

Report to:

Montana Department of Public Health and Human Services,
Early Childhood Services Bureau

Montana's Early Childhood System

A Comprehensive Statewide Needs Assessment

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Executive Summary

Montana received a 2019 Preschool Development Birth through Five (PDG B-5) grant from the Administration for Children and Families (ACF) to conduct early childhood systems work in the state. The resultant Strengthening Montana's Early Childhood System Project (project) is focused on developing the state's comprehensive early childhood system to support early learning and development, family support and engagement, and health. The first activity within the project was to conduct a needs assessment.

Montana's comprehensive statewide needs assessment analyzed early childhood system strengths and gaps related to access, quality, workforce, coordination, family engagement, and governance.

Access

Access to early care and education (ECE) is a critical step in ensuring strong foundations for Montana's children. In Montana, ECE services are provided through a range of service delivery models and funding streams, including public, private, and blended service models. ECE capacity varies widely across the state; in general, Montana has an insufficient supply of ECE to meet demand. The state's licensed ECE capacity serves 44% of children ages 0-5 with all parents/caregivers in the workforce. Capacity/access problems are worse for specific subpopulations and regions, including infants and toddlers, rural communities, tribal communities, poorer communities, families with children with special needs (physical health and disability, mental health, developmental delays and disability), and families with irregular work hours. Recommendations reflect the need for improved ECE provider recruitment and retention, targeting underserved populations and regions. They also address family engagement-focused efforts to support informed and effective decision-making to facilitate access to high-quality ECE options.

Quality

Montana has made significant strides in increasing ECE program quality through its Quality Rating Improvement System (QRIS). There are opportunities to continue to refine and increase participation in the QRIS to continue to increase the quality of ECE options for families statewide.

Child care licensing regulations, practices, and collaboration with partner agencies present opportunities for improvement. State licensing exemptions and lack of licensing reciprocity with state, tribal, and Head Start programs result in a system where many ECE providers are not licensed by the state. This impacts quality, access, and equity for families.

Workforce

Regarding the infrastructure to support Montana's ECE workforce, many important components are in place, including a workforce registry, coordination with higher education, professional development support, and an apprenticeship program. However, analyzing outcomes in terms of ECE provider capacity, workforce recruitment and retention, and salaries, reveals opportunity for continued improvement.

Professional development is generally siloed among state licensed programs and other early childhood stakeholders, including Head Start programs, K-12 educators, early intervention providers, home visitors, child and family services social workers, and the healthcare workforce. ECE workforce professional development creation and approval processes can be duplicated, with limited use of distance learning options.

Coordination

Within the area of coordination, the assessment focused on screening children for social-emotional concerns; broader family navigation issues including extended social determinants of health screening and assessment, referrals, and navigation; the extent to which providers work together; transitions; and how data is used to support service coordination at the individual and system level.

Currently, a multitude of child screening tools are used by early learning and development, family support, and health providers. Developmental screening is not universal. Inconsistency in tools and application, and lack of a screening registry or other information sharing mechanism have led to barriers to screening.

System navigation can be confusing for families, particularly those with experiences of trauma and stress. Lack of up-to-date, comprehensive, and centralized information about early childhood services make both assisted and self-directed system navigation hard. Providers generally support navigation through referrals, but often not with more intensive navigation or coordination support such as warm handoffs or follow up. Provider coordination challenges are more pronounced when trying to work across early childhood system sectors – disparate rules and data hinder effective coordination.

Transitions are places where things are more apt to go wrong or be hard for children, families, and providers. Families report often feeling dropped or unsupported through transitions, demonstrating the importance of effective family engagement for successful transitions. Kindergarten transitions are inconsistent in Montana, with no statewide kindergarten readiness assessment (KRA) or transition process.

Child and family data are in multiple, primarily disconnected systems, making the unique identification of children currently impossible. Many systems are older legacy systems with limited data analytics ability and general low data quality. Within Medicaid, the state is implementing new information technology infrastructure including a common client index, allowing for unique identification across data systems.

Family Engagement

Family engagement is a common thread throughout the assessment's analysis of access, quality, workforce, coordination, and governance. Recommendations focused on increasing or improving family engagement are included throughout the report. The needs assessment survey focused on family and provider perception of family engagement practices. Survey results show that family engagement is not consistently valued across the early childhood system, with many providers perceiving family interactions as primarily transactional.

Governance

Despite most of the state's early childhood systems being housed within one state agency – the Department of Public Health and Human Services (DPHHS) – there is fragmentation between programs

located in multiple divisions and bureaus, which are subject to different policies, business processes, evaluation criteria, and program leadership.

The role of the statewide advisory council, the Best Beginnings Advisory Council (BBAC), has become complex as the council has grown in membership and grant management responsibilities.

Local coalitions also face challenges as more grants rely on them for implementation support. Communities can have multiple local coalitions with similar membership working on related or duplicated issues.

Montana invests limited state dollars into early childhood programs. Disparate federal funding requirements, disaggregated information technology systems, a siloed and uncoordinated state early childhood system, and worries about perceived misuse of funds are barriers to funding coordination (also referred to as blending or braiding of funds).

Montana's Legislative session convenes biennially. Each session informs budget and policy direction for the subsequent biennium. This model can offer a biennium of support or a two-year roadblock, depending on the priorities set in a given session. Montana has an opportunity to better educate and engage the state legislature in prioritizing and supporting early childhood issues through policy and system governance.

Next Steps

Montana is prepared to invest in its early childhood system, with effective early childhood champions in place in state government, philanthropic and non-profit organizations, and local and tribal agencies. Needs assessment findings and recommendations are informing Montana's early childhood system strategic plan, associated indicators, and evaluation plan. These documents together will support further strengthening of Montana's early learning and development, family support, and health systems to ensure young children and families thrive.

Introduction

Montana received a 2019 Preschool Development Birth through Five (PDG B-5) grant from the Administration for Children and Families (ACF) to conduct early childhood systems work in the state. The resultant Strengthening Montana’s Early Childhood System Project (project) is focused on developing the state’s comprehensive early childhood system to support early learning and development, family support and engagement, and health. The project is intended to promote access to high-quality early childhood care and education (ECE) for infants, toddlers, and preschool age children in a mixed-delivery system to support the state’s vision that children achieve their highest potential in school and in life. The target populations are underserved children, families, and geographic regions, and the early childhood providers and supporting system.

The first activity of the project was to conduct a comprehensive statewide needs assessment of Montana’s early childhood system. The needs assessment was conducted January—July 2019, with a significant focus on engaging family and provider voices throughout the process. The needs assessment is intended to provide detailed findings and recommendations to support subsequent strategic and evaluation planning efforts.

The project will support the state’s ability to ensure that every child has access to high-quality ECE where their learning and development are supported so they are ready to succeed in school and beyond.

Why investment in early childhood matters

Children have an enormous rate of early brain development – more than 1 million neural connections are formed per second in the first few years of life.¹ However, this growth and plasticity declines over one’s life course, requiring increasingly greater effort to learn or change behaviors.² Indeed, research has demonstrated that a community can reap substantial return on investment – both in terms of reducing human suffering and saving public dollars – by investing earlier in the lifespan. For example, research finds that children from low-income families who attend quality preschool are more likely than their peers who did not attend preschool to have higher educational attainment and income, lower involvement with drugs or the criminal justice system, and better mental and physical health.³ Every dollar invested in quality early childhood development programs for children ages 0-5 from low-income families produces a 13% return, per child, per year.⁴ What is more, high-quality ECE can have positive second-generation impacts, where the children of original ECE participants saw significant increases in education, health, full-time employment, and reduced incidence of anti-social behavior or crime.⁵

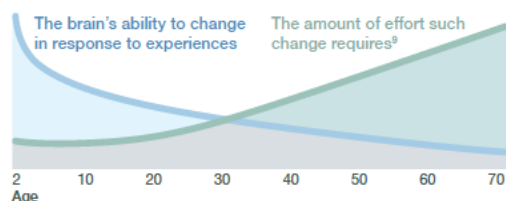
High-quality birth-to-five programs for children from low-income families can deliver a

13%

return on investment.

ABILITY TO LEARN AND CHANGE DECLINES OVER THE LIFESPAN

Figure 1. Neural plasticity over the lifespan



Source: Harvard University, Center on the Developing Child, “Brain Architecture”⁶

¹ *Brain Architecture*, Harvard University, Center on the Developing Child, Accessed on April 4, 2018

<https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>.

² Ibid.

³ Julia B. Issac and Emily Roessel, *Impact of Early Childhood Programs*, Brookings Institute, September 4, 2008,

<https://www.brookings.edu/research/impacts-of-early-childhood-programs/>.

Frances Campbell, Gabriella Conti, James Heckman, Seong Hyeok Moon, Rodrigo Pinto, Elizabeth Pungello and Yi Pan, “Early Childhood Investments Substantially Boost Adult Health,” *Science* 343, no. 6178 (2014): 1478-1485.

Deborah Lowe Vandell, Jay Belsky, Margaret Burchinal, Nathan Vandergrift, and Laurence Steinberg, “Do Effects of Early Childhood Extend to Age 15 Years? Results from the NICHD Study of Early Child Care and Youth Development,” *Child Development* 81, no. 3 (2010): 737-756.

⁴ James J. Heckman, *13% ROI Research Toolkit*, University of Chicago, Accessed on September 17, 2019,

<https://heckmanequation.org/resource/13-roi-toolbox/>.

⁵ James J. Heckman, *Intergenerational and Intragenerational Externalities of the Perry Preschool Project*, University of Chicago, May 14, 2019, <https://hceconomics.uchicago.edu/news/new-research-professor-heckman-shows-intergenerational-benefits-high-quality-ece>.

⁶ Accessed April 4, 2018 at <https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>

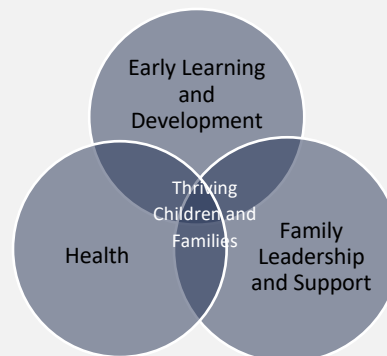
Understanding early childhood service systems

The diagram at right, depicting the three key sectors of an early childhood system, shows how young families at the center often interact with multiple early childhood sectors. Research and practice show that families are best supported when there is coordination across these sectors. Doing so improves assessment, referrals, and connections to services, which can in turn improve outcomes.⁷

Early childhood systems are typically viewed as regional or community systems, comprising the services that a family in a given region may encounter as they seek out their needs or are referred. In this way, early childhood systems are family-centered – ideally providing coordinated and seamless services, both universal and specialized, for the families in their community.

Early childhood systems also exist at the state level in the form of oversight agencies for state or federally funded programs. These state-level agencies can play critical roles in how cross-sector services are delivered at the local level. The findings and recommendations in this report demonstrate the importance of state-level actions on system functioning.

Montana's early childhood system includes agencies or services that are either for children and their families exclusively (such as home visiting) or children and their families are one of the populations served (such as Medicaid). The Governance section provides a diagram of the many child-serving agencies in Montana.



Results that a comprehensive early childhood system should deliver:

EARLY LEARNING AND DEVELOPMENT: Nurturing relationships, environments, and enriching experiences that foster learning and development.

HEALTH: Comprehensive services that promote children's physical, developmental, and mental health.

FAMILY LEADERSHIP AND SUPPORT: Resources, experiences, and relationships that strengthen families, engage them as leaders, and enhance their capacity to support children's well-being.

*Source: BUILD Initiative, *The Early Childhood Systems Working Group* (<https://www.buildinitiative.org>).*

⁷ Appendix B: Context provides additional detail on the value of early childhood system coordination, as well as an evaluation framework by the Center for the Study of Social Policy used in this needs assessment that helps communities measure system functioning. The appendix also provides a description of the conceptual framework that guided this research and the resulting recommendations. This conceptual framework marries a socioecological model and an expanded social determinants of health model to promote system-levels thinking while at the same time understanding the specific drivers contributing to child and family outcomes. Finally, this appendix describes the Montana TANF Family Bridge Model, which is a real-world application of this conceptual framework.

Research framework

The research conducted in support of the Needs Assessment of Montana’s Early Childhood System evaluated six broad early childhood issues areas:

- **Access.** The chapter devoted to access analyzes issues related to the capacity of the state’s early care and education sector to serve Montana families children, particularly those who are vulnerable. Results related to family support and healthcare access are provided in the appendices.
- **Quality.** The chapter pertaining to quality focuses on supporting quality early care and education.
- **Workforce.** The workforce chapter shares findings related to the early care and education workforce, professional development, and organizational capacity building.
- **Coordination.** The chapter on coordination looks at how well Montana stakeholders within the early childhood system are screening, referring, and coordinating across sectors to improve outcomes for children. It also shares family perspectives on their experience navigating the early childhood system in pursuit of services to fulfill their family’s needs. Finally, we present findings on data systems and sharing.
- **Family Engagement.** The chapter on family engagement investigates the state of family participation and engagement in early childhood settings in Montana.
- **Governance.** The governance chapter provides best practices and recommendations for statewide organizational structures that deliver early childhood services efficiently and effectively.

The definition of early childhood systems described in the previous section undergirds the research framework, providing a systems lens to the data collection and analysis. The report is largely focused on early learning and development sector findings, however, data were also collected and analyzed for family support and health; many of those findings are provided in the appendices.

Before reporting on research findings, we present contextual information in the context chapter. In this chapter we look at social-demographic data important for understanding the landscape within which families and children live, and the state, tribes, and local communities provide services and supports. We also analyze Montana’s definition of vulnerable children and families to understand who they are, how they are currently supported by the state’s early childhood system, and how they could be better supported.

Because of the breadth of the needs assessment scope, appendices are used to present significant amounts of supporting data, including best practice research, considered less essential to the central narrative of the assessment. The appendices are organized by the same topic areas as those in the main report.

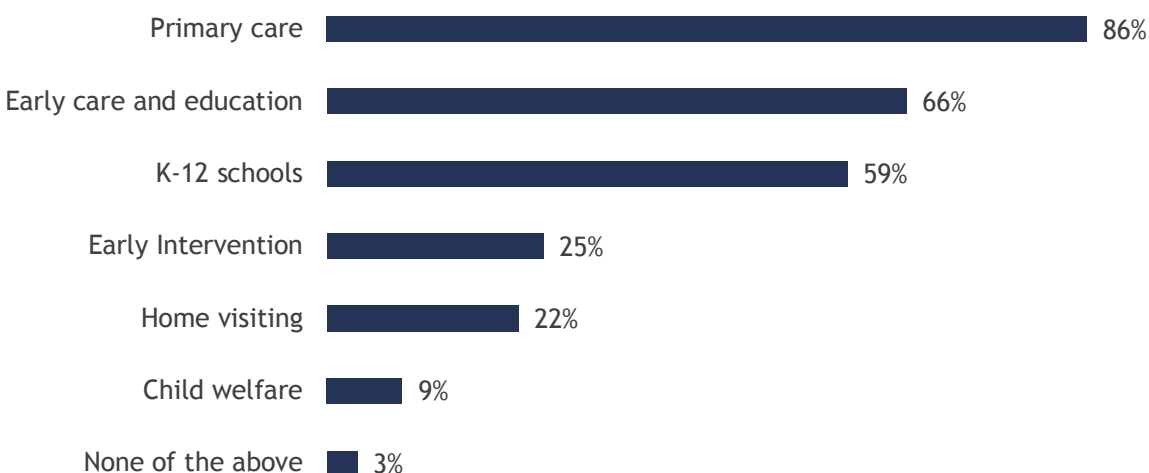
Methodology

Researchers employed a mixed methods approach, using administrative, secondary, and primary data to complete the early childhood needs assessment.

- Administrative data was utilized to depict the current utilization of services across selected components in the early childhood system.
- Secondary data accessed through the U.S. Census was primarily utilized to provide detailed information about demographic characteristics of Montanans. Secondary data that is not publicly available was also provided by DPHHS key staff, as the project team requested and received data files for surveys that had previously been completed by relevant departments.
- Primary data collection was intended to provide unique insights into the early childhood system in Montana and to inform the specific research questions associated with this needs assessment. Primary data was collected in three different ways: parent/family and provider survey (1217 responses), focus groups with families and providers (291 in person participants in 13 locations plus virtual focus groups), and individual interviews with the governor’s office, state-level administrators, program staff, and stakeholders from other states (Montana: 78 interviewees; 4 other states: 7 interviewees). Primary data collected reflected experience across all early childhood system sectors.

THE TWO MOST COMMON PARTS OF THE EARLY CHILDHOOD SYSTEM USED BY SURVEY RESPONDENTS ARE HEALTHCARE AND EARLY CARE AND EDUCATION

Figure 2. Use of the early childhood system as reported by needs assessment survey respondents



Source: Montana PDG B-5 Needs Assessment Family Survey

Data analysis was completed in Excel, SPSS and R. A detailed methodological framework and stakeholder participant overview is included Appendix A: Methods.

Context

This chapter provides data on the number of young children in Montana, including those living in families with low income. We also provide Montana's definition of vulnerable and underserved children and display a map that estimates relative levels of vulnerability by Montana county. Finally, given the impact of rurality, in particular, on ECE accessibility (i.e., child care deserts), we include these data in the main report, while additional detail on vulnerability characteristics can be found in Appendix B: Context.

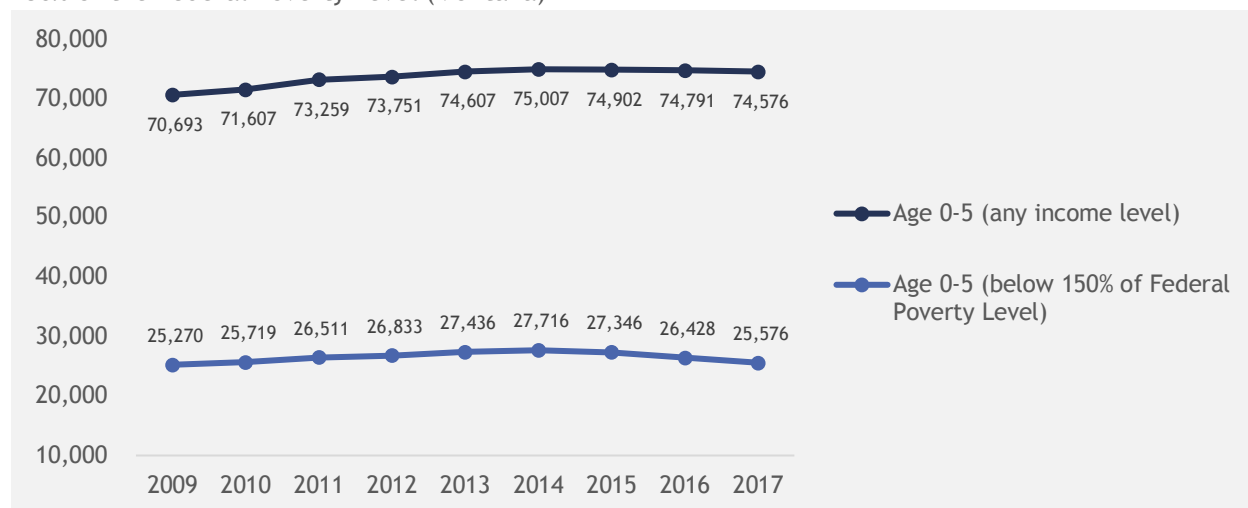
Young children in Montana

The number of children ages zero through five (0-5) rose consistently between 2009 and 2014; however, in recent years there has been a gradual decline in the number of young children in Montana (down 1% since 2015). As of 2017, there were an estimated 74,576 children ages 0-5 in Montana.

The number of children ages zero through five living in families with low income, defined as under 150% of the Federal Poverty Level, was estimated at 25,576 in 2017. This represents a decline of 8% since the high in 2014.

SINCE 2014, THE NUMBER OF LOW-INCOME YOUNG CHILDREN DECLINED 8%

Figure 3. Number of young children and number of young children living in families with income below 150% of the Federal Poverty Level (Montana)

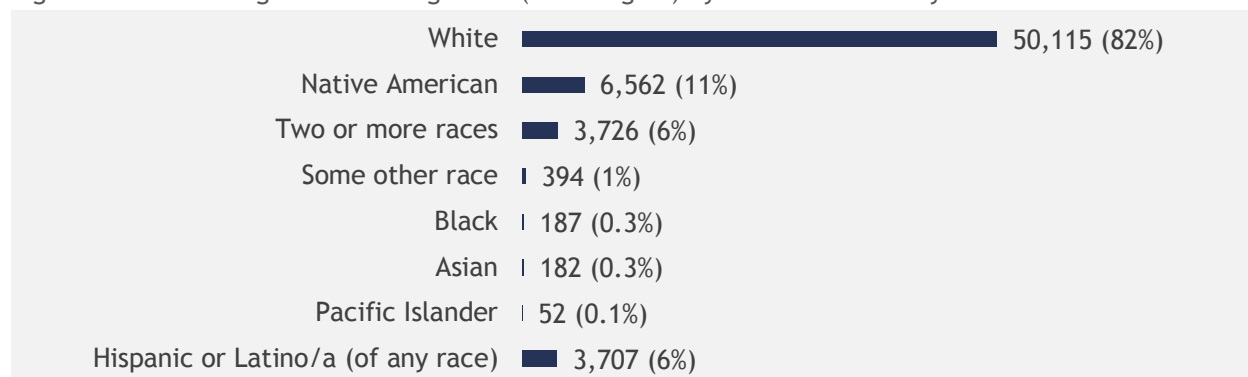


Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates

The vast majority (82%) of Montana children under age five (0-4) are white (no other race). Another 11% are Native American and 6% are two or more races. Of all Montana children under age five, 6% are Hispanic or Latino/a.

82% OF MONTANA'S YOUNG CHILDREN ARE WHITE

Figure 4. Children ages zero through four (under age 5) by race and ethnicity in Montana



Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates

Vulnerable populations

Not everyone starts in the same place, has the same experiences, or has the same needs. While all children have a need to be nurtured and supported, some children need additional supports in order to thrive. Factors such as race and ethnicity, family income, neighborhood, language spoken at home, disability status, trauma, and other factors can impact a child's outcomes. These factors are referred to collectively as vulnerabilities, since they increase a child's or families' risk for poorer outcomes.

Montana defines children as being vulnerable and/or underserved when they experience any of the following:

- Have a disability, identified developmental concern, or behavioral health issue.
- Have special healthcare needs (such as food allergies, asthma, diabetes, special dietary restrictions, on extended prescribed medication, etc.).
- Are an infant age 0-19 months.
- Are an enrolled tribal member or reside on tribal lands.
- Are children of teenage parent(s).
- Are low income.
- Are children of migrant families.
- Are homeless or at risk of becoming homeless.
- Are English language learners (ELL) or dual language learners (DLL).
- Have experienced trauma or maltreatment, including children in foster placements.
- Have a parent or guardian that is active in the military.
- Live in rural and underserved areas.

The early childhood system can play a substantial role in improving outcomes for vulnerable families and children by understanding the needs of young children and families, targeting interventions to vulnerable populations, and revising policy to reduce inequities.⁸

⁸ The Center for Law and Social Policy has created *Child Care and Early Education Equity: A State Action Agenda* to educate policymakers about key state early childhood programs, describe challenges such as underinvestment and

Figure 5 presents counts and percentages of children by vulnerability characteristic for which there are data. The data do not allow for combining characteristics without duplication to arrive at an unduplicated count and percentage of vulnerable and underserved young children. However, the vulnerability index presented in the next section combines these data points to arrive at a proxy method for understanding relative variation in levels of vulnerability across the state. Currently the state has not identified additional initiatives to improve vulnerability data.

