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North Carolina Statewide Birth-5 Needs Assessment

Final Report

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EXECUTIVE SUMMARY

The Statewide Birth-5 Needs Assessment is the first activity required as part of North Carolina's Preschool Development Grant (PDG).[1] Research has established the importance of the early years for children's later success in school and life,[2,3,4] including knowledge about how growth of the brain and other body systems beginning prenatally is influenced by the physical, social, economic, and cultural contexts in which children live. This Needs Assessment highlights what North Carolina is doing to meet children's needs and where gaps exist in early childhood care and education (ECCE) services with information gathered through three key activities: (1) reviewing and synthesizing existing data and recent needs assessment reports addressing the services and needs of families with children birth to age five in North Carolina, (2) conducting listening sessions with families representing key target populations in the state, and (3) administering a statewide provider survey to gather information about services and barriers from providers who serve young children and their families.[5] This Needs Assessment is organized around the four themes that emerged through the data collection activities: providing high-quality ECCE, ensuring children are on track for school success, fostering social-emotional resilience, and creating conditions for supportive and supported families.

High-Quality Early Childhood Care and Education

North Carolina's strengths in this area include overall high quality in its ECCE systems and efforts to improve quality (e.g., data systems, access to services through home visiting and subsidized child care, efforts to meet the needs of specific populations, and enhancing specific aspects of service delivery). Nevertheless, waitlist data, existing reports, family listening sessions, and provider survey data all suggest the need for: (1) expanding services, (2) increasing supports for the programs and personnel who care for North Carolina's youngest children, and (3) improving data systems.

On Track for School Success

North Carolina has made noteworthy strides toward implementing a set of coordinated practices for children's transitions within and between settings, including resources for providers as well as targeted supports for vulnerable subpopulations. However, existing reports, family listening sessions, and provider survey data indicate the need for: (1) offering more options for specialized services for children with disabilities and other specific populations, (2) leveraging other efforts in the state around transitions and assessment, and (3) gathering evaluation data to describe effective transition practices.

1 See Appendix A for a crosswalk of elements required for the Needs Assessment and page numbers for this report.
2 National Research Council. (2019). Vibrant and healthy kids: Aligning science, practice, and policy to advance health equity. Washington, DC: The National Academies Press. doi: 10.17226/25466.
3 Institute of Medicine and National Research Council. (2015). Transforming the workforce for children birth through age 8: A unifying foundation. Washington, DC: The National Academies Press. doi: 10.17226/19401
4 Dodge, K. A., Bai, Y., Ladd, H.F., Muschkin, C. G. (2019). Evaluation of North Carolina early childhood program among middle school students. Retrieved from https://duke.app.box.com/s/ospjbc5z1021crd5i1cn48vzj3htu57g
5 See Appendix D for details on methods used to conduct these activities.

Social-Emotional Resilience

North Carolina has placed special emphasis on social-emotional resilience by making it a goal in its Early Childhood Action Plan, recognizing that there is substantial work to do for its ECCE systems to be responsive to promoting young children's social-emotional resilience. Data gathered for the Needs Assessment suggest the need for: (1) improving data sources to better understand service needs for promoting young children's social-emotional resilience and (2) increasing the number, type, and accessibility of different services that are intended to promote children's social-emotional resilience.

Supportive and Supported Families

The high-quality ECCE system that North Carolina has built provides needed support to children and their families, particularly those who are vulnerable, through child care subsidies, home visiting services, and the provision of services and information to meet family needs. Nonetheless, data gathered for this Needs Assessment, particularly from family listening sessions, suggest the need for: (1) expanding and improving family access to information, (2) understanding more fully family needs for services (e.g., child care coverage during nontraditional hours), and (3) offering more comprehensive language supports for families with limited English skills.

Conclusions

This Needs Assessment identified North Carolina's strengths and weaknesses in the areas of high-quality ECCE, on track for school success, social-emotional resilience, and supportive and supported families. Research suggests that supporting children and families through policies, initiatives, systems, services, and practices in these four areas during the early years can set children on positive developmental trajectories and build resilience.

Several themes emerged across recommendations to address gaps: expand services; provide more information and supports to parents; increase the quality, usability, and accessibility of ECCE data systems; and offer informational, infrastructural, and financial supports for ECCE quality. With this better understanding of the current landscape of the ECCE system, North Carolina is poised to enhance these areas through its new Birth – Five Strategic Plan.

INTRODUCTION

The Statewide Birth-5 Needs Assessment is the first activity required as part of North Carolina's Preschool Development Grant (PDG).[6] The purpose of the Needs Assessment is to provide comprehensive information to guide North Carolina's strategic planning efforts to strengthen its early childhood system and services.

The North Carolina Context

At a systems level, North Carolina has been viewed as a pioneer in developing and coordinating early childhood care and education (ECCE) programs to support positive outcomes for children.[7] Support for the overall maintenance and improvement of ECCE quality in North Carolina began in the early 1990s through statewide initiatives, such as Smart Start, the Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood® Scholarship Program, Child Care WAGE$®, the voluntary Star Rated License system (North Carolina's quality rating and improvement system [QRIS]), and the More at Four Program (North Carolina's state Pre-K program), now known as NC Pre-K. In addition, North Carolina has a long history of a well-organized child care subsidy funding program and a robust Child Care Resource and Referral (CCR&R) network. These programs not only have promoted ECCE in North Carolina, but also have served as models for other states in establishing systems to promote high quality care, including the QRIS movement. This innovative perspective has continued as these programs have been maintained, expanded, and improved over time.

Part of the success of North Carolina's ECCE programs is due to broad community support across the state, including collaborations across state agencies, institutions of higher education, non-profit organizations, and the business community. Historically, North Carolina's ECCE initiatives have been viewed as innovative and successful in achieving interagency collaboration and meeting children's and families' needs. The NC Pre-K program represents a collaboration at both the local governance level (i.e., leadership from local education agencies [LEAs] and local Partnerships for Children co-chair local NC Pre-K committees, which include representatives from other stakeholder agencies) and the practice level (i.e., NC Pre-K is provided in programs in Head Start sites, private child care settings, and public school pre-K classrooms). The North Carolina Partnership for Children, or Smart Start, another collaborative effort, was created in 1993 as a birth-to-5 public/private partnership to address school readiness. Smart Start is designed to work by giving communities local control to determine the best approaches to addressing community-identified needs and achieving goals, although Smart Start's top priority is increasing the quality of early care and education across the state.[8]

6 See Appendix A for a crosswalk of elements required for the Needs Assessment and page numbers for this report.
7 Washington Early Learning State and Local Coordination Project. (2013). Final report and recommendations of project steering committee. Retrieved from: http://cedarrivergroup.com/crgwpf/wp-content/uploads/2013/12/State-Local-Coordination-Final-Report-June-2013_r.pdf
8 Smart Start. (2015). Why Smart Start works. Retrieved from http://www.smartstart.org/wp-content/uploads/2015/11/Why-Smart-Start-Works-June-2015.pdf

More recently, the re-establishment of the North Carolina Early Childhood Advisory Council (ECAC) and the creation of the North Carolina Early Childhood Action Plan (ECAP), reflect the state's commitment to ensuring that all North Carolina children have access to needed services through system integration and interagency collaboration. In addition, the Birth to Third Grade Interagency Council is a state-level body that develops policy recommendations in support of collaboration. The Council is charged with establishing a vision and accountability for a birth through grade three system of early education that addresses seven focus areas: standards and assessment, data-driven improvement, teacher and administrator preparation and effectiveness, instruction and environment, transitions and continuity, family engagement, and governance and funding.[9] Another cross-sector state-level body is the North Carolina Interagency Coordinating Council (NC-ICC) and related Local Interagency Coordinating Councils (LICCs), which bring together policy makers, service providers, and parents to ensure that the supports and services offered to families with young children (birth to age five) with disabilities and delays are in line with their needs.

Furthermore, the North Carolina Early Childhood Foundation (NCECF) promotes understanding, spearheads collaboration, and advances policy to support children birth through age eight. The Pathways to Grade-Level Reading process includes collaboration across NCDHHS divisions, with the North Carolina Department of Public Instruction (NCDPI) and with many other cross-sector stakeholders to align around shared measures and coordinated strategies that put children on the pathway to third-grade reading proficiency.[10] Many of the actions and measures that the Pathways stakeholders co-created are relevant for the birth to age five system.[11,12] Additional emerging collaborative efforts include the Child Development at Kindergarten Entry Data Workgroup funded by the PDG[13] and efforts to integrate data from across programs and services, including the P-20W System, the North Carolina Early Childhood Integrated Data System (ECIDS), and NCCARE360.[14] NCDPI and the Division of Child Development and Early Education (DCDEE) are also collaborating to pilot a statewide effort to support transition from preschool to kindergarten, including the supports that teachers, children, and families need as part of the transition. Additionally, the North Carolina Early Learning Network (NC-ELN) is providing training and technical assistance to support a cross-sector pilot program to implement practices to support social and emotional development within community Head Start programs.

9 North Carolina Department of Public Instruction, 2018
10 North Carolina Early Childhood Foundation. (2019a). Pathways to grade-level reading. Retrieved from https://buildthefoundation.org/initiative/pathways-to-grade-level-reading/
11 North Carolina Early Childhood Foundation. (2018). Pathways to grade-level reading action framework. Retrieved from https://files.buildthefoundation.org/wp-content/uploads/2019/02/FINAL_NCECF_report-pathways-actionframework_digital-spreads-020519.pdf
12 North Carolina Early Childhood Foundation. (2019c). Shared measures of success to put North Carolina's children on a pathway to grade-level reading. Retrieved from https://files.buildthefoundation.org/wp-content/uploads/2018/03/Measures-of-Success-Framework_FINAL.pdf
13 North Carolina Early Childhood Foundation. (n.d.) Child development at kindergarten entry workforce group. Retrieved from https://buildthefoundation.org/child-development-at-kindergarten-entry-data-workgroup/
14 NCCARE360 is a coordinated care network that will electronically connect those with identified needs to community resources, with a built-in "feedback loop" to understand the outcome of that connection

Together, North Carolina's history of ECCE initiatives and interagency collaborations provide a strong foundation for enhancing systems and services through a new Birth through Five Strategic Plan, which will be informed by this present Needs Assessment.

Needs Assessment Goals

The present Needs Assessment intends to build on this strong history by helping North Carolina examine the current landscape of its ECCE system in order to support efforts to maximize the availability of high-quality ECCE and access for low-income, vulnerable families;[15] improve the quality of care across providers and partners; streamline administrative structures; and increase funding efficiencies.

The Needs Assessment also aims to contribute knowledge about how North Carolina is supporting the goals outlined in its ECAP, which was released in early 2019 and is intended to establish shared stakeholder accountability to achieve statewide goals for young children from birth through age eight.[16] The specific ECAP goals that are most aligned with ECCE systems and services examined in this Needs Assessment include: ECAP Goal 7, Social-Emotional Health and Resilience; ECAP Goal 8, High-Quality Early Learning; and ECAP Goal 9, On Track for School Success. The purposeful connection to information for families throughout the Needs Assessment also links to ECAP Goals 3 and 4 related to food security and housing. As such, the Birth-5 Needs Assessment builds on other efforts in the state, notably the ECAP, to contribute to the development of North Carolina's Strategic Plan.

To achieve the primary goal of providing comprehensive information to guide North Carolina's strategic planning efforts to strengthen its early childhood system and services, the Needs Assessment consisted of three key activities:

1. Reviewing and synthesizing existing data and recent needs assessment reports addressing the services and needs of families with children birth to age five in North Carolina
2. Conducting listening sessions with families representing key target populations in the state
3. Administering a statewide provider survey to gather information about services and barriers from providers who serve young children and their families[17]

This report summarizes the results of these activities and describes briefly what is known from developmental science about the needs of young children, describes what North Carolina is doing to meet children's needs, identifies gaps in data and knowledge about needs related to early childhood services, and offers recommendations for addressing challenges and gaps. By combining the three sources of data—existing reports and data sources, family perspectives, and provider perspectives—North Carolina has in this report a comprehensive picture of the status of its ECCE system and areas where improvement efforts should be directed to ensure that children are healthy, supported, learning, and flourishing.

15 For definition of terms and focal populations for the PDG, see Appendix B and Appendix C, respectively.
16 North Carolina Department of Health and Human Services. (2019a). Early childhood action plan. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan
17 See Appendix D for details on methods used to conduct these activities.

The next sections summarize the results of the Needs Assessment, followed by some concluding thoughts. More detailed information supporting these results can be found in the Appendices.

What Does the Science Say About What Young Children Need?

Decades of research tell us what is critically important for young children's development and learning, and why. This information, summarized below, informs the goals North Carolina should be striving toward through its services targeting children birth to age five.

The importance of the early years for children's later success in school and life has been well established.[18,19,20] The significant growth of the brain and other body systems experienced prenatally and during the first years of life is positively and negatively affected by environmental influences, including the physical, social, economic, and cultural contexts in which children live. These influences on child development are interrelated and cumulative, and although they are predictive of outcomes, they do not determine outcomes. Science-based interventions, particularly those provided early in life, can shift children likely to be at-risk for negative outcomes toward more positive developmental trajectories. In addition, building resilience—the ability to correct or overcome what otherwise might have been negative outcomes as a result of life stressors is important.

At the most basic level, children need supportive and stable living conditions that include adequate family income, food security, stable and safe housing, accessible health care, and absence of exposure to environmental toxicants.[21] Meeting these fundamental needs provides children the opportunity for basic well-being and healthy development. The most effective strategies for meeting basic needs are aligned and integrated across systems (e.g., health care, education, and social services) and are available within communities. To ensure high-quality, integrated services at the local level, states must implement a well-functioning system that includes critical infrastructure components addressing governance, finance, personnel, data systems, accountability, and quality standards.[22]

18 National Research Council. (2019). Vibrant and healthy kids: Aligning science, practice, and policy to advance health equity. Washington, DC: The National Academies Press. doi: 10.17226/25466
19 Institute of Medicine and National Research Council. (2015). Transforming the workforce for children birth through age 8: A unifying foundation. Washington, DC: The National Academies Press. doi: 10.17226/19401
20 Dodge, K. A., Bai, Y., Ladd, H.F., Muschkin, C. G. (2019). Evaluation of North Carolina early childhood program among middle school students. Retrieved from https://duke.app.box.com/s/ospjbc5z1021crd5i1cn48vzj3htu57g
21 Krieger, J., & Higgins, D. L. (2002). Housing and health: time again for public health action. American Journal of Public Health, 92(5), 758–768. doi:10.2105/ajph.92.5.758
22 Kasprzak, C., Hebbeler, K., Spiker, D., McCullough, K., Lucas, A., Walsh, S., … Bruder, M. B. (2019). A State System Framework for High-Quality Early Intervention and Early Childhood Special Education. Topics in Early Childhood Special Education. https://doi.org/10.1177/0271121419831766

Meeting these basic needs is key to reducing caregiver stress and is important for enabling caregivers to have the capacity and supports to care for their children and serve as buffers against adversity and help build resilience. Having a supportive family and strong attachments to primary caregivers is the single most important factor for children's well-being. Specific subgroups of children are particularly vulnerable and face unique challenges adjusting to adversity, including those in families that experience chronic poverty, immigrants, those experiencing homelessness, those in foster care, those who confront adverse experiences and toxic stress, and those with disabilities or chronic health conditions. African American, Hispanic, and American Indian children are much more likely than their White counterparts to be poor and experience the negative impacts of poverty.[23] Exposure to chronic adversity can create conditions, such as toxic stress, which are especially detrimental to children's learning, behavior, and health with effects lasting well beyond the early childhood years.[24]

High-quality ECCE for children birth to age five is a strategy for increasing children's cognitive, social-emotional, and health outcomes through stimulating and motivating environments, responsive caregiving, and the early identification and intervention of problems that can be barriers to learning. Research suggests that high-quality programs are those that (1) adopt a comprehensive approach to school readiness that focuses on multiple domains of child development and (2) maintain high standards for staff competencies while supporting educators' own health and well-being.[25] Evidence suggests that access to ECCE may lower the risk of dropping out of school and increase school engagement, thus improving educational attainment.[26] Furthermore, evidence indicates that when K-3 classroom instruction (e.g., curricula, assessments, instructional practices, teacher-child interaction quality) is aligned with pre-K experiences, children have better outcomes, suggesting the need for attention to understanding transitions between educational settings.[27] ECCE services have been shown to be associated with positive outcomes for all children, but may be especially beneficial for vulnerable children.[28,29]

23 U.S. Census Bureau. (2017a). 2017 American Community Survey 1-Year estimates: Demographic and housing estimates. Retrieved from https://factfinder.census.gov/
24 Harvard Center for the Developing Child. (n.d.) Toxic Stress. Retrieved from https://developingchild.harvard.edu/science/key-concepts/toxic-stress/
25 Peisner-Feinberg, E. S., & Yazejian, N. (2010). Research on program quality: The evidence base. In P. W. Wesley & V. Buysse (Eds.), The quest for quality: Promising innovations for early childhood programs (pp. 21-45). Baltimore, MD: Brookes
26 Campbell, F. A., Pungello, E. P., Burchinal, M., Kainz, K., Pan, Y., Wasik, B. H.,...Ramey, C. T. (2012). Adult outcomes as a function of an early childhood educational program: An Abecedarian Project follow-up. Developmental Psychology, 48, 1033-1043
27 Cunha, F., & Heckman, J. (2007). The technology of skill formation. The American Economic Review, 97, 31-47. doi: 10.1257/aer.97.2.31
28 Morrissey, T. W., & Vinopal, K. (2018). Center-based early care and education and children's school readiness: Do impacts vary by neighborhood poverty? Developmental Psychology, 54(4), 757-771. doi: 10.1037/dev0000470
29 Odom, S. L., Zercher, C., Li, S., Marquart, J., Sandall, S., & Brown, W. (2006). Social acceptance and social rejection of young children with disabilities in inclusive classes. Journal of Educational Psychology, 98, 807-823

This Needs Assessment focuses on four areas in which North Carolina's ECCE policies, initiatives, systems, services, and practices support children in ways that matter most. These four areas are

1. Providing high-quality ECCE
2. Ensuring that children are on track for school success
3. Fostering social-emotional resilience
4. Creating conditions for supportive and supported families

The following sections describe the strengths of North Carolina's systems in each of these four areas, the gaps in knowledge, and recommendations for next steps in bolstering each of the four areas toward a stronger early childhood system.

High-Quality ECCE

Many of the approximately 600,000 North Carolina children birth to age five face challenges to healthy growth and development during these years, including adversities associated with poverty, such as hunger, homelessness, and limited access to health care and high-quality ECCE[30] services. These challenges during the first five years can make it difficult for children to learn and be ready to succeed once they enter primary school settings, with effects manifesting throughout childhood and adolescence. In North Carolina, only 39% of fourth graders read proficiently, only 35% of eighth graders are proficient in math, and only 86% of high school students graduate on time.[31] High-quality ECCE represents a strategy for ensuring healthy development and setting children on positive trajectories, particularly for children who are vulnerable.

Many of the approximately 600,000 North Carolina children birth to age five face challenges to healthy growth and development during these years.

30 See Appendix E for tables and figures related to North Carolina's ECCE services, including quality, availability, enrollment, and waitlist data.

31 Annie E. Casey Foundation. (2018). 2018 Kids Count data book. Retrieved from http://www.aecf.org/m/databook/aecf-2018kidscountdatabook-embargoed-2018.pdf

Strengths of North Carolina in Providing High-Quality ECCE

As noted previously, North Carolina has long recognized the importance of the early years and has a history of strong leadership in ECCE efforts. In 1990, North Carolina introduced the T.E.A.C.H.® Scholarship Program to address the issues of under-education, poor compensation, and high turnover within the early childhood workforce. The program has since become national and, as of 2018, operates in 22 states and the District of Columbia. In addition, Smart Start began in 1993 as an innovative model for public-private funding and coordination of early childhood services, one that has been widely copied or adapted by other states. Further, the Child Care WAGE$® Program was created in North Carolina in 1994 in response to research evidence showing that the quality of care children receive is lowered by high turnover rates. (A companion program available only for infant-toddler teachers, AWARD$®, was started in 2018.) In 1999, North Carolina was the second state to implement a statewide QRIS and has one of the highest participation rates in the country. In 2001, North Carolina's high-quality state pre-K program targeting vulnerable children, More at Four (now called NC Pre-K), was begun. Along with these long-standing statewide efforts, initiatives managed by CCR&Rs, such as the Infant Toddler Enhancement Project and the Healthy Social Behaviors Project, have targeted specific needs for quality enhancement through the use of statewide specialists.

Finally, the NC Early Learning Network (NC-ELN), funded by the North Carolina Department of Public Instruction (NCDPI), was created in 2012 to organize and implement an infrastructure for statewide professional development support for professionals working with children with disabilities in public preschool classrooms.

The North Carolina QRIS, a 1-5 star rating system with tiered subsidy reimbursements based on staff qualifications and global environmental quality, provides an overall structure and process for helping ensure high quality, particularly for vulnerable children living in poverty. Combining this system with workforce and quality enhancement supports (e.g., T.E.A.C.H.®, WAGE$®, Smart Start), North Carolina has been able to raise the quality of ECCE programs.[32] Currently, the quality of ECCE services across North Carolina is relatively high, with similar proportions of 4- and 5-star programs in rural, suburban, and urban counties and across regions.[33] An estimated 31% of North Carolina children under the age of 6 were served in licensed child care based on 2019 data, with 72% receiving services in 4- and 5-star programs. At an even higher quality level, NC Pre-K meets 8 out of 10 national quality standards.[34]

32 Bassok, D., Dee, T., & Latham, S. (2017). The effects of accountability incentives in early childhood education. NBER Working Paper 23859. Retrieved: http://www.nber.org/papers/w23859

33 There are however differences by auspice; the majority of North Carolina ECCE programs (62%) are operated by for-profit organizations. These programs vary in quality and have lower quality care as measured by star ratings than those operated by public or quasi-public organizations (see Appendix E). A higher proportion of public and quasi-public programs and not-for-profit programs have 5-star ratings compared to for-profit programs.

34 Friedman-Krauss, A. H., Barnett, W. S., Garver, K. A., Hodges, K. S., Weisenfeld, G. G., & DiCrecchio, N. (2019). The state of preschool 2018: State preschool yearbook. New Brunswick, NJ: Rutgers University, National Institute for Early Education Research. Retrieved from http://nieer.org/wp-content/uploads/2019/04/YB2018_Full-ReportR2.pdf

During the 2018-19 school year, over 29,000 at risk four-year-old children (47%) were enrolled in NC Pre-K across the state.[35] Evidence suggests that Smart Start and NC Pre-K programs, which must achieve at least a 4-star rating and meet additional quality standards, increased math and reading achievement and decreased the probability of students being retained or receiving special education services.[36,37,38,39]

North Carolina is also making improvements to its ECCE data systems. For example, there is evidence of strong progress toward achieving linked, or coordinated, data across ECCE systems (e.g., the North Carolina Early Childhood Integrated Data System, ECIDS) and many concurrent initiatives to build capacity to improve the quality, access, and use of ECCE systems data. The Early Childhood Data Advisory Council[40] is one example of an innovation in this area, especially given its focus on equity. Data from linked ECCE data systems have proved useful for answering several critical questions, illustrating the effectiveness of these efforts. Indeed, efforts underway to explicitly improve North Carolina's ability to document data on unduplicated children participating in ECCE services is an innovation that promises to meet the goal of a more coordinated ECCE system.

Promising efforts are underway to meet the needs of specific vulnerable populations, upon which the state can build to improve its overall ECCE system. For example, work is being conducted by Yay Babies, North Carolina, and the Salvation Army in partnership with the SchoolHouse Connection to better connect North Carolina children experiencing homelessness to ECCE services.[41] In addition, approximately 36% of children in the Part B 619 Preschool Special Education program attend regular ECCE programs and receive the majority of their special education services in those programs.[42]

35 North Carolina Department of Health and Human Services Division of Child Development and Early Education, 2019a; U.S. Census Bureau, 2017a.
36 Bryant, D., Bernier, K., Peisner-Feinberg, E., Maxwell, K., Taylor, K., & Poe, M. (2003). Smart Start and preschool child care quality in North Carolina: Changes over time and relation to children's readiness. Chapel Hill, NC: Frank Porter Graham Child Development Institute
37 Peisner-Feinberg, E. S., & Schaaf, J.M. (2010). Long-term effects of the North Carolina More at Four Pre-Kindergarten Program: Children's reading and math skills at third grade. Chapel Hill: The University of North Carolina, FPG Child Development Institute
38 Dodge., K. A., Bai, Y., Ladd, H.F., Muschkin, C. G, 2019
39 Peisner-Feinberg, E., Zadrozny, S., Kuhn, L., & Van Manen, K. (2019). Effects of the North Carolina Pre-Kindergarten Program: Findings through Pre-K of a Small-Scale RCT Study. Chapel Hill, NC: The University of North Carolina, FPG Child Development Institute.
40 See Appendix I for complete description.
41 The Yay Babies initiative serves homeless families with children under age 6 with the goals of enrolling them in high-quality and affordable ECCE and early intervention for developmental and mental health, if needed. The Salvation Army and SchoolHouse Connection are currently working with ECCE programs, CCR&Rs, county departments of social services, homeless providers, and other partner agencies to provide assistance with program eligibility determination, consumer education for parents, information about the effects of homelessness on child development and the importance of high-quality ECCE programming, and strategies for connecting families to programs.
42 U.S. Department of Education. (2018b). Number of children ages 3 through 5 served under IDEA, Part B, by disability and state. Retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/2017-2018/part-b/child-count-and-educational-environment/1718-bchildcountandedenvironment-2.xlsx

Gaps in ECCE Knowledge or Services and Recommendations

Although North Carolina provides numerous programs and services to meet the needs of children birth to age five, several gaps remain to be addressed. In particular, there are needs for services, including NC Pre-K, home visiting, child care subsidies, and access to high quality early learning programs, to meet the needs of vulnerable children and families. Better data on numbers and characteristics of children and families served and eligible for services are also needed.

First, data available from program waitlists indicate a large discrepancy between services and demand for the following three programs in particular: home visiting, NC Pre-K, and child care subsidies. As shown in Table E-3 in Appendix E, estimates suggest that home visiting programs serve fewer than 1% of eligible children, and 72% of home visiting programs maintain a waitlist, with an average of 26 families per program. Child care subsidy waitlist data suggest an even greater discrepancy between available services and family needs for support. Data show that more than 33,000 children are on waitlists for child care subsidies. In NC Pre-K, while the goal is to serve 75% of estimated eligible children, currently funding provided only supports 47% to enroll.

Data from existing reports corroborate waitlist data. For example, it has been reported that more than 40% of North Carolina residents live in a "child care desert,"[43] defined as a census tract that lacks any or has very few child care options. In addition, the proportion of programs that enroll infants and toddlers has decreased over the last decade, which has widened gaps in access to ECCE programs for this age group relative to preschool-age children.[44] Data from the listening sessions and provider survey conducted for this Needs Assessment also support the need for high-quality early education services. **As one parent noted regarding Early Head Start:**

> Early Head Start has such a long waitlist that they've closed some of the Head Start classes to open up more Early Head Start.

Another parent noted the scarcity of child care programs more generally in the area:

> [Where] I used to live … it's like every corner there's a daycare. I feel like if there was more daycares around here than there was grocery stores, then I feel like it would help out a lot. But we have three auto parts stores here. And I'm like, "What? Only two daycares, three daycares?"

43 Malik, R., Hamm, K., Schochet, L., Novoa, C., Workman, S., & Jessen-Howard, S. (2018). America's child care deserts in 2018. Retrieved from Center for American Progress website: https://www.americanprogress.org/issues/ early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/

44 Child Care Services Association. (2017). Who's caring for our babies? Early care and education in North Carolina. Retrieved from https://www.childcareservices.org/wp-content/uploads/2017/11/IT-State-Report-final-7-27-2017.pdf

ECCE providers echoed these concerns in survey responses. The majority of respondents (57% overall; 63% of centers and 47% of family child care homes) maintained a waitlist for slots. These percentages were relatively similar across star ratings (see Table 3b.2 in Appendix G). Generally, reported waitlist numbers were greater for infants and toddlers than for preschoolers. **In written comments to the survey, one provider noted:**

...almost all high-quality programs have VERY long wait-lists.

The majority of licensed slots in North Carolina (82%) are high-quality, defined as a star rating of 4 or 5 stars in the state's QRIS. Provider survey data indicated that access to professional development and enrollment in coursework was more likely for staff working in programs rated at higher star levels of quality.

Second, it is difficult to determine accurate numbers and characteristics of children and families eligible for, being served by, and on waitlists for services within and across programs. Duplicated counts of children, lack of linked data, inadequate maintenance of waitlist information, and lack of disaggregated data all contribute to this challenge. Unique identifiers are integral for tracking service use at the child level. North Carolina's school-age children who use services in the state are assigned a unique identifier.[45]

Relatedly, data across sectors and programs are not currently linked or readily shared to determine the array of services that children and families are receiving, seeking, or awaiting. Another reason for the difficulty is that waitlist data are not maintained accurately (if at all) across programs. Finally, much of the data available on children and families are presented only in the aggregate and do not include sub-group data. This limits knowledge about specific groups of vulnerable children, such as children from low-income families, dual language learners, those experiencing homelessness, or those affected by adverse childhood experiences. Head Start services data are a promising example of disaggregating different groups of vulnerable children.[46] Data collection is needed to fully understand the number and characteristics of children and families who are eligible for programs but do not access them, and why. Knowing more about the underlying reasons why families may not access services is needed to determine how to overcome potential barriers for specific subpopulations.

In sum, the gaps in North Carolina's ECCE system include:

1. Needs of vulnerable children and families for more services, including NC Pre-K, home visiting, child care subsidies, and access to high-quality early learning programs

2. Needs for better data on numbers and characteristics of children and families served and eligible for services

45 North Carolina Department of Public Instruction. (2019a). Unique statewide identifier (UID) for students and staff. Retrieved from http://www.dpi.state.nc.us/cedars/uniqueid/

46 See Appendix L for additional PDG activities progress report

These gaps in services and data suggest the following recommendations:

Recommendation #1

Expand ECCE services

Waitlist data, existing reports, family listening sessions, and provider survey data all suggest the need for expanding services. The following specific strategies should be considered to increase the supply of high-quality ECCE services for children and families in North Carolina:

- **Expand NC Pre-K**
  A recent report offers suggestions for addressing barriers to expansion that North Carolina should consider (see Appendix K), including offering incentives for 4- and 5-star private centers to meet higher-quality standards and offering grants for expansion start-up costs (e.g., outreach, recruitment, facilities, equipment, capital costs).
- **Expand home visiting services**
  A recent report[47] suggests several recommendations for achieving this goal, including identifying new funding streams to support an integrated family support system anchored by home visiting and doing more to build and support a well-trained, well-resourced workforce.
- **Increase the number of slots available for infants and toddlers**
  There are fewer slots available for infants and toddlers than for preschool-aged children; expansion strategies may include increasing the subsidy reimbursement for this age group.
- **Improve pipelines for early childhood educators**
  With expansion of services will come the need for more well-trained and educated early childhood educators. North Carolina should explore strategies, such as high school apprenticeships, universal competencies, and reciprocity of credentials across states, to ensure that teacher supply keeps up with demand and is representative of the children served.
- **Gather contextualized data on child care demand**
  Information is needed on possible child care deserts, infant-toddler care needs, and other service needs for vulnerable populations that go beyond counts of slots available, which speak to only half the equation. An accurate representation of coverage gaps is needed, which would include information about the types of services provided via different delivery options for children of various ages at various times of the day (e.g., full/part-time, non-traditional hours), and disaggregated by subgroups of vulnerable families (e.g., children with disabilities, dual language learners, families experiencing homelessness) living in specific areas of the state.

47 Bryant et al., 2018.

- **Fund short-term studies**
  The state should learn more about needs for services and how best to expand access, which may require addressing barriers related to facilities,[48] cost and subsidies, and funding mechanisms.[49] The studies should center on the perspectives of families, particularly those from vulnerable groups. Once additional evidence is obtained on these topics, the state can then plan improvements to ECCE programs and services. For example, this may involve greater focus on programming to address parents' needs, which might involve developing new programs or embedding them within the existing ECCE infrastructure (e.g., home visiting, early intervention, licensed child care).

Recommendation #2

Improve supports for high-quality programming

Data from waitlists, listening sessions, and provider surveys also converged to indicate that the state should increase supports for the programs and personnel who currently care for North Carolina's youngest children. Specific strategies for achieving this might include the following:

- **Increase funding for child care subsidies**
  This would allow a greater number of vulnerable children to access high-quality programs.
- **Increase child care subsidy reimbursement rates**
  Provider survey data suggested that funding barriers make it difficult to provide high-quality services.
- **Increase the NC Pre-K reimbursement rate**
  This amount has been stagnant since 2012 during a time when inflation has increased nearly 12%.
- **Explore barriers to quality improvement for lower rated programs**
  Provider survey data suggest that these programs may be less likely to access supports for quality improvement, despite likely being the programs that need such supports the most. Barriers may include lack of equitable wages and coordinated professional development.
- **Consider raising the ceiling of the quality rating and improvement system**
  Given that the majority of programs have achieved the highest level in the system and to support a culture of continuous quality improvement, North Carolina should consider revisions to the system that include high standards and appropriate supports for reaching and sustaining higher quality levels.

48 See Appendix G for Provider Survey Report.
49 See Appendix K for a list of recommendations to ease policy and regulatory barriers.

Recommendation #3

Improve data systems

North Carolina should continue efforts to improve data systems in the state. Although North Carolina has many specific measurable indicators for tracking progress for the PDG and the state Strategic Plan,[50] data needs extend beyond enrollment numbers or available slots. Specific strategies for improving data systems include the following:

- **Assign all children unique identifiers**
  Ideally, identifiers would be consistently assigned across programs from an early age, at birth if possible, but preferably as soon as a child's parent applies for or receives any type of public service for the child.
- **Gather better data on the unduplicated number and characteristics of children and families eligible for different ECCE programs**
  Data are needed on enrolled children, children on waitlists, and eligible children who are either not enrolled or on waitlists, to understand and address barriers.
- **Improve the quality, usability, and access of ECCE systems data**
  These efforts are needed both within and across data sources, some of which are currently linked and some that are not.
- **Gather disaggregated data on various groups of vulnerable populations**
  The current lack of information limits what is known about the needs of those populations and how to address their needs in ways that are consistent with the equity needs relative to those groups.

50 See Appendix J for list of measurable indicators of progress.

On Track for School Success

Ensuring that young children are on track and ready to experience school success, particularly when they enter kindergarten, starts with making sure that children receive the services and supports they need when enrolled in and transitioning in and out of ECCE. Services and supports should be embedded in the general practices that characterize high-quality ECCE. However, effectively promoting young children's school success requires special attention to the following: 1) providing specialized services to children who need them, 2) using a set of coordinated practices to support children's transition from ECCE to kindergarten, and 3) identifying and utilizing mechanisms to determine and respond to children's strengths and needs. This Needs Assessment examined the strengths and current gaps in North Carolina's efforts in this area.

Strengths of North Carolina's Efforts to Support Young Children's School Succes

North Carolina has made noteworthy strides toward implementing a set of coordinated practices for children's transitions within and between settings. In practice, transition activities tend to focus on the enrollment process and introductory experiences to a new school setting, with most of the practices aimed at families of rising kindergartners[51] and less attention to other age groups. For children transitioning to kindergarten, much of North Carolina's approach is detailed in the Elementary and Secondary Education Act of 1965, as amended by the 2018 ESSA Consolidated State Plan.[52] The ESSA requirement that school systems have transition plans was elaborated in a plan developed collaboratively by NCDHHS and NCDPI, dictating that local NC Pre-K agencies be responsible for developing and implementing transition plans for their communities.[53]
The transition plans should address expectations, communications among stakeholders (primarily parents, Pre-K teachers, and kindergarten teachers), and issues of ownership of the transition process. In addition, some schools require or encourage kindergarten teachers to make home visits at the beginning of the school year. Fully 85% of North Carolina counties provided at least one community-level transition activity. Based on legislation passed in 2017, NCDHHS/NCDCDEE and NCDPI developed a plan to implement a method for preschool teachers to prepare a preschool-to-kindergarten transition plan for all children enrolled in the NC Pre-K program.[54] Eighteen counties currently participate in this innovative pilot program.[55]
So far, a child information form has been drafted and is in use by state Pre-K providers.
As described in Appendix L, DCDEE and NCDPI continue to plan and negotiate the following initiatives: finding a data-sharing solution between Pre-K and kindergarten teachers about each child's development, finding and promoting connections with family engagement work in the PDG, addressing language translation needs across the state, and developing a communication protocol and plan for participating communities.

