29.8
American Indian/Alaska Native	26.3
Other race/ethnicity	19.3
Programs Serving Multiple Languages	
2 or more languages	33.9
4 or more languages	8.2
6 or more languages	2.0
Sample Size (Programs)	**646–648**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Race/ethnicity is provided by programs according to the group the family chooses. All race and ethnicity categories are mutually exclusive. Hispanic or Latino families of any race are included in one category and other race categories exclude families that are Hispanic or Latino.

Table D.6. Prevalence of Developmental Concerns Among All Early Head Start Children

Characteristic	Percentage of Enrolled Children
Children Who Have Been Referred for Evaluation	20.4
Sample Size (Children)	**41,333**
Among Referred Children	
Eligible for/Receiving Part C services or has IFSP	75.6
Specific Concerns Among Children Eligible for Part C Services[a]	
Communication disorder	42.3
Developmental delay	32.3
Emotional or behavioral issues	7.8
Physical or orthopedic impairment	9.1
Sensory impairment	3.0
Health or mental condition	0.8
Other developmental concern	4.6
Sample Size (Children)	**6,335**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]These children have been referred for Part C evaluation, found eligible, and may be receiving Part C services.

CHAPTER IV WEIGHTED TABLES

Table D.7. Program Models for Delivering Early Head Start Services Directly and in Partnership

Program Approach	Number of Programs	Percentage of Programs
Direct Services Provided by Programs		
Direct home-based (home visits at least monthly)	162	24.4
Direct center-based (home visits less than monthly)	132	20.0
Direct mixed (monthly home visits for some families and center care for other families)	284	42.8
Direct combination (center care plus home visits monthly or more for the same families)	57	8.9
No direct services[a]	25	3.9
Sample Size (Programs)	**660**	**100**
Services Received by Families, Including Partners		
Received home-based (home visits at least monthly)	114	17.1
Received center-based (home visits less than monthly)	152	23.2
Received mixed (monthly home visits for some families and center care for other families)	334	50.3
Received combination (center care plus home visits monthly or more for the same families)	56	8.7
Received other services	4	0.6
Sample Size (Programs)	**660**	**100**
Serving Children Through Child Care Partnerships		
Provides services through child care partners	188	28.6
Does not provide services through child care partners	472	71.4
Sample Size (Programs)	**660**	**100**
Has a Formal Agreement with a Child Care Partner	268	42.1
Does Not Have a Formal Agreement with a Child Care Partner	369	57.9
Sample Size (Programs)	**637**	**100**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]25 programs do not provide services directly, instead partnering with center-based or family child care providers.

Table D.8. Early Head Start Program Service Models and Frequency of Home Visits

Program Model	Number of Programs	Percent Offering Home Visits that Meet Standards[a]	Percent Offering Home Visits at or Above Standards
Home-Based Services	436	95.6	3.0
Home-Based with Additional Early Head Start Services[b]	55	32.6	21.5
Own Center with Home Visits	395	47.9	51.6
Partner Center with Home Visits	104	35.2	64.9
Family Child Care with Home Visits	56	40.8	59.2

Source: Survey of Early Head Start Programs.

Note: Number of programs includes any program that indicates serving one or more children through each service approach in the survey. Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a] Head Start Program Performance Standards require home visits weekly in home-based options and home visits twice a year in other options.

[b]For this program approach, we consider programs that offer home visits weekly or more often, to meet performance standards.

CHAPTER V WEIGHTED TABLES

Table D.9. Types of Staff in Early Head Start Programs

Staff Characteristics	Percentage of Programs
Program Employs or Has Access to	
Mental health specialist	95.5
Disability specialist	91.9
Health care professional or nurse	90.9
Speech or language specialist	64.8
Father or male involvement specialist	57.1
Literacy specialist	56.8
Dietitian or nutritionist	18.8
Any other specialist	27.9
Program Employs	
Home visitors (own)	81.7
Home visitors (partner)	15.8
Primary caregivers (own centers)	83.0
Primary caregivers (partner centers)	33.9
Program Operates Own Preschool Head Start	81.8
Sample Size (Programs)	**423–652**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

Table D.10. Qualifications and Education of Early Head Start Staff

Staff Characteristics	Percentage of Programs
Highest Degree Held by Director	
Graduate degree in Early Childhood Education	62.1
Baccalaureate degree in Early Childhood Education	32.7
Associate degree in Early Childhood Education	2.5
GED or high school diploma	2.8
Highest Degree Held by Manager	
Graduate degree in Early Childhood Education	59.2
Baccalaureate degree in Early Childhood Education	35.9
Associate degree in Early Childhood Education	4.1
GED or high school diploma	0.9
Employs **Only** Directors with a Baccalaureate or Graduate Degree	83.5
Employs **Only** Managers with a Baccalaureate or Graduate Degree	51.2
Employs 50 Percent or More Primary Caregivers Who Hold[a]	
Baccalaureate degree or higher in Early Childhood Education	17.5
Associate degree in Early Childhood Education	15.5
Child Development Associate credential or equivalent state credential	15.9
Employs **Only** Primary Caregivers with at Least an Associate Degree in Childhood Education	13.2
Employs **Only** Primary Caregivers with at Least a Child Development Associate Credential	29.4
Employs 50 Percent or More Home Visitors Who Hold[b]	
Baccalaureate degree or higher in Early Childhood Education	52.0
Associate degree in Early Childhood Education	18.9
Child Development Associate credential or equivalent state credential	12.2
Employs **Only** Home Visitors with at Least an Associate Degree in Childhood Education	46.7
Employs **Only** Home Visitors with at Least a Child Development Associate Credential	63.3
Sample Size (Programs)	**422–581**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Among programs reporting any caregivers.
[b]Among programs reporting any home visitors.

