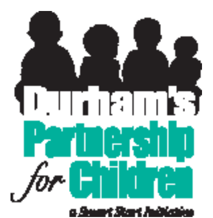
2006/2007

Final Activity Evaluation Report

Engaging Durham to make a difference
in the lives of our young children.



Durham's Partnership for Children

Final Activity Evaluation Report

Fiscal Year 2006-07

Prepared by
The Program Evaluation Group
October 2007

Introduction

Durham's Partnership for Children (DPfC) is a non-profit organization that administers state Smart Start funds to local funded partners in Durham County.   DPfC solicits proposals every two years and funds those partners, or funded partners, that appear best able to help DPfC pursue its mission to "continuously mobilize and unify the Durham community…to [serve] the needs of all young children and their families, enhancing their readiness for school."[1]

When the Smart Start Initiative was created by the North Carolina General Assembly in 1993, the authorizing legislation also created the non-profit North Carolina Partnership for Children (NCPC) and charged the organization with providing oversight and technical assistance to local partnerships, like DPfC. The principal mechanism through which NCPC monitors accountability in the local partnerships is the Performance-Based Incentive System (PBIS). The system stipulates minimum and high-performing standards for the local partnerships related to

[1] From handout entitled "Long-Range Strategic Plan, 2005-2008 (Plan Updated June 2006)."

child care placements, child care staff, family support, and health. Performance on these standards is used to distinguish partnerships that are performing well from those that are in need of technical assistance from NCPC. Failure to meet the minimum standards on one or more of the PBIS criteria can seriously jeopardize a partnership's Smart Start funding.

Prior to the 2006-07 fiscal year, we believe it is fair to say that the PBIS standards were not well known or fully understood by DPfC's funded partners. Although the funded partners were generally aware of the standards, they did not necessarily consider them when setting outcomes or making programming decisions. Then, too, the Partnership also had a limited view of how these partnership-level standards might shape the work of the funded partners to (1) better prepare all of Durham's children to succeed in school, and (2) help the Partnership to meet NCPC's standards for accountability.

The Program Evaluation Group (TPEG) has been engaged by DPfC since August 2006 to provide external evaluation services to the Partnership and its funded partners. Given the high stakes associated with the PBIS standards, TPEG set about revising the formats of the funded partners' evaluation plans, mid-year reports, and year-end reports to raise the profile of the PBIS standards in the work of the funded partners. Our rationale has been that, if ongoing funding is tied to performance on these standards, then they should be used at both the Partnership and funded partner levels as a framework for program design and evaluation. They should inform decisions about what activities to propose and fund with Smart Start dollars (i.e., those that best promote progress on the PBIS standards), and they should influence the outcomes toward which the funded partners aim.

The transition to a more PBIS-focused evaluation system is still in process. In our first two reports (Final Activity 2005-06 and Mid-Year 2006-07) we grouped outcomes on the basis of what we deemed to be the "best fit" with specific PBIS criteria. In the current report (Final Activity 2006-07), we distinguish between outcomes that relate directly to a specific PBIS criterion and those that are either indirectly related or related to the broader issue area. Our purpose in making a firm distinction between these two kinds of outcomes (direct vs. indirect or broad) is to illustrate how little data is currently available to the Partnership for monitoring progress on the PBIS standards in a timely manner and adjusting program activities accordingly. In the absence of PBIS outcome-related data that is collected by the funded partners and reported

at the end of each fiscal year, the Partnership must wait until the end of the next fiscal year to receive NCPC's analysis of Durham County's progress on mandatory and selected PBIS criteria.

At the time this report is being prepared, we are meeting with the 2007-08 funded partners to develop evaluation plans that directly reflect the specific PBIS standards for which the Partnership is now holding them accountable. Future mid-year and year-end reports will showcase outcomes that have been negotiated in collaboration with the funded partners and are more closely linked to the PBIS. Even so, the funded partners are still being encouraged to maintain or identify outcomes that describe what they accomplish outside the bounds of the PBIS.

The purpose for this second strand of outcomes is to begin to establish an agenda for finding funding outside of Smart Start. Through the funded partners, Smart Start enables DPfC to provide a variety of much-needed services to Durham County residents. However, because of static funding and the limits of what Smart Start will fund, there are still unmet needs in the community. Expanding the partners' evaluation plans to include non-PBIS outcomes is one strategy for establishing needs and building a case for funding from other sources.

DPfC's Funded Partners

Fifteen (15) funded partners were awarded Smart Start funds in 2006-07 by DPfC for direct services.[2] Table 1 summarizes the number of children, parents/guardians, teachers, center directors, and child care facilities that were served directly and indirectly by these 15 funded partners.[3] The numbers in this table are aggregations of unduplicated counts received from all of the funded partners. However, an unknown number of children, families, and others in Durham County are served by more than one Smart Start-funded program; so there is duplication in the numbers in Table 1.

[2] A brief description of the activities provided by each service provider can be found in Attachment A at the end of this report.

[3] Direct recipients are those who were served directly by the funded partners. Indirect recipients were not served directly, but they nevertheless benefited from services that were delivered directly to others (e.g., children are indirectly served through programs that support parents and child care providers).

Table 1
Numbers served with Smart Start dollars, 2006-07

Recipients	Served by Funded Partners: Directly	Served by Funded Partners: Indirectly	Total population in Durham County
Children, 0-5	8,867	23,171	21,926
Parents/Guardians	8,203	7,445	Not available at this time*
Lead child care teachers	1007	412	Not available at this time*
Assistant teachers	322	30	Not available at this time*
Child care directors	268	26	Not available at this time*
Child care centers	362	26	165
Child care homes	379	1	237

*Estimates of these populations are being sought for future reports.
NOTE: "Numbers served" were compiled from unduplicated counts reported by funded partners; however, because multiple Smart Start-funded partners may serve the same individuals and organizations, the numbers in Table 1 include duplicated counts.

The next four sections of the report summarize outcomes reported by the funded partners in the three "issue area" categories used by PBIS: Early Care and Education Placements, Early Care and Education Staff, Family Support, and Health. Goals for these issue areas include:

- **Early Care and Education**
  - **ECE Placements** – Children have access to high quality early childhood education.
  - **ECE Staff** – Children are enrolled in child care facilities that provide a consistent high quality early education program by retaining competent, qualified staff.
- **Family Support** – Families have the knowledge and skills needed to insure that their children enter school healthy and ready to succeed.
- **Health** – Children are safe and healthy.

