

# Children's Investment Fund

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## **Early Childhood Education and Development Cluster Evaluation Project** *Final Report*

**October 2005**

**Child Welfare Partnership**  
Portland State University  
Graduate School of Social Work  
Portland, Oregon

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# EXECUTIVE SUMMARY

## BACKGROUND

In 2002, the City of Portland voters passed Measure 26-33 which created the Children's Investment Fund. The purpose of the Children's Investment Fund is to support proven programs that provide high quality childcare to children and families in need, promote school readiness, provide safe and constructive after-school alternatives for children, and/or help to prevent child abuse, neglect or family violence.

Thirteen of the funded programs with similar goals and services aimed at school readiness and quality childcare were grouped into an Early Childhood Education and Development (ECED) cluster. The programs in the ECED cluster include: *Albina Early Head Start, Albertina Kerr Early Intervention Program, Child Care Improvement Project, Early Head Start Family Center of Portland, Friendly House Preschool, Insights Teen Parent Program SEEDS Program, IRCO Parenting Program, Mt. Hood Community College Head Start at Gateway Center, Neighborhood House Early Oregon PreKindergarten, Peninsula Children's Center, Portland Community College Child Development Center, Portland Impact Parent Child Development Services, Portland Public Schools Head Start at Kelly Center.*

From January 2004 to October 2005, the Child Welfare Partnership at Portland State University designed and conducted a pilot evaluation of the ECED cluster. The purpose of the study was to assess and report on the impact of the Fund and its investments on children receiving services from programs in the cluster and to strengthen evaluation capacity among the programs as well.

## EVALUATION OBJECTIVES AND DESIGN

Based on a framework for evaluation that was drawn from the literature on school readiness and national standards for quality childcare, the evaluation was designed to answer the following questions:

- Did the programs serve the population that was intended to benefit from the provision of Children's Investment Fund dollars?
- How did children benefit from Children's Investment Fund grants?
- Did ECED programs deliver evidence-based curricula, demonstrate adherence to best practices linked with school readiness, and high quality childcare practices?
- How were children in ECED programs doing with respect to developmental status? How did they do over time?
- How did programs respond to children and families when there were concerns about developmental status or other issues related to school readiness?

ECED programs submitted data quarterly, beginning October 2004, on children and families served and the nature and extent of services delivered. In addition, each program conducted developmental screenings and/or assessments on children at the point of intake and again six months later. These data were submitted to PSU on a regular basis for analysis of the status of children at entry and overtime.

## KEY FINDINGS

### Key Findings from the Process Study

- *Children's Investment Fund dollars provided services to 1028 children and their families over an 18-month period, serving a population that was largely low-income and strikingly diverse:*
  - *75% were living at or below the federal poverty line;*
  - *40% spoke a first language other than English;*
  - *Nearly half were Latino/Hispanic or African American.*
- *467 children also exited programs during this period; providers noted the challenges of retaining low-income families who are frequently highly mobile.*
- *Children and families received a wide array of services linked with school readiness and quality early education and development including 2480 health and developmental screenings, referrals for a wide array of services, and caregiver education delivered through center-based programs and home visiting.*
- *Children and families for whom English was the second language benefited from: bilingual staff, specialized classroom instruction, translation/interpreter, and/or program materials in appropriate languages.*
- *Programs within the ECED cluster utilized standardized curricula and/or program models that are recognized nationally as a best-practice in early childhood care and education. Programs all had reported procedures in place to monitor quality.*
- *Staff salaries, education, and training reflected a wide range. The majority of staff had college degrees but only one in five had a graduate degree. Salaries were relatively low, and turnover among employees hired with Investment Fund dollars was approximately 35% over 18 months.*

### Key Findings from the Child Tracking Study

- *Programs provided data to the evaluation on the developmental status of 700 children. For more than half of these children, data were provided across two points in time to track their progress, substantially increasing the monitoring of children's progress.*
- *Most children were doing well. Eighty percent of children at both screening points were on track in all developmental domains based on the screening and assessment instruments used.*

- *When screening suggested risk for developmental delay, it was most often in language/literacy (communication skills).*
- *The large majority of children for whom there were initial concerns either no longer showed potential delay by the second screening (64%) or maintained their status (23%).*
- *Concerns emerged or increased for approximately 14% of the children who were screened a second time six months after intake, pointing to the importance of monitoring children over time.*
- *When teachers/child care providers had a concern about a child, based on their direct experience, referrals were made at least 75% of the time; children for whom potential developmental delays were identified based on formal screenings/assessments received fewer referrals.*

## **SUMMARY AND DISCUSSION**

Programs in the ECED cluster served a diverse population of primarily low-income families whose children might be expected to benefit greatly from high quality childcare and early education programs. This was especially true for the large number of children for whom English was a second language or who entered programs with special challenges or needs.

Screenings and assessments of children’s developmental status across the 12 direct service programs in the ECED cluster present a picture of children who are by and large doing well. Children for whom English is a second language may need more time to develop the communication and language skills that will help them prosper in K-12 educational settings, and children who have diagnosed disabilities may not be able to match the developmental trajectory of their peers, as measured with these screening tools.

The findings from the child tracking component point to the importance of ongoing screening, given that potential concerns emerged for some children when they moved from one age range to the next. Without these second screenings, these potential problems would not have been identified or addressed. Programs provided many referrals (or direct services) to address concerns about the children in their care, but the rates of referrals varied, with more referrals apparently made based on provider’s judgment about children than on the results of developmental screening or assessment tools.

In sum, the ECED cluster did an exemplary job of serving the intended population and of compiling and submitting data on service delivery and developmental screenings when children entered their programs. Fewer children were screened six months later, in part due to attrition but also in part due to the time and resources required for the paperwork involved. To sustain ongoing tracking of children in Portland’s early childcare and education programs and the monitoring of other program outcomes, additional resources will need to be allocated for this purpose.

## SECTION I: BACKGROUND

### Introduction

In 2002, the City of Portland voters passed Measure 26-33, which created the Children's Investment Fund. The purpose of the Children's Investment Fund is to support and strengthen programs that help children arrive at school ready to learn, provide safe and constructive after-school alternatives for children, and prevent child abuse, neglect or family violence.

In its first round of grant-making, the Children's Investment Fund awarded contracts to 25 early childhood programs aimed at enhancing school readiness and related outcomes for young children. These programs serve children and families throughout the Portland area and include Head Start, Early Head Start, childcare, respite, and transitional care programs.

Thirteen of the funded programs shared similar goals and services with respect to early childhood education, child development, and childcare and were grouped into an Early Childhood Education and Development (ECED) cluster. Within the ECED cluster, twelve provide direct services to children 0-5 years of age and their families, with the majority targeting low-income families for service slots paid for with Children's Investment Fund dollars. One program in the ECED Cluster provides services to family day care providers rather than directly to children. This program enhances the quality of family day care by providing education, support, and resources. The programs in the ECED cluster include:

- *Albertina Kerr Early Intervention Program*
- *Albina Early Head Start*
- *Child Care Improvement Project*
- *Early Head Start Center of Portland*
- *Friendly House Preschool*
- *Insights Teen Parent Program*
- *IRCO Parenting Program*
- *Mt Hood Community College Head Start at Gateway Center*
- *Neighborhood House Early Oregon PreKindergarten*
- *Peninsula Child Care Center*
- *PCC Child Development Center*
- *Portland Impact Parent Child Development Program*
- *Portland Public Schools Head Start at the Kelly Center*

### Evaluation Objectives

In January of 2004, the Children's Investment Fund contracted with the Child Welfare Partnership at Portland State University (PSU) to design and pilot an evaluation of the ECED cluster. The purpose of the evaluation was to assess and report on the impact of the Children's Investment Fund grants on children receiving services from programs in the cluster. The

Partnership research team worked closely with staff and volunteers of the Children's Investment Fund and the grantees to develop an approach to the evaluation that would meet this objective and would also enhance evaluation capacity among programs in the cluster. This report summarizes results from the first 18 months of evaluation of the ECED cluster.

The following sections provide a brief description of the components of school readiness, a conceptual framework for the evaluation, a description of the design and methodology, and a report on the findings, limitations and implications of the study.

## Understanding School Readiness

The National Educational Goals Panel (NEGP), an independent agency established by the federal government to assess and report national and state progress toward achieving the National Education Goals, identified three components of school readiness:<sup>1</sup> 1) the readiness in the child; 2) the school's readiness for children; and 3) family and community supports and services. The NEGP defines these components as follows:

*School readiness is "the state of early development that enables an individual child to engage in and benefit from first grade learning experiences." Maryland Board of Education<sup>2</sup>*

- *Readiness in the child* is defined by the child's physical well-being and motor development, social and emotional development, language development, approaches to learning, and cognitive development.
- *Family and community* supports and services available, including access for all children to high-quality and developmentally appropriate services; supports and training for parents and caregivers to be the child's first teacher; and nutrition, physical activity, and health care for children so that they arrive at school mentally and physically alert.
- *Readiness of schools* includes the continuity of care between early childhood education programs and elementary schools, a commitment to the child's success, a commitment to adults who interact with children, the use of appropriate interventions that promote achievement, and referrals to services that are available in the community.

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<sup>1</sup> The National Education Goals Panel (1997). *Getting a good start in school*. Washington, DC: National Education Goals Panel.

## Evaluation Framework

Programs in the ECED cluster were selected by the Children's Investment Fund because they addressed the components of school readiness in the following ways:

- 1) By serving children who may be at-risk for poor school outcomes because of contextual or family factors such as poverty, cultural or language barriers, lack of parenting skills or other challenges. These children and their families can be expected to benefit substantially from high quality childcare and early education programming.<sup>2,3,4</sup>
- 2) By providing high quality childcare, which is characterized by:<sup>5</sup>
  - strong health and safety standards,
  - low student-to-teacher ratios,
  - qualified and well-compensated teachers,
  - and meaningful parental involvement.
- 3) By delivering curricula in early education classrooms and/or through home visits that are evidence-based or recognized as best practices to ensure that children achieve developmental milestones. Evidence-based early education curricula include components that address cognitive development, communication skills, social-emotional development, fine motor skills, gross motor skills, and problem solving skills. These areas directly affect readiness to benefit from K-12 education.<sup>6</sup>
- 4) By delivering critical additional supports and services to children and families to promote positive parenting, health and well-being<sup>7</sup>. The program supports and services address the need for children to arrive at school ready to learn, i.e., *nourished, healthy, and safe*. For low-income families, it is especially important that programs assist families by screening to ensure that children's health needs are met (e.g., vision, hearing, well-child health care and immunizations). It is also important that parents and other caregivers have opportunities to learn about child development and positive parenting strategies, and that families have assistance in finding help with challenges such as substance abuse, domestic violence or other circumstances that directly affect children's health, safety and wellbeing. Services are delivered through center-based and home visiting programs, both of which have a body of evidence to support their effectiveness.<sup>8</sup>

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<sup>2</sup> Lee, V. E. and D. T. Burkam. (2002). *Inequality at the Starting Gate: Social Background Differences in Achievement as Children Begin School*. Washington, D.C.: Economic Policy Institute.

<sup>3</sup> Schweinhart, L. J., Montle, J., Xiang, Z., Barnett, W. S., Belfield, C. R., & Nores, M. (2005). *Lifetime effects: The High/Scope Perry Preschool study through age 40*. (Monographs of the High/Scope Educational Research Foundation, 14). Ypsilanti, MI: High/Scope Press.

<sup>4</sup> Adapted from: Zill, Nicholas, Mary Collins, Jerry West, and Elvie Germino Hausken. (1995). Approaching Kindergarten: A Look at Preschoolers in the United States. *Young Children* 51(1, Nov): 35-38. PS 524 215. <http://ceep.crc.uluc.edu/eecearchive/digests/1995/zill95.html>

<sup>5</sup> Denton, D. (2001). *Improving Children's Readiness for School: Preschool Programs Make a Difference But Quality Counts*. Atlanta, GA: Southern Regional Education Board

<sup>6</sup> L. Dunn & S. Kontos, "Research in Review: What Have We Learned about Developmentally Appropriate Practice?" *YOUNG CHILDREN* 52 (5): 4-13. Copyright 1997 by the National Association for the Education of Young Children. PS 526 718.