Table D.11. Early Head Start Staff Turnover

Staff Characteristics	Number of Programs	Percentage of Programs
Director Left Program in the Past 12 Months	77	11.8
Coordinator or Manager Left Program in the Past 12 Months	185	28.7
Among Programs with Any Management Change, Most Cited Reasons		
Personal reasons	128	61.2
Higher compensation (same field)	69	36.5
Change in job field	68	34.1
Fired or laid off	30	15.0
Other reasons	8	4.4
Average Rate of Turnover in the Past 12 Months[a]		Average Percentage of Staff Leaving Each Year
Turnover of Home Visitors	422	23.9
Turnover of Primary Caregivers Employed by Program	437	19.8
Turnover of Primary Caregivers Employed by Childcare Partner	121	17.4
Sample Size (Programs)	**192–650**	

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Calculated within each program as the number of each type of staff leaving divided by total home visitors or total primary caregivers, averaged across all programs with that type of staff.

Table D.12. Supervisory Practices and Training Opportunities in Early Head Start

Supervision and Training	Percentage of Programs
Staff Supervisory Practices	
Conducts performance appraisals for all staff	99.2
Conducts group case conference sessions	92.7
Assigns mentors to less experienced staff	83.5
Received outside training for reflective supervision	69.3
Conducts reflective supervision with primary caregivers[a]	82.7
Conducts reflective supervision with home visitors[a]	80.8
Staff Development and Training	
Conducts staff training	99.1
Meets with staff individually	98.9
Holds staff meetings	99.5
Observes frontline staff providing services	98.9
Program Provides Tuition Reimbursement for (Some or All)	
Primary caregivers	85.0
Home visitors	79.2
Program Provides Workshop Fees or Other Training Costs for (Some or All)	
Primary caregivers	85.1
Home visitors	86.4
Program Provides Time for Staff Development for (Some or All)	
Primary caregivers	79.6
Home visitors	82.8
Sample Size (Programs)	**398–644**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

[a]Reflective supervision is generally considered to be a collaborative learning relationship between the supervisor and supervisees, in which staff members are encouraged to reflect on the progress of their work with children and families on a regular basis.

Table D.13. Parent/Family Assessments in Early Head Start

Parent/Family Assessment Instruments and Uses	Percentage of Programs
Family Partnership Agreement	79.5
Agency Created Assessment	31.6
Family Needs Scale	10.4
Use of Parent/Family Assessments	
Refer for additional services	93.4
Plan activities for home visits	64.4
Create lesson plans for home visits	49.5
Update IFSP	46.9
Other	11.2
Sample Size (Programs)	**402–404**

Source: Survey of Early Head Start Programs.

Note: Among 404 programs that use a parent/family assessment. Data are weighted to adjust for survey nonresponse.

Table D.14. Early Head Start Program Efforts to Ensure Quality of Child Care

Quality Assurance Activities	Percentage of Programs
Conduct Classroom Assessments	92.4
Among Those Who Conduct Assessments, Percentage Who Have Found Improvements Were Needed	93.7
Among Those Who Found Needed Improvements, Steps Taken	
Provided staff training	90.9
Developed written improvement plan	75.9
Scheduled follow-up assessment	71.2
Obtained technical assistance	50.6
Terminated partnership	5.9
Improvements to facility/equipment	3.7
Other	3.3
Sample Size (Programs)	**386–456**

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.

Table D.15. Use of Management Information Systems (MIS) in Early Head Start

	Number of Programs	Percentage of Programs
Program Uses a Computerized MIS	538	88.4
Type of MIS		
Head Start Family Information System	183	34.1
Child Plus	197	36.9
Access	18	3.4
COPA	19	3.6
Galilleo	7	1.4
Genesis	11	2.0
Prinis	19	3.5
Locally designed	26	4.8
Combination of software	54	10.1
Satisfaction with MIS (Among Programs Using Any)		
Very satisfied	132	24.6
Somewhat satisfied	269	50.3
Somewhat dissatisfied	100	18.8
Very dissatisfied	34	6.3
Reasons for Dissatisfaction with MIS (Among Those Somewhat or Very Dissatisfied)		
Difficult to use	56	42.3
Reports not useful	53	39.3
Problems with software	76	57.2
MIS does not meet current needs	19	14.1
Lack of technical support or trained staff	20	14.5
Sample Size (Programs)	**133–609**	

Source: Survey of Early Head Start Programs.

Note: Data are weighted to adjust for survey nonresponse. Sample sizes are unweighted.