Each of the following sections identifies the related PBIS standards that DPfC's funded partners addressed in a given issue area and the outcomes they achieved. In all, 15 funded partners were awarded Smart Start funds in 2006-07 by DPfC. A brief description of the

activities provided by each service provider can be found in Attachment A at the end of this report.

Early Care and Education Placement Outcomes

Table 1 summarizes PBIS criteria and minimum performance standards related to placement services and subsidies in early care and education. NCPC's analysis of 2005-06 data indicates that Durham County is performing well against most of these criteria. However, PLA50 (percent of children with subsidy who are enrolled in 4-5 star rated child care programs) and PLA60 (average star rating of placements for special needs children with subsidy, and percent of special needs children with subsidy who are enrolled in 4-5 star rated programs) require some attention.

No data were reported this year for PLA60 or PLA70. Beginning in 2007-08, all funded partners that are accountable for these criteria will collect and report relevant data.

Table 2
PBIS Criteria and Standards – ECE Placements

PBIS ID and Criteria	NCPC's Minimum Performance Standard	DPfC Results FY 2005-06[4]
PLA20[S] – Regulated child care programs	**90%** of children receiving subsidy will be enrolled in regulated child care programs.	**100%**
PLA40[M] – Child placements in regulated child care programs	**3.25** average star rating of child placements in regulated child care programs, OR **50%** of children will be enrolled in 4- or 5-star rated child care programs.	**3.36** **51%**
PLA50[M] – Subsidized child placements in regulated child care programs	**3.25** average star rating of the placements for children receiving subsidy in regulated child care programs, OR **60%** of children receiving subsidy will be enrolled in 4- or 5-star rated child care programs.	**3.53** **49%**
PLA60[D] – Subsidized placements for children with special/ developmental needs in regulated child care programs	**4.00** average star rating of placements for children with special/developmental needs and receiving subsidy in regulated child care programs, OR **75%** of children with special/developmental needs and receiving subsidy will be enrolled in 4- or 5-star rated child care programs.	**3.53** **49%**
PLA70[D] – Nationally accredited child care programs	**12%** of children will be enrolled in regulated child care programs that are nationally accredited.	**12%**

M = Mandated by NCPC, S = Selected by DPfC to comply with NCPC requirements, D = Selected by DPfC for its own accountability purposes

[4] Fiscal year 2005-06 results as reported to DPfC by NCPC in July 2007, based on independent data analysis.

PLA20 - Regulated child care programs

DPfC funds DACCA to address PLA20. The agency was established specifically as a "one-stop shop" for administering child care subsidy money from a variety of sources, including Smart Start funds allocated by DPfC. In 2006-07, DACCA met the highest performance standard for PLA20, with 100% of children receiving subsidy enrolled in regulated programs (see Table 3).

Table 3
PLA20 – Regulated child care programs, 2006-07

PBIS Minimum Standard: 90% of children receiving subsidy will be enrolled in regulated child care programs.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
DACCA	By June 30, 2007, **100%** of all children receiving subsidy [of any kind] will be in regulated programs.	**100%**

PLA40 – Child placements in regulated child care programs

Three service providers (Choosing & Using, DACCA, and QUIP) projected that children placed in care would be enrolled in programs with at least a 3.25 average star rating. Both Choosing & Using and DACCA set the bar a little higher at 3.4 and 3.5 average stars, respectively. All three service providers exceeded their projections (see Table 4). With education and referral services from Choosing & Using, parents chose to enroll their children in child care programs with an average star rating of 3.98. DACCA placed children in child care centers with an average star rating of 3.66. QUIP helped increase the quality of care in the centers it works with to achieve an average of 3.85 stars.

Table 4
PLA40 – Child placements in regulated child care programs, 2006-07

PBIS Minimum Standard: 3.25 average star rating of child care placements in regulated child care programs, OR 50% of children will be enrolled in 4- or 5-star rated child care programs.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
Choosing & Using	**3.5** is the average star rating of child care placements (0-5) in regulated programs (including centers, homes, and facilities that operate under notices of compliance).	**3.98**
DACCA	By June 2007, the average star rating of child placements in regulated day care will be **3.4**.	**3.66**

Table 4 (continued)

PLA40 – Child placements in regulated child care programs, 2006-07

PBIS Minimum Standard: 3.25 average star rating of child care placements in regulated child care programs, OR 50% of children will be enrolled in 4- or 5-star rated child care programs.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
QUIP	By June 30, 2007, the average star rating of licenses for programs on contract to receive technical assistance services will be **3.25**.	**3.85**

PLA50 – Subsidized child placements in regulated child care programs

Virtually all child care subsidy in Durham County flows through DACCA, which projected that children receiving subsidy from the agency would use those subsidies to enroll in programs with an average star rating of 3.4. This projection was higher than the 3.25 minimum established in PBIS for PLA50, but lower than DACCA's projection for 2005-06 (3.6). DACCA met and slightly exceeded its projection, with an average star rating of 3.66 for programs enrolling children with subsidy dollars from DACCA (see Table 5). This result was the same in 2005-06 (3.67).

Table 5

PLA50 – Child placements in regulated child care programs, 2006-07

PBIS Minimum Standard: 3.25 average star rating of the placements for children receiving subsidy [of any kind] in regulated child care programs, OR 60% of children receiving subsidy will be enrolled in 4- or 5-star rated child care programs.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
DACCA	By June 2007, the average star placement for all children receiving subsidy [of any kind] will be **3.4**.	**3.66**
	By June 2007, the average star placement for all children receiving Smart Start subsidy will be **3.64**.	**3.71**

PLAother – Quality enhancement and quality maintenance

QUIP has established multiple outcomes related to enhancing or maintaining the quality of child care in Durham County. In 2007-08, these activities (Quality Enhancement, Quality Maintenance) are being broken out into separate activities; but in 2006-07, they were implemented under the umbrella of QUIP. Next year these outcomes will be revised to more directly reflect PLA40, PLA50, PLA60, and PLA70. As stated in Table 6, all outcomes have been achieved or exceeded with the exception of maintain star ratings of centers that underwent

reassessment by DCD in 2006-07. The shortfall in performance is most likely due to recent changes in how star ratings are calculated, making it more difficult to maintain previous ratings.