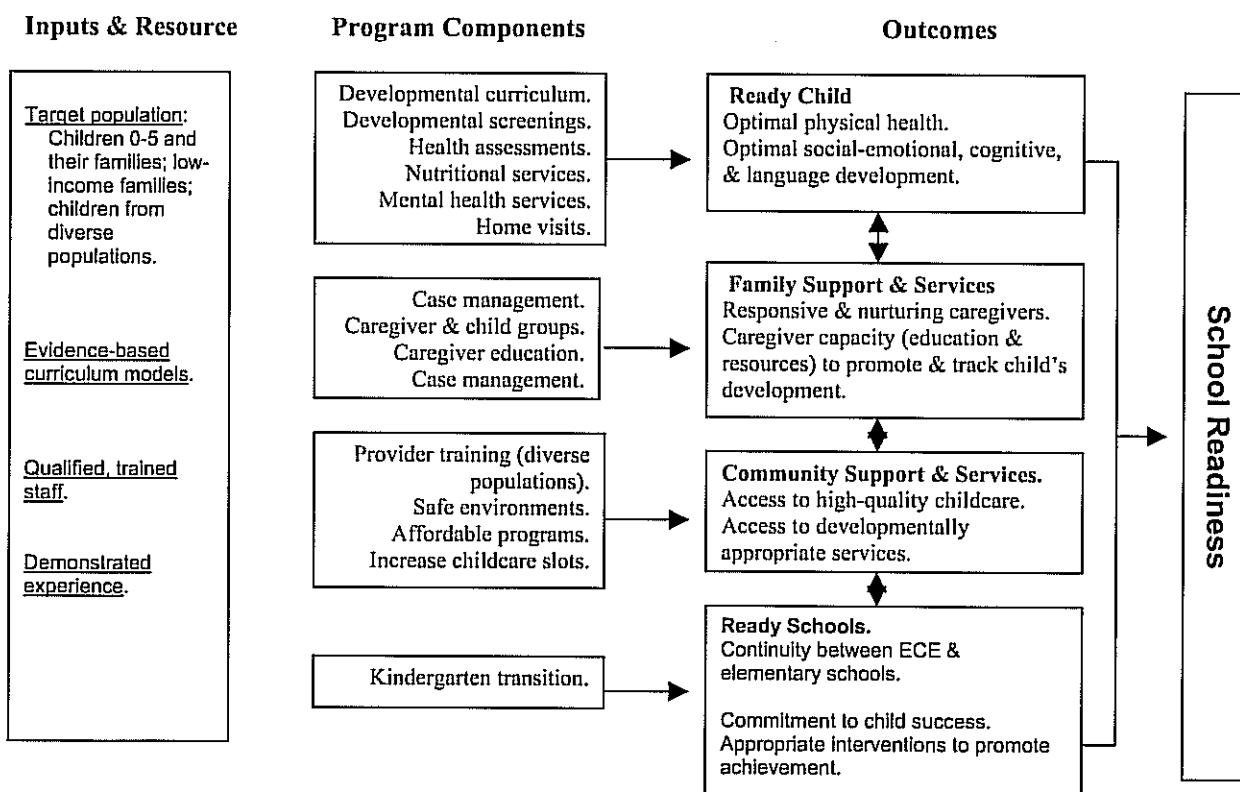
<sup>7</sup> Rhode Island KIDS COUNT, (2005). *Getting ready: Findings from the national school readiness indicators initiative a 17 state partnership*. Retrieved September 22, 2005, from <http://www.gettingready.org/matriarch>.

<sup>8</sup> Raver, C.C. & Knitzer, J. (2002). *Reading to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children*. National Center for Children in Poverty: Policy Paper. Columbia University, Mailman School of Public Health. Retrieved from: [www.nccp.org](http://www.nccp.org).

Some programs in the cluster also addressed the *readiness of schools* by providing services to ensure a smooth transition to kindergarten for children exiting their care.

A framework for the evaluation was formulated connecting programs' services and activities to the dimensions of school readiness (see Figure 1 below). In keeping with the limited resources for evaluation in this pilot project, we focused on two aspects of the framework: first, the degree to which programs successfully addressed school readiness through the appropriate Inputs and Program Components (as represented in Figure 1); and second, the degree to which children in the programs appeared to be on track for achieving the developmental milestones associated with school readiness (the Ready Child Outcome) and/or were receiving services to address concerns about potential risk for developmental delay.

**Figure 1: The Early Childhood Education and Development Cluster**



## SECTION II: EVALUATION DESIGN AND METHODS

The evaluation was designed to answer the following core questions derived from the framework presented in Figure 1:

- Did programs serve the population that was intended to benefit from the provision of Children’s Investment Fund dollars?
- Did ECED programs deliver evidence-based curricula, demonstrate adherence to best practices linked with school readiness, and show evidence of high quality childcare?
- To what extent were services and supports provided to families to promote school readiness?
- How did programs assess the developmental status of the young children they served and how did children fare with respect to developmental status over time in the ECED cluster?
- How did programs address the needs of children for whom there were concerns about developmental status or other issues related to school readiness?

Two separate components of the evaluation were designed to address these questions:

- 1) A process study, focusing on service delivery and adherence to best practices and/or evidence based programming. This component speaks to the quality, implementation and performance of programs funded.
- 2) A child-tracking component, gathering information about the developmental status of children as they entered programs and at six-month intervals thereafter and linking that information with data on services or referrals for children who may have needed additional supports.

The evaluation was designed also to collect qualitative data from grantee staff to supplement both components of the design, focusing on program highlights, implementation barriers or challenges, and recommendations with respect to future funding and program priorities.

### Process study

Through a collaborative process with grantees in the cluster, the evaluation team developed a common protocol and timeline for reporting process data (see Appendix A for this protocol). These data were grouped into three focus areas to capture information that would answer the evaluation questions related to implementation. The focus areas were;

- **Program quality:** information about adherence to best practices in early childhood education and development, including curricula and program models, program monitoring or fidelity practices, licensures and certifications, provider education and training, provider salaries, provider/child ratios, and provider turnover.

- **Population served:** numbers of children served, demographics of the children and families served, special needs among children served, primary languages spoken in the home.
- **Service delivery:** nature, scope, and level of services provided to children and families based on the evaluation framework described above. These include health and wellness screenings, mental health services, home visits, parent/caregiver education and support groups, provision of concrete assistance to families; referrals for children identified as potentially needing additional services.

Grantees were responsible for compiling and submitting process data, using the jointly-developed common protocol. These data were aggregated at the program level (i.e., across all children in slots funded by the grants rather than for individual children or families). Program-level process data were submitted quarterly to the PSU evaluation team, beginning October 2004, with the last round of data submitted for the quarter ending June 2005.

### **Child Tracking Component**

To monitor the developmental progress of children served by the Children’s Investment Fund, data were collected at two points in time on individual children in the study. These data included the results of screenings/assessments and a small number of other variables collected to help with interpretation of screening results. The more detailed set of questions shaping the child tracking component included:

- What was the developmental status of children in the ECED cluster at six-month screening points, beginning with intake?
- How many children were screened “at-risk” or in need of further evaluation with respect to specific developmental domains at these screening points?
- To what extent were age, language barriers, or diagnosed disabilities related to developmental screening results?
- Did the developmental status of children change over time and if so in what direction?
- When children were screened as “at-risk,” to what extent were they provided services and/or referrals to address their needs?

**Assessment procedures.** Grantees were responsible for assessing children’s developmental status and collecting additional data on child characteristics at the time of intake or enrollment in the program and at six-month intervals post intake. The PSU evaluation team provided child tracking forms and assistance to grantees in developing and maintaining a schedule of assessments for children in the study. Raw data on individual child assessments were submitted to PSU on a regular basis but without names or other personal identifiers, in keeping with guidelines for the protection of human subjects. Children were identified for purposes of longitudinal tracking with a research identification number.

The PSU evaluation team created and maintained databases for both program-level service data and for the child-level assessment data. Evaluators worked closely with grantees on the accuracy, consistency and completeness of these data. A discussion of the overall quality of the data appears in the Limitations section on p. 36 of this document.

**Assessment tools.** Children’s Investment Fund grantees used several different tools to screen children for possible delays across developmental domains. In general these tools were already in use by the programs, having been selected as most appropriate for the context and ways in which screenings were conducted (e.g., home visits versus classroom; screenings with parents versus screenings by providers alone, and age of the children served). The possibility of adopting a single measure for use by all programs was initially considered but determined not to be feasible for this preliminary study, given the diversity among the grantees in terms of their populations, service delivery models, goals, and resources.

The instruments that were used differed in a number of respects including how the instrument was administered and who provided the information about the child. However, the developmental domains assessed were similar and included social/emotional, cognitive, gross and fine motor skills, and language and literacy (referred to as communication skills in the case of very young children). Results from these measures range from a finding that the child is “at-risk” or not, to calculating a developmental level score and percentile ranking. At a minimum, each instrument illustrates that a child is “on track” developmentally or in need of further evaluation for one or more specific domains. The child development assessment tools are listed and briefly described in Appendix B.

### **Capturing Program Highlights and Challenges**

The evaluation plan included provision to gather and report the experience of Children’s Investment Fund grantees, in particular:

- Program highlights, including examples of how the services or supports that grantees provided to individual children or families were important to their health and development.
- Grantees’ experiences with the referral process, including information-sharing and coordination with other providers in addressing identified needs among the children they serve.
- The impact of the Children’s Investment Fund on grantees from the perspective of program staff, particularly how the grants may have resulted in changes to program infrastructure, services, or service delivery.
- Challenges or barriers that grantees perceive to implementing their programs, including barriers for children and families, barriers to programs, community-level barriers, gaps in services or interventions for children with special needs, etc.

Procedures for gathering this information included informal discussions with grantees throughout the year and a more formal meeting in May 2005 where evaluators posed a structured set of questions to capture additional information.

## SECTION III: FINDINGS FROM THE PROCESS STUDY

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### ***Key Findings: Process***

- Children’s Investment Fund dollars provided services to 1028 children and their families over an 18-month period, serving a population that was largely low-income and strikingly diverse:
    - 75% were living at or below the federal poverty line;
    - 40% spoke a first language other than English;
    - Nearly half were Latino/Hispanic or African American.
  - 467 children also exited programs during this period; providers noted the challenges of retaining low-income families who are frequently highly mobile.
  - Children and families received a wide array of services linked with school readiness and quality early education and development including 2480 health and developmental screenings, referrals for a wide array of services, and caregiver education delivered through center-based programs and home visiting.
  - Children and families for whom English was the second language benefited from: bilingual staff, specialized classroom instruction, translation/interpreter, and/or program materials in appropriate languages.
  - Programs within the ECED cluster utilized standardized curricula and/or program models that are recognized nationally as a best-practice in early childhood care and education.
  - Staff salaries, education, and training reflected a wide range. The majority of staff had college degrees but only one in five had a graduate degree. Salaries were relatively low, and turnover among employees hired with Investment Fund dollars was approximately 35% over 18 months.
- 

### **The Process Study Findings**

Program-level data on services and service delivery were submitted quarterly by each of the grantees and are aggregated here to present findings for the ECED cluster as a whole. The process study addressed three evaluation questions:

- *Did programs serve the population that was intended to benefit from Children’s Investment Fund dollars?*
- *Did ECED programs deliver evidence-based curricula, demonstrate adherence to best practices linked with school readiness, and show evidence of high quality childcare?*
- *To what extent were services and supports provided that are directly tied to children’s readiness to learn?*

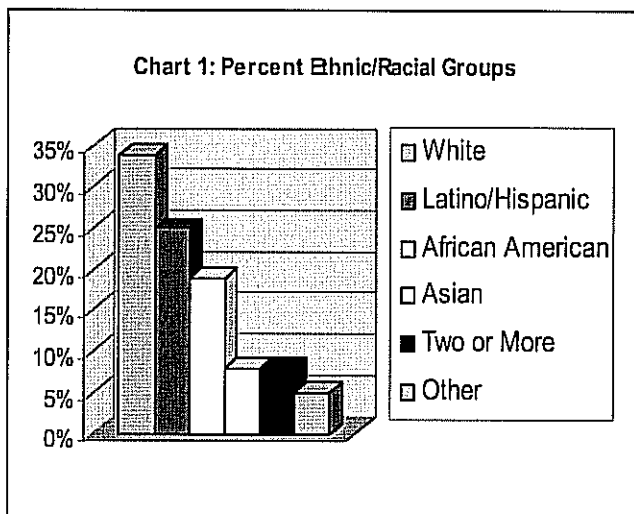
Each of these questions is addressed in turn.