51 Compass Evaluation and Research, Inc. (March 2017). Transition to kindergarten survey of practices. Submitted to the North Carolina Partnership for Children. Obtained from DCDEE.
52 North Carolina Department of Public Instruction. (2018). Every Student Succeeds Act (ESSA). Retrieved from http://www.dpi.state.nc.us/succeeds/
53 North Carolina Department of Public Instruction, 2018.
54 The North Carolina Early Learning Network. (2019). Preschool to kindergarten transition pilot project 2018-2019. Retrieved from: https://nceln.fpg.unc.edu/node/3354
55 The counties participating in the pilot transition program are Buncombe, Caldwell, Craven, Davidson, Guilford, Henderson, Iredell, Lincoln, Montgomery, Edgecombe-Nash, Northampton, Onslow, Pender, Randolph, Rockingham, Sampson, Transylvania, and Wake.

Efforts to support children's transitions are facilitated by existing resources North Carolina offers for providers to document children's areas of strength and need. These include the North Carolina Foundations for Early Learning and Development, the North Carolina Early Learning and Development Progressions (for ages 0-5), and the construct progressions from the Kindergarten Entry Assessment (KEA). ECCE teachers can use these tools to document children's strengths and needs in different domains of learning and development. This information can then be shared with children's families to help them understand their children's developmental progress. In addition, this information can be used to create transition plans for individual children which can then be shared with kindergarten teachers to help them understand where children are developmentally, so they can provide individualized support and plan instruction at the beginning of the school year.

Furthermore, North Carolina provides specific transition supports for certain subpopulations of children, such as children enrolled in NC Pre-K, as described above. In addition, for children receiving child care subsidy assistance in 4- and 5-star rated child care facilities, programs are required to develop transition strategies as children move from preschool to kindergarten. For children with disabilities, evidence of systematic efforts to support the transition of infants and toddlers to preschool programs comes from guiding principles created in 2012. These efforts involve a transfer of responsibility from Children's Developmental Services Agencies (CDSA), which offer Part C services from the Individuals with Disabilities Education Act (IDEA) within the North Carolina Division of Public Health, to the Local Education Agency (LEA) Part B 619 Preschool Special Education Program, within the auspices of NCDPI.[56] In addition, NC-ELN provides resources for parents to help explain the transition from early intervention to preschool and also gathers and posts statewide and LEA data on transitions as reported to the federal Office of Special Education Programs and provides training and technical assistance to LEAs on how to interpret and use the transition data to track and improve transition practices.

56 North Carolina Department of Public Instruction and Department of Health and Human Services. (2015). Early childhood transitions in North Carolina: A parent's guide to the infant-toddler and preschool programs. Retrieved from https://beearly.nc.gov/data/files/pdf/transitionshandbook.pdf

Families who have children with disabilities who participated in the listening sessions were grateful for and complimentary of the specialized services that they access for their children, such as speech and language therapy (the most commonly delivered service according to ECCE provider survey data), physical and occupational therapy, and therapy for autism spectrum disorder (when these services were available). Assessments and treatment services conducted via home visits helped families by providing the needed interventions while coming to the home, thus minimizing the travel burden.

Data from the ECCE provider survey showed that providers were generally able to provide some specialized services for children, such as speech-language therapy. When asked what was working well in their efforts to serve children with disabilities, the most salient response for programs that enrolled children with disabilities was collaboration among agencies, therapists, and child care programs. This was particularly true for center-based providers.

Taken together, policies and practices designed to support children's transition to kindergarten are an area of strength in North Carolina's efforts to support children to be on track for school success. In addition, there is evidence that North Carolina is providing some specialized services that are responsive to the needs of individual children.

Gaps in Supporting Young Children's School Success and Recommendations

Nonetheless, a gap exists in North Carolina's efforts to support young children to be on track for school success, which can be seen in inconsistent efforts to provide specialized services to children who need them, particularly related to type and quality of ECCE programs. As noted in the provider survey data (Appendix G), for children who have or who are suspected of having disabilities, almost 60% of center-based programs offered screening services, relative to 26% of home-based programs. As program quality increased, so did the likelihood that programs offered screening services. In terms of specific services for children with disabilities, the most commonly provided service across programs was speech-language therapy (60%), followed by physical therapy, occupational therapy, nutrition services, social work services, and family training, counseling, and home visits. In general, programs tended to rely on contracted staff to provide these services. As program quality increased, so did the likelihood that programs offered specific services for children with disabilities (Appendix G, Table 6b.4). When asked what was challenging about serving children with disabilities, most providers, and particularly home-based providers, responded that they did not experience challenges for children with disabilities because they did not have children with disabilities enrolled. Some center-based providers reported that training for staff was a challenge or that they do not have enough staff to meet children's needs. Only a few home-based providers endorsed these reasons.

Significant gaps exist in North Carolina to meet the needs of children with disabilities, particularly for children who do not attend high-quality care.

Gaps in accessing specialized services were also reported by families who participated in the listening sessions. As noted in Appendix F, specialized services and therapies were used by many families, with speech and language therapy being the most often accessed. Some children received these supports in Head Start/Early Head Start or NC Pre-K, whereas some accessed them from other locations, such as the local Children's Developmental Services Agency (CDSA), private practitioners who accept Medicaid, and the NC Infant and Toddler Program. In addition to speech and language therapy, families mentioned utilizing services related to asthma, autism spectrum disorder, behavior, play, physical, and occupational therapies. Over 80% of the families who reported that they had children with a disability indicated that their children had Individualized Education Programs/Individual Family Service Plans (IEPs/IFSPs), and three attended a special preschool center. Relatedly, parents also expressed wanting parent education on advocacy, laws, and rights under IDEA and the Americans with Disabilities Act (ADA), sign language, and child development. These comments illustrate parents' interest in learning more about the IEP/IFSP process and their commitment to advocate for their child's needs.

There appears to be an unmet service need for speech-language therapy and services for children with autism spectrum disorder. Some families are unable to access services, and even when some ECCE programs offer these services, families who do not meet the eligibility income criteria for these programs are left out. **One parent noted:**

> Finally, after one year and a half on the waiting list, they did test, and he meets the criteria for autism. He got it. So, for me, one really bad experience because I couldn't find any way to do it sooner when he was small. I tried with Head Start, they don't want to accept him because the salary.

Further, many families have to travel extensively to access specialized services, despite ESSA requiring that public schools provide transition support for families not participating in public facilities. Many services were not available locally or families had to depend on program-provided transportation to access these services. Even when transportation is available, other barriers limited them from utilizing the specialized services for their children. For example, when families had more than one non-school-aged child and transportation services only accommodated the parent and the child receiving the services, this placed additional burden on families to either arrange child care for their other children or figure out some other arrangement to get their child to the service. **Families reported that being able to receive specialized services at home mitigated these concerns, as in the example below.**

> It's really hard. There was a time when I was driving a total of, round about 800 miles a week to get my kids to where they needed to go every week and get to work.

In addition, there appears to be a gap in the cultural competency and tailoring of specialized services to meet the needs of specific populations. One clear need relates to availability of competent interpreters with specialized expertise who can interact with families and for families to get informational materials in their preferred language. Beyond this, parents from tribal communities spoke of the challenge in finding professionals who are knowledgeable about the experiences of members of an indigenous community. **For example, one parent noted:**

> I think a lot of that has to do with you're dealing with an indigenous community and you're bringing in Western therapies and there's a clash there. I think our community as a whole is dealing with that, trying to figure that out.

Another parent said:

> He was a white person and he was a really great therapist, but we had a long conversation about how we spent over half the time of me explaining indigenous experiences for him to understand what I was talking about before we ever got into the actual therapy and whenever you're dealing with indigenous person there's certain things you don't have to explain. And that's really hard to deal with. I know that goes across all the health care occupations.

A second gap relates to North Carolina's ability to document whether children are on track for school success. Specifically, despite the value of the North Carolina Foundations guiding ECCE programs to provide high-quality care and the KEA providing understanding of child skills at kindergarten entry, these resources do not currently illuminate how individual children prior to kindergarten are on track for school success. More resources are needed to determine how children from vulnerable populations are on track, which is especially critical because vulnerable children from certain subgroups, such as children with disabilities and children who are dual language learners, may have unique educational needs. For example, no data exist on whether children have access to ECCE programming in their native language (see Appendix J). Further, according to a preliminary report on survey data from 57 early childhood stakeholders about their use of ECCE data in the education, health, child welfare, and other relevant sectors[57] for ECAP Goal 9, the most common indicator collected was "use, and knowledge of social-emotional skills" and the least common was "Kindergarten Entry Assessment." The largest indicator area for secondary data use was "early childhood special education services" and the lowest was "Kindergarten Entry Assessment." These data confirm that the KEA is not utilized by stakeholders as anticipated to learn about whether children are on track for school success.

57 Bryant, K., Lanier, P., & Nicholls, E. (2019, June 28). Preschool Development Grant B-5 Survey of Early Childhood Education Data Users: Preliminary Report. University of North Carolina at Chapel Hill.

Substantial debate frames the discussion about children being on track for school success. Some of these discussions focus on children's "readiness" for school, with some concerns raised about whether children are indeed "ready:" "It seems normative that children come to kindergarten not ready."[58] Although these discussions may focus on academic skills, kindergarten teachers as well as other early childhood experts point to the importance of including social and emotional competencies as part of a definition that identifies the developmental goals children should have reached by the time of kindergarten entry. More broadly, there is even disagreement among early childhood experts as to what constitutes "readiness."

Other discussions focus on whether schools are "ready" for children, that is "whether schools are prepared to provide a learning environment that meets the needs of each child so that children can be successful in school."[59] Policies reflecting a "Ready Schools" approach are not the norm across schools and districts and may not be consistently applied within schools and districts. Further, any discussion about whether children are on track for school success and whether schools are "ready" for children should include systems-level as well as other potential factors. Systems-level factors might include limited ECCE opportunities, long waitlists, and inflexible caps on programs. As a result, families often do not get what they need during the critical time when their children need to be on track for school success.

In addition, families are generally unaware of the developmental goals children should reach by kindergarten entry so that they are on track for school success, as well as the process for enrolling their children in kindergarten. Another systems-level factor to consider when examining whether children are on track for school success is a lack of communication between agencies and with parents, especially Spanish-speaking parents. In addition, the extent to which teachers use KEA and other information to support transition planning is unknown, as is information on the extent to which teachers need and are receiving support to use these resources. In total, even with attention to designing an assessment for individual children that goes beyond what the KEA can provide, determining whether children are on track for school success is a complex process that must account for multiple contextual factors rather than a singular emphasis on children's individual performance. This perspective is needed when considering how to support children's transitions.

58 Pathways Community Conversation. (2017). Community conversations. Full report: Summer 2017. Retrieved from: https://files.buildthefoundation.org/wp-content/uploads/2018/03/Final-Full-Community-Conversation-Aggregate-Report-2017_For-workbooks.pdf

59 Ready for School Goal Team. (2000). School readiness in North Carolina: Strategies for defining, measuring, and promoting success for all children. Available: https://files.buildthefoundation.org/wp-content/uploads/2019/05/Ready-for-School-Goal-Team_Full-Report.pdf

In addition to transition activities primarily focusing on rising kindergartners and less so for transitions at other ages, there are several gaps in knowledge regarding transition supports for specific subgroups of vulnerable children and families. Apart from children with disabilities, there is little information to illustrate how transitions are supported for children and families from other subgroups. A clear gap is evident regarding whether and to what extent information on transitions is provided to families in a culturally and linguistically sensitive manner. Indeed, a minimal requirement for providing information to families involves ensuring that families can receive written materials in their home language from their ECCE program and the receiving K-12 setting, but the extent to which ECCE programs and school settings engage in these practices is unknown. In addition, the availability of school personnel who can speak the family's home language would also seem to be a foundational requirement, but very few programs and schools are able to provide this service. Given that programs and schools gather information about which languages are represented among children enrolled, this would present an opportunity to learn more about barriers to providing information about transitions to culturally and linguistically diverse families.

Further, little information exists on how transitions are supported for children experiencing homelessness or who are living in North Carolina's rural counties. For example, the Rural Education Achievement Program (REAP), a federal initiative, mandated by Title V, Part B of the Elementary and Secondary Education Act, allows for the provision of high-quality preschool or full-day kindergarten to facilitate the transition from early learning to elementary education programs. There are two parts to the REAP legislation within ESSA, both of which are in use in North Carolina.

In total, the critical gaps in North Carolina's efforts to support young children to be on track for school success span:

1. Limited offerings and access barriers for specialized services
2. Population-level assessment data on children's strengths and needs
3. Specialized transition services for specific populations of children

To address these gaps, we recommend the following:

Recommendation #1

Identify and increase mechanisms providing specialized services to children with disabilities and other speci ic populations

Providers and parents agree that limited options are available for children to access specialized services, which are critical for children to be on track for school success. Barriers such as cost, access, and availability of program or contracted staff are significant impediments to providing children with needed services, some of which are required by law. Specific strategies to address this recommendation are:

- **Conduct a specific study to examine cost, access, and program availability barriers, as well as areas where programs and families have experienced success with services**
  This strategy may help identify innovative approaches for addressing these service gaps.
- **Address some service gaps through partnering with university or professional training programs in those service areas**
  These groups might be able to provide those services at reduced costs from trainees under the supervision of a qualified professional.

Recommendation #2

Leverage efforts stemming from ECAP Goal 9 to inform next steps regarding assessment of whether children are on track for school success, and any related service gaps

North Carolina's Birth–5 Strategic Plan (Appendix L) and the ECAP highlight the KEA as a critical indicator of children's developmental progress. ECAP Goal 9 states: "by 2025, increase the percentage of children across North Carolina who enter kindergarten at a level typical for their age group, according to the five domains of the NCDPI KEA." Specific strategies for utilizing the KEA and other indicators to pinpoint service gaps are:

- **Make KEA data available on an annual basis to document trends for children entering kindergarten (see Appendix J)**
  Potential applications include: identifying targets for instruction and needs for transition supports; informing clear expectations for children entering kindergarten; connecting pre-K and kindergarten curricula and approaches; and facilitating communication between pre-K and kindergarten teachers.

- **Use data on children's grade-level promotion across kindergarten through third grade (Appendix J) as an indicator of developmental progress**
  This will help ECCE systems utilize a prevention lens to prepare children to be on track for school success.

- **Use active initiatives in North Carolina to identify service gaps**
  These include: the Transitions Pilot work; the ESSA activities; and the NCECF's Pathways to Grade-Level Reading initiative and the Child Development at Kindergarten Entry Data Workgroup which are charged with recommending a measure or set of measures to capture children's development at kindergarten entry at the population level (see Appendix I).

- **Document the extent that children with disabilities are being connected to early intervention and educational services**
  Supplement data on children with disabilities who show improvement with Early Intervention services with additional data from the National Center for Education Statistics (see Appendix J) and the Institute for Children, Poverty, and Homelessness (ICPH).

Recommendation #3

Evaluate changes in programs' practices to create systematic approaches to support children's transitions

Existing efforts to support children's transitions represent rich opportunities to learn more about the effectiveness of these programs in general, from families' perspectives, and for specific subgroups of children and families. Specific strategies include:

- **Implement a systematic process to evaluate whether programs met their goals to support children's transitions, including a continuous improvement process**
  Because populations of children arriving from ECCE settings are continually changing and therefore possibly presenting different transition needs, a reflective, rather than a "cookbook," approach would be helpful for gathering data to inform transition practices.
- **Solicit information from families about their experiences leading up to and following the transition**
  Families who are going through the transition process for the first time and information from the children themselves may be especially valuable for developing family-centered transition practices. For example, the Transitions Pilot work involves using All About Me forms to share information about children with their new teacher, as well as a Community Transition Plan.
- **Leverage existing efforts to gather data that can be disaggregated to highlight the transition experiences and supports for specific subgroups of children and families**
  The Transitions Pilot work disaggregates data for children with or suspected of having developmental delays, culturally and linguistically diverse children and families, and children living in rural communities. Information about children and families experiencing homelessness can be garnered by the Institute for Children, Poverty, and Homelessness (ICPH).
- **Expand the Transitions Pilot work to include infants and toddlers**
  This is consistent with recommendations from the Birth to Third Grade Interagency Council to address transitions at all levels.
- **Identify opportunities to gather information on other groups**
  For example, more information is needed including children who are not enrolled in public school programs or other ECCE provider or school programs.

Social-Emotional Resilience

Social-emotional resilience is a key developmental competency for children to be on track for school success, and must not be overlooked as a component of high-quality ECCE services. Accordingly, North Carolina has placed special emphasis on this domain by making it a goal in its Early Childhood Action Plan (ECAP Goal 7: Social-Emotional Health and Resilience).

Strengths of North Carolina's Efforts to Promote Young Children's Social-Emotional Resilience

North Carolina recognizes that there is substantial work to do for its ECCE systems to be responsive to promoting young children's social-emotional resilience. Of the work that has happened at the state level, in 2012 the North Carolina Institute of Medicine (NCIOM) Task Force on the Mental Health, Social, and Emotional Needs of Young Children and Their Families issued *Growing Up Well: Supporting Young Children's Social-Emotional Development and Mental Health in North Carolina*,[60] which developed recommendations to ensure that systems and services are in place to meet the mental, social, and emotional health needs of young children, ages 0-5, and their families. Although the NCIOM report provides recommendations across the broad landscape of services for young children and includes a general recommendation to raise awareness of the social-emotional and mental health needs of young children, one priority recommendation centered on the ECCE system: Increase understanding of the role of social-emotional development among early care and education professionals.

Responses to the NCIOM report included the creation of the North Carolina Infant Mental Health Association (NCIMHA), a statewide organization dedicated specifically to the healthy emotional, cognitive, and social development of children prenatal to five years old, as well as local groups focused on early childhood mental health that work to address the NCIOM recommendations in their communities. Some of these include efforts related to the ECCE system and may interface with ECCE systems to varying degrees.

Among the efforts that are intentionally targeting the ECCE system, the Healthy Social Behaviors Initiative was established to address behavioral issues in young children by offering services designed to identify, prevent, and modify challenging behaviors with a goal of reducing the expulsion rate and promoting social-emotional development of all children in North Carolina licensed child care centers. In addition, the NC-ELN is implementing a cross-sector professional development effort focused on early learning including social-emotional development of young children. This involves working with NCDPI to develop guiding practices and related training to support appropriate early childhood discipline which includes awareness of inequity and bias when addressing challenging behavior, and may result in reducing disproportionalities in discipline practices.[61]

60 North Carolina Institute of Medicine. (2012). Growing up well: Supporting young children's social-emotional development and mental health in North Carolina. Morrisville, NC: North Carolina Institute of Medicine.

61 Gilliam, W. S., Maupin, A. N., Reyes, C. R., Accavitti, M., & Shic, F. (2016). Do early educators' implicit biases regarding sex and race relate to behavior expectations and recommendations of preschool expulsions and suspensions. Research Study Brief. Yale University, Yale Child Study Center, New Haven, CT.

Finally, from a data perspective, existing data are relevant to understanding children's social-emotional resilience. Specifically, data from NCDPI are available regarding children suspended and expelled from schools for grades kindergarten through third grade and for preschoolers enrolled in the public school system (Appendix J). Using these data, it is possible to compute the state average, 5-year trends, national comparisons, and disaggregation by county, school district, or by race/ethnicity. With the recent national attention to racially disproportionate suspensions and expulsions, these data should be interpreted with caution as these rates may reflect teacher behaviors (e.g., lack of teacher training on developmentally appropriate discipline practices, implicit racial bias) rather than children's social-emotional competencies.[62]

In sum, it is noteworthy that North Carolina has recognized a call to action to improve practices, services, and data regarding young children's social-emotional resilience, with promising initial progress regarding professional development efforts and some useful extant data related to suspensions and expulsions.

62 LaForett, D. R., & De Marco, A. (2019). A logic model for educator-level intervention research to reduce racial disparities in student suspension and expulsion. Cultural Diversity & Ethnic Minority Psychology. doi: 10.1037/cdp0000303. Advanced online publication.

Gaps in Supporting Young Children's Social-Emotional Resilience and Recommendations

There are substantial data and service gaps in North Carolina's efforts to support young children's social-emotional resilience. As noted in the ECAP, North Carolina currently lacks a statewide data source on young children's social-emotional health and resilience. Although the ECAP suggests some possible data sources (e.g., measures from the National Survey of Children's Health, the Survey of Well-Being of Young Children, and Medicaid claims data), the Social-Emotional Health Data Workgroup, funded by the Duke Endowment, will recommend a portfolio of indicators to measure children's social-emotional health at the population level. As mentioned, data are available on children's suspension and expulsion (Appendix J), though they are not disaggregated by income level or child age. As discussed in the on track for school success section, survey data from early childhood stakeholders about their use of ECCE data in education, health, child welfare, and other relevant sectors[63] revealed that the most common indicator collected for ECAP Goal 9: On Track for School Success was "use and knowledge of social and emotional skills." Yet, when asked about data indicators for ECAP Goal 7: Social-Emotional Health and Resilience, the most common indicator collected was "child behaviors" and the least common was whether the child was "flourishing"; for secondary data use, the largest indicator area was "child behaviors" and the lowest was "Medicaid claims for developmental screens." These data raise questions about whether these stakeholders may view social and emotional resilience primarily through the lens of challenging behaviors rather than one of children's social and emotional strengths.

Another pressing gap concerns significant unmet needs in services to promote children's social-emotional resilience. The ECCE provider survey data (Appendix G) indicated that supporting children with challenging behaviors was the most sought after topic for technical assistance (81% of providers). Psychological services for children were not often provided, but when provided it was by contracted staff. Even though programs with a family- and whole child-focus (e.g., Head Start and Early Head Start) may be better equipped to provide ancillary services through their own or through contracted staff, they still experience challenges with providing these services to children; these challenges are magnified for other programs that may be less resourced. Further, even when programs offer services, other challenges with contracted services arise with staff turnover or case backlog for contracted service providers.

63 Bryant, K., Lanier, P., & Nicholls, E. (2019, June 28).

For child and family mental health and health services, overall programs were most likely to provide mental health screenings (31%), followed by mental health coordination (21%), dental services (19%), drug and substance abuse services (10%), and pediatric services (10%). In some instances, center-based programs were twice or more likely to provide some of these services as compared to home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of awareness or need. Provision of these services increased with program quality. Overall, programs tended to refer families for these services rather than have their own staff provide them. These patterns were generally consistent across program quality, although lower quality programs were less likely to provide some specific services.

Parents participating in the listening sessions also identified challenges in accessing behavior therapy services for their children. When specific services are limited to center-based ECCE programs, this places great accessibility burden on families unless services can be delivered in the home. Given the strong connection between parents' mental health and children's social-emotional resilience,[64] parents' calls for post-partum depression services and mental health services for families coping with homelessness speak to how mental health services targeting parents or the family unit can be part of a comprehensive response to supporting young children's social-emotional resilience. **One parent who was interviewed at a homeless shelter said:**

> Mental health referrals, I worked ... going from a home environment to a shelter or motel. It changed my children just a little bit, especially my little one, because he's always been in a home, even though the last place wasn't necessarily my home. It was my sister's, but it was a home. Then coming to here, it was like, well, first of all the first 10 days you stayed in a motel and he was starting to act out. Very good as far as now I can get them [Mental health services] so that when we do transition out, it's there. They can verbalize now with someone else, not that they can't verbalize with me, but when you're talking to your own children, you can't get the wording or you are not asking the right questions for them, where a therapist or a coach or somebody can get that questioning from them and they're able to articulate their feelings a little better.

Further, as noted in Appendix I, the NCIOM's goals related to preventing trauma and abuse are aligned with promoting children's social-emotional resilience.

64 Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. Clinical Child and Family Psychology Review, 14(1), 1-27. doi: 10.1007/s10567-010-0080-1

Taken together, North Carolina's efforts to promote young children's social-emotional resilience are currently constrained by significant gaps in data and in service delivery, including:

1. Lack of a statewide data source on young children's social-emotional health and resilience
2. Unmet needs in services to promote children's social-emotional resilience

To address these gaps, we recommend the following:

Recommendation #1

Improve data sources to better understand the broad and specific service needs for promoting young children's social-emotional resilience

The 2025 target in the NC ECAP's Goal 7 is to have a reliable, statewide measure of young children's social-emotional resilience at the population level. This goal recognizes that there are increasing numbers of children experiencing poverty, adverse childhood experiences, and toxic stress; therefore, measures of social-emotional functioning are needed to determine program outcomes as well as guide improvement and tailoring of services and programming. Strategies to improve data sources include:

- **Obtain more comprehensive data on suspensions and expulsions**
  The ECCE system only has data available for children enrolled in public preschool programs. These data do not provide information for infants and toddlers and are not disaggregated by income.
- **Make data sources more useful by integrating their collection in routine practices** One way to do this is by using universal screening practices.
- **Expand the focus of data sources beyond the child to include family members, particularly parents**
  Comprehensive data sources that apply a family-focused lens are needed to identify parental depression, domestic abuse, trauma histories, and other family systems issues that affect children's social-emotional resilience.

Recommendation #2

Increase the number, type, and accessibility of different services that are intended to promote children's social-emotional resilience

Data from the provider survey showed that strategies to offer ECCE providers professional development and expert resources to support their interactions and practices that promote children's social-emotional resilience are insufficient to meet the current demand, as are the actual services provided to children.

- **Increase the number and intensity of professional development offerings focused on children's social-emotional resilience**
  Possible approaches include requiring workforce competencies, such as those developed by the NCIMHA[65], or specific evidence-based Social-Emotional Learning programs, such as the Preschool Promoting Alternative Thinking Strategies (PATHS)[66] program and the Incredible Years ® Teacher Classroom Management[67] and Incredible Beginnings[68] programs.

- **Enhance the effectiveness of ongoing coaching or consultation from an expert in early childhood mental health, such as an early childhood mental health consultant, by making these services regular and universal aspects of high-quality ECCE**
  Such systemic changes are needed to address barriers that include programs and teachers viewing such services as crisis intervention rather than preventive, and limited time in the classroom day for coaches and consultants to effectively support providers.

- **Partner with university or professional training programs in those service areas to address programs' challenges with providing ancillary services**
  These options may help address barriers such as staff turnover, case backlog, and non-center based options.

- **Address other accessibility barriers using a family-focused lens**
  This includes offering more local and more home-based services, and considering transportation needs from the family's perspective.

65 North Carolina Infant/Young Child Mental Health Association. (2016). Early Childhood Social-Emotional Competencies: A Competency-Based System for Professional Development and Support of North Carolina's Early Childhood Workforce. Greensboro, NC: NCIMHA. Retrieved from: http://www.ncimha.org/wp-content/uploads/2012/10/NCIMHA-EC-Social-Emotional-Competencies.pdf
66 Bierman, K., Domitrovich, C., Nix, R., Gest, S., Welsh, J., Greenberg, M., . . . Gill, S. (2008). Promoting academic and social-emotional school readiness: The Head Start REDI program. Child Development, 79(6), 1802-1817.
67 Webster-Stratton, C. (1994). The Incredible Years Teacher Training series. Seattle, WA: Incredible Years, Inc.
68 Webster-Stratton, C. (2015). The Incredible Years Incredible Beginnings Training series. Seattle, WA: Incredible Years, Inc.

Supportive and Supported Families

Meeting children's fundamental needs for safe, stable environments requires supporting families so that they can provide food, health care, housing, and other necessities for their children. Nearly 24% of North Carolina's children from birth to age five are living in families whose incomes are below the federal poverty level and therefore struggle to meet basic needs.

Supporting families is critical to ensuring that children thrive.

Strengths of North Carolina's Efforts to Create Conditions for Supportive and Supported Families

The high-quality ECCE system that North Carolina has built provides needed support to children and their families, particularly those who are vulnerable. Child care subsidies are provided to families to help pay for high-quality child care while parents are working or in school to support families in meeting their children's basic needs. Home visiting services are provided to families, including universal newborn home visiting in some counties, which help identify needs and connect parents to other services in their communities. Families from the listening sessions reported that the Federal Head Start/ Early Head Start, Special Supplemental Nutrition Program for Women, Infant and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and Medicaid programs were helpful, as were home visiting and specialized therapies for children with disabilities.[69]

North Carolina provides information to parents about child care through the North Carolina CCR&R system, through a searchable child care website maintained by DCDEE, and through required posting of star ratings in child care facilities. Research shows that North Carolina parents respond to the star ratings; programs rated lower in the QRIS experienced drops in enrollment.[70]

North Carolina has an emerging strategy to build the capacity of the ECCE system for greater family engagement, leadership, and advocacy through a State Family Engagement and Leadership Coalition. The vision guiding this work is an early childhood system that is family-driven and equitable, serving children in the contexts of their families and communities. The Coalition has conducted initial work to establish guiding principles and an initial framework for statewide implementation. The work includes 10 local pilot or early adopter communities that are participants in and provide feedback to the State Coalition.

69 See Appendix F for Listening Sessions Report.
70 Bassok, D., Dee, T., & Latham, S, 2017

Gaps in Family Support Knowledge or Services and Recommendations

As noted previously, North Carolina families, particularly those from vulnerable populations, have needs for affordable high-quality care, including infant-toddler care, NC Pre-K, or home visiting. Through the listening sessions, three categories of needs surfaced from families' feedback:

1. Information needs
2. Enhanced child care needs
3. Services for adults to help them take best care of their children and families

Perceptions of ECCE providers, as shown in survey responses, were more likely to center on basic supports such as housing, transportation, employment/wages, health care, and other social services. Thirty percent or fewer respondents to the provider survey indicated they provide these kinds of supports directly or through referrals.

Regarding information needs, families wanted access to parent networks and community support groups as well as a comprehensive, networked system to notify families about all available services in an area and how to access them. **As one parent noted:**

> Looking for information. Nobody's telling you anything. Child care, nobody's telling you can get subsidy for your child. Nobody's helping you get speech therapies for your child. You see every other child can talk. They can speak. But your own child can't. Nobody is pushing you into the light telling you to see what is happening.

Regarding enhanced child care options, families expressed the need for shorter waiting lists, more slots, child care during nontraditional hours (e.g., second or third shift, weekends), "drop-in" child care, and more affordable quality child care in all areas of the state. **Lack of access to child care at non-traditional hours was noted as a barrier to employment by this parent:**

> Another issue that I find is child care that's not open late enough, not open on the weekends. I had a lot of job offers, like third shift. I couldn't take them because of child care. They're not open on Saturday.

Finally, regarding services for adults, families noted the need for English language classes; interpreters with specialized knowledge in medical, educational, and support environments; postpartum depression support; parent education classes; and cultural competency training for service and medical providers as well as basic needs supports. Respondents to the provider survey also noted the need for language supports, particularly for families who speak Spanish, the predominant language spoken by dual language learner families in North Carolina.

The need for support for this population was evident in the listening sessions, as illustrated by two quotes from parents:

> Why don't they send information to every home with the services that exist and in Spanish, too? I'll volunteer to translate.

> In this country you are scared to talk when you don't speak English.

The data gathered by this Needs Assessment, particularly during the listening sessions, suggest the following recommendations:

Recommendation #1

Improve family access to information

Parents in every listening session lamented that information about services was not readily available. Some parents relied on word-of-mouth to learn of services and how to receive them, but less-connected parents simply did not know about resources potentially available in their communities. One strategy for improving family access to information is the following:

- **Develop a technology platform (e.g., an app or NCCARE360) that would serve as a directory of available services and supports, contact information, and eligibility requirements**
  An app that lists local community services, is searchable by type of need, and includes eligibility requirements and contact information would meet a great need in communities across North Carolina.

Recommendation #2

Better understand family needs for services

Many jobs do not conform to a 9-5 schedule, but most child care coverage does. North Carolina should better understand the need for weekend and/or second and third shift child care coverage in communities across the state to incentivize providers to meet these needs. Strategies for addressing this include the following:

- **Better understand the need for weekend and/or second and third shift child care**
  Family needs for care at non-traditional hours should be fully understood so they can be addressed. The state should systematically and periodically find out from families what they need regarding child care coverage.
- **Support family child care providers to meet needs**
  Family child care providers can fill an important gap in communities by offering second and third shift or weekend care and should be supported to do so.

Recommendation #3

Better meet the language support needs of families with limited English skills and particularly Spanish-speaking families

Data from the listening sessions and provider survey highlighted the language support needs for families, particularly those who speak Spanish. There is a need to better understand what other language and content-competent interpreters and translators are needed. Strategies for addressing language support needs include the following:

- **Provide families with access to interpreters**
  Interpreters need to have content knowledge in medical, educational, and support environments to best help families navigate these systems.
- **Ensure that service and medical providers have cultural competency training**
  This will ensure that such personnel are able to build trusting relationships with families that form the basis of successful service delivery.
- **Provide English language classes**
  These classes should be held at convenient locations at times that coordinate with work schedules and child care availability.

CONCLUSIONS

This Needs Assessment identified North Carolina's strengths and weaknesses in the four areas of **providing high-quality ECCE**, ensuring that children are **on track for school success**, fostering **social-emotional resilience**, and creating the conditions for **supportive and supported families**. Research suggests that supporting children and families through policies, initiatives, systems, services, and practices in these four areas during the early years can set children on positive developmental trajectories and build resilience. Beyond its strong historical foundation in ECCE and interagency collaboration, North Carolina's strengths identified in this Needs Assessment include overall high quality in its ECCE systems and committed efforts to improve quality that extend beyond the QRIS. These efforts are represented in a number of specific initiatives such as improving data systems, improving access to services such as home visiting and through subsidized child care, trying to meet the needs of specific populations (e.g., infants and toddlers, children and families experiencing homelessness), and enhancing specific aspects of service delivery (e.g., improving transition activities).

Across the four areas and the recommendations suggested to address identified gaps, several broad themes emerged.

- First, it is clear that services across the ECCE system must be expanded to meet current needs and improve access. This recommendation applies to expanding services more broadly (e.g., increasing the number of slots in ECCE programs) but also for specialized services (e.g., specific services for children with disabilities) and specific subgroups of children (e.g., infants and toddlers).

- Second, the ECCE system must respond to families' feedback that they do not have the information and supports they need to access ECCE services that can benefit them and their children. Related recommendations reinforce the importance of continued efforts to seek input from families, provide supports that are culturally and linguistically responsive to families' needs, and provide streamlined and accessible information to families about services.

- Third, improvements to the ECCE system must be informed by increasing the quality, usability, and accessibility of ECCE data systems. Recommendations in this area repeatedly point to the critical need for disaggregated, unduplicated data that are collected routinely and systematically.

- Finally, informational, infrastructural, and financial supports are needed to maintain or attain high overall ECCE quality and to bolster quality in specific areas. To achieve this, recommendations focus on enhancing the quality and the capacity of the ECCE workforce and improving specific aspects of service delivery to promote children's developmental growth as they progress through the ECCE system.

This Needs Assessment contributes knowledge related to how North Carolina is supporting the ECAP goals and the vision of the state's Strategic Plan including areas where there are gaps in knowledge, additional data needs, and recommendations. With a better understanding of the current landscape of the ECCE system, including information directly from vulnerable families and community ECCE providers, North Carolina is poised to begin planning enhancements in the areas of high-quality ECCE, supporting children to be on track for school success, promoting children's social-emotional resilience, and supporting families so that they can best support their children. Because this Needs Assessment is a snapshot in time, North Carolina recognizes the importance of examining the needs of its ECCE system on a continual basis. This practice will prepare North Carolina to anticipate and respond to emergent issues and the overall dynamic nature of systems delivery, such as population changes and policies outside the ECCE system that have the potential to impact ECCE services. For example, a new policy reducing class size in the early elementary grades has the potential to limit spaces for NC Pre-K classrooms housed in public elementary schools. Nonetheless, a strong history of ECCE services, interagency collaboration, and innovation gives North Carolina the leadership, experience, and infrastructure needed to be nimble in responding to any changes in the ECCE landscape that may impact its new Strategic Plan.

Appendices Table of Contents

Appendix A: North Carolina Needs Assessment Crosswalk with PDG B-5 Needs Assessment Requirements

This is an **optional** crosswalk that grantees can use to accompany their executive summary. The executive summary should be a concise narrative that outlines the various documents and/or links that comprise a grantee's comprehensive, statewide, B-5 needs assessment. This **optional** crosswalk confirms to grantees that they have addressed all required pieces and will also help to speed up the review process by identifying where to look for evidence of each piece.