Table 6
PLAother – Quality enhancement and quality maintenance, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
QUIP	**750** children are enrolled in child care facilities that applied to DCD for a) at least a 3-star license or b) to increase current star rating by at least 1 star by June 30, 2007.	**1,066**
	40 child care facilities will maintain their current star rating based on the re-assessment by DCD conducted by June 30, 2007.	**28**
	50 child care facilities with a current 3, 4, or 5 star license will apply to be reassessed by DCD by June 30, 2007.	**51**
	20 child care facilities received either a) at least a 3-star license or b) at least 1 star rating increased by June 30, 2007.	**23**
	25 child care facilities applied to DCD either a) for at least a 3-star license or b) to in-crease current star rating by at least 1 star by June 30, 2007.	**38**
	600 children are en-rolled in child care facilities that received either a) at least a 3-star license or b) at least 1 star rating in-creased by June 30, 2007.	**608**

PLAother – Increase parents' knowledge

Choosing & Using established two outcomes related to parents' knowledge about how to choose high quality child care and their use of quality indicators to select child care. In both cases, they exceeded their expectations for impacting parents' ability to select high quality care (see Table 7).

Table 7
PLAother – Increasing parents' knowledge, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
Choosing & Using	**90%** of the number of responding families will report using three or more quality indicators in their search for child care.	**99.7% (436)**
	80% of the number of responding families will agree that after speaking with a CCSA family support counselor, they were more informed about choosing high quality child care.	**92% (406)**

Summary – ECE Placement Outcomes

Enrolling children in high quality, regulated child care programs is a particular strength of DPfC. As a result of the work of the funded partners, all children with subsidy are in regulated care. All children placed in care with the support of SS-funded activities are in centers with an average star rating of 3.71. All children with subsidy of any kind are enrolled in centers with an average star rating of 3.66. Funded partners have also contributed to quality enhancement and quality maintenance in local child care programs and increased parents' knowledge about how to select quality child care.

The Partnership needs to make progress on two ECE Placement criteria:

- PLA50 – NCPC reported that the 2005-06 average star rating of centers enrolling children who receive child care subsidy was 3.53, above the NCPC minimum. However, to meet the state's high performing standard for PLA50, the Partnership and its funded partners should also increase the percentage of children receiving subsidy that are enrolled in 4-5 star rated centers, from 49% to at least 60%.
- PLA 60 – To meet NCPC's minimum standard for PLA60, the Partnership and its funded partners need to increase the average star rating of centers enrolling children with special needs who receive child care subsidy, from 3.53 to 4.00; OR increase the percent of children with special needs who receive subsidy that are enrolled in 4-5 star rate CC programs, from 49% to at least 75%). To meet NCPC's high performing standard, they need to achieve both of these minimum standards.

In addition to NCPC-mandated ECE Placement standards, DPfC elected to hold itself accountable for raising the average star rating of regulated programs in which children with special/developmental needs who received subsidies are enrolled (PLA60) and increasing the percentage of children placed in regulated programs that are also nationally accredited (PLA70). For the second year in a row, none of DPfC's service providers have collected or reported data to provide evidence of progress on these criteria. In 2007-08, two funded partners (More at Four and DACCA) will collect and report data for PLA 60, and two of them (CCQE and CCQM) will collect and report data for PLA70.

Early Care and Education Staff Outcomes

Table 8 indicates the PBIS criteria and minimum standards related to education levels, compensation, benefits (for), and stability of child care teachers. These are relatively new criteria. EDU10 was introduced for baseline purposes in 2006-07, and has already been revised. Partnerships have until June 2010 to achieve the new minimum performance standard of 60% of children being enrolled in regulated child care centers that have 5 lead teacher education points in the new two-component star rating system. Some programs may need to be restructured in order to have the maximum impact on this criterion. In the meantime, while the three-component system is still in place, at least 60% of children are expected to be enrolled in child care programs that have at least 4 stars.

Table 8
PBIS Criteria and Standards – ECE Staff

PBIS ID and Criteria	NCPC's Minimum Performance Standard	DPfC Results FY 2005-06
EDU10[M] – Lead Teacher Education	**60%** of children will be enrolled in 1-5 star rated child care centers that have 4 or 5 lead teacher education points.	**35%**[5]
COMP10[M] – Median Teacher Salaries	The median salary plus supplement for teachers with a 2 year degree in ECE or its equivalent is at least **$8.98** per hour, AND The median salary plus supplement for teachers with a 4 year degree in ECE or its equivalent is at least **$11.23** per hour.	No data available
BE20[S] – Sick Leave[6]	**70%** of regulated child care centers offer paid sick leave.	No data available
S10[S] – Stability/ Turnover	The turnover rate among staff in regulated child care centers is equal to or less than **25%**.	No data available

M = Mandated by NCPC

S = Selected by DPfC to comply with NCPC requirements

EDU10 – Lead Teacher Education Points

In 2006-07, EDU10 stipulated that a minimum of 60% of children in Durham County will be enrolled in 1-5 star rated child care centers that have 4 or 5 lead teacher education points. Lead teacher education points are based on the percentage of lead teachers with a specific level of education and at least two years of experience as a lead teacher. QUIP was the only partner to

[5] Based on planning data provided by NCPC; FY 2006-07 was baseline year for EDU10. DPfC has until June 2010 to meet this criteria.

[6] In 2006-07, none of the providers directly addressed BE20. In the coming months, the Program and Evaluation Coordinators will meet with the CC Substitute Program to discuss restructuring program components as needed to more directly impact BE20.

directly address EDU10 this year, and the program was able to slightly exceed its expected outcome (see Table 9).

Table 9
EDU10 – Lead teacher education points, 2006-07

PBIS Minimum Standard: 60% of children will be enrolled in 1-5 star rated child care centers that have 4 or 5 lead teacher education points.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
QUIP	By June 30, 2007, among all children enrolled in all child care programs on contract for TA services, **35%** of them will be enrolled in 1-5 star child care centers that have 4 or more lead teacher points.	**39%**

EDUother – Increase teacher education

In addition to QUIP, More at Four has also works to increase teacher education levels, measured by credit hours or degrees earned rather than center-based lead teacher education points. The Program and Evaluation Coordinators will work with these programs in the coming year to help them revise their data collection strategies so they can translate outcomes for individual teachers into outcomes for child care centers (i.e., lead teacher education points).

As indicated in Table 10, QUIP was able to exceed its expectation that teachers in centers receiving technical assistance could earn at least 3 credit hours in ECE. More at Four set the bar higher (at a minimum of 6 credit hours earned) and fell short of its expectations. In 2007-08, the Allocations Committee recommended that the minimum expectation for all teachers in these kinds of programs should be at least 6 credit hours earned each year.