## Population Served

Between October 2003 and June 2005, programs in the ECED cluster served 1028 children with Children's Investment Fund dollars; 467 children exited services during the same period. Virtually all of the children served were between 0-5 years of age (96%); 45% (n=461) were 0-2 years and 51% (n=527) were 3-5 years old. More than 75% of

children receiving services as a result of Children's Investment Fund dollars were noted to be living at or below the federal poverty line and English was the second language for more than 40%. Ethnic and racial diversity exceeded that of the general population in Portland, with Latino/Hispanic and African American children comprising nearly half of those served (see Chart 1). Approximately 4% (46) had a diagnosed disability.

*The ECED cluster served a population of children and families that were predominantly low-income and highly diverse.*



Children from all over Portland received services, with the majority residing in Southeast (n=543, 53%) followed by those residing in the Northeast (n= 213, 21%). Children from North, Southwest, and Northwest Portland comprised 23% (n=241) of the total number; approximately 2% (n=18) were homeless.

Some providers noted that Children's Investment Fund grants resulted in increased capacity, allowing them to serve children and their families who would otherwise remain on waiting lists or would not have been eligible for services.

## Program Quality

This section presents findings related to the use of evidence-based curriculum and/or best-practice program models, as well as aspects of staffing and staff training that are linked to overall program quality. Data were reported to the evaluation by programs in the ECED cluster and not independently corroborated.

**Curriculum and Programming.** Seven programs were affiliated with Head Start (n=3) or Early Head Start (n=4), utilizing models developed and funded by the U.S. Department of Health and Human Services to provide early education and service to low-income families. Early Head Start provides services to children and families 0-2 years and Head Start provides service to children and families 3-5 years. Nine programs (including the Early and Head Start programs) provided preschool and/or center-based childcare programs and five provided services only through home visits.

All of the programs within the ECED cluster report administering a standardized curriculum. The most common were Parent As Teachers and Creative Curriculum. These are briefly described as follows:

- Parents as Teachers (PAT) is an international early childhood parent education and family support program serving families throughout pregnancy until their child enters kindergarten, usually age 5. The program is designed to enhance child development and school achievement through parent education accessible to all families. It is a universal access model.<sup>9</sup>
- The Creative Curriculum® for Early Childhood describes and demonstrates how to plan a developmentally appropriate program focusing on ten well-organized interest areas. Its underlying philosophy draws from Jean Piaget's work on cognitive development, Erik Erikson's stages of socio-emotional development, and accepted theories of how children learn best.<sup>10</sup>

**Fidelity and Quality Control Monitoring.** Each of the programs in the cluster reported being certified, licensed, and/or accredited either for early childhood education, childcare, a particular curriculum model, safety standards or a combination.

*Programs meet standards of practice for Head Start, Early Head Start, Certified Child Care Centers, NAEYC, and Parent as Teachers.*

These licensing, accrediting and/or funding entities (e.g., NAEYC, USDHHS, OCD<sup>11</sup>) require programs to meet similar standards of practice that are consistent with the components of quality child care and education addressed above

such as child-to-staff ratios, developmental curriculum, and services to promote health and development. All programs providing classroom-based services adhered to staff-child ratios of no more than 1 to 4 for infants and toddlers and 1 to 10 for preschoolers.

In addition to licensing, all programs report self-monitoring for quality control or fidelity to their curriculum or program model(s). Procedures for self-monitoring are dependent on the program's resources and the type of funding received (e.g. Federal versus State funding). Within the ECED cluster there were a variety of quality control procedures, including federally required reports, child assessments, accreditation processes, supervision, classroom observations, and client satisfaction surveys. Self-monitoring activities occur as frequently as weekly, through supervision and case reviews, to monthly progress reports and/or annual program self-assessments. Regular reports are generated in eight programs about the self-monitoring activities and findings and on an "as needed" basis by other programs in the cluster.

**Staffing.** Data on staff retention, education, training and salaries were gathered from nine of the 13 programs in the cluster as important elements of program quality. These nine programs reported that 90 employees were in some part funded by the Children's Investment Fund. For 85 of these employees, we have information about when they were hired and their current employee

<sup>9</sup> Parents as Teachers. <http://www.parentsasteachers.org>

<sup>10</sup> The Creative Curriculum® 2002-2005 Teaching Strategies, Inc. <http://www.teachingstrategies.com/>

<sup>11</sup> NAEYC: National Association for the Education of Young Children  
USDHHS: United States Department of Health and Human Services  
OCD: Oregon Childcare Division

status. Most (87%) were hired by the time, or shortly after, grant funding began in October 2003 (11 were already employed by the program prior to the grant). Since then, 29 have left their jobs (representing approximately 35% of those hired at the time of the grant). The most frequent reason for leaving was to take a similar job in a different program (n=10); eight employees left because the program ended (e.g., summer-based programs). Overall, out of the 74 employees hired since October 2003 (see Table 1 below), 64% still remain in their positions.

**Table 1: Employment Status**

Hire Date	Still employed	No longer employed	Totals
<i>Before 10/03</i>	8	3	11
<i>After 10/03</i>	48	26	74

Most employees were hired to provide direct services to children and families. The largest proportion (approximately 37%) had a college degree; only about 20% had graduate-level education. The remainder had a high school diploma and/or some college. Salaries for those working directly with children ranged from \$7.60 per hour to \$30.00 per hour. These data are illustrated in Table 2 below.

**Table 2: Position Breakdowns**

Job Title	Number of People Hired	Percent of Hired	Average Hourly Wage	Range of Hourly Wages
Teachers and Classroom Aides	22	24%	\$15.30	\$8.50-30.00
Home Visitor, Parent Educator	18	20%	\$13.09	\$7.60 – 16.15
Program Administration	17	19%	\$17.28	\$10.00-47.55
Family Advocates/ Case Managers	12	13%	\$14.20	\$13.50-15.55
Mental Health	9	10%	\$11.30	\$9.25-16.00
Childcare	6	7%	\$8.00	\$8.00-8.00
Special Services	4	4%	\$14.32	\$13.00-15.60
Substitutes	2	2%	*	*

\* Mean not computed due to sample size.

**Training.** Another measure of program quality is the extent to which direct service providers receive training and continuing education. Half of the direct service providers still employed with the program (n=32) received up to 25 hours and the remaining received 25 or more hours of training. Ten providers received more than 100 hours of training for the year; for some, this included field hours related to requirements for degree programs or certificates.

**Table 3: Annual Training Hours**

Hours per Year	Direct Service Providers	
	%	#
Up to 25 hours	50%	16
25 or more hours	50%	16
100 + hours	28%	10

### *SERVICES TO CHILDCARE NETWORKS*

One program in the ECED cluster provides services to support quality family child care businesses serving diverse populations that live in low-income neighborhoods. The goals of this program are to improve the quality of family child care; strengthen these small businesses; increase low-income families access to affordable, quality child care; and provide a model for a city-wide coordinated system of child care networks. The activities provided by this program are consistent with the literature regarding affordable quality childcare.<sup>12</sup>

This program provides services to support four neighborhood based networks of family child care providers including North and Northeast Portland, Southeast Portland, Mid/East Multnomah County, and Southwest Portland. There are more than 95 providers within these four networks providing services to approximately 700 children. Services offered to family care providers seek to strengthen the quality of programs to provide an accessible and affordable childcare option for families. The description and frequency of services provided by this program are illustrated in Table 4.

<sup>12</sup> Denton, D. (2001). *Improving Children's Readiness for School: Preschool Programs Make a Difference But Quality Counts*. Atlanta, GA: Southern Regional Education Board

**Table 4: Services to Childcare Networks**

Services	Description of Service	Number Provided 7/04-6/05
Home Visits	Network coordinators visit individual family daycares to provide consultation regarding curriculum, child development, and business development.	334
Family Day Care Rating Scale Assessments	Providers complete an assessment of their programs using the Family Day Care Rating Scale designed to assess how well the program is addressing space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children.	31
Grants to Providers	Small grants are received by providers to assist with purchasing art supplies, curriculum, physical activity equipment, and safety equipment.	116
Training/Workshops and Meetings	Providers attend trainings and meeting to increase knowledge and skill related to child development, child abuse and child safety, cultural diversity, and managing a child care business.	111
Tuition Scholarships to Parents	Scholarships are provided to parents to assist with child care expenses in emergency cases or while completing high school or a college education.	58
Disability Grants	Providers access funds to enhance their ability to provide services to children with different abilities. This may include receiving training, contracting for special services, or improving the facility.	8
Education Fund	Providers access funds to support continued education by taking early education courses, sign language classes, and business practices.	4

*Services and Supports to Children and Families*

Service data were submitted to the evaluation team for a 12-month period, beginning July 2004, and thus pertain to a subset (n=559) of the total population of children served.

*Programs provided: health, wellness, and developmental screenings; nutrition; home visits; parent education; recreation; case management and referrals; and other services to promote children's readiness to learn.*

The core early education, development, and childcare services were delivered to children through center-based and home-based programs, using the curriculum models described on p. 10 above. Some center-based programs (Head Start programs, for example) served

children as much as 15 hours per week, while others served children and families primarily through home visits that occurred on a weekly basis or in some cases less frequently.

In addition to the developmental curricula designed to stimulate children’s cognitive, physical, and social-emotional development, programs provided a range of other services to address the health and well-being of children and families linked with the Evaluation Framework presented on p. 4 of this document.

These included screenings to address health, wellness and development as well as direct services to children and families linked with well-being and readiness for school. Data on screening and direct services are presented in Tables 5 and 6 below.

**Table 5: Screenings for Health and Wellness**

<b>Screening Type</b>	<b>Number of Screenings</b>	<b>Number of Programs</b>
<b>Hearing</b>	394 (67%)	8
<b>Vision</b>	330 (60%)	10
<b>Dental Care</b>	311 (56%)	6
<b>Immunizations</b>	400 (72%)	9
<b>Ht-Wt/Wellness</b>	479 (86%)	8
<b>Developmental Status</b>	846 (151%)	12

**Table 6: Services Provided to Children and Families**

<b>Service Type</b>	<b>Service Description</b>	<b>Programs Delivering this Service</b>
<b>Nutritious Meals</b>	<i>breakfast, snacks and/or lunch to children in their care.</i>	11
<b>Home Visits</b>	<i>planned services in the home to provide support to parents; teaching parents developmentally appropriate activities; conducting screenings and providing referrals.</i>	11
<b>Child Safety</b>	<i>training for parents; teaching parents about home safety and car seat safety.</i>	10
<b>Transportation</b>	<i>to parents and children to childcare centers; to referrals.</i>	10
<b>Recreation Activities</b>	<i>planned recreational activities including the zoo, parks, summer children's museum, OMSI, &amp; libraries</i>	10
<b>Concrete Services</b>	<i>providing tangible services; clothing, food, diapers.</i>	11
<b>Case Management / Advocacy</b>	<i>programs worked to determine family needs and make appropriate referrals and connections.</i>	10
<b>Social Skills Training</b>	<i>planned lessons and groups to promote socialization in young children; peer socialization.</i>	10
<b>Parent Education/ Support Groups</b>	<i>addressing child development, language/literacy, and parenting/positive discipline</i>	10
<b>Mental Health Services</b>	<i>consultations with staff and direct services to children</i>	8
<b>Parent/Child groups</b>	<i>planned groups to promote parent child attachment.</i>	8
<b>Nutrition Services</b>	<i>services provided by a professional nutritionist related to weight/nutritional concerns.</i>	7
<b>Speech, Occupational, or Physical Therapies</b>	<i>provided directly to children with special needs</i>	6
<b>Mentoring</b>	<i>organized mentoring program for young children.</i>	3

**Home visits**, which were a key component for most programs, were delivered either alone or in combination with classroom programming. Activities during home visits varied across programs, depending on whether there were also center-based activities. Services provided during home visits included health, wellness and developmental screenings, case management and referral services, parent education and support, and direct work with children or parent-child dyads. Data on the number and frequency of home visits appears in Table 7 and 8 below.

**Parent support/education groups** and/or parent-child groups were also an important service element. Nine programs provided 363 parent-child groups with an average attendance of 13 parent-child dyads. All programs reported providing parent/caregiver support and/or education

groups including groups about child development, literacy, health and safety, financial planning, school planning, and parenting.