Needs Assessment Domain	Corresponding Page Number
Definitions: Quality Early Childhood Care and Education (ECCE), ECCE Availability, Vulnerable or Underserved Children, Children in Rural Areas, ECCE System as a Whole	Appendix B
Focal Populations for the Grant: Vulnerable or underserved children in your state/territory, and children who live in rural areas in your state/territory	Appendix C
Quality and Availability: Current quality and availability of ECCE, including availability for vulnerable or underserved children and children in rural areas	Appendix E; Pages 12-19
Children Being Served and Awaiting Service: Data available and/or plan for identifying the unduplicated number of children being served in existing programs and unduplicated number of children awaiting services in existing programs	Appendix E; Pages 12-19
Gaps in Data on Quality and Availability of Programming and Supports for Children and Families	Appendix F and G; Page 15
Gaps in Data or Research to Support Collaboration Between Programs/Services and Maximize Parental Choice	Appendix F and G; Pages 39-44
Measurable Indicators of Progress that Align with the State/Territory's Vision and Desired Outcomes for the Project	Appendix J; Pages 12-19
Issues Involving Early Childhood Care and Education Facilities	Appendix G and H; Pages 12-19
Barriers to the Funding and Provision of High-Quality Early Childhood Care and Education Services and Supports and Opportunities for More Efficient Use of Resources	Appendix K; Pages 12-19
Transition Supports and Gaps	Pages 20-31
System Integration and Interagency Collaboration	Appendix I; Pages 5-7

The table below provides an opportunity for grantees to show how stakeholders provided input on the needs assessment.

Stakeholder Input	Corresponding Appendix
Parents/family members or guardians	Appendix F
Child care providers from different settings (e.g., center-based, Head Start, home-based)	Appendix G
Child care providers from different parts of the state including rural areas and areas with diverse populations	Appendix G
Other early childhood service providers	Appendix G
State/Local Early Childhood Advisory Council(s) or other collaborative governance entity	Appendix M
Key partner agencies	Appendix M

Appendix B: Definition of Terms

Children in Rural Areas. Children in rural areas are defined as those birth-5 living in 80 counties (out of North Carolina's 100 total counties) designated as rural by the North Carolina Rural Center. All tribes in North Carolina are in one of these rural counties.[1]

Early Childhood Care and Education Availability. Availability is defined as conveniently located services for all children from birth through 5-years-old and their families, especially vulnerable or underserved children. Access is a combination of availability and affordability.

Early Childhood Care and Education System. Similarly to many other states, North Carolina's system is a mixed-delivery system that includes federal, state, and local funding sources, public and private settings, and state-level leadership spread across a number of different agencies. These agencies include the North Carolina Department of Health and Human Services (NC DHHS), the Division of Child Development and Early Education (DCDEE) within DHHS, North Carolina Department of Public Instruction (NC DPI), the North Carolina Partnership for Children (NCPC), Head Start/Early Head Start, Early Intervention (IDEA Part C), IDEA Part B and the Office of Early Learning within DPI.

High-Quality Early Childhood Care and Education. North Carolina's quality rating and improvement system is a 1-5 star rated license. High-quality is defined as those programs with 4- and 5-star licenses. This includes programs operating NC Pre-K classrooms, which are required to achieve at least 4 stars as well as meet higher quality standards, and typically includes Early Head Start/Head Start programs, which are required to meet Federal Head Start Performance Standards.

Underserved Children. North Carolina defines underserved children birth-5 as those whose families wish to access services but are not able to do so, including families who have requested services but have not yet received them (i.e., on a waiting list), or children enrolled in lower-quality ECCE programs (i.e., those with 1-, 2-, or 3-star rated licenses) who are not attending the high-quality programs that could best support their development and academic achievement.

Vulnerable Children. North Carolina defines vulnerable children, birth-5, as those who: (a) live in a household with an income at or below 75% of the State Median Income (SMI)[2], (b) have had multiple adverse childhood experiences, (c) are experiencing homelessness, (d) have an identified developmental disability or chronic health condition, or (e) have Limited English Proficiency.

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1 North Carolina Early Childhood Foundation. (2017c). Not About Me, Without Me: NC Early Childhood Foundation Report. Retrieved from https://files.buildthefoundation.org/wp-content/uploads/2018/03/ncecf_reports-parents-121017-digital.pdf

2 Although the state defines vulnerable children as those living in households making 75% or less of the state median income, various services potentially available to children and families may utilize different definitions for eligibility. Therefore, we can estimate the number of families and their children accessing these services, but not the total percent of the eligible population accessing services.

Appendix C: Focal Populations for the Preschool Development Grant

The focal populations for the Preschool Development Grant consist of children defined by the State as vulnerable and underserved. This definition includes children with the following characteristics: 1) live in families with incomes at or below 75% of the State Median Income (SMI), 2) have experienced multiple adverse childhood experiences, 3) are experiencing homelessness, 4) have an identified disability or chronic health condition, 5) have Limited English Proficiency, 6) live in rural areas, or 7) are part of a tribal population (all tribes in North Carolina live in one of the 80 counties designated as rural by the North Carolina Rural Center). This appendix will provide further information on the characteristics of these vulnerable and underserved populations in North Carolina, such as prevalence rates, disparities in these characteristics by race/ethnicity, and the extent to which poverty is associated with other vulnerabilities, as well as strengths and weaknesses about the data available in North Carolina to describe these populations.

The total number of children from birth to age five residing in North Carolina in 2017 was 602,070.[3] Of these, 23.7% were living in families whose incomes were below the federal poverty level (FPL) in 2017[4], or 142,691 children[5]. This number represents a low estimate of those who would qualify for all available services designed for children from low-income families, as many programs have lower qualification thresholds (e.g., < 200% FPL, < 75% SMI).[6]

When examining the racial and ethnic distributions of young children in North Carolina, there are significant disparities related to those living in poor families. The racial distribution of children under age 5 in 2017 was as follows: White, 61.2%; Black or African American, 21.6%; Two or more races, 7.1%; Other Race, 5.6%; Asian, 3.3%; and American Indian and Alaska Native, 1.2%. Hispanic children accounted for 17.6% of children under age 5.[7] In contrast, the distribution of race among the 142,691 children living in a poor family in 2017 was as follows: White, 42.5%; Black, 33.8%; Other Race, 9.9%; Two or more races, 8.7%; American Indian and Alaska Native, 2.7%; and Asian, 2.5%. Further, almost 30% of Hispanic children under age 5 are living in poverty.[8]

3 Detailed subgroup calculations on race and poverty were calculated by the FPG team using the raw data from the 2017 American Community Survey 1-Year estimates: S0201 Selected Population Profile in the United States. This source did not include data on the "Hawaiian or Other Pacific Islander" population they are not included in the detailed race/ethnicity or poverty calculations.
4 U.S. Census Bureau. (2017b). 2017 American Community Survey 1-Year estimates: Economic characteristics. Retrieved from https://factfinder.census.gov/
5 U.S. Census Bureau. (2017c). 2017 American Community Survey 1-Year estimates: Poverty status in the past 12 months by sex by age. Retrieved from https://factfinder.census.gov/
6 For a family of 4, the FPL is $24,600, while 75% of NC's SMI is $52,500.
7 The U.S. Census Bureau defines "Hispanic or Latino" as "a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race," thus this subgroup's calculations were broken down separately from the other race categories as it could apply to all races.
8 U.S. Census Bureau, 2017a.

Vulnerable and underserved children include those exposed to multiple **adverse childhood experiences.** For instance, child maltreatment is more frequent among children in low-income families[9], and child maltreatment reports in North Carolina are 10% higher than the national average.[10] In the Early Childhood Action Plan, North Carolina includes state-level data on adverse child experiences for Goal 5, Safe and Nurturing Relationships. The only data that are collected for North Carolina at this time come from the National Survey of Children's Health which is conducted every 1-2 years.

Children experiencing homelessness are another focal population for North Carolina. As of January 2018, an estimated 1.68% of North Carolina's population was **experiencing homelessness**; however, those North Carolina data are not reported by age groups. As of 3 years ago, North Carolina DHHS estimated that homelessness among children was 1 in 28 (3.57%).[11] According to the U.S. Department of Housing and Urban Development (HUD), homelessness includes individuals who are living in shelters, transitional housing, and Safe Havens. The McKinney-Vento Education of Homeless Children and Youth Assistance Act is the primary piece of legislation addressing the education of children and youth experiencing homelessness. State-level data on homeless children are available from HUD and the U.S. Department of Education, but each of these departments has a different definition of homelessness, making estimates drastically different based on narrow versus broader definitions. Further, these estimates are typically point-in-time estimates; therefore, we do not know for how long children experience homelessness. Children from various ethnic groups experience homelessness in North Carolina; however, African American, American Indian, and Hispanic children are overrepresented. In addition, very rural counties have limited resources to connect with and help those who are homeless, and therefore there may be people in need who are not counted simply because they are not receiving services.

Data on homelessness can be accessed through North Carolina's Homelessness Management Information System, a data system used to track HUD services provided in each Continuum of Care in the state; however, a standard process is not in place for requesting data through this system. These data are based on the number of resources provided to those in need, so if HUD resources are not available due to limited budgets, some homeless people may "double up" instead of going to a shelter. Thus, we have underestimates of the true number of people experiencing homelessness or unstable housing, making it challenging to estimate the need for resources for the number of children experiencing homelessness.

9 Eckenrode, J., Smith, E. G., McCarthy, M. E., & Dineen, M. (2014). Inequality and child maltreatment in the United States. Pediatrics, 133(3): 454-461. doi: 10.1542/peds.2013-1707
10 North Carolina Department of Health and Human Services, 2019a
11 North Carolina Department of Health and Human Services, 2019a

Young children who have **disabilities or chronic diseases** are another priority group of vulnerable children for North Carolina. Under the Individuals with Disabilities Education Act (IDEA), North Carolina identifies and supports young children with developmental delays or disabilities, age birth through 5. North Carolina serves infants and toddlers ages birth through 2 years through the Part C program (also known as early intervention or the North Carolina Infant-Toddler Program) and serves preschool children ages 3 through 5 years under the Part B, Section 619 program (also known as preschool special education). North Carolina has reported that in 2017-18, 40,252 children under age 5 had an identified disability. Children served under the age of 5 were White (50.9%), Black (24.5%), Hispanic (17.1%), Two or More Races (3.2%), Asian (2.5%), American Indian and Alaska Native (1.6%), and Native Hawaiian (0.1%). There are no data that identify home language or family income of children with disabilities.

English Limited Proficiency Dual language learners (DLLs) are children who are learning two or more languages simultaneously or learning a second language while acquiring another language.[12] Given that children are learning two languages, their proficiency in English might be limited in their earlier years. In the past 15 years, North Carolina has experienced an 86% growth in its young DLL population as compared to a 24% increase nationally. In addition, a disproportionate number of DLLs in North Carolina live in low-income families (70%), as compared with non-DLLs (50%). Sixty-five percent of DLLs in North Carolina are Hispanic, and 63% report Spanish as their home language.[13] Although the state has some information related to home language, these data are not collected or reported consistently statewide. For example, there may be data collected on primary language spoken, but there may not be data on English proficiency, or the data may be of lower quality.

Very little data are available regarding two of the focal populations for the Preschool Development Grant – **children who live in rural areas and children who are part of a tribal population**.

12 U.S. Department of Health and Human Services, & U.S. Department of Education (2017). Policy statement on supporting the development of children who are dual language learners in early childhood programs. Retrieved from https://www.acf.hhs.gov/sites/default/files/ecd/dll_guidance_document_final.pdf

13 National Center on Immigrant Integration Policy. (2017). Dual Language Learners: A demographic and policy profile of North Carolina. Retrieved from file:///C:/Users/xfranco/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/DLL-FactSheet-NC-FINAL%20(1).pdf

Appendix D: Methods

This section provides a brief description of the methods used to conduct the three key activities performed as part of the Needs Assessment.

Review of Existing Data and Reports

A review and synthesis of existing data and reports to inform the overall PDG Needs Assessment was conducted between March - June 2019. **This activity was conducted in the following steps:**

First, the FPG team met with leaders at the Division of Child Development and Early Education (DCDEE) to design the study by clarifying the scope and identifying reports and resources that contained data relevant to describing the needs and services for families with children birth to age five. All reports were publicly available and could be accessed electronically. A total of 68 resources were included in the review (see Appendix N for bibliography).

Second, the FPG team read the executive summaries of the reports and developed a matrix that mapped each report onto the 11 domains specified in the Needs Assessment Federal Guidelines. The 11 domains include: (1) Definition of terms, (2) Focal Populations for the Grant, (3) Number of Children Being Served and Awaiting Service, (4) Quality and Availability of Early Childhood Care and Education (ECCE) Services, (5) Gaps in Data or Research to Support Collaboration and Maximize Parental Choice, (6) Availability and Usefulness of Programs and Supports for Families, (7) Measurable Indicators of Progress, (8) Issues Involving ECCE Facilities, (9) Barriers to the Funding and Provision of High-Quality ECCE Services and Supports and Opportunities for More Efficient Use of Resources, (10) Transition Supports and Gaps, and (11) System Integration and Interagency Collaboration. This matrix served two purposes: (1) to inform DCDEE about which reports were included in the review and for which domains we were lacking publicly available data/information and (2) to guide the FPG review team in the analyses of documents within each domain. DCDEE suggested additional resources during the review process which were added to the matrix and reviewed by the FPG team.

Third, each of the 11 domains were divided up and reviewed by one of five members of the FPG team with expertise in ECCE. The team was provided with the Federal Guidelines, information from DCDEE on state priorities, and the list of guiding questions within each of the 11 domains to focus the review and write the section summaries. Particular attention was paid to analyses of areas of success and promise, areas for improvement, and recommendations for next steps.

Fourth, the individual summaries were reviewed by the FPG team's Senior Technical Experts for accuracy, completeness, and clarity. The section writers reviewed the feedback and made adjustments to address any concerns.

Fifth, the project leads conducted a further review and synthesis of the individual summaries to extract higher-order themes from the data.

Listening Sessions

The purpose of the listening sessions was to gather additional input from vulnerable or underserved families about the current early childhood system and potential challenges or needs in the state.

The listening sessions were conducted in May and June of 2019 in 12 of North Carolina's 100 counties: Alamance, Carteret, Caswell, Cherokee, Duplin, Hertford, Johnston, Macon, Orange, Pasquotank, Tyrell, and Wake counties. Most of the 72 participants were female (94%) and in the 25-44 age range (73%). Forty percent were Hispanic, 32% White, 22% African-American, and 6% other racial/ethnic group.

Eleven listening sessions were conducted with an average of 7 participants per session. Each listening session lasted on average an hour and thirty minutes. The sessions were audio-recorded, and notes were taken by the FPG team. Participants were given an incentive of $50 gift card, and snacks were provided. Six parents who were unable to attend the listening session were invited to participate in a 15-20 minute phone interview.

The structured guide (available in English and Spanish, see pp. 58-59) that was used for conducting the listening sessions was developed by FPG in collaboration with DCDEE to learn about families' perceptions of availability, usefulness, and sources of information about services.

The data from all listening session groups and parent interviews were analyzed qualitatively and summarized in stages. First, all audio-recordings were transcribed and the notes from the sessions were read. NVivo software was used for coding and to generate themes based on the key questions being asked. Two members of the FPG team coded the data. All pertinent data were then condensed and synthesized according to the major themes that were found and the questions posed during the listening sessions by the FPG team. The themes were then synthesized into a final report.

Provider Survey

A survey was developed to collect input from licensed child care directors and family child care providers to identify, describe, and address barriers that they face in providing high-quality ECCE services, including facility related concerns and funding challenges in North Carolina. The online survey was sent via e-mail to all programs in the licensing database provided by DCDEE.
To encourage participation, twenty $50 Walmart gift cards were raffled among providers who completed the self-report survey. Analyses and summaries of quantitative and qualitative data were conducted, and the results were synthesized into a final report (see copy of provider survey in Appendix H). Results from the provider survey should be interpreted with caution. Surveys are cost effective and allow for data collection from a large number of respondents but are not without limitations. Limitations include response bias as providers who were willing and able to complete the survey may have been different from those who were not, participants might have opted out from answering some questions, respondents might not have felt comfortable providing honest responses, and/or survey questions might be interpreted differently by respondents leading to inaccurate data.

Synthesis of Three Data Sources

Once the data from the document review, family listening sessions, and provider survey were gathered, coded, and summarized, a final review and synthesis was conducted by the FPG project team leads. This final step was conducted to combine the three sources to create an integrated description of the ECCE landscape in North Carolina.

Guiding Questions for Family Listening Sessions & Parent Interviews

1. What types of services do you receive to support your family and children up to age 5? These services might include child care, special services for individual children, or services for your whole family.

    - *Allow group to brainstorm and keep a list with tallies on flip chart for each service/support mentioned. (You may refer to the list of probes for question 1 document as a resource)*
    - *Probe with other services that may not have been mentioned, such as speech/language therapy, OT, PT, health department visits, etc.*
    - *Probe child care arrangements with Head Start/Early Head Start, church child care, family child care home, preschool, NC Pre-K*
    - *Probe child care arrangements with length of day. Poll for half day program, full day program, and school-day long program*

2. How did you find out about those services?
3. How do these services meet your family's needs?
4. What is working well?
5. What is not working well?
6. What else do you wish you had?

Preguntas orientativas para las sesiones de escucha familiar y entrevistas a los padres

1. ¿Qué tipo de servicios recibe para apoyar a su familia e hijos hasta los 5 años? Estos servicios pueden incluir cuidado infantil, servicios especiales para niños individuales o servicios para toda la familia.

    - *Permite al grupo pensar en varias ideas y guarda una lista con registros en el rotafolio para cada servicio/apoyo mencionadas (Puede consultar la lista de sondeos para el documento de la pregunta 1 como recurso)*

    - *Investiga con otros servicios que no fueron mencionados, como terapia de discurso/lenguaje, terapia ocupacional, terapia física, visitas del departamento de salud, etc.*

    - *Investiga arreglos del cuidado de los niños con Head Start/Early Head Start, cuidado de los niños en la iglesia, cuidado de los niños por la familia en casa, preescolar, preescolar de Carolina del Norte.*

    - *Investiga arreglos del cuidado de los niños con duración al día. Encuesta el programa de medio día, día completo y programa de día escolar largo.*

2. ¿Cómo se dieron cuenta de estos servicios?

3. ¿Cómo cumplen estos servicios las necesidades de su familia?

4. ¿Qué está trabajando bien?

5. ¿Qué no está trabajando bien?

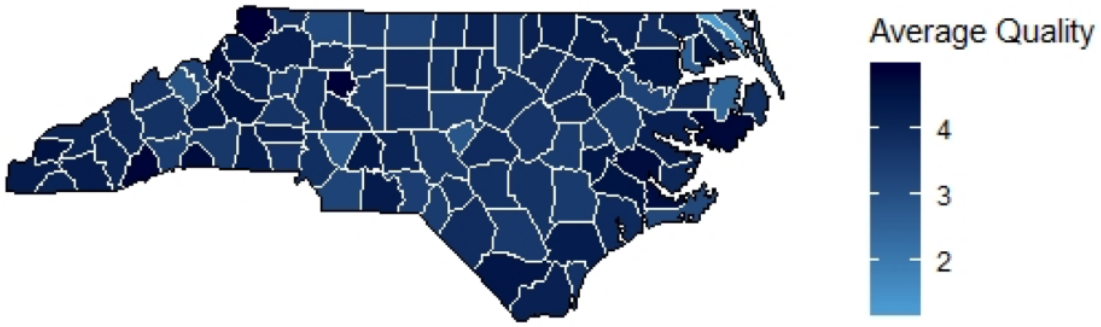
6. ¿Qué más desean tener?

Appendix E: Tables and Figures Related to North Carolina Early Childhood Care and Education Services: Quality, Availability, Enrollment and Waitlist Data

Table E-1. *Quality of ECCE slots by population density in North Carolina, with 82% of regulated slots on average located in 4- and 5-star licensed programs and few differences by population density*[14]

Rurality[15]	Number of ECCE Programs	Number of Exempt Programs	Number of Temp/ Prov/ Prob	Number of Regulated Programs	Average Star Levels – Regulated Programs	Number of Children Enrolled - Regulated	Average Quality – Regulated Slots	% Regulated Slots 4-5 Stars
Rural Counties	2,512	149	49	2,314	4.03	63,560	4.26	80%
Suburban Counties	1,389	93	42	1,254	4.09	38,190	4.34	83%
Urban Counties	2,060	91	72	1,897	3.96	63,579	4.29	83%
Total	5,961	333	163	5,465	4.02	165,329	4.32	82%

Figure E-1. *Average quality of ECCE slots by North Carolina county is in the 3.5 to 5-star range with no clear regional patterns*[16]



14 North Carolina Department of Health and Human Services Division of Child Development and Early Education. (2019a). [Child care centers enrollment and facility information capacity.] Unpublished raw data.
15 North Carolina Rural Center (2019), Rural/Suburban/Urban designations. Retrieved from https://www.ncruralcenter.org/about-us/
16 These results are different than a previous 2015 analysis of statewide quality data suggesting that smaller and more rural regions lagged in average ECCE quality.

Figure E-2. *Proportion of programs at each quality level by type of ECCE organization, with for-profit programs varying more in quality and having lower quality care as measured by star ratings than those operated by public or quasi-public organizations; a higher proportion of public and quasi-public programs and not-for-profit programs have 5-star ratings compared to for-profit programs*

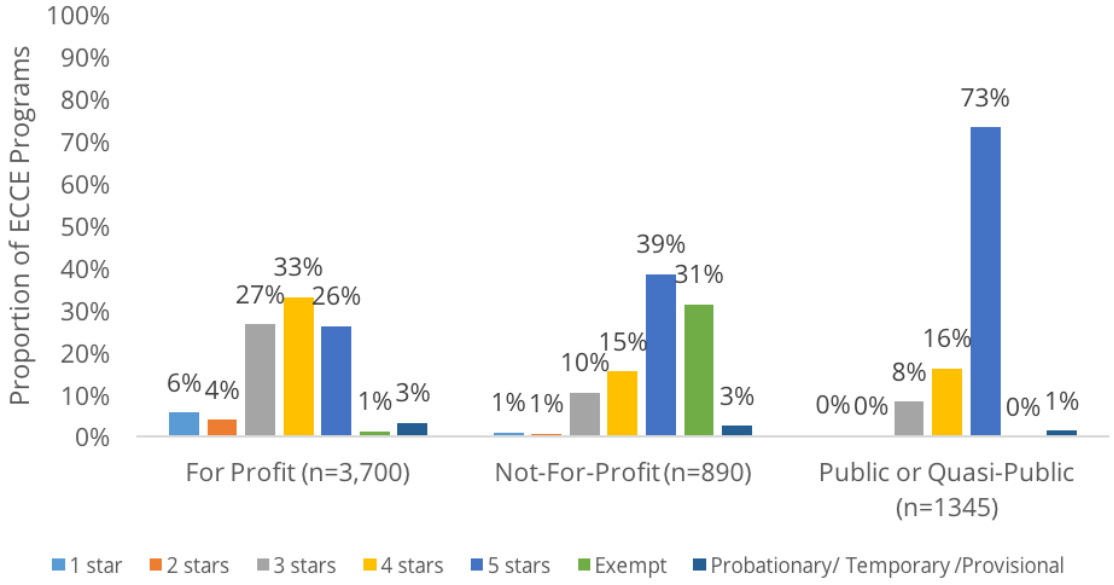
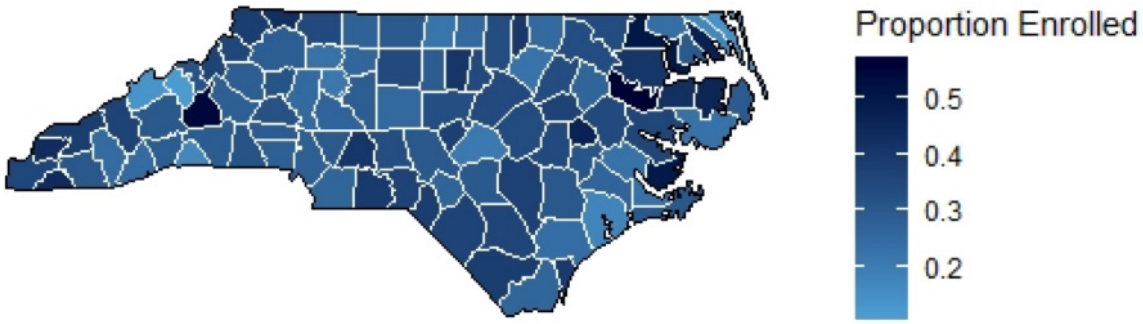


Table E-2. *Number of children and ECCE slots by age and rurality in North Carolina, with similar access ratesto ECCE slots for children birth through age 5 across rural, suburban, and urban counties*

		Infants and Toddlers[18]			Birth-Five Years[19]		
	Number of Counties[17]	Population	ECCE Slots (Enrollment)	Proportion Enrolled	Population	ECCE Slots (Enrollment)	Proportion Enrolled
Rural Counties	80	237,579	22,040	9%	233,148	70,627	30%
Suburban Counties	14	87,795	16,040	18%	150,620	44,703	30%
Urban Counties	6	131,555	28,680	22%	225,945	71,654	32%
Total	100	356,929	66,760	19%	609,713	186,984	31%

17 North Carolina Rural Center, 2019
18 Think Babies Campaign. (2019). State of babies yearbook 2019: The state of North Carolina. Retrieved from https://stateofbabies.org/data/#/North_Carolina)
19 North Carolina Department of Health and Human Services Division of Child Development and Early Education, 2019a

Figure E-3. *Proportion of children enrolled in ECCE slots by North Carolina count, showing no clear geographic pattern*[20,21]



20 North Carolina Rural Center, 2019
21 North Carolina Department of Health and Human Services Division of Child Development and Early Education, 2019a

Table E-3. *Children Eligible, Served, and on Waitlists in North Carolina's ECCE Programs*

Program	Population	Year of Data or Report	Number Eligible	Children Served	Number on Waitlist[22]
Licensed child care[23]	Ages birth to age 5	May 2019	NA	31% of all children in North Carolina, estimate based on 186,984 slots in 5,961 programs providing ECCE services in May 2019 (186,984 slots / 601,181 children under five24 = 31%)	Data Not Available
Subsidized child care assistance program[25,26]	Ages birth to age 5	2018-19	253,032	17% of subsidy-eligible children in North Carolina, estimate based on 43,646 children served in May 2019 (43,646 served children / 253,032 eligible children = 17%)	33,098[27]
Early Head Start[28]	Ages birth-under 3 years	2019	117,975	4% of Early Head Start-eligible children under three in North Carolina in 2019, estimate based on 4,719 funded Early Head Start slots in 40 programs (4,719 served children / 117,975 eligible children = 4%)	Data Not Available
Head Start[29]	Ages 3-5 years	2019	103,806	17% of Head Start-eligible children ages 3-5 in North Carolina in 2019, estimate based on 17,647 funded Head Start slots in 48 programs (17,647 served children / 103,806 eligible children =17%)	Data Not Available
Title I Preschool[30]	Ages 3-5 years	2018-19 (projected)	NA	7,417 children were projected to be enrolled in ECCE classrooms using 100% Title 1 funds 3,765 children were projected to be enrolled in ECCE classrooms using Title 1 funds blended with other funding sources (note: number of eligible children was unavailable and thus we were unable to calculate percentage served)	Data Not Available
NC Pre-K[31]	Age 4, and meeting income or risk requirements	2018-2019	59,566	50% of NC Pre-K-eligible children in North Carolina, estimate based on 29,509 children served in 2018-2019 (29,509 served children / 59,566 income-eligible children = 50%)	74% of NC Pre-K programs maintain a waitlist, averaging 73–92 children per program[32]

22 When waitlist data are available, they have limitations. Counties and NC Pre-K contractors are not required to maintain actual waitlists of families seeking to enroll in NC Pre-K, no standardized process exists for how contractors contribute to waitlists, and no verification processes are used. In addition, waitlists only include children in families who tried to enroll in the program, and do not represent eligible families who do not enroll because of the following: (1) they do not know about the program; (2) they know the program is full; (3) they are hesitant to enroll in a state-run program; (4) they have difficulties proving eligibility; or (5) they have challenges related to transportation, work schedules, language, or homelessness. Barnett, S. W. & Kasmin, R. (2019). Barriers to expansion of NC Pre-K: Problems and potential solutions. Retrieved from the National Association for Early Education Research website: http://nieer.org/wp- content/uploads/2019/01/NIEER_North_Carolina_2019.pdf

Program	Population	Year of Data or	Number Eligible	Children Served	Number on Waitlist[22]
Home visiting programs[33]	Families, with some programs having specific requirements	2016-2017	723,800 children	<1% of home visiting-eligible children in North Carolina, estimate based on 6,379 children served in 2016 (6,379 served children / 723,800 eligible children = 0.009%)[34]	72% of programs with waitlist, averaging 26 families per
Early Intervention, IDEA, Part C[36]	Ages birth to age 3, having or suspected of having a developmental delay	2017-2018	NA	10,517 children were served in 2017-2018 (the percentage of the North Carolina population birth through 2 years served in 2017-2018 was 2.88%, less than the 2017-2018 national average of 3.12%)[37] (note: all children who are deemed eligible are offered placement; however, parents/caregivers may decline services)	Not lawful to have a waitlist
Preschool Exceptional Children, IDEA Part B, 619[38]	Ages 3-5 years, with identified need per the Individual Education Program (IEP) team	2017-2018	NA	19,899 children were served in 2017-2018 (the percentage of the North Carolina population ages 3-5 years served in 2017-2018 was 5.42%, less than the 2017-2018 national average of 6.44%)[39] (note: all children who are deemed eligible are offered placement; however, parents/caregivers may decline services)	Data Not Available

23 North Carolina Department of Health and Human Services Division of Child Development and Early Education, 2019a
24 U.S. Census Bureau, 2017a
25 North Carolina Department of Health and Human Services Division of Child Development and Early Education. (2019b). [Subsidy SFY 18-19 eligibility by age (0-5) by county.] Unpublished raw data.
26 R. Kaplan (personal communication, July 1, 2019).
27 Data from the subsidized child care assistance program indicate that a substantial number of children are eligible for subsidies, but their families do not know about or receive subsidies. North Carolina Early Childhood Foundation. (2017a). Community conversations round one report. Retrieved from https://buildthefoundation.org/2018/06/local-communities-provide-input-to-pathways-to-grade-level-reading-initiative/
28 National Head Start Association. (2019). 2019 North Carolina Head Start profile. Retrieved from https://www.nhsa.org/national-head-start-fact-sheets
29 National Head Start Association, 2019
30 NC. Garrett (personal communication, June 16, 2019)
31 North Carolina Department of Health and Human Services Division of Child Development and Early Education. (2019d). [NC Pre-K eligibility SFY 18-19 estimates.] Unpublished raw data.
32 Peisner-Feinberg, E. S., Van Manen, K. W., & Mokrova, I. L. (2018). Variations in enrollment practices in the NC Pre-K program: 2016-2017 statewide evaluation. Chapel Hill, NC: University of North Carolina at Chapel Hill FPG Child Development Institute. Retrieved from https://ncchildcare.ncdhhs.gov/Portals/0/documents/pdf/2/2016-17_NC_Pre-K_Eval_Report.pdf?ver=2018-12-13-162243-093
33 National Home Visiting Resource Center. (2017). State profile – North Carolina: Families served through evidenced-based home visiting in 2016. Retrieved from https://www.nhvrc.org/wp-content/uploads/DS-NC-Profile.pdf
34 Bryant, K., Chung, G., Lanier, P., & Verbiest, S. (2018). North Carolina early home visiting landscape analysis. Retrieved from the University of North Carolina at Chapel Hill, School of Social Work, Jordan Institute for Families website: https://jordaninstituteforfamilies.org/collaborate/data-informed-policy-practice/home-visiting/
35 Bryant et al., 2018
36 U.S. Department of Education, 2018a.
37 The percentage served was calculated as the number of infants and toddlers (birth through age 2) served under IDEA, Part C, divided by the estimated U.S. resident population of infants and toddlers (birth through age 2), multiplied by 100 (U.S. Department of Education, 2018a)
38 U.S. Department of Education, 2018b.
39 U.S. Department of Education. (2018c). Children ages 3 through 5 served under IDEA, Part B, as a percentage of population, by disability category and state. Retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/2017-2018/part-b/child-count-and-educational-environment/1718-bchildcountandedenvironment-7.xlsx; the percentage served was calculated as the number of children ages 3-5 served under IDEA, Part B, divided by the estimated U.S. resident population of children ages 3-5, multiplied by 100

Figure E-4. *Proportion of children on waitlists for subsidized child care assistance by county*

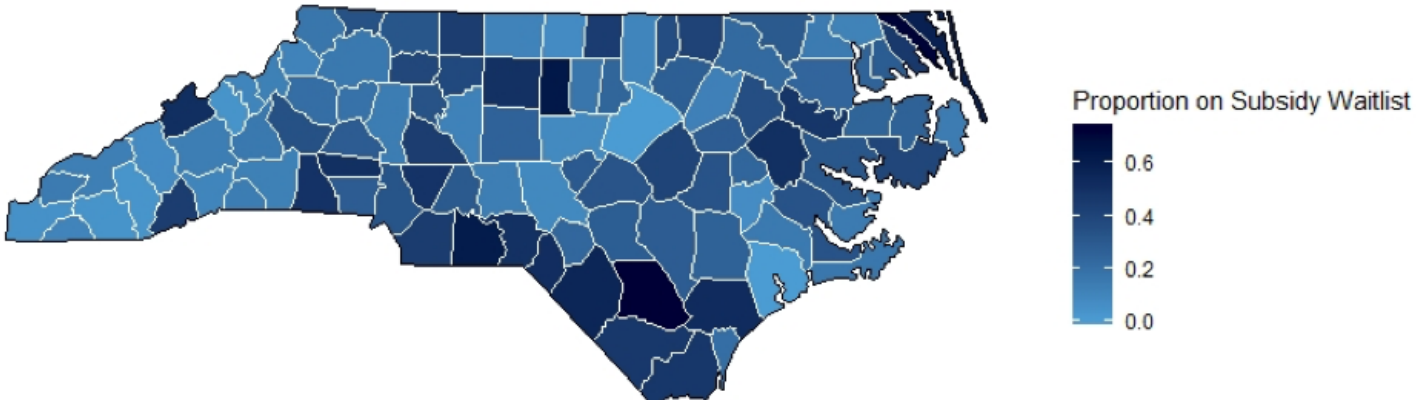
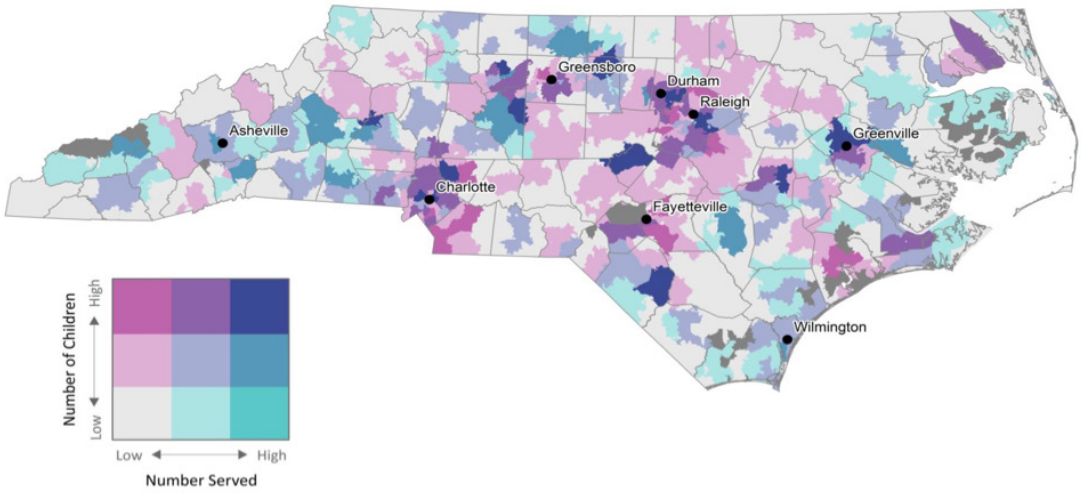


Figure E-5. *Unmet need for home visiting services: Trend map*[40]



40 Bryant et al., 2018

Appendix F: Listening Sessions Report

FULL SAMPLE

Families for the 11 listening sessions and six interviews were recruited through networks of connections with colleagues, starting with the leadership of DCDEE. Leadership members suggested contacting their colleagues, who then connected us to others. Specialists working in the areas of families experiencing homelessness, children with disabilities, Smart Start, and Head Start/Early Head Start were instrumental in helping to reach out to their communities to share recruitment flyers and establish hosting locations. Members of one of the state's vulnerable populations – citizens who are part of tribal communities – were unavailable for listening sessions, so five telephone interviews were conducted with willing participants of this community, along with one interview of a family attending a migrant Head Start program. The same protocol was used for both the listening sessions and the phone interviews. We targeted counties for which the state had no existing data from families (Table1).