Table 10
EDUother – Increasing teacher education, 2006-07

Service Providers	**Expected Outcomes**	**Actual Outcomes**
More at Four	By June 30, 2007, **90%** of More at Four assistant teachers who do not yet have the CDA or AA degree in Early Childhood will have completed at least 6 semester hours toward their AA degree in Early Childhood.	**67%**
	By June 30, 2007, **90%** of More at Four teachers who do not yet have the B-K license will have completed at least 6 semester hours toward their B-K degree.	**60%**

Table 10 (continued)
EDUother – Increasing teacher education, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
QUIP	By June 30, 2007, **90** teachers employed in programs receiving technical assistance or support services will complete at least 3 semester credit hours toward a degree in ECE.	**101**

COMPother – Teacher Salary Supplements

DPfC funds WAGE$ in Durham, a Tier Two level county, to address COMP10. As indicated above in Table 8, the standards for COMP10 are phrased in terms of hourly wage rates that reflect "median salary plus supplement." However, WAGE$ currently reports compensation in terms of the "average six-month [salary] supplement" received by WAGE$ participants. DPfC's Allocations Committee has made the current award to WAGE$ contingent upon the development of a local evaluation plan that more directly reflects the PBIS standard for COMP10. Early in the new fiscal year (2007-08), WAGE$ staff will meet with the Program and Evaluation Coordinators to work out an evaluation plan that better reflects the Partnership's need for outcome data.

In the meantime, Table 11 indicates that the average six-month salary supplement for Durham WAGE$ participants exceeds the average for all Tier Two counties. Durham's 06-07 average was $864; the 06-07 average for all counties which funded WAGE$ at the Tier Two level all year (of which Durham is one) was $684.

Table 11
COMPother – Teacher salary supplements, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
WAGE$	Six month salary supplements received by WAGE$ participants will exceed the average for all counties funded at the Tier Two level (>**$684**).	**$864**

S10 – Teacher Stability/Turnover

DPfC also funds WAGE$ in Durham to address S10. As shown in Table 12, the turnover rate among teachers who receive WAGE$ salary supplements is lower than both the minimum (<25%) and high performing (<20%) PBIS standards for the S10 criterion.

Table 12

S10 – Teacher stability/turnover, 2006-07

PBIS Minimum Standard: The turnover rate among staff in regulated child care centers is equal to or less than **25%**.		
Service Providers	**Expected Outcomes**	**Actual Outcomes**
WAGE$	The annual turnover rate of Child Care WAGE$ participants will be lower than the minimum Smart Start benchmark (< **25%).**	**16%**

Summary – ECE Staff Outcomes

ECE Staff outcomes include EDU10 (Lead Teacher Education Points), COMP10 (Median Teacher Salaries), BE20 (Sick Leave), and S10 (Stability/Turnover). NCPC currently provides the Partnership with data for EDU10 only. Data are not yet available from NCPC about Durham County's progress on COMP10, BE20, and S10.

2005-06 data received from NCPC for EDU10 indicated that Durham County needed to increase the percent of children in centers with 4-5 lead teacher education points from 35% to 60%. QUIP, the only funded partner to provide data on EDU10, reported that 39% of children in all the centers they serve are enrolled in centers that have 4-5 lead teacher education points. Related to EDU10, both More at Four and QUIP encourage teachers to seek additional education to improve their qualifications for teaching young children. QUIP found that, among teachers who work in the centers on contract to receive technical assistance, more teachers than expected completed at least 3 credit hours toward a degree in Early Childhood Education. However, More at Four reported lower than expected percentages of teachers who completed at least 6 credit hours toward an AA degree in ECE (67% instead of 90%) and teachers who completed at least 6 hours toward the Birth-Kindergarten license (60% instead of 90%).

Since the 2005-06 data was received from NCPC, both the star rating system and the standards for EDU10 have been revised. The Partnership now has until 2010 to increase enrollment of children in regulated child care centers that have 5 lead teacher education points from less than 35% to 60%.[7] In the coming months, the Program and Evaluation Coordinators will meet with the four partners who are now accountable for EDU10 (CC Substitute, Grow a

[7] The current minimum standard for EDU10, under the existing three-component rating system, requires that 60% of children be enrolled in 4-5 star centers. In Durham in 2005-06, 35% of children were enrolled in 4-5 star centers. Therefore, the percentage of children currently enrolled in 5 star centers, must be less than 35%.

Teacher, More at Four, and TEACH AmeriCorps) to discuss collection of relevant data and develop new strategies as needed to more directly impact the EDU criterion.

In the category of ECE Staff outcomes, WAGE$ also reported positive outcomes for S10 and related to COMP10. Data on S10 indicate that the turnover rate of teachers participating in that program is already below the state's high performing standard of 20%. Related to COMP10, WAGE$ data indicates that six-month teacher salary supplements were higher than expected in Durham County ($864 actual vs. $684 expected).

Family Support Outcomes

Table 13 indicates PBIS criteria and minimum performance standards related to family support activities. FS10 was introduced for baseline purposes in 2005-06, and performance at the county level almost meets expectation. Although FS20 was not selected by the Partnership to report to NCPC, DPfC nevertheless provides funding to support family literacy programming.

Table 13
PBIS Criteria and Standards – Family Support

PBIS ID and Criteria	NCPC's Minimum Performance Standard	DPfC Results FY 2005-06
FS10[S] – Parenting Skills	**90%** of families report that they "agree" or "strongly agree" that they feel competent and confident to apply the parenting information presented in a Smart Start funded activity.	**87%**[8]
FS20 – Family Literacy	Of the families who reported engaging in literacy activities with their children less than 4 times a week before participating in a Smart Start funded literacy activity, **60%** report that they increased the number of times they engaged in literacy activities to 4 or more times a week.	No data available (not a selected criteria)

M = Mandated by NCPC

S = Selected by DPfC to comply with NCPC requirements

FS10 – Parenting Skills

FS10 specifies that 90% of families surveyed will agree or strongly agree that they feel competent and confident to apply the parenting information they gleaned from participation in parent education and support activities. Three funded partners projected outcomes related to this criterion (see Table 14).

[8] Fiscal year 2005-06 results as reported to DPfC by NCPC in July 2007, based on independent data analysis.