21% OF MONTANA’S HOUSEHOLDS WITH YOUNG CHILDREN ARE LOW-INCOME

Figure 5. Counts and percentages by vulnerability characteristic in Montana

Vulnerability Characteristic	Count	Percent	
Children under age 5 (0-4) with disability	548	0.9%	of all children ages 0-4 (under age 5)
Children under age 3 (0-2)	35,592	48%	of all children ages 0-5 (under age 6)
Children under age 5 (0-4) who are Native American	6,562	11%	of all children ages 0-4 (under age 5)
Women ages 15-19 who gave birth in the past 12 months	446	4%	of all women who gave birth in the past 12 months
Households with children under age 5 (0-4) with income below 150% of the Federal Poverty Level	6,753	21%	of all children with households that include children under age 5
Households that are limited English-speaking	1,816	0.4%	of all households
Children age under age 6 (0-5) living in rural county	8,485	11%	of all children ages 0-5 (under age 6)

Source: U.S. Census Bureau (2017 American Community Survey, 5-Year Estimates) and Center for American Progress

Vulnerability by county

TO HELP UNDERSTAND THE VARIATION IN YOUNG CHILDREN’S VULNERABILITY ACROSS THE STATE, WE PROVIDE AN AT-A-GLANCE VIEW OF RELATIVE LEVELS OF VULNERABILITY BY COUNTY. THE MAP SHOWS THAT THE HIGHEST LEVELS OF VULNERABILITY CLUSTER IN NORTH-CENTRAL AND SOUTH-EASTERN MONTANA

Figure 6 depicts the results of the “vulnerability index” – the combination several vulnerability characteristics into a single value or score for each county. The vulnerability characteristics included in the index were based on data available for the characteristics within Montana’s definition of vulnerable and underserved. They include:

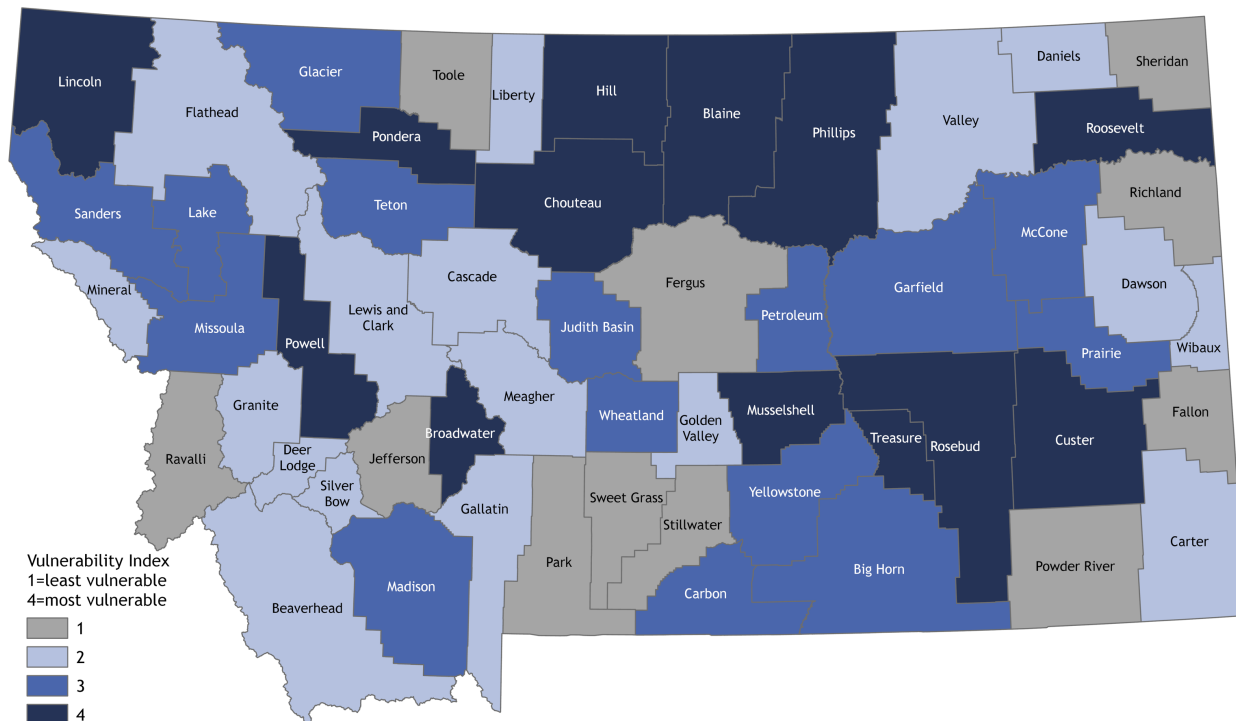
- Percentage of children with disability.
- Percentage children under age five that are infants and toddlers (under age 3).
- Percentage of children under five who are Native American.
- Percentage of births to teens.
- Percentage of households with young children that have low income.
- Percentage of households that are limited English-speaking.
- Level of rurality.

racial inequities, and offer recommendations for how public policy can improve these programs. Stephanie Schmitt (2019), <https://www.clasp.org/publications/report/brief/child-care-and-early-education-equity-state-action-agenda>.

A score ranging from 1 (least vulnerable) to 4 (most vulnerable) was assigned to each county is based on the underlying results for each vulnerability characteristic. For example, a county with the highest levels of vulnerability on all or most of the seven characteristics would score a 4, a county with lowest levels of vulnerability on all or most of the seven characteristics would score a 1, while counties with mixed levels would score either a 2 or 3.⁹ Please see Appendix B: Context for maps depicting results for each of the seven index characteristics.

HIGHEST LEVELS OF VULNERABILITY CLUSTER IN NORTH-CENTRAL AND SOUTH-EASTERN MONTANA

Figure 6. Vulnerability index map showing the relative vulnerability of children in Montana counties



Source: Bloom Consulting analysis of data from U.S. Census Bureau (2016 American Community Survey, 5-Year Estimates) and Center for American Progress

Rurality

Rurality contributes to vulnerability in a number of ways, including lower employment opportunities and wages, which contributes to typically higher rates of poverty in rural areas.¹⁰ Further, research has

11%

of Montana children ages 0-5 live in rural counties.

⁹ Please see Appendix A: Methods for a full technical description of the index methodology.
¹⁰ Leila Schochet, *5 Facts to Know About Child Care in Rural America*, Center for American Progress, June 4, 2019, <https://www.americanprogress.org/issues/early-childhood/news/2019/06/04/470581/5-facts-know-child-care-rural-america/>.

found that, overall, rural areas have the highest concentration of child care deserts.¹¹

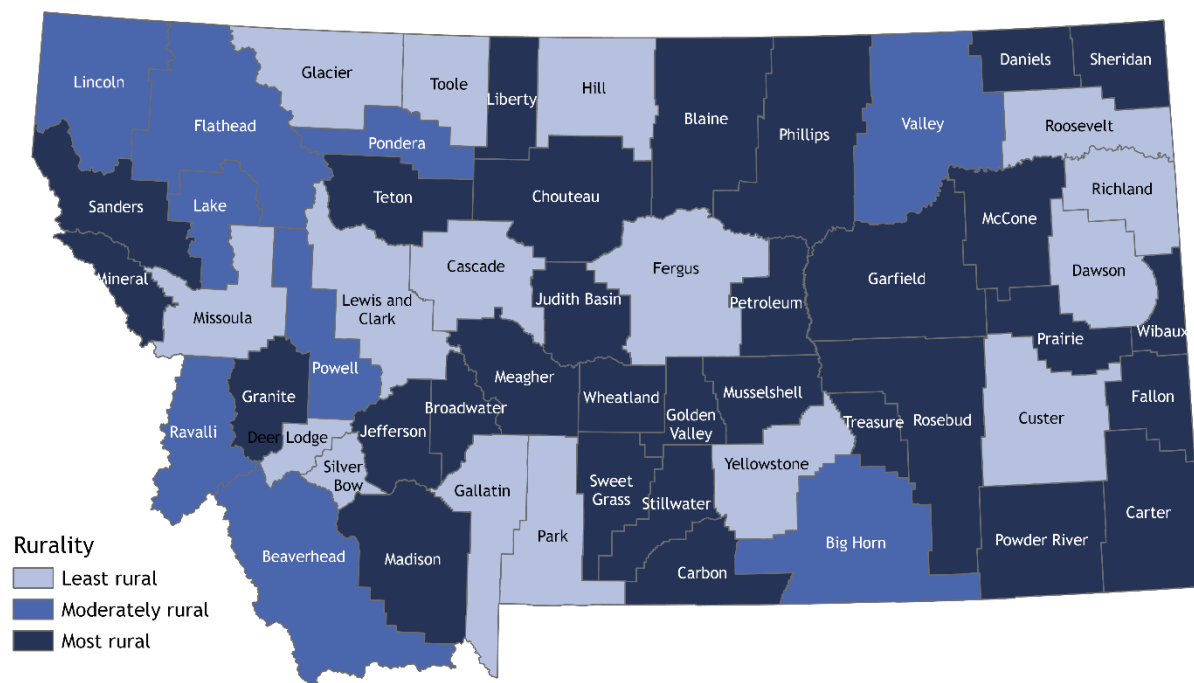
Nationwide, 20% of the population is categorized as rural. In Montana, 13% of the population live in counties categorized as rural.¹² However, more than half (55%) of Montana counties are considered rural, while 16% are considered suburban, and 29% are considered urban.

According to the three-level rurality index by the Center for American Progress, a score of 1 is the least rural (urban), a score of 2 is somewhat rural (suburban), and a score of 3 is the most rural (rural). The measure is based on household density (the number of occupied households per square mile). As indicated above and shown in Figure 7, most Montana counties are rural.

In the Montana counties identified as rural under the Center for American Progress definition, there are an estimated 8,485 children ages 0-5. Children living in rural areas account for 11% of all Montana children ages 0-5.¹³

55% OF MONTANA COUNTIES ARE RURAL

Figure 7. Designation of rurality by county



Source: Center for American Progress

¹¹ Rasheed Malik, Katie Hamm, Leila Schochet, Cristina Novoa, Simon Workman, and Steven Jessen-Howard, *America's Child Care Deserts in 2018*, Center for American Progress, December 6, 2018, www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/.

¹² Population according to the U.S. Census Bureau, *American Community Survey, 5-Year Estimates (2017)* of Montana rural counties as determined by the Center for American Progress, Rasheed Malik and Leila Schochet, *A Compass for Families*, Center for American Progress, April 10, 2018, <https://www.americanprogress.org/issues/early-childhood/reports/2018/04/10/448741/a-compass-for-families/>.

¹³ Ibid.

Figure 8 provides a summary of the aggregated characteristics of the counties identified as rural (see “most rural” counties in Figure 7). These tables show that most rural residents are white, speak English at home, and have poverty rates on par with the national averages (14.6% of all people, and 22.5% of children under age 5). However, looking at each county individually provides a greater understanding of the variable culture and conditions in each county. Appendix B: Context provides detailed data by rural county.

22% OF YOUNG CHILDREN IN RURAL COUNTIES ARE BELOW THE POVERTY LEVEL

Figure 8. Aggregated characteristics of 31 Montana counties designated rural

Population			Ethnicity		Immigrants/Foreign Born			
Total population	Population 0-5		Hispanic or Latino (of any race)		Foreign born		Foreign born: recent (2010 or later) immigrants	
Count	Count	Percent	Count	Percent	Count	Percent	Count	Percent
131,024	8,485	6%	3,439	2.6%	2,224	1.7%	434	20%

Language spoken at home among population 5 years of age and over									
English only		Spanish		Other Indo-European languages		Asian and Pacific Islander languages		Other languages	
Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
118,644	96%	1,544	1.2%	2,413	1.9%	301	0.2%	1,143	0.9%

Race					
White		Black or African American		American Indian and Alaska Native	
Count	Percent	Count	Percent	Count	Percent
116,963	89%	282	0.2%	9,822	7%
Asian/Pacific Islander		Some other race		Two or more races	
Count	Percent	Count	Percent	Count	Percent
538	0.4%	642	0.5%	2,777	2%

Poverty and Low Income Status					
Below poverty (all ages)		Below poverty (under 5 years)		All individuals with income below 185% of poverty level (low-income)	
Count	Percent	Count	Percent	Count	Percent
18,140	14%	1,537	22.4%	40,179	31%

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2017 for Montana counties designated rural by the Center for American Progress

Access

Access to early care and education is a critical step in ensuring strong foundations for Montana’s children. In Montana, ECE services are provided through a range of service delivery models and funding streams, including public, private, and blended service models. ECE capacity varies widely across the state, with rural and Native American reservations experiencing significant shortage. Families with infants and toddlers, children with special needs, and families with low-income also face pronounced barriers to ECE access.

In the needs assessment, we use the terms “access” and “availability” interchangeably. We follow the U.S. Department of Health and Human Services Administration for Children and Families definition of access to ECE (or ECE availability) as described in *Defining and Measuring Access to High-quality Early Care and Education: A Guidebook for Policymakers and Researchers*: “Parents, with reasonable effort and affordability, can enroll their child in an arrangement that supports the child’s development and meets the parents’ needs.”¹⁴

The chapter focuses on access issues related to early care and education. Access issues associated with health and family support are included when they impact ECE access, particularly for children with special needs. Additional findings related to access to family support and health services are presented in Appendix C: Access.

¹⁴ S. Friese, V. Lin, N. Forry and K. Tout, *Defining and Measuring Access to High-quality Early Care and Education: A Guidebook for Policymakers and Researchers* (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2017), OPRE Report #2017-08.

Reach of and access to ECE

24% of the Montana population are children under 18

74,576 children under six reside in Montana

58% of children under six in two-parent households in Montana live in households where both parents work

78% of children in one-parent households in Montana live in households where the parent is working

The early care and education (ECE) landscape in Montana is comprised of a mixed delivery system including public and private providers offering child care, preschool, and Pre-Kindergarten programs. In 2018, there were 1,117 known licensed or registered ECE providers in the state, including child care centers; group home child care providers; family home child care providers; family, friend and neighbor providers; and relative care exempt providers.¹⁵

In Montana, children up to age 18 comprise 24% of the population.¹⁶ According to 2017 Census estimates, there were 74,576 children under the age of six in the state. Among children under six years old living in two-parent households in Montana, 58% were living in households where both parents worked; among children in one-parent households, 78% were in households where the parent was working.¹⁷

Not all families with children under six will seek care. An estimated figure of child care demand is determined by multiplying the percent of all parents who are participating in the labor force by the overall number of children in the

region. Child care capacity can be measured by the number of licensed child care centers, licensed group or family providers, and registered family, friend, neighbor (FFN) caregivers.¹⁸ These estimates do not include unlicensed ECE options, including unlicensed preschools, unlicensed family and informal providers, which supplement the licensed capacity and may increase access for some families.¹⁹ Only Head Start programs that are state licensed are include in the capacity count. ECE capacity can be communicated by the percent of children needing care (demand) that can be served by existing licensed providers (supply).

¹⁵ For more detail on the ECE provider options in Montana, please see Appendix C: Access.

¹⁶ Catalyst Center, *Chartbook of Montana State Data*, School of Social Work, Boston University, Accessed on March 7, 2019, <https://chartbook.ciswh.org/statedata>.

¹⁷ U.S. Census Bureau, *American Community Survey 1-Year Estimates* (2015).

¹⁸ Licensed capacity only includes partial count of Head Start, Early Head Start, and tribal ECE capacity.

¹⁹ In 2018, registered FFNs provided 773 additional child care slots across the state. There is no systematic count of unregistered, informal child care capacity in Montana.

KEY FINDING: ECE capacity does not meet demand.

Less than half of children needing care can be served by existing ECE capacity. In September 2018, point in time total statewide licensed ECE capacity was 19,982 as shown in Figure 9; 44% of children likely needing care can be served by the existing ECE capacity.²⁰ As discussed in greater detail below, lack of access to child care may dissuade some parents from entering the labor force. When considering all families in the state, regardless of their labor market status, existing ECE slots in the state could serve 28% of all children under age 6.

44% of Montana’s children needing care can be served by existing ECE capacity

FORTY-FOUR PERCENT OF CHILDREN NEEDING CHILD CARE CAN BE SERVED BY EXISTING STATEWIDE ECE LICENSED CAPACITY

Figure 9. Statewide 0-6 population and existing ECE capacity

Statewide population under 6	Labor force participation rate of parents	Total ECE licensed capacity statewide	Percent of children with parents in the labor force that can be served by existing ECE capacity	Percent of all children under 6 that can be served by existing ECE capacity
71,610	63%	19,982	44%	28%

Source: Montana Early Childhood Service Bureau capacity data and U.S. Census Bureau population figures

KEY FINDING: ECE capacity varies greatly by county.

ECE capacity to serve children varies by county in Montana. ECE capacity ranges from no capacity in multiple counties, to 75% in Lewis and Clark County, as shown in Figure 10. While county level data provides a broad picture of variation in ECE capacity across the state, county-level data may not universally represent the experience of families within a county. For example, two towns in one county may have very different ECE capacity, impacting family access.

Rural counties lack ECE providers. Eight counties in the state had no licensed child care centers, group, or family providers; all of these counties were rural counties. Statewide, more than half of all counties (29 counties) could serve less than 25% of children under six likely to need child care based on 2018 capacity; all but five of these counties were rural. In contrast, of the remaining 27 counties that could serve 25% or more of the children under six likely to need care through their existing systems, only 7 were rural. Forty-three of the 56 counties that could serve less than 25% of infants and toddlers likely to

²⁰ Currently, Montana child and family data are in multiple, primarily unconnected systems, making the unique identification of children receiving and awaiting services impossible. The data used to estimate children awaiting service are a combination of licensed capacity data and population data. Capacity data on total number of child care slots available comes from state licensing data. Child care enrollment data comes from STARS to Quality participation data. The state does not collect enrollment data for licensed or unlicensed providers who are not participating in STARS to Quality. Additionally, there is no consistent statewide waitlist data across programs. This is a gap in understanding of the unduplicated number of children being served in existing programs or awaiting services.

need care based on 2018 slots were rural counties. When asked about access to child care in eastern Montana, parents describe limited providers.

Child care outside of Miles City? What child care? -Parent

Native American communities face greater child care access challenges. Among the nine counties where Native Americans comprise more than 10% of the population, seven of them could serve less than 25% of children likely to require ECE capacity using state licensed providers.²¹ When considering all children under six, independent of parent labor force participation, none of these nine counties could serve more than 25% of expected demand using state licensed providers.²²

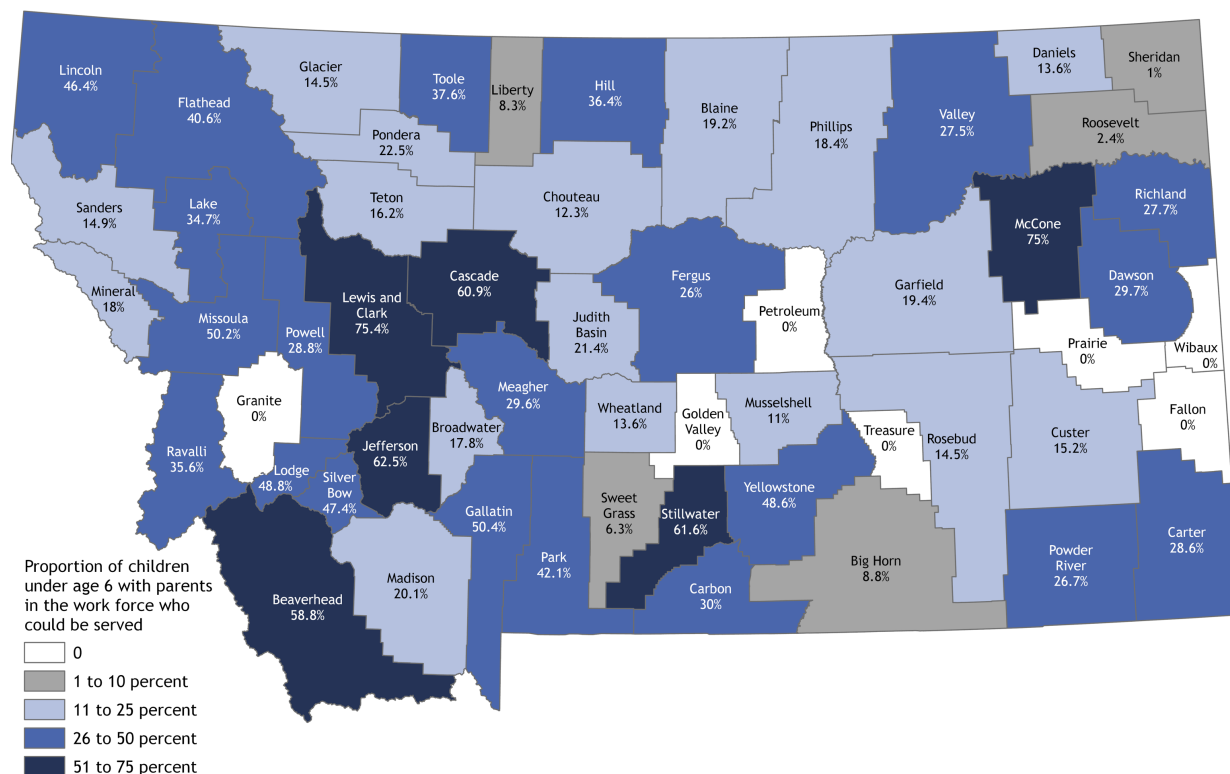
Most counties with limited access were low-income communities. Nine out of the 29 counties that could serve less than 25% of expected demand had median household incomes less than \$50,000, compared to two of the 27 counties that could serve 25% or more of the children under six likely to require services.

²¹ This figure does not include tribal ECE options not licensed through the state, for which data were unavailable.

²² This figure does not include tribal ECE options not licensed through the state, for which data were unavailable.

ECE CAPACITY VARIES GREATLY ACROSS THE STATE, WITH POCKETS OF HIGH CAPACITY AND MORE WIDESPREAD LIMITED CAPACITY

Figure 10. Percent of children with all parents in the labor force that can be served by existing ECE capacity



Source: Montana Early Childhood Service Bureau capacity data and US Census Bureau population figures

RECOMMENDATION: Increase supply of ECE statewide, with targeted focus on the most significant child care deserts in rural, tribal, and poorer counties. Increasing ECE supply will be the result of many strategies focused on increasing the early childhood workforce and developing deeper commitment around early childhood as a priority in the state. Public understanding and leadership engagement are required for policy and funding support needed to invest in the ECE workforce. Stakeholders want to see business and legislative investment in terms of subsidies, incentives, ECE infrastructure, building/development codes, and educator pay. Additionally, licensing changes should be considered to remove licensing exemptions, increase reciprocity with tribal and Head Start programs, and remove/reduce other licensing barriers. The remainder of this section focuses on detailed recommendations to increase ECE supply/capacity.

Barriers to ECE access

Families may face multiple barriers to accessing child care, from lack of information about available options, limited availability near home or work, prohibitive cost, and lack of preferred ECE setting. These factors influence family employment decisions and impact statewide workforce participation.

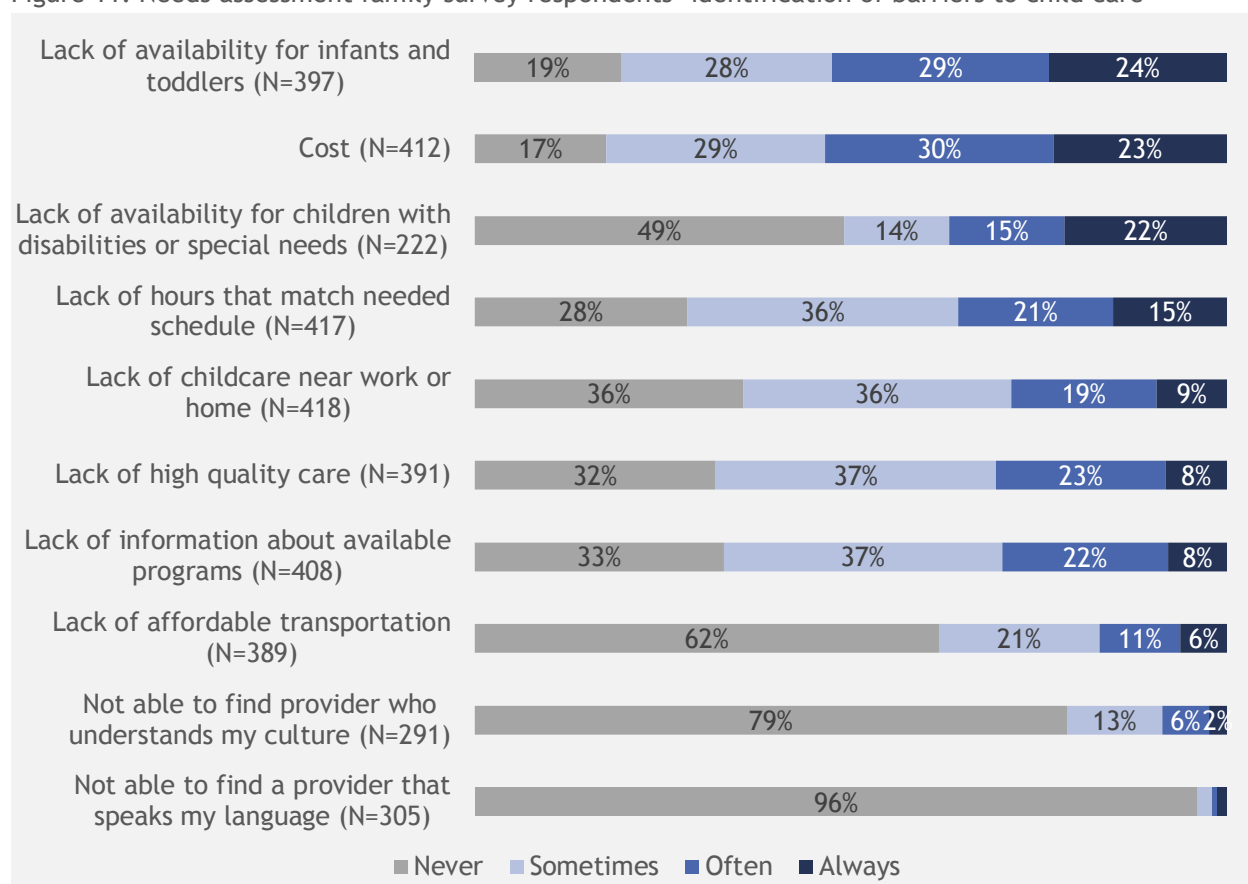
KEY FINDING: Families face multiple barriers to accessing child care, including lack of availability for infants and toddlers, cost, and lack of care for children with special needs.