Table 1. *NC Needs Assessment Birth to Age Five Listening Sessions*

Group	Host Agency	City	County	# of Participants
1	Personal interview East Coast Migrant Head Start	Clayton	Johnston	1
2	East Coast Migrant Head Start	Faison	Duplin	7
3	Gunn Memorial Public Library	Yanceyville	Caswell	7
4	Child Development Services Agency	Columbia	Tyrrell	10
5	Macon Program for Progress	Franklin	Macon	11
6	Region A Partnership for Children	Murphy	Cherokee	3
7	Coastal Community Action	Beaufort	Carteret	6
8	Personal interview Community Empowerment Fund	Chapel Hill	Orange	1
9	Albemarle Alliance for Children & Families	Elizabeth City	Pasquotank	10
10	Northampton Smart Start	Murfreesboro	Hertford	7
11	Centro La Comunidad Child Care Services Assn	Burlington	Alamance	9
12	Salvation Army of Wake County	Raleigh	Wake	10
13-1	Personal interview Cherokee Tribal Community	Cherokee	Swain	1
13-2	Personal interview Cherokee Tribal Community	Cherokee	Swain	1
13-3	Cherokee Tribal Community	Cherokee	Swain	3
13-4	Personal interview Cherokee Tribal Community	Cherokee	Swain	1
13-5	Personal interview Cherokee Tribal Community	Cherokee	Swain	1
Total				89

Population. Of the 89 participants, 85 (95%) were female, 10 (11%) were experiencing homelessness, and 7 (8%) reported being a member of a tribal nation. Languages mentioned were English (n=54), Spanish (n=29), and Cherokee (n=5). Forty-eight percent of Spanish speakers also listed English as a language spoken at home. Respondents reported a total of 215 children,[41] 55% of whom were boys and 45% of whom were girls. Forty children had a disibility. Note that many participants reported more than one race, so the totals do not equal 100%.

SERVICES ACCESSED

Participants were asked what types of services they received to support their families and children. Parents and other caregivers spoke openly about the services they accessed for their children and families. Services generally fell into five broad categories, each of which will be discussed in turn. A frequency table showing the number of times categories were coded can be seen in Table 2. These five categories are: (1) **basic needs support** (such as food, housing, transportation, and medical care services); (2) **specialized services and therapies** (including physical, occupational, and speech and language therapy, among others); (3) **local community outreach;** (4) **child care** (including NC PreK, Head Start/Early Head Start, and other un-named centers and arrangements); and (5) **state agencies/initiatives.**

Table 2. *Frequency of Coded Themes: Services Accessed*

Theme	N
Basic needs support	192
Specialized services and therapies	136
Local community outreach	105
Child care	92
State agencies/initiatives	25

Basic needs supports are those services that aid families in meeting their needs for food, housing, transportation, and medical care. These were widely reported in all sessions. WIC, Medicaid, and SNAP (aka, food stamps) were the most commonly mentioned basic needs supports. Child care subsidy was referenced a few times, notably in the more urban locations that the FPG team visited. Transportation services are used when offered and available. Basic needs support provided by state and/or federal funding (WIC, Medicaid, and SNAP) and local community outreach entities were accessed by nearly every participant. This is because health departments, social workers, clinics, and friends and neighbors shared information about them easily and readily. Specialized services and therapies, such as speech and language therapy, in addition to asthma, autism, behavioral, play, physical, and occupational therapies were accessed by many families, even when having to travel great distances for some of them.

41 Child age was asked for all children. They were not all 0-5 though the participant had at least one child in that age range.

Parents continually emphasized their desire to provide their children with every available option possible, some making difficult compromises such as giving up employment or sending a child to live with relatives in another city in order to make this happen. Child care is a must-have for most families.

Specialized services and therapies were used by many families, with speech and language therapy being the most often accessed. Some children received these supports in Head Start/Early Head Start or NC Pre-K, while some got them from other locations such as the local Children's Developmental Services Agency (CDSA), private practitioners who accept Medicaid, and the NC Infant and Toddler Program. In addition to speech and language therapy, families mentioned asthma, autism, behavioral, play, physical, and occupational therapies. Twenty-five children had Individualized Education Programs/Individual Family Service Plans (IEPs/IFSPs) and three attended a special preschool center.

Local community outreach is characterized by local agencies and organizations that provide supplemental, life-enriching services and supports to families with young children. Food banks and food pantries fall into this category, as do libraries, free book programs, programs through local parks and recreation departments, and church ministries. It should be noted that some communities did not have ready access to these types of supports, and the availability of these services depends wholly upon a community's ability to and interest in providing them.

Child care is the next category of services reported by session attendees. Head Start/Early Head Start and NC Pre-K were both named – and lauded - specifically. Many respondents answered "child care" or "Pre-K" without elaborating. A few parents engaged in-home sitters or family members to watch their children while they worked. Four times as many family members classified their child care arrangement as full day than reported half day.

Finally, several state-run agencies and initiatives were mentioned as services accessed by the session participants. These include the Department of Social Services, the Health Department, the NC Infant and Toddler Program, and Child Care Resource and Referral (CCR&R).

The characteristics of service options that made them accessible include visibility, proximity, and matching up with needs of families. All respondents appeared to be aware of providers of basic needs supports, such as WIC, SNAP, Medicaid, and local transportation partly because health departments, clinics, and friends and neighbors shared information about them easily and readily. When families have difficulty getting to service providers, either due to lack of transportation, needed child care for their other children, or travel burden, they become unable to use the services, even if they know about them. Local community agencies and groups proved to be a common and useful resource for people needing assistance, because they were able to tune in directly to the needs of their neighbors.

AVENUES FOR LEARNING ABOUT SERVICES

Listening session attendees were then asked how they learned about the services they used. Seven primary means of obtaining information about services surfaced in the analysis of the session transcripts. A frequency distribution can be found in Table 3. Respondents learned about services from (1) other services; (2) other people; (3) medical personnel; (4) personal experience; (5) the internet and social media platforms; (6) schools; and (7) flyers and posters.

Table 3. *Frequency of Coded Themes: Avenues for Learning About Services*

Theme	N
Other services	59
Other people	49
Medical personnel	44
Personal experience	38
Internet/social media	14
School	12
Flyers/posters	6

Getting information from other services was the most common method families used to get connected with other services that they needed. In some cases, individual service providers were cited as being particularly helpful in making connections for communities. Health departments, WIC staff providers, and Head Start staff were common sources of referrals.

We've got two children, one just turned four and the other one nine. And, we received information about this program (Head Start) through social services, and once here, through this program, we've received the information about everything.

(WIC) social workers. Once you meet one social worker, they all talk, say everything about everything else. Or they hook you up with another one who knows.

Oh, I think the WIC program does really well with trying to help you find the resources that you need and giving information about other resources. I think what works well is individual employees, not the program as a whole cause you'll find individuals who leads in different programs that truly want to be there and truly care and they're the ones that make it work. Everything else that makes it really difficult to get through. If we didn't have them, it'd be worse.

Hearing about services from other people, either friends and family members or sometimes just via word of mouth proved to be almost as common a method of hearing about other helpful services.

Parent 1: *Most talk about word of mouth. Somehow, it'll happen. You hear about such and such and they'll tell you about it.*
Parent 2: *It's a bunch of word of mouth that I find out about a lot of stuff. Right?*

I feel like there's probably even more services that I don't know about, but it's just more as I meet people. So, I feel like most of the service around here you end up finding through word of mouth…

Medical personnel, at clinics, hospitals, health departments, and in private practice often provided helpful referrals and suggestions to families.

Aha. When I was asked for vaccines from the older girl, I went there to give her the vaccine and had to take the other three boys to also vaccinate them and there they gave me the WIC information.

My child's doctor, because of the baby having Down syndrome. She actually started with the CDSA first and then we found out that the two-year-old has a speech problem. Then she started like that.

Personal experience also played a role in knowing where to turn.

I am my resource person. Because like (participant) said, we help others and help yourselves, and never in a million years did I thought that I would be adopting a child at this age in my life. So, it's like I already knew a few resources to use like WIC and the health department and social services got me on the right track. What do I need to do next because the first day, that I actually had her, got her, I brought her here with me because I knew what they do.

Basically, by having children before and going through the same system, I knew that they had a program already available.

Parents shared instances using the internet and social media, of googling their children's conditions and services needed to find out where to turn. Some communities spoke of helpful social media groups, especially when parents are looking for family activities and needed supplies such as car seats, sports equipment, clothes, and other material needs.

I find out sometimes about a lot of stuff just through Facebook. So social media is really great for that. The Parks Department had a circus coming into town. So, one of my friends told me about it, but then she shared the event. I'm like, "Oh wow, circus, $10. This is great."

Facilitator: *Nice. How else did folks learn about the services that they use?*
Parent 1: *You said how? Word of mouth, Google.*

Information was shared by schools …

At the center where my daughter goes, the coordinator always has that kind of information. If you are looking for those services, she refers you to those places and they are free.

So, the school has this thing as we have kids in school. Like if it's a community thing, sometimes they will call you for work. And if you have school age kids and your phone number is on file, they call. It's like a mass communication call. But someone like her don't have school age kids know nothing about it. I do because they call us on the phone because I have school age kids and said there's someone who'll provide this, this and this. So that's how I knew about it. But that's why I'm saying it's communication. Not everybody's going know about it.

…and through flyers and posters at local gathering spaces.

Facilitator: *Okay, and these ads, papers they leave, were the same usually?*
Parent 1: *In the clinics, in the clinics where you go. And I think I saw it in the library, too.*
Parent2: *In the laundromats.*

BARRIERS TO ACCESSING SERVICES

Families were asked to describe what was not working well for them. They were open about the barriers they faced in receiving needed supports for their families. Barriers summarized into four main categories: (1) too few services, (2) communication, (3) regulations and policies, and (4) stigma and judgment.

Too few services. More child care slots, including nontraditional hours, medical services, and specialized services and therapies are most in need. Frequent turn-over in service providers was also reported in child care and case worker situations.

The Early Head Start has such a long waitlist that they've closed some of the Head Start classes to open up more Early Head Start.

I used to live in XXX and it's like every corner there's a daycare. I feel like if there was more daycares around here, than there was grocery stores, then I feel like it would help out a lot. And I mean I know yesterday was still be. But we have three auto parts stores here. And I'm like, "What? Only two daycare, three daycares?"

We could use some doctors around here. Like closer in town where is easy access to the dentist? Definitely, yes. We have Dr. XXX but her office here is small. She's open only one day a week here in town. And when she's open everybody in town is there on a Tuesday. So, it would be nice to have other services like dentists' and doctors' offices that are closer in town.

There were many reports of "a waiting list that's not ending" for child care and other services and inequity across communities, resulting in families having to travel extensively to access services (particularly for medical and special needs specialists). Speech/language therapy, autism services, and extended hour and non-traditional timed child care options are in high demand, as is reliable and convenient transportation assistance. The following excerpts from the transcripts of the sessions and interviews highlight the service-based obstacles faced by NC's birth-to-five children and families. Relatedly, transportation to services was cited as a barrier, particularly when families had more than one non-school aged child and transportation services only accommodate the parent and the child receiving the services, so home-visiting mitigated these concerns.

Finally, after one year and a half on the waiting list, they did test, and he meets the criteria for autism. He got it. So, for me, one really bad experience because I couldn't find any way to do it sooner when he was small. I tried with Head Start, they don't want to accept him because the salary.

Parent: *It's really hard. There was a time when I was driving a total of, round about 800 miles a week to get my kids to where they needed to go every week and get to work.*

Another issue that I find is child care that's not open late enough, not open on the weekends. I had a lot of job offers, like third shift. I couldn't take them because of child care. They're not open on Saturday.

Personal experience also played a role in knowing where to turn.

I am my resource person. Because like (participant) said, we help others and help yourselves, and never in a million years did I thought that I would be adopting a child at this age in my life. So, it's like I already knew a few resources to use like WIC and the health department and social services got me on the right track. What do I need to do next because the first day, that I actually had her, got her, I brought her here with me because I knew what they do.

Basically, by having children before and going through the same system, I knew that they had a program already available.

Communication. Communication was a frequent obstacle to families getting the services that they need for the adults and the children in their families. Local community supports have an important role in helping families meet needs, but their advertising systems need networking and expanding. Information sharing across agencies is not very fluid. Requests for complete lists of all available services and programs was a frequent comment. This excerpt illustrates the frustrations felt by many parents:

I mean I know that that's not their program, but just when I'm just trying to find out some information, it'd just be nice. Even today I had asked at WIC for my friend … who was supposed to be here, and I've heard there's a place where you can get diapers at some health center or some women's center, I don't even know where it is. So, I was asking WIC, because we went to the XXX Center. I'm like, "Oh, do you know where we can … Do you guys do the diapers?" And they're like, "Oh no." And they were like, "I know there are other places that do it." And I was thinking to myself, "Well it would be nice if you'd tell me what those other places are, because I don't know where to go."

Communication challenges encompassed several themes, the most pervasive of which was the lack of a state-wide system or network of getting information to families about available services and how to access them. The search for information was described as "the octopus approach" by one parent. Many, many examples abound:

Looking for information. Nobody's telling you anything. Child care, nobody's telling you you can get subsidy for your child. Nobody's helping you get speech therapies for your child. You see every other child can talk. They can speak. But your own child can't. Nobody is pushing you into the light telling you to see what is happening.

Because there's a lot of referrals and outsourcing going on, everybody's not on the same page. The main agency that is helping you or establishment that's helping you has more information than where you are. Then you got to try to play catch up or try to understand what one is saying. You're getting misinformation, misconstrued information, even no information.

Families needed translators and interpreters who also have content knowledge (including medical services).

In my case, I moved to United States like seven years ago, when my son was like six months old. So, my case, I'm not from here. It was really hard to get information because in my country, my home country, it doesn't' exist. Some of them they're different. So, in this area, at least for me, maybe Latin people, it's really hard to get information.

It's really hard for explain what is happening in the home…And more with ladies translated sometimes it's confused. Because in English it's saying different with the Spanish. It's so different. And (name) say, I know a lot of people…Spanish people have a lot of problem with social services with translate.

***Regulations and policies*.** Regulations and policies were reported as frustrating, vague, and in some cases, like with Medicaid and SNAP, left holes in the support that families need. Gaps in services as children aging out or family circumstances changing was a real concern for parents throughout the state.

Okay. Yeah, that's tricky. If you're changing circumstances, make it difficult to continue. I know other families have talked about this tricky spot between being eligible for services and then when you are employed, and your income goes up a little bit then not being eligible but still having need and being in that state.

We keep running into her missing a whole month waiting on the Medicaid to approve more when obviously if she's three and she's not hopping and she's not doing stairs successfully, she definitely needs the PT. And the OT she needs as well, but we haven't run into problems with them letting that overlap. I mean, they set them up for a certain amount, and you'd think that the physical therapist could tell them in advance, "Yeah, she's going to need more," to where it would pick right up and go more, but she's missing, twice now she's missing a month. I mean she's still missing a month. Now she's finally approved, and unfortunately the physical therapist is out sick. That's what we've run into problems mostly is right there, and then the ABA.

Stigma and Judgment. The FPG team noticed 34 cases of family members reporting times when they felt racism, stigma, and/or negative judgment associated with asking for and/or receiving services for their families or from service providers who did not honor family members' perspectives on the needs of their children. Plans for systemic racial equity and cultural humility training for service providers may be in order. The following excerpts illustrate family members feelings:

But what I've seen is that there are racist there, because there are moments that say things or talk while in the room and I think they think we don't speak English. And we understand them, and it makes us feel bad.

We don't feel comfortable that we're there. And there have been times when I had to leave that hospital because the things I hear aren't right. It's hard for me. It made me feel bad.

So, it's like, "Do I reach out and be vulnerable to them because I need the help?" Or do I sit here and just be like, "You know what? Let me just struggle between if I'm going to pay the rent or pay day care or kind of thing." So, it's you don't know what's out there because you afraid to go ask. Because, you don't want them to be looking at you like, "Oh, he's just trying to get a hand. But he really don't need a hand." And I think that's the thing. Why you don't want to reach out. It may be services out there, but you are afraid to reach out. Because even though you're at home and you're trying, you're working and you're going to school. I still need just a tad bit of help to help me. And I feel like when you go up there it's just like, "Here's another one. Here's another statistic that needs help that is not trying."

But they don't know my background. They know nothing I'm going nursing school. You don't know that I'm working full time. You don't know.

WHAT IS WORKING WELL

Participants were also invited to talk about which services and programs were working well. By and large, the services that families were accessing were helpful and supportive and participants were appreciative of the benefits they provide to their families. When asked what was working well, most people named the services themselves. Connections with people who provided support were also discussed. Of the services named, WIC, Head Start/Early Head Start, SNAP, and Medicaid were most often (and highly) praised. These are also the services most often cited as accessed. The families who had children with disabilities were grateful for and complimentary of the specialized services that they access, such as speech and language therapy, physical and occupational therapy, and therapy for autism when these services were available. Home visiting assessments and treatments helped families by providing the needed interventions while coming to the home, thus minimizing the travel burden. Some communities had local agencies, organizations, and groups that provide things for families such as food banks, diaper trains, book programs, and car seat initiatives and when those were available, families reported them to be very helpful. Provisions of food and family activities and ways to connect with other families were the most appreciated.

I was going to say a plus too with the Head Start. I find they get the get the families involved. Where they do parent and child. They get the parents to come in and do stuff in the facilities when they got someone on account of keep that whole family involvement thing going on…

It's been a few years. But when I knew they had… they didn't celebrate Halloween, but they called it Orange Day. And everybody got to wear orange and you just got to come in. And the parents they had little stations for the kids that play in and do stuff. And the parents ran all that kind of stuff. So, it was like the parents got involved with everybody's kids, and with their own kids. They always have information sessions. I think it's once a month maybe. And they invite you to that. Where you get to come up, they provide dinner and they talk about different stuff in the community that you can be involved in. Or just ways… I know one time I think… I feel like it was on resume writing and how to find a job or some stuff where they had different education workshops that they try to invite you out to. So, I think that's a plus.

NEEDED PROGRAMS AND SERVICES

Last, the FPG team asked if there were services or programs that families needed and encouraged participants to share their thoughts. Thoughtful discussions emerged in each of the sessions, resulting in six main categories. In order of frequency of appearance with the first being discussed the most often, the six types of wishes were: (1) more information; (2) child care and funding for child care; (3) services for adults to help them care for their children and families; (4) parent networks and community support groups; (5) affordable family activities; and (6) basic needs supports. The number of times each theme was coded can be seen in Table 4.

Table 4. *Frequency of Coded Themes: Needed Programs and Services*

Theme	N
More information	49
Child care and funding	41
Services for adults	40
Parent networks	32
Family activities	21
Basic needs support	16

More information. There were a pervasive need for a comprehensive, networked system to notify families about available services in an area and how to access them. Participants shared this idea in every session, and a few even offered suggestions for ways to increase families' awareness and knowledge.

If there was a way to put it all together, but not just, here's a 17-page document of things that three of them will apply to your child and the other 1700 won't. Some sort of way to filter without getting overwhelmed and come up with this many options, or hey this is your only bet, or I'm sorry we have nothing. Even if I knew that nobody out there did what I needed, at least I would know I had gone through everything without having to call 1700 people to find out nobody did what I needed.

Yeah, I know money's always an issue. I wonder if it could be like a project for like a college thing for them to develop an app or something. Seriously, why is there not an app? It's 2019, somebody could get all that information and do some kind of algorithm and make it an app.

I have a suggestion. I remember at the beginning of this year I received the water quality something (in the mail). Why don't they send a letter to each home like in the mail? Once or twice a year. We have these services if you have child with this condition. You know, this kind of stuff to reach every home at least here. I don't know. In Spanish and in English.

Child care. The need for enhanced child care options – shorter waiting lists and more slots, alternatively timed child care availability that is outside of "regular business hours", and more affordable quality child care were mentioned often and in all areas of the state. Child care especially seemed to have been a very big issue for families being able to find and maintain work.

Basically, we need more child care, just child care.

Yeah, (child care) would be a big one for my life, child care. It seems like you have to have a caseworker or someone to advocate for you for you to even, you know what I'm saying, get the help, or you have to... I don't know. Like I said, I think child care would make a big difference. My kids go to summer camp Monday. If I can get this little guy in daycare, I will be okay. My stress level will go from here, just a little bit, to right here. I don't know, just got to be patient with it because everybody's situation is different. Yes, because they're not going to move on our time unless we keep bugging and bugging and bugging them. It's just a process that everyone has to go through.

Child care is important because not everybody can afford child care. If we're working minimum wage jobs, how are we going to afford it? Child care is, what, $400 a week? A month?

Services for adults. Participants shared ideas for some specific programming and opportunities that would help them directly and ultimately help them to better care for their children and families. These ideas included (1) English language classes held at times that coordinate with work schedules and child care availability; (2) better access to interpreters with content knowledge in medical, educational, and support environments; (3) access to postpartum depression support; (4) "drop-in" child care for young children with disabilities so that parents could run errands alone or spend a few hours to tend to personal needs; (5) parent education on advocacy, laws and rights under Individuals with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA), sign language, and child development; and (6) cultural competency training for service and medical providers. Many listening sessions served as a beginning parent support group. Some sessions ended with the participants organizing themselves into networks and sharing information with each other, because there were none otherwise available.

Parent networks. Families strongly advocated for parent networks. Families needed support for themselves as well as their children. Especially for parents of children with disabilities, the need to connect with other parents of children with similar concerns was voiced often. The listening sessions themselves proved to be an important vehicle for families to connect and share information. Some groups made plans to share information and organize themselves into a support system following the session.

Facilitator: *Great. That's part of what we've seen in these sessions is sometimes families are sharing, parents are sharing information with each other about the programs and especially if you're working with an agency that's helping facilitate that.*

Facilitator: *I love that you guys are networking, but I'm going to keep us going.*
Parent 1: *Sorry.*
Parent 2: *Sorry.*
Facilitator: *No, it's okay. I love it. I truly do. So, keep sharing, maybe after, but we have about a half an hour and we have a few more questions that we want to be sure to get through.*

I wish they would've done something like that. I wish they would've done a meeting for parents during these programs so that parents can get together and compare notes or I could give you input on … that would help you get what you need for your son. Some stuff like that, some where we've already been through the fight to share it.

Whatever's convenient. Because I'm not working any longer, so I'm kind of free. But you know, an hour, a couple of hours. I think it's necessary. I think we need it. Knowing you're not alone, knowing that there's someone that understands what you're talking about. Education is the key.

Family activities. Rural communities expressed a unique need for free or reasonably priced places to take children and family members for activities, such as pools, local parks and recreation programs, indoor play areas for cold weather months.

We have no place. Literally, no place. During the summertime, we take them to the park, we let them play outside. During the wintertime …From October until about March … A big gap.

All the festivals are for adults. They're not meant for kids. The ones that are meant for kids that XXX or the health department does try to do. They don't do so great. They had a petting zoo a couple weeks ago. They had two goats … Three goats out there. That was the petting zoo.

Basic needs supports. Additional supports for housing, health care, clothing and diapers, and reliable transportation remained on respondents' wish lists. These needs were greatest for people experiencing extreme poverty and homelessness and for migrant families who were learning English.

SUBGROUP THEMES

Listening sessions were conducted with several subgroups: dual language learners, migrant families, tribal families, families experiencing homelessness, rural families, and families with children with special needs.

Dual Language Learners (DLL) Subgroup. Thirty-five individuals across four listening sessions and five telephone interviews comprised the participants of the dual language learners (DLL) subgroup. Unique themes that emerged were:

- Not having service provider staff and information readily available in their native languages makes accessing supports even harder.
    - *Because my son received therapy in Asheville and the teacher speak in Spanish and speak in English. But we can't go Asheville two weeks and two weeks and two weeks. I can't.*

- Families reported that papers come home from schools and/or child care centers to be signed, but without being able to understand in their native language, they do not know what they are signing. Interpreters who also have content knowledge are needed desperately in all areas: medical, child care/schools, community groups (including places like the drivers' license offices), and specialized services and therapies.
    - *Why don't they send information to every home with the services that exist and in Spanish, too. I'll volunteer to translate.*
    - *In this country you are scared to talk when you don't speak English.*

- Conversations with other communities throughout the state are needed before NC has a full sense of the successes, challenges, and needs of the state's full population of DLL families. Home language support difficulties were great for the families with whom we connected, and knowing what languages other than Spanish are spoken should be a focus.

Migrant Subgroup. A total of 8 individuals across two listening sessions comprised the participants of the migrant population subgroup. Their unique responses were as follows.

- Immigration status affected whether they were eligible to access certain services. Some families had children who were born in the United States and in other countries, and based on this information, they could not always get the same things for all their children. This even happened at church outreach groups.

- Another challenge faced by migrant families related to their immigration status itself. They repoted living in fear of deportation and this concern sometimes kept them from accessing services.
    - *If you start talking to them or if you misbehave, and being Hispanic, they talk to immigration.*

- Like the families in the DLL group, migrant families had challenges with language translation – both the language itself and content knowledge for individual services like medical, child care, DMV, etc.
    - *It totally depends on who is talking to you, because she noticed a difference when she was talking with a Spanish social worker and when she went to talk with Americans. They ask different questions, or they put different food on their account.*

- A final challenge to getting information about services was the stigma and judgment felt by families. The following examples illustrate their experiences:
    - *They're like… Rude. Like they don't want to work, or like they look at you that you don't bring Medicaid or a certain insurance you don't … you're the last. You don't count. And I've noticed that when I take my child, they take good care of him. But if I take my husband, who has no insurance, he doesn't count. He stays until the last one.*
    - *But what I've seen is that there are racist there, because there are moments that say thing or talk while in the room and I think they think we don't speak English. And we understand them, and it makes us feel bad. We don't feel comfortable that we're there. And there have been times when I had to leave that hospital because the things I hear aren't right. It's hard for me. It made me feel bad.*

Tribal Subgroup. A total of seven individuals across four interviews and one listening session comprised the participants of the tribal population subgroup. Unique themes were:

- This was a tight-knit community and members worked hard to keep each other informed.
    - *I found about the program whenever my oldest son went through the tribal child care program. And I was working at the program, and I was one of these mothers, with a first-time mom and was on the program through the daycare, and so the lady that was over that program was actually the lady that started the Baby FACE program too.*

- Part of the challenge with establishing providers for this tribal population was finding professionals who were fluent in the experiences of members of an indigenous community. One participant explained this challenge succinctly:
    - *I think a lot of that has to do with you're dealing with an indigenous community and you're bringing in western therapies and there's a clash there. I think our community as a whole is dealing with that, trying to figure that out.*
    - *He was a white person and he was a really great therapist, but we had a long conversation about how we spent over half the time of me explaining indigenous experiences for him to understand what I was talking about before we ever got into the actual therapy and whenever you're dealing with indigenous person there's certain things you don't have to explain. And that's really hard to deal with. I know that goes across all the health care occupations.*

- The rural location of their community only served to intensify the challenge of establishing and maintaining service providers given the geographical remoteness of services and activities.

- The intense connection to each other and to the group was a special feature of this subgroup that was not seen elsewhere. The tribe supported its members in ways that other communities did not. Because everyone was connected to each other, services were delivered with shared goals in mind.

People Experiencing Homelessness Subgroup. A total of 11 individuals from two listening sessions comprised the subgroup of people experiencing homelessness. Key themes from that group were:

- This was the only subgroup that talked unanimously about being on the waitlist for and receiving child care subsidies

- Some participants accessed mental health support for themselves and their children and found it very important.
    - *Mental health referrals, I worked … going from a home environment to a shelter or motel. It changed my children just a little bit, especially my little one, because he's always been in a home, even though the last place wasn't necessarily my home. It was my sister's, but it was a home Then coming to here, it was like, well, first of all the first 10 days you stayed in a motel and he was starting to act out. Very good as far as now I can get them so that when we do transition out, it's there. They can verbalize now with someone else, not that they can't verbalize with me, but when you're talking to your own children, you can't get the wording or you are not asking the right questions for them, where a therapist or a coach or somebody can get that questioning from them and they're able to articulate their feelings a little better.*

- This particular group of parents had a unique and urgent need: housing. They were able to secure temporary shelter for themselves and their families, but they were in temporary quarters and avidly pursuing housing assistance.
    - *They want you to go to rapid rehousing because you get out of here so much quicker. Oh, let's just shove everybody into rapid rehousing, but there's a lot of people that rapid rehousing may not be beneficial for because rapid rehousing only pays you to get in. Rapid rehousing pays your first month's rent, your security deposit, your past due water and electric, and the deposit. For me personally, a place to stay on my own, to be real. That would make everything much better.*

- Challenges faced by this community manifested at the family level, affecting all members. Common themes included needing child care slots that extend past the usual hours of 8:00 AM to 5:00 PM, stable housing, a networked system for sharing information about available supports and services in an area, and help navigating regulations and policies that create gaps in eligibility for services. A comment from one participant summed up this experience clearly: *"if you're not struggling hard enough, you're not a problem yet."*

Rural Subgroup. The majority (78%) of the participants represented rural communities. A total of 69 individuals from 10 listening sessions and five interviews comprised the subgroup of people from rural areas. Unique themes from their responses are presented below.

- Rural communities had weaker knowledge systems for sharing news about service providers and options than more suburban or urban communities.

- Home visiting assessments and treatments helped families by providing the needed interventions while coming to the home, thus minimizing their travel burden.

- Providers themselves were concerned that their staff was spread too thinly across many counties and acknowledged that families were not receiving optimal contact hours.
    - *I get, for service, you keep coming back to service delivery. So, for this area, northeastern North Carolina, we're so rural that I notice that a lot of us, I guess I'm speaking out as through my job, we cover different counties. Like at any given time, we're an eight-district health department, so we can cover eight health departments. Just like with the school systems are stretched. When I call and try to refer my clients, I'm calling five and six times, myself, during the day trying to refer some different programs where other people are also covering not just that county, but they're covering … I mean, you're covering this huge span. The priority, and I don't know that this makes any difference of what I'm saying, but the priority is are we going to have people stretched so thin and we're just like touching people, or can we have one person doing a service for … Do you see what I'm saying? That's frustrating, and I think that's how a lot of other professionals are. We're covering large quantities.*

- Parents lamented the lack of local specialized services and therapies and the burden of having to travel great distances to reach the ones in other cities. One parent stated that *"you have to be able to drive."* Local community supports were less common and plentiful in the most rural areas than in denser locations. Local family activities were few and far between.
    - ***Parent:*** *But here in XXX, no.*
      Facilitator: *So, you had to move your daughter to Raleigh.*
      Parent: *Yeah to get services.*

- Creation of parent networks was another frequent request, as was additional child care slots, the establishment of a comprehensive, networked system to notify families about all available services and how to access them. Service providers reflected directly on this need:
    - *Oh, that's very important for me to know now is what she's saying. A lot in the community we don't know about it. I am the only Latin community between Greensboro and Raleigh. And I receive calls from Girl and Boy Scouts, Salvation Army, United Way, with different agencies trying to help us, but I never receive any approach from the department of social services at all trying to find out how to help our community.*

- This particular group of parents had a unique and urgent need: housing. They were able to secure temporary shelter for themselves and their families, but they are in temporary quarters and avidly pursuing housing assistance.

Families with Children with Disabilities Subgroup. From the demographic information provided by the participants, 40 children with disabilities were in the families across the state with whom the FPG team conducted listening sessions and interviews. Key themes included:

- Speech and language therapy was the most commonly mentioned therapy. Some children received these supports in Head Start/Early Head Start or NC-PreK, while some got them from other locations such as the local Children's Developmental Services Agency (CDSA), private practitioners who accept Medicaid, and the NC Infant and Toddler Program. In addition to speech and language therapy, families mentioned asthma, autism, behavioral, play, physical, and occupational therapies.

    - *Oh, I do want to go back to one thing. My son who is five and autistic is not potty trained, and it took going to the circle of parents and other parents letting me know that Medicaid covers the Pull-ups! I had been spending so much money and penny pinching to make sure that my child had something to cover his hiney because we're trying hard, but he just doesn't feel the sensation before it comes. We've been down here four years. It took three years to finally find out. For the last two years we've been paying for diaper that we didn't need to be paying for, and again, that's where I found my information, the circle of parents through XXX.*

- The distance families must travel in order to get assessments, as well as services and therapies for their children, was a real challenge.
    - *We're originally from XXX County, and XXX pediatric specialties. It's terrible. If you want any kind of pediatric care outside of your regular pediatrician, your closest bet was Raleigh. And we would get referrals, and they said, "Do you care Duke or UNC?" And I was like, "Whoever can see him quicker."*
    - *What happens is when you get transported you can't take two or three kids. And sometimes I don't have a place to leave them.*

SUMMARY

Characteristics of service options that made them accessible and useful included visibility, proximity, and matching up with needs of families. WIC, Head Start/Early Head Start, SNAP, and Medicaid were highly praised services. Families who had children with disabilities were grateful for and complimentary of the specialized services that they access, such as speech and language therapy, physical and occupational therapy, and therapy for autism when they were available. Home visiting assessments and treatments helped families by providing the needed interventions while coming to the home, thus minimizing the travel burden. Some communities had local agencies, organizations, and groups that provide food, other material provisions (such as diapers, care seats, and clothing), family activities, and ways to connect with other families.

Six categories of needs surfaced from families' feedback: (1) a comprehensive, networked system to notify families about all available services in an area and how to access them; (2) enhanced child care options – shorter waiting lists , more slots, alternatively timed child care availability, and more affordable quality child care in all areas of the state; (3) services for adults to help them take the best care of their children and families (English language classes; interpreters with content knowledge in medical, educational, and support environments; postpartum depression support; 'drop-in" child care; parent education classes; and cultural competency training for service and medical providers); (4) parent networks and community support groups; (5) affordable family activities; and (6) basic needs supports and specialized services and therapies.

RECOMMENDATIONS

- Better understand the need for weekend and/or second and third shift child care coverage
- Better understand what other language and content-competent translators and interpreters needed
- Hold English language classes at times that coordinate with work schedules and child care availability
- Provide better access to translators and interpreters with content knowledge in medical, educational, and support environments
- Provide access to postpartum depression support
- Provide "drop-in" child care for young children with disabilities so that parents could run errands alone or spend a few hours to tend to personal needs
- Conduct parent education on advocacy, laws and rights under Individuals with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA), sign language, and child development
- Provide cultural competency training for service and medical providers
- Develop an app that would serve as a directory of available services and supports, contact information, and eligibility requirements

Appendix G: Provider Survey Report

This survey was developed to collect input from licensed child care directors and family child care providers to identify, describe, and address barriers that they face in providing high-quality ECCE services, including facility-related concerns and funding challenges in North Carolina. Analyses and summaries of quantitative and qualitative data were synthesized into this final report. Results from the provider survey should be interpreted with caution. Surveys are cost effective and allow for data collection from a large number of respondents but are not without limitations. Limitations include response bias as providers who were willing and able to complete the survey may have been different from those who were not, participants might have opted out from answering some questions, respondents might not have felt comfortable providing honest responses, and/or survey questions might have been interpreted differently by respondents leading to inaccurate data.

SURVEY PARTICIPANTS

A total of 4,443 early child care education professionals were invited by email to complete the online North Carolina Need Assessment Provider Survey between 8/1/2019 and 8/30/2019. There were 1,145 providers who responded, yielding a 24.5% participation rate (Table 1a). Among those who responded, 35% were providers from home-based child care. Across both center-based and home-based providers who responded, most were in direct/administrator or owner roles. Over 80% of providers in both groups had over 10 years working in Early Childhood Care and Education (ECCE). Across respondents, the most heavily represented program types were for-profit center-based care and home-based care, followed by non-profit center-based care and then NC Pre-K. Less than 10% of respondents were from faith-based, Head Start or Early Head Start, public preschool, or multi-site center-based child care programs. As shown in Table 2, most providers indicated that their program met the definition of high-quality (i.e., a 4- or 5-star rating).