Table 14
FS10 – Parenting Skills, 2006-07

PBIS Minimum Standard: 90% of families report that they "agree" or "strongly agree" that they feel competent and confident to apply the parenting information presented in a Smart Start funded activity.		
Funded partners	**Expected Outcomes**	**Actual Outcomes**
FAMOSA	90% (36/40)	88% (58/66)
Little River	90% (36/40)	90% (27/30)
Welcome Baby	90% (32/35)	98% (79/80)

FSother –Improve parenting skills

Healthy Families Durham (HFD) is officially accountable for PBIS criteria H10 (early intervention for children with special needs, see Table 21). However, the program also provides intensive family support using the *Parents as Teachers* curriculum. Because HFD is not accountable for FS10, the program does not currently administer NCPC's Parenting Skills Survey and, therefore, is unable to report data that directly reflects FS10. Instead they use the HOME Inventory to assess change in positive parenting behaviors. Table 15 shows that HFD served almost as many parents as expected and for all intents and purpose achieved their expected outcome.

Table 15
FSother – Improve parenting skills, 2006-07

Service Providers	**Expected Outcomes**	**Actual Outcomes**
Healthy Families Durham	Of the 85 families receiving services for at least 6 months, 64 (75%) will show improvement in at least 1 of the 6 areas measured by the HOME Inventory.	**74%** (61/82)

FS20 – Family Literacy

The minimum standard for FS20 calls for increasing literacy activities with children. The standard stipulates that 60% of families participating in related Smart Start programs will increase their engagement in literacy activities from fewer than four activities a week to four or more activities a week. FAMOSA, Little River, and Welcome Baby projected outcomes related to this criterion with mixed results (see Table 16). In 2006-07, FAMOSA was able to serve more families than expected and also exceeded their expectations for the current year and their

performance of the previous year. Little River and Welcome Baby both achieved far less than their expected outcomes. Parents in all three of these programs typically enter Smart Start-funded activities with very little history of involvement in literacy activities at home. For this reason, they take longer to reach the desired target of engaging their children in literacy activities four or more times a week. Next year, these programs will report progress in smaller increments (e.g., increases from one to two, or one to three, activities per week) in order to better convey the impact they are having on their clients.

Table 16
FS20 – Family Literacy, 2006-07

Funded partners	**Expected Outcomes**	**Actual Outcomes**
FAMOSA	**60%** (18/30)	**66%** (27/41)
Little River	**60%** (12/20)	**25%** (3/12)
Welcome Baby	**60%** (15/25)	**37%** (14/38)

FSother –Increase academic readiness

In addition to promoting family literacy, FAMOSA also works to promote general academic readiness. They measure progress toward this outcome using the Creative Curriculum Ongoing Assessment. Using the CCOA for the first time this year, they were not able to show any progress on this assessment among children enrolled in their preschool program (see Table 17). FAMOSA has since concluded that the CCOA is better suited to a more intensive program than it can offer at its current level of funding. Next year, FAMOSA will ask parents to report whether they feel their children are more ready for school as a result of their participation in the preschool activity.

Table 17
FSother – Increase academic readiness, 2006-07

Service Providers	**Expected Outcomes**	**Actual Outcomes**
FAMOSA	Of 10 children 3-5 yrs. old who attend the FAMOSA preschool, 8 (**80 %**) will increase their scores on 50% of the total of the 10 criteria from the Creative Curriculum Ongoing Assessment.	**0%** (0/13)

FSother – Car Seat Safety

Welcome Baby offers a number of Car Seat Safety workshops. In 2006-07, they were not able to serve as many parents/guardians as they projected, but they did exceed expected results with the nearly 500 parents/guardians that they did serve (see Table 18).

Table 18
FSother – Care seat safety, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
Welcome Baby	90%, or 95 of 106 parents/guardians surveyed (out of projected 530 participants), will answer 3 out of 5 questions about car seat safety correctly during a telephone survey 3 or more months after completing the class	**99%** (105/106 surveyed; 485 participants)
	90%, or 95 of 106 parents/guardians surveyed (out of a projected 530 participants), will report using their car seat three months or more after completing the class.	**95%** (101/106 surveyed; 485 participants)

FSother –Increase awareness and use of community resources

FAMOSA and Healthy Families Durham set outcomes related to increasing knowledge or use of available community resources among its client families. Both groups were able to serve more families than originally projected, and both exceed their expected outcomes (see Table 19).

Table 19
FSother – Increase awareness and use of community resources, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
FAMOSA	Of an estimated 800 families with children 0-5 using the Linkages program this year, 25% or 200 people will be surveyed, and of the 200 surveyed, an estimated **90%** or 180 will report an increase in knowledge of available community resources.	**97%** (1300 served, 232 surveyed, 226 reported increase)
Healthy Families Durham	Of the 150 parents who are offered a referral to community services, 75 (**50%**) will link with the community service.	**53%** (97/182)

Summary – Family Support Outcomes

Of the two PBIS criteria for Family Support (FS10 and FS20), DPfC elected to be accountable for FS10 (Parenting Skills). Data received from NCPC indicates that Durham

County falls slightly short of the minimum standard for FS10 (87% actual vs. 90% minimum). However, the three partners that are funded to provide direct services in family support (FAMOSA, Little River, Welcome Baby) all reported outcomes above the county's overall performance (88%-98%, or 93% for all three partners combined). Although not accountable for FS10, Healthy Families Durham provides intensive family support and achieved the outcome it projected for families that receive their services.

The same three funded partners that are accountable for FS10 also provide family literacy services and collect data for FS20. Results indicate that they have been more successful at achieving their outcomes for parenting skills. The minimum standard for FS20 (increasing at-home literacy activities to 4 times a week) is quite high for families that have previously engaged in few, if any, literacy activities with their children. The Program and Evaluation Coordinators are currently working with the funded partners that conduct family literacy activities to develop intermediate outcomes that capture more incremental progress.

Funded partners also reported positive outcomes related to car seat safety (Welcome Baby) and increased awareness and use of community resources (Healthy Families Durham). FAMOSA set an outcome related to increasing academic readiness, but was unable to capture the impact of its efforts with the assessment tool it used.

Health Outcomes

Table 20 summarizes PBIS criteria and minimum performance standards related to health in early childhood. County-level performance on H10 meets (for ages 3-5) and slightly exceeds (for ages 0-2) the minimum expectation for H10. However, figures received from NCPC indicate a shortfall in DPfC's performance on H20.[9] Failure to meet expectation for H20 in the next year could jeopardize DPfC's Smart Start funding in the future. At the beginning of 2007-08, the Partnership hired a part-time Health Program Coordinator to facilitate and support the efforts of the Department of Social Services (DSS) and the Durham County Health Department (DCHD) to increase and/or better document the Health Check participation rate of Medicaid-eligible children in Durham County.