**Table 7: Home Visits**

Home Visits	Total
Attempted	3855
Completed	3636
Families Visited	1402
Children Visited	1715

**Table 8: Frequency of Visits**

Frequency	# Programs
Weekly	5
Monthly	4
Quarterly	5
As Needed	4

**Referrals for services** and activities to address needs of children and families that were beyond the scope of the ECED programs were part of case management services. Data on referrals appear in Table 8 below.

**Table 9: Referrals**

Referral Type	# Children Referred	# Programs Referring
Recreation Activities	115	8
Medical care	75	8
Community Health Services	44	8
Domestic Violence	4	4
Early Intervention	31	9
Child Protective Services	26	9
Mental Health	22	9
Childcare	20	7
Legal/Advocacy	17	5
Other ( e.g., libraries, community centers, nonprofits)	41	7

All 12 programs that provided direct services to children reported that they addressed the needs of non-English speaking families through bilingual staff, specialized classroom instruction, translation/interpreter, and/or program materials in appropriate languages.

Finally, 2383 books were provided to 1351 children by nine programs receiving Children's Investment Fund dollars, and 11 programs directly assisted with the transition to Kindergarten through coaching and educating parents, providing services within the elementary school, and developing transitions plans with the receiving school.

### **Summary of Findings from the Process Study**

The ECED cluster served a diverse population of primarily low-income families whose children might be expected to benefit greatly from high quality childcare and early education programs. It is also evident that programs served substantial numbers of children and families over the evaluation period and provided a wide range of services and/or referrals to meet the multiple needs of families in ways that can be expected to impact school readiness.

Substantial numbers of children also exited programs during the data collection period (467 over the 18 months). More information about the reasons children exited programs would help determine whether attrition is largely the result of children moving on to new age-appropriate settings or is associated with other issues. Providers noted that the turnover in children receiving services was often related to serving low-income families who move in and out of service areas in order to secure employment. Providers also noted concerns about their ability to reach out to vulnerable families and to continue to provide comprehensive services as their budgets grow tighter and manpower and other resources are reduced as a result.

ECED programs all demonstrated elements of evidence-based or best practices for young children, incorporating recognized curricula as well as services to address the health and well-being of children. Data on staff education levels, staff/child ratios, staff turnover, and salaries were difficult to capture but suggested that, not surprisingly, child care workers and early education teachers/providers in the ECED may be relatively underpaid for the important work they do and that substantial turnover may be one result. Programs provided an array of evidenced based services but providers noted that recruiting bilingual and bicultural staff with training in early education and development was challenging.

## SECTION IV: THE CHILD TRACKING STUDY

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### *Key Findings: Child Tracking*

- Programs provided data to the evaluation on the developmental status of 700 children. For more than half of these children, data were provided across two points in time to track their progress, substantially increasing the monitoring of children's progress.
- Most children were doing well. Eighty percent of children at both screening points were on track in all developmental domains based on the screening and assessment instruments used.
- When screening suggested risk for developmental delay, it was most often in language/literacy (communication skills).
- The large majority of children for whom there were initial concerns either no longer showed potential delay by the second screening (64%) or maintained their status (23%).
- Concerns emerged or increased for approximately 14% of the children who were screened a second time six months after intake, pointing to the importance of monitoring children over time.
- When teachers/child care providers had a concern about a child, based on their direct experience, referrals were made at least 75% of the time; children for whom potential developmental delays were identified based on formal screenings/assessments received fewer referrals.

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### **Purpose**

Programs in the ECED cluster provided a limited amount of data to the evaluation about individual children in their programs. These data were intended to provide a profile of how children were faring with respect to developmental milestones and how programs responded when there were concerns about risk for potential developmental delay or other problems identified by providers. Tracking measures and formal assessment/screening tools were completed at the time the child entered the program and at a second point six months later. Four types of information were collected and submitted to the PSU evaluation team on these children:

- Key child characteristics that might potentially affect the risk for possible developmental delay, including age, gender, presence of diagnosed disability, use of English as a second language.
- Any provider concerns about potential risks or problems and the nature of those concerns.

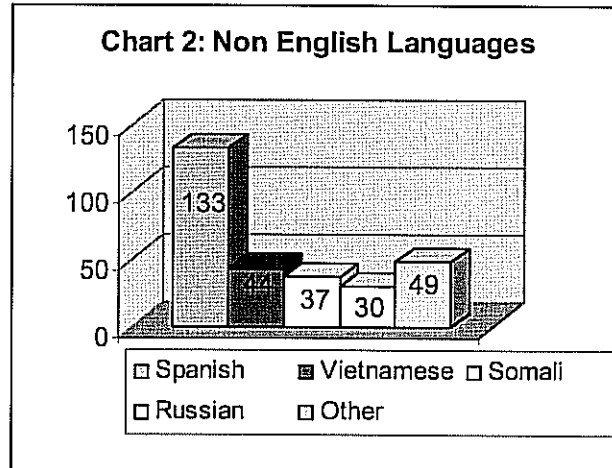
- Developmental status based on formal screening or assessment tools in domains associated with school readiness.
- Information about referrals made as a result of provider concerns or because of risks that emerged as a result of formal screening or assessment.

Although most programs in the ECED cluster reported that they typically assessed children’s developmental status at least once during the year, one of the results of the Children’s Investment Fund grants was the commitment on the part of cluster programs to track children’s progress at six-month intervals over time. Developmental status for children was recognized to be a function of many things beyond the control of early childcare and education programs, including genetic and biological factors, family factors, and environmental factors. It was not expected, therefore, that programs could change the developmental trajectory for all children in their care. However, programs expected that children who were at risk would maintain their current developmental status or gain over time, rather than fall further behind. With that in mind, the evaluation examined assessment/screening results at intake and again six months following intake.

## Child Tracking Study Findings

### Child Characteristics

The sample of children for whom intake data were available in general matched the characteristics of the population described by the program level data submitted as part of the process study (see p. 9). Almost all were ages 0-5 at the point of intake (97%). Nearly half (45%) were 3-5 years old; 36% were 1-3 years old; the remainder were less than a year old. Nearly 300 children (41%) spoke English as a second language. Fifty-six children (8%) had a diagnosed disability; among these children, physical disabilities were the most common (13 children) followed by Attention Deficit Hyperactivity Disorder (11 children) and Disruptive Behavior (8 children).



### Child Tracking Data

Twelve programs in the ECED cluster (those providing direct services to children) submitted data on approximately 700 children across a 10-month data collection period. Among these 700 children, 675 (96.4%) completed an initial screening and 371 (53%) completed a second screening. When children were not screened a second time, in most cases it was because they exited the program (n=132) or the project ended prior to the six month follow-up screening point

(n=84). In some cases, the screening instrument was considered inappropriate due to the child's age or disabilities. Lack of staff time, lack of parent/child availability or other reasons accounted for the remainder of children who missed a second screening.

*Concerns about Children Noted by Teachers/Childcare Providers*

Teachers or childcare providers who completed tracking forms on children in the sample were asked to note (at both intake and the six-month follow-up point) whether they had a concern about the child and, if so, in what area. At the point of initial screening, a concern was noted for approximately 17% (n=118) of the children in our study. The specific areas of concern appear in Table 10 below. They range across health, mental health, speech, and language issues as well as other potential special needs. The number of children for whom concerns in these areas are noted adds up to more than 100% because of multiple concerns about some children. In fact, there were two or more concerns for approximately half the children (n=61) in this group.

*Addressing Concerns about Children*

One important component of service delivery reported by grantees at the program level was the capacity to provide referrals or services to address identified needs of children and their families. When there were concerns noted by providers, we asked that programs report on referrals made and, when referrals were made, whether those referrals resulted in services.

*When teachers/childcare providers had a concern about a child, a referral was made more than 75% of the time.*

The following tables present the concerns noted by teachers/childcare providers at intake and the six-month follow-up point, referrals made as a result of concerns (or reasons why referrals were not made), and whether services were initiated as a result. These data indicate that when teachers/childcare providers had a concern about a child, a referral was made more than 75% of the time. Among those referrals, services were initiated at least 95% of the time.

**Table 10a: Referrals to Address Provider Concerns at Intake**

FIRST SCREENING N=676	Concerns Noted	Referral or Service Provided			
		Yes	No already provided	No Other Reason	Service Initiated
Mental Health	63	56	4	3	56
Special Education	52	44	3	4	44
Speech	61	47	8	5	44
Medical	12	8	1	2	6
Nurse	7	5	0	1	4
ESL	2	0	2	0	1

**Table 10b: Referrals to Address Provider Concerns at Follow-Up**

SECOND SCREENING N=386	Concerns Noted	Referral or Service Provided			
		Yes	No already provided	No Other Reason	Service Initiated
Mental Health	45	37	6	0	42*
Special Education	40	35	3	2	34
Speech	33	22	6	4	20
Medical	5	3	1	1	2
Nurse	1	1	0	0	1
ESL	0	0	0	0	0

\* Includes services already in place.

### Formal Developmental Screenings and Assessments

In addition to noting concerns identified by teachers in their direct work with children and families, programs formally assessed and/or screened children in their care for potential risk of developmental delay. *Screening tools* (such as the Ages and Stages Questionnaire<sup>13</sup>) identify children who may potentially be at risk for developmental delay and could benefit from more thorough assessment. *Assessment tools* (e.g., the Devereux Early Childhood Assessment<sup>14</sup>), on the other hand, place a child specifically within the normal range for his/her age or alternatively indicate that the child's score falls outside the norm.

*More than 80% of the children supported by Children's Investment Fund dollars appeared to be achieving developmental milestones across two time points.*

Programs utilized one or more screening or assessment tools to track developmental status in key domains including physical (gross and fine motor), social emotional, cognitive, and language/literacy (see Table 11 below). The tools differed in a number of respects, including their purpose (screening versus assessment), how they were administered, who provided information about the child (parent or teacher/childcare provider), and the context in which they were administered (classroom/childcare setting or home visit). The tools are also differently constructed and scaled. For all these reasons, it is not possible to directly compare results across them. Each, however, helps teachers/providers to identify areas where children may need more assistance to progress through developmental tasks.

<sup>13</sup> Ages & Stages Questionnaires® (ASQ) A Parent-Completed, Child-Monitoring System, Second Edition By Diane Bricker, Ph.D., & Jane Squires, Ph.D. Paul H. Brookes Publishing Co., Inc

<sup>14</sup> *The Devereux Early Childhood Assessment (DECA)* . LeBuffe & Naglieri, 1998. The Devereux Foundation 444 Devereux Dr. Villanova, PA 19085. Web site: www.devereuxearlychildhood.org

Using each tool's unique convention for identifying children with potential needs, a review of screening/assessment results across the sample of children in the child tracking component would tentatively suggest that more than 80% of the children supported by Children's Investment Fund dollars in these programs were progressing adequately at these two time points.

**Table 11: Assessment/Screening Tools**

Measure	# Children	% n=679
Ages and Stages Questionnaire (ASQ)	443	65%
Devereux Early Childhood Assessment (DECA)	34	5%
Developmental Continuum Assessment System	31	5%
Galileo	119	18%
Head Start Child Outcome Assessment	33	5%
No Instrument Used*	19	2%
<b>TOTAL</b>	<b>679</b>	<b>100%</b>

*\* instrument considered inappropriate because of child's age or disability.*

However, it is important to note that there was significant attrition in the sample from intake to the six-month follow-up point, making it problematic to generalize findings to the entire population served.

In light of the differences among the measures and the lack of direct comparability across them, findings on children's developmental status are presented based on the results of specific instruments used.

### **INSTRUMENT 1: Ages and Stages Questionnaire**

By far the largest number of children in our sample (n=443) were screened with the Ages and Stages Questionnaire (ASQ). The ASQ is a comprehensive screening measure for health/physical, social/emotional, language, cognition, and parental concerns for children from four months to 60 months of age. The ASQ is used in both home visiting and classroom settings and is relatively easy to use for providers and family members. The ASQ is a screening tool to determine if further assessment may be needed in one or more developmental domains based on pre-determined cut-off scores.

Six programs reported using the ASQ to screen 443 children at intake (information about eleven additional children was provided as well, but these children were not formally screened because the instrument was considered not appropriate due to disability or age of the child). Among these 443 children, 247 received a follow-up ASQ screening approximately six months later. For children not screened a second time, in most cases it was because they exited the program (n=79) or the project ended prior to the six month follow-up screening point (n=76). In the remaining

cases the screening instrument was not appropriate due to the child’s age or disability, or because of scheduling challenges with family and staff.