Table 1a. *Respondent Information by Program Type*

	Center-Based Child Care (*n* = 747, 65%)		Home-Based Child Care (*n* = 398, 35%)		Total (*n* = 1,145)	
	N	**%**	**N**	**%**	**N**	**%**
Respondent Role						
Director/administrator	638	75	57	11	695	61
Owner	168	20	154	29	322	28
Family child care provider	11	1	309	59	320	28
Other	32	4	7	1	39	3
Years working in ECCE						
Less than 1 year	5	1	5	1	10	1
1-2 years	17	2	18	5	35	3
3-4 years	25	3	9	2	34	3
5-10 years	72	10	48	12	120	11
More than 10 years	620	84	318	80	938	82
Program type						
Non-pro it center-based child care	236	23	6	1	242	21
For pro it center-based child care	388	39	19	4	407	36
Multi-site center-based child care	34	3	1	0.2	35	3
Home-based child care	0	0	398	89	398	35
NC Pre-K	160	16	8	2	168	15
Head start/Early head start	52	5	6	1	58	5
Public school program	49	5	4	1	53	5
Faith-based	87	9	3	1	90	8

Note. The percentages for Role and Program Type may not add up to 100% due to multiple responses.

Table 1b. *Respondent Information by Star Rating*

Star Rating (*n*=1104)								
	1-2 Stars (*n* = 69, 6%)		3 Stars (*n* = 211, 19%)		4-5 Stars (*n* = 756, 69%)		Notice of Compliance (*n* = 68, 6%)	
	N	%	N	%	N	%	N	%
Role								
Director/ administrator	20	23	105	39	489	54	65	96
Owner	26	30	78	29	201	22	2	3
Family child care provider	39	45	83	31	186	21	1	1
Other	1	1	6	2	31	3	0	0
Years working in ECCE								
Less than 1 year	2	2	2	1	2	1	0	0
1-2 years	5	7	12	6	14	1	1	1
3-4 years	3	4	7	3	16	13	8	12
5-10 years	8	12	16	8	79	14	11	16
More than 10 years	51	75	174	82	645	71	48	71
Program type								
Non-profit center-based child care	9	13	28	12	157	16	41	42
For profit center-based child care	15	21	82	34	297	29	2	2
Multi-site center-based child care	0	0	2	1	33	3	0	0
Home-based child care	47	66	107	45	228	23	1	1
NC Pre-K	0	0	5	2	161	16	0	0
Head start/Early head start	0	0	4	2	53	5	1	1
Public school program	0	0	2	1	51	5	0	0
Faith-based	0	0	8	3	28	3	52	54

Note. The percentages for Role and Program Type may not add up to 100% due to multiple responses.

Table 2. *Program Information*

Variable	Center-Based Child Care (*n* = 739)		Home-Based Child Care (*n* = 397)		Total (*n* = 1136)	
Star Rating	**N**	**%**	**N**	**%**	**N**	**%**
Temporary	5	1	13	3	18	2
Probationary	6	1	1	1	7	1
Special provisional	7	1	0	0	7	1
One star	19	3	22	6	41	4
Two star	3	1	25	6	28	3
Three star	104	14	107	27	211	19
Four star	175	24	166	42	341	30
Five star	353	48	62	16	415	37
Notice of compliance (religious sponsored)	67	9	1	1	68	6

SUMMARY OF SURVEY RESULTS

Below we present survey results highlighting key take-aways for the four Needs Assessment areas: (1) providing high-quality ECCE, (2) ensuring that children are on-track for school success, (3) fostering social-emotional resilience, and (4) creating conditions for supported and supportive families. Detailed data describing the frequency of responses and emergent themes are presented in tables following this summary. These tables present disaggregated results for center-based and home-based ECCE programs. For selected tables, data are further disaggregated by star rating, and also include programs with a notice of compliance.

High-Quality ECCE

- Most programs (57%) reported maintaining a waitlist (63% center-based vs. 47% home-based). For each program type, about 3/4 of programs reported having a waitlist for children ages birth through 3 years. Centers were more likely to have waitlists for ages 3-5 years (63% vs. 25% for home-based).
- Approximately 3/4 of providers from both center- and home-based programs indicated that they enroll all age groups of children. Two exceptions to this were that 62% of home-based providers enroll 4-5 year old children, and 71% and 50% of center-based and home-based programs, respectively, currently enroll infants.
- About 2/3 of respondents stated that there is a need for additional facilities that enroll infants; more than half of the primary reasons given for why additional infant and toddler care is needed were extensive waitlists.
- For providers who do not enroll infants the most common reason given for why not was that they enroll children of other ages including pre-K, toddlers, and school-aged children indicating that "other" programs provide care for infants. The second most common response among center-based providers was the lack of facilities to accommodate infants.
- A total of 82% of respondents accept child care subsidies (85% of centers, 77% of homes). The top four reasons for not accepting subsidies were policy, accepting other forms of subsidy (Head Start, NC PreK; center-based programs only), no requests (lack of need), and regulations (too complex). Home-based programs more frequently reported that they had not received requests to accept subsidy and that they were not eligible for subsidies because of star rating. Not surprisingly, 87% of 1-2 star programs indicated they do not accept subsidies, whereas more than 90% of programs with 3 or more stars accepted subsidies. For programs with a notice of compliance, 60% accepted subsidies.
- Close to 70% of center-based programs report enrolling dual language learners (DLLs) compared with 16% of home-based programs. Spanish was by far the dominant language other than English spoken by children and their families. About 60% of 4-5 star programs and programs with a notice of compliance enrolled DLLs, compared with 30% of 1-2 star programs enrolling DLLs.

- Compared with home-based programs, a greater proportion of center-based programs enrolled children with disabilities (59% vs. 13%). Over 50% of 3-star and 4-5 star programs enrolled children with disabilities, compared with 28% of programs with a notice of compliance and 10% of 1-2 star programs.
- The vast majority of programs (90%) reported that staff have access to Technical Assistance offerings. Of the relatively small number who reported "no," providers from center-based care indicated "other reasons," and equal proportions (about 24%) endorsed lack of general availability, lack of interest, or specific topics of interest were not available. For home-based providers, the most common reasons they reported "no" were "other reasons" and lack of interest. Access to TA was greater in higher quality programs, and lower quality programs were more likely to cite lack of interest for the reason why they did not access TA.
- When asked which technical assistance supports are needed to improve quality, the most popular answer across program type was supporting children with challenging behaviors (81%). The next most highly endorsed options were general coaching for teachers, children with special needs, family engagement, and high-quality services for infants and toddlers. Transitions, supporting DLLs, and effective business practices were mentioned by less than half of respondents. These patterns were generally consistent across program type and star ratings. For respondents who indicated "other," most providers reported that no TA was needed to support their programs. The second most common response was wanting TA to help with program operations, which included a wide array of services spanning health, grant-writing, recruitment, and regulations.
- Nearly all center-based providers and about 91% of home-based providers indicated that they/their staff have access to professional development. For center-based programs, 80% of providers indicated that they have staff currently enrolled in formal ECCE coursework; about half that rate was reported for home-based providers. Access to professional development and enrollment in coursework increased with program quality. When asked why staff were not enrolled in coursework, the two most common reasons were that they do not have staff (home-based providers) and that their training was already complete (center-based providers). Center-based providers also reported not having an interest and cost as reasons why staff were not enrolled in coursework.
- When asked what supports would make a difference for their programs, the most common support noted was funding, including higher subsidy reimbursement rates. This was true for all providers. The next most common response was not needing any supports, which was particularly salient for home-based programs. For center-based programs, training and personnel (i.e., specialized staff, contractors, behavior specialists, therapists) were the next most common areas in need of support.

On-Track for School Success

- When asked why infant and toddler care was needed, providers described how this would help children be successful in school in the future.
- Regarding services for children who have or who are suspected of having disabilities, almost 60% of center-based programs offered screening services relative to 26% of home-based programs.
- In terms of specific services for children with disabilities, the most commonly provided services across programs are speech-language therapy, physical therapy, occupational therapy, nutrition services, social work services, and family training, counseling, and home visits.
- As program quality increased, so did the likelihood that programs offered disability screening and specific services for children with disabilities.
- When asked what was working well in their efforts to serve children with disabilities, the most salient response across program type was collaboration between agencies, therapists, and child care programs (45% center-based, 23% home-based). This was particularly true for center-based providers.
- For challenges, most providers, and particularly home-based providers, responded that they did not experience challenges for children with disabilities because they did not have children with disabilities enrolled. Some center-based providers reported that training for staff was a challenge or that they do not have enough staff to meet children's needs. Only a few home-based providers endorsed these reasons. About the same proportion of providers described limited access to specialists as a challenge they experience in meeting the needs of children with disabilities, and that having this service would make a difference for their program. This is consistent with data showing that programs tended to rely on contracted staff to provide these specialized services.

Social-Emotional Resilience

- For child and family mental health and health services, overall, programs were most likely to provide mental health screenings (31%) followed by mental health coordination (21%), dental services (19%), drug and substance abuse services (10%), and pediatric services (10%). In some instances, center-based programs were more likely to provide some of these services twice or more as often as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of awareness or need. Provision of these services increased with program quality.
- Of the specialized services related to social-emotional resilience, less than 5% of providers described challenges with offering behavioral supports, mental health services, and supports to help children adjust to classroom transitions; these, along with social work supports, would make a difference for their program.

Supported and Supportive Families

- Approximately 35% of center-based programs indicated that their families who speak Spanish needed language supports to communicate, compared with about 5% of home-based programs. For center-based programs, 57% reported having staff who speak Spanish. Few programs report having staff who speak other languages besides Spanish or English. In general, the higher quality a program is the more likely they have families who need language supports and also the staff who speak those languages.
- For services that can help families access ECCE services, approximately 2/3 of programs do not offer transportation directly to families; approximately 20% provide other transportation assistance. Higher quality programs were more likely to provide transportation assistance. When asked why they did not provide transportation services, providers' most common response was that there was no need, followed by not having a vehicle for transportation and concerns about the liability of providing the service.
- Services such as home visiting are a mechanism that can help families access ECCE services and provide other family support. Across both program types, about 75% provide home visiting services. When they do not, costs, lack of staff, and lack of need were identified as the greatest barriers. The higher the program quality, the more likely they provided home visiting.
- For services that aim to promote parents' social capital, overall programs were most likely to provide education/job training (34%) followed by scholarships (29%), family literacy programs (20%), and employment assistance (15%). In general, center-based programs provided these services at twice the rate as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality.
- For services that aim to reach parents with limited English skills, 16% of programs offered workshops and activities in Spanish for parents of DLLs, and 11% of program offered English classes; center-based programs were twice as likely to provide these services as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality.
- For basic needs and other services, programs were mostly likely to offer food/emergency services (35%) and financial assistance (15%), and housing assistance and legal assistance to a lesser degree (9% and 7%, respectively). Center-based programs and home-based programs provided all but financial assistance services at relatively the same rates, and center-based programs offered financial assistance services at about twice the rate as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality.

- Overall, programs tended to refer families for services rather than have their own staff provide them. The services that were more likely to be provided by staff included home visiting and transportation assistance. Services that were generally provided equally by staff or via referral included food assistance/emergency services, education/job training, and activities and workshops in Spanish for parents of DLLs. These patterns were generally consistent across program quality, although lower quality programs were less likely to provide some specific services.
- Many respondents (42% overall) reported that there were no parent needs that were not being met. When respondents indicated that parents' needs were not being met, the most frequently reported needs were basic supports like housing, transportation, jobs/employment/wages, health care, and other social services. This was particularly key for providers in center-based programs. For home-based programs, a few providers mentioned several different needs including basic needs, parent education, and child evaluation and assessment services.

DETAILED SURVEY RESULTS

ECCE Enrollment and Waitlist Trends

For each program type, most providers reported that over the last two years their enrollment has either increased or stayed the same (Table 3a.1). The greatest percentage of programs whose enrollment stayed the same were rated as 1-2 stars, with those programs experiencing very little decreases in enrollment (Table 3a.2). When asked why their enrollment might have decreased (Table 3a.3), the most frequent response was for financial reasons with a number saying this was because of limited subsidy. Others reported that decreases were because the cost of care is high. For center-based programs, the second most common response was lower demand. The second most common response for home-based programs was that providers did not know why their numbers decreased. Several reasons endorsed by fewer providers included children moving out of the area and children aging out of the program, moving to either NC Pre-K or Kindergarten in the school system.

Table 3a.1. *Enrollment Changes Over the Last Two Years by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total (*n* = 1075)	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Increased	346	50	108	29	454	42
Decreased	104	15	77	20	181	17
Stayed the same	246	35	194	51	440	41

Table 3a.2. *Enrollment Changes Over the Last Two Years by Star Rating*

Star Rating								
	1-2		3		4-5		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Increased	21	31	84	41	294	42	37	58
Decreased	3	4	46	23	122	17	6	10
Stayed the same	45	65	72	36	295	41	20	32

Table 3a.3. *Reasons Why Enrollment Numbers Decreased by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 117)	Home-Based (*n* = 70)	Total (*n* = 187)
FINANCIAL REASONS • Subsidy is frozen • Waitlist for subsidy • Vouchers suspended • Cost of care • Parent lost job • Infant care costs more	*Subsidy waiting list is over 3 years long. Way too long to get service* *The DSS Vouchers are on a waiting list and parents cannot afford child care*	45 (38%) 15 12 13 1 3 1	29 (41%) 5 7 2 12 3 0	74 (41%) 20 19 15 13 6 1
LOWER DEMAND • Lower demand for slots • Glut of options in area • School back in session • Summer • Stopped caring for infants • No alternative hours offered • Unlicensed centers taking kids	*Parents job hours changed that were outside of operating child care hours*	22 (19%) 7 10 3 1 1 0 0	8 (11%) 5 1 0 0 0 1 1	30 (16%) 12 11 3 1 1 1 1
CHILDREN MOVED	*Military families have come up for orders and some have moved. We are in a military town so we have families in and out.*	13 (11%)	4 (6%)	17 (9%)
CHILDREN TO NC PRE-K Children left our center and went to NC Pre-K	*Some children going to PreK programs in the school system*	13 (11%)	3 (4%)	16 (9%)
CHILDREN TO KINDERGARTEN		6 (5%)	8 (11%)	14 (7%)
I DON'T KNOW		1 (1%)	9 (13%)	10 (5%)
PERSONAL CHOICE	*We decided to make our class sizes smaller to provide better ratios/care.*	4 (3%)	6 (9%)	10 (5%)
OTHER • Rural location • Changed admin • Not on referral list • Hurricane Florence • Changed our hours • Regulations • Foster children		7 (6%) 2 2 0 0 1 1 1	1 (1%) 0 0 1 0 0 0 0	8 (4%) 2 2 1 1 1 1 0
LACK OF RESOURCES • Get/Keep staff • Staff retired • Facility	*Because I have been unable to find qualified staff and have had to close classrooms*	6 (5%) 5 1 0	2 (3%) 0 1 1	8 (4%) 5 2 1

Most programs reported maintaining a waitlist (Table 3b.1), with a higher percentage of center-based programs reporting having waitlists (63% vs. 47% home-based). For each program type, about 3/4 of programs reported having a waitlist for children ages birth through 3 years. For ages 3-5 years, about 2/3 of center-based programs maintained a waitlist. However, waitlists for this age group were much less common for home-based programs. Approximately 60% of 1-star, 4-5 star, and notice of compliance programs maintained a waitlist relative to 51% of 3-star programs (Table 3b.2).

Table 3b.1. *Program Waitlist Information by Program Type*

	Center-based Child Care		Home-based Child Care		Total (*n* = 1085)	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Do you have kids on a waitlist						
Yes	440	63	181	47	621	57
No	261	37	203	53	464	43
By age group						
0-12 months						
0	110	27	38	23	148	26
≤ 9	186	46	123	75	309	54
≥ 10	108	27	3	2	111	20
12-24 months						
0	82	20	45	29	127	23
≤ 9	206	51	110	70	316	56
≥ 10	115	29	2	1	117	21
2-3 years old						
0	89	22	50	32	139	25
≤ 9	226	56	101	65	327	58
≥ 10	92	23	5	3	97	17
3-4 years old						
0	87	31	63	59	150	39
≤ 9	137	50	41	39	178	47
≥ 10	51	19	2	2	53	14
4-5 years old						
0	148	37	108	75	256	47
≤ 9	177	44	34	24	211	39
≥ 10	77	19	2	1	79	14

Table 3b.2. *Program Waitlist Information by Star Rating*

	1-2 Stars		3 Stars		4-5 stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Do you have kids on a waitlist								
Yes	44	64	103	51	424	59	38	60
No	25	36	99	49	293	41	25	40
By age group								
0-12 months								
0	11	28	23	24	97	25	11	31
≤ 9	24	62	67	71	198	51	17	47
≥ 10	4	10	5	5	92	24	8	22
12-24 months								
0	9	24	15	16	92	24	10	29
≤ 9	23	61	71	78	196	51	20	57
≥ 10	6	15	5	4	98	25	5	14
2-3 years old								
0	15	38	22	24	91	24	9	26
≤ 9	20	51	64	71	215	56	21	60
≥ 10	4	11	4	4	81	20	5	14
3-4 years old								
0	14	54	37	55	91	36	4	17
≤ 9	9	35	28	42	122	48	16	67
≥ 10	3	11	2	3	42	16	4	16
4-5 years old								
0	24	65	55	64	162	43	12	34
≤ 9	12	32	25	29	147	39	22	63
≥ 10	1	3	6	7	69	18	1	3

Characteristics of Children Enrolled in ECCE

As shown in Table 4a.1, approximately 3/4 of providers from both program types indicated that they enroll all age groups of children. Two exceptions to this are that 62% of home-based providers enroll 4-5 year old children, and 71% and 50% of center-based and home-based programs, respectively, currently enroll infants. This same general pattern was replicated at the different star-level ratings (Table 4a.2). For programs with a notice of compliance, approximately 90% of programs enrolled children ages 2 and older but 65% and 76% of programs enrolled children younger than 12 months and children 13-24 months, respectively.

Table 4a.1. *Enrollment by Child Age by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total (*n* = 1075)	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Programs with current enrollment by child age						
0-12 months	474	71	161	50	635	64
12-24 months	557	83	241	72	798	79
2-3 years old	594	88	291	83	885	86
3-4 years old	634	94	241	74	875	87
4-5 years old	617	92	192	62	809	82
Programs' current enrollment numbers by child age						
0-12 months	4,113	9	252	10	4,365	9
12-24 months	6,503	14	518	20	7,021	14
2-3 years old	8,881	19	687	27	9,568	20
3-4 years old	12,434	27	582	23	13,016	27
4-5 years old	14,267	31	546	21	14,813	30
Program's enrollment capacity (current enrollment/fully enrolled)						
0-12 months	955	81	332	43	1287	77
12-24 months	1120	85	249	68	1369	84
2-3 years old	1420	86	194	78	1614	86
3-4 years old	2211	85	297	66	2508	84
4-5 years old	3200	82	371	60	3571	81

Table 4a.2. *Enrollment by Child Age by Star Rating*

Star Rating								
	1-2		3		4-5		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Current enrollment numbers								
0-12 months	36	64	117	65	421	65	41	65
12-24 months	48	87	145	77	534	77	47	76
2-3 years old	52	84	170	89	583	89	56	89
3-4 years old	49	82	155	87	588	87	61	97
4-5 years old	39	68	132	75	562	75	58	94
Programs' enrollment capacity by star rating								
0-12 months	9	96	250	68	921	77	78	83
12-24 months	2	101	205	79	979	84	115	83
2-3 years old	24	107	224	84	1146	86	171	84
3-4 years old	20	95	331	77	1627	86	408	70
4-5 years old	81	77	392	74	2467	83	485	67

Given North Carolina's interest in increasing ECCE for infants, additional questions about infant care showed that across program type, only 12% of the respondents indicated not enrolling infants, though center-based programs were three times as likely to say they did not enroll infants (Table 4b.1). About 2/3 of respondents stated that there is a need for additional facilities that enroll infants. Many providers gave spontaneous responses for why additional infant and toddler care is needed, with more than half citing extensive waitlists as their primary reason (Table 4b.3). Relatedly, the second most common response across providers was that there is not enough care (as is evident by long wait lists). They noted that there are few centers that provide care for this age group and some centers are closing. There was little difference in response across home-based and non-home-based providers. These general patterns were replicated by star rating (Table 4b.2).

Table 4b.1. *Enrollment for Infants by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Currently enroll infants						
Yes	614	83	379	95	993	88
No	124	17	18	5	142	12
If not, enrolled infants in the past						
Yes	19	16	10	56	29	21
No	104	84	8	44	112	79
Need for additional child care facilities that enroll infants and toddlers						
Yes	486	66	230	59	716	64
No	246	34	159	41	405	36

Table 4b.2. *Enrollment for Infants by Star Rating*

Star Rating								
	1-2		3		4-5		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Currently enroll infants								
Yes	63	91	197	94	652	94	53	78
No	6	9	13	6	103	6	15	22
If not, enrolled infants in the past								
Yes	1	17	6	46	20	46	1	7
No	5	83	7	54	82	54	14	93
Need for additional facilities that enroll infants and toddlers								
Yes	46	67	129	62	474	62	43	63
No	21	31	78	38	84	38	25	37

Table 4b.3. *Reasons Why Additional Infant Care is Needed by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 509)	Home-Based (*n* = 167)	Total (*n* = 676)
WAITLISTS All references to waitlists and instances of having people call and care centers unable to serve them.	*We have a Call List/Waiting List of over 200 families.* *We have a 24-page toddler waitlist*	**255 (50%)**	**75 (45%)**	**330 (49%)**
NOT ENOUGH CARE • Low availability of centers caring for infants/toddlers • Infant care centers closing • More FDCH needed • Kids are left home • Need places that take vouchers • Need Montessori	*We get calls from parents of infants looking to place their children, but they ask if we accept vouchers and we do not, so we cannot take them. This makes me think it is hard to find a place that takes infants and also accepts vouchers.* *There are only 2 facilities in my area. This includes my facility* *We have lost many FCCH in our surrounding area leaving a lack of care available*	**139 (27%)** 108 18 9 1 2 1	**44 (26%)** 36 7 0 1 0 0	**183 (27%)** 144 25 9 2 2 1
REGULATIONS • General mentions of regulations being restrictive of infant and toddler care offerings • Low ratios required make it difficult to provide care to this group	*There have been several parents to call and state their concerns about daycares not enrolling infants because they have to do extra paperwork. Most 5-star providers do not offer infant care. It is very hard for a school to make a profit in infant care and regulations can be onerous.*	35 (7%) 13 22	18 (11%) 8 10	53 (8%) 21 32
WORK Need care so parents can work		38 (7%)	13 (8%)	51 (8%)
FUNDING All mentions of needing unspecified funding/money.	*The funding is frozen until a budget is passed and i have had parents calling and requesting care and when i tell them what private pay is they say they cannot afford it.*	26 (5%)	5 (3%)	31 (5%)
ALT HOURS Mentions of needing alternate hours care, such as weekend or 2nd and 3rd shift care	*There is a need for child care after hours (7a.m. - 6p.m). There is funding only for m-f and none for the weekend care. If there was funding centers would open*	4 (1%)	3 (2%)	7 (1%)
NONE None/NA/IDK, "other"		1	5 (3%)	6 (1%)

Superordinate Theme	Quotes	Center-Based (*n* = 509)	Home-Based (*n* = 167)	Total (*n* = 676)
I DON'T KNOW		2 (0.5%)	3 (2%)	5 (0.5%)
QUALITY STAFF Need quality/trained staff	*We need more qualified teachers because the ratio of teacher/child is too high*	4 (1%)	0	4 (0.5%)
READY FOR SCHOOL So that children will be ready for school	*To ensure school readiness*	2 (0.5%)	1 (0.5%)	3 (0.5%)
FACILITIES	*Would offer to keep infants of I had the space*	3 (1%)	0	3 (0.5%)

However, when asked why they themselves do not enroll this age group (Table 4b.4), the most common reason spontaneously given from providers of both program types was that they enroll children of other ages including pre-K, toddlers, and school-aged children indicating that "other" programs provide care for infants. The second most common response was the lack of facilities to accommodate infants, which was endorsed by several center-based providers but no home-based providers. Home-based providers' second most frequent response was that they choose not to provide such care.

Based on their previous responses, few providers were asked why they stopped enrolling infants (Table 4b.5), and the most frequently reported reason was choice. They noted preferring to provide care for older children and the physical burden of caring for babies. This was the most common response for all providers, both home-based and center-based. The second and third most frequent responses were regulations and cost. Regulations was the second most common reason for home-based providers, while cost was the second for center-based providers.

Table 4b.4. *Reasons Why Programs Do Not Enroll Infants by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 142)	Home-Based (*n* = 18)	Total (*n* = 160)
ENROLL OTHER AGES • Head Start center • Before/after care only • Children in my care aged up. • License is for other ages • Serve preschool • NC Pre-K or 4-year olds • School aged only • Toddlers only • Other providers do infants	*We offer a pre-K curriculum and do not feel that this could be implemented successfully with infants and toddlers present.*	**73 (51%)** 5 1 1 17 15 24 1 8 1	**9 (50%)** 0 0 1 0 1 2 1 4 0	**82 (51%)** 5 1 2 17 16 26 2 12 1
FACILITIES All mentions of lack of space or inadequate facilities		23 (16%)	0	23 (14%)
REGULATIONS All mentions of the restrictions of existing regulations and requirements being a factor in the decision to not enroll infants.	*The increase in I/T regulations was more than I can do and still provide exceptional care and run my business.* *I can't take other kids outside when baby is sleeping, even with a monitor. Also, I don't like having to document sleep positions.*	9 (6%)	2 (11%)	11 (7%)
FUNDING All mentions of needing unspecified funding/money.		10 (7%)	0	10 (6%)
CHOICE • All mentions of the decision being a personal choice • Too much physical work		4 (3%) 3 1	5 (28%) 2 3	9 (6%) 5 4
STAFF Need work staff in order to care for infants.		7 (5%)	1 (6%)	8 (5%)
NONE None/NA/IDK, "other"		6 (4%)	1 (6%)	7 (4%)
LIABILITY Too much liability involved with or need for insurance in order to keep infants.	*Liability and strict child care laws*	4 (3%)	0	4 (3%)
TRAINING		3 (2%)	0	3 (2%)
NOT MY DECISION		3 (2%)	0	3 (2%)

Table 4b.5. *Reasons Why Programs Stopped Enrolling Infants and Toddlers by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 21)	Home-Based (*n* = 9)	Total (*n* = 30)
CHOICE • Demand for older high • Prefer older kids • Physical burden • Do enroll toddlers • Never did infants • Licensing	*I prefer teaching & infants can be distracting* *my age - can no longer carry infants around*	8 (38%) 4 0 0 2 1 1	4 (44%) 0 1 2 0 1 0	12 (40%) 4 1 2 2 2 1
REGULATIONS All mentions of the restrictions of existing regulations and requirements being a factor in the decision to not enroll infants.	*More regulations and requirements for infants.*	2 (10%)	2 (22%)	4 (13%)
FUNDING All mentions of needing unspecified funding/money.	*The cost of care for infants & toddlers is too expensive which has resulted in a decrease in demand for those age groups in our area.*	4 (19%)	0	4 (13%)
NONE None/NA/IDK, "other"		1(5%)	2 (22%)	3 (10%)
STAFF Need work staff in order to care for infants.		2 (10%)	0	2 (7%)
LIABILITY Too much liability involved with or need for insurance in order to keep infants.		2 (10%)	0	2 (7%)
OTHER	*Includes children in my care ageing up, not my decision, reduced enrollment (without elaboration)*	2 (10%)	1 (11%)	3 (10%)

A total of 82% of respondents accepted child care subsidies (Table 4c.1), with a slightly greater proportion of center-based providers accepting subsidy compared with home-based providers (85% vs. 77%). Reasons providers gave why subsidies were not accepted were varied (Table 4c.3). The top 4 reasons were having a policy about subsidies, accepting other forms of subsidy (Head Start, NC PreK), not receiving requests (lack of need), and regulations (too complex). Only center-based programs, not surprisingly, reported receiving other forms of subsidy. Home-based programs more frequently reported that they had not received requests to accept subsidy and that they were not eligible to receive subsidy because of their star rating. Indeed, 87% of 1-2 star programs indicated they do not accept subsidies (Table 4c.2), whereas over 90% of programs with 3 or more stars accepted subsidies. For programs with a notice of compliance, 60% indicated they accept subsidies.

Table 4c.1. *Enrollment for Children with Subsidy by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Currently enroll children with subsidy						
Yes	593	85	294	77	887	82
No	109	15	90	23	199	18

Table 4c.2. *Enrollment for Children with Subsidy by Star Rating*

Star Rating								
	1-2		3		4-5		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Enrollment with subsidy								
Yes	9	13	184	91	634	91	38	60
No	60	87	18	9	84	9	25	40

Table 4c.3. *Reasons Why Programs Do Not Enroll Children with Subsidy by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 132)	Home-Based (*n* = 76)	Total (*n* = 208)
POLICY • All references to center policy decisions and/or choice not to accept subsidies • Personal choice • Don't target kids with subsidies	*School board voted against it.*	**25 (19%)** 21 3 1	**10 (13%)** 0 10 0	**35 (17%)** 21 13 1
OTHER FORMS OF SUBSIDY Program uses other forms of subsidy such as Head Start, NC Pre-K, public school, Title 1	*Head Start is based on parent's income*	34 (26%)	0	34 (16%)
NO REQUESTS No families have asked or no children with subsidies are enrolled.	*I have not had anyone that receives subsidy contact me in years so I just don't fool with the paperwork.*	14 (11%)	18 (24%)	32 (15%)
REGULATIONS Too much burden due to paperwork, policies, etc.	*Too much paperwork*	17 (13%)	14 (18%)	31 (15%)
INELIGIBLE Center or FDCH is ineligible due to low ratings	*We declined the star-rated system in favor of our Reggio inspired, emergent curriculum and use of open-ended materials that do not fit within the Environmental Rating Scales. While we have the quality of a 5-star center, we are not eligible to receive subsidies because of our 1-star rating. We are more than happy to accept subsidies if the system was structured differently.*	16 (12%)	14 (18%)	30 (14%)
PAYMENT ISSUES • Reimbursement rates are too low • Payment is delayed	*We have in the past accepted the UNC scholarship but when the family missed more days than was acceptable why them they refused to pay us even though we had provided the slot. Also they always pay after the period of service and the delay in payment can be prohibitive in a small program when cash flow is tight. Also DSS subsidy doesn't cover our entire tuition costs. Providers who make very. little in comparison to the people who administer these programs are expected to bear the brunt of the money loss.* *The reimbursement system takes too long to receive your funds, the parents do not pay their portion and we get left with unpaid balances. The financial risk is too great for us as a new program.*	19 (14%) 14 5	10 (13%) 6 4	29 (14%) 20 9

Superordinate Theme	Quotes	Center-Based (*n* = 132)	Home-Based (*n* = 76)	Total (*n* = 208)
WORKING TOWARDS Not yet able to take subsidies (still working on paperwork, building, need to be open longer, etc.)	*Waiting for my star rating at the end of the temporary period so that the rate will be acceptable*	4 (3%)	6 (8%)	10 (5%)
NA		1 (1%)	3 (4%)	4 (2%)
DON'T KNOW WHY/HOW		2 (2%)	0	2 (1%)
SPACE Not enough space		0	1 (1%)	1

As shown in Table 4d.1, whereas nearly 75% of more of center-based programs enrolled children from White, African American, and Hispanic/Latino groups, for home-based programs, while most (76%) enrolled African American children, relatively fewer programs enrolled other racial/ethnic groups. In terms of current enrollment, nearly twice as many White children than African American children were enrolled in center-based care, and for home-based care current enrollment of African American and White children was relatively equal (47 % vs. 41%, respectively). Children from Asian, Native American, Middle Eastern, and Other groups were enrolled less frequently, but when enrolled tended to be in center-based care by about a 2:1 margin. When looking at the distribution by star rating (Table 4d.2), White children enrollment was relatively equal across star rating. Higher numbers of African American children and Hispanic/Latino children were enrolled in 3 and over star programs.

Table 4d.1. *Child Race/Ethnicity Enrollment by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Programs with current enrollment by child race/ethnicity						
White/Caucasian	548	91	214	65	762	83
African American/Black	570	94	256	76	826	88
Hispanic/Latino	443	84	67	23	510	58
Asian	191	35	28	10	219	26
Native American	82	15	17	6	99	12
Middle Eastern	108	20	6	2	114	14
Other	74	15	23	9	97	13
Programs' current enrollment numbers by child race/ethnicity						
White/Caucasian	20,638	53	1,173	41	21,811	52
African American/Black	12,600	32	1,349	47	13,949	33
Hispanic/Latino	3,317	9	214	7	3,531	8
Asian	830	2	45	2	875	2
Native American	671	2	39	1	710	2
Middle Eastern	403	1	8	0	411	1
Other	476	1	55	2	531	1

Note. The percentages for race/ethnicity may not add up to 100% due to multiple responses.

Table 4d.2. *Child Race/Ethnicity Enrollment by Star Rating*

Star Rating								
	1-2		3		4-5		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Child Race/Ethnicity								
White/Caucasian	55	86	135	76	498	77	52	91
African American/Black	32	57	161	88	558	88	51	91
Hispanic/Latino	20	38	72	43	365	52	40	73
Asian	12	23	21	13	167	13	14	27
Native American	2	4	15	9	72	9	9	18
Middle Eastern	8	16	12	8	83	8	8	16
Other	4	9	13	9	69	9	10	21

Note. The percentages for race/ethnicity may not add up to 100% due to multiple responses.

Close to 70% of center-based programs reported enrolling dual language learners compared with 16% of home-based programs (Table 5a.1). Spanish was by far the dominant language other than English spoken by children and their families. Among other languages reported, programs had families that spoke Arabic, Chinese, Hindi/Urdu, Vietnamese. As shown in Table 5a.2, about 60% of 4-5 star programs and programs with a notice of compliance enrolled dual language learners, with 30% of 1-2 star programs enrolling DLLs.

Table 5a.1. *Enrollment of Dual Language Learners and Family Language Information by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Programs that have dual language learners attending their programs	449	69	60	16	509	50
Programs with children speaking languages other than English						
Spanish	391	87	42	70	433	85
Arabic	67	15	6	10	73	14
Chinese	87	19	5	8	92	18
Hindi/Urdu	60	13	9	15	69	14
Vietnamese	34	8	4	7	38	7
Other	128	29	29	48	157	31
Programs with families that speak:						
Spanish	373	83	36	60	409	80
Arabic	48	11	3	5	51	10
Chinese	67	15	2	3	69	14
Hindi/Urdu	42	9	4	7	46	9
Vietnamese	20	4	1	2	21	4
Other	83	18	15	25	98	19
Programs' numbers of dual language learners	3,948	9	244	9	4,192	9
Programs' numbers of families that speak:						
Spanish	2,583	65	106	43	2,689	64
Arabic	177	4	7	3	184	4
Chinese	175	4	2	1	177	4
Hindi/Urdu	219	6	8	3	227	5
Vietnamese	41	1	1	0	42	1
Other	83	2	15	6	98	2

Note. The percentages for the language variables may not add up to 100% due to multiple responses.

Table 5a.2. *Enrollment of Dual Language Learners and Family Language Information by Star Rating*

	Star Rating							
	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
	N	%	N	%	N	%	N	%
Dual language learners attending your program	19	30	59	39	381	57	36	63
Languages other than English spoken in your program								
Spanish	15	79	47	80	330	87	32	89
Arabic	3	16	4	7	60	16	5	14
Chinese	5	26	4	7	74	19	7	19
Hindi/Urdu	2	11	4	7	57	15	4	11
Vietnamese	2	11	2	3	29	8	4	11
Other	14	74	11	19	117	31	11	31
Number of families that speak:								
Spanish	14	74	44	75	310	81	33	92
Arabic	3	16	3	5	42	11	3	8
Chinese	5	26	3	5	54	14	6	17
Hindi/Urdu	2	11	3	5	38	10	2	6
Vietnamese	2	11	1	2	15	4	2	6
Other	9	47	7	12	73	19	7	19

Note. The percentages for the language variables may not add up to 100% due to multiple responses.

Compared with home-based programs, as shown in Table 5b.1, a greater proportion of center-based program enrolled children with disabilities (59% vs. 13%). An average of 5 children with IEPs or IFSPs were enrolled in a program. Over 50% of 3-star and 4-5 star programs enrolled children with disabilities, compared with 28% of programs with a notice of compliance and 10% of 1-2 star programs (Table 5b.2). Programs with 4-5 star ratings had an average of 6 children with IEPs or IFSPs enrolled, whereas other programs had 2 or fewer children on average.