Families in Montana face diverse and often multiple barriers to child care. As shown in Figure 11, among the survey respondents who were participating in ECE services, the barriers identified as “always” a barrier by the largest share of families were:

- Lack of availability for infants and toddlers (24%)
- Cost (23%)
- Lack of availability for children with special needs (22%)

CHILD CARE COST AND LACK OF AVAILABILITY FOR INFANTS AND TODDLERS ARE GREATEST BARRIERS TO CHILD CARE ACCESS REPORTED

Figure 11. Needs assessment family survey respondents’ identification of barriers to child care



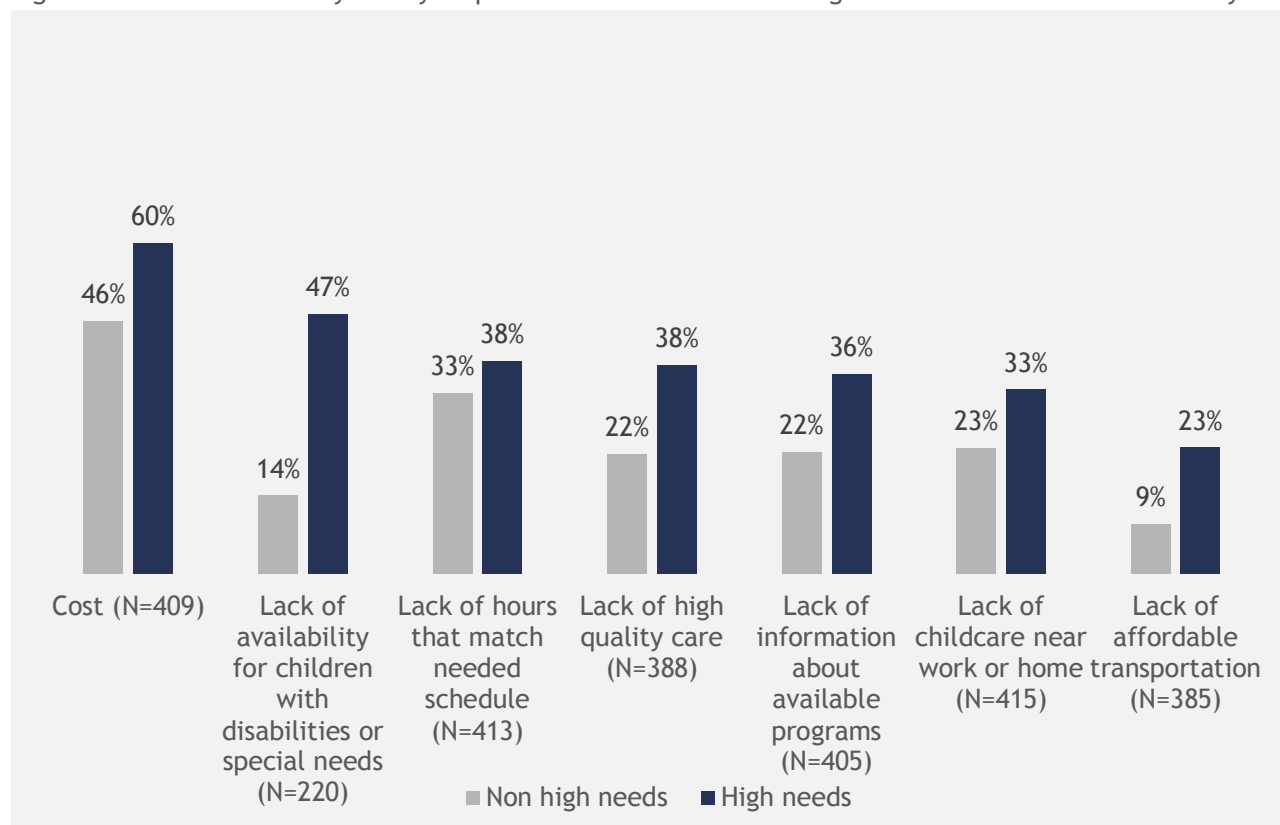
Source: Montana PDG B-5 Needs Assessment Family Survey

Families of children with high needs face additional barriers to accessing early care and education.

Figure 12 illustrates the variation in response across parents of children with high needs and parents without children with high needs who identify select issues as posing a barrier to child care sometimes or always.

FAMILIES OF CHILDREN WITH HIGH NEEDS CITE MORE FREQUENT BARRIERS TO CHILD CARE ACCESS

Figure 12. Percent of family survey respondents that indicated facing child care barrier often or always



Source: Montana PDG B-5 Needs Assessment Family Survey

Further differences in barriers to child care access varied by family characteristic, as shown in Figure 13.

- Families of children who were enrolled tribal members or who resided on tribal land** were more likely to state more frequent barriers to child care due to lack of affordable transportation; lack of availability for infant and toddler care; lack of providers who speak their language; and lack of providers who understand their culture. Families with children who are enrolled tribal members who were not participating in ECE services at the time of the survey were more likely to state that lack of infant and toddler care availability and lack of a providers who speak their language were reasons why they do not use ECE services. Parents who participated in focus groups in both Browning and Lame Deer shared how access to child care is complicated by the almost complete lack of facilities, “There are no day care centers on the reservation – there was one at the school and one at Dull Knife College but they weren’t making enough money...In Ashland there is one day care center for employees of the school but not for anyone else.”
- Families of children for whom English is not the primary language spoke at home** were more likely to state lack of providers who understand my culture or who speak my language as barriers to child care.

- **Families of children involved in the child welfare system** were more likely to cite barriers to child care access resulting from lack of affordable transportation; lack of open slots for children with special needs; lack of high-quality care in their community; and lack of providers who understand their culture.

FAMILY CHARACTERISTICS ASSOCIATED WITH INCREASED BARRIERS TO CHILD CARE ACCESS

Figure 13. Difference in report of barriers to child care by family characteristics

Family characteristic	Lack of affordable transportation	Lack of availability for infant or toddler care	Lack of providers who speak my language	Lack of providers who understand my culture	Lack of information about available programs	Lack of providers with open spots for children with disabilities or special health care needs	Lack of high quality child care
Caregiver of child who is an enrolled tribal member or resides on tribal land	X	X	X	X		X	
Caregiver of child for whom English is not the primary language spoken at home			X	X			
Caregiver for child with disability or special health care need					X	X	X
Caregiver of child involved in the child welfare system	X			X		X	X

Source: Montana PDG B-5 Needs Assessment Family Survey

KEY FINDING: Families use a variety of methods to find child care providers in Montana.

Families use diverse methods to identify child care. Seventeen percent (17%) of needs assessment survey respondents indicated that they had used STARS to Quality to find a child care provider. Among those families, 41% noted that STARS to Quality ratings were very helpful in giving them information about child care options. Beyond STARS to Quality ratings, families use other options for identifying child care options, including first-hand referrals from friends, Facebook postings and online community or parent groups. Parents discussed use of CCRR agencies for child care provider lists but suggested that the lists are often out of date and provide limited information since they do not include externally observed program feedback. Providers noted several innovative efforts to increase universal access to information about child care providers, including provision of ECE resource and referral by medical staff when babies are born or during subsequent well-baby visits.

RECOMMENDATION: ECE stakeholders recommended increased cross-disciplinary efforts and technological improvements to support ECE awareness and referrals. Suggested strategies include incorporating ECE information and referral into all contact points with new families, such as hospital staff, medical providers, and related service providers. Increased awareness of ECE options can

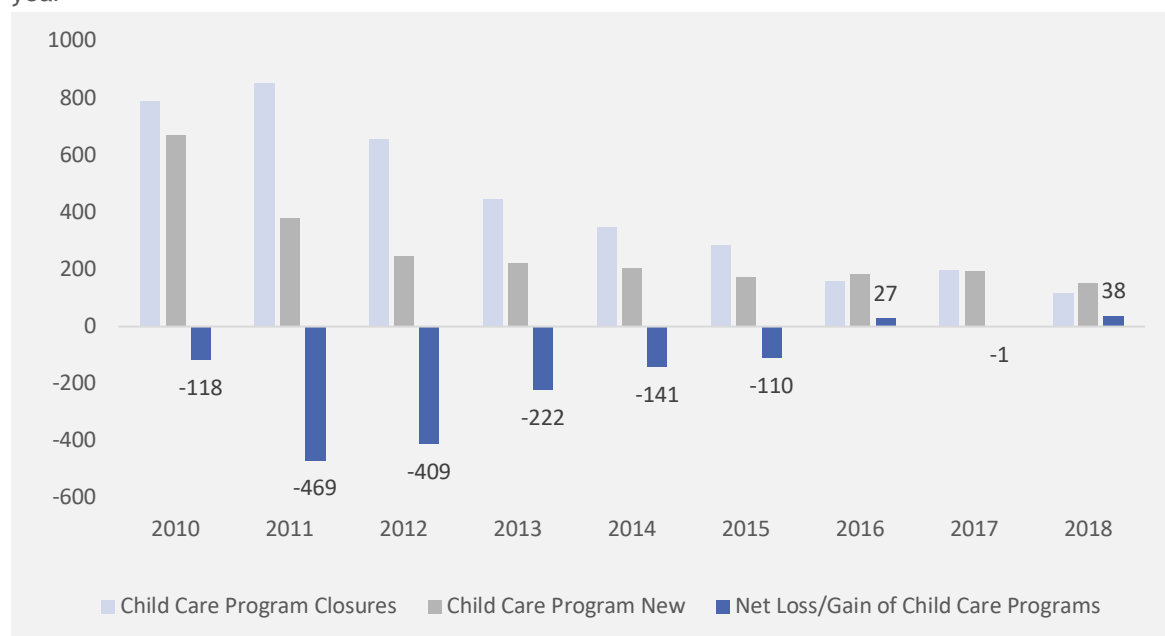
expand parent choice in selecting ECE providers. Additionally, improved information technology can expand resource and referral processes. Montana's currently uses the nationally approved software system to support ECE resource and referral. This information technology does not provide current or adequate information for CCRRs to share with families seeking care. The onus is currently on families to reach out to ECE providers to determine whether they have openings. This is burdensome and costly when families need to register on multiple waiting lists. There is an opportunity to advocate for the federal administration to offer an improved technical solution which can support a more family-friendly process with current and accurate information.

KEY FINDING: Child care centers are providing an increasing proportion of ECE services.

The number of child care facilities has been decreasing over the past 10 years, with child care centers serving an increasing share of children. Analysis of child care program closures versus openings across all provider types shows net loss of programs from 2010 through 2015, with a net gain of 38 programs in 2018, as shown in Figure 14.

MONTANA EXPERIENCED OVERALL NET LOSS OF CHILD CARE PROGRAMS OVER TIME

Figure 14. Number of child care program closures, new child care programs, and net difference, by year



Source: Montana Early Childhood Services Bureau

The monthly average number of ECE facilities has decreased across all ECE settings except child care centers, where average monthly facility counts have remained relatively steady over time. This pattern suggests an increasing share of children in Montana are being served in child care centers, compared to other care settings, which may have implications for parent choice, scheduling, and infant and toddler

capacity. In 2014 child care centers were serving 59% of children in licensed care; by 2019, child care centers were serving 66% of children in licensed care.²³

Providers who participated in the focus groups had some theories about why capacity and the number of providers has decreased over time. These included challenges associated with staff retention, adequate physical spaces for centers, finding rental properties for in-home facilities, increased appeal of being an unlicensed provider to avoid paperwork and inspections, and the difficulty of making a child care facility financially solvent.

RECOMMENDATION: Explore additional approaches for recruiting new ECE providers. A diverse array of ECE providers allows for increased parental choice and preference. The state should explore additional approaches for recruiting new providers, with a focus on underserved regions and families. Stakeholders felt that recruitment of group and family provider types will be the most successful and impactful, and suggested expanded outreach to prospective FFN providers to encourage transition to family home status. Many of the recommendations in this access chapter and the workforce chapter discuss structural supports that could help to make entering this industry and workforce more attractive. An outreach/marketing campaign or other mechanism would then be needed to disseminate information to target audiences.

Access to ECE for specific, underserved populations

This section of the report analyzes families facing additional barriers to ECE access, including families with infants and/or toddlers, children with special needs, low or moderate incomes, and with non-traditional work/education hours.

Access to ECE for families with infants and toddlers

Lack of availability for infant and toddler care is reported across all needs assessment data sources.

33%

of Montana infants and toddlers likely to require ECE can be served by existing licensed capacity

KEY FINDING: Infant and toddler capacity supply is extremely limited.

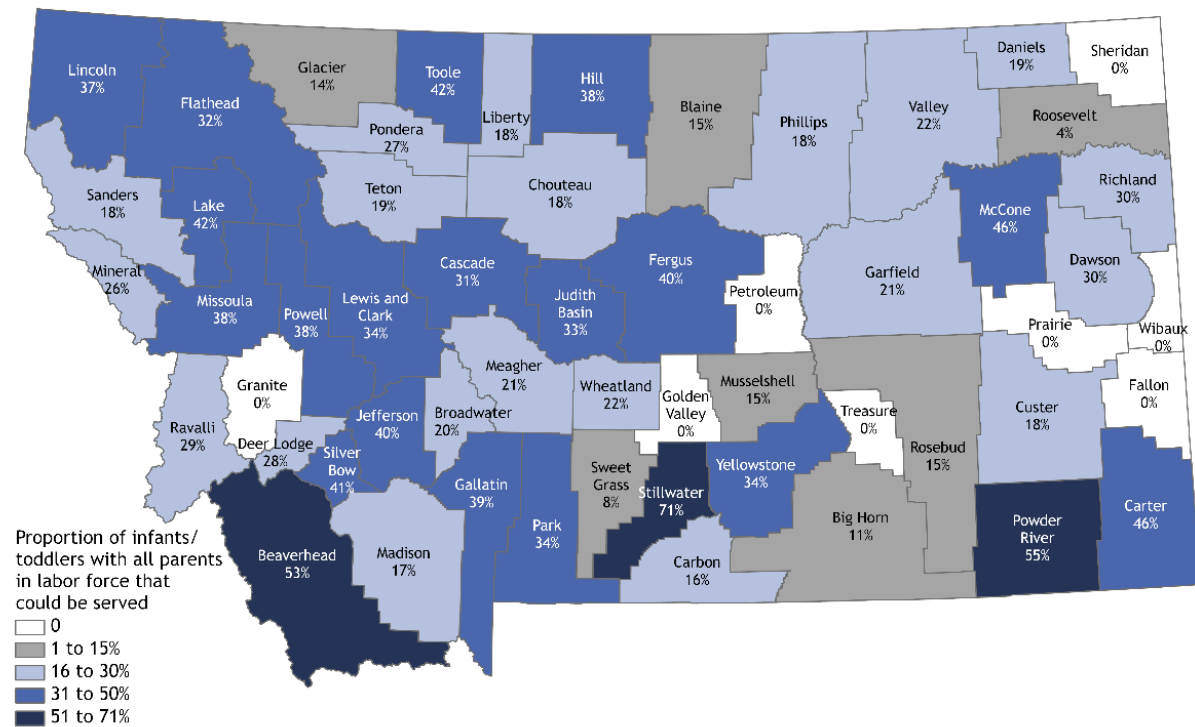
Lack of capacity to serve infants and toddlers is widespread. Thirty-three percent (33%) of infants and toddlers in the state that are likely to require child care can be served by existing system capacity, ranging from no capacity in multiple counties to the ability to serve nearly 71% of infants and toddlers in need of care in Stillwater County, as shown in Figure 15. When considering all infants and toddlers in the state, regardless of parental labor market status, existing licensed capacity can serve 20%. This service capacity is shaped, in part, by the financial burden of providing care to infants.

²³ For more detail on ECE caregiver staff and workload analysis, please see Appendix C: Access.

You're already losing money on every infant you have, it's just a community service to provide infant care. -Provider

THIRTY-THREE PERCENT OF INFANTS AND TODDLERS IN THE STATE LIKELY TO REQUIRE ECE CAN BE SERVED BY EXISTING SYSTEM CAPACITY

Figure 15. Percent of infant and toddlers with all parents in the labor force that can be served by existing ECE capacity

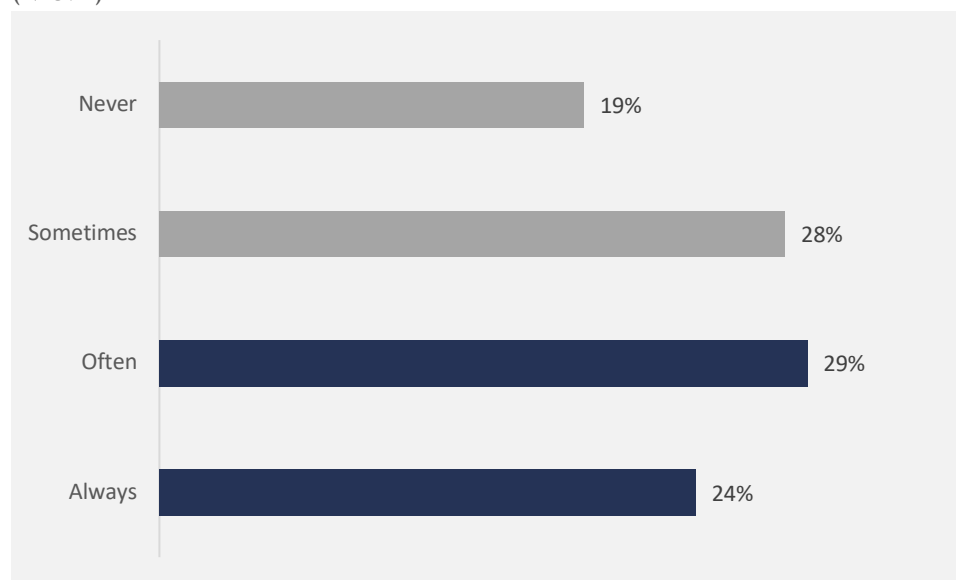


Source: Montana Early Childhood Service Bureau capacity data and US Census Bureau population figures

Among needs assessment survey family respondents who participate in ECE services, more than half report lack of providers with open spots for infants and toddlers as often or always a barrier to child care in their community, as show in Figure 16.

LACK OF OPEN SPOTS FOR INFANTS AND TODDLERS IS OFTEN OR ALWAYS A BARRIER FOR HALF OF FAMILY SURVEY RESPONDENTS

Figure 16. Percent of family needs assessment survey respondents who are receiving ECE services (N=397)²⁴



Source: Montana PDG B-5 Needs Assessment Family Survey

Additionally, among family survey respondents not currently participating in ECE services, nearly half of them (45%) cited lack of infant and toddler care as a reason why they don't use ECE options. Montana has implemented several strategies to help increase infant toddler care, including increasing the subsidy reimbursement rate up to age three to cover toddlers, and providing a 60-hour infant/toddler training module in STARS. However, despite these modifications, ECE stakeholders note that no one entity has assumed responsibility for resolving the infant toddler care crisis.

KEY FINDING: Providing infant and toddler care can be cost-prohibitive for ECE providers.

Providers noted increased expense in working with infants and toddlers. Additional costs include infant/toddler supplies, such as formula, diapers, cribs, and the need to staff lower child to caregiver ratios. The expense of infant and toddler care impacts both families and providers—it can be difficult for families to find affordable infant care, but at the same time, providers are going out of business because they can't make sufficient money to cover the costs of infant care. Providers also noted that the state age cutoff for mixed-age classrooms is 19 months, so some providers don't accept children under that age, further limiting infant toddler capacity.

Lack of infant and toddler care is pronounced in rural communities and within Native American reservations. Lack of affordable infant/toddler care is a statewide crisis, but it is particularly acute in rural regions and within tribal communities which may have no access to care for children under three years of age. Waiting lists for infant toddler care in these regions are ubiquitous and intractable.

²⁴ These percentages exclude respondents who answered, "I don't know" or "Not applicable."

RECOMMENDATION: Explore financial assistance to infant providers. Increased reimbursement rates for infant toddler providers, beyond recent adjustments, can also help offset ongoing staff costs that support lower child: caregiver ratios. Additionally, providers suggest that start-up grants to infant/toddler providers need to be increased to cover the true cost of care.

RECOMMENDATION: Support additional research to identify sustainable solutions that address the cost of infant/toddler care. Beyond reimbursement levels and start-up grants, stakeholders recommended broader systems-level efforts to increase financial support for infant/toddler care, including tax breaks or business subsidies for infant/toddler providers, or development incentives to build infant/toddler ECE centers. Stakeholder suggested development of a strategic plan specific to increasing sustainable infant/toddler capacity in the state.

RECOMMENDATION: Study Early Head Start-Child Care Partnership/Expansion grants to identify critical factors of partnership success. Families and providers alike advocated for increased Early Head Start infrastructure to serve the demand for infant toddler care. In an effort to increase access, communities obtained Early Head Start-Child Care Partnership and Expansion grants beginning in 2015 to extend the Early Head Start model through CCDF child care providers using a layered funding model in multiple communities.²⁵ Promising practices from these grants include Early Head Start partnership with community resources, including a church, to develop infant/toddler care infrastructure. However, lack of licensed care, particularly in smaller communities, impedes developing additional Early Head Start partnerships.²⁶ Further reflection on lessons learned from this grant implementation could identify factors necessary to develop successful Early Head Start-Child Care partnerships to expand capacity.

Access to ECE for children with special needs

In Montana, the National Survey of Children's Health (NSCH) estimates suggest that 10% of children age 0-5 in Montana have a special health need, which include acute and chronic physical, developmental, behavioral or emotional conditions.²⁷ As shown in Figure 17, in Montana, more non-white children were reported to have special healthcare needs when compared to white children within the state, and compared to the share of non-white children with special healthcare needs reported for the country as a whole.²⁸ As shown in Figure 4, Hispanic and Native American children ages 0-5 make up 6% and 11% of Montana's overall population.

²⁵ *Early Head Start-Child Care Partnership and Early Head Start Expansion Awards*, Administration for Children and Families, Early Childhood Development, Accessed on September 17, 2019, <https://www.acf.hhs.gov/ece/early-learning/ehs-cc-partnerships/grant-awardees>.

²⁶ State administrators in discussion with authors, April 2019.

²⁷ *National Survey of Children's Health (NSCH) 2016-2017*, Health Resources and Services Administration, Maternal and Child Health Bureau, 2018, <https://www.childhealthdata.org/browse/survey>. Data retrieved from the Data Resource Center for Child and Adolescent Health which is supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB).

²⁸ *National Survey of Children's Health (NSCH) 2016-2017*.

MORE NON-WHITE CHILDREN WERE REPORTED TO HAVE SPECIAL HEALTH CARE NEEDS COMPARED TO OTHER RACIAL/ETHNIC GROUPS

Figure 17. Percentage of children with reported special healthcare needs, by race/ethnicity

Race/ethnicity	Percent of Children with Reported Special Healthcare Needs	
	Montana	United States
Hispanic	23.4%	16.8%
White, non-Hispanic	17.8%	18.7%
Black, non-Hispanic	--	25.6%
Other, non-Hispanic	23.5%	15.3%

Source:

As of January 1, 2019, STARS to Quality enrollment data indicate 727 children with special healthcare needs or receiving Part B or Part C services were enrolled in a program participating in STARS to Quality. Interviewees and focus group attendees reported increasing behavior issues in classrooms having classroom-wide impacts, and the need for additional support to successfully care for and educate all children.

Montana ECE providers rely on a portfolio of strategies to support caring for children with special needs, including:

- Guaranteed subsidy eligibility for families of children with special needs.
- Higher reimbursement rates to providers who care for children with special needs.
- Targeted training and technical assistance to build capacity of providers to care for children with special needs.
- Collaboration with the Individuals with Disabilities Education Act (IDEA) Part C grant program that supports state-level implementation of early intervention services for infants and toddlers with disabilities and their families.
- Collaboration with IDEA Part B programming that provides special education preschool services for children with special needs between the ages of three and five.

Analysis of stakeholder input and secondary data suggest continued obstacles to ECE services for families of children with special needs, and opportunities for improved outreach to raise awareness of available program strategies to facilitate services for these families.

KEY FINDING: Families of children with special needs face additional barriers to accessing child care.

Needs assessment survey family respondents of children with special needs cited increased barriers to ECE access. Noted barriers for families of children with special needs included lack of information about available programs, lack of providers with open spots for children with disabilities or special healthcare needs, and lack of high-quality child care.²⁹

²⁹ For additional detail on barriers to care for families of children with high or special needs, please see Appendix C: Access.

KEY FINDING: Supply of providers able to care for children with special needs is insufficient.

There are not enough providers that serve children with special needs. Despite efforts to increase access to child care for children with disabilities or special healthcare needs, as described above, administrators, providers, and families all cite availability of child care for these children as a critical barrier to care. Stakeholders recommended continued efforts to expand access in a mixed delivery system for children with special needs; strategies may include increased training, increased mental health consultation, increased provider incentives, and expansion of Head Start facilities.

RECOMMENDATION: Provide ongoing training and technical assistance to build capacity to care for children with special needs. Providers discussed their inability to provide children with special needs with the extra support they require without limiting their ability to provide adequately for the remaining children in the classroom. Stakeholders noted limited provider experience and expertise in supporting children with special needs. Targeted professional development, coaching, and on-site support can build capacity and competency to provide care for children with special needs. Stakeholders suggested including a particular focus on related professional development for family and group home providers, who may not have easy access to broader training opportunities to build capacity for caring for children with special needs. Moreover, stakeholders recommend providing training opportunities that expand beyond QRIS provider participants to develop more widespread system capacity for children with special needs.

RECOMMENDATION: Provide mental health consultation to support providers within and outside of the STARS to Quality system. Mental health consultation, described in greater detail in the Quality chapter, should provide ongoing support and technical assistance to all ECE providers, regardless of STARS to Quality status. More consistent mental health consultation and on-call assistance may increase providers' willingness to care for children with special needs.

RECOMMENDATION: Increase incentives to encourage providers to work with children with special needs. Financial incentives could support the additional training, smaller class sizes, or additional of classroom aids that are needed to appropriately care for children in a mixed ability classroom setting. Recent increases to reimbursement to care for children with special needs was viewed as insufficient.

KEY FINDING: Part B and Part C services are not optimized for supporting children with special needs in ECE settings.

Part C eligibility compliance may impact program participation. There are two types of Part C eligibility. Type I Established Condition is a developmental condition signed off on by a medical doctor and defined as having a 'high likelihood' of developmental delays. Type II Measured Delay is when a child has a 25% delay in two developmental areas or a 50% delay in one developmental area (per a standardized tool). Eligibility determination reviews found individual contractors had developed differing determination procedures that were not compliant with the Part C regulations. This led to reeducation of the two eligibility types and the development of tools supporting proper identification of Type I Established Condition or Type II Measured Delay eligibility types. Providers discussed perceived challenges with maintaining fidelity to eligibility requirements, and their belief that factors associated with increased risk, like participation in the foster care system, an incarcerated parent, the presence of drugs in the home, etc., are not adequately considered in determining Part C eligibility. The state has

been having ongoing conversations with providers regarding implications of the state expanding its approved two-tier eligibility system to include children determined eligible through ‘Informed Clinical Opinion’ or through meeting ‘at-risk’ criteria.

Coordination between IDEA Part C early intervention services and ECE providers is limited. In Federal Fiscal Year 2017, 842 Montana infants and toddlers aged two and under were served through IDEA Part C. Almost all these infants and toddlers (826, or 98%) were served in their home.³⁰ In some areas of the state, access to an early intervention service provider such as physical therapy, occupational therapy, or speech therapy, is limited due to the availability of those service providers in a local area. Findings indicated that even though transportation to an early intervention service provider is a service offered through IDEA Part C free of charge to eligible children, this service was not used. Therefore, infants and toddlers were not offered the opportunity to access early intervention services beyond what was offered in their home or community setting by the regional contractor of the program. Part C services are generally not coordinated with ECE providers or provided in ECE classrooms, which may impede children receiving Part C services from participating in ECE.