### Child with Potential Risk

The majority of children receiving the ASQ screening were developmentally on track at both first and second screenings in all areas (n= 376, 83%). At the point of intake, however, 78 children were screened as potentially at risk for developmental delays in one or more areas (approximately 17% of the total). Most of these children were 0-2 years of age (n=42) and two-thirds (n=49) were boys. Almost half (n=38) spoke English as a second language, and ten (12.8 %) had a diagnosed disability. At the second screening, girls and boys were equally likely to be screened as potentially at risk for delays. This finding may reflect the different developmental trajectories of boys and girls, i.e., some boys who may have appeared potentially behind initially had “caught up” by the time of the second screening.

<i>Most children looked fine at intake, on track in:</i>	
<i>Communication skills</i>	<i>83%</i>
<i>Problem solving skills</i>	<i>94%</i>
<i>Fine Motor skills</i>	<i>94%</i>
<i>Social skills</i>	<i>96%</i>
<i>Gross motor skills</i>	<i>97%</i>

### Areas of Potential Delay

Among children screened for further assessment at the time of intake, most frequently the potential risk was in the domain of communication skills. This domain entails abilities such as using words to make complete sentences, naming items from a common category, and using endings of words such as “s”, “ed”, or “ing” for example (ASQ, 48 Month Questionnaire). Likewise, at the six-month follow-up point, communication was again the area where children were most likely to demonstrate potential risk (n=29, 11.7%).

**Table 12: Developmental Domains where Risk Appeared**

<b>Domain</b>	<b>Children with initial concern (n=78)</b>	<b>Children with concern at six months (n=50)</b>
Communication	45 (58%)	29 (58%)
Gross Motor	14 (18%)	12 (24%)
Fine Motor	26 (33%)	16 (32%)
Problem Solving	25 (32%)	20 (40%)
Personal/Social	16 (21%)	7 (14%)

### Progress Over Time

Substantially fewer children were screened a second time with the ASQ (247 versus 442) making it difficult to draw conclusions about progress over time. In general, however, children screened twice seemed to have fared reasonably well across the six-months from intake to the second

screening. Among children for whom there were initial concerns, most either lost the concern (63.8%) or maintained their status (23.4%). For a small number of children (n=6), concerns emerged at a second screening which had not initially been apparent. These data are presented in Table 13 below.

**Table 13: Changes in Potential Risk Across 2 Screening Points (n=247)**

**For children with ONE or MORE concerns at the initial screening (n=47).**

Change in Amount of Concern	# of Children	Percent
Maintained same number of concerns	11	23.4%
Decreased amount of concerns	30	63.8%
Increased amount of concerns	6	12.7%
<b>Total with 1 or more concerns at initial</b>	<b>47</b>	<b>100%</b>

**For children with NO concerns at the initial screening (n=204).**

Change in Amount of Concern	# of Children	Percent
Still had no concerns at 2 <sup>nd</sup> screen	175	85.8%
Gained one or more concerns	29	14.2%
<b>Total with no concerns at initial</b>	<b>204</b>	<b>100%</b>

The children for whom concerns emerged or increased over time (14%, n=35) were slightly older than those initially screened for potential risk (62% were three years or older). Moreover, equal numbers of boys and girls appeared in this group, and the majority (n=22, 63%) spoke English as a second language.

### **Progress Over Time by Domain**

For those children who were screened with the ASQ at intake and again six months later, we examined changes over time in each of the domains (the sample size differs because some children were not screened on all domains). Most appeared to be on track developmentally at both time points. Some children remained stable or appeared to catch up to developmental milestones. However, some children who initially appeared to be doing fine were screened as potentially at risk six months later. Data on children in the sample are presented for each of the domains screened with the ASQ.

**Communication skills.** Table 12 illustrates the results at intake and six-months later for children on the communication domain, the most common area of concern. Most children (83%) appeared on track at both measurement occasions. A small number screened as at-risk in this area initially remained at-risk (4%), while for about the same number, the concern disappeared

on a second screening. However, risks emerged for about 7% of children who initially looked fine, when expected milestones had not been achieved at the six-month mark.

**Table 14: Communication**

N=246	Status of Risk from 1 <sup>st</sup> to 2 <sup>nd</sup> Screening
Maintained No Risk	205 (83.3%)
Maintained a Risk	11 (4.4%)
Lost Risk	12 (4.8%)
Gained Risk	18 (7.3%)

**Gross motor skills.** The gross motor domain on the ASQ assesses a child’s ability to complete large motor tasks such as catch a ball, climb a ladder, and jump forward. The majority of children screened with the ASQ (93%) had no risk in the area of gross motor development at either 1<sup>st</sup> or 2<sup>nd</sup> screening.

**Table 15: Gross Motor Skills**

N=247	Status of Risk from 1 <sup>st</sup> to 2 <sup>nd</sup> Screening
Maintained No Risk	230 (93%)
Maintained a Risk	4 (1.6%)
Lost Risk	5 (2%)
Gained Risk	8 (3.2%)

**Personal/Social** assesses a child’s ability to interact with others and care for self through tasks such as knowing your name, age, gender, washing hands, and recalling names of playmates. The majority of children (95%) had no risk in the area of personal/social development at either 1<sup>st</sup> or 2<sup>nd</sup> screening.

**Table 16: Personal/Social**

N=246	Status of Risk from 1 <sup>st</sup> to 2 <sup>nd</sup> Screening
Maintained No Risk	234 (95%)
Maintained a Risk	5 (2%)
Lost Risk	5 (2%)
Gained Risk	2 (1%)

**Problem-solving** assesses a child’s cognitive ability through tasks such as repeating in sequence, following three directions, and engaging in pretend play. The majority of children (89%) had no risk in the area of problem-solving at either 1<sup>st</sup> or 2<sup>nd</sup> screening.

**Table 17: Problem-Solving**

N=247	Status of Risk from 1 <sup>st</sup> to 2 <sup>nd</sup> Screening
Maintained No Risk	220 (89%)
Maintained a Risk	7 (2.8%)
Lost Risk	7 (2.8%)
Gained Risk	13 (5.2%)

**Fine motor** assesses a child’s ability to complete fine motor tasks such as putting together puzzles, cutting with child-safe scissors, and buttoning and unbuttoning. The majority of children (88.7%) had no risk in the area of fine motor development at either 1<sup>st</sup> or 2<sup>nd</sup> screening.

**Table 18: Fine Motor Skills**

N=248	Status of Risk from 1 <sup>st</sup> to 2 <sup>nd</sup> Screening
Maintained No Risk	220 (88.7%)
Maintained a Risk	4 (1.6%)
Lost Risk	12 (4.8%)
Gained Risk	12 (4.8%)

## Service Referrals to Address Potential Risk

When the ASQ suggested that children were potentially at risk for development delays, more than half (55%) were referred by program staff for mental health, special education, speech, and/or medical services and many children received more than one referral or service. The number of children referred for additional services varied depending on the domain where concerns had emerged, as illustrated in Table 17 below. Children with concerns about communication skills (the most common domain where screening suggested risk for developmental delay) appeared least likely to receive a referral. More information is needed to know whether this is simply an artifact of very small sample sizes or because of a lack of appropriate services for the children and families (e.g., bilingual programs) or for other reasons.

**Table 19: Referrals for Children Screened with a Risk at Follow-up**

Domains	# Children with Risk	# Children Referred or Provided Service	Referrals or Services Provided			
			Mental Health	Medical / Nurse	Speech	Special Education
Communication	29	14	5	4	13	5
Fine Motor	16	10	4	2	9	8
Gross Motor	12	8	2	3	7	5
Personal-Social	7	6	2	4	6	4
Problem-Solving	20	8	3	2	6	6

## Summary of ASQ Findings

Although the majority of children screened for potential developmental delays with the ASQ appeared to be on track, approximately 17% raised concerns about potential delays at the time of intake in communication skills, fine motor skills, problem solving skills, or other areas. The majority of these children (64%) appeared to catch up by the second screening, and another 23% at least did not worsen over time. Nonetheless, 14% of the children who had no concern at the time of the first screening appeared at potential risk by the time of the second screening, and some children initially screened as at risk appeared to fall further behind.

Children for whom English was a second language were somewhat more likely than others to be screened as potentially at risk, but it is unclear whether this is a function of developmental status or of the assessment/screening tools, which may or may not be valid across a diverse population. ESL was not associated with a greater likelihood of an emerging risk six months after intake. It is more likely, as providers noted, that potential risks emerged as teachers/childcare providers had more opportunity to observe children, as parents were more forthcoming about their own observations, and possibly as children failed to meet new milestones as they moved into the next age group.

## Additional Child Screening/Assessment Data

Sample sizes are small for children screened with instruments other than the ASQ and therefore the data are difficult to extrapolate to the larger population of children served by the ECED cluster. Data from each of the additional screening/assessment tools are presented individually in the following section, in light of the substantial differences in their administration, scoring, interpretation, and in some cases population served.

### INSTRUMENT 2: Devereux Early Childhood Assessment

A small number of children in our study were assessed with the Devereux Early Childhood Assessment (DECA).<sup>15</sup> All these children were served by a single program that is specifically designed for children with diagnosed disabilities. The DECA assesses social-emotional development only and examines the strengths and potential behavioral challenges of children.

Thirty-four children received an initial screening with the DECA and 27 were screened again six months later. Six children had exited the program by the six-month mark and one child had not been in the program long enough to receive a 2<sup>nd</sup> screening. All of the children had a diagnosed disability; most were boys (70.6%). One child spoke English as a second language. All of these children received a mental health and special education referral.

The DECA assesses both protective factors (initiative, self-control and attachment), and behavioral concerns. In each area a child is assessed as *demonstrating a strength*, appearing *typical* for her/his age, or exhibiting behaviors that should cause *concern*. Table 20 illustrates that concerns related to protective factors at the initial screening were present for the majority and that for approximately half of those screened, there were concerns about behavior. At the second screening, fewer children who were assessed caused concern with respect to protective factors and the proportion of those with behavioral concerns remained roughly the same.

**Table 20: DECA Results**

Domain	1 <sup>st</sup> Screening		2 <sup>nd</sup> Screening	
	Typical	Concern	Typical	Concern
<i>Total Protective Factors</i>	13 (38.2%)	21 (61.8%)	16 (59.3%)	7 (25.9%)
<i>Behavioral Concerns</i>	16 (47.1%)	18 (52.9%)	14 (51.9%)	13 (48.1%)

However, the DECA also allows us to determine if there has been significant change in individual children from intake to 6-month follow-up assessments. Table 21 and 22 illustrate the number of children who improved, stayed the same, or appeared to decline in protective factors and behavioral concerns over this time period. The numbers are very small, but suggest

<sup>15</sup> *The Devereux Early Childhood Assessment (DECA)*. LeBuffe & Naglieri, 1998. The Devereux Foundation 444 Devereux Dr. Villanova, PA 19085. Web site: [www.devereuxearlychildhood.org](http://www.devereuxearlychildhood.org)

that children with concerns about protective factors were the most likely to show improvement (41%) and most children with behavioral concerns showed no change over this time period. This is not surprising, given that these are all children who entered the program with pre-existing diagnosed disabilities. The emergence of protective factors is encouraging.

**Table 21: Change in Protective Factors**

Total Protective Factors	2 <sup>nd</sup> Screening Change			
	1 <sup>st</sup> Screening	Significant Improvement	No Change	Significant Worsening
Typical		3 (11%)	5 (19%)	2 (7%)
Concern		11 (41%)	6 (22%)	0

**Table 22: Change in Behavioral Concerns**

Behavioral Concerns	2 <sup>nd</sup> Screening Change			
	1 <sup>st</sup> Screening	Significant Improvement	No Change	Significant Worsening
Typical		1 (4%)	8 (30%)	2 (7%)
Concern		3 (11%)	11 (41%)	2 (7%)

### INSTRUMENT 3: Head Start Outcomes

One program tracks developmental status by assessing mastery of specific Head Start outcome skills.<sup>16</sup> Children are assessed based on their level of mastery for a group of skills such as “associates sounds with written words” and “uses all words to make a sentence”. Each skill may be noted as *not applicable due to language differences, new skill/needs developing, beginning to develop/practice skill, demonstrates progress, or highly developed skill*. These assessments are intended to help teachers select or adapt classroom activities to meet the needs of children in their program but do not directly indicate risk for developmental delay. In general, however, children would be expected to progress over the course of the year on skills which they have not yet developed at the beginning of the year.