Table 5b.1. *Enrollment of Children with Disabilities by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)
Did the program report having at least 1 child with an IFSP or IEP enrolled?						
Yes	355	59	45	13	400	43
No	243	41	295	87	538	57
Of programs serving children with disabilities, how many children with IFSP/IEPs were enrolled?	355	6 (1-84)	45	2 (1-11)	400	6 (1-100)

Table 5b.2. *Enrollment of Children with Disabilities by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)
Did the program report having at least 1 child with an IFSP or IEP enrolled?								
Yes	6	10	56	32	315	50	15	28
No	52	90	120	68	309	50	39	72
Of programs serving children with disabilities, how many children with IFSP/IEPs were enrolled?	6	2 (1-3)	56	3 (1-11)	317	6 (1-84)	15	2 (1-7)

Specialized Services in ECCE

Approximately 35% of center-based programs indicated that their families who speak Spanish needed language supports to communicate, compared with about 5% of home-based programs (Table 6a.1). For center-based programs, 57% reported having staff who speak Spanish. Few programs report having staff who speak other languages besides Spanish or English. About 14% of the programs who currently do not enroll families that speak other languages, have staff that speak other languages, especially Spanish. In general, the higher quality a program is the more likely they have families who need language supports and also the staff who speak those languages (Table 6a.2).

Table 6a.1. *Supports for Families Who Speak Other Languages by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Programs with enrolled families that need language supports						
Spanish	131	34	2	5	133	31
Arabic	7	5	0	0	7	4
Chinese	14	9	0	0	14	8
Hindi/Urdu	2	2	0	0	2	1
Vietnamese	7	6	0	0	7	5
Other	16	5	0	0	16	4
Programs' numbers of families that need language supports						
Spanish	633	16	86	35	719	17
Arabic	271	7	48	20	319	8
Chinese	290	7	46	19	336	8
Hindi/Urdu	256	6	46	19	302	7
Vietnamese	223	6	42	17	265	6
Other	680	26	128	121	808	30
Number of staff who speak these languages						
Spanish	256	57	11	18	267	52
Arabic	11	2	1	2	12	2
Chinese	9	2	0	0	9	2
Hindi/Urdu	10	2	3	5	13	3
Vietnamese	3	1	0	0	3	1
Other	17	4	8	13	25	5
Number of staff who speak these languages in programs that do not enroll DLLs						
Spanish	53	26	20	6	73	14
Arabic	0	0	2	1	2	0
Chinese	0	0	0	0	0	0
Hindi/Urdu	1	0	0	0	1	0
Vietnamese	0	0	0	0	0	0
Other	14	7	12	4	26	5

Table 6a.2. *Supports for Families Who Speak Other Languages by Star Rating*

Star Rating								
	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
	N	%	N	%	N	%	N	%
Number of families in your program that need language supports								
Spanish	14	7	10	23	114	36	4	11
Arabic	0	0	0	0	7	6	0	0
Chinese	42	25	0	0	11	8	0	0
Hindi/Urdu	0	0	0	0	2	2	0	0
Vietnamese	21	13	0	0	4	4	1	8
Other	3	16	2	4	9	3	1	8
Number of staff who speak these languages								
Spanish	8	42	21	36	214	56	21	58
Arabic	0	0	2	3	10	3	0	0
Chinese	0	0	1	2	8	2	0	0
Hindi/Urdu	0	0	0	0	12	3	0	0
Vietnamese	1	5	0	0	2	1	0	0
Other	0	0	2	3	18	5	2	6
Number of staff who speak these languages in centers without DLLs								
Spanish	4	9	23	17	38	13	5	24
Arabic	0	0	1	1	1	0	0	0
Chinese	0	0	0	0	0	0	0	0
Hindi/Urdu	1	2	0	0	0	0	0	0
Vietnamese	0	0	0	0	0	0	0	0
Other	7	16	4	3	14	5	0	0

Regarding services for children who have or who are suspected of having disabilities, almost 60% of center-based programs offered screening services relative to 26% of home-based programs (Table 6b.1). As program quality increased, so did the likelihood that programs offered screening services (Table 6b.2).

Table 6b.1. *Screening Services for Disabilities by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)
Yes	361	59	90	26	451	47
No	253	41	254	74	507	53

Table 6b.2. *Screening Services for Disabilities by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)	N	% or Mean (Range)
Did the program report having at least 1 child with an IFSP or IEP enrolled?								
Yes	10	18	68	38	340	53	21	38
No	47	82	113	62	297	47	35	63

In terms of specific services for children with disabilities, the most commonly provided services across programs are speech-language therapy, physical therapy, occupational therapy, nutrition services, social work services, and family training, counseling, and home visits (Table 6b.3). In general, programs tended to rely on contracted staff to provide these services. As program quality increased, so did the likelihood that programs offered specific services for children with disabilities (Table 6b.4).

Table 6b.3. *Specific Services for Disabilities and Staff Who Provide Them by Program Type*

	Center-Based Child Care				Home-Based Child Care				Total				Grand Total	
	Own Staff		Contract Staff		Own Staff		Contract Staff		Own Staff		Contract Staff			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Assistive technology	64	9	87	15	9	3	21	6	73	8	108	11	155	19
Audiology services	22	3	127	17	3	1	19	5	25	6	146	15	161	20
Family training, counseling and home visits	107	18	126	21	16	5	32	9	123	13	158	17	268	33
Health services	30	5	90	15	5	1	21	6	35	4	111	12	139	18
Medical services	17	3	58	10	3	1	15	4	20	2	73	8	83	11
Nursing services	26	4	53	9	5	1	21	6	31	3	74	8	95	12
Nutrition services	110	18	89	15	22	6	57	17	132	14	146	15	305	38
Occupational therapy	32	5	307	51	2	15	39	11	34	4	346	37	393	47
Physical therapy	30	5	256	43	4	1	29	8	34	4	285	30	328	40
Psychological services	24	4	144	24	0	0	21	6	24	3	165	18	183	24
Service coordination services	36	6	83	14	6	2	18	5	42	4	101	11	138	18
Sign language and cued language services	51	9	57	10	11	3	15	4	62	7	72	8	126	16

	Center-Based Child Care				Home-Based Child Care				Total				Grand Total	
	Own Staff		Contract Staff		Own Staff		Contract Staff		Own Staff		Contract Staff			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Social work services	47	8	160	27	9	3	34	10	56	6	194	21	264	33
Special Instruction	74	12	75	13	10	3	19	6	84	9	94	10	156	20
Speech-language pathology services	39	7	349	58	4	1	71	21	43	5	420	45	499	59
Transportation and related costs	79	13	43	7	13	4	12	4	92	10	55	6	149	19
Vision services	32	5	149	25	4	1	14	4	36	4	163	17	190	24
Other service for children with disabilities	18	3	31	5	8	2	10	3	26	3	41	4	63	10

Table 6b.4. *Specific Services for Disabilities by Star Rating*

Star Rating								
	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
	N	%	N	%	N	%	N	%
Assistive technology	3	6	14	9	131	25	5	12
Audiology services	2	4	15	10	135	26	5	12
Family training, counseling & home visits	7	14	37	24	211	39	8	18
Health services	2	4	20	13	111	21	3	7
Medical services	2	4	10	7	68	13	1	2
Nursing services	3	6	9	6	80	15	1	2
Nutrition services	11	23	49	32	228	42	10	21
Occupational therapy	6	12	51	32	307	55	23	50
Physical therapy	4	8	38	25	263	48	16	36
Psychological services	5	10	22	15	145	28	7	17
Service coordination services	2	4	11	7	120	23	1	2
Sign language and cued language services	4	8	18	12	93	18	8	18
Social work services	4	8	40	26	205	38	9	20
Special Instruction	2	4	14	10	131	26	7	17
Speech-language pathology services	12	24	68	43	379	66	31	65
Transportation and related costs	2	4	16	11	122	23	5	12
Vision services	2	4	18	12	156	30	8	19
Other service for children with disabilities	1	2	7	5	49	12	2	6

When asked what was working well in their efforts to serve children with disabilities (Table 6a.5), the two most salient responses across program type were collaboration and "none" (meaning that they did not have any children with disabilities enrolled in their program). Providers talked about collaboration between agencies, therapists, and child care programs. This was particularly true for non-home-based providers. It was much more common for home-based providers to report "none" because they did not have any children with disabilities enrolled in their programs.

For challenges (Table 6a.6), most providers, and particularly home-based providers, responded that they did not experience challenges for children with disabilities because they did not have children with disabilities enrolled. Some center-based providers reported that training for staff was a challenge or that they do not have enough staff to meet children's needs. Only a few home-based providers endorsed these reasons.

Table 6b.5. *What is Working Well in Serving Children with Disabilities by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 532)	Home-Based (*n* = 183)	Total (*n* = 715)
COLLABORATION • All mentions of the benefit of the collaboration that happens between agencies, therapists, and child care when services come to the centers to treat the children • Help from DSS • Mental health services and/or supports	*We offer speech and they come to our center to help the children and this is very helpful to our families that cannot do it because of their work schedule.* *Therapists coming to the center works well for our children.*	**237 (45%)** **235** 1 1	**42 (23%)** **41** 1 0	**279 (39%)** **276** 2 1
NONE None/NA/IDK, "other", no children with disabilities		95 (18%)	98(54%)	193 (27%)
STAFF The staff's kindness, initiative, skills,	*My own staff's initiative to determine what each child needs.* *We have a strong intake process for children with disabilities and staff work hard to provide all service needed.* *Our teachers are phenomenal.*	36 (7%)	2 (1%)	38 (5%)
SPEECH/LANGUAGE PATHOLOGY SERVICES		24 (5%)	9 (5%)	33 (5%)
OPEN COMMUNICATION	*Open communication between every party involved.* *We have great communication between staff, therapists, and families.*	25 (5%)	5 (3%)	30 (4%)

Superordinate Theme	Quotes	Center-Based (*n* = 532)	Home-Based (*n* =183)	Total (*n* = 715)
NEEDS MET We are able to meet the children's needs with what/who we have	*They are getting the help they need.*	23 (4%)	7 (4%)	30 (4%)
EVALUATION SERVICES		21 (4%)	1	22 (3%)
THE REFERRAL PROCESS		17 (3%)	2 (1%)	19 (3%)
TRAINING All references to the training available to staff.		10 (2%)	8 (4%)	18 (2.5%)
RESOURCES All general mentions having the needed resources, including having all the needed staff and specialists		12 (2%)	5 (3%)	17 (2%)
FACILITIES All references to the facilities/buildings, space available, and accessible		10 (2%)	3 (2%)	13 (2%)
INCLUSION The inclusion practices used	*They are getting the help they need.*	9 (2%)	1	10 (2%)
OCCUPATIONAL THERAPY		5 (1%)	0	5 (1%)
PHYSICAL THERAPY		4 (1%)	0	4 (1%)
OTHER	*Includes Aba/autism therapy, Families get home visits, IEP, and time (no elaboration provided)*	4 (1%)	0	4 (1%)

Table 6b.6. *Challenges in Serving Children with Disabilities by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 517)	Home-Based (*n* = 204)	Total (*n* = 721)
NONE None/NA/IDK, "other"		**144 (28%)**	**127 (62%)**	**271 (38%)**
TRAINING Staff need PD and training	*Staff are not always trained or equipped to handle certain disabilities.*	72 (14%)	8 (4%)	80 (11%)
NOT ENOUGH STAFF All references to not having enough center-based or home-based personnel to meet children's needs.		55 (11%)	14 (7%)	69 (10%)
NOT ENOUGH FUNDING All mentions of having too little money or funding to meet children's needs.	*Funding. The DD rate has not increased in over 20 years to serve a child's IEP.* *Not enough state funds to cover increasing cost.*	40 (8%)	8 (4%)	48 (7%)
PARENTS All references to lack of participation, understanding, education, willingness to evaluate/assess, and cooperation of parents with staff to meet children's needs.	*Having parents to accept the help for their children.* *Parents admitting that there may be a delay with their children when they are first approached.*	42 (8%)	5 (2%)	47 (7%)
FACILITIES Too little space/inadequate facilities to meet children's needs.	*When (therapists) remove the child to provide services during their visit, we don't have a lot of extra space to provide.*	36 (7%)	11 (5%)	47 (7%)
RESOURCES AND MATERIALS • Lack of resources - unspecified • We lack needed equipment		28 (5%) 18 10	12 (6%) 9 3	40 (6%) 27 13
TOO FEW SPECIALISTS	*A shortage of specialists in our county.* *Getting services to come to our remote location if needed.*	23 (4%)	0	23 (3%)
BEHAVIOR SUPPORTS All mentions of needing supports and/or resources for working with children with challenging behaviors.	*We have been on the waitlist for behavioral services with CCRI for 5 months.* *Not enough behavioral support specialists in our county to serve a high volume of students who need it.*	21 (4%)	0	21 (3%)

Superordinate Theme	Quotes	Center-Based (*n* = 517)	Home-Based (*n* = 204)	Total (*n* = 721)
REGULATIONS All mentions of strict regulations and requirements making it difficult to meet children's needs	*Often takes months to get a child identified and services started.* *Our biggest challenge is being near the border of two counties. We have a good deal of our children residing in each of those counties. DPI will not cross the border from XX County into XXX County to assist students who qualify for services.*	11 (2%)	4 (2%)	15 (2%)
EVALUATIONS Mentions of too few evaluation specialists and services.		13 (3%)	0	13 (2%)
COLLABORATION • Lack of collaboration with agencies. (NOTE – private centers and family homes have more trouble with this) • Doctors don't respect teachers' observations and perceptions		7 (1%) 4 3	5 (2%) 5 0	12 (2%) 9 3
SCHEDULING		8 (2%)	2 (1%)	10 (1%)
ACCESS Families lack access to needed services because of cost or lack of insurance or because they are in a FDCH.	*Some of these programs are not available for family child care providers.*	4 (1%)	5 (2%)	9 (1%)
TOO FEW SERVICES FOR KIDS UNDER AGE 3		6 (1%)	0	6 (1%)
NEED MORE SLOTS		6 (1%)	0	6 (1%)
NEED TRANSPORTATION		4 (1%)	1	5 (1%)
HARD TO BALANCE NEEDS OF ALL CHILDREN		5 (1%)	0	5 (1%)
KIDS WITH DISABILITIES DISRUPT THE CLASS		4 (1%)	0	4 (1%)
NEED MENTAL HEALTH SERVICES/SUPPORTS		4 (1%)	0	4 (1%)
ADJUSTMENT OF CHILDREN TO CENTER ROUTINES, ETC.		1	1	2
TOO FEW SERVICES FOR KIDS OLDER THAN AGE 3		2	0	2

Superordinate Theme	Quotes	Center-Based (*n* = 517)	Home-Based (*n* = 204)	Total (*n* = 721)
INEQUITABLE DISTRIBUTION OF KIDS WITH NEEDS ACROSS THE DISTRICT		2	0	2
THE FOLLOW-UP SERVICES ARE INADEQUATE		0	1	1
COMMUNITY SUPPORT		1	0	1
EVERYTHING/ALL		1	0	1

Services for Families

For services that can help families access ECCE services, approximately 2/3 of programs do not offer transportation to families (Table 7a.1) and approximately 20% provide transportation assistance. Higher quality programs were more likely to provide transportation assistance (Table 7a.2). When asked why they did not provide transportation services (Table 7a.3), providers' most common response was that there was no need. The second and third most common responses were not having a vehicle for transportation and concerns about the liability of providing the service. Not having a vehicle was more of a concern for non-home-based programs whereas home-based programs endorsed liability concerns. Some less commonly reported reasons were lacking staff to drive and personal preference. Non-home-based providers more frequently reported that it was too expensive.

Table 7a.1. *Transportation Services by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Program provides transportation						
Yes	233	33	106	28	339	31
No	465	67	275	72	740	69
Transportation assistance for families						
Yes	124	23	54	18	178	21
No; if no, barriers:	416	77	248	82	664	79
Not available in this area	32	8	13	5	45	7
Not accessible	16	4	7	3	23	3
Not affordable	163	39	76	31	239	36
Lack of staff in this area	35	8	19	8	54	8
Regulations make provision difficult	31	7	10	4	41	6
Language barriers	13	3	4	2	17	3
I am not aware of this service	26	6	13	5	39	6
Children/families don't need this service	73	18	55	22	128	19
Other	30	7	16	6	46	7

Table 7a.2. *Transportation Services by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Transportation assistance for families								
Yes	2	4	28	18	139	25	5	10
No; if no, barriers:	43	96	131	82	423	75	46	90
Not available in this area	3	7	11	8	30	7	1	2
Not accessible	3	7	4	3	16	4	0	0
Not affordable	11	26	44	34	169	40	9	20
Lack of staff in this area	4	9	11	8	37	9	2	4
Regulations make provision difficult	2	5	8	6	30	7	1	2
Language barriers	1	2	2	2	14	3	0	0
I am not aware of this service	1	2	5	4	30	7	1	2
Children/families don't need this service	12	28	17	13	83	20	12	26
Other	4	9	11	8	27	6	2	4

Table 7a.3. *Reasons Why Programs Do Not Provide Transportation by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 330)	Home-Based (*n* = 79)	Total (*n* = 409)
No families in need of this service	*The families who attend our center have reliable transportation* *We have not had a parent indicate it as a need.* *No off-site activities*	**78 (24%)**	**13 (16%)**	**91 (22%)**
Does not have a vehicle	*No vehicle to transport children.*	42 (13%)	6 (8%)	48 (12%)
It is a liability, insurance concerns	*Too much of a liability*	30 (9%)	14 (18%)	44 (11%)
Too expensive	*Not financially sound for us to provide transportation for preschoolers* *Private pay customers would haveto pay more to offset costs.*	40 (12%)	3 (4%)	43 (11%)
Work alone, too hard for our staffing level	*Only one person working in the home.* *No one to do it!*	29 (9%)	10 (13%)	39 (10%)
No interest in providing, personal preference	*The owner chooses not to.*	22 (7%)	10 (13%)	32 (8%)
Provide for school-aged children only	*Only after-school transportation provided for 5-12.*	26 (8%)	1 (1%)	27 (7%)
Trouble/hassle/policy	*Too much trouble*	15 (5%)	9 (11%)	24 (6%)
Safety issues	*I wouldn't feel safe having all the kids in the car.*	14 (4%)	8 (10%)	22 (5%)
Only serves children 0-5	*Not age appropriate* *The children I serve are 5 and under.*	13 (4%)	2 (3%)	15 (4%)
Non-responsive, none, N/A		9 (3%)	1 (1%)	10 (2%)
Don't know, never thought of it		4 (1%)	0	4 (0.01%)
Not allowed to	*We aren't allowed to transport 4-year olds.* *No tengo licencia para proveer transportación.*	4 (1%)	0	4 (0.01%)
Takes too much time	*Not feasible for my schedule*	2 (0.1%)	1 (1%)	3 (0.01%)
Will start providing soon	*Pending approval from LLC*	2 (0.1%)	1 (1%)	3 (0.01%)

Note. This question was coded to saturation. 347 responses coded (71 home-based and 276 non-home-based)

In addition, services such as home visiting are a mechanism that can help families access ECCE services. Across both program types, about 75% provide home visiting services (Table 7b.1). When they do not, costs, lack of staff, and lack of need were identified as the greatest barriers. The high the program quality, the more likely they provided home visiting (Table 7b.2).

Table 7b.1. *Home Visiting Services by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Home visiting*						
Yes	169	31	72	24	241	28
No; if no, barriers:	386	70	234	77	620	72
Not available in this area	44	11	18	8	62	10
Not accessible	19	5	12	5	31	5
Not affordable	111	29	73	31	184	30
Lack of staff in this area	78	20	29	12	107	17
Regulations make provision difficult	30	8	18	8	48	8
Language barriers	13	3	9	4	22	4
I am not aware of this service	23	6	21	9	44	7
Children/families don't need this service	70	18	52	22	122	20
Other	34	9	22	9	56	9

Note. It is unclear if respondents interpreted this question about home visiting services as intended; that is, we do not know whether respondents offer true home visit services/programming or whether homes are simply visited once or twice during the school year.

Table 7b.2. *Home Visiting Services by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Home visiting								
Yes	8	18	25	15	202	35	1	2
No; if no, barriers:	37	82	137	85	375	65	50	98
Not available in this area	4	11	16	12	39	10	1	2
Not accessible	2	5	8	6	20	5	0	0
Not affordable	10	27	45	33	115	31	9	18
Lack of staff in this area	5	14	22	16	71	19	8	16
Regulations make provision difficult	3	8	12	9	31	8	1	2
Language barriers	3	8	3	2	15	4	0	0
I am not aware of this service	3	8	8	6	28	7	2	4
Children/families don't need this service	13	35	14	10	77	21	12	24
Other	4	11	14	10	33	9	2	4

For child and family mental health and health services, overall programs were most likely to provide mental health screenings (31%) followed by mental health coordination (21%), dental services (19%), drug and substance abuse services (10%), and pediatric services (10%) (Table 7c.1). In some instances, center-based programs were more likely to provide some of these services twice or more as often as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of awareness or need. Provision of these services increased with program quality (Table 7c.2).

Table 7c.1. *Child and Family Health and Mental Health Services by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Pediatric services						
Yes	52	10	23	8	75	9
No; if no, barriers:	481	90	279	92	760	91
Not available in this area	42	9	18	6	60	8
Not accessible	20	4	12	4	32	4
Not affordable	164	34	94	34	258	34
Lack of staff in this area	36	7	25	9	61	8
Regulations make provision difficult	37	8	20	7	57	8
Language barriers	13	3	10	4	23	3
I am not aware of this service	53	11	20	7	73	10
Children/families don't need this service	64	13	51	18	115	15
Other	34	7	22	8	56	7
Child mental health screenings or assessments						
Yes	169	31	45	15	214	25
No; if no, barriers:	379	69	261	85	640	75
Not available in this area	37	10	15	6	52	8
Not accessible	16	4	10	4	26	4
Not affordable	126	33	83	32	209	33
Lack of staff in this area	34	9	19	7	53	8
Regulations make provision difficult	24	6	10	4	34	5
Language barriers	11	3	7	3	18	3
I am not aware of this service	38	10	16	6	54	8
Children/families don't need this service	40	11	54	21	94	15
Other	26	7	19	7	45	7
Mental health care coordination or therapy						
Yes	140	26	34	11	174	21
No; if no, barriers:	405	74	269	89	674	79
Not available in this area	38	9	16	6	54	8
Not accessible	14	3	11	4	25	4
Not affordable	140	35	86	32	226	34

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Lack of staff in this area	41	10	20	7	61	9
Regulations make provision difficult	27	7	13	5	40	6
Language barriers	10	2	7	3	17	3
I am not aware of this service	41	10	18	7	59	9
Children/families don't need this service	43	11	55	20	98	15
Other	27	7	19	7	46	7
Child dental services						
Yes	136	25	23	8	159	19
No; if no, barriers:	409	75	276	92	685	81
Not available in this area	29	7	18	7	47	7
Not accessible	15	4	10	4	25	4
Not affordable	147	36	88	32	235	34
Lack of staff in this area	34	8	23	8	57	8
Regulations make provision this service	29	7	13	5	42	6
Language barriers	10	2	6	2	16	2
I am not aware of this service	36	9	16	6	52	8
Children/families don't need this service	54	13	54	20	108	16
Other	25	6	18	7	43	6
Services for drug or alcohol abuse						
Yes	58	11	26	9	84	10
No; if no, barriers:	476	89	274	91	750	90
Not available in this area	38	8	17	6	55	7
Not accessible	17	4	12	4	29	4
Not affordable	162	34	86	31	248	33
Lack of staff in this area	40	8	19	7	59	8
Regulations make provision difficult	29	6	14	5	43	6
Language barriers	11	2	5	2	16	2
I am not aware of this service	42	9	15	5	57	8
Children/families don't need this service	60	13	56	20	116	15
Other	34	7	19	7	53	7

Table 7c.2. *Child and Family Health and Mental Health Services by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Pediatric services								
Yes	1	2	11	7	59	11	0	0
No; if no, barriers:	44	98	147	93	498	89	50	100
Not available in this area	4	9	13	9	42	8	1	2
Not accessible	2	5	7	5	23	5	0	0
Not affordable	9	20	51	35	180	36	13	26
Lack of staff in this area	3	7	11	7	43	9	4	8
Regulations make provision difficult	3	7	10	7	43	9	1	2
Language barriers	1	2	3	2	19	4	0	0
I am not aware of this service	4	9	11	7	52	10	4	8
Children/families don't need this service	14	32	14	10	74	15	8	16
Other	4	9	12	8	36	7	2	4
Child mental health screenings or assessments								
Yes	6	13	28	17	164	29	7	13
No; if no, barriers:	40	87	133	83	406	71	45	87
Not available in this area	4	10	11	8	36	9	1	2
Not accessible	2	5	8	6	16	4	0	0
Not affordable	12	30	43	32	139	34	11	24
Lack of staff in this area	3	8	9	7	37	9	4	9
Regulations make provision difficult	2	5	9	7	23	6	0	0
Language barriers	1	3	3	2	14	3	0	0
I am not aware of this service	2	5	8	6	37	9	5	11
Children/families don't need this service	10	25	16	12	60	15	5	
Other	3	8	12	9	26	6	2	4
Mental health care coordination or therapy								
Yes	3	7	23	14	134	24	7	14
No; if no, barriers:	42	93	137	86	433	76	44	86
Not available in this area	4	10	13	9	35	8	1	2
Not accessible	2	5	7	5	15	3	0	0

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Not affordable	12	29	46	34	151	35	11	25
Lack of staff in this area	3	7	9	7	44	10	5	11
Regulations make provision difficult	2	5	9	7	28	6	0	0
Language barriers	1	2	3	2	13	3	0	0
I am not aware of this service	1	2	8	6	42	10	5	11
Children/families don't need this service	11	26	16	12	62	14	5	
Other	4	10	10	7	28	6	2	5
Child dental services								
Yes	2	5	17	11	133	23	4	8
No; if no, barriers:	42	95	139	89	434	77	48	92
Not available in this area	3	7	10	7	33	8	1	2
Not accessible	2	5	6	4	17	4	0	0
Not affordable	13	31	49	35	156	36	12	25
Lack of staff in this area	3	7	9	6	39	9	6	13
Regulations make provision difficult	2	5	10	7	30	7	0	0
Language barriers	1	2	3	2	12	3	0	0
I am not aware of this service	1	2	7	5	37	9	5	10
Children/families don't need this service	12	29	16	12	70	16	6	
Other	4	10	12	9	22	5	2	4
Services for drug or alcohol abuse								
Yes	2	4	16	10	95	17	6	12
No; if no, barriers:	43	96	140	90	463	83	44	88
Not available in this area	3	7	11	8	36	8	1	2
Not accessible	2	5	5	4	17	4	0	0
Not affordable	12	28	47	34	172	37	14	32
Lack of staff in this area	4	9	6	4	35	8	4	9
Regulations make provision difficult	2	5	9	6	26	6	1	2
Language barriers	2	5	2	1	14	3	0	0
I am not aware of this service	3	7	6	4	38	8	4	9
Children/families don't need this service	13	30	13	9	65	14	6	14
Other	4	9	11	8	24	5	3	7

For services that aim to promote parents' social capital, overall programs were most likely to provide education/job training (34%) followed by scholarships (29%), family literacy programs (20%), and employment assistance (15%) (Table 7d.1). In general, center-based programs were twice as likely to provide these services as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality (Table 7d.2).

Table 7d.1. *Social Capital Promoting Services for Parents by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Scholarship funds						
Yes	214	38	40	13	254	29
No; if no, barriers:	345	62	263	87	608	71
Not available in this area	43	12	30	11	73	12
Not accessible	14	4	19	7	33	5
Not affordable	163	47	111	42	274	45
Lack of staff in this area	26	8	29	11	55	9
Regulations make provision difficult	24	7	24	9	48	8
Language barriers	14	4	15	6	29	5
I am not aware of this service	26	8	26	10	52	9
Children/families don't need this service	41	12	59	22	100	16
Other	29	8	23	9	52	9
Family literacy services						
Yes	125	23	42	14	167	20
No; if no, barriers:	412	77	260	86	672	80
Not available in this area	35	8	16	6	51	8
Not accessible	17	4	9	3	26	4
Not affordable	132	32	75	29	207	31
Lack of staff in this area	31	8	17	7	48	7
Regulations make provision difficult	22	5	12	5	34	5
Language barriers	13	3	5	2	18	3
I am not aware of this service	36	9	13	5	49	7
Children/families don't need this service	60	15	50	19	110	16

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Other	34	8	18	7	52	8
Education or job training						
Yes	225	41	61	20	286	34
No; if no, barriers:	323	59	243	80	566	66
Not available in this area	22	7	13	5	35	6
Not accessible	10	3	7	3	17	3
Not affordable	113	35	78	32	191	34
Lack of staff in this area	33	10	16	7	49	9
Regulations make provision difficult	17	5	9	4	26	5
Language barriers	10	3	5	2	15	3
I am not aware of this service	29	9	12	5	41	7
Children/families don't need this service	54	17	52	21	106	19
Other	19	6	16	7	35	6
Employment assistance						
Yes	100	19	26	9	126	15
No; if no, barriers:	432	81	275	91	707	85
Not available in this area	36	8	16	6	52	7
Not accessible	13	3	10	4	23	3
Not affordable	148	34	92	33	240	34
Lack of staff in this area	37	9	19	7	56	8
Regulations make provision difficult	27	6	12	4	39	6
Language barriers	9	2	5	2	14	2
I am not aware of this service	42	10	15	5	57	8
Children/families don't need this service	66	15	57	21	123	17
Other	24	6	18	7	42	6

Table 7d.2. *Social Capital Promoting Services for Parents by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Scholarship funds								
Yes	9	20	26	16	198	34	11	21
No; if no, barriers:	37	80	136	84	379	66	41	79
Not available in this area	4	11	13	10	53	14	2	5
Not accessible	3	8	5	4	25	7	0	0
Not affordable	14	38	61	45	178	47	14	34
Lack of staff in this area	4	11	11	8	36	9	3	7
Regulations make provision difficult	4	11	7	5	36	9	1	2
Language barriers	3	8	3	2	22	6	0	0
I am not aware of this service	3	8	6	4	37	10	3	7
Children/families don't need this service	11	30	13	10	68	18	5	12
Other	5	14	10	7	34	9	2	5
Family literacy services								
Yes	6	13	20	13	129	23	6	12
No; if no, barriers:	39	87	136	87	433	77	45	88
Not available in this area	3	8	12	9	35	8	1	2
Not accessible	2	5	5	4	19	4	0	0
Not affordable	10	26	43	32	141	33	10	22
Lack of staff in this area	3	8	8	6	34	8	3	7
Regulations make provision difficult	2	5	8	6	24	6	0	0
Language barriers	1	3	3	2	14	3	0	0
I am not aware of this service	2	5	9	7	32	7	4	9
Children/families don't need this service	12	31	16	12	69	16	9	20
Other	4	10	12	9	31	7	3	7
Education or job training								
Yes	15	33	48	30	196	34	15	28
No; if no, barriers:	30	67	112	70	373	66	38	72
Not available in this area	3	10	6	5	25	7	1	3
Not accessible	2	7	4	4	11	3	0	0
Not affordable	9	30	37	33	131	35	10	26
Lack of staff in this area	3	10	9	8	33	9	4	11

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Regulations make provision difficult	2	5	6	4	29	6	2	4
Language barriers	1	2	2	1	11	2	0	0
I am not aware of this service	2	5	8	6	43	9	2	4
Children/families don't need this service	12	29	16	12	80	17	12	25
Other	4	10	11	8	23	5	2	4

For services that aim to reach parents with limited English skills, 16% of programs offered workshops and activities in Spanish for parents of DLLs, and 11% of program offered English classes; center-based programs were twice as likely to provide these services as home-based programs (Table 7e.1). When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality (Table 7e.2).

Table 7e.1. *Services for Parents with Limited English Skills by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Activities & workshops taught in Spanish or other languages for parents of DLLs						
Yes	108	20	28	9	136	16
No; if no, barriers:	433	80	275	91	708	84
Not available in this area	33	8	14	5	47	7
Not accessible	12	3	8	3	20	3
Not affordable	127	29	79	29	206	29
Lack of staff in this area	33	8	19	7	52	7
Regulations make provision difficult	15	3	13	5	28	4
Language barriers	12	3	6	2	18	3
I am not aware of this service	35	8	14	5	49	7
Children/families don't need this service	68	16	59	21	127	18
Other	26	6	20	7	46	6
English classes for parents						
Yes	66	12	24	8	90	11

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
No; if no, barriers:	469	88	276	92	745	89
Not available in this area	34	7	17	6	51	7
Not accessible	14	3	9	3	23	3
Not affordable	145	31	75	27	220	30
Lack of staff in this area	37	8	19	7	56	8
Regulations make provision difficult	19	4	12	4	31	4
Language barriers	14	3	7	3	21	3
I am not aware of this service	39	8	13	5	52	7
Children/families don't need this service	63	13	58	21	121	16
Other	35	7	21	8	56	8

Table 7e.2. *Services for Parents with Limited English Skills by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Activities & workshops taught in Spanish or other languages for parents of DLLs								
Yes	2	4	15	10	112	20	1	2
No; if no, barriers:	43	96	141	90	455	80	50	98
Not available in this area	3	7	9	6	33	7	2	4
Not accessible	2	5	4	3	14	3	0	0
Not affordable	10	23	41	29	141	31	11	22
Lack of staff in this area	4	9	10	7	34	7	4	8
Regulations make provision difficult	2	5	6	4	20	4	0	0
Language barriers	1	2	4	3	13	3	0	0
I am not aware of this service	1	2	5	4	37	8	4	8
Children/families don't need this service	14	33	18	13	80	18	10	20
Other	4	9	11	8	27	6	2	4

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
English classes for parents								
Yes	2	4	12	8	70	12	2	4
No; if no, barriers:	43	96	141	92	491	88	49	96
Not available in this area	3	7	10	7	36	7	2	4
Not accessible	2	5	4	3	17	3	0	0
Not affordable	10	23	39	28	156	32	12	24
Lack of staff in this area	4	9	8	6	39	8	5	10
Regulations make provision difficult	2	5	6	4	23	5	0	0
Language barriers	1	2	3	2	17	3	0	0
I am not aware of this service	2	5	6	4	39	8	3	6
Children/families don't need this service	12	28	18	13	80	16	7	14
Other	5	12	12	9	34	7	2	4

For basic needs and other services, programs were mostly likely to offer food/emergency services (35%) and financial assistance (15%), and housing assistance and legal assistance to a lesser degree (9% and 7%, respectively) (Table 7f.1). Center-based programs and home-based programs provided all but financial assistance services at relatively the same rates, and center-based programs offered financial assistance services at about twice the rate as home-based programs. When programs reported barriers to offering these services, they most frequently endorsed costs or lack of need. Provision of these services increased with program quality (Table 7f.2).