The transition from Part C to Part B services is complicated and may hinder continued participation across programs. In FFY 2017, 1,660 children between the ages of three and five were served through IDEA Part B in Montana. Forty percent (40%) of these children were served in a regular early childhood program, and 31% were served in a separate early childhood classroom. The remaining children were served in other service provider locations.³¹

All children enrolled in Part C are considered potentially eligible for Part B services. Families may choose to opt-out of this opportunity, and many do. When a child is referred for Part B services, Part C Family Support Specialists (FSSs) contact the local school district to say they have a child who may need Part B services. The school district then reviews the child’s file and decide whether they will evaluate the child. If the school district decides to evaluate, they will select the areas to evaluate and test the child to determine eligibility.³²

Part C and Part B disability criteria differ. A medical diagnosis alone does not mean a child will be eligible for Part B. The district also must decide that the child is in need of special education or services.³³ Children may also enter Part B services directly without previous participation in Part C services.

³⁰ Department of Education, *IDEA Section 618 Data Products: State Level Data Files. Part B Child Count and Educational Environments* (Washington, DC: Department of Education, 2017), <https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bcc>.

³¹ Department of Education, *IDEA Section 618 Data Products: State Level Data Files. Part C Child Count and Settings* (Washington, DC: Department of Education, 2017), <https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bcc>.

³² All Montana school districts have special education preschool services, but some do not have programs. School districts without programs can contract with a neighboring district, a Head Start, or another qualified child care provider. The school district may be responsible for paying for the child to attend the contracted program, special education staff support, and transportation.

³³ National Center for Hearing Assessment and Management, *Eligibility and Service Delivery Policies: Differences Between IDEA Part C and IDEA Part B: A Comparison Chart* (Logan, UT: Utah State University, 2016), <http://www.infanthearing.org/earlyintervention/docs/aspect-idea-part-c-and-idea-part-b.pdf>.

Statewide in FFY 2015, 825 children ages zero to three were expected to enroll in Part C services. If we assume normal distribution of children across the three years of Part C services (infants up to 12 months, one-year-olds, and two-year-olds), we would expect to serve approximately 275 children in each age group.³⁴ In SFY 2015, 139 children were referred to Part B by Part C, suggesting that at least 100 Part C participants: 1) no longer needed services; 2) were opted out of referral to Part B by their families; or 3) may not have been deemed a candidate by a school district to evaluate for or receive Part B services and supports.

RECOMMENDATION: Increase communication between Part C early intervention specialists, physicians, psychologists, and ECE providers support value of early intervention and facilitate provision of early intervention services in child care settings. Increased communication between physicians and psychologists and early intervention service providers could express the value of intervening early when an infant or toddlers is not meeting developmental milestones. ECE providers would be a valuable link between families and medical personnel when a child in their care is showing atypical development. Increased communication between early intervention specialists and ECE providers could potentially increase access to ECE services for infants and toddlers with special needs, and build capacity among ECE providers who collaborate with early intervention specialists delivering services in child care settings.

RECOMMENDATION: Conduct further research to understand the process by which children are referred to, assessed by, and deemed eligible for Part B services. This investigation would identify the outreach strategies, assessment procedures, and eligibility decisions that influence Part B participation and determine whether refinements to the Part B assessment are needed.

RECOMMENDATION: Increase outreach and capacity building to school district leaders to increase awareness of preschool special education options. State administrator interviewees felt smaller school districts may be less informed about preschool special education and less likely to determine children needed these services. Interviewees theorized that this was a result of lack of awareness regarding Part B services and funding among school district leadership. Montana receives just over \$1 million dollars in Part 619 funds annually for the entire state. Some school districts receive as little as \$50; Billings, the largest school district, receives approximately \$200,000. No additional state funding supports the special education preschool services; awareness of Part B resources is critical to supporting implementation of these strategies.³⁵

KEY FINDING: Utilization of Best Beginnings special needs subsidies is limited.

Best Beginnings special needs subsidies reach a limited number of families. Best Beginnings provided 81 special needs subsidies in 2014, 55 special needs subsidies in 2016 and 2017, and 75 special needs subsidies in 2018.

³⁴ Like national data, the number of infants served at birth to 12 months in the Part C Program in Montana is well-below what is expected. Contractors identify more children entering the program between the ages of 18 months to 24 months as the most common timeline. The contractors state frequently that medical personnel in their communities do not consistently refer to the Part C program preferring to “watch and see” if an infant will “catch up” by meeting developmental milestones later than typically expected.

³⁵ Montana state administrators in discussion with authors, March and April 2019.

RECOMMENDATION: Increase capacity of trained providers and awareness of subsidy availability to expand subsidy utilization. Lack of supply of trained providers prepared to care for children with special needs may limit the number of families able to use subsidies; increased supply of trained providers, as described above, could increase utilization of special needs subsidies. Furthermore, increased outreach of subsidy availability could increase subsidy uptake among families of children with special needs.

My son has special needs but no one, a lot of people don't cater to it. I mean in one year he got kicked out of three daycares because they couldn't give him what he needed. I had to quit my jobs, nobody would take him I felt helpless, you know what I mean? And even right now my husband works but we're barely making it meet because I have a daughter who has heart problems so nobody wants to watch her. -
Parent

KEY FINDING: Health access issues and limited integration of health and early learning sectors exacerbate ECE access issues for children with special needs.

Children with Autism may struggle or be perceived to struggle to access needed services. Services for individuals with Autism have been funded through the Montana Medicaid program beginning as early as 2003 when the diagnosis was first included in the medical necessity criteria for children's mental health Medicaid-funded services. Many families and providers focused on limited access to Applied Behavioral Analysis services and low numbers of children receiving services through the Autism State Plan. The 2017 Montana Legislative Session created Board Certified Behavior Analysts (BCBAs) as a newly licensed provider type with a new career path served through Montana State University-Billings ([Montana ARM 24.189.9 Behavior Analysts](#)). BCBAs are the providers who are licensed to provide Applied Behavioral Analysis services. As of June 2019, there were 33 licensed BCBAs in Montana, and only some of which accept Medicaid/CHIP insurance.³⁶ In order to receive Autism State Plan services in the state, it must be through a BCBA. As a result, very few individuals (8 unique individuals in as of April 30, 2019) receive services through the Autism State Plan.

CMS neither endorses nor requires any particular treatment modality for Autism including Applied Behavioral Analysis.³⁷ Children do not have to receive services through the Autism State Plan to have their service needs met. Individuals diagnosed with Autism are able to have their symptoms treated through a broad array of Medicaid-funded community based services, including: case management, outpatient therapy provided by a licensed clinical social worker or licensed clinical professional counselor, mental health center services such as day treatment or community based psychiatric and rehabilitation services, physician services, personal care services, psychiatry services, psychologist services, Home Support Services or Therapeutic Foster Care, mental health therapeutic group home

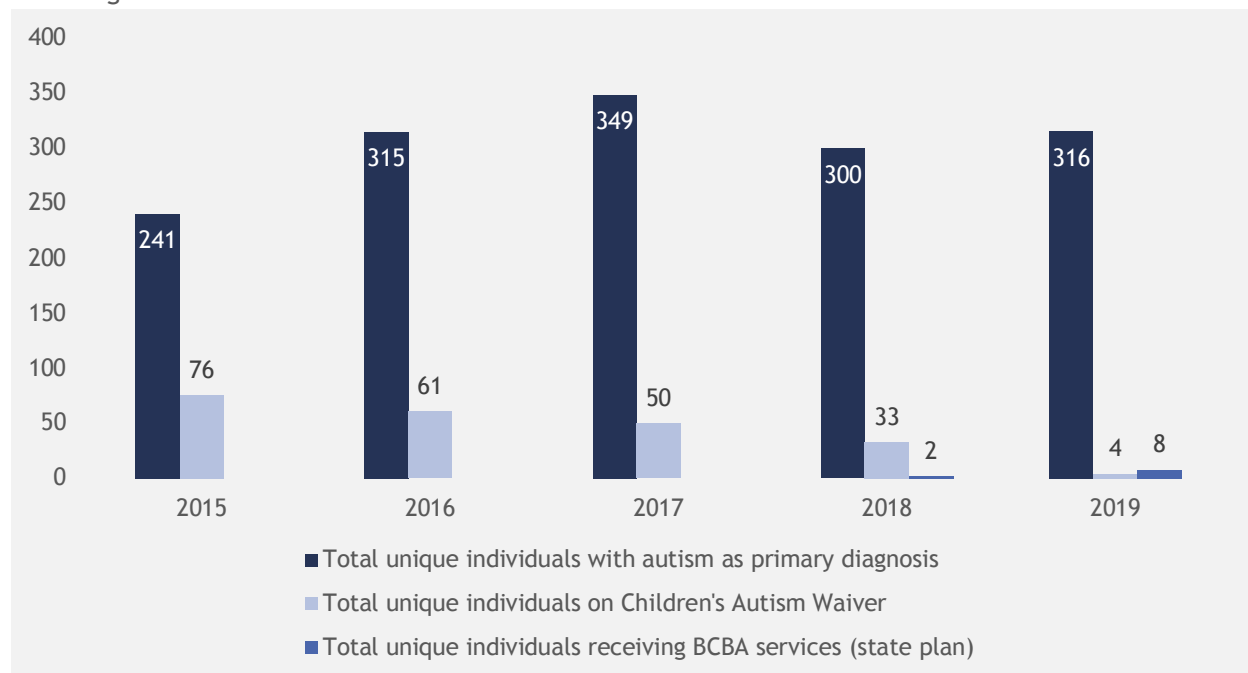
³⁶ Montana Department of Public Health and Services, *Medicaid Provider Database* (Helena, MT, 2019).

³⁷ Center for Medicare and Medicaid Services, *Medicaid and CHIP FAQs: Services to Address Autism* (Baltimore, MD: Department of Health and Human Services, 2014), <https://www.medicare.gov/federal-policy-guidance/downloads/faq-09-24-2014.pdf>.

services, speech pathology services, school based mental health or psychological aid services, optometric services, occupational therapy, and audiologist services.

AUTISM DIAGNOSES NOT ASSOCIATED WITH SERVICE PROVISION UNDER AUTISM STATE PLAN OR SUNSETTING WAIVER

Figure 18. Total unique Medicaid members age 0 to 5 with autism as a primary diagnosis; total unique individuals covered by the Children’s Autism Waiver; and total unique Medicaid members age 0 to 5 receiving BCBA services



Source: Medicaid claims and Developmental Disabilities Program data

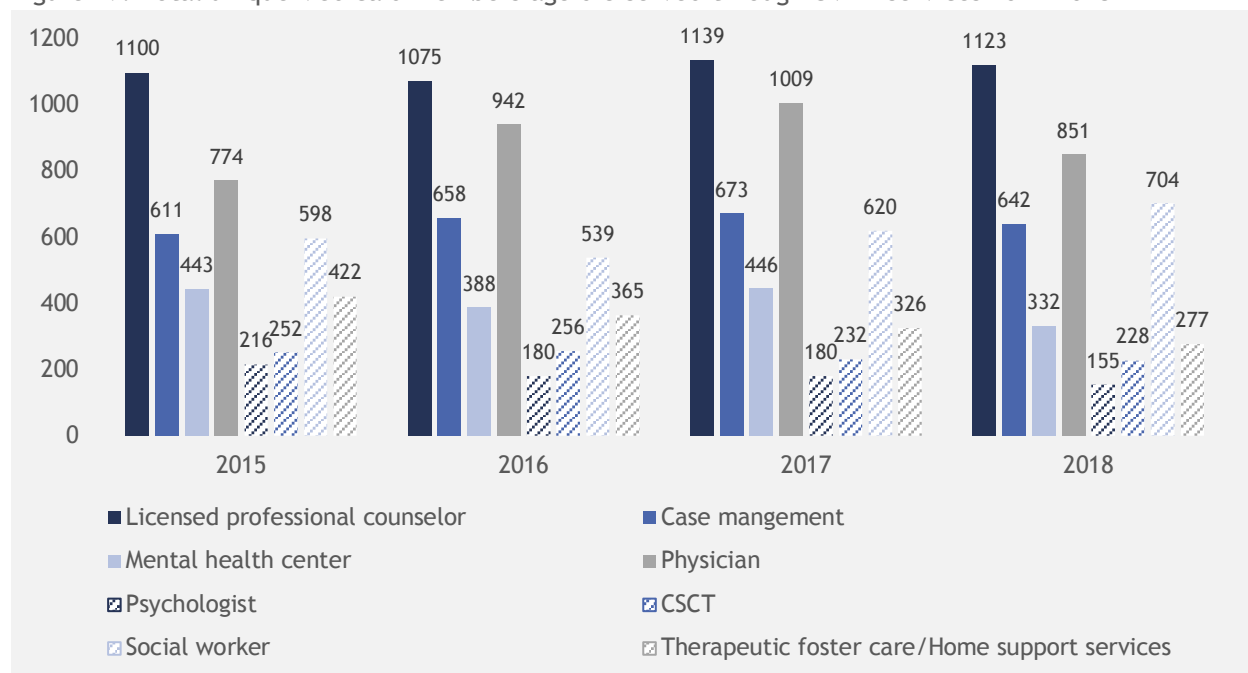
Autism services can be provided in ECE or school settings, but it is unclear how often this occurs. ECE assessment stakeholders consistently requested additional training and support to help them support children with Autism in the classroom. Teachers expressed how having therapeutic services provided in the ECE setting could support the child and the ECE provider.

Providers and families may be encouraged to place all children with delays on comprehensive developmental disabilities waiver waiting list. The 0208 DD Comprehensive Services Waiver (DD waiver) is a Medicaid funding source under the Developmental Disabilities Program (DDP) that funds services for individuals of all ages with developmental disabilities; the waiver provides eligible individuals with comprehensive services in a variety of settings. In 2018, 808 children age 0-5 were on the DD waiver waiting list. Administrators note that this is a significantly higher number than in previous years, and wonder if families are receiving good information about disability, the waiver, and broader service options. Stakeholders report that providers struggle to discuss delays and disability with families; without accurate information, families cannot advocate for their children. Program administrators worry that children may be placed on the DD waiver waiting list and exited from Part C services. The lack of a shared data system or ability to uniquely identify children across systems makes this issue difficult to address ongoing.

Mental health services are provided to a small number of young children. Children’s Mental Health Bureau provides mental health services to Medicaid and CHIP covered children 0-5, including Comprehensive School and Community Treatment (CSCT) services provided through a minority of schools, as well as other services primarily provided in health or home settings (Figure 19).

CHILDREN MOST LIKELY TO USE COUNSELOR AND PHYSICIAN MENTAL HEALTH SERVICES

Figure 19. Total unique Medicaid members age 0-5 served through CMHB services 2014-2018



Source: Medicaid claims data

RECOMMENDATION: Conduct additional research and planning on how to better integrate health services in ECE settings. In addition to better coordinating Parts C and B services in ECE settings, there is an opportunity to coordinate other health services, including those for Autism and mental health.

RECOMMENDATION: Increase family and provider education around disabilities. Families need information about disabilities so they can make optimal decisions for their children and families. Providers need to be effectively relaying accurate information regarding children’s disabilities and developmental concerns.

Access to ECE for low income families

The annual cost of child care in Montana exceeds that of in-state tuition at state’s public universities. Child care costs are a particular barrier for low income families: a minimum wage worker earning \$8.30 an hour would need to work more than a year to cover the average cost of infant care alone,

independent of rent, healthcare, and food expenses.³⁸ The reality of child care costs can serve as a deterrent to entering the labor market, and impacts the capacity of the statewide workforce as a whole.

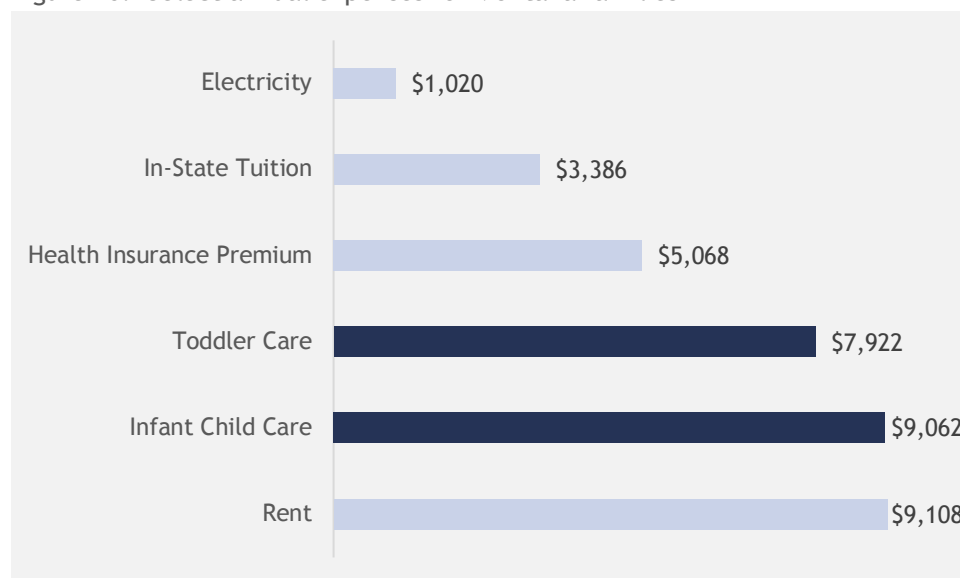
KEY FINDING: ECE cost is a key barrier to participation.

Cost is a barrier to ECE participation for many Montana families. Among parent respondents to the needs assessment who indicated use of ECE services, 21% said that they always face cost barriers to finding child care or preschool in their community. Fifty-three percent (53%) of parent survey respondents said that cost is often or sometimes a barrier to finding care, and just 10% said cost is never a barrier to finding child care in their community. Among families who were not participating in child care services at the time of the needs assessment survey, 42% cited cost as a reason for not using ECE options.

The average cost of full-time child care for an infant in Montana is \$9,000 a year; average annual cost for full-time child care for a four-year old in the state is \$7,900.³⁹ Child care is the greatest expense after rent for Montana families, as shown in Figure 20.

CHILD CARE COSTS EXCEED MANY OTHER FAMILY EXPENSES

Figure 20. Select annual expenses for Montana families



Source: Tuition and fees reported at MSU-Bozeman and UM-Missoula for FY17. 2018 average rate filings for Blue Cross, PacificSource, and Montana Co-Op for a 40-year-old individual participating in the least expensive plan living in the most expensive county. Rent and electricity costs reported by the 2012-2016 ACS data. Child care costs reported by the Economic Policy Institute, April 2016.

³⁸ Amy Watson, *Childcare in Montana: Support Montana Families and Caring for the State's Most Precious Resource* (Helena, MT: Montana Department of Labor and Industry, 2018), Montana Economy at a Glance.

³⁹ Montana Budget and Policy Center, *Child Care in Montana: Access to Affordable and Quality Care* (Helena, MT: Montana Budget and Policy Center, 2016), <https://www.mbadmin.jaunt.cloud/wp-content/uploads/2016/09/Child-Care-Final.pdf>.

It becomes cost-prohibitive to work outside the home. All of my income would go towards child care. -Parent

KEY FINDING: Child care subsidies do not reach all low-income children.

Subsidies to offset cost of child care are the primary mechanism for increasing access to child care for low-income families. In Montana, the Best Beginnings Child Care Scholarship provides financial assistance for families to access child care services. Families who are working and earning less than 150% of the Federal Poverty Level and meet additional eligibility requirements are eligible to receive subsidies. Family co-payments start at \$10 and increase depending on family size and income based on the Child Care Sliding Fee. Over the past five years, the number of children under six receiving child care subsidies has remained relatively steady over time.

CHILD CARE SUBSIDIES REACH 25% OF ALL LOW-INCOME CHILDREN

Figure 21. Number and percent of children receiving subsidy, by poverty level

Number of children under 6 living at or below 150% FPL	25,576
Number of children under 6 receiving child care subsidy	6,497
Percent of children under 6 living at or below 150% FPL that are receiving child care subsidy	25%

Source: Montana Early Childhood Services Bureau

Subsidies are not reaching all eligible families. There are several potential barriers to subsidies uptake. Eligibility processes to receive subsidies may be siloed across service systems, lengthy, and require duplicative documentation requests. Families may not be aware of subsidy availability since it is within CCRRs, not a part of other family support eligibility processes, including through Offices of Public Assistance (OPAs). Finally, even families that receive subsidies may not be able to find providers in their community with availability to care for their children.

RECOMMENDATION: Increase outreach to families to inform them of subsidy availability.

Information can be shared through varied parent engagement efforts.

RECOMMENDATION: Improve subsidy eligibility process. At a minimum, continue efforts to streamline subsidy eligibility and application requirement to encourage participation. Additionally, explore a shared or single application/no-wrong door approach to coordinate child care subsidy eligibility with other family support services eligibility.

KEY FINDING: Pervasive waitlists produce a false set of demands on the system and perpetuate barriers to care among families with low incomes.

Families described pervasive use of non-refundable wait-list fees among ECE providers. Because infant and toddler capacity is so limited, many families apply for care with multiple providers as a means to increase their chances of securing one spot. Waitlist fees may impede families from applying for care and hinder their ability to secure a spot; this dynamic is particularly acute for families with low income who cannot afford waitlist fees across multiple providers.

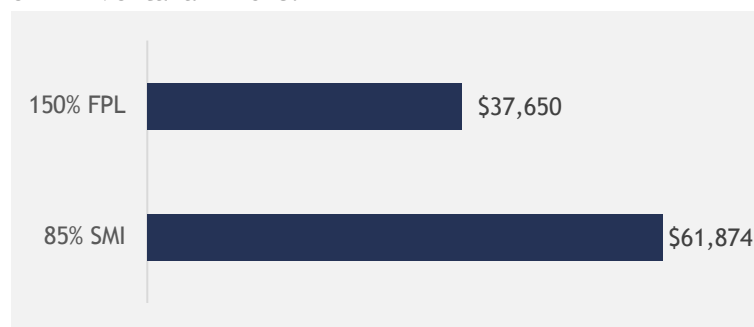
One of the things that shocked me when I was looking for care when I was pregnant was the amount of fees to be on the waiting list. You have to be on so many waiting lists and find care or apply for it and then to pay fifty dollars, seventy-five dollars for a waiting list and you don't get that back if you don't get that spot. That's crazy to me, so you can spend easy five hundred dollars and still not have child care lined up. It makes no sense. -Parent

Stakeholders perceive a gap in affordability for median income families. Many families and providers described a gap in affordability for families above the subsidy threshold but for whom unsubsidized child care is cost prohibitive. These families are unable to pay the unsubsidized cost of child care, and may turn to lower quality, less expensive options for care. Providers note that due to the cost of providing care, they default to serving an increasingly greater share of high-income families just to recoup the cost of doing business.

States can allow families to qualify for CCDF child care subsidies up to 85% of the state median income. Montana's eligibility threshold is 150% FPL, which equates to approximately 60% of the federal eligibility cap. Figure 22 outlines what this looks like for a family of 4.

MONTANA CHILD CARE SUBSIDY ELIGIBILITY AT 60% OF FEDERAL CAP

Figure 22. 85% SMI (federally allowed eligibility limit) and 150% FPL (Montana eligibility limit) for family of 4 in Montana in 2018.



And, part of the problem with the sliding fee thing though is I think, I worry it's going to hit people like me that are in that gap. I've grown up always being well below the poverty line and so were like, "Holy cow, in this new job I'm going to make sixty thousand dollars - I have so much!" No. I almost have less money than I did when I was on assistance....so I worry about the whole sliding scale thing because, is it going to hit people like me that are median income? -Parent

Stakeholders report an ongoing benefit cliff for families receiving services. Families who receive child care subsidies and other public benefits described concern over increasing their income or work hours for fear of losing access to affordable care and supplemental support. Some described their experience losing the benefits that enabled their children to attend high-quality early care due to increased wages, which in turn forced them to stop working since they could no longer afford child care. Many spoke in frustration of the cyclical nature of this dynamic. In response to this dynamic, the state has recently implemented graduated eligibility, continuous 12-month eligibility, and sustained child care subsidy eligibility through temporary household changes.

RECOMMENDATION: Expand eligibility for child care subsidies to include median income families.

Adjusting the income eligibility threshold for child care subsidies could increase supply for families priced out of unsubsidized care.

RECOMMENDATION: Study the impact of recent policy changes that provide graduated child care subsidy eligibility for Montana families.

In response to the loss of child care subsidies as income increases or employment status changes, the state has recently implemented graduated eligibility, continuous 12-month eligibility, and child care subsidy eligibility through temporary household changes. Stakeholders recommend assessing the impact of these changes on families' ability to access affordable care over time.

KEY FINDING: Cohesive funding of ECE as a system is needed to address underlying cost margins of delivering ECE services.

Lack of public understanding and support for ECE quality limits public resources' ability to subsidize implementation of high-quality ECE settings. Parents and providers report that the financial models for providing care produce very tight margins that are not fully mediated by current subsidy rates. The cost of care versus a living wage for providers appear incompatible. Without public consensus on the importance of high-quality care for children from birth through age five, ECE provision is unlikely to benefit from ongoing, sustained funding that matches the true cost of care.

RECOMMENDATION: Increase public awareness and support of sustained ECE funding. In absence of universal public policy to support and fund ECE services at the scale of K-12 education, policymakers, providers, and families will continue to balance tensions related to the true cost of care, the quality of care, and the ability for families to pay for care.

KEY FINDING: Further research on ECE funding models could contribute to development of effective ECE funding and increased cost accessibility.

Providers noted variation in cost of care across different service models. In particular, stakeholders noted increased funding costs for Head Start programs and more comprehensive services models compared to traditional program delivery. Existing funding structures may no longer adequately support service expectations.

Equipment, staffing and insurance costs are particularly burdensome for smaller group and family ECE homes. Program providers cite difficulty in covering program operating costs while maintaining fees that are affordable to families. Access to shared transportation, substitute pools, and training resources among these providers is limited. Program providers noted the benefits of umbrella organizations that

can decrease costs for key program expenses and staff benefits through pooled resources and greater leverage with benefit organizations or suppliers.