Thirty-three children were assessed with this instrument at intake and for 29 children, these skills were assessed again in the spring. Children were assessed on 13 skills related to language, math, and motor skills. During the initial assessment 26 (78.8%) children had one to seven skills that needed development. In the spring, when children were re-assessed, 11 (33.3%) children had

<sup>16</sup> Administration for Children: Head Start Bureau. [www.hsnr.org](http://www.hsnr.org).

one or two skills needing development and all received referrals resulting in services initiated to address these concerns.

**Table 23: Head Start Results**

Number of skills needing development	First Screening		Second Screening	
	# of Kids	Percent	# of Kids	Percent
0	7	21.2	22	66.7
1	3	9.1	7	21.2
2	5	15.2	4	12.1
3	5	15.2		
4	3	9.1		
5	4	12.1		
6	3	9.1		
7	3	9.1		

Of the 13 skills assessed, there were only three for which any children maintained a *needs developing* rating. Of the 5 children still needing to develop “recognized matching sounds and rhymes at the second screening” all were noted as ESL. For the eight children still needing to develop “associates sounds with written words,” six were ESL and one had a diagnosed disability; two speech referrals were made as well as a nursing referral. For the two children still needing to develop “identified at least 10 letters,” one child was ESL.

#### **INSTRUMENT 4: Development Continuum Assessment**

Two programs use the Developmental Continuum Assessment (DCA)<sup>17</sup>, an instrument that in conjunction with the Creative Curriculum program, measures change in skills learned by fall, winter, and spring. The DCA is primarily used to individualize curriculum plans for children but also helps providers identify children who may need additional help.

Thirty-one children were assessed initially with the DCA including seven children identified as ESL and no children with diagnosed disabilities. Only ten children were assessed at a six-month follow-up as most children had been transferred to Oregon Pre-Kindergarten prior to that point.

The DCA includes 4 subscales: physical (gross and fine motor), cognitive, language, and social/emotional. Each subscale includes a set of skills (e.g., “shows ability to adjust to a new situation”) for which children are rated from *forerunner* (indicating the child has not been

<sup>17</sup> Teaching Strategies, Inc P.O. Box 42243 Washington, DC 20015 Phone: 800-637- 3652 The Creative Curriculum Developmental Continuum (Dodge, Colker, & Heroman 2002) www.teachingstrategies.com

exposed to that skill or is having difficulty) to *level 3* (indicating that the child has mastered that skill as appropriate for her/his age).

For the 31 children who were assessed at intake, the domains where children were rated as *forerunner* and the number of children rated as forerunner in each appear in Table xxx below.

**Table 24: DCA Results**

Domain	# of Skills Rated as Forerunner	Number of Children
Social Emotional	0	0
Gross Motor	0	0
Fine Motor	1	1
Cognitive	10	5
Language	15	5

For the ten children who were reassessed at 6 month follow-up, progress was made in all domains. For each domain there was a decrease in the number of skills needing development. Two children continued to have some language skills *needing development* though the number of skills decreased from 10 to three.

**Table 25: Change in DCA Over Time**

Domain	Children with Forerunners Intake	# of Skills	Children with Forerunner Follow-up	# of Skills
Social Emotional	1	1	0	
Gross Motor	0		0	
Fine Motor	0		0	
Cognitive	2	6	0	
Language	2	10	2	3

## INSTRUMENT 5: Galileo

One hundred and nineteen children in two programs were assessed for developmental status using the Galileo,<sup>18</sup> a comprehensive tracking and monitoring system often used by Head Start affiliated programs. As with other assessment tools, Galileo addresses relevant domains based on the age of the child, including social/emotional, language/literacy, cognitive, and gross and fine motor skills. The Galileo software generates a variety of reports for providers at both the

<sup>18</sup> Galileo. Copyright © 2002. Assessment Technology, Inc. <http://www.ati-online.com/ati/index.htm>

child and classroom level. Raw scores for children are transformed into normal curve equivalents so that it is possible to examine children's status relative to what would be expected, on average, for their age.

Data presented here are on the subset of 33 children for whom child status reports were derived from raw scores (this information was not available for the remainder of children screened with the Galileo). Among these 33 children, all children scored within two standard deviations from the average in the developmental areas of self-help, perceptual motor, early math, and language and literacy. Two children, 0-2 years scored below average for early cognitive development and social development but increased to an average score at the second screening.

### **Summary of Findings from the Child Tracking Study**

Screenings and assessments of children's developmental status across the 12 direct service programs in the ECED cluster present a picture of children who are by and large doing well. Children for whom English is a second language, not surprisingly, may need more time to develop the communication and language skills that will help them prosper in K-12 educational settings, and children who have diagnosed disabilities may not be able to match the developmental trajectory of their peers, as measured with these screening tools. Many children appeared to catch up over a six-month period; for others, however, concerns emerged or increased over this time period. Without more information about these children, the reasons are unclear. Providers noted that sometimes more information was available about the child, leading to more accurate assessment, but this warrants further study.

These findings underscore the need for ongoing assessment of young children to monitor developmental status and to identify potential needs for services. Ideally, programs would adopt common screening protocols so that data could be more easily interpreted and used for program and policy planning. The pattern of referrals for children with potential developmental delay bears further study to understand whether disparities in referrals across domains was due to chance, variations in service availability in the community, or other circumstances.

## SECTION V: PROGRAM HIGHLIGHTS AND CHALLENGES

As part of the evaluation process, we asked providers to respond to a series of questions to help us better understand their experience as grantees and the experience and outcomes for children and families in their programs.

### **Findings: *At the Program Level***

*What have been the benefits associated with CHIF funding?*

- A common benefit from receiving CHIF funding was the ability of programs to serve more children. Not only did funding provide more slots for children but providers reported that the flexibility of the funding allowed programs to “serve kids that wouldn’t have been served” by expanding their requirements for service. For instance, programs could serve non-OHP children who could not be served prior to CHIF funding or could provide services to children who otherwise would remain on their waiting lists.
- Programs discussed the benefits of receiving evaluation and data collection support. Programs felt being a part of the evaluation project gave them “credibility” though it was also noted that program could benefit from more resources and staff to better evaluate their programs.
- Several providers mentioned that one benefit was building partnerships between other programs in the cluster. Providers expressed feeling as though they were “a part of a bigger movement with a focus on early childhood” and “children at-risk.”

*What have been challenges implementing your CHIF funded program?*

- A common theme concerned client recruitment and retention. Providers shared that they did not always have the time and staff to market their programs. A more frequently reported challenge was working with families with low-incomes who are often mobile and move in and out of the service area to maintain employment. Mobility was also a challenge for persons receiving child-care welfare benefits as reform efforts change requirements and eligibility.
- Another challenge mentioned was the difficulty when a program is dependent on services or resources from another program. For example, providers mentioned the long waits and complex requirements to refer a child to special education or early intervention. Some programs were dependent on others for facilities needed to provide services (e.g. school classrooms in the summer, evening services).
- Programs also experienced challenges providing bilingual services. Specifically, programs had difficulty finding staff with an early education and development background that were bilingual and/or bi-cultural. Programs reported that having printed material translated into one or more languages was expensive; not all programs had access to funds to cover this cost.

- A final challenge reported by programs related to funding and budgets. Some programs noted that it was difficult to provide comprehensive services when one or more line-items were cut from their budgets. Others reported that there was not enough money allowed for infrastructure, supervision, administrative, and data collection.

### **Findings: *Child Tracking Component***

*What have been the benefits of assessing/screening children's developmental status twice?*

- The most common benefit of screening twice was that it enabled programs to track a child's needs and possible delays and to affirm a child's progress. Providers felt it was helpful to be able to demonstrate a child's development over time to parents and caregivers. Providers also identified that this was helpful for modifying curricula or material to promote individual growth.
- Several programs also stated that tracking twice informed program supervisors about training needs of staff.

*What have been the challenges of assessing/screening children twice?*

- A common challenge implementing screenings twice was time and logistics. Several programs mentioned difficulty trying to match the 6-month timeline to parents' schedules and the time spent scheduling and re-scheduling, especially when doing home-visits. Providers mentioned that the screening process was also time consuming with respect to tracking, entering, and managing data.
- Providers felt that the assessments utilized were not comprehensive. A few providers reported that the assessments did not measure environmental factors and needed to be combined with observations. There was also a concern that six-month screening intervals were too long for infants because delays or potential difficulties could be identified sooner, but in some cases too soon for older children, who might take longer to show progress.
- Providers were also concerned about the consistency in how screening and assessment data were collected. It was a challenge with staff-turnover to train and retrain on how to conduct the assessments, when the staff needed to focus on building relationships with the families. Finding the same interpreter for consistency with families was also challenging.

*How effective are the instruments in assessing children's development?*

- Providers reported that the instruments were helpful in determining the child's developmental level and in planning activities to meet the child's needs. Additionally providers reported the instruments helped to "get a variety of input" about the child from parents and staff.

*What are reason children may have no risk at the first screening but a risk at the second?*

- The most common reason providers reported was exposure to the child. By re-assessing after six months, providers had the opportunity to observe the child in a variety of settings (home, classroom, groups) providing more opportunities to demonstrate skills. Relationships between the provider and child developed over time and therefore children were more open and providers more knowledgeable about the child's progress.
- Parental knowledge and resources were also reported as a reason risks were identified at the second screening versus the initial. Several programs provide services to parents to increase their knowledge about child development and increase parental language and literacy. As the parent's knowledge increases, they were more likely to identify possible concerns in their child. Providers also reported that families at the first screening did not have the resources to promote developmental skills (crayons, scissors, and books) but after receiving these resources from programs concerns emerged. Working with families over time also increased trust between providers and parents who were then more likely to report concerns about their child.
- Transitions and environmental factors in the child's life also were reported as a reason for an increase in risk from the initial to the follow-up screening. School-based programs reported that children often "act-out" at the end of the year because of upcoming changes (going to kindergarten, leaving familiar staff, summer plans). It was also reported that for some children an event occurred in their lives between screenings to derail development (environmental stress, family changes).

*What are challenges in referral process?*

- Common reasons reported about the difficulties in referring children and families were language barriers, eligibility requirements (income, insurance), waiting lists, and the lack of services available.

*What are the gaps in services needed for children and families?*

- When programs identified needs for the children and families they served, it was not always possible to ensure accesses to needed services. Specific gaps reported by providers included dental care, housing, transportation, mental health, culturally appropriate services, bi-lingual and bi-cultural services, and other preschool options for families. Several providers reported that monies should follow the child instead of the program.

## **SECTION VI: SUMMARY AND CONCLUSIONS**

### **Limitations**

Limitations in the measurement and data collection methods for the evaluation make it important to be cautious in interpreting or generalizing from results. In the process component, for example, it was difficult to aggregate service data across programs that have varying operational structures, serve children over differing time periods, serve children in different settings with different service models, and compile data for many different purposes and audiences. In the child tracking component, the challenges of examining developmental status across the entire cluster when programs assessed or screened children with a variety of different measures, with different sources of data (parents, teachers, or case managers) made it impossible to draw clear-cut conclusions about the population as a whole. Attrition of children from the programs between intake and the six-month follow-up point also limits the interpretability of findings.

It is also important to note that the evaluation was reliant on data submitted by programs rather than on data that were externally collected. Given the limited resources for evaluation in most of the programs, there were inevitable problems with consistency and completeness, despite the provision of substantial technical assistance by the evaluation team. Missing service data and missing data on children resulted in a picture that was not complete and therefore not easily interpreted. Moreover, more extensive data would be needed to make definitive statements about the result of service referrals, the progress of children over time, or the impact of program components on children and families served.

These limitations are common among descriptive studies of this nature. They are difficult to eliminate without a level of funding for evaluation that is rarely available.

### **Discussion**

From the data provided by grantees for this preliminary evaluation, it is clear that the ECED cluster served a diverse population of primarily low-income families whose children might be expected to benefit greatly from high quality child care and early education programs. This was especially true for the large number of children for whom English was a second language or who entered programs with special challenges or needs. It is also evident that programs served substantial numbers of children and families over the evaluation period and provided a wide range of services and/or referrals to meet the multiple needs of families in ways that can be expected to impact school readiness. It was also evident that many children exited these programs as well. This points to potential serious challenges for programs in engaging and retaining vulnerable families in services, but more information is needed to support specific conclusions.