Table 7f.1. *Basic Needs and Other Services by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Food or other emergency assistance						
Yes	200	37	100	32	300	35
No; if no, barriers:	345	63	208	68	553	65
Not available in this area	26	8	9	4	35	6
Not accessible	10	3	6	3	16	3
Not affordable	128	37	64	31	192	35
Lack of staff in this area	22	6	12	6	34	6
Regulations make provision difficult	15	4	10	5	25	5
Language barriers	9	3	3	1	12	2
I am not aware of this service	27	8	7	3	34	6
Children/families don't need this service	50	14	46	22	96	17
Other	22	6	14	7	36	7
Housing assistance						
Yes	55	10	23	8	78	9
No; if no, barriers:	477	90	273	92	750	91
Not available in this area	30	6	15	5	45	6
Not accessible	16	3	10	4	26	3
Not affordable	175	37	82	30	257	34
Lack of staff in this area	35	7	18	7	53	7
Regulations make provision difficult	28	6	12	4	40	5
Language barriers	12	3	5	2	17	2
I am not aware of this service	40	8	15	5	55	7
Children/families don't need this service	68	14	56	21	124	17
Other	34	7	18	7	52	7
Financial assistance						
Yes	98	18	28	9	126	15
No; if no, barriers:	436	82	272	91	708	85

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Not available in this area	35	8	16	6	51	7
Not accessible	15	3	9	3	24	3
Not affordable	164	38	84	31	248	35
Lack of staff in this area	31	7	18	7	49	7
Regulations make provision difficult	26	6	12	4	38	5
Language barriers	12	3	7	3	19	3
I am not aware of this service	41	9	12	4	53	7
Children/families don't need this service	50	11	51	19	101	14
Other	26	6	18	7	44	6
Legal assistance						
Yes	41	8	15	5	56	7
No; if no, barriers:	491	92	284	95	775	93
Not available in this area	37	8	17	6	54	7
Not accessible	18	4	10	4	28	4
Not affordable	178	36	86	30	264	34
Lack of staff in this area	41	8	20	7	61	8
Regulations make provision difficult	33	7	15	5	48	6
Language barriers	11	2	7	2	18	2
I am not aware of this service	42	9	18	6	60	8
Children/families don't need this service	66	13	57	20	123	16
Other	36	7	19	7	55	7

Table 7f.2. *Basic Needs and Other Services by Star Rating*

	1-2 Stars		3 Stars		4-5 Stars		Notice of Compliance	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Food or other emergency assistance								
Yes	9	20	50	31	214	37	17	32
No; if no, barriers:	36	80	109	69	357	63	36	68
Not available in this area	3	8	8	7	24	7	0	0
Not accessible	2	6	3	3	11	3	0	0
Not affordable	10	28	33	30	135	38	10	28
Lack of staff in this area	3	8	5	5	22	6	4	11
Regulations make provision difficult	2	6	5	5	18	5	0	0
Language barriers	1	3	1	1	10	3	0	0
I am not aware of this service	1	3	5	5	24	7	3	8
Children/families don't need this service	12	33	14	13	59	17	8	22
Other	4	11	8	7	21	6	2	6
Housing assistance								
Yes	2	4	15	10	112	20	1	2
No; if no, barriers:	43	96	141	90	455	80	50	98
Not available in this area	3	7	9	6	33	7	2	4
Not accessible	2	5	4	3	14	3	0	0
Not affordable	10	23	41	29	141	31	11	22
Lack of staff in this area	4	9	10	7	34	7	4	8
Regulations make provision difficult	2	5	6	4	20	4	0	0
Language barriers	1	2	4	3	13	3	0	0
I am not aware of this service	1	2	5	4	37	8	4	8
Children/families don't need this service	14	33	18	13	80	18	10	20
Other	4	9	11	8	27	6	2	4
Financial assistance								
Yes	2	4	16	10	95	17	6	12
No; if no, barriers:	43	96	140	90	463	83	44	88
Not available in this area	3	7	11	8	36	8	1	2
Not accessible	2	5	5	4	17	4	0	0

	1-2 Stars		3 Stars		4-5 Stars		Notice of	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Not affordable	12	28	47	34	172	37	14	32
Lack of staff in this area	4	9	6	4	35	8	4	9
Regulations make provision difficult	2	5	9	6	26	6	1	2
Language barriers	2	5	2	1	14	3	0	0
I am not aware of this service	3	7	6	4	38	8	4	9
Children/families don't need this service	13	30	13	9	65	14	6	14
Other	4	9	11	8	24	5	3	7
Legal assistance								
Yes	6	13	20	13	129	23	6	12
No; if no, barriers:	39	87	136	87	433	77	45	88
Not available in this area	3	8	12	9	35	8	1	2
Not accessible	2	5	5	4	19	4	0	0
Not affordable	10	26	43	32	141	33	10	22
Lack of staff in this area	3	8	8	6	34	8	3	7
Regulations make provision difficult	2	5	8	6	24	6	0	0
Language barriers	1	3	3	2	14	3	0	0
I am not aware of this service	2	5	9	7	32	7	4	9
Children/families don't need this service	12	31	16	12	69	16	9	20
Other	4	10	12	9	31	7	3	7

Overall, programs tend to refer families for services rather than have their own staff provide them (Table 7g.1). The services that are more likely to be provided by staff include home visiting and transportation assistance. Services that were generally provided equally by staff or via referral included food assistance/emergency services, education/job training, and activities and workshops in Spanish for parents of DLLs. These patterns were generally consistent across program quality, although lower quality programs were less likely to provide some specific services (Table 7g.2).

Table 7g.1. *Mechanisms for Providing Services to Families by Program Type*

	Center-Based Child Care				Home-Based Child Care				Total			
	By Staff		By Referral		By Sta		By Referral		By Sta		By Referral	
Variable (n offering service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Scholarship funds (n = 254)	90	42	112	52	11	28	24	60	101	40	136	54
Home visiting (n = 241)	132	78	27	16	41	57	28	39	173	72	55	23
Pediatric services (n = 75)	3	6	49	94	4	17	16	70	7	9	65	87
Child mental health screenings or assessments (n = 214)	27	16	126	75	7	16	32	71	34	16	158	74
Mental health care coordination or therapy (n = 174)	18	13	108	77	7	21	23	68	25	14	131	75
Child dental services (n = 159)	13	10	119	88	3	13	15	65	16	10	134	84
Transportation assistance for families (n = 178)	13	10	119	88	3	13	15	65	16	10	134	84
Food or other emergency assistance (n = 300)	77	62	36	29	37	69	14	26	114	64	50	28
Employment assistance (n = 126)	104	52	101	51	42	42	55	55	146	49	156	52
Education or job training (n = 286)	41	41	58	58	11	42	12	46	52	41	70	56
Services for drug or alcohol abuse (n = 84)	111	49	100	44	23	38	26	43	134	47	126	44
Legal assistance (n = 56)	9	16	45	78	3	12	19	73	12	14	64	76
Housing assistance (n = 78)	8	20	34	83	3	20	9	60	11	20	43	77
Financial assistance (n = 126)	12	22	42	76	4	17	14	61	16	21	56	72
Family literacy services (n = 167)	51	42	73	58	9	21	30	71	60	36	103	62
Activities & workshops taught in Spanish or other languages for parents of DLLs (n = 136)	53	49	54	50	8	29	15	54	61	45	69	51
English classes for parents (n = 90)	22	33	44	67	5	21	16	67	27	30	60	67

Table 7g.2. *Mechanisms for Providing Services to Families by Star Rating*

	1-2 Stars				3 Stars				4-5 Stars				Notice of Compliance			
	By Staff		By Referral		By Staff		By Referral		By Staff		By Referral		By Staff		By Referral	
Variable (n offerin service)	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Scholarship funds	4	44	3	33	10	38	15	58	77	39	108	55	8	73	3	27
Home visiting	5	63	2	25	10	40	14	56	156	77	36	18	0	0	1	100
Pediatric services	0	0	1	8	1	9	9	82	6	10	51	86	0	0	0	0
Child mental health screenings or assessments	0	0	3	50	4	14	21	75	29	18	101	62	1	14	5	71
Mental health care coordination or therapy	0	0	2	67	2	9	20	87	23	17	99	74	0	0	4	57
Child dental services	0	0	1	50	2	12	15	88	14	11	111	83	0	0	4	100
Transportation assistance for families	1	50	0	0	21	75	7	25	89	64	39	28	2	40	1	20
Food or other emergency assistance	3	33	3	33	26	52	25	50	102	48	118	55	9	53	4	24
Employment assistance	1	33	1	33	10	45	12	55	38	41	53	47	1	33	1	33
Education or job training	4	27	6	40	20	42	22	46	97	49	89	45	6	40	4	27
Services for drug or alcohol abuse	1	50	0	0	2	17	8	67	8	12	22	34	0	0	1	100
Legal assistance	0	0	0	0	1	13	6	75	10	23	13	30	0	0	1	100
Housing assistance	0	0	1	33	4	31	7	54	12	22	41	75	0	0	1	100
Financial assistance	0	0	0	0	6	38	7	44	30	32	52	55	3	50	1	17
Family literacy services	2	33	2	33	4	20	15	75	52	40	77	60	2	33	3	50
Activities & workshops taught in Spanish or other languages for parents of DLLs	1	50	0	0	3	20	11	73	55	49	53	47	1	100	0	0
English classes for parents	1	50	0	0	2	17	10	83	22	31	47	67	1	50	0	0

Many respondents (42% overall) reported that there were no parent needs that were not being met (Table 7h). When respondents indicated that parents' needs were not being met, the most frequently reported needs were basic supports like housing, transportation, jobs/employment/wages, health care, and other social services. This was particularly key for providers in center-based programs. For home-based programs, a few providers mentioned several different needs including basic needs, parent education, and child evaluation and assessment services.

Table 7h. *Parents' Needs That Are Not Being Met by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 264)	Home-Based (*n* = 93)	Total (*n* = 357)
NONE None/NA/IDK, "other"		**82 (31%)**	**68 (73%)**	**150 (42%)**
BASIC NEEDS SUPPORTS • Housing support • Transportation • Jobs/ higher wage employment • Food support • Medical/health care services • Clothes • Diapers • Legal assistance/services • Health insurance • Domestic violence support • Help from DSS	*Increase funding for subsidized housing.* *Transportation is a great need.*	98 (37%) 25 27 21 11 7 2 1 1 1 1 1	11 (12%) 2 5 2 2 0 0 0 0 0 0 0	109 (31%) 27 32 23 13 7 2 1 1 1 1 1
PARENT EDUCATION • Financial literacy classes for parents • Literacy skills • Classes on discipline • Classes on nutrition • Classes for parents on time management • Classes on stress management • Parental understanding of ins and outs of running a child care center		21 (8%) 7 5 3 2 1 0 3	4 (4%) 0 0 1 0 0 1 2	25 (7%) 7 5 4 2 1 1 5
PARENT INVOLVEMENT AND ENGAGEMENT • More parent involvement with their children • More parent engagement with the school/child care center		14 (5%) 11 3	2 (2%) 1 1	16 (4%) 12 4
DISABILITY SERVICES All mentions of general Special education services and/or screenings Speech/language pathology services		13 (5%) 8 5	2 (2%) 0 2	15 (4%) 8 7

Superordinate Theme	Quotes	Center-Based (*n* = 264)	Home-Based (*n* = 93)	Total (*n* = 357)
DUAL LANGUAGE SUPPORTS All mentions of language supports including translation/ ESL		13 (5%)	0	13 (4%)
EVALUATION SERVICES Evaluation/assessment services for their children		7 (3%)	3 (3%)	10 (3%)
RESOURCES All mention of "resources" or "supports"		9 (3%)	1 (1%)	10 (3%)
MORE STAFF		3 (1%)	2 (2%)	5 (1%)
QUALITY CARE Better quality care in classrooms		2 (1%)	0	2 (1%)
TEACHER STABILITY	*Teacher stability. these education requirements are making us hire badly rather than hiring for inner character and work ethic. I'm on the verge of giving up my stars completely.*	1	0	1
DIVERSITY		1	0	1

Technical Assistance and Professional Development Opportunities

Approximately 90% of programs reported that staff have access to Technical Assistance offerings (Table 8a.1). Of those who reported "no," providers from center-based care indicated "other reasons," and equal proportions (about 24%) endorsed lack of general availability, lack of interest, or specific topics of interest were not available. For home-based providers, the most common reasons they reported "no" were "other reasons" and lack of interest. Access to TA was greater in higher quality programs, and lower quality programs were more likely to cite lack of interest for the reason why they did not access TA (Table 8a.2). For providers who reported they were not able to access TA for other reasons, the four most common responses were availability, not having staff, cost, and not knowing how to find TA. For center-based programs, the top responses were availability and cost. Home-based providers much more often reported not having staff, followed by not knowing what TA is or where to find it.

Table 8a.1. *Technical Assistance Access by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Staff access to TA						
Yes	570	93	309	89	879	92
No	42	7	38	11	80	8
Of those who said no, why not?						
Not available	10	24	1	3	11	14
Not interested	10	24	17	45	27	34
Topics not available	10	24	4	11	14	18
Other	13	31	13	34	26	33
Type of TA supports that will help improve quality						
General coaching for teaching staff	429	75	105	34	534	61
Supporting children with challenging behaviors	531	93	182	59	713	81
Providing high-quality infant/toddler care	315	55	160	52	475	54
Supporting family engagement	336	59	139	45	475	54
Implementing effective business practices	173	30	100	32	273	31
Meeting the needs of DLLs	198	35	58	19	256	29
Supporting children with special needs	364	64	121	39	485	55
Supporting children and families in the transition to school	255	45	140	45	395	45
Other	26	5	24	8	50	6

Table 8a.2. *Technical Assistance Access by Star Rating*

	1-2 Stars (*n* = 55)		3 Stars (*n* = 174)		4-5 Stars (*n* = 632)		Notice of Compliance	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Staff access to TA								
Yes	47	5	159	19	599	70	50	6
No	9	12	22	28	41	53	6	8
Of those who said no, why not?								
Not available	0	0	2	9	7	17	1	17
Not interested	5	56	6	27	15	37	1	17
Topics not available	2	22	0	0	8	20	2	33
Other	3	33	8	36	13	32	2	33
Of those who said yes, type of TA supports?								
General coaching for teaching staff	17	36	93	58	367	61	37	74
Supporting children with challenging behaviors	30	64	115	72	497	83	49	98
Providing high-quality infant/toddler care	22	47	87	55	326	54	22	44
Supporting family engagement	18	38	78	49	345	58	22	44
Implementing effective business practices	10	21	46	29	194	33	13	26
Meeting the needs of DLLs	9	19	36	23	194	33	9	18
Supporting children with special needs	13	28	69	43	362	60	26	52
Supporting children and families in the transition to school	17	36	62	39	289	48	13	26
Other	5	11	13	8	30	5	0	0

Programs with higher quality star ratings tend to have more access and opportunities to receive TA, attend professional development opportunities and enrolled in formal coursework.

Table 8a.3. *Reasons Why Providers Are Not Able to Access Technical Assistance by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 264)	Home-Based (*n* = 93)	Total (*n* = 357)
AVAILABILITY	*I have applied for TA the last three years and never received any.* *contacted them per CCSA direction but no-one had time to come*	7 (54%)	1 (8%)	8 (31%)
HAVE NO STAFF	*I have no staff*			
COST	*Financial not able and not provided by the school*	3 (23%)	1 (8%)	4 (15%)
DON'T KNOW WHAT TA IS/WHERE TO FIND	*I don't know about TA*	1 (8%)	2 (15%)	3 (12%)
NA				
NO INTEREST	*Owner isn't interested*			
REQUIREMENTS	*Too many requirements and long procedures*	0	1 (8%)	1 (4%)

When asked which technical assistance supports are needed to improve quality, the most popular answer across program type was supporting children with challenging behaviors (81%) (Table 8b.1). The next most highly endorsed options were general coaching for teaching staff, supporting children with special needs, supporting family engagement, and providing high-quality services for infants and toddlers. Transitions, supporting DLLs, and effective business practices were mentioned by less than half of respondents. These patterns were generally consistent across program type and for higher quality programs (Table 8b.2). For respondents who indicated "other," most providers reported that no TA was needed to support their programs. This was particularly true for home-based providers, by far the most common response. The second most common response was wanting TA to help with center/home operations, which included a wide array of services spanning health, grant-writing, recruitment, and regulations. This response was slightly more common for center-based programs than "none." Some of these providers also reported that TA to address child and family needs would be helpful.

Table 8b.1. *Technical Assistance Supports That Will Improve Quality by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Type of TA supports that will help improve quality						
General coaching for teaching staff	429	75	105	34	534	61
Supporting children with challenging behaviors	531	93	182	59	713	81
Providing high-quality infant/ toddler care	315	55	160	52	475	54
Supporting family engagement	336	59	139	45	475	54
Implementing effective business practices	173	30	100	32	273	31
Meeting the needs of DLLs	198	35	58	19	256	29
Supporting children with special needs	364	64	121	39	485	55
Supporting children and families in the transition to school	255	45	140	45	395	45
Other	26	5	24	8	50	6

Table 8b.2. *Technical Assistance Supports That Will Improve Quality by Star Rating*

Star Rating								
	1-2 Stars (*n* = 55)		3 Stars (*n* = 174)		4-5 Stars (*n* = 632)		Notice of Compliance	
	N	%	N	%	N	%	N	%
Of those who said yes, type of TA supports?								
General coaching for teaching staff	17	36	93	58	367	61	37	74
Supporting children with challenging behaviors	30	64	115	72	497	83	49	98
Providing high-quality infant/toddler care	22	47	87	55	326	54	22	44
Supporting family engagement	18	38	78	49	345	58	22	44
Implementing effective business practices	10	21	46	29	194	33	13	26
Meeting the needs of DLLs	9	19	36	23	194	33	9	18
Supporting children with special needs	13	28	69	43	362	60	26	52
Supporting children and families in the transition to school	17	36	62	39	289	48	13	26
Other	5	11	13	8	30	5	0	0

Table 8b.3. *Other Suggestions for Technical Assistance Supports That Will Improve Quality by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 30)	Home-Based (*n* = 18)	Total (*n* = 48)
NONE		12 (40%)	13 (72%)	25 (52%)
TA TO HELP WITH CENTER/FDCH OPERATIONS	*Includes administrative leadership, grant writing, health and safety training, in Spanish, maintaining quality standards, free/affordable training, online, more time with child care consultant, preparation for environmental rating scales, recruitment and hiring, regulations, teacher motivation, and teacher self-efficacy*	13 (43%)	5 (28%)	18 (38%)
TA TO HELP WITH CHILD AND FAMILY NEEDS	*Includes Autism; handling divorce, drug addiction, and job loss; mental health*	5 (17%)	0	5 (10%)

Nearly all center-based providers indicated that their staff have access to professional development, whereas about 91% of home-based providers endorsed this (Table 8c.1). For center-based programs, 80% of providers indicated that they have staff currently enrolled in formal ECCE coursework; about half that rate was reported for home-based providers. Access to professional development and enrollment in coursework increased with program quality (Table 8c.2).

For the few providers indicating a lack of access to professional development opportunities (Table 8c.3), home-based programs most commonly reported that they did not have any staff to need PD. Other reasons, convenience, N/A, and cost were much less common responses. For center-based programs, the most common response was convenience – or actually lack of convenience, such as classes occurring when they are working or other timing reasons. The second and third most common responses were N/A and that they were not informed about the TA opportunities. When asked why staff were not currently enrolled in ECCE coursework (Table 8c.4), the two most common reasons were providers indicating that they do not have staff and that their training was already complete. Providers in home-based programs were the only ones to report not having staff. Center-based providers more commonly reported that they had already completed their training, indicating that their staff have earned degrees or their annual requirement has been met. Center-based providers also reported not having an interest and the cost as reasons why staff was not enrolled in formal ECCE coursework.

Table 8c.1. *Access to Professional Development and Formal Coursework by Program Type*

	Center-Based Child Care		Home-Based Child Care		Total	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Access to professional development						
Yes	596	99	307	91	903	96
No	9	2	31	9	40	4
Staff enrolled in formal coursework						
Yes	482	80	126	37	608	64
No	123	20	216	63	339	36

Table 8c.2. *Access to Professional Development and Formal Coursework by Star Rating*

Star Rating								
	1-2 Stars (*n* = 55)		3 Stars (*n* = 174)		4-5 Stars (*n* = 632)		Notice of Compliance	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Access to professional development								
Yes	49	6	160	18	613	70	55	6
No	6	15	14	36	19	49	0	0
Staff enrolled in formal coursework								
Yes	23	4	97	16	437	74	32	5
No	32	10	81	25	195	59	23	7

Table 8c.3. *Reasons Why Staff Have No Access to Professional Development by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 8)	Home-Based (*n* = 20)	Total (*n* = 28)
HAVE NO STAFF	*I have no staff*	0	10 (50%)	10 (36%)
CONVENIENCE	*Most of the classes I have a hard time they are when I am working. This is a home daycare I am working by myself. Need things for a Saturday or online and not saying at certain times during the day. This too is impossible for me. The timing does not coincide with my time.*	3 (38%)	2 (10%)	5 (18%)
NA		2 (25%)	2 (10%)	4 (14%)
COST	*Not available that the center can afford*	1 (13%)	2 (10%)	3 (11%)
DIDN'T HEAR ABOUT IT • No info about opportunities • Never offered to me	*Daycare home providers are not aware of some opportunities like daycare centers* *Never been offered*	2 (25%) 1 1	1 (5%) 1 0	3 (11%) 2 1
NOT REQUIRED	*We have the education*	0	2 (10%)	2 (7%)
NOT SURE		0	1 (5%)	1 (4%)

Table 8c.4. *Reasons Why Staff Are Not Currently Enrolled in Formal ECCE Coursework by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 134)	Home-Based (*n* = 194)	Total (*n* = 328)
HAVE NO STAFF	*I have no staff*	0	108 (56%)	108 (33%)
TRAINING COMPLETE All mentions of training being complete or staff having earned degrees.	*Annual requirement has been met*[42] *They are already licensed*[42] *We attend workshops when offered, at the present there are none being offered*[42] *Teachers all have their Bachelor's degrees and teaching license and Assistants all have Associates degrees* *Most have already completed some type of formal coursework in early childhood education*	42 (31%)	25 (13%)	67 (20%)
COST	*They are paid a very minimal wage and I find it difficult to require ongoing education with no expectation of any more money.*	21 (16%)	14 (7%)	35 (11%)
NO INTEREST		22 (16%)	5 (3%)	27 (8%)
NOT ENOUGH TIME	*They don't feel there is time to go to school.*	11 (8%)	12 (6%)	23 (7%)
NA or nonresponsive answer		7 (5%)	13 (7%)	20 (6%)
NOT REQUIRED		8 (6%)	7 (4%)	15 (5%)
WAITING FOR REGISTRATION WINDOW	*Will begin online classes soon* *Teachers will be enrolling in the fall*	13 (10%)	2 (1%)	15 (5%)
WE DO HAVE ENROLLED STAFF		5 (4%)	5 (3%)	10 (3%)
OTHER	*Includes I don't know, none have been offered, online, transportation, and staff has trouble with entrance exams.*	5 (4%)	3 (2%)	8 (2%)

Other Feedback

When asked what supports would make a difference for their programs (Table 9a), the most common support noted was funding, including higher subsidy reimbursement rates. This was true for all providers. The next most common response was not needing any supports, which was particularly salient for home-based programs. For non-home-based programs, training and personnel (i.e., specialized staff, contractors, behavior specialists, therapists) were the next most common areas in need of support.

42 There may have been some confusion about the tern "formal coursework". Many comments were similar to the first 3 presented here.

Table 9a. *Suggestions for Supports That Would Make a Difference for Their Program by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 456)	Home-Based (*n* = 137)	Total (*n* = 594)
FUNDING • General: All mentions of needing unspecified funding/money. • All mentions referring to need for more affordable child care and/or higher subsidies. • All mentions referring to the need for better pay for staff/financial help for teachers	*Everything comes down to not having the financial resources in order to pay for these services.* *Grants to support child care, but you always get turned down in this area (geography).* *NC Pre-K needs to be funded to match the cost related to the program. A higher DSS subsidy rate. We have not applied for a rate increase in over 10 years because the private pay families in our area cannot afford the higher rate.* *An increase in the NC Pre-k slot reimbursement rate so that we can fund teacher salary increases.*	161 (35%) 105 29 27	42 (31%) 34 5 3	203 (34%) 139 34 30
NONE None/NA/IDK, "other"		53 (12%)	37(27%)	90 (15%)
TRAINING All mentions of needing education, new knowledge, or training, in a few cases (N=7) respondents mentioned needing the $ to pay for it. Note these are NOT double counted under funding.	*…ways to achieve trainings that are more cost effective and time efficient for the teachers. We have high standards set for all training and certifications which we should but when child care centers are understaffed and under paid when are they supposed to complete these trainings? On their own time? Then the centers would be expected to pay the teachers for their time training but with what funds?* *…teacher training in infant toddler mental health and in-depth teacher training in recognizing red flags in development and supporting them.* *…how to administrate your business* *Coaches for teachers similar to NC Pre-K coaches.*	52 (11%)	6 (4%)	58 (10%)

Superordinate Theme	Quotes	Center-Based (*n* = 456)	Home-Based (*n* = 137)	Total (*n* = 594)
PERSONNEL • All mentions of the need for specialized staff, contractors, behavior specialists, therapists. • More staff/more qualified staff/substitutes – regular classroom staff or unspecified	*Access to PT or OT services.* *We can't mainstream kids without professional support.* *We need substitute teachers.* *Additional teachers. Centers cannot find people that want to work in this field anymore.*	46 (10%) 25 21	6 (4%) 2 4	52 (9%) 27 25
RESOURCES All mentions of unspecified or detailed materials, services, or resources.	*Free services even if my kids don't qualify*	28 (6%)	8 (6%)	36 (6%)
BEHAVIOR SUPPORT All mentions of need for support, training, or resources for working with children who have challenging behaviors	*Training for staff on dealing with challenging behaviors.*	22 (5%)	3 (2%)	25 (4%)
FEWER REGULATIONS All mentions of needing fewer regulations and strict requirements.	*There are so many rules and regs that it is hard to do everything. We are striving to offer high-quality child care with a good staff and provision of the needs of our children.* *I need … for the state to stop changing everything that we must be accountable for with no support from DCDEE.*	16 (4%)	6 (4%)	22 (4%)
BASIC NEEDS SUPPORTS • All mentions referencing parents' need for transportation. • Food support/funding for family food needs • Housing supports		14 (3%) 6 6 2	7 (5%) 5 2 0	21 (4%) 11 8 2
INFORMATION • All mentions of needing more information about resources and services. • Chances to connect with agencies to provide services	*A better resource guide to help support families when they need some sort of service.*	14 (3%) 11 3	6 (4%) 3 3	20 (3%) 14 6
PARENT AND COMMUNITY SUPPORT • Parent support and/or involvement • Community support		10 (2%) 5 5	7 (5%) 4 3	17 (3%) 9 8

Superordinate Theme	Quotes	Center-Based (n = 456)	Home-Based (n = 137)	Total (n = 594)
PARENT EDUCATION All mentions of needing classes/training for parents.	*Parent education on ways to strengthen home school connection and limiting screen time for both parents and students.* *More parenting classes in convenient locations.* *Time management for families.*	12 (3%)	3 (2%)	15 (3%)
EVALUATION SERVICES Evaluation/assessment services for their children resources.		5 (1%)	3 (2%)	8 (1%)
MENTAL HEALTH SERVICES		7 (2%)	0	7 (1%)
DUAL LANGUAGE SUPPORT All dual language related needs – training, translation, staff		5 (1%)	1 (1%)	6 (1%)
TECHNOLOGY SUPPORT		2	1 (1%)	3 (1%)
FACILITY IMPROVEMENTS		3 (1%)	0	3 (1%)
TIME		2	0	2
BETTER ENROLLMENT		2	0	2
SOCIAL WORK SUPPORTS		2	0	2
INFANT AND TODDLER QUALITY INITIATIVE		0	1	1
SMART START		0	0	1

When asked about other feedback (Table 9b), responses were very similar across provider types. The three most common responses were none, wanting help from the state (e.g., communication, funding, coordination of services, and policies), and being thankful for the opportunity to give feedback via the survey. There were no differences by provider type.

Table 9b. *Other Feedback and Suggestions by Program Type*

Superordinate Theme	Quotes	Center-Based (*n* = 95)	Home-Based (*n* = 44)	Total (*n* = 139)
NONE None/NA/IDK, "other"		32 (34%)	19 (43%)	51 (37%)
HELP, STATE All mentions referring to a wish for help from the state – communication, $, coordination of services, policies, regulations	*I have been a child care provider for over 15 years in XXX county and my major concern is the lack of communication and teamwork between us as providers and the state. This is causing quality child care professionals to leave which in turn effects the children.* *Current changes coming from DCDEE are resulting in programs closing. There needs to be more support offered to help meet these changes or the child care crisis is only going to get worse!* *If NC Pre-K is a free program for the children who are at risk, didn't those factors start at infancy? So why is not free for infancy up?* *Parents can only pay so much. Regulations are expecting more and more from staff; therefore, wages go up. For-profit schools are being squeezed to the point where the star program is becoming useless.* *…almost all high-quality programs have VERY long wait-lists.*	19 (20%)	8 (18%)	27 (19%)
THANK YOU Thanks for letting us share our ideas/perspectives/for doing the survey	*This has been the best survey I've felt that was really thinking about the providers.* *CONTINUE reaching out to us and keeping us updated.*	17 (18%)	6 (14%)	23 (17%)
QUALITY COSTS MONEY All mentions referring to the fact that If we want quality, it costs money to get the best staff	*The largest obstacle to offering high quality care is the pay early childhood educators receive in the state. They do not make enough for the level of education that is desired. Even if we find a competent applicant with ECCE education, we cannot offer more than Walmart or the fast food restaurants can offer them.*	10 (2%) 5 5	7 (5%) 4 3	17 (3%) 9 8

Superordinate Theme	Quotes	Center-Based (n = 95)	Home-Based (n = 44)	Total (n = 139)
DISPARITIES EXIST FOR DIFFERENT CARE OPTIONS Disparities exist for getting staff, help, and materials	*I feel that family child care homes are over looked when it comes to any grants offered to help with educational and developmentally appropriate toys and materials for us to offer the children in our care.* *Home child care providers need more funding grants and scholarship funding.*	3 (3%)	3 (7%)	6 (4%)
COLLABORATION BRINGS SUCCESS All mentions of success when all parties need to work together	*We all succeed if we work together. We all have an important roll (sic) in this job, because honestly ONE HAND WASH THE OTHER.*	4 (4%)	1 (2%)	5 (4%)
SURVEY Comment/complaint about the survey itself	*This was difficult to fill out since we only have two children and my husband and myself run the family daycare and we have no employees.* *This was very long.* *restaurants can offer them.*	3 (3%)	2 (5%)	5 (4%)
INFORMATION SHARING NEEDED • Need info • More services from the library needed	*I would like information on how to get many of the services that was mentioned in this survey just in case I did need it I would already know where to look. Is this possible?*	3 (3%) 2 1	2 (5%) 2 0	5 (4%) 4 1
WANT TO EXPAND		2 (2%)	1 (2%)	3 (2%)
SUCCESS • Love what I do and will continue to do it my way • I provide all needed services		2 (2%) 1 1	1 (2%) 1 0	3 (2%) 2 1
SHOUT OUT Positive comments about a particular person		1 (1%)	0	1 (1%)

Appendix H: North Carolina Needs Assessment for Early Education Services for Children Birth to Age Five Child Care Provider Survey

Thank you again for agreeing to help us with this project. We know how busy you are, and we really appreciate your help.

The Division of Child Development and Early Education (DCDEE) is seeking to identify/describe and address barriers to providing high-quality Early Childhood Education (ECE) services, including facility related concerns and funding challenges in North Carolina. The Frank Porter Graham Child Development Institute (FPG) at the University of North Carolina at Chapel Hill has been funded to identify these barriers as part of a state-wide Needs Assessment. We know you may have received other surveys that are related to your program. We encourage you to complete those as well as appreciate your support in completing this one.

This survey should be completed by either the director/administrator or owner of the program. If you received this survey and are not in one of those roles, please forward to the director/administrator or owner, and do not complete yourself.

The survey should take about 15-20 minutes to complete. It might be helpful to have your enrollment and waitlist data at hand, as some of the questions ask about numbers of children in your care. Completion is voluntary. You may choose not to answer any question. All information gathered will be confidential and the report FPG provides to DCDEE will be group summaries only; we will not report what individuals have said. Your feedback will be helpful as DCDEE works with key partners and stakeholders.

***We will hold a drawing for ten $50 Walmart gift cards from among those who complete this survey by August 15th**. A link for your contact information will be provided after you complete your survey.*

Information about You and Your Program:

We would like to learn a little bit about you and your program.

1. What is your role? **(check all that apply)**
    - o Director/Administrator
    - o Owner
    - o Family Child Care Provider
    - o Other (specify)_____

2. How long have you been working in the field of early care and education?
    - o Less than 1 year
    - o 1-2 years
    - o 3-4 years
    - o 5-10 years
    - o More than 10 years

3. In what type of program do you currently work? **(check all that apply)**
    - o Non-profit center-based child care
    - o For-profit center-based child care
    - o Multi-site center-based child care (3 or more sites)
    - o Home-based child care
    - o NC Pre-K
    - o Head Start/Early Head Start
    - o Public school program
    - o Faith-based

4. What is the zip code for this program? _____

5. What is this program's current star rating?
    - o Temporary
    - o Probationary
    - o Special Provisional
    - o One Star
    - o Two Star
    - o Three Star
    - o Four Star
    - o Five Star
    - o Notice of Compliance (religious sponsored)

6. Do you currently enroll infants and toddlers in your program?
    - o Yes
    - o No

If No, 6a. Why not?

7. In the past have you enrolled infants and toddlers?
    - o Yes
    - o No

If Yes, 7a. Why did you stop enrolling infants and toddlers?

8. Is there a need in your community for additional child care facilities that enroll infants and toddlers?
    - o Yes
    - o No

If Yes, 8a. Please explain why you think there is a need?

9. How many children are currently enrolled in your program by age, and how many total children do you serve when you are at full enrollment?

[programming check: fully enrolled column > or = to currently enrolled]

	Number of Children Currently Enrolled	Total Number of Children When Fully Enrolled
0-12 months		
12-24 months		
2-3 years old		
3-4 years old		
4-5 years old		

10. Does your program enroll children who receive a child care subsidy?
    - o Yes
    - o No

If No, 10a Why does your program not enroll children who receive a child care subsidy?

11. Do you currently have a waitlist for your program?
    - o Yes
    - o No

If Yes, 11a. What is the number of children on your waitlist by age-group?

0-12 months	o 0 o 1-9 o 10-20 o 21+
12-24 months	o 0 o 1-9 o 10-20 o 21+
2-3 years old	o 0 o 1-9 o 10-20 o 21+
3-4 years old	o 0 o 1-9 o 10-20 o 21+
4-5 years old	o 0 o 1-9 o 10-20 o 21+

12. In the last two years, enrollment numbers have
    - o Increased
    - o Decreased
    - o Stayed the same

If your numbers have decreased,12a. Why did your enrollment numbers decrease?

13. Do you provide transportation?
    - o Yes
    - o No

If No, 13a. Why do you not provide transportation?

14. Indicate the approximate number of children enrolled for each of the following racial and ethnic groups?

- White/Caucasian_____
- African American/Black____
- Hispanic/Latino_____
- Asian_____
- Native American_____
- Middle Eastern_____
- Other (please specify) _____

15. How many enrolled children are dual language learners (children whose home or primary language is not English)?

(If >0, go to 15a)

15a. What languages other than English are spoken?	**How many families speak this language?**	**Do any of these families need assistance in their native language to be able to communicate?**	
Language	**Number**	**Yes**	**No**
Spanish		Yes	No
Arabic		Yes	No
Chinese		Yes	No
Hindi/Urdu		Yes	No
Vietnamese		Yes	No
Other Specify: _____		Yes	No
Other Specify: _____		Yes	No
Other Specify: _____		Yes	No

(If >0, go to 15a)

	15b. Do you have staff who speak this language?	
Language	**Yes**	**No**
Spanish	Yes	No
Arabic	Yes	No
Chinese	Yes	No
Hindi/Urdu	Yes	No
Vietnamese	Yes	No
Other Specify: _____	Yes	No
Other Specify: _____	Yes	No
Other Specify: _____	Yes	No

16. How many children in your program have Individual Family Service Plans (IFSPs) or Individual Education Programs (IEPs)?

17. Does your program conduct screenings to identify children who are at risk for disabilities?

- o Yes
- o No

18. Please indicate whether any of the following are provided at your site for children with disabilities, either through your own staff or other agency staff.

Provided services				Is that service... *Check all that apply*		
		YES	NO	Provided by your staff	Provided by contracted staff	NA
a)	Assistive technology					
b)	Audiology services					
c)	Family training, counseling and home visits					
d)	Health services					
e)	Medical services					
f)	Nursing services					
g)	Nutrition services					
h)	Occupational therapy					
i)	Physical therapy					
j)	Psychological services					
k)	Service coordination services					
l)	Sign language and cued language services					
m)	Social work services					
n)	Special instruction					
o)	Speech-language pathology services					
p)	Transportation and related costs					
q)	Vision services					
r)	Other service for children with disabilities **(Specify: _____)**					

19. What is working well within your program to provide services for children with disabilities?

20. What challenges does your program face providing services for children with disabilities?

Information about your staff and your progra

21. Are your staff able to access technical assistance in order to improve quality?
    - o Yes
    - o No

    If No, 21a Why are you not able to access technical assistance?
    - o Not available in my County/City
    - o Not interested
    - o Topics for needed TA are not available (e.g., Challenging Behaviors, Safety)
    - o Other **(please specify)** _____

22. What type of technical assistance would best support your program in improving or maintaining quality? **(check all that apply)**
    - o General coaching for teaching staff
    - o Supporting children with challenging behaviors
    - o Providing high-quality Infant/toddler care
    - o Supporting family engagement
    - o Implementing effective business practices
    - o Meeting the needs of dual language learners
    - o Supporting children with special needs

23. Do your staff have access to professional development opportunities such as conferences, coursework, pre-service?

    Yes

    No

If No, 23a Why do your staff not have access to professional development opportunities?