[9] Figures provided by the Division of Medical Assistance indicate that Durham's Heath Check participation rate in 2005-06 was actually 70.3%, with a rate of 66% for children ages 0-5.

Table 20

PBIS Criteria and Standards - Health

PBIS ID and Criteria	**NCPC's Minimum Performance Standard**	**DPfC Results FY 2005-06**[10]
H10[M] – Early intervention for children with or at risk for special needs/disabilities	**3%** of the total birth through age 2 population will have been identified and will have received early intervention services, AND **3%** of the total three to five year old population will have been identified and will have received special education.	**3.9%** **3%**
H20[M] – Medicaid-eligible children enrolled in Health Check will have accessed well child care	**70%** of Medicaid-eligible children enrolled in Health Check will have accessed well child care.	**60%**

M = Mandated by NCPC

S = Selected by DPfC to comply with NCPC requirements

H10 – Early intervention for children with or at risk for special needs/disabilities

H10 requires that 3% of the total 0-2 population in Durham County be identified and receive early intervention services, AND 3% of the county's 3-5 population be identified and receive special education. EChO, Healthy Families Durham, and Hispanic/Latino Consultation all conduct initial screenings of children whom they suspect of having special needs and refer them (when appropriate) for more in-depth screening by the Early Intervention Branch of the Children's Developmental Services Agency (CDSA) in Durham County or by the Durham Public Schools (DPS). As shown in Table 21, Healthy Families Durham (HFD) exceeded its expected outcome. Early intervention services were received by all (100%) of the children served by HFD who were found to be eligible for these services. The percentage of children served by EChO and Hispanic/Latino Consultation who actually received early intervention services was not reported.

Table 21

H10 – Early intervention for children with or at risk for special needs/disabilities

PBIS Minimum Standard: 3% of the total birth through age 2 population will have been identified and will have received early intervention services, AND **3%** of the total three to five year old population will have been identified and will have received special education.		
Service Providers	**Projected Outcomes**	**Outcomes To Date**
EChO	6 children (**8.5%**) of a projected 70 children served by EChO will be made eligible by CDSA or DPS and will receive early intervention services through CDSA or DPS by June 30, 2007.	7.4% "made eligible"

[10] Fiscal year 2005-06 results as reported to DPfC by NCPC in July 2007, based on independent data analysis.

Table 21 (continued)

H10 – Early intervention for children with or at risk for special needs/disabilities

PBIS Minimum Standard: 3% of the total birth through age 2 population will have been identified and will have received early intervention services, AND **3%** of the total three to five year old population will have been identified and will have received special education.		
Service Providers	**Projected Outcomes**	**Outcomes To Date**
Healthy Families Durham	Of the 155 children receiving HF services for 3 months or more, 131 (85%) will receive a developmental screening. Of those identified in need of early intervention services, **90%** will receive early intervention services.	**100%** "received services"
Hispanic/Latino Consultation	**80%** of the 20 children who receive a developmental screening will be referred for additional evaluation and will access the suggested referral services.	100% "referred"

Hother – Health Check participation

An important reason for capturing data related to the PBIS standards at the funded partner-level is so DPfC can monitor progress on high stakes criteria like H20 and seek solutions long before NCPC alerts the Partnership about serious deficiencies in performance. Although H20 is mandatory for all partnerships to address, attainment of this outcome more directly depends on the customary activities of the local Health and Social Services departments.

Of all the funded partners, only Healthy Families Durham is expected to have an effect—albeit indirect—on H20 through its child abuse prevention and family support activities. However, HFD's Health Check-related outcome does not provide a simple accounting of the number of children served by the program who also access well child care (see Table 22).

Table 22

Hother – Health Check participation, 2006-07

Service Providers	**Expected Outcomes**	**Actual Outcomes**
Healthy Families Durham	Of the 185 children receiving HF services for 2 weeks or more, 167 (**90%**) will have an equal or better Health Check participation rate than the overall county rate and will have updated immunizations.	**92%**

Hother – Increase knowledge and skills

Several of the funded partners offer workshops or training sessions to increase parents' knowledge of health-related issues and skills to handle potentially harmful or unhealthy situations. In each case, actual outcomes surpass expectations (see Table 23). Parents who were served by these funded partners learned about managing children's difficult behaviors (EChO, CCBMH), supporting their children's dental health (Healthy Smiles), and providing good nutrition (Nutrition Consultation).

Table 23
Hother – Increase knowledge and skills, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
EChO	**80%** of all workshop participants will strongly agree or agree that this workshop provided them with new knowledge/skills.	**100%**
Healthy Smiles	**80%** (400 of 500) of parents/caregivers who attend a workshop will report an increase in knowledge about dental health.	**98%** (107/109 surveyed)
Child Care-Based Mental Health (CCBMH)	**80%** (12 of 15) of teachers who complete the training series (minimum of 4 sessions) will agree or strongly agree that the CCCB training increased their ability to care for children with challenging behaviors.	**100%** (20/20 "returned evaluations")
	80% (12 of 15) of teachers who complete the training series (minimum of 4 sessions) will name at least one new way to manage challenging behaviors that they learned in the training sessions.	**95%** (19/20 "returned evaluations")
Nutrition Consultation	By June 30, 2007, **80%** of staff who receive training through the nutrition consultation project will have answered 90% of child nutrition questions correctly.	**97%** (223/230)

Hother –Complete action plans

Several projects work out action plans or treatment goals to help their clients make positive changes in their health-related behaviors (see Table 24). All of them came close to (CCBMHI) or exceeded (EChO, Nutrition Consultation) their expected outcomes. For most of their closed cases, EChO was able to place or keep children in a stable childcare environment and link them to needed services. CCBMHI helped many of the teachers it trained and children they served

make significant progress on their action plans and treatment plans, respectively. Nutrition Consultation enabled most or all of the child care facilities they work with to complete action plans that target improved nutrition for the children in their care.