Programs all demonstrated elements of evidence-based or best practices for young children, incorporating recognized curricula as well as services to address the health and well-being of children. The evaluation was not designed to gather independent data on fidelity to these

models, however, and relied on program reports of self-monitoring or their required adherence to licensing and certification standards as evidence of fidelity. Data on staff education levels, staff/child ratios, staff turnover, and salaries was difficult to capture but suggested that, not surprisingly, child care workers and early education teachers/providers in the ECED may be relatively underpaid for the important work they do and that substantial turnover may be one result. In the long run, a commitment to high quality childcare and early education in this community may require a greater commitment to providing salaries that will attract and retain talented and dedicated professionals.

Given the limited resources at the program level and the burden associated with any evaluation requirement, we were impressed with the degree to which providers in the ECED cluster contributed time and effort to this project. In particular, programs' willingness to collaborate on common protocols, timeframes and procedures was essential to our work. Even more important, though, was the commitment to learning more about how children fared over time in their individual programs and across the cluster as a whole. The findings from the child tracking component point to the importance of ongoing screening, given that potential concerns emerged for some children when they moved from one age range to the next, as providers spent more time with the child in different settings, and as parents'/caregivers' knowledge about child development increased. Without these second screenings, these potential problems would not have been identified or addressed. Programs provided many referrals (or direct services) to address some of these concerns, but without more detailed data on individual children and their outcomes, it is difficult to draw conclusions about the effectiveness of the referral process. Moreover, the lack of referrals for some children may point to gaps in services (e.g., bilingual services) that could help address potential problems.

It is also difficult to set targets for programs with respect to children's developmental progress, when underlying issues (such as pre-existing cognitive delay) may not be reversible. Without more detailed child-level data than were possible to collect in this evaluation, it is not possible to set clear and realistic outcome goals for children who enter programs with potential risk for developmental delays. At the same time, most children in the cluster were doing well and continued to do well, and many initial concerns disappeared as children caught up with their peers. Many more concerns did not appear worse on a second screening. Overall, the child tracking component proved especially useful in increasing programs' capacity to monitor children in their care but not as a means for evaluating program performance or effectiveness. We hope that resources will permit continued tracking of children across two or more time points in the ECED cluster.

## **Recommendations**

Specific recommendations that emerge from the evaluation include:

- Resources to support ongoing assessment/screening of children's developmental status so that potential problems are identified and responded to early. The Children's Investment Fund resulted in increased capacity, but it is unlikely to be sustained without continued investment.

- Adoption of consistent measures across early childcare and education programs so that results of screenings/assessments are more easily interpretable. Without consistency, it is difficult to make a clear case for resources to meet the needs of Portland's most vulnerable children.
- More study of attrition/retention in childcare and early education programs to help providers and policy makers address the needs of the most vulnerable families.
- Close tracking of service provision over time, as many programs reported they are stretched further each year with fewer resources. This is particularly important in light of the need for comprehensive services and supports for families in these programs.
- Additional examination of the referral process and service referral outcomes for children served by ECED programs. Further study is needed to track service provision and outcomes for children identified as potentially a risk in early childcare and education settings.

Finally, a clear need emerges to follow children into their next educational setting (especially those transitioning to kindergarten), since the literature is clear that *school readiness* requires both a "ready" child and a school with the resources, supports and structures in place to promote success. More emphasis on the transition process could contribute to achieving the overarching goals of the Children's Investment Fund and thereby assist Portland voters to ensure the most promising beginning for all young children reaching school age in this community.

**APPENDIX A:**  
*Process Data Protocols*

## CHIF EVALUATION QUARTERLY DATA COLLECTION FORM

Agency or Program Name:

Person Completing Form:

Phone #:

Quarter: July-Sept. 2004

Date:

Email:

### Shared Data

*The information you provide in this section will be shared with CHIF staff and fulfill your quarterly reporting requirement.*

Please fill out the following table on your primary population served (children or caregivers):

	Children		Caregivers	
	New Intakes	New Exits	New Intakes	New Exits
Totals				
Gender:				
Male				
Female				
Other				
Race/Ethnicity:				
White				
Black/African-American				
Latino/Hispanic				
Asian				
Native American / Native Alaskan				
Native Hawaiian / Pacific Islander				
Two or More Race/ Ethnicities				
Not Given				
Other				
Diagnosed disability				
Ages:				
0-2				
3-5				
6-8				
9-12				
13-15				
16-18				
19-24				
25-30				
31-40				
40-50				

	Number of Children		Number of Caregivers	
	New Intakes	New Exits	New Intakes	New Exits
Not Given / Unknown				
<b>Residence:</b>				
SE Portland				
NE Portland				
North Portland				
SW Portland				
NW Portland				
Homeless				
Not Given				
<b>Primary Language in Home:</b>				
English				
Spanish				
Vietnamese				
Russian				
Chinese				
Romanian				
Somali				
Swahili				
Congolese				
Not Given/ Unknown				
Other				
If other, describe:				
<b>Socio-Economic Status:</b>				
100% of FPL or Less				
101-150% FPL				
151 - 200% FPL				
201-250% FPL				
251% of FPL or Higher				
Not Given				

Have there been any changes in the services proposed in your grant agreement compared to the actual services currently offered and planned with your Children's Investment Fund grant?

Yes       No

If so, what are those changes and why did they occur?

How many new staff members did you hire this quarter?:

Has there been any staff turnover this quarter?

Yes       No

If yes, why?

What have been your program's challenges and successes thus far?

What press has the Children's Investment Fund-supported program received?

## PSU Evaluation Data

*The information you provide in this section will be reported in the final evaluation report in aggregate only.*

1. What curriculum and/or program model(s) do you use? *(Check all that apply.)*

Creative Curriculum

Early Head Start

PAT

Head Start

Healthy Start

Other *(choose only if none of the other models are selected.)*

2. If you chose other, briefly describe how you support each of the developmental domains listed below:

Cognitive:

Language / Literacy:

Social - Emotional:

Health / Wellness:

Fine Motor:

Gross Motor:

3. Do you provide: *(Check all that apply.)*

Infant-Toddler Program (with or without home visits)

Preschool (with or without home visits)

Childcare / Daycare (with or without home visits)

Home visits Only

4. If you provide preschool, how many classes do you offer and what are your hours of operation?

5. If you provide child care or daycare, what are your hours of operation?

6. What certifications / licensures does your program have? (Check all that apply.)

- NAEYC
- Oregon Child Care Certification
- PAT Certified
- State Teacher Certification
- CPR / First Aid
- None of the above / Not applicable

7. How do you monitor your program and/or insure fidelity to your program model?

7.a. Do you have a recent monitoring report / results available?

- Yes  No  Not applicable

8. What services to CHIF children have you provided this quarter? (Check all that apply.)

- Speech / Occupational / Physical Therapy
- Home visits
- Mental Health Services
- Transportation
- Recreation activities
- Concrete services (clothing, diapers, baby supplies, etc.)
- Mentoring
- Nutritionist services
- Social skills training
- Case management / advocacy
- Adoption services
- Child safety (inc. car seats)
- None of the above / Not applicable

9. If you provide home visits, please complete the following table:

Number this quarter (CHIF only)	
# Visits Attempted	
# Visits Completed	
# Families Completed	
# Children Completed	

9.a. Based on your program model, how often do you typically provide home visits? (check all that apply)

- Weekly  Monthly  Quarterly  As Needed  Other

9.b. If you chose other, please explain:

10. What type(s) of mental health services do you provide? (Check all that apply.)
- Individual, Family and/ or Group Therapy     Psychiatric Services (inc. assessment)
- Consults / Classroom Observation                       Referrals only
- Other (please describe):                                       None / Not applicable

11. Did you provide books in the home this quarter?  Yes     No
- How many books have you sent home for CHIF children?
- How many CHIF children have received books?

12. Did you provide Parent-Child groups this quarter?  Yes     No
- How many groups?
- Average group attendance?

13. Which of the following meals did you provide this quarter? (Check all that apply.)
- Breakfast     Lunch     Snack     None / Not applicable

14. Did you provide services to support the transition to Kindergarten this quarter?
- Yes     No

14.a. If yes, please describe:

15. If you provide other services not mentioned, describe them in space below:

16. Do you provide child screenings?  Yes     No     Not Applicable

17. If yes, complete the following table:

	Number this quarter (CHIF children only)
Hearing	
Vision	
Dental	
Immunizations	
Height-Weight / wellness	
Developmental	

18. What type of referrals did you provide to CHIF children this quarter?

Referral type	# of CHIF children this quarter
Child Welfare Services	
Childcare	
Community Health	
Domestic Violence Services (inc. legal services)	
Early Intervention	
Legal / Advocacy	
Medical	
Mental Health (inc. fire setting and eating disorders)	
Recreation Activities	
Other	

19. If other, please describe:

20. What services to CHIF parents have you provided this quarter?

Parent Education / Support Groups: *(check all types that apply)*

- Child Care Provider Training
- Child Development
- Child Literacy / Language
- Child Safety / First Aid
- Community Education
- Family Planning

- Financial Management
- Goal Setting / Life Skills
- Parenting Skills
- Positive Discipline
- Relationship Skills
- Stress Management

- Education Funds
- Financial Assistance (Housing, Energy, etc.)
- Recreation / Social Activities
- Parent Participation in Program Governance
- Childcare during meetings
- Prenatal services
- Housing support
- Services to siblings and/or grandparents
- Food boxes

21. What type of referrals did you provide to CHIF primary caregivers / families this quarter?

- Community Health
- Domestic Violence Services (inc. legal services)
- Education Assistance
- Employment Services (inc. job training and Voc. Rehab.)
- Energy Assistance
- Family Planning
- Financial Assistance (inc. TANF)
- Food Assistance (inc. WIC, Food Stamps, food boxes)
- Housing / Rental Assistance
- Legal / Advocacy
- Mental Health
- Parent Groups
- Prenatal Services
- Substance Abuse

22. What ESL services did you provide? *(check all types that apply)*

- Bilingual staff
- Classroom instruction in native language
- Translation / Interpreter services
- Program materials in languages other than English
- Other

22.a. If other, please describe:

23. Fill out the following table on staff working *directly* with CHIF children:

Job Title	Salary Range	FTE	Years Experience In ECE	Turnover this quarter?	Training Hours this quarter

24. Indicate the number of staff (who work directly with CHIF children) for whom each educational level listed below is the highest level attained:

	Number of Staff
High School Degree	
ECE Certificate	
Associates Degree	
B.A. / B.S.	
M.A. / M.S.	
Ph.D.	

25. How many of the above staff with post-high school education got their degrees in early childhood care or education or other related subject?

**APPENDIX B:**  
*Assessment Instruments*

## **AGES AND STAGES QUESTIONNAIRE (ASQ)**

**Authors:** Jane Squires, LaWanda Potter, and Diane Bricker

**Publisher:** Paul H. Brookes Publishing Co. (800) 638-3775 [www.pbrookes.com](http://www.pbrookes.com)

**Description:** This series of 19 parent-completed questionnaires with 30 developmental items in each questionnaire helps screen infants and young children for developmental delays during their first 5 years. It is completed by parents or caregivers for children 4 to 60 months of age. The questionnaires focus on assessment of five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social. The ASQ also includes a section where parents can record general concerns/issues that are not captured in the questionnaire.

**Uses of Information:** The ASQ provides comprehensive initial screening for developmental delays, monitoring and identification of areas needing further assessment, and parent education and involvement. It can also be used to monitor at-risk children.

**Languages:** English, Spanish, French, and Korean

**Age Range and Administration Interval:** 4 to 60 months; administered at months 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age, although users can vary the interval to fit their program or population need.

**Reliability:** (1) Internal consistency reliability (Cronbach's alpha): Communication (.63 to .75); Gross Motor (.53 to .87); Fine Motor (.49 to .79); Problem Solving (.52 to .75); Personal-Social (.52 to .68). (2) Test-retest reliability: percent agreement between administrations was 94 percent. (3) Inter-rater reliability: percent agreement between observers was 94 percent.

**Validity:** (1) Concurrent validity: percent agreement between the ASQ and other measures (the Revised Gesell and Armatruda Developmental and Neurological Examination and the Bayley Scales of Infant Development) was 84 percent overall and ranged from 76 percent for the 4-month questionnaire to 91 percent for the 36-month questionnaire. (2) Predictive validity: not described.