Paid vacation, sick time, health benefits. If you don't have a larger umbrella organization, you can't afford those things. -ECE provider

RECOMMENDATION: Conduct further research on diverse funding models, including Head Start, to better align funding structure with service expectations. This research could shed light on the true cost of ECE provision and inform future decisions related to reimbursement and subsidy policy, as well as development of broader funding infrastructure to support ECE quality and access.

RECOMMENDATION: Explore options to increase access to co-operative models or shared services, including those offered by the state, to help offset providers costs and expand capacity. Stakeholders expressed interest in opportunities to pursue pooled efforts to obtain program resources, including supplies and insurance, as well as shared services, such as transportation and substitutes. Shared services networks are a resource strategy, used increasingly among family child care providers, to create alliances or systems of services that support provider management and allow providers to dedicate more focus to program implementation and quality improvements.⁴⁰ Shared Services Alliances are typically supported by a combination of member fees, philanthropy, and government funds. Program cost savings that result from participation are often expected to be re-invested into providers' program quality initiatives. Most Shared Services Alliances, or Family Child Care Networks, serve both home-based child care providers as well as centers.

Access to ECE for families with non-traditional schedules

Finding child care that matches family work hours was reported as a barrier to child care often or always for 36% of family survey respondents. Moreover, 29% of family survey respondents who did not use ECE services reported lack of availability that matched their family work hours as a reason for not utilizing care.

KEY FINDING: Families need more flexible ECE schedules to accommodate work demands.

Family stakeholders noted difficulty in finding care outside of traditional 9:00 to 5:00 schedules. Lack of ECE availability that aligns with work schedules is particularly prevalent for health care workers, first responders, and service industry workers. Providers and families remarked that private preschool programs are typically limited in number of days and hours per day. Families often need child care outside of these preschool hours and cannot transport children between preschool and child care options while working; very few child care providers will pick up children from preschool during this transition. Summer child care is also challenging. As one provider said, "We're really struggling with what to do with our kids now in the summer. Because if you're not in a daycare, you can't get into a

⁴⁰ Early Learning Challenge Technical Assistance Program, *Shared Services as a Strategy to Support Child Care Providers* (Washington, DC: Department of Education, 2016), <https://elc.grads360.org/services/PDCService.svc/GetPDCDocumentFile?fileId=18922>.

daycare for summer. And trying to find a high school or college kid who doesn't already have a job in their field or is in sports is really hard.”

It's hard to find a daycare if you don't have that normal eight to five, nine to five, Monday through Friday kind of job. It is very hard to find services for daycare. -Parent

Greater regulation of drop-in care centers could increase consistency of this flexible model of ECE services. In some regions, drop-in care facilities centers may offer extended service hours that accommodate non-traditional work hours, however, families and provider both discussed limited availability for drop-in care. They also stated that drop-in care typically serves toddlers over 18 months, so finding extended care for infants is particularly difficult. Provider and parent stakeholders also noted wide variability in drop-in care quality, with little to no regulation of these providers.

RECOMMENDATION: Expand high-quality child care capacity available during non-traditional work hours. These options could also provide back-up when regular child care provisions fall through. Stakeholders suggested consistent regulation of drop-in care facilities to ensure quality ECE services in these facilities.

RECOMMENDATION: Stakeholders discussed opportunities to adjust regulations to support more after hour care. For example, stakeholder suggested adjusting regulations that may be appropriate during the day (for example, staff ratios when kids are awake and active) for after hour or overnight care. Stakeholders also proposed the possibility of increasing revenue for child care centers by extending service hours and attracting a new client base for quality care.

KEY FINDING: Child care availability impacts workforce participation.

Access to child care can influence parents' participation in the labor force. In Montana, 10% of families note having to quit a job, not take a job, or greatly change a job because of problems with child care for a child through age five; these experiences may influence families' decisions to enter the labor force.⁴¹ An estimated 42% of Montana residents who are not in the labor force cite family responsibilities as the reason they are not looking for employment; although some of these individuals may voluntarily stay home to care for children or other family members, others may like to work but cannot find appropriate help for family responsibilities, including child care.⁴²

I live in Philipsburg and the child care here is very limited. There is one lady who is always full and another lady whose days and hours are limited. The Ranch at Rock Creek is opening a daycare at their

⁴¹ U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB), *National Survey of Children's Health, Child and Adolescent Health Measurement Initiative 2016-2017*, www.childhealthdata.org, www.cahmi.org

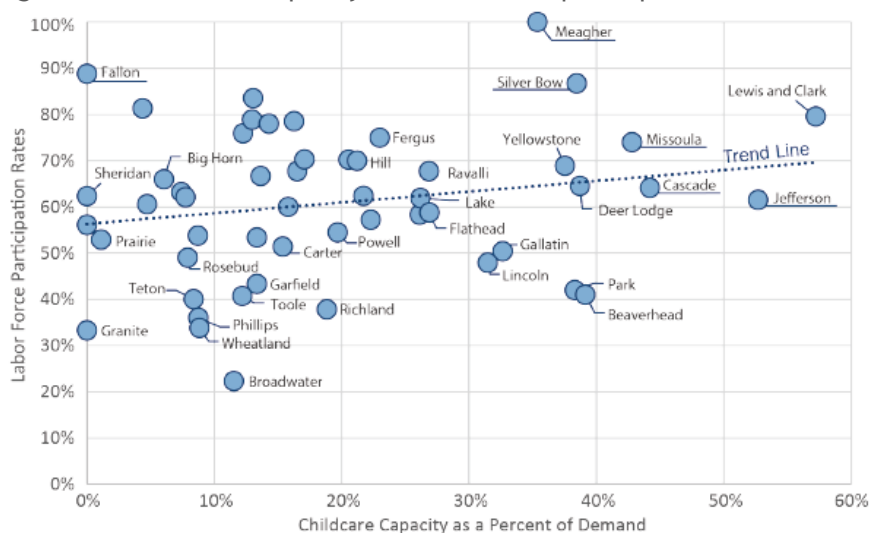
⁴² Watson, *Childcare*.

property come May. However, you have to work there in order to utilize it. The problem is daycare is expensive when the providers do not accept the Best Beginnings program....Daycare has always been a struggle in this town. It is pointless to get a minimum wage job when all of it goes to daycare, you might as well stay home with your kids. - Parent

Lack of available child care may also limit families' ability to work desired hours. In Montana, 4% of part-time workers wanting full time work cite child care as the barrier to working more hours, and 23% report inability to hold a full time job due to family responsibilities, including caring for children.⁴³ Women with young children are more likely to participate in the labor force if there is ample child care capacity. As demonstrated in Figure 23, a recent Montana Department of Labor and Industry study suggests that a one percentage point increase in child care availability is correlated with a 0.4 percent increase in labor force participation rates of women with children under six years old.⁴⁴

MORE LABOR FORCE PARTICIPATION BY MOTHERS IN COUNTIES WITH MORE ECE CAPACITY

Figure 23. Child care capacity and labor force participation rates of mothers



Source: U.S. Census Bureau 2012-2016 ACS data and DPHHS Childcare licensing September 2018

RECOMMENDATION: Conduct further research on the impact of child care accessibility on statewide workforce, employment, and income outcomes. This research can identify the degree to which lack of child care access impacts the economic viability of the state, and garner support for broader public commitment to quality ECE provision. Include in this analysis the impact on future workforce/talent development through early brain development in high-quality ECE programs.

⁴³ Ibid.

⁴⁴ Ibid.

Quality

This chapter on Quality is focused on supporting quality early care and education. High-quality early care and education relies on strong organizational foundations and effective practice implementation. Key components of quality ECE programs include effective instructional leaders, collaborative teachers, involved families, a supportive environment, and ambitious instruction. Organizational development provides the infrastructure to support children’s development and achievement by:

- Promoting trust and responsibility for excellence and continuous improvement among both staff and families.
- Implementing ongoing systematic, formal, and informal assessments to provide information on children’s learning and development and inform continuous improvement and instruction refinement.
- Building strong partnerships across service delivery systems.
- Coordinating resources.
- Encouraging alignment in standards across systems.

In Montana, the broadest of the organizational quality capacity building efforts is the Quality Rating and Improvement System (QRIS) called Best Beginnings STARS to Quality (STARS to Quality). The STARS to Quality program was established in Montana in 2010 with the goal of raising the quality of care in Montana, increasing the number of children in high-quality child care settings, and enhancing workforce development.

In addition to STARS to Quality, Montana has implemented two programs to build organizational capacity and expand access to quality care: the Montana Preschool Development Grant (MPDG) initiative to build or enhance high-quality preschools services and expand access to high-quality preschools in targeted communities, and STARS Preschools to develop high-quality preschool programs in rural and urban communities throughout the state. In addition to the state supported initiatives described above, Montana also operates 20 Head Start programs (13 non-tribal and 7 tribal) and 14 Early Head Start programs (9 non-tribal and 5 tribal) that are funded by federal dollars with local direct or in-kind contributions. Several Montana Head Start programs participate in the initiatives discussed above, such as STARS to Quality, STARS Preschool, and MPDG preschools, though participation in these efforts is voluntary for Head Start programs. Head Start and Early Head Start provide additional validated high-quality ECE options for children in Montana.

ECE program quality

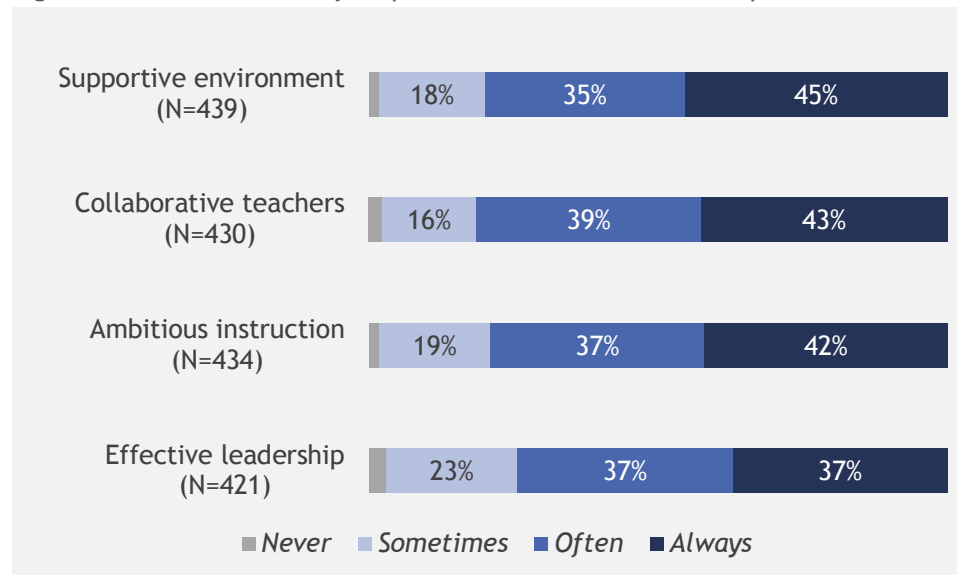
Several data sources provide initial assessment of Montana’s efforts to improve ECE quality, including needs assessment family survey responses and program environmental assessments. These measures provide an initial understanding of existing quality in Montana ECE services.

KEY FINDING: Families participating in ECE services report quality program implementation.

Families report frequent program implementation of best practices. Needs assessment survey family respondents were asked to assess how frequently their early care and education program uses each of the best practices identified in the research literature: supportive environments, collaborative teachers, ambitious instruction, and effective leadership.⁴⁵ Three-quarters of families felt that their program always or sometimes included best practice characteristics, as shown in Figure 24. In addition to needs assessment survey responses, STARS Preschool parent and provider feedback reported overwhelming quality programming, parental engagement opportunities, program leadership, and staff opportunities for professional development.⁴⁶

THREE-QUARTERS OF FAMILIES USING ECE BELIEVE THEIR PROGRAM ALWAYS OR SOMETIMES INCLUDES BEST PRACTICE CHARACTERISTICS

Figure 24. Percent of family respondents that identified best practice characteristics by frequency



Source: Montana PDG B-5 Needs Assessment Family Survey

KEY FINDING: ECE programs use a variety of assessment tools to measure progress.

In addition to family feedback, ECE providers use a variety of tools to understand quality in their programs and inform program improvement. STARS to Quality programs, for example, use the following environmental rating scales to assess quality care in Montana: Early Childhood Environment Rating Scale-Revised (ECERS-R), Family Child Care Environment Rating Scale Revised (FCCERS-R), and Infant Toddler Environment Rating Scale Revised (ITERS-R), DIAL-4, CLASS-ES, CLASS-CO, and CLASS-IS.⁴⁷

⁴⁵ See Appendix D: Quality for more detail regarding quality best practices in early care and education.

⁴⁶ For more detail on STARS Preschool caregiver and staff survey responses, please see Appendix D: Quality.

⁴⁷ For more detail on environmental rating scales and outcomes, see Appendix D: Quality.

ECE PROGRAMS USE A RANGE OF ASSESSMENT TOOLS TO MEASURE QUALITY

Figure 25. Environmental and classroom assessment scores across ECE programs⁴⁸

Program	ECERS R	FCCERS R	ITERS R	PAS	BAS	DIAL 4	CLASS ES	CLASS CO	CLASS IS	Data
STARS to Quality	4.6	4.5	4.0	4.7	4.6	--	--	--	--	2018
STARS Preschool	4.8	--	--	--	--	66.7%	--	--	--	Spring 2018
MPDG Preschools	4.5	--	--	--	--	74%	6.2	5.7	3.6	2017-2018
Head Start	--	--	--	--	--	--	6.1	5.8	3.0	2017

Source: Montana CCUBS data; STARS Preschool evaluation report 2018; MPDG Year 3 annual report

STARS to Quality programs also implement assessment tools that measure program and business administration. The Program Assessment Scale (PAS) is conducted for centers by a certified assessor and measures the overall quality of administrative practices. The Business Assessment Scale (BAS) is an analogous tool conducted by an assessor for family and group homes and is designed to measure the overall quality of business practice. STARS to Quality programs averaged 4.6 on the BAS, with no difference in score across STAR Level, and 4.7 overall on the PAS, with scores increasing as providers increased in STAR Level. PAS and BAS scores remained relatively stable over time, with slight dips for each assessment in 2016, which coincided with a large, temporary increase in number of programs completing assessments.

STARS to Quality program assessment tools each include a subscale related to space and furnishings. This subscale measures indoor space arrangements, furnishings, space for privacy, child-related displays, space for large motor skills, and equipment. Early childhood education physical infrastructure and facilities are an important component of providing safe, high-quality, and developmentally appropriate care. Practitioners must provide services and supports in natural and inclusive environments to promote each child's access to and participation in diverse learning experiences.⁴⁹ Furnishing and Quality subscale scores ranged from 1.7 to 6.8, indicating variable status in achieving high-quality environments among STARS to Quality programs. Across all program assessment tools, STARS to Quality providers' score on the space and furnishings subscale improved consistently over time.

KEY FINDING: Quality measures of ECE programs are improving over time across ECE initiatives.

Quality measures have improved over time in key ECE initiatives, including STARS to Quality, STARS Preschools, MPDG Preschools, and Head Start programs.

Program assessment scores have increased over time for STARS to Quality programs across all environment rating scales, as shown in Figure 26. Program scores on the environmental rating scales

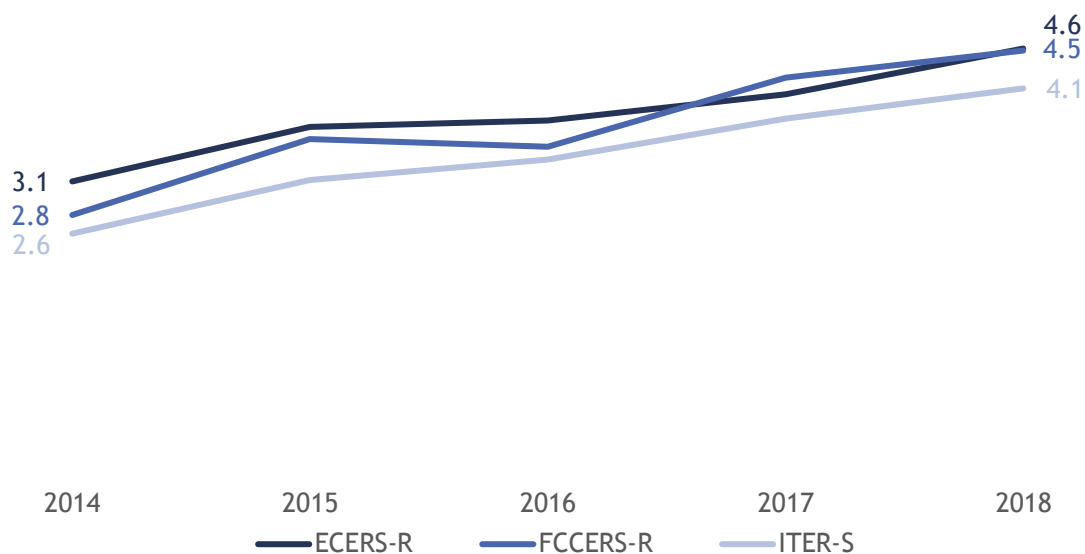
⁴⁸ Dashed lines indicate data that is not available or that the program does not use the identified assessment.

⁴⁹ Division of Early Childhood Commission, *DEC Recommended Practices in Early Intervention/Early Childhood Special Education* (Los Angeles, CA: Council for Exceptional Children, 2014).

increased as program STAR Level increased, which would be expected since STAR Levels can serve as proxies for program quality.

ENVIRONMENT RATING SCALE SCORES FOR STARS TO QUALITY PROGRAMS INCREASED OVER TIME

Figure 26. Environment rating scale scores of STARS to Quality programs over time



Source: ECP STARS to Quality assessment data, 2018

MPDG and STARS Preschools improved measures of quality in key domains. All STARS Preschools increased their ECERS-R observation score from Fall 2017 to Spring 2018. STARS Preschool students also made significant gains in DIAL-4 percentile rank from Fall 2017 to Spring 2018 across all DIAL domains, including motor, concepts, and language. Similarly, MPDG expanded the number of children who are ready for kindergarten. MPDG DIAL-4 percentile ranks increased over time, and average MPDG ECERS-R scores increased over time in total and across all ECERS-R subscales. MPDG scores on the CLASS assessment, implemented to assess the quality of interaction between teachers and children, varied over time and were largely comparable to Head Start CLASS results.

Part B and Part C outcomes do not consistently meet target goals. Part C met target goals related to the percent of infants and toddlers with Individual Family Service Plans, but fell short of target goals related to the percent of children functioning at age level in social emotional skills, knowledge and skills, and use of appropriate behavior to meet their needs. There is a desire among state program staff to link outcome measures to practices within Part C, similar to the approaches used in Michigan and South Dakota's Early Intervention programs. This would require increased implementation of evidence-based practices with qualified personnel; Part C administrators described intentional efforts already underway to integrate best practices into program services, including implementing a social-emotional screening, using a two-tiered, interactive coaching format (in agencies and with families), consistently using multi-tiered evaluations, using consistent eligibility criteria, and implementing a new focus on fiscal systems. Per interviewees, IDEA Part B (619) is supposed to measure the same outcomes as Part C, however stakeholders note that this does not occur consistently.

RECOMMENDATION: Conduct additional research on linking outcomes to practices in IDEA Parts C and B.

Further analyze approaches implemented in other states, including Michigan and South Dakota, to link practices to outcome measures and determine next steps for Montana.

KEY FINDING: Programs are pursuing quality through continuous improvement.

ECE programs use evaluations to improve program quality and outcomes. High performing ECE programs implement ongoing systematic, formal, and informal assessments to provide information on children’s learning and development and inform continuous improvement and instruction refinement. These assessments provide feedback loops to program leaders and teachers to determine responsive implementation adjustments. Sixty-nine percent (69%) of needs assessment provider survey respondents report that they evaluate their programs on a regular basis to inform change.

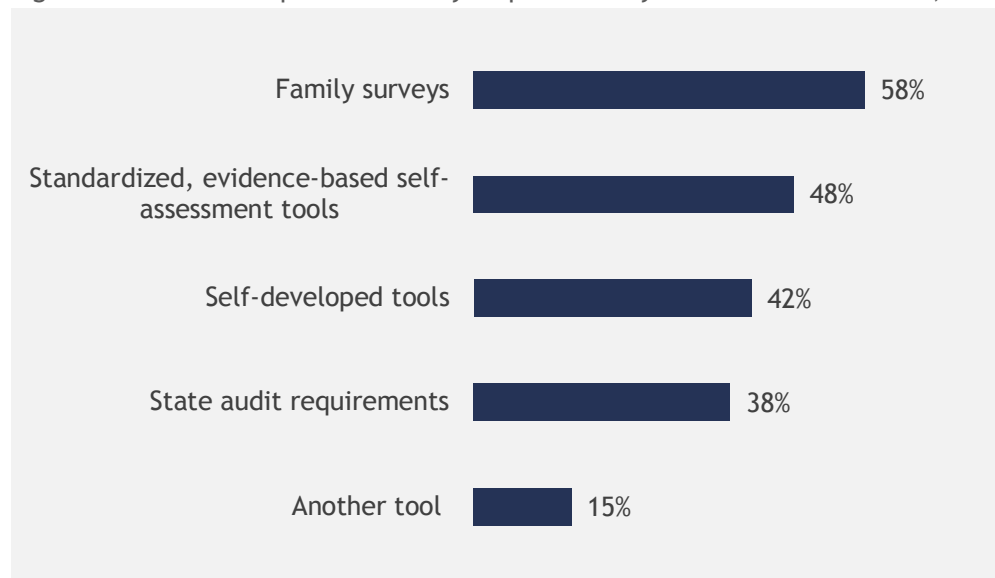
Program providers described using data to track trends over time, assessing output and outcome indicators for lessons on program services, and using available pre and post program survey data to identify opportunities for improvement. Programs also described efforts to share model programs for broader observation, consumption, and modeling. Family surveys are the most common program evaluation tools used among providers, as shown in Figure 27.

Continuous improvement by the numbers

- 69% of needs assessment survey respondents conduct evaluations regularly to inform program change
- 92% of those who evaluate their programs were pleased with their evaluation tools
- 42% of those who do not evaluate their programs were not aware of evaluation tools
- 22% of those who do not evaluate their programs felt that evaluation requirements were too complicated or demanding

FAMILY SURVEYS ARE THE MOST COMMONLY USED EVALUATION TOOL AMONG PROGRAMS

Figure 27. Percent of provider survey respondents by use of evaluation tools, N=349



Source: Montana PDG B-5 Needs Assessment Provider Survey

STARS to Quality implementation

QRIS systems in the early childhood education system have multiple intersecting goals. They are designed to assess program quality, inform parents about program quality, and provide a vehicle for program quality improvement.⁵⁰ Early childhood education research highlights the important policy impact that QRIS systems can support. Several QRIS strategies can prioritize quality improvement in early childhood education, including targeting most QRIS resources to professional development and quality improvement, collecting data to design quality improvement supports that focus on teachers, and developing marketing campaigns that promote the quality improvement supports providers can access when they participate in QRIS.⁵¹

STARS to Quality is an ambitious QRIS effort in Montana designed to support high-quality early care and education programs through a quality ratings and improvement system that strengthens programs and practitioners with continuous improvement strategies and provides a resource on program quality to inform parent choices. Licensed center-based programs, licensed family and group child care homes, and Head Start and Early Head Start programs are able to voluntarily participate in the program. As of

⁵⁰ Simon Workman, *Don't Stop Improving: How States Can Help Early Childhood Programs on Their Journey to High-quality*, Center for American Progress, May 11, 2017, <https://www.americanprogress.org/issues/early-childhood/reports/2017/05/11/432153/dont-stop-improving-states-can-help-early-childhood-programs-journey-high-quality/>.

⁵¹ Ibid.

November 16, 2017, 35% of licensed center-based programs were participating in STARS to Quality, and 15% of licensed family child care was participating in STARS to Quality.⁵²

Key components of the STARS to Quality process include:⁵³

- Application and both self and external rating related to education, qualifications and training, staff/caregiver to child ratio and group size, family/communication partnership, and leadership program management.
- STARS to Quality participating programs must meet articulated program requirements that vary by STAR level and duration of time in the program; certain refresher courses must be maintained over time after initial training is complete.
- Quarterly STARS incentives for programs participating in the STARS to Quality system at or above STAR Level 2; the value of incentives varies based on STAR level, program size, and how long the program has been in the system.
- STARS to Quality participating programs receive technical assistance and support as they work toward advancing or maintaining a STAR level. Technical assistance can be delivered through mentoring, coaching, consultation, or professional development advising.

KEY FINDING: The share of child care capacity served by STARS to Quality providers is increasing.

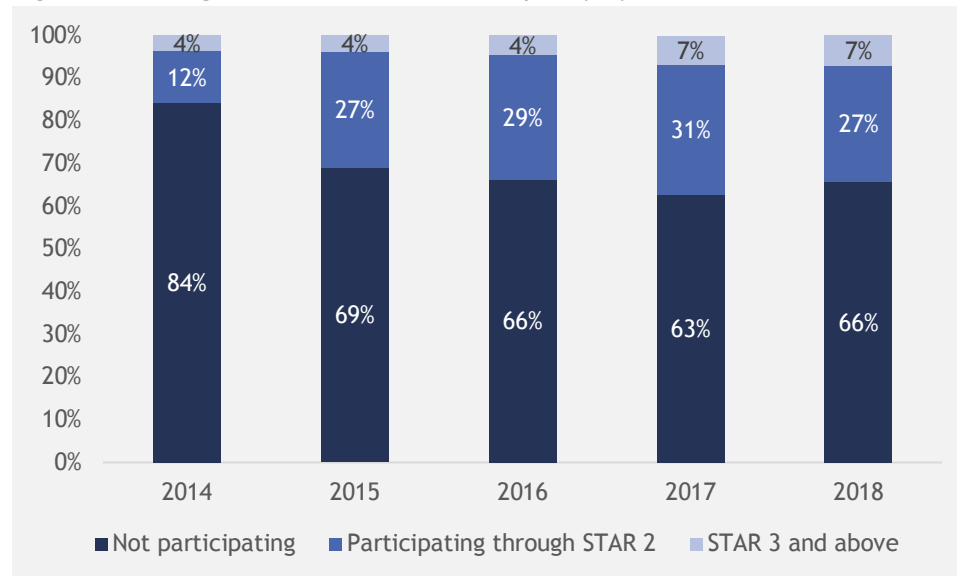
The share of child care capacity provided by STARS to Quality providers has grown from 16% of all child care capacity in 2014, to 34% in 2018. In 2018, there were 21,901 licensed child care slots available throughout the state. Among these slots, 34%, or 7,492, were with providers participating in STARS to Quality: 1,582 child care slots were available with providers who had been assigned a STAR Level of 3 or higher, as shown in Figure 28.