Table 24
Hother – Complete action plans, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
EChO	45 children (**90%**) of a projected 50 EChO cases closed, will be in a stable childcare environment and linked to any needed early intervention services by June 30, 2007.	**95%** (53/56)
Child Care-Based Mental Health Initiative (CCBMHI)	**80%** (12 of 15) of teachers enrolled in the training for Children with Challenging Behaviors will report the implementation of a minimum of 2/3's of their action plan goals.	**79%** "enrolled" (91% of those completing course)
	70% (5 of 7) of children will reach 2/3's of their treatment goals at the time of service termination.	**67%** (4/6)
Nutrition Consultation	By June 30, 2007, **80%** of the participating facilities will have demonstrated movement forward on 80% of the planned goals based on the assessment of the menu and compliance with child nutrition rules.	**93%** (38/41)
	By June 30, 2007, **90%** of child care facilities fully enrolled in the program will have moved forward on at least one goal in their action plans.	**100%** (44/44)

Hother – Dental Care

Recognizing the contribution of proper dental care to overall health and well-being, DPfC funds Healthy Smiles, which conducts workshops to encourage parents to actively pursue their children's dental health. As indicated in Table 25, a substantial number of parents attended Healthy Smiles workshops (944), but very few of them (18) made appointments for their children at the Durham County Health Department Dental Clinic. Most of those who made appointments, kept them.

Table 25
Hother – Dental Care, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
Healthy Smiles	**20%** (150 of 750) of the preschool children of parents/caregivers who attend a workshop will have appointments made for them at the dental clinic.	**2%** (18/944)
	60% (90 of 150) of new appointments will be kept.	**83%** (15/18)

Hother –Miscellaneous

Other health-related outcomes being pursued by funded partners include:

- Family Support Subsidy provides eligible children with specialized equipment or therapies needed to maintain or improve developmental growth. Based on the data they reported, their progress on expected outcomes appears positive but unclear.
- EChO provides some early intervention services for children who do not qualify for serves at CDSA or DPS. They were able to provide such services for a higher percentage of children than originally expected.

Table 26
Hother – Miscellaneous, 2006-07

Service Providers	Expected Outcomes	Actual Outcomes
Family Support Subsidy	By 6/30/07, of 100 children who receive specialized therapies or interventions, **25%** (25) will maintain their developmental growth and **75%** (75) will improve their developmental skills as reported by assisting professionals.	**91%** (maintained or improved?)
EChO	18 children (**25%** of the projected total of 70) who are not eligible for CDSA or DPS services will receive therapies or interventions by June 30, 2007.	**35%** (24/68)

Summary – Health Outcomes

Data provide by NCPC indicate that Durham County is already meeting the minimum standard for H10 (3% of children age 0-5 with or at risk of special needs identified and receiving early intervention services). Children ages 0-2 have been identified and served slightly more than children ages 3-5 (3.9% of children age 0-2 vs. 3% of children age 3-5). EChO, Healthy Families Durham (HFD), and Hispanic/Latino Consultation all refer likely candidates to CDSA and DPS for developmental screening, but only HFD was able to report that all the children they referred for developmental screening actually received early intervention services.

The minimum standard for H20 (70% of Medicaid-eligible children enrolled in Health Check and accessing well child care) has not yet been met. DPfC has hired a part-time Health Program Coordinator to support efforts by the Department of Social Services and the Durham County Health Department to raise county-wide participation from 60% to at least 70%. Healthy

Families Durham is the only funded partner that attempts to track Health Check participation of the children it serves, but the actual outcome is unclear.

Funded partners reported numerous other positive Health-related outcomes related to increasing parents' and teachers' knowledge and skills, helping children and child care facilities make progress on individualized treatment goals or action plans, and improving dental hygiene.

Lessons Learned

Fifteen service providers were asked to describe the lessons they had learned during the past year about factors that facilitated and/or hindered their work.[11] Providers' open-ended responses are summarized in Table 1.

Table 1. Lessons learned by providers (n=15)

Category of response	Percent of providers reporting
Staffing issues/needs (e.g., turnover, need for staff development)	53%
Need for better outreach strategies	40%
Impact of collaboration	33%
Impact of using resources/tools/formalized process	33%
Challenges of data collection/tracking clients	27%
No response	6%

Note: Percents add to more than 100% since some providers offered responses which fit into more than one category.

Over half of the providers (53%) cited issues related to staffing when describing lessons learned. The majority of these comments related to staffing problems/inadequacies, including turnover, insufficient staff to address client needs, and the need for bilingual staff. Providers also commented on the impact of, and the need for, professional development. In one case, staff participation in trainings on using a screening tool and addressing challenging behavior in children had enabled them to provide greater support to teachers around children's social/emotional development. Another provider mentioned that child care directors had

[11] One of the providers did not provide responses to any of the open-ended questions.

expressed an interest in pursuing accreditation by the National Association for the Education of Young Children (NAEYC), and would require training for meeting NAEYC requirements.

Forty percent of the providers had learned about the need for developing more effective outreach strategies. Two providers cited language/cultural differences as "*significant*" barriers to their work. Said one provider: *"The biggest lesson learned this year is that it is going to take a lot of work and time to make people perceive regular dental visits and ongoing preventative care as a necessity for their overall health."* In two other cases, providers had completed screenings, made referrals, and/or distributed materials, but did not meet targeted goals because of "*no shows*" or poor participation by targeted audiences.

One third of the providers (33%) mentioned having a better understanding of the importance of collaboration in their work—with other professionals, as well as with clients. Said these providers:

> *Changing habits may begin at the individual or family level, but maintaining change relies on reinforcement and approval at the community level, involving many different organizations where people access information. [We are] working hard to use a variety of venues and media to spread [our] key messages…to make long-lasting successful behavior changes surrounding oral care.*

> *One thing that facilitated our work was being connected to the Center for Child and Family health. Being connected with a professional organization made training available to us that wouldn't have been possible in the past.*

> *Open lines of communication and the willingness to collaborate with our clients have facilitated the effective delivery of our services.*

One third of the providers (33%) also cited the positive impact of using well-designed tools and resources, and formalizing their processes for working with clients. Among these were:

- Having a pre-screening process in place for wait-listed families
- Using a "*universal*" pre-K application
- Creating a policy as part of the intake process to help ensure family participation in mental health services
- Developing self-study modules in child nutrition

Over one quarter of the providers (27%) cited challenges related to data collection and tracking clients. High mobility rates and the reticence of potential clients to answer the phone and/or provide personal information were among the problems noted by providers in trying to recruit clients or track their participation. Lack of contact information also hindered response rates for parent surveys. Finally, one provider noted that, in tracking program impact, it was difficult to directly attribute client use of services to outreach by providers when media coverage, referrals, word of mouth, and provider workshops had all promoted client participation. As one provider said: "*Working through so many avenues…has made it difficult to accurately track the reasons why parents bring their children to the dental clinic.*"

Unmet Needs

Providers were asked to describe any unmet needs or gaps in services that they had identified during the past year. Table 2 summarizes these open-ended responses.