**Representativeness of Norming Sample:** Families with children between ages 4 to 36 months from both risk and non-risk populations whose families are educationally, economically, and ethnically diverse (primary sample derived between 1980 and 1988). Normative sample children met the following criteria: (1) no history of developmental or serious health problems; (2) full-term birth; and (3) not placed in a neonatal intensive care unit.

**Method of Scoring:** For each item in the ASQ, the parent responds with "yes," "sometimes," or "not yet." These items are then converted to point values and summed. The scorer can then compare the summed total score to established screening cutoff points. Scoring can be done by trained program staff either in their offices or on site

during a home visit to give parents immediate feedback). If necessary, parents can also score the questionnaires themselves, using the Information Summary Sheet.

**Interpretability:** Professionals or paraprofessionals are required to provide feedback to parents who have completed the questionnaire. There is an Information Summary Sheet intended to assist program staff (or parents) with scoring and provide them with a summary of the child's performance on the questionnaire. The Information Summary Sheets can be kept by program staff as a record of the child's performance on the ASQ so that the actual questionnaires can be returned to the parents for reference.

### DEVELOPMENTAL CONTINUUM ASSESSMENT SYSTEM

**Authors:** Diane Trister Dodge, Laurie Colker and Cate Heroman

**Publisher:** Creative Curriculum

**Description:** The DCAS is an assessment system within the *Creative Curriculum* program. Developmental progression is measured in four developmental areas including social, physical, cognitive, and expressive language corresponding to 10 broad curriculum goals. The goals are measured by 50 items on a continuum. Teachers complete the instrument ranking children per item as Forerunner, Step I, Step II, or Step III levels. The Forerunner level indicates a delay or that the child has not been exposed to the skill and Step III indicates mastery of a skill. Step I and II indicate phases of development necessary to accomplish Step III. Children are assessed at fall, spring, and winter.

**Uses of Information:** This assessment tool is used by teachers to assess child progress and guide them in their curriculum planning.

**Languages:** English

**Age Range and Administration Interval:** Pre-school age children (3-6) in classrooms using Creative Curriculum are assessed at fall, spring, and winter.

**Reliability and Validity:** Two studies have been conducted to determine the technical merits of the tool. Dr. Martha Abbott-Shim, Quality Counts, conducted a content validity study of the Continuum. She developed a questionnaire that was completed by 39 early childhood professionals (including trainers, teachers, directors, and early childhood professors) to assess the degree to which the content of the instrument was appropriate and important to preschool children's development. 90% or more of the reviewers reported that all items were a "good" to "excellent" match to their respective goals. The majority of reviewers rated that each item was very important to a preschool child's development.

To assess the construct validity and reliability of the Continuum, Dr. Richard Lambert, University of North Carolina at Charlotte, conducted a study using a sample of children representative of the Head Start population. He used factor analysis to determine that 47 of the 50 Continuum objectives fit neatly in four developmental areas: 1) social development; 2) physical development; 3) cognitive development; and 4) expressive language development. The other three crossed several areas. He concluded that the tool is scientifically sound and appropriate for assessing children. Dr. Lambert also assessed the consistency of data obtained through the use of the Continuum. He found that each of the factor scores yielded good reliability coefficients (each coefficient was above .92).

**Representativeness of Norming Sample:** Normed on a sample of 2,600 children representative of the Head Start population.

**Method of Scoring and Interpretability:** Teachers make ratings of each child three times during the school year: fall, winter, and spring. Teachers are encouraged to maintain portfolios of student work along with anecdotal records, accumulating multiple sources of evidence that can inform the ratings. The process of completing the ratings requires the teacher to identify the developmental level of a specific child on a specific item according to a four-point scale. Each item is phrased in terms of specific behaviors and functional areas, and each of the four levels on the accompanying rating scale is anchored to descriptions of specific examples of these behaviors. The four levels have been identified as Forerunner, Step I, Step II, and Step III. The Forerunner level represents behaviors that may indicate a developmental delay or that a child has not previously been exposed to that skill. Still, this level represents strengths of the child upon which both future development and instructional strategies can build. Step III represents complete mastery of a particular goal while Steps I and II indicate the phases of development through which a child will pass on the way to mastery.

## GALILEO

**Publisher:** Assessment Technology, Inc. 877-358-7617 [www.atonline.com](http://www.atonline.com)

**Description:** Galileo is a comprehensive tracking and monitoring system often used by Head Start affiliated programs. Galileo addresses all relevant domains depending on the child's age including social/emotional, language/literacy, cognitive, and gross and fine motor skills. Teachers regularly assess children on skills as Learned, Ready Now, Almost Ready, and Ready Later. The items are organized according to typical development theory. Information is entered directly into the computer system and reports per child include a developmental profile report, developmental milestone report, and a developmental summary report, which includes a developmental level score.

**Uses of Information:** The information provided by Galileo is used by for curriculum planning. Galileo also provides information about the typical developmental progress for individual children, classrooms, and programs. It can inform where a child is developing typically and where a child may need more support.

**Languages:** English

**Age Range and Administration Interval:** Children 0-5 are assessed often weekly by teachers. Teachers are prompted to assess the next level of skills for the development stage directly into the computer.

**Reliability and Validity:** Psychometric properties available regarding Galileo include internal consistency, test information, observer agreement, validation of developmental sequences, and validation of assessment-planning link. Information for each of these properties is provided for multiple age groups and all are found to indicate a reliable and valid measure. Please consult the technical manual for further details (see below).

**Representativeness of Norming Sample:** Normed samples were different per age group to represent the developmental expectation per age. Please see the technical manual for further details.

**Method of Scoring:** Teachers rate children on specific skills regularly (often weekly). Teachers rate skill achievement as Learned (skill is mastered), Ready Now (ready to master), Almost Ready (ready in 60 days), and Ready Later (ready in 90 days). After a skill is mastered, all skills prior are rated as learned since Galileo is based on typical development.

**Interpretability:** The Galileo assessment system can report on multiple developmental conclusions that indicate a child's developmental status but also outcomes about classes, programs, and entire agencies. Conclusions relevant to individual children include:

Path-Referenced Score

- Developmental level score - indicates change in developmental ability. Also considered a measure of ability.

Norm-Referenced Score

- Percentile – provides a percentile ranking of development in comparison to children in similar age group.
- Normalized Standard Score or Z-Score – measures ability in terms of standard deviations from the mean score in a normal distribution.
- Normal Curve Equivalent – indicate position of the individual in a norm group with a mean of 50 and a standard deviation of 21.06.

\*Bergan, J.R., Bergan, J.R., Rattee, M., Feld, J., Smith, K., Cunnigham, K., & Linne, K. (2003). The Galileo System for the Electronic Management of Learning. *Assessment Technology Incorporated*. [www.atonline.com](http://www.atonline.com)

**DEVEREUX EARLY CHILDHOOD ASSESSMENT (DECA)**

**Authors:** Paul LeBuffe and Jack Naglieri

**Publisher:** Kaplan Press (800) 334-2014 [www.kaplanco.com](http://www.kaplanco.com)

**Description:** The DECA is a 37-item rating scale designed to evaluate self-protecting factors and behavioral concerns among preschool children ages 2 to 5. A 27-item Total Protective Factors scale that assesses self-protective factors represents a compilation of three subscales: Initiative, Self-control, and Attachment. In addition, a 10-item Behavioral Concern scale assesses challenging and problem behaviors that children may exhibit. Family members or early care and education professionals who have observed the focal child's behavior over a period of at least four weeks can complete the DECA, which yields raw scores, percentile scores, T-scores, normal curve equivalent scores, and individual profiles.

**Uses of Information:** The DECA is used to (1) develop an individual profile to identify strengths and weakness of self-protective factors in order to develop strategies to strengthen these abilities to reduce behavioral problems of pre-school children; (2) develop a classroom profile that identifies the relative strengths of all children in a classroom in order that classroom strategies might be implemented to build upon strengths and promote healthy social and emotional child development; (3) identify children with behavioral problems through the Behavioral Concerns Scale so that interventions can be made before behavioral disorders develop; (4) help Head Start programs to meet Program Performance Standards; (5) assist early childhood programs in building on children's strengths to promote healthy child development; (6) provide programs with an outcome measure that can be compared over time to evaluate the effectiveness of prevention and intervention strategies; (7) compare scores between different raters for the same child to explore any differences that might exist in a child's behavior across different environments; and (8) provide a measure of self-protective factors in preschool children that can be used for research purposes.

**Languages:** English; Spanish (Record Form only)

**Age Range and Administration Interval:** 2 to 5 years, interval not prescribed, but there should be at least a four-week interval between assessments by the same adult.

**Reliability:** (1) Internal consistency (Cronbach's alpha): total protective factors scale alpha is .91 (.76 to .86 for the individual protective scales) for parent raters and .94 (.85 to .90 for the individual scales) for teacher raters and for behavioral concerns, .71 and .80, respectively. (2) test-retest reliability: total protective factors scale reliability coefficient is .74 (.55 to .80 for the individual scales) for parent raters and .94 (.87 to .91 for individual scales) for teacher raters and for behavioral concerns, .55 and .68, respectively. (3) inter-rater reliability: coefficients for total protective factors scale are .21 (.26 to .33 for the individual scales) pairs of teacher raters, .69 (.57 to .77 for the individual scales) among pairs of parent raters, and .29 (.19 to .34 for individual scales) among pairs of parent-teacher raters. Coefficients for behavior concerns are .44 among pairs of parents, .62 among pairs of teachers, and .23 for pairs of parent-teacher raters.

**Validity:** (1) Content-related validity: comparison to well-established measures or related research findings not possible since DECA is the first behavior rating scale to examine self-protective factors; however, the items selected for the DECA were based on an

extensive review of the literature on resilience, as well as results from focus groups with parents and teachers. Factor analysis procedures were used to select the items for each of the protective scales and the 10 items in the Behavioral Concerns Scale. (2) Criterion validity: The DECA scores of a group of pre-school children with identified emotional and behavioral problems were found to have significantly lower protective factor scale scores and significantly higher behavioral concern than a matched sample of children with no identified emotional and behavioral problems. Using the same samples, the authors correctly predicted group members for 69 percent of the children using the Total Protective Factor Scale and 71 percent of the group membership using the Behavioral Concerns Scale. **1** (3) Construct validity: The authors reported findings consistent with DECA's theoretical construct. Low- to average-risk children with high protective factors had the lowest behavioral concern scores, while high-risk children with low protective factors had the highest behavioral concern scores.

**Representativeness of Norming Sample:** Two non-randomly selected samples of preschool children ages 2 through 5 from 28 states that closely represent the 1995 U.S. population on such important characteristics as age, gender, geographical region, race/ethnicity, and socioeconomic status. One sample of 2,000 children was used to norm the protective scale and the other sample of 1,108 children was used to norm the behavioral problem scale.

**Method of Scoring:** Raters complete the Record Form by indicating the number of times they have observed the child performing particular behaviors in the past four months. For each item, they place a checkmark next to one of the following descriptors: never, rarely, occasionally, frequently, or very frequently. The checkmarks are then transferred onto a separate page of the Record Form, where corresponding boxes have raw score values that correspond to each rating: never = 0, rarely = 1, occasionally = 2, frequently = 3, and very frequently = 4. To score the DECA, examiners copy the raw score value (0-4) from the box with its raw score to an empty box that corresponds to the item being scored. The raw scores for the items that comprise each of the scales are summed to obtain the scale raw scores. The scale raw scores for the Initiative, Self-control, and Attachment scales are then summed to obtain the Total Protective Factors Scale Raw Score, which does not include the Behavioral Concerns scale raw score. The raw scores are converted into T-scores and percentiles through the use of the Individual Profile form or tables in the manual. The manual provides tables to help interpret the differences between scores on the protective sub-scales, by different raters, and over time.

**Interpretability:** High scores on the Protective Factor scales indicate that a child is doing well, while high scores on the Behavioral Concerns scale may indicate the need for intervention. It is difficult to interpret the meaning of raw scores, so they are converted into percentile scores, T-scores, or normal curve equivalents. This allows scores to be compared to ratings that children typically receive on the scales. T-scores on the DECA range from 30 to 70, and are classified as Below Average (30-40), Average (41-59), or Above Average (60-70). Above Average scores on the Behavioral Concerns scale and Below Average scores on the Total Protective Factors scale may warrant attention.