⁵² Quality Compendium, *Montana State Profile Report*, Montana Public Health and Human Services, 2017, <https://qualitycompendium.org/profile-report>.

⁵³ For more information on the STARS to Quality implementation process, please see Appendix D: Quality.

AN INCREASING SHARE OF CHILD CARE CAPACITY IS PROVIDED BY STARS TO QUALITY PROVIDERS

Figure 28. Change in share of child care capacity by STAR level over time



Source: Montana CCUBS data

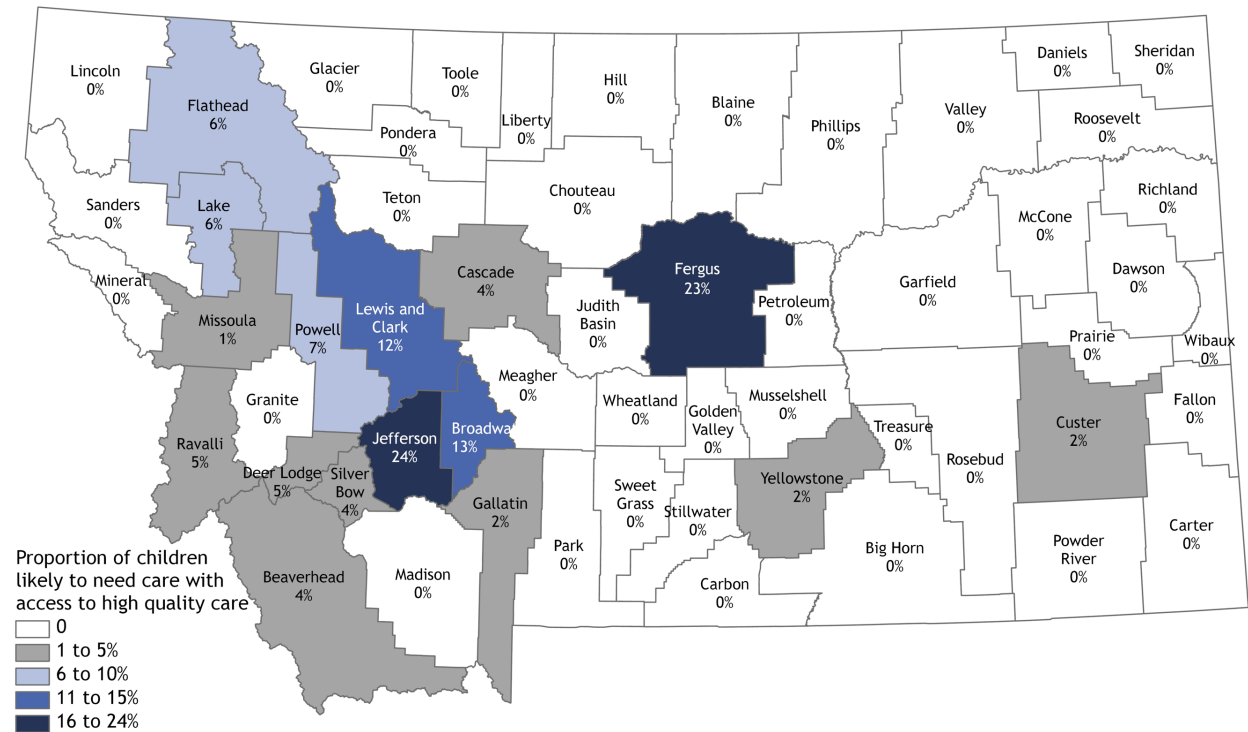
KEY FINDING: High-quality ECE capacity is limited.

Most regions do not have access to high-quality ECE. Across the state, most regions do not have any child care providers that are documented as high-quality through the STARS to Quality process.⁵⁴ The percent of children likely to need child care with access to high-quality care, considered STAR Level 3 or higher for purposes of this analysis, ranges from zero in 40 counties, to a high of 24% in Jefferson County, as shown in Figure 29.

⁵⁴ Note that these counties may have Head Start programs operating in their county that are not part of the STARS to Quality system, but are considered to be high-quality care providers.

MOST CHILDREN LIKELY TO NEED CARE UNABLE TO ACCESS HIGH-QUALITY CARE

Figure 29. Percent of children likely to need care because all parents in labor force by access to high-quality ECE (providers at STAR 3 or higher)



Source: Montana Early Childhood Service Bureau capacity data and Montana CCUBS data

KEY FINDING: STARS to Quality providers appreciate the focus on professional development and program improvement.

Providers valued STARS to Quality’s emphasis on quality and professional development and appreciated the external accountability for pursuing these goals. As one provider noted, “It’s supportive. It pushes you to be better than just the minimum of what the license requires.” Additionally, providers reported connection between professional development opportunities and QRIS standards. Seventy-three percent (73%) of ECE program staff respondents to the needs assessment survey reported some or substantial progress in the alignment between professional development opportunities and QRIS standards.

Providers appreciated the ability to provide additional staff compensation, bonuses, or benefits as a result of incentive payments. Some providers drew direct connection from STARS to Quality incentives to increased hourly rates, which can increase retention of staff, improve underlying financial model, and increase marketing opportunities due to STARS to Quality participation.

The STARS program has allowed me to be able to give my staff bonuses.
-ECE provider

KEY FINDING: STARS to Quality training requirements may dissuade program participation.

Several providers found training to be inflexible and demanding. Multiple providers perceived trainings to be too one-size-fits-all, and not sufficiently adaptable. For example, providers suggested that staff in preschools should not be required to take shaken baby syndrome training since they do not work with infants or toddlers

Providers also discussed difficulty in maintaining training requirements. Some providers felt that the education and ongoing training requirements were unrealistic in time commitment and cost, and that they served to dissuade certain providers from participating in STARS to Quality. For example, several providers noted that they had dropped out of the STARS to Quality program because it was not cost effective to remain; for some providers the staff and financial resources to support training and administrative requirements overshadowed the STARS incentive payments.

I'd recommend financial support or help to get staff trained, and provide better training for them, I think that would help alleviate some of the stress. Or stretch it out over more than 90 days. Pushing it all in the first 90 days is setting centers up for failure, because they can't afford it. -ECE provider

Providers described a particularly steep entry into both licensing and STARS to Quality implementation. Several providers noted that the immediate training and administrative requirements upon entry into the programs served as barriers to successful participation for many providers.

RECOMMENDATION: Provide a more graduated entry into STARS to Quality requirements.

Stakeholders recommended a six-or 12-month grace period on training mandates while new programs orient themselves to the expectations and resource requirements of participation.

KEY FINDING: Lack of alignment between Head Start and STARS to Quality requirements and training content limits Head Start participation in STARS to Quality.

Head Start programs expressed frustration in the lack of a systematic approach for incorporating Head Start programs into the STARS to Quality system. Although the state has cross-walked STARS to Quality requirements with Head Start requirements, it has not enabled Head Start programs to enter the STARS to Quality system at a given level based on recognition of program quality, as providers indicate has been done in other states. Head Start providers suggest that the rigorous program standards, monitoring, and evidence-based practices across Head Start programs, as required by federal regulations, should facilitate its entry into STARS to Quality at a pre-determined STAR Level.

We have federal oversight and annual site visits from our office at Head Start. So why then, do you at STARS, not accept that as quality indicators and measures when we come into your quality rating systems? —Head Start provider

RECOMMENDATION: Review other states’ policies regarding Head Start coordination with QRIS.

Other states may have identified mechanism to facilitate increased Head Start reciprocity while maintaining integrity of state-specific QRIS norms. Facilitating Head Start participation in QRIS could streamline administration across programs and provide more consistent information and cohesive ECE options for parents.

Structural support to providers to promote quality

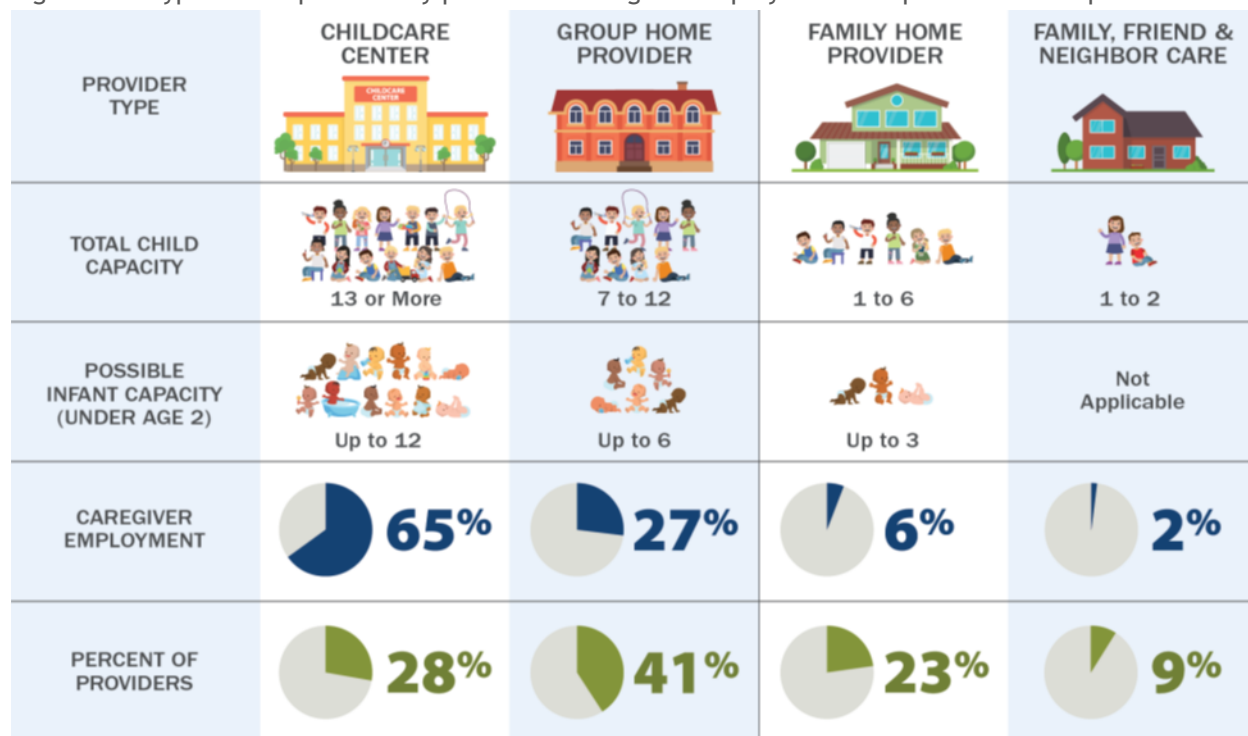
Similar to other market industries, child care wages in Montana are governed by the nexus of providers’ cost of care and families’ ability to pay. Yet child care providers remarked on the difficulty in maintaining affordable prices while covering the costs of providing care. Providers describes the considerable expense of operating child care facilities, including staff, training, facility, supplies, and insurance, among other costs. Multiple providers provided anecdotal evidence of child care providers closing due to costs; these tensions are particularly apparent in infant and toddler care settings, which providers reported as considerably more expensive to operate compared to preschool age care. Yet program compensation is connected to broader, more complicated pressures of supply and demand, which includes parents’ recognition of the importance of quality ECE services on long term well-being, and their willingness and ability to pay more money for quality care.

KEY FINDING: Provider compensation varies by provider type.

There are four primary types of child care providers in Montana: child care centers, group home providers, family home providers, and family, friend, and neighbor care, as shown in Figure 30, developed by the Montana Department of Industry and Labor.

CHILD CARE CENTERS EMPLOYED THE LARGEST SHARE OF THE ECE WORKFORCE IN MONTANA

Figure 30. Type of ECE provider by percent of caregiver employment and percent of ECE providers



Source: Montana Department of Labor and Industry: Montana Economy at a Glance, April 2019

Child care provider compensation averaged \$13,000. Recent analysis by the Montana Department of Labor and Industry sheds light on child care compensation in the state. In Montana, child care workers' average hourly rate was \$9.84, but this varied by where they work. The average child care worker made \$13,000 in wages in 2018, ranging from \$9,000 among workers in group homes to \$14,000 among workers in child care centers.^{55, 56}

Child care providers are more likely to work more than one job. Child care workers are more likely than average Montana workers to hold multiple jobs. Roughly one-in-five child care workers (21%) hold multiple jobs, compared to 8% of the Montana workforce more broadly. Working in multiple jobs raised Montana child care workers annual salary to \$15,700 in 2018; however, this wage is still below the federal poverty level for a family of two.⁵⁷

KEY FINDING: ECE provider compensation impacts workforce stability and professionalization.

There is wide disparity between ECE and K-3 compensation. Lack of universal public infrastructure and resources for early care and education creates disparity in compensation between ECE environments and K-3 environments, which benefit from standing public support and long-term policy for universal

⁵⁵ Watson, *Childcare*.

⁵⁶ Childcare workers in small family homes providers, or who are FFN caregivers are often self-employed and do not have payroll wages; they are not included in this analysis.

⁵⁷ Watson, *Childcare*.

access. ECE providers noted that even with comparable credentials and education they do not earn as much as K-3 teachers. Child care workers annual salaries average \$22,360 compared to \$28,860 for preschool teachers and \$50,000 for kindergarten teachers.⁵⁸ The compensation disparity between early learning and K-3 environments erodes the recognition of ECE as a profession.

The low pay among early care providers contributes to a broad sense of staffing instability among ECE providers. Stakeholders remarked that many staff are willing to change providers frequently for a minimal increase in pay since the starting wages are typically so low. One Head Start provider suggested that in a three- to five-year time frame, there may be as much as 80% staff turnover due to low compensation.

Providers indicate lack of internal consensus on early care and education as a profession. Stakeholders suggested that this perspective stems in part from the low pay scale among many ECE programs, and the lack of typical professional benefits such as paid time off and health insurance. Because of this compensation environment, some providers may see their work in the ECE setting as a stepping stone to other positions and occupations, and may not be as committed to training or continuing education that support continued professionalization of the field.

RECOMMENDATION: Continue to work toward credential-based compensation more consistently across the birth to elementary continuum. To this end, providers recommended analyzing required education and experience across the early care and education system to work toward aligned pay on a shared scale.

KEY FINDING: Lack of public consensus on the importance of quality ECE provision limits access to high-quality care.

Low wages and limited benefits prevent further professionalization of the ECE workforce. Due to the lack of sustained public funding for ECE provision, most providers will continue to rely on family fees as the primary source of their operating budget. This dynamic pressures providers to keep costs as low as possible, limiting their ability to increase staff compensation, and perpetuating ongoing staff turnover and instability. This instability in staffing is not only administratively challenging for providers, but impacts quality of care for children, who benefit from continuity of care. Moreover, low compensation and limited benefits hinder prospective workers from viewing ECE provision as a long-term career, limiting their incentive to participate in ongoing professional development opportunities to increase the quality of their care.

The price it is, sometimes when you tell families who are on the Best Beginnings scholarship that the scholarship doesn't cover the whole rate and they're responsible for the rest, they're just like, "What? It's just daycare." And that's really disheartening for professionals and it's really disheartening that you know they're choosing somewhere that's

⁵⁸ Watson, *Childcare*.

cheaper because they don't understand the quality of care that's being offered. -ECE provider

Lack of public support and sustained public resources hinder access to quality care for Montana children. At the provider level, the public funding context of ECE services limits staff tenure and professionalism of the workforce, as described above, and thus reduces the opportunity to build workforce capacity to provide high-quality ECE services in the state. At the family level, providers stated that family income levels often hinder families' ability to afford tuition of licensed child care providers, and encourages many parents to turn to family members or informal licensed providers for care. Without public outreach regarding the benefits of high-quality care, family members may not appreciate the cost differential in delivering high-quality care; moreover, families may be unable to pay for higher quality care even if they recognize the benefits.

RECOMMENDATION: Increase public and family awareness on the benefits of high-quality care.

Increased awareness will create more informed consumers of child care options, increasing families' ability to judiciously seek higher quality care within their income limits.

I think [it would be good] if more people were more educated on the whole subject of early education - like when you walk into a classroom and they are all playing, [for parents] to understand all the different kinds of education that's happening at that moment. -ECE provider

KEY FINDING: Lack of universal licensing requirements impacts the number of children in low quality care and creates an unlevel playing field for providers.

There is no licensing for preschools or drop-in daycares, which is a huge problem. Parents don't know this. There's nothing at the state level that ensures that preschool is high-quality. -ECE provider

Inconsistencies in licensing requirements across provider types may decrease licensed providers competitive advantage and increase the number of children participating in lower quality care. Providers note that parents may not understand that certain child care options, such as preschools and drop-in centers, are not required to be licensed. Providers report wide variability in quality among these unlicensed options, and recommend universal licensing requirements for all child care providers.

We talk about the importance of getting into licensed child care...and oftentimes they have no option. They are in survival mode for their

child and their families, and they're just looking for anyone who can take care of their child so that they can go to work. -ECE provider

RECOMMENDATION: Eliminate exemptions to licensing requirements across providers. Universal licensing requirements would promote a higher level of quality care and level the playing field across provider types. Montana should seek to eliminate licensing exemptions for preschools, out of school time care providers, and drop-in centers.

KEY FINDING: Inflexible or inconsistent licensing regulations can deter prospective providers from entering the system.

Stakeholders suggested that some individual providers may be dropping out of the licensing system, or failing to enter to begin with, to avoid perceived training and paperwork burden. Barriers to licensing may be particularly acute for small providers, who may not have resource capacity to address all immediate facility or environmental requirements. Additionally, multiple providers noted a punitive culture within licensing, where licensors seemed more eager to catch a wrongdoing than support improvement; however, they also mentioned that this culture seems to be shifting toward more assistance and support.

I feel like it's easier. I mean, if I was going to open a facility, I would just open an unlicensed one because I'd make more money. I don't have to go through all the paperwork and actually have people come in and check on it. -ECE licensed provider

Providers licensed through Head Start or tribal CCDF programs do not have reciprocity with state child care licensing. Head Start and Tribal CCDF programs must be licensed through the state to take advantage of QRIS incentives and associated professional development support as well as to accept Best Beginnings child care subsidies. Current state licensing regulations create licensing obstacles by requiring Head Start and tribal CCDF ECE providers to complete duplicative and sometimes inconsistent steps for state licensing. In addition, Head Start performance standards require Head Start programs to meet state licensing standards whether or not they are licensed with the state, creating a tangible opportunity to align CCDF and Head Start health and safety training and processes.

Concerns expressed over Head Start-licensing reciprocity included frequency and quality of monitoring. Although it is possible that programs that operate Early Head Start programs only may receive the minimum site visit standard every five years, stakeholders note that all programs operating Head Start or Head Start and Early Head Start combined will receive multiple site visits spread out over the five year grant, including visits to monitor implementation approach, apply continuous quality improvement processes, and assess service delivery and outcomes. Stakeholders note opportunity to review monitoring schedules to confirm adequacy of alignment and facilitate greater reciprocity across programs.

Providers also observed that licensing takes a very long time with little feedback and frequent communication lags from the state in the process. Stakeholders across the state noted the need for more licensors to follow up on reports or renewals; frequent licensor turnover hinders stable capacity. Delay in inspection and licensing visits is challenging for existing providers, who have to have paperwork on time and up to date to receive certain payments, including child care subsidies. Providers also remarked that although online licensing renewal is a good idea, it feels like a big black box to providers with no communication or follow up from state staff.

RECOMMENDATION: Evaluate support structures and incentives to help providers come into compliance with licensing requirements. This may include evaluation of fire and sanitation requirements. Incentives could address infrastructure needs such as better fencing, playground equipment, sleep mats, or freezers to keep snacks, that may impede licensing. Montana has recently introduced start up and expansion grants to assist with resource capacity issues. Additionally, licensing regulations have been modified to allow exceptions.

The hardest thing we did was meeting regulations - period. We had to put in a fire suppression system in the church sanctuary even though we never went near it. It was \$25,000 and we are still paying it off, thank you. -ECE provider

RECOMMENDATION: Provide greater guidance to programs when onboarding into licensing. The initial licensing period can be especially overwhelming to new providers. Stakeholders recommended more targeted guidance and one-on-one assistance to new ECE programs to help them understand licensing requests and meet requirements.

RECOMMENDATION: Examine opportunities for more responsive and frequent communication related to licensing for providers. These improvements to the process could encourage greater provider participation.

RECOMMENDATION: Continue to pursue licensing reciprocity between state CCDF, tribal CCDF, and Head Start ECE programs. Increasing state licensing will bolster efforts to support ECE workforce quality, overall ECE system capacity, and family access/equity. Efficiency gained from aligned health and safety requirements across systems can also contribute to increased access by redirecting licensing resources to other points in the system.

KEY FINDING: Lack of coordination between licensing and STARS to Quality increases participation burden on providers.

Providers expressed confusion and frustration over the lack of coordination between licensing and STARS to Quality participation. Although providers were aware of the rationale for separating licensing from the STARS to Quality initiative (separating regulatory control from support), they noted the extra burden of having additional, uncoordinated monitoring visits, paperwork, and requirements. They also expressed frustration with the lack of communication between agencies, and licensing stakeholders themselves noted frustration regarding the lack of coordination across their work and STARS to Quality. Challenges were particularly acute when programs were newly licensed or onboarding into STARS to

Quality and the amount of information and communication from different sources was likely to overwhelm or confuse.

RECOMMENDATION: Increase coordination between STARS to Quality and licensing. Stakeholders recommended identifying one consultant to handle both licensing and STARS to Quality participation per site. This coordination would be particularly helpful during the onboarding process, when a dedicated liaison per site could organize, prioritize, and communicate requests from different agencies. Some stakeholders recommended folding licensing in to QRIS, while others felt this would dilute the integrity of the QRIS system. More regular communication and established protocols between STARS to Quality, licensing, and program staff could reduce inefficiencies and provide more unified direction to providers. Aligning licensing regions with CCRR regions would be a first step in streamlining coordination across initiatives. Licensing-QRIS coordination improvements is an area for ongoing research and planning work.

RECOMMENDATION: Provide greater guidance to programs when onboarding into STARS to Quality. Stakeholders recommended more targeted guidance to programs as they enter STARS to Quality. More dedicated initial resources and one-on-one assistance could decrease onboarding burden and increase provider participation in the initiative.

Workforce

Over the past decade, Montana has implemented multiple initiatives to enhance the quality of ECE in the state by improving the education, expertise, and skills of the workforce. Numerous research studies have found that a more educated ECE workforce provides higher quality care and facilitates improved child outcomes. Professionalization of the ECE workforce can improve ECE quality.

The Montana Early Childhood Project (ECP) is the state's primary organizing body for ECE professional development. It promotes professional development of ECE providers through implementation of the state plan for early care and education career development, collaboration with partner organizations to promote early childhood professional development, and involvement with the National Workforce Registry Alliance to promote a knowledgeable and skilled early childhood workforce. Primary professional development efforts include establishment of an early childhood knowledge base, development of a statewide practitioner registry, articulation of a provider Career Path, and implementation of related professional development training opportunities.⁵⁹

- Knowledge Base.** The Montana Early Care and Education Knowledge Base was developed to communicate what practitioners need to know, understand, and be able to do. It is intended to introduce individuals to the early childhood field, encourage providers to become reflective practitioners, facilitate development of individual professional development goals, and help leadership plan professional development experiences. The Knowledge Base revolves around 10 content areas: observation, documentation, and assessment; program management; family and community partnerships; environmental design; child growth and development; health and well-being; professionalism; curriculum; diversity; and child guidance. The Knowledge Base is currently being revised to facilitate use by individuals across the career spectrum. It will also incorporate NAEYC standards and include modules on trauma informed care and technology integration.
- Practitioner Registry.** The statewide practitioner registry is intended to increase the number of high-quality early care and education programs by helping to develop a skilled early childhood workforce. Data from the practitioner registry communicates important information about early childhood workforce that can raise visibility, professionalism, and compensation for providers. Multiple stakeholders suggest opportunity for leveraging the registry infrastructure for the broader infrastructure workforce, including home visitors, early intervention specialists, child welfare social workers, direct service workers, and related professions.
- Career Path.** Practitioners who participate in the statewide registry are placed at a level in the Career Path, which is a framework for recording and recognizing provider experience, training, and education. Individuals can use the Career Path to identify an individualized career trajectory in early care and education.
- Professional Development Approval/Identification.** The Montana ECP, which manages the practitioner registry and Career Path, has also developed a process to identify professional development specialists throughout the state, approve training in key early care and education

⁵⁹ For more detail on Montana Early Childhood Project initiatives, please see Appendix E: Workforce.

content areas, and provide a central repository for communicating approved ECP training opportunities.

- Professional Development Incentives.** ECP also manages incentives and awards for individual and professional development, including P-3 and Leadership Financial Assistance, the Professional Development Incentive Award-higher Education, Award for Achievement of GED or HiSET, NAFCC Accreditation, and NAEYC Accreditation. They also coordinate the Early Childhood Higher education consortium and the Montana Child Development Specialist Apprenticeship program.