Table 2. Gaps in services (n=15)

Category of response	Percent of providers reporting
Need for ongoing client support	53%
Staffing needs	27%
Need for addressing barriers to client participation	27%
No response	6%

Note: Percents add to more than 100% since some providers offered responses which fit into more than one category.

Over half of the providers (53%) cited gaps/needs in both the kinds of services provided and the quality of these services. For example, one provider whose programs focus on children aged 0-5 noted "*a huge need*" for services for children ages 6-12. This same provider cited the need for educational programming specifically directed toward fathers, and for a larger facility to accommodate clients who had been turned away and/or wait-listed due to a lack of space. Other gaps noted by providers included the following:

- Lack of an accessible, low-cost dental clinic

- Need for a "*continuum of support*" for families with multiple children, particularly in the area of behavior management skills
- Lack of skilled child care providers, resulting in an uneven quality of service
- Need for support groups for Spanish-speaking families
- Lack of high quality educational materials in Spanish

Over one quarter of the providers (27%) cited gaps/needs related to staffing. Issues related to the need for bilingual staff; additional staff to meet client needs; turnover/absence of staff members; and the need for professional development. Over one quarter of the providers (27%) also cited the need for addressing barriers to client use of services. For example, one provider noted that there had been a decline in the number of clients who identify themselves as Latino, due to their reluctance to work with agencies that may be linked to the government or media. Another provider cited lack of parent participation (e.g., on surveys) as the most challenging component of the project, despite outreach and follow-up efforts. Two providers cited "*basic living needs*" of clients, including housing, transportation, and lack of employment as the most salient needs for families supported by their programs.

Future Plans

Providers were asked to describe future plans for their projects. Table 3 summarizes their responses.

Table 3. Future Plans (n=15)

Category of response	Percent of providers reporting
Strengthen outreach strategies	53%
Build capacity of providers and clients	53%
Initiate program improvement strategies	40%
Strengthen collaboration	20%
No response	6%

Note: Percents add to more than 100% since some providers offered responses which fit into more than one category.

The majority of responses on future plans fell into two broad categories: 1) strengthening outreach strategies, and 2) building capacity to improve services. Plans for enhancing outreach efforts included a number of strategies. For example, two providers noted that greater attention would be given to outreach efforts in the Latino community to improve awareness and accessibility to programs—through public service announcements on the radio, the use of parent advisory groups, and free developmental screenings at El Centro. Among the future plans cited by other providers were soliciting more community input; determining the location of targeted populations that the program was currently missing; expanding services by recruiting additional sites throughout the community; and reducing language and cultural barriers.

Plans for capacity building focused on agency staff, providers, parents, and others. One provider noted plans for working with child care centers to increase their ability to make programs more inclusive. Another provider planned a multi-pronged approach that included developing a self-study module to educate child care providers on children's oral health care, providing in-service education at worksites throughout the county, and targeting organizations that work with low-income families to enhance their knowledge about oral health. Another provider planned to do literacy trainings for classroom staff and promote continuing education requirements. Still another provider planned to use a research-based tool that included training modules for child care staff; the nutrition consultant also planned to work with agency staff and parents to increase knowledge about nutrition. Finally, one provider described plans to deliver technical assistance and support to child care providers, help child care providers develop professional development plans, and connect providers to local colleges and universities.

Over one quarter of the providers (27%) cited plans for improving program quality. Strategies variously included looking for funding to support additional staff (especially bilingual staff); developing an internal database to improve planning; and improving needs assessment strategies. Twenty percent of the providers also cited plans for increasing collaboration—by sharing resources, coordinating referrals and professional development efforts, and reaching out to other agencies/organizations offering similar services to help disseminate information.

Conclusion

The greatest strength of DPfC and its funded partners continues to be placement of children in high-quality, regulated child care. Positive outcomes have also been achieved in teacher compensation, parent education and support, and early intervention for children with or at risk of special needs or disabilities. Areas for improvement include the quality of child care placements for children with developmental needs, lead teacher education points earned by child care programs, family literacy, and Health Check participation in Durham County. Strategies for improvement in these areas are already being implemented.

Funded partners report having a better understanding of the importance of collaboration and using well-designed tools, resources, and processes that help them to better serve their clients. They continue to struggle with staffing issues (e.g., adequate staffing levels, turnover, professional development needs); the need for more effective outreach strategies, especially for serving Spanish-speaking communities in Durham County; residential mobility of participants; privacy concerns that hinder data collection and client tracking; and the ongoing needs of older children, parents, and providers for support. Priorities for the future include strengthening outreach strategies, building capacity of staff and clients, and improving existing programs.

Attachment A

Main Activities of DPfC Funded partners, 2006-07[12]

Activity	Brief description of services provided
1. Child Care Based Mental Health Initiative (CCBMHI)	• Provides training to child care providers on caring for children with challenging behaviors • Provides "play therapy" services to high-risk children
2. Child Care Quality Improvement Project (QUIP)	• Provides technical assistance to child care sites interested in achieving higher licensure/accreditation • Provides professional development workshops to child care providers • Provides substitute teachers to child care centers so that staff may pursue professional development • Provides child care centers with staff support thru the TEACH Early Childhood Corps
3. Choosing & Using Quality Child Care	Educates parents about, and refers parents to, quality child care services
4. Community Awareness and Outreach	Works to increase community awareness and support for partnership activities
5. Durham Alliance for Child Care Access (DACCA)	Administers the money allocated to child care subsidy and More at Four child care subsidy
6. Early Childhood Outreach (EChO)	Serves families with children with challenging behavior that adversely affects their success in child care
7. Family Support Subsidy	Provide financial assistance and referrals to families with children with developmental disabilities
8. FAMOSA	Parent education/support (Hispanic)
9. Healthy Families Durham	Child abuse prevention/family support
10. Hispanic/Latino Consultation Services	Provides interpretation and translation services to Spanish-speaking families who have children with, or at risk for, special needs. Also conduct developmental screenings of children with, or at risk for, special needs.
11. Little River Family Resource Center	Parent education/support
12. More at Four Coordinator	Coordinates the placement and progress of children eligible for and receiving More at Four child care subsidies.
13. Nutrition Consultation	A nutritionist consults with child care center food preparation staff (and parents) to increase healthy food offerings.
14. WAGE$	Provides child care professionals with education-based salary supplements
15. Welcome Baby Family Resource Center	Parent education/support

[12] Though not listed in this table, Program Coordination and Evaluation is also funded by Smart Start.