24. Do you currently have staff enrolled in formal coursework related to early care and education?

    Yes

    No

If No, 24a Why not?

PROGRAM SERVICES and PARTNERSHIPS

The following questions are related to any child and family services that your program might offer such as medical care, job training, or family literacy. This includes services you provide directly to families with your own staff or through referral to an outside agency.

25. Program offerings		*Check one per row*		*Check all that apply*		*Check all that apply*
		If "YES," Go to 25a; If "NO," Go to 25b		**25a. That service is provided……**		**25b. Why do you not offer this service? (check all that apply for each service)**
		Yes 1	No 0	Directly by program staff	By a referral	(For each "no" response, these options would pop up)
a)	Activities & workshops taught in Spanish or other languages for parents of Dual Language Learners (DLL)					Service not available in this area Service not accessible (e.g., too far away) in this area My program cannot afford to provide this service Lack of staff in this area to provide this service Regulations make this service difficult to provide Language barriers make it difficult for families to get this service I am not aware of this service The children/families served by my program do not need this service Other (specify: _____)
b)	Child dental services					
c)	Child mental health screenings or assessments					
d)	Education or job training					
e)	Employment assistance					
f)	English language classes for parents					
g)	Family literacy services					
h)	Financial assistance					
i)	Food or other emergency assistance					
j)	Home visiting					
k)	Housing assistance					
l)	Legal assistance					
m)	Mental health care coordination or therapy					
n)	Pediatric services					
o)	Scholarship funds					
p)	Services for drug or alcohol abuse					
q)	Transportation assistance for families					

26. What supports would benefit your program?

27. In your opinion, what are some of the needs of the parents of the children enrolled in your program that are not being met?

28. *Thank you for your time. We sincerely appreciate the information you have provided*. In closing, if you have any other feedback that you'd like to share, please provide those comments below.

*Please **CLICK HERE** to enter your contact information to be entered into a drawing for the opportunity to receive a $50 Walmart gift card for participating in the survey.*

Thank you again!

Contact Information **[separate survey link]**

Program Name

Your Name

Address

City

Zip Code

Appendix I: Tables and Figures Related to North Carolina Early Childhood Care and Education System Integration and Interagency Collaboration

Table I-1. *North Carolina Early Childhood Initiatives and Workgroups*

Initiative	Description
AWARD$	AWARD$ implemented through the Child Care Services Association (CCSA) to provide salary incentives to better compensate and retain teachers of infants and toddlers.
Birth through Third Grade (B-3) Interagency Council[43]	The B-3 Interagency Council was established by the North Carolina General Assembly in 2017. Its focus areas include the following: 1) Standards and assessment, 2) Data driven improvement and outcomes, including Teacher and administrator preparation and effectiveness, 3) Instruction and environment, 4) Transitions and continuity, and 5) Family engagement governance and funding shared accountability measures
Business for Educational Success and Transformation (BEST)[44]	The BEST North Carolina collaboration was formed in 2013 to "unite an engaged and informed business perspective to dramatically transform and improve education in North Carolina." The vision defined in 2015 includes the following three goals: support students, elevate educators, and raise expectations. Efforts since 2015 have largely focused on K-12 education.
Early Childhood Data Advisory Council[45]	Improving the data collected in the state around ECCE and use a racial equity lens in their efforts
Infant Toddler Enhancement Project	Established to improve the quality and availability of infant/toddler care in North Carolina by providing technical assistance for child care programs and other community consultants and training specific to infant and toddler care best practices through the state.
North Carolina Early Childhood Action Plan (ECAP)[46]	The North Carolina Early Childhood Action Plan provides a framework for galvanizing public and private action to achieve a bold vision and measurably improve outcomes for our state's young children by 2025. The plan prioritizes 10 goals for children from birth through age eight that, when achieved, will provide all North Carolina's children with a fair opportunity to grow up healthy in safe and nurturing families, schools and communities, so that they are learning and ready to succeed. North Carolina Early Childhood Action Plan Data Dashboard: To track progress toward the targets and sub-targets of the 2025 goals in the North Carolina Early Childhood Action Plan, each of the 10 goals of the plan has its own page of data and information.
North Carolina Early Childhood Foundation (NCECF)	Pathways to Grade-Level Reading: A data-informed framework using a systems approach to improve reading outcomes. To recommend a measure or set of measures to capture children's development at kindergarten entry at the population level. Child Development at Kindergarten Entry Data Workgroup: Charge to recommend a measure or set measures to capture children's development at kindergarten entry at the population level.

43 North Carolina Department of Health and Human Services, & North Carolina Department of Public Instruction. (2019). Birth through third grade (B-3) interagency council. Retrieved from https://www.b3council.nc.gov/
44 BEST NC. (2017). Business for educationalsSuccess and transformation. Retrieved from http://best-nc.org/
45 North Carolina Early Childhood Foundation. (n.d.) NC Early Childhood Data Advisory Council. Retrieved from https://buildthefoundation.org/nc-early-childhood-data-advisory-council/
46 North Carolina Department of Health and Human Services, 2019a.
47 North Carolina Department of Health and Human Services. (2019b). NCCARE360. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360
48 North Carolina Institute of Medicine (NCIOM). (2015). NCIOM task force on essentials for childhood: Safe, stable, and nurturing relationships and environments to prevent child maltreatment. Retrieved from http://nciom.org/task-force-on-essentials-for-childhood/

Initiative	Description
NCCARE360[47]	North Carolina is the first state in the US to implement NCCARE360, a coordinated care network that will electronically connect those with identified needs to community resources, with a built-in "feedback loop" to understand the outcome of that connection.
North Carolina's Institute of Medicine's (NCIOM, 2015) Task Force on Essentials for Childhood[48]	Prevent early childhood trauma and abuse. They have 4 goals: 1) raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment, 2) use data to inform actions, 3) create the context for healthy children and families through norms change and programs, and 4) create the context for healthy children and families through policies.
Preschool to Kindergarten Transition Pilot Project[49]	Designed to provide high-quality educational experiences to enhance school readiness for eligible four-year-old children. To implement a method for preschool teachers to prepare a preschool to kindergarten transition plan for all children enrolled in NC-Pre-K. They also provide resources for parents to help explain the transition from early intervention to preschool.
Promoting Social Behaviors in Child Care Settings	Established to address behavioral issues in young children by offering services designed to identify, prevent and modify challenging behaviors with a goal of reducing the expulsion rate and promoting social-emotional development of all children in North Carolina licensed child care centers.
State Family Engagement and Leadership Coalition	To ensure that the Early Childhood System is family-driven and equitable, serving children in the contexts of their families and communities. The SFEL seeks to establish guiding principles and an initial plan for statewide implementation.
State-level Home Visiting Integration with Early Childhood Data Systems (SHINE)[50]	Technical and financial support to link home visiting data with other early childhood program data (Child Trends, 2017).
T.E.A.C.H. Early Childhood®	Provides educational scholarships to early care professionals and those who perform specialized functions in the early care system.
The P-20W System is a Statewide Longitudinal Data Systems (SLDS) that links data from Early Learning, K-12, Higher Education, and Workforce	The P-20W data system was designed as a real-time data system to track student performance across years and sectors, exchange individual data between agencies, help evaluate institutions and program performance (e.g., schools, LEAs, programs, and IHE systems), analyze data in more detail to validate or improve performance, find areas for improvement and offer solutions (e.g., supplemental education services, professional development). • P = Preschool • 20 = Grade 20 or higher education • W = Workforce
Think Babies™ NC[51]	The Think Babies™ North Carolina initiative seeks to build public awareness and policymaker support for what North Carolina's youngest children and their families need to thrive: healthy beginnings, supported families and quality early care and learning experiences. This statewide initiative to support the healthy development of children age 0-3.
Wages$ NC	To ensure that no family pays more than 10% of its gross earnings to purchase child care for one child. To ensure that high quality child care is accessible to all children. To ensure that all child care is of high quality.
Yay Babies, NC	To improve connections between North Carolina children experiencing homelessness to early childhood services

49 North Carolina Early Learning Network, 2019
50 Child Trends. (2017). Child Trends selects five states to participate in initiative to connect home visiting information with other early childhood data. Retrieved from https://www.childtrends.org/news-release/child-trends-selects-five-states- participate-initiative-connect-home-visiting-information-early-childhood-data
51 Think Babies Campaign, 2019.

Figure I-1. *List of Members for North Carolina Early Childhood Advisory Council*

NC ECAC Members

- NC DHHS Secretary
- The State Director of the Head Start – State Collaboration Office
- Three members from the NC DHHS representing child care, NC Pre-K, health, mental health, social services
- Part C Infant-Toddler Program with at least one of these members also serving on the B-3 Inter agency
- Council and at least one of these members serving on the Child Well-Being Transformation
- Council
- Two members from state institutions of higher education
- One member from the North Carolina Office of State Budget and Management
- The President of the North Carolina Partnership for Children
- Two current ECCE providers
- One member from a North Carolina Head Start agency
- One LEA member
- Two current consumers of ECCE services
- One member from NC DPI
- Up to 9 additional members that may include, but are not limited to, representatives from the private sector, philanthropic institutions and organization, early childhood research institutions and organizations, nonprofit agencies providing early childhood services, the faith community, and early childhood policy institutions and organizations

Figure I-2. *List of Members for North Carolina Birth to Third Grade Interagency Council*

Interagency Council Members

- Superintendent of Public Instruction
- Associate Superintendent of Early Education at the Department of Public Instruction
- Secretary of Health and Human Services
- Deputy Secretary of Human Services
- Four public members appointed by the Speaker of House of Representatives who represent organizations that focus on early childhood education and development, one of whom shall be a representative of Smart Start
- Four public members appointed by the President Pro Tempore of the Senate who represent organizations that focus on early childhood education and development, one of whom shall be a representative of the North Carolina Partnership for Children
- Two members of the House of Representatives appointed by the Speaker of the House of Representatives to serve as nonvoting advisory members
- Two members of the Senate appointed by the President Pro Tempore of the Senate to serve as nonvoting advisory members.

Table I-2. *Initiatives to Create Infrastructure and Improve Capacity to Track Participation Across Services*

Initiative	Anticipated Results
The P-20W System is a Statewide Longitudinal Data Systems (SLDS)[52]	A universal identifier (UID) that tracks with the student across services and educational programs, linking data from Early Learning, K-12, Higher Education, and Workforce
North Carolina Early Childhood Integrated Database (NC ECIDS)[53]	Integrate data for children birth to age five across service sectors to: • answer key program and policy questions • provide unduplicated counts of children across multiple programs and services • produce aggregate level reports for commonly asked program and policy questions • provide data for approved research requests • connect with the P-20W (Preschool through age 20/Workforce) system to examine the Participating programs as of May 2019 include NC Pre-K; subsidized child care subsidy program; IDEA, Part C; IDEA, Part B (619), Food and Nutrition Services, and Child Protective Services. Programs and projects that will be added include Early Head Start, Head Start, Temporary Assistance for Needy Families, home visiting data, and educational outcomes data from the North Carolina Department of Public Instruction.
NCCARE360[54]	• A statewide resource directory, including a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities. • A data repository to integrate resource directories across the state to share resource data. • A shared technology platform that enables health care and human service providers to send and receive secure electronic referrals, seamlessly communicate in real-time, securely share client information and track outcomes. • A community engagement team working with community-based organizations, social service agencies, health systems, independent providers and more to create a statewide coordinated care network.
State-level Home Visiting Integration with Early Childhood Data Systems (SHINE)[55]	Link home visiting data with other early childhood program data (Child Trends, 2017).
NC Early Childhood Action Plan (ECAP),[56] NC Early Childhood Action Plan Data Dashboard[57]	Lists the data sources used for each target or sub-target included in the ECAP

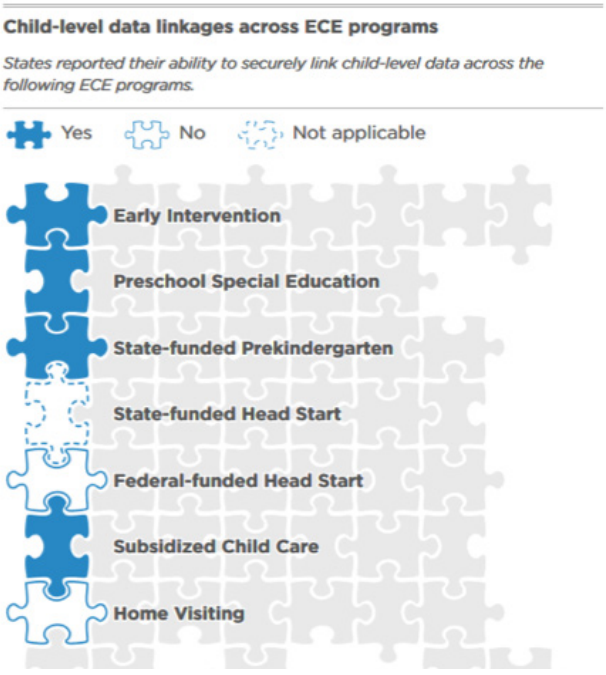
52 North Carolina Department of Public Instruction. (2019b). North Carolina P-20W SLDS grant. Retrieved from http://www.dpi.state.nc.us/data/ncp-20w/
53 North Carolina Department of Health and Human Services Division of Child Development and Early Education. (2019e). NC early childhood integrated data system. Retrieved from https://earlylearningchallenge.nc.gov/nc-early-childhood-integrated-data-system
54 North Carolina Department of Health and Human Services, 2019b.
55 Child Trends, 2017.
56 North Carolina Department of Health and Human Services, 2019a.
57 North Carolina Department of Health and Human Services. (2019c). NC Early childhood action plan data dashboards. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/early-childhood/nc-early-childhood-action-plan-data-dashboards
58 North Carolina Department of Health and Human Services, & North Carolina Department of Public Instruction, 2019.
59 North Carolina Early Childhood Foundation, 2019a.
60 North Carolina Institute of Medicine (NCIOM), 2015.

Figure I-3. *Summary of North Carolina Early Childhood Data Systems and Status of Linkages*[61]

Summary of State Early Childhood Data Systems	
Has a Quality Rating and Improvement System	Yes
Has a Workforce Registry	Yes
Has an Early Childhood Integrated Data System	Yes
Has a defined data governance body	Yes
Status of Linkages	
Links child data across ECE programs	Yes
Links ECE data with K-12 data system	No, but plans to
Links child data with health data	No, but plans to
Links child data with social services	Yes
Links ECE program data	No, but plans to
Links workforce data	No, but plans to

Source: 2018 Early Childhood Data Systems Survey

Figure I-4. *Child-Level Data Linkages across ECCE Programs*[62]



61 Early Childhood Data Collaborative (2019). State early childhood data systems snapshot. Retrieved from https://www.ecedata.org/2018-state-of-early-childhood-data-systems/

62 Early Childhood Data Collaborative, 2019

Figure I-5. *Data Governance Structures*[63]

State entities included in data governance body

The state governance body oversees the ECIDS, but each specific ECE program database is overseen by its respective agency or department

Types of ECE data overseen by governance body

Early Intervention (IDEA, Part C)	No ○
Preschool Special Education (IDEA, Part B 619)	No ○
State Prekindergarten	No ○
State-funded Head Start	N/A
Federal-funded Head Start	No ○
Subsidized child care	No ○
Home visiting	No ○
Screenings and assessments databases	No ○
Quality rating and improvement databases	No ○
Professional development databases	No ○
Health databases	No ○
Social services databases	No ○
None	N/A
Other data systems	Yes ●

Method for forming data governance body

State legislation	No ○
State charter	No ○
Voluntary collaboration	Yes ●
State/federal grant	No ○
State early childhood advisory council	No ○

Uses of coordinated early childhood data

Answer key policy questions	Yes ●
For accountability/compliance purposes	No ○
Develop standard data reports using cross-program data	Yes ●
Respond to external data requests	Yes ●
Evaluate early childhood program/initiative outcomes	No ○
Conduct research studies	Yes ●
Share information with policymakers	Yes ●
Share information with parents	No ○
Other ways	No ○

63 Early Childhood Data Collaborative, 2019

Appendix J: Tables Related to Measurable Indicators of Progress

Table J-1. *Measurable Indicators of Progress on child and family outcomes and ECCE service to help measure performance of ECCE programs and children's development*

Data system/source	Managed by	Anticipated Results
Kindergarten Entry Assessment (KEA)	NC Department of Public Instruction (NC DPI)	A formative assessment covering 5 developmental domains: • Approaches to Learning: Engagement in Self-Selected Activities • Cognitive Development: Object Counting • Emotional-Social Development: Emotional Literacy • Health and Physical Development: Grip Manipulation, Crossing Midline, Hand Dominance • Language Development and Communication: Following Directions, Letter Naming, Book Orientation, Print Awareness
North Carolina QRIS system	NC Division of Child Development and Early Education (NCDCDEE)	• Staff Qualifications and Professional Development Curriculum • and Learning Activities • Administration and Business Practices • Family Engagement • Staff-Child Ratios and Group Size • Child Assessment • Health and Safety • The Environment Rating Scales (ERS) are used to assess program quality. These data are collected every 3 years. These indicators differ from the others as they are program-level rather than child-level, thus are not easy to disaggregate by race/ethnicity, age, or income.
High Quality Child Care	North Carolina Rated License Assessment Project/NCDCDEE	• State average number of children birth to age five attending licensed child care who are in high quality centers or homes (4- or 5- star). • These data are disaggregated by county or school district and by age
High Quality Child Care	NCDCDEE	• Estimated eligible four-year-olds attending NC Pre-K • Percent of early childhood teachers with post-secondary early childhood education
Child Care Subsidy/Cost	NCDCDEE	• Children birth to age five receiving subsidy attending licensed child care who are in high quality centers or homes (4- or 5- star) • Estimated eligible children age 6 receiving child care subsidies Families paying 10% or less of income on child care
Special Education	The National Center for Education Statistics	Preschool children receiving special education services
Grade-level Promotion	NC DPI Statistical Data Profile and US Department of Education, Office of Civil Rights Data Collections	Children promoted to next grade level (K-3)

Data system/source	Managed by	Anticipated Results
Suspensions/ expulsions	NC DPI	• Children suspended from schools (K-3 and preschool within public school system)
Services for children experiencing homelessness	Institute for Children, Poverty, and Homelessness (ICPH)	How well homeless children of all ages are being connected to early intervention and educational services

Table J-2. *Strengths and weaknesses of progress indicators of ECCE services and outcomes*

Indicators	State average	Trend (5 year)	National Comparison	Disaggregated by county or school district	Disaggregated by race/ethnicity	Disaggregated by income level	Disaggregated by age
Children showing improvement with early intervention	X	X	---	X	X	---	n/a
Children birth-to-five attending licensed child care who are in high quality centers, homes (4- and 5-star) *	X	X	---	X	---	---	X
Children birth-to-five receiving subsidy attending licensed child care who are in high-quality centers, homes (4- and 5-star) *	X	X	---	X	X	X	X
Children suspended from programs and schools	X	X	X	X	X	---	---
Children expelled from programs and schools (K-3 and preschool)	X	X	X	X	X	---	---
Children attending schools that systematically involve child care programs and families before school transition	No Data						
Preschool children receiving special education services	X	X	X	X	---	---	---
Students with access to programs in native language	No Data						
Estimated eligible children under age 6 receiving child care subsidies	X	X	X	X	---	---	X
Families paying less than 10% of income on child care*	X	---	---	X	---	---	---
Estimated eligible four-year-olds attending NC Pre-K*	X	X	X	---	---	---	---
Early childhood teachers with post-secondary ECCE education*	?	?	?	?	?	?	?
Kindergarten Entry Assessment (KEA)	---	---	?	---	?	?	N/A
QRIS	X	X	X**	X	---	Yes, for subsidy	---
How well children experiencing homelessness of all ages are being connected to early intervention and educational services (ICPH)	No Data						

**ECAP Goal 8 target*
***Each state has its own system, which may not be directly comparable.*
? Unknown if data exists in this form

Appendix K: Recommendations to Ease Policy and Regulatory Barriers

Source	Recommendations
NC Pre-K[64]	• Create expansion targets to reach 75% of eligible children, using census data estimates rather than waiting lists. Target areas with underserved child populations and low saturation of NC Pre-K. • Offer financial incentives for four- and five-star private centers to meet the higher-quality standards to serve NC Pre-K eligible children. • Increase reimbursement rates, which have been stagnant since 2012. • Offer grants for expansion start-up costs (e.g., outreach, recruitment, facilities, equipment, capital costs). • Develop county supplements to increase funding rates. • Provide supplemental funds related to teacher compensation to achieve parity between private centers and public schools. • Increase the allowable amount of state funding that can be used to cover administrative costs. • Explore mechanisms to utilize child care subsidy funds and NC Pre-K funds to serve the same child (i.e., wrap around services). • Explore shifting NC Pre-K funding into the public-school funding formula (regardless of NC Pre-K setting), which could enable all eligible children to be served, as funding could include state,
The Birth through Third Grade (B-3) Interagency Council[65]	• Amend G.S. 115C-105.41 to include a requirement that LEAs work with community ECCE partners to develop a plan for transitioning all children into kindergarten. • Request funding for a data system to facilitate sharing child and family information between programs serving 4-year-old children and LEAs. • Conduct analysis and assessment of 0-8 landscape. • Conduct survey among teachers, administrators, policy-makers, governmental agencies, organizations and other stakeholders of 0-8 data. • Undertake study of the teaching licensure system. • Develop professional development related to early childhood for elementary school principals and provide incentives for completion. • Requirements for all pre-K teachers should include minimum CDS, working toward early childhood AAS, and 15-hours annual professional development. • Increase NC Pre-K reimbursement rates.
Home Visiting Landscape Study[66]	• Be responsive to local communities. • Develop a statewide home visiting strategic vision and action plan that is completely integrated with a comprehensive system of care. • Identify new funding streams to support an integrated family support system anchored by early home visiting. • Build and support a well-trained, well-resourced workforce by developing a shared educational platform, providing continuing education, creating regional learning collaboratives, and providing skill-building opportunities for core competencies. • Report annually on a set of common indicators across all programs to provide information about the families served, outcomes achieved, and return on investment. • Assess community capacity, fit, need, and usability in the selection of models. • Improve coordination among programs and with other services, including medical homes and social services to comprehensively address family needs.

64 Barnett & Kasmin, 2019
65 North Carolina Department of Health and Human Services, & North Carolina Department of Public Instruction, 2019
66 Bryant et al, 2018

Appendix L: PDG Progress – Year 1

Activity 1: Needs Assessment

There are two Needs Assessment-related projects. The Frank Porter Graham Child Development Institute at UNC Chapel Hill (FPG) was contracted to complete a state-wide early care and education (ECE) needs assessment. The Center for American Progress (CAP) was contracted to develop a cost of quality model for infants, toddlers and pre-kindergarten across the state.

1.1– FPG report

The focus of the Needs Assessment required by PDG is on access to high quality early care and education (ECE) especially for vulnerable, rural and special needs children. In assessing needs and access of children, the need for improved data measures has emerged. In addition to collecting the most up-to-date and relevant early childhood data, FPG examined prior existing NA reports completed at county, regional and state levels, and conducted many focus groups including ones with Spanish speaking families, tribal and homeless populations, and parents of children with disabilities. A survey has been distributed to ECE providers with results expected by mid-to-late August 2019. The final reports assessing North Carolina's needs are expected by early-September.

1.2 – CAP report

Initial cost modeling work on the cost of quality child care and education for infants, toddlers and preschooler children in urban, suburban and rural counties has been completed and improvements are now being sought for some data in order to recommend a rate methodology. The report is expected by November 2019.

Activity 2: B5 Strategic Plan

This project consists of four components:

- The drafting of a B5 Strategic Plan (B5SP), using existing state plans and frameworks, including the Early Childhood Action Plan, B3 Interagency Council findings, the work of the Governor's Commission on Access to Sound Basic Education, the Pathways to Third Grade Reading project, and the Think Babies quality enhancement program;
- Gathering feedback from stakeholders on the Early Childhood Action Plan and the B5SP working draft and subsequent iterations to inform the final published plan;
- The development of an early childhood data strategy aligned to NC early childhood data policy, with special emphasis on social-emotional measures, and;
- The development of indicators or proxy indicators on child development at the population level at K entry.

2.1 – B5 Strategic Plan (B5SP)

The Governor's North Carolina Early Childhood Action Plan includes a series of early childhood education, care, health and other policy goals identified to promote optimal child development across the state. The B5 Strategic Plan builds on this foundation but focuses on ECE, and provides greater strategic detail, measures of progress and analysis of how to meet the demands identified in the Needs Assessment.

DCDEE Contracted with NC Early Childhood Foundation (NCECF) to assist in the Strategic Plan B5SP drafting. NCECF engaged Forthright Consulting to complete the work. The first draft has been completed and undergone favorable review by DCDEE. Plans are in process for NCECF, DCDEE and Forthright Consulting to continue their partnership. The goal is to incorporate in a final copy-edited draft by the end of 2019 the findings of the FPG Needs Assessment and NCECF and NCPC community feedback focus groups, plus the results of data-users surveys and recommendations arising from further DCDEE draft reviews.

2.2 – Community feedback on B5SP

DCDEE contracted with NC Early Childhood Foundation (NCECF) to assist in the family and community feedback work. NCECF contracted with Smart Start to run 14 feedback sessions in the fall of 2019 via local Partnership for Children organizations. In addition, the ten groups organized by the ten local Partnerships for Family Engagement work in Activity 3 will include questions on the B5SP.

2.3 – Development of Early Childhood Data Strategy

An expert committee has been formed (North Carolina Early Childhood Data Advisory Council, or NCECDAC). See Activity 4.3 for more.

2.4 – Kindergarten entry data

A stakeholder committee has been formed and over 50% of the meetings held. The final report is due by the end of 2019.

Activity 3: Parental Knowledge and Choice

Activity 3 is comprised of four projects:

- The convening of a group of state-level stakeholders to provide input and draft a Family Engagement Framework and a first iteration of an accompanying toolkit or action guide for local communities;
- A pilot, managed by NCPC and informed by community-based parent leadership coaching clinics, of ten early adopter counties to enact the family engagement framework and toolkit or action guide;
- The entry of early education providers into a state-wide, consumer-friendly, early child hood provider and services information application called NCCARE360, and;
- The contracting of UNCTV to hold community block parties to improve parental knowledge of the importance and choices in early education.

Activity 3.1 – State Family Engagement Leadership Coalition

A state-level Family Engagement and Leadership Coalition (FELC) has been formed. It has the mandate to create a family engagement framework to drive policy and practice, and to draft an action guide for local communities. Stakeholders include parent representatives and cross-sector representation from: DCDEE, Head Start, DPI, child welfare, Title 1, NC Pre-K, MIECHV, DPH Children and Youth branch, Smart Start, Child Care Resource and Referral, UNC-TV, Prevent Child Abuse NC, NC Early Childhood Foundation, Frank Porter Graham Child Development Institute, and other statewide organizations prioritizing family engagement.

A DCDEE State-level Family Engagement Coordinator in partnership with NCPC personnel and a State-level Family Engagement and Leadership Accelerator Team (a sub-committee of the FELC) leads the work.

Activity 3.2 – Strengthening Statewide Family Engagement Local Coalition

The North Carolina Partnership for Children was contracted to support local community planning initiatives. Ten local communities were selected through NCPC's RFP process to participate: Beaufort-Hyde, Catawba, Guilford, Johnston, New Hanover, Orange, Randolph, Transylvania, Wake, and Yadkin counties. Local Coalition communities will conduct focus groups of community members, lead a pilot capacity-building for family-centered approach, including leadership and facilitation training, coaching and peer learning. Community representatives from each of the ten selected local coalitions serve on the State-level coalition to provide a feedback loop between state and local work.

Activity 3.3 – NCCARE360

This work with the Foundation for Health Leadership and Innovation is just beginning. The intent is to on-board multiple ECE providers in each of a group of approximately 40 counties to the NCCARE360 platform. This process involves training in the use of the services information and referral platform.

Activity 3.4 – UNCTV block parties

These events took place in the fall of 2019. Previous events such as these typically attract up to 8000 people. One block party took place at University Place, Chapel Hill on August 24. A second party took place in New Hanover County in late-September. A third is under discussion. UNCTV coordinates with the local Partnership and county administration to mobilize community partners to staff booths at each event. Many activities for children, including musical performances feature. Each party is preceded by a training for community partners by UNCTV on the use of PBS early education resources.

Activity 4: Sharing Best Practices

Activity 4 now consists of four projects:

- A mentor-county led pilot to plan and implement a universal application process for pre-kindergarten in multiple counties;
- The further development and further implementation of a pilot to improve the PK-K transition, with a focus on the transfer of information of each pre-kindergarten child's development to their kindergarten teacher;
- The enhancement of ECIDs, North Carolina's early childhood data system, and finally;
- A new project approved in Q2 by the Office of Child Care: an outcomes-based contracting feasibility and evaluation pilot.

Activity 4.1 – Universal enrollment

Universal pre-kindergarten application and enrollment process using a single application across multiple pre-k programs has been successfully piloted in several counties. Under the guidance of a state-level PDG financed coordinator and with the heavy involvement of the Headstart Collaboration Office, Title 1, NC Pre-K, and state NCPC consultants, Wake, Durham, Alamance and Forsyth Partnerships will mentor two or three mentee counties each to help them develop and implement a similar universal pre-k enrollment process. Mentee counties are currently applying to be mentored intensely by the four counties and will receive budget assistance via the PDG for their Tier 3 activities. There are two other levels of support available: Tier 1 for counties who need minimal assistance or are just beginning to explore this process, e.g. coming to state-wide. Tier 2 is for counties seeking 'office hours' assistance from DCDEE consultants and mentor counties via phone and email as they work independently to implement a universal pre-k application process.

Activity 4.2 – PKK transition

This work relies on coordination between DCDEE and the Office of Early Learning at DPI and continues pre-PDG pilot work. Seventeen local education agencies (LEAs or school districts) and the pre-k system in that county or counties are involved. A child information form has been drafted and is in use by State Pre-k providers. **Planning and negotiation between DCDEE, DHHS and DPI continues around:**

- Finding a data-sharing solution between PK and K teachers about each child's development;
- Finding and promoting connections with family engagement work in the PDG;
- Addressing language translation needs across the state, and;
- A communication protocol and plan for participating communities.

Activity 4.3 – Enhance ECIDS

North Carolina (NC) is engaged in several initiatives to promote the sharing and alignment of early childhood data, which include:

- Partnering with stakeholders to establish alignment on home visiting data metrics;
- Connecting data in the North Carolina Early Childhood Integrated Data System (NC ECIDS) to academic outcomes data,
- Building a more user-friendly online platform for NC ECIDS to promote data use at the state and local level,
- Conducting a survey of key ECE data users to align ECE data priorities across the state, and
- Incorporating Head Start data into NC ECIDS

Partnering with stakeholders to establish alignment on home visiting data metrics

NC has established a Core Data Workgroup consisting of experts in public health, home visiting, early childhood policy, and information technology, to develop and execute on an implementation plan for this work. The Core Data Workgroup meets weekly. The Core Data Workgroup has worked with the NC Home Visiting Consortium to complete an initial review of key data elements that could be included on a list of standardized metrics to be collected across multiple home visiting programs. An initial draft list of metrics has been shared for review with two home visiting models participating in the pilot data integration project with NC ECIDS. The Core Data Workgroup has also mapped out the current process for collecting and reporting data from the local to the state level to understand the best point to extract data and has met with the state of Virginia to learn about their approach to similar data alignment work in home visiting.

In order to fulfill this activity, we have contracted with Child Trends to provide ongoing technical assistance.

Connecting data in the North Carolina Early Childhood Integrated Data System (NC ECIDS) to education outcomes data AND Building a more user-friendly online platform for NC ECIDS to promote data use at the state and local level

In order to better connect NC ECIDS with other early childhood and outcomes-related data across the state, as well as to improve the accessibility of the NC ECIDS platform, NCDHHS is partnering with DIT and GDAC to modernize the technical solutions behind the NC ECIDS system. NC ECIDS was originally built on an IBM technology platform. However, in order to better connect with ongoing statewide efforts to build an aligned longitudinal data infrastructure that can be used to monitor and track long-term outcomes for young children, GDAC is supporting NCDHHS to transition NC ECIDS to a modernized SAS platform. The SAS platform is also being used for other longitudinal systems across the state, which will allow NC ECIDS to be more easily connected to a statewide longitudinal data system. The new platform will also provide easier access to NC ECIDS data and will enable more robust reporting. The departments have drafted a detailed scope of work and are collaborating across agencies to coordinate data sharing in the new technology platform. Work is also being completed within NCDHHS to update the way data is brought in to NC ECIDS to account for NC FAST migration updates that occurred after NC ECIDS went live in 2016.

Additionally, ongoing coordination between DCDEE, the Office of the Secretary of DHHS and NCECF over data development strategy continues, including the NC ECIDS Governance Council's participation in the statewide Early Childhood Data Advisory Council. This group is charged with building out a long term vision for early childhood data in the state.

Conducting a survey of key ECE data users to align ECE data priorities across the state

Early childhood data is collected and used every day by a variety of professions and organizations. Unfortunately, we have limited knowledge of how this data is used and collected. In partnership with State leaders, a team of researchers from the UNC School of Social Work, led by Dr. Paul Lanier, conducted a first-of-its-kind statewide survey of early childhood data users. The audience for this survey included state and local agencies, researchers, policy makers, teachers, and other members of the public. The responses to this survey support a comprehensive understanding of: 1) the primary state-level data sources used by early childhood stakeholders today, 2) the purposes for which early childhood data are currently used, 3) the current unmet data needs that early childhood data users in NC continue to face. The research team is using this data to inform formal recommendations for the state to consider in setting an aligned data strategy for the state across multiple early childhood initiatives. The survey will be shared by early September. A preliminary report was shared in late June.

Incorporating Head Start data into NC ECIDS

A data extract of Head Start information at the child level was produced by Child Plus in the spring of 2019. This extract will be integrated into the NC ECIDS platform as the system is transitioned through the support of GDAC.

4.4 – Outcomes-based contracting

This is a new project approved by the Office of Child Care during Q2 and is in the process of being contracted. The contractor is expected to provide data analysis on key NC Pre-K and kindergarten outcomes for the NC Pre-K program (by end of October 2019), as well as planning a pilot of outcomes-oriented contracting for NC Pre-K contracts (by end of December 2019).

Activity 5: Sharing Best Practices

The purpose of this project is to increase access to high quality, center-based early learning programs for families with children Birth – 3. In the rest of Y1, the contractor, the Child Care Services Association, will revise the Standard Operating Procedures for the NCB1 program utilizing a stakeholder advisory committee, pilot the Orientation and Site Preparation process for the NCB1 program in 32 classrooms and draft a program evaluation design that will examine the short- and long-term effectiveness and impact of the NCB1.

The NCB1 program was successfully piloted through the Race to the Top-Early Learning Challenge (RTT-ELC) grant. It was modeled after the NC Pre-K program. The NCB1 program targets center-based, 5-star ECE settings in areas of the state with the greatest need for high quality infant and toddler care not currently served by Early Head Start. Five-star programs have shown their commitment to quality through their achievement of this highest QRIS level and are best primed to take the next step to meeting higher standards.

Appendix M: Collaborative Governance Entities and Key Partner Agencies

- Alamance Partnership for Children
- BEGINNINGS
- Catawba Partnership for Children
- Charlotte Bilingual Preschool
- Child Care Resources Inc.
- Child Care Services Association
- Duke University
- Excel
- Frank Porter Graham Child Development Institute
- Head Start Collaboration Office, North Carolina Department of Public Instruction
- NC Pre-K, North Carolina Division of Child Development and Early Education
- NC Child
- North Carolina Association for the Education of Young Children
- North Carolina Child Care Coalition
- North Carolina Child Care Commission
- North Carolina Community Colleges
- North Carolina Department of Health and Human Services
- North Carolina Department of Public Health
- North Carolina Department of Public Instruction
- North Carolina Department of Public Instruction: Exceptional Children Division
- North Carolina Division of Child Development and Early Education
- North Carolina Early Childhood Foundation
- North Carolina Early Education Coalition
- North Carolina Early Learning Network
- North Carolina Head Start Association
- North Carolina Partnership for Children
- Office of Governmental Relations, Department of Health and Human Services
- Office of Governor
- Reach Out and Read Carolinas
- Southwestern Child Development Center
- Third Sector Capital Partners, Inc.
- University of North Carolina-TV
- Unite US
- University of North Carolina at Charlotte
- University of North Carolina at Greensboro

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