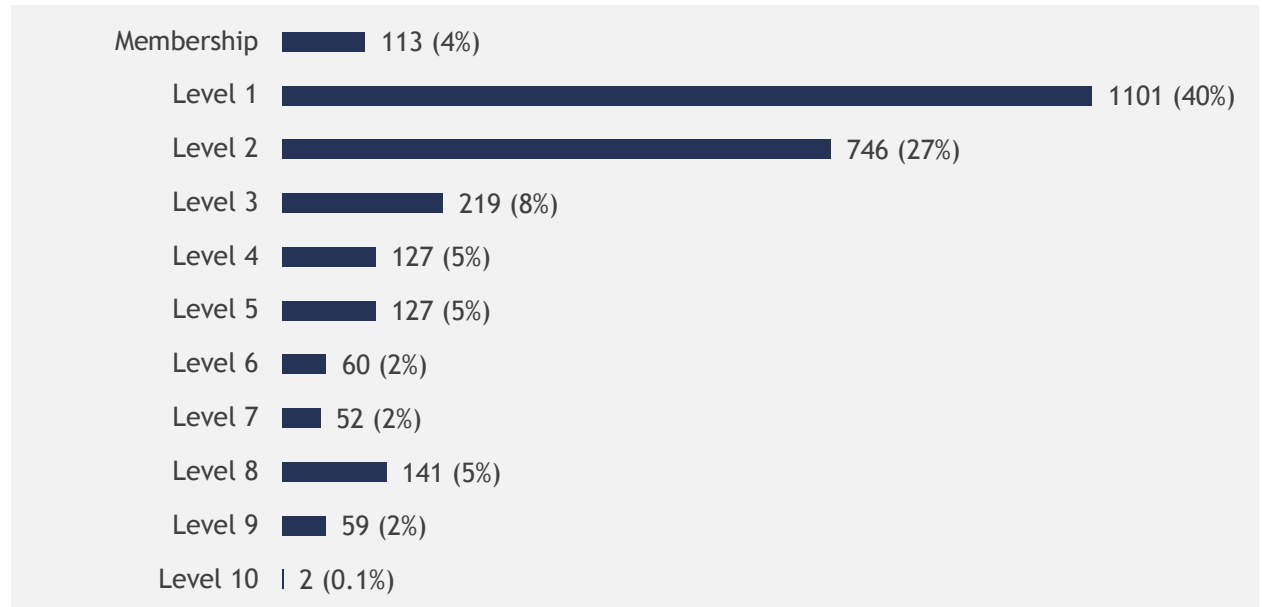
ECE provider educational background and participation in professional development

KEY FINDING: Most registry participants are at low registry levels.

Among providers on the statewide ECE registry as of March 29, 2019, the largest share were participating at Level 1, as shown in Figure 31. Level 1 participants have high school diplomas or equivalent and are working in ECE settings, but do not have additional related training or education. One percent (1%) of practitioner registry participants had a director’s credential.

MOST REGISTRY PARTICIPANTS ARE CAREER PATH LEVEL 1 OR LEVEL 2

Figure 31. Number of registry participants by Career Path level



Source: ECP practitioner registry participation data as of March 29, 2019

The vast majority (81%) of providers enrolled in the practitioner registry were working in licensed programs.⁶⁰ Program position varies by registry level, with practitioner registry participants in low

⁶⁰ For more detail on ECE education background, please see Appendix E: Workforce.

registry levels more likely to be in assistant teacher positions, while participants in higher registry levels more likely to fill a wide range of positions, from teacher to director, administrator, or trainer.

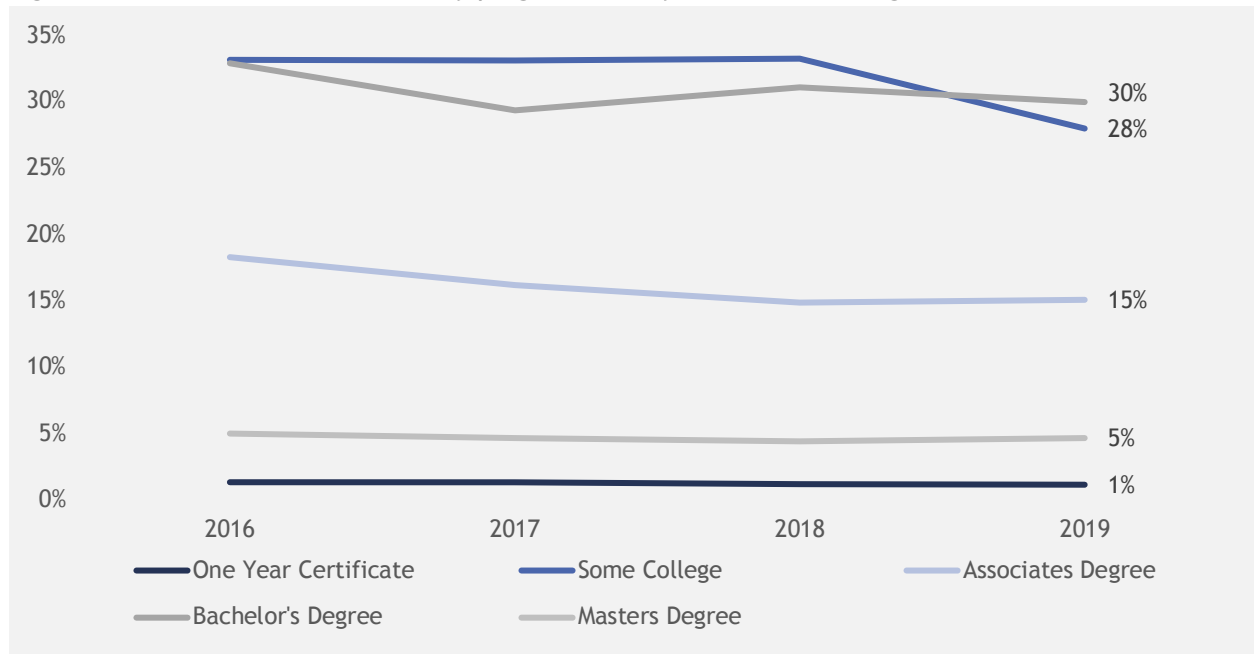
KEY FINDING: STARS to Quality program staff are likely to have some college or a Bachelor’s degree.

We can also understand the current status of ECE provider qualifications by examining education background of STARS to Quality program staff.

Higher education background among STARS to Quality program staff has remained relatively stable over the past four years, as shown in Figure 32. The percent of STARS to Quality program staff with various education and training background varied by STAR level and by facility type, with a slightly greater share of staff with bachelor’s or master’s degrees working at registered family child care homes compared to other facility types.

NEARLY ONE-THIRD OF STARS TO QUALITY PROGRAM STAFF HAVE A BACHELOR’S DEGREE

Figure 32. Percent of STARS to Quality program staff by educational background, over time



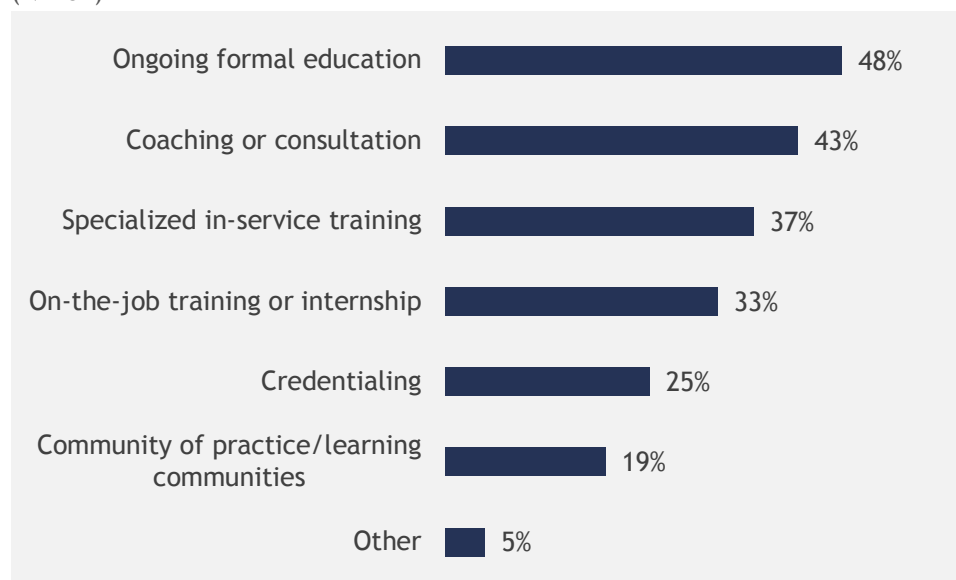
Source: ECP practitioner registry participation data as of March 29, 2019

KEY FINDING: ECE providers participate in diverse professional development activities.

ECE providers report participation in diverse professional development opportunities to increase their education and acquire new skills. Ongoing formal education was the most common type of professional development participation among ECE providers responding to the needs assessment survey, followed by coaching or consultation and specialized in-service training, as shown in Figure 33.

ONGOING FORMAL EDUCATION WAS THE MOST COMMON TYPE OF PROFESSIONAL DEVELOPMENT PARTICIPATION

Figure 33. Percent of ECE provider survey respondents by professional development participation (N=207)



Source: Montana PDG B-5 Needs Assessment Provider Survey

ECE provider needs assessment survey respondents were also likely to have participated in professional development activities within the past six months. Child Care Resource and Referral Agencies (CCRRs) were the most common source of ECE professional development among ECE provider survey respondents, followed by childcaretraining.org (CCT) resources.⁶¹

ECE provider needs assessment survey respondent providers note progress in multiple professional development domains. Provider respondents noted “substantial progress” in the following professional development activities, and shown in Figure 34:

- Rigorous and relevant ongoing professional development opportunities (51%)
- Quality and content of ECE preparation programs (50%)
- Coaching, consulting, and mentoring opportunities (45%)

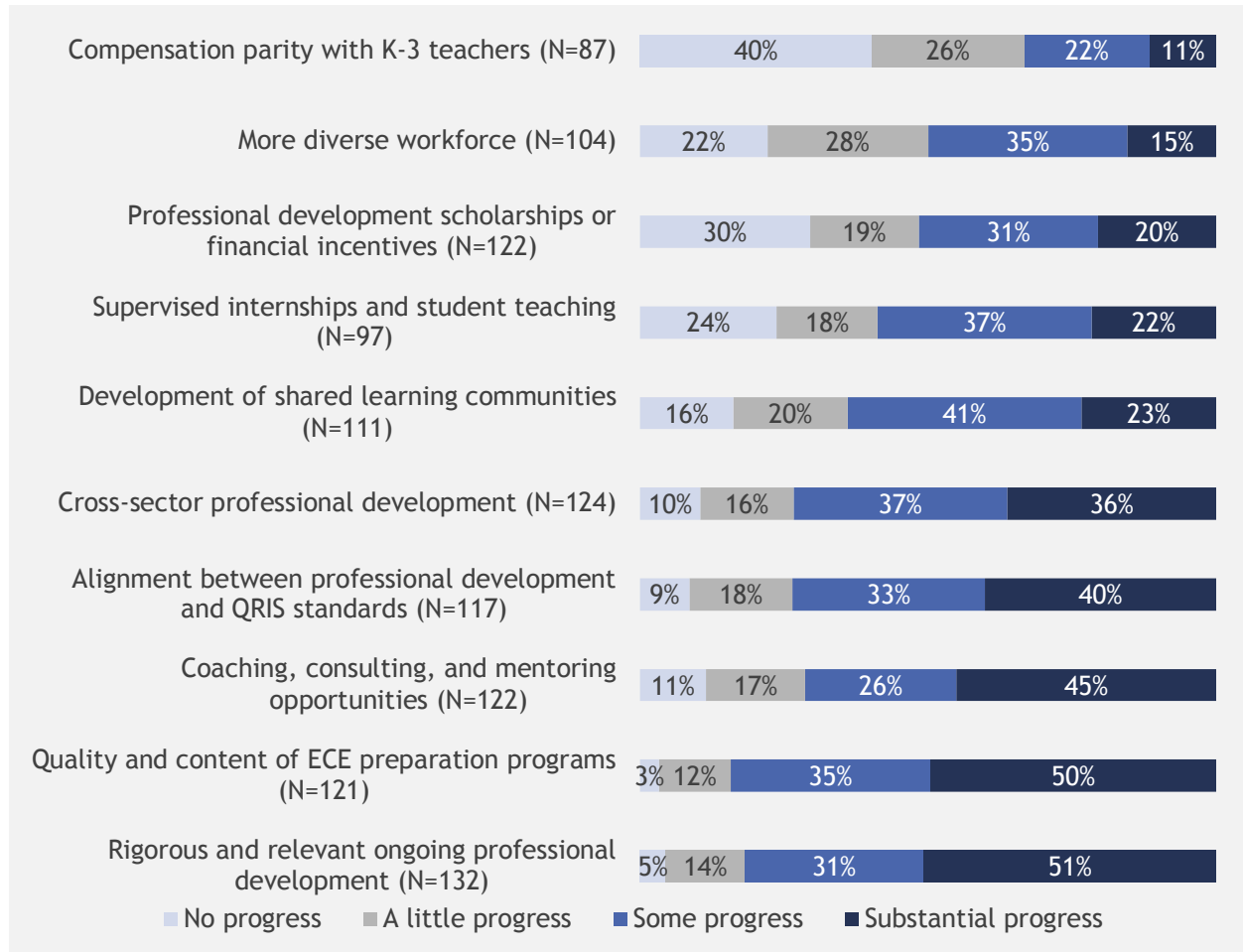
Provider respondents were more likely to report “no progress” related to the following professional development domains:

- Compensation parity with K-3 teachers (40%)
- Professional development scholarships or financial assistance (30%)
- Development of a more diverse workforce (22%)

⁶¹ Please see Appendix E: Workforce for more detail on ECE professional development participation in Montana.

PROVIDERS NOTE SUBSTANTIAL PROGRESS IN PROFESSIONAL DEVELOPMENT RIGOR AND LITTLE PROGRESS RELATED TO COMPENSATION PARITY WITH K-3 TEACHERS

Figure 34. Percent of ECE provider survey respondents reporting progress in professional development activities



Source: Montana PDG B-5 Needs Assessment Provider Survey

KEY FINDING: Professional development recognition may overlook relevant training.

Providers noted a tension between respecting articulated standards and recognizing high-quality staff who may not have identified prerequisites. They also expressed some frustration with misalignment between registry levels and backgrounds, and lack of recognition for non-traditional degrees. For example, one provider described a staff member with a college degree in psychology and expertise in behavioral techniques, but because her degree was not in early childhood specifically, she only enters the practitioner registry at a Level 2. Another provider described a staff member who was a behavioral technician, but because the system does not recognize that background, she had to attend duplicative trainings.

ECE provider participation in education and training activities

Recent studies have found that increasing teachers' use of research-based instruction increased learning by children, and that professional development intervention in early childhood education improved both academic and social outcomes for young at-risk children.⁶² To be effective at improving teacher-related outcomes, professional development must be learner centered, building on individuals teachers' needs; address important content knowledge; provide opportunities to test new strategies and receive feedback; and occur within a collaborative environment.⁶³

The development of the ECP practitioner registry to recognize provider education backgrounds and the creation of financial scholarships and incentives to promote education pursuit are key state strategies for increasing ECE provider education levels. In addition to the ECP practitioner registry, described above, the P-3 and Leadership Financial Assistance Project was established with MPDG funds to provide financial assistance to individuals pursuing coursework leading to the Montana ECE: P-3 teacher endorsement or an early childhood master's degree. The P-3 teacher endorsement can be added to a K-8 teaching license to enhance teacher preparation to work with young learners and is a required endorsement for all public preschool teachers in the state.

Montana ECP also approves, coordinates, and communicates opportunities for ECE training. The ECP training approval process evaluates non-college credit training in the early care and education Knowledge Base content areas and the National Child Development Associate (CDA) competency areas. College courses that are taken from accredited colleges and universities and relate to Knowledge Base content areas may count toward annual required training hours. Select professional development opportunities, such as national conferences, may not have ECP training approval prior to attendance, but providers may submit to the ECP for approval of these events within three months of attendance.

KEY FINDING: The P-3 and Leadership Financial Assistance Project supported participation in early care and education coursework.

More than 200 individuals received P-3 and Leadership Financial Assistance. The P-3 and Leadership Financial Assistance Project was implemented to build early childhood teacher and leadership capacity by providing financial assistance to individuals pursuing coursework towards their P-3 teacher endorsement or early childhood master's degree. From the Fall of 2015 through the Spring of 2019, 915 applications for P-3 and Leadership Financial Assistance were submitted; this accounts for 293 unduplicated individuals applying for assistance. Out of all applications, 707 (77%) applications, or 202 individuals, were approved and received assistance. The total number of applications approved as well as the total funding across all institutions peaked in Fall 2016 and Spring 2017, with general decrease since that time as funding declined.⁶⁴

⁶² Karen Diamond, Laura Justice, Robert Siegler and Patricia Snyder, *Synthesis of IES Research on Early Intervention and Early Childhood Education* (Washington, DC: Institute of Education Sciences, 2013), <https://ies.ed.gov/ncser/pubs/20133001/pdf/20133001.pdf>.

⁶³ Ibid.

⁶⁴ For more detail on P-3 and Leadership participation please see Appendix E: Workforce.

The majority (62%, or 125 individuals) of P-3 and Leadership Financial Assistance participants pursued bachelor's degrees at participating institutions. Twenty-one percent (21%) of recipients (42 individuals) were pursuing P-3 Endorsement, and 15% (30 individuals) were pursuing their master's degrees in early childhood. Through Fall 2018, P-3 and Leadership Assistance supported a total of 4,652 credits (\$1,353,458), or an average of 23 credits (\$6,700) per student. Nearly all participants (189 out of 202) used P-3 Assistance for college credits. Twelve percent (12%) each earned the PK-3 Endorsement (24 participants) or an associate degree (24 participants). Seven percent (7%) each earned a bachelor's (15) or a master's (14) during their participation in P-3 Assistance.

KEY FINDING: Apprenticeship and pre-apprenticeship programs are an untapped resource.

The Montana Early Childhood Apprenticeship Program (MECAP) combines education and experience-based training through mentor-supported on-the-job training and college-level classroom instruction. Apprentices earn a Child Care Development Specialist Certificate and achieve Level 4 on the Practitioner Registry. The state also recently established a pre-apprenticeship program for high school students using a similar format. Apprenticeship and pre-apprenticeship programs are part of the state funding structure and not reliant on grant funds. As of January 1, 2019, 12 unique individuals had received their Child Care Development Specialist Certificate.⁶⁵

RECOMMENDATION: Increase promotion of apprenticeship and pre-apprenticeship programs with students and providers. Work with ECE providers, colleges, high schools, and other Department of Labor and Industry suggested mechanisms to promote apprenticeship and pre-apprenticeship opportunities for students.

KEY FINDING: Professional Development Specialist trainers are limited in eastern counties.

Providing diverse and numerous training opportunities requires sufficient trainer capacity. In Montana, Professional Development Specialists (PDS) develop and provide training throughout the state; all ECP approved events identify a PDS or Specialty Training during the application process for training approval. PDS designation ranges from PDS I to PDS III and Specialty Trainers. To be eligible to serve as a PDS, individuals must be current on the Practitioner Registry and must be at least a Level 4 on their Career Path.⁶⁶

PDSs reside throughout the state with greater concentration in the western counties. The distribution of PDS by residence is illustrated in Figure 35. Although PDSs may provide training outside of their resident counties, the limited number of PDSs in eastern Montana, where many of the counties have no

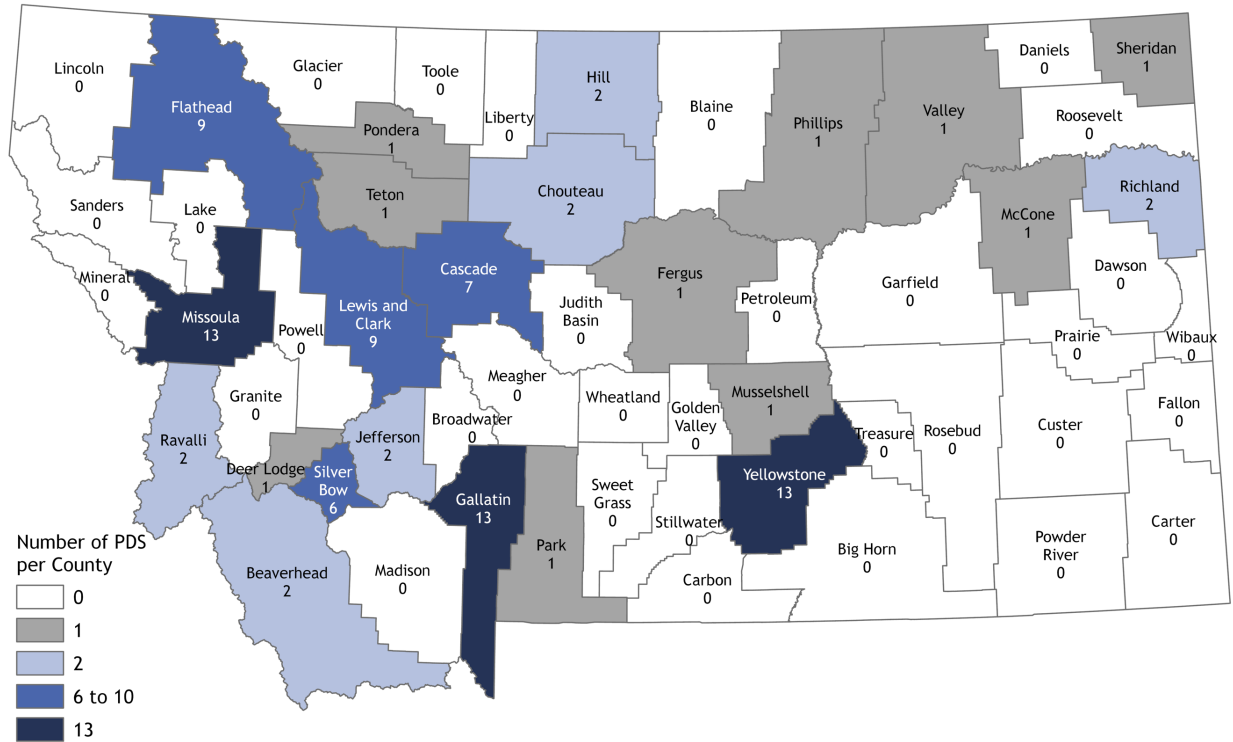
⁶⁵ Early Childhood Project, *ECP Practitioner Registry Data* (March 29, 2019).

⁶⁶ The Montana ECE Career Path ranges from Level 1 (High School diploma or GED/HiSet, currently working in ECE setting, First Aid Certified, and 16 required hours of annual approved training) to Level 10 (Doctorate in ECE or Doctorate in related field with ECE emphasis, minimum 1000 hours in an ECE setting, First Aid certified, and 16 required hours of approved training). Level 4, the minimum to serve as a PDS in the state requires current CDA credential plus at least 20 semester college credits in ECE OR current MT CCDS Apprenticeship Certificate OR One-year certificate requiring 30 college credits in ECE OR minimum of Bachelor's degree plus at least 12 semester college credits in ECE. In additional Level 4 career path requires a minimum of 1000 hours working in ECE setting, First Aid certification, and 16 required hours of approved training annually.

approved residential PDS, may limit access to training in those regions and suggest geographic opportunities to target for additional PDS certification.⁶⁷

LIMITED PDSS IN EASTERN MONTANA MAY LIMIT ACCESS TO TRAINING IN THOSE REGIONS

Figure 35. Number of PDS by County



Source: ECP PDS data

At least half of PDSs are verified to provide training in Family Community Partnerships, Child Guidance, Environmental Design, Observation Documentation and Assessment, Curriculum, and Child Growth and Development. Almost all PDSs have age area expertise with preschoolers, and the majority have expertise with infants and toddlers.

KEY FINDING: ECP approved broad training opportunities; the majority were directed at beginning level practitioners.

In 2018, 1,103 ECE classroom training events and 60 distance training events were offered.

Cumulatively, these events totaled 5,563 classroom training hours and 450 distance training hours, with an average of 5 hours per classroom training and 7.5 hours per distance training.

⁶⁷ For more information on PDS capacity, please see Appendix E: Workforce.

The majority of training events were provided for beginning level practitioners. Stakeholders suggest that this may reflect the fact that beginning level trainings are free, perhaps promoting greater take-up, and that staff turnover is common within the ECE field, creating ongoing demand for beginning level training as new providers enter the workforce. They noted challenges in connecting providers to the right level of training in the existing training structure.

Individuals participate in multiple training events per year. The total number of unduplicated individuals participating in approved training events in 2018 was 1,182. The duplicated count of training participation across approved events was 28,174, suggesting that many individuals participate in multiple training events per year. In 2018, 513 individuals participated in individual request or college credit training events. Collectively, training participants spent 109,708 hours in approved events, and 16,180 in individual request training events.

Several providers found training to be inflexible and demanding. Multiple providers perceived trainings to be too one-size-fits-all, and not sufficiently adaptable. For example, providers suggested that staff in preschools should not be required to take shaken baby syndrome training since they do not work with infants or toddlers

RECOMMENDATION: Target training requirements and increase connection between training options and staff education background. Stakeholders recommended targeting certain licensing training requirements for lead teachers or key staff, rather than every staff member of a facility, and encouraged more varied training options that respond to staff education background.

KEY FINDING: Lack of alignment of training requirements across programs creates duplication.

Providers appreciated the movement to standardize or validate educational backgrounds for ECE providers and recommended greater alignment across programs. Providers felt that the multi-pronged professional development effort, including the practitioner registry, P-3, and other education scholarships, and the STARS to Quality system had increased the skill level of providers. Stakeholders across the state also expressed the need to further align training requirements across programs. They noted lack of efficiency, duplication, and confusion in training requirements across the ECP Career Path, the STARS to Quality system, Head Start programs, and MPDG and STARS Preschool initiatives.

Head Start and Early Head Start described challenges stemming from lack of alignment and reciprocity between STARS to Quality training requirements and Head Start standards. Head Start staff and state program administrators noted lack of alignment between Head Start and STARS to Quality required trainings and sought a more streamlined system of shared training or reciprocal training recognition. The state has developed a crosswalk to compare training between Head Start,

2018 Training by the numbers

1,163 approved training events held
 6,013 training hours provided
 1,182 unduplicated training participants
 28,174 duplicated training participants
 109,708 cumulative participant hours in training

STARS to Quality, and related quality ECE efforts in the state, but it has not clarified the confusion around variation in requirements or lack of reciprocity. Head Start, STARS Preschool, and MPDG are responding to multiple, varying requirements regarding training, professional development, and program implementation, and a more unified system would provide improved efficiency.

RECOMMENDATION: Increase training coordination and reciprocity across ECE initiatives. Greater alignment across programs would reduce administrative burden to track compliance and increase efficiency in training provision.

KEY FINDING: Cross-sector trainings increase efficiency and communication.

Stakeholders appreciated efforts to support cross-sector training and capacity building. Program providers appreciated open community trainings that welcomed participation from providers across the field, including child care providers, preschool teachers, home visitors, and other specialists. This facilitated cross specialty communication and allowed for customized training to meet shared content demands experienced across local systems.

RECOMMENDATION: Increase cross-sector training and skill alignment. In addition to more efficient use of training resources and increased communication across sectors, cross-sector training can build capacity to streamline program experiences for families. For example, stakeholders suggested that cross-sector training between home visitors and Part C providers could enable one staff person to perform tasks across systems and minimize the number of staff with whom families must coordinate.

RECOMMENDATION: Consider increasing Early Childhood Partnership registry infrastructure for broader early childhood professions. Stakeholders suggest using ECP registry infrastructure to develop joint or aligned registries for home visitors, early intervention specialists, child and family services workforce, direct service health workers, and related early childhood professions.

KEY FINDING: Distance learning options increase professional development flexibility.

Online training is providing increased training options for rural areas, and providers appreciated the efficiency and flexibility of distance learning. Providers discussed their desire to see more distance learning options approved to better leverage national and other state resources, and to align with Head Start, public school, and other early childhood sector practices and standards. However, several providers noted that older generations may have more difficulty accessing and fully benefiting from the online format. Online training formats may offer less personal relationship building or direct support, and providers noted that existing online training options may not provide the requisite feedback now required for distance learning.

RECOMMENDATION: Expand opportunities for high-quality distance learning. Distance learning options can increase training and technical assistance reach for rural areas and provide more flexible learning schedules for individuals throughout the state. Greater identification of high-quality distance learning modules and standardization of online protocols can facilitate consistent implementation.

KEY FINDING: Increased centralization of training development can improve access and facilitate cross sector utilization.

Stakeholders noted opportunities to centralize training development and access. Instead of the current system where CCRRs develop training content as individual agencies, stakeholders suggested providing opportunities for local providers to contribute input on training needs. This input could then be aggregated to support development of responsive training content consistent across regions and providers. National and state best practices, as well as Head Start material, could be leveraged to align resources with industry standards.

A centralized training repository could also facilitate cross-sector learning. Stakeholders suggest that a more centralized training repository could also be used for broader early childhood sector providers, including child welfare workers, home visitors, and early intervention providers. This would ensure more common practices among providers and consistent experiences across families.

RECOMMENDATION: Refine the process to create and implement ECE professional development content. The state has an opportunity to restructure its professional development system to better support consistent, high-quality professional development.

KEY FINDING: Additional training is needed to support children with special needs.

Providers noted opportunities for additional training to fill identified gaps. Broadly, stakeholders recommended increased funding to support training, coaching, and mentoring regarding child development, quality environments, curriculum, and kindergarten readiness to improve program quality. More specifically, providers across the state noted insufficient training in working with children with high needs, including developmental delays, mental health issues, and children in foster care who have attachment barriers. The most common training sources were CCRRs, AWARE, Project LAUNCH, and university coursework.⁶⁸ Stakeholders also discussed ongoing needs for additional occupational therapists, speech therapists, and behavioral analysts to support service provision for children with high needs.

RECOMMENDATION: Provide additional training and technical assistance to support children with special needs. Opportunities include traditional training and online formats, as well as teleconsultation to support behavioral health and mental health consultation. This gap is particularly apparent in rural regions and on Native American reservations. Stakeholders note a need to develop cross agency consensus on response and clear delegation of next steps.

ECE provider participation in coaching activities

Coaching in early childhood education settings, when combined with broader professional development, contributes to improvement in teaching quality that leads to gains in children's learning.⁶⁹

Characteristics of individual coaches vary in the field, however, research suggests that successful coaches typically: are former teachers; have experience training adults; have strong relationship-

⁶⁸ Project LAUNCH, *Infant and Early Childhood Mental Health Consultation Survey: Results Report*, 2019.

⁶⁹ Lauri Connors-Tadros and Sarah Daily, *CEELO Fast Fact: Strategies to Improve Instructional Practices in Early Childhood Settings* (New Brunswick, NJ: National Institute for Early Education Research, 2018), http://ceelo.org/wp-content/uploads/2018/04/2ceelo_fast_fact_LA-Instruction-LCT_041218_final.pdf.

building skills, document and track their work; and implement coaching models with fidelity.⁷⁰ Coaches may be experts, peers, or teachers themselves. Research findings suggest that video and face-to-face coaching can both lead to improvement in teacher and student outcomes, and practice-based coaching both helps teachers use newly acquired skills and strategies on the job, and links those skills and strategies to positive child outcomes.^{71,72} In terms of who receives coaching, volunteer teacher participants may be more open to coaching than others. However, larger scale programs may pursue greatest impact by assigning coaching to those most in need of support.⁷³

KEY FINDING: Multiple coaching initiatives support ECE professional development.

Forty-three percent (43%) of ECE provider needs assessment survey respondents report participating in coaching or consultation at some point over the course of their career in Montana. Nearly three-quarters (71%) believe that their ECE program has made substantial or some progress in providing coaching, consultation, and mentoring opportunities over the past five years. Montana ECE programs have multiple coaching efforts braided throughout the system. Figure 36 provides a brief summary of coaching efforts across programs.

⁷⁰ Bonnie O-Keefe, *Primetime for Coaching: Improving Instructional Coaching in Early Childhood Education* (Washington, DC: 2017), https://bellwethereducation.org/sites/default/files/Bellwether_ECECoaching_GHS_Final.pdf.

⁷¹ National Center on Quality Teaching and Learning, *What Do We Know About Coaching? Practice Based Coaching: Collaborative Partnerships* (Seattle, WA: University of Washington, 2015), <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/pbc-what-do-we-know.pdf>.

⁷² Diamond, *Synthesis*.

⁷³ O-Keefe, *Primetime*.

THE EARLY CHILDHOOD SYSTEM HAS MULTIPLE INTERSECTING COACHING INITIATIVES TO PROMOTE PROFESSIONAL DEVELOPMENT

Figure 36. Montana professional development coaching initiatives

Home Visiting	Part C	Mental Health Consultation	STARS Preschool	Head Start	MPDG	STARS to Quality
<p>Healthy Montana Families and Maternal, Infant, and Early Childhood Home Visiting use evidence-based reflective supervision models. Parents as Teachers (PAT) and Nurse Family Partnerships (NFP) require reflective supervision; SafeCare requires reflective coaching. Safe Care coaches observe providers’ sessions, assess fidelity to protocols, provide feedback, and convene monthly team and administrative meetings.</p>	<p>Montana Milestones/Part C of IDEA Early Intervention Program use Routines-based Interview and Routines-based Early Intervention coaching strategies to provide support and services to families within the context of daily routines. Montana Milestones is currently developing a coaching profile to increase consistency of implementation, and creating social-emotional content focus for coaching sessions.</p>	<p>The Infant Early Childhood Mental Health Consultation strategy within Project LAUNCH intends to enhance program strategies that support children’s social and emotional development. The wrap-around model includes constant communication among the STARS Consultant, the Pyramid Model Coach, and the IECMHC consultant to coordinate schedules, reduce duplicative services, and leverage team assets.</p>	<p>Coaching is imbedded in the STARS Preschool criteria and program design and is implemented through existing CCRR coaching infrastructure and part-time specialists. Coaching focuses on program specific goals, including strategies to increase environmental scores, adapt curriculum, or meet health and safety standards.</p>	<p>Head Start has historically supported a variety of coaching pilots and technical assistance, leading to greater experimentation, adoption, and documentation of coaching strategies. In 2014, 75% of HS teacher reported a coach or mentor, and coaching has been a requirement of HS/EHS since 2016.</p>	<p>The Montana Preschool Development Grant incorporate coaching for classroom teachers and leadership teams. An Instructional Consultant and Regional Specialist jointly coordinate coaching support, drawing on program data and goal setting results to drive coaching activities.</p>	<p>CCRR agencies support STARS Pyramid Model Coaches, who focus on supporting program staff in implementing the Pyramid Model of ECE delivery and providing robust social-emotional supports for children. STARS Consultants provide technical assistance on STARS to Quality criteria ad application processes.</p>

KEY FINDING: Coaching content and delivery vary.

Montana has made progress in increasing coaching opportunities across programs; however, the content, frequency, and structure of coaching activities vary. Responses to the practitioner and coach surveys that were conducted in September 2018, along with qualitative input from focus groups and interviews, describe a variable coaching profile. Stakeholders described variability in coaching quality and resulting inconsistency in coaching impact. Most participants indicate that multiple coaches may work with one practitioner or group of practitioners. For example, some sites receive separate coaching for the Pyramid Model and for social emotional development tools.⁷⁴ Key input on coaching implementation include:⁷⁵

- Coaching format and frequency vary both within and across programs.
- Most coaching is focused on individualized support for teachers.
- The training provided to coaches varied by program.
- Coaching impact is limited by capacity and staff turnover.

RECOMMENDATION: Continue to improve coaching infrastructure and implementation. Coaching quality and consistency can be improved through greater standardization of training resources, a shared coaching resource bank, systematic coaching supervision, and implementation of recommendations from the Montana Coaching Advisory forum.

Stakeholders recommended more standardized training to ensure a baseline level of coaching quality. Although several stakeholders suggested using the Pyramid Model as the basis for coaching training to ensure greater consistency across coaches from different systems, others cautioned against identifying one model or too rigid of a structure. Interviewees described the opportunity for greater standardization in training without being too prescriptive in coaching model. For example, although coaching is teacher and program responsive, the coaching cycle, in terms of initial goal setting, classroom support, post classroom reflection, and renewed goal setting, can be standardized.

Stakeholders also suggested opportunities for more standardized coach training specifically on assessments. Multiple stakeholders noted the need for more consistent coach training on implementing and evaluating classroom assessments. As one provider noted: *“They don’t have the skillset to coach off the data from our assessments.”* Program providers would appreciate additional coaching on assessments to optimize their child-centered strategies and overall program learning. In cases where coaches are providing coaching around assessments more regularly, they noted that they are coaching teachers on how to read the assessment data, how to use it, and how to adjust services based on it. This has allowed them to identify students that need extra help and integrate a curriculum to support the effort.

Coaches recommended development of a shared coaching resource bank to help operationalize concepts with teachers. Creation of a centralized coaching bank including articles and videos that teachers and

⁷⁴ According to The National Center for Pyramid Model Innovations, *the Pyramid Model* is “a conceptual framework of evidence-based practices for promoting young children’s healthy social and emotional development,” Accessed on September 17, 2019, <https://challengingbehavior.cbcs.usf.edu/Pyramid/overview/index.html>.

⁷⁵ For more detail on coaching, please see Appendix E: Workforce.

coaches can access would help contextualize teaching strategies and provide modeling of abstract principles. It may also provide more consistent content across programs and coaches.

Beyond initial training and shared resources, coach stakeholders recommend more systematic supervision of coaching to continue coaching development. Respondents appreciated the monthly meetings as opportunities to provide ongoing support to coaches as they progress in the system. They noted the importance of providing constructive feedback on coaching approach, techniques, and capacity for self-assessment and reflection.

Consider Montana Coaching Advisory Forum recommendations as coaching implementation continues. Representatives of the early childhood coaching system in the state convened a Montana Coaching Advisory Forum in September 2018 to discuss ECE coaching implementation and opportunities. The forum developed a series of recommendations to address implementation variability and provide more consistent and best practice-based coaching throughout the state. The following recommendations are presented in order of priority, as determined by coaching advisory forum members:

- Develop a Montana Office of Coaching to house the infrastructure and build capacity for coaching across the state.
- Continue the coaching workgroup to maintain progress on coaching system development.
- Develop common orientation and training for new coaches and a way to track who has completed the process.
- Research development of coaching competencies and certifications in other states.
- Implement a parallel process of coaching preparation where coaches are coached with the same model they will be implementing.
- Create a common definition and guidelines of what coaching means, including minimum coaching standards.
- Create a pool of master coaches who can train and coach coaches.
- Connect and support programs to find money for and sustain internal coaching.
- Coordinate or streamline efforts across sectors to avoid duplication of coaching.
- Pilot coaching implementation strategies.
- Research the coaching models that have been used in Montana to select a common framework.
- Review current grants to make sure roles and requirements of coaches meet coaching definition.
- Provide coach training in state.
- Partner with higher education to build coaching competencies through coursework

KEY FINDING: Coaching impact is limited by capacity and staff turnover.

Providers suggested ongoing need for more coaching, but coaches noted limited capacity to meet the demand. Many coaches are also substitute teachers, program managers, or supervisors. Stakeholders noted very few cases of dedicated, full-time coaches, and coaching funding is not stable; most coaches report that their funding is tied to time limited grants which limits the projected sustainability of coaching implementation. Coaching that relies on state CCRR resources was perceived to be more stable as it was not dependent on specific grant funding streams. When a coaching grant ends, coaching

is integrated into someone’s existing position, which can be challenging. As one respondent noted, *“There is not a lot of training on how to be a coach and a supervisor—this can be a tricky dynamic.”*

Teacher turnover limits coaching progress. Coaching stakeholders remarked that frequent teacher turnover limits lasting impact of coaching as coached providers are replaced by new, less experienced teachers. As one coach noted, *“Staff turnover is the biggest problem—of the people you coach, very few remain.”*

ECE provider participation in early learning communities

Professional learning communities in the early childhood education field include a range of collaborative, job-embedded approaches to instructional and program improvement. Broadly, professional learning communities posit that by working together with other professionals with experience in the same subject or with similar students, teachers can draw on their immediate experience and performance in structured dialogue regarding how to refine and improve teaching strategy to improve outcomes.⁷⁶ Professional learning communities assume a continuous cycle of improvement and expect teachers to engage in ongoing assessment and problem solving. Findings related to early learning community implementation in Montana include:

KEY FINDING: ECE learning community uptake is not widespread in Montana, but implementation appears to be of high-quality.

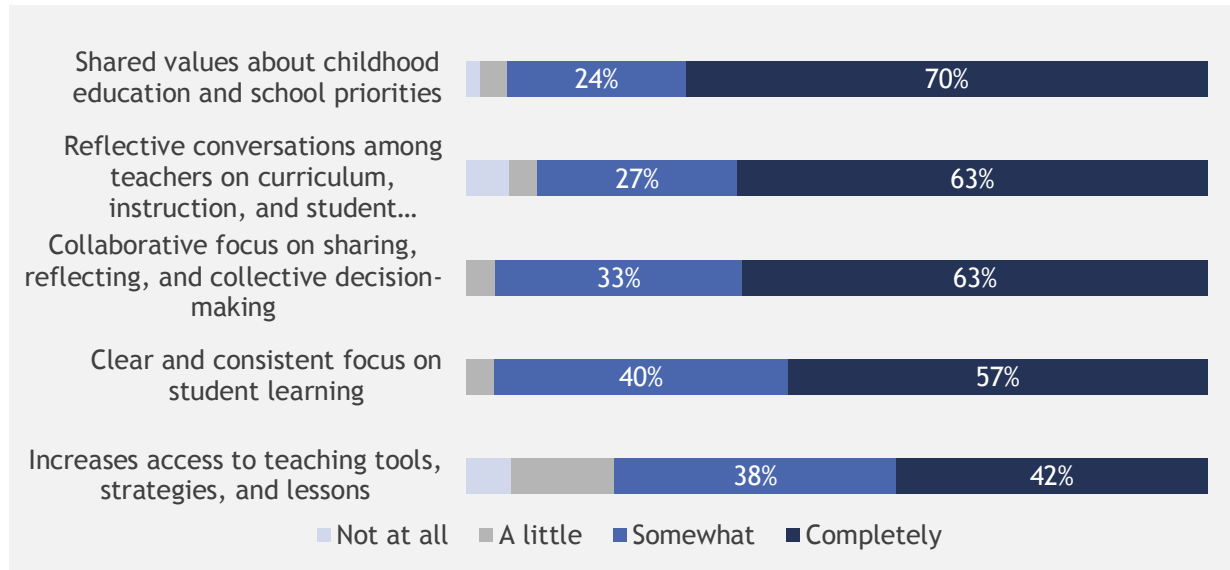
Nineteen percent (19%) of ECE provider needs assessment survey respondents had participated in a community or practice or learning community during their tenure in Montana. Twenty-seven percent (27%) of ECE providers indicated that they currently participate in an ECE learning community. Among ECE provider needs assessment survey respondents, 64% believe that their ECE program has made substantial or some progress in the development of shared learning communities or communities of practice.

ECE provider needs assessment survey respondents that indicated they were participating in an ECE learning community perceived their learning community to include best practice features. As shown in Figure 37, 70% of ECE learning community participants believe that their learning community completely includes shared values about childhood education and school priorities. Forty-two percent (42%) of ECE learning community participants believe that their learning community completely increases public and shared access to teaching tools, strategies, and lessons, suggesting and opportunity for targeted ECE learning community capacity building.

⁷⁶ Rebecca Woodland, “Evaluating PK-12 Professional Learning Communities: An Improvement Science Perspective,” *American Journal of Evaluation* 37, no. 4 2016: 505-521.

ECE LEARNING COMMUNITY PARTICIPANTS REPORT HIGH-QUALITY LEARNING COMMUNITY IMPLEMENTATION

Figure 37. Percent of ECE learning community participants by how much their learning community includes best practices



Source: Montana PDG B-5 Needs Assessment Provider Survey

RECOMMENDATION: Increase implementation of learning communities. Expanding early learning communities can increase the number of ECE providers exposed to early learning community benefits.

Implementation of mental health consultation

Infant and Early Childhood Mental Health Consultation (IECMHC) is a multilevel preventive intervention that builds adult capacity to support infant and children’s social, emotional, and behavioral health and development.⁷⁷ IECMHC uses a combination of training, reflective consultation, and skill building to support teachers, supervisors, directors, aides, food service and transportation staff in early learning environments.⁷⁸ Benefits of mental health consultation include reduced staff stress and turnover in child-serving agencies, decreased mental health symptoms in young children, reduced educational disparities experienced by children of color, reduced expulsion of children from child care and early learning, and increased early learning staff competence in addressing trauma, adversity, and early childhood and family mental health conditions.

⁷⁷ Zero to Three, *Infant and Early Childhood Mental Health Consultation: A Briefing Paper* (Washington, DC: Zero to Three), 2017, <https://www.zerotothree.org/resources/1952-infant-and-early-childhood-mental-health-consultation-a-briefing-paper>.

⁷⁸ Wright, Catherine, *Minnesota’s Mental Health Consultation System* (St. Paul, MN: Minnesota Department of Human Services, 2019).

Stakeholder feedback identifies lessons learned through Montana’s IECMHC efforts, including system progress and opportunities for continued improvement.⁷⁹

KEY FINDING: IECMHC can improve provider quality and job satisfaction.

Stakeholders believe that mental health consultants have made a positive difference in increasing ECE provider familiarity with issues and their ability to have conversations with parents. Stakeholders praised both Head Start and Project LAUNCH IECMHC efforts for raising capacity around mental health issues and improving collaboration across providers. An assessment of Project LAUNCH pilot sustainability indicates that because of pilot site implementation, bureau chiefs and directors of service delivery systems (child care, home visiting, Part C) are increasingly interested in IECMHC.⁸⁰

Stakeholders suggested that IECMHC can improve staff retention among ECE providers. IECMHC providers noted that caregiver stress resulting from children’s social, emotional and behavioral issues can affect ECE providers. Several stakeholders suggested that this dynamic contributes to high turnover among staff. IECMHC can facilitate retention by supporting teachers and directors, decreasing challenging behaviors, and building a culture of identity and pride as child development providers versus babysitters. Stakeholders believed IECMHC can play a role in increasing retention in related sectors, such as child and family services, by providing targeted support and consultation to caseworkers who may otherwise internalize lack of visible progress with their families.

KEY FINDING: Stakeholders noted need for more mental health consultation capacity across the state.

Stakeholders discussed Head Start expertise in caring for children with special needs, while advocating for additional resources to serve children with high needs. Focus group and interview respondents valued programs with capacity to care for children with high needs. Respondents provided particular feedback on Head Start programs’ ability to care for children with special needs, and noted lack of sufficient capacity to meet community demand for these services. Stakeholders suggested additional resources to effectively respond to children with high needs, including special healthcare needs, behavioral issues, and experiences of trauma.

Despite progress within Head Start and Project LAUNCH pilot efforts, ECE stakeholders described insufficient mental health providers and lack of systematic consultation infrastructure. Among service respondents to the Project LAUNCH provider survey, just 16 reported providing IECMHC, and 38 reported that they maybe provide such consultation. Interview and focus group participants also noted a dearth of mental health expertise for infant and young children. Of those survey respondents who do or maybe do provide infant and early childhood mental health consultation, nearly half, 45%, reported that they were not able to get the necessary training in Montana. Yet the Project LAUNCH provider survey results also describe a strong potential IECMHC workforce in Montana, with nearly 300 mental

⁷⁹ Details on Montana initiatives using IECMHC in ECE settings are included in Appendix E: Workforce.

⁸⁰ The Center of Excellence for Infant and Early Childhood Mental Health Consultation, *Pilot Site Sustainability Assessment Report: Montana*, 2019.

professionals interested in providing consultation.⁸¹ This suggests opportunity to bring pilot lessons to scale and provide more comprehensive capacity statewide.

RECOMMENDATION: Continue to pursue opportunities to increase Infant and Early Childhood Mental Health Consultation capacity in the state. Several strategies could expand IECMHC, including increasing teleconsultation options, pursuing alternative funding streams to maintain IECMHC resources, and ensuring reflective supervision to optimize delivery.

Teleconsultation may support future mental health consultation capacity. Stakeholder respondents suggested that telehealth or teleconsultation can increase IECMHC capacity, especially across rural regions. Project LAUNCH implemented teleconsultation in one pilot site, and though the program was initially hesitant, stakeholders indicate successful implementation. A key to successful teleconsultation is building the relationship with initial in-person meetings with teachers and directors before transitioning to distance options. Any increase in teleconsultation approaches should be informed by and coordinated with a broader state/Department strategy for telecommunications utilization for workforce development and access improvements.

Alternative funding streams may help maintain and build IECMHC capacity in the state. As the Project LAUNCH grant winds down, stakeholders offered numerous suggestions for possible funding streams that have been used successfully in other states, including Medicaid reimbursement for preschool day treatment, mental health federal block grant, and the CCDF federal block grant.

In addition to strong training, reflective supervision is important to program fidelity. Stakeholders believe that ongoing reflective conversations are critical to successful implementation of IECMHC. As one stakeholder noted, “If we are going to roll out mental health consultation, it’s very important that they get reflective supervision—we don’t want to cut corners on this. This needs to be a part of the practice to implement with fidelity.”

Development of a trauma-informed ECE approach in Montana

As the state considers its structure to support prevention and early intervention services that support all families, including those with high needs, it is critical to develop a shared trauma-informed approach. A systemwide trauma-informed framework facilitates shared language, common outcomes, and mutual focus on families with high needs that may require dedicated support to prevent negative child and family outcomes. Child care is a primary point of interaction with families, and a common trauma-informed approach across the system can ensure consistency in context, care, and service.

Providing trauma-informed care in all early childhood settings is increasingly important as the pervasive impact of childhood trauma is recognized. To promote trauma-informed practices in education and care settings, all staff, including administrators, direct care staff, managers, and support staff must receive training regarding the impact of trauma. Clinical staff must be trained in trauma-specific treatments,

⁸¹ Project LAUNCH, *Infant and Early Childhood Mental Health Consultation Survey: Results Report*.

and providers must have an awareness of their own cultural attitudes and beliefs—and those of their students—to provide culturally relevant approaches.⁸²

Secondary trauma in providers may be common in early childhood education settings. Secondary trauma is a reaction to working with clients who have experienced trauma and mirrors Post Traumatic Stress Disorder (PTSD). Providers may also experience compassion fatigue, or a state of exhaustion as a result of prolonged exposure to compassion stress. They may also experience vicarious traumatization, or negative transformation in the provider resulting from engagement with student’s trauma and the provider’s sense of responsibility to help.⁸³

KEY FINDING: Additional capacity building can support delivery of trauma-informed care and attention to secondary caregiver trauma.

Multiple providers noted increasing awareness of trauma-informed strategies among educators, and cross-over in practices across agencies. For example, one provider noted a bridge between Head Start and CCDF programs in their use of a reflective practice framework to develop professional development courses or modules on trauma-informed approaches that can be embedded in courses throughout the state. Providers also remarked that Head Start has integrated trauma-informed care into their service delivery model fairly consistently, and said that Project LAUNCH has been increasing professional development and capacity building for schools around trauma-informed care.

Despite growing awareness, providers indicate that the level of implementation of trauma informed care varies greatly across communities and across ECE providers, and the overall system lacks trauma-informed care as a guiding service delivery structure. Some programs may have well operationalized trauma-informed strategies, while other have only cursory training without leadership.

Multiple stakeholders also noted overwhelming lack of acknowledgement and/or response to secondary trauma experienced by ECE providers working with vulnerable children. As one provider noted, “Head Start has handled trauma-informed care fairly well, but we’re still not processing secondary trauma among providers as well as we could.” Head Start providers report that secondary trauma will be an increasing focus of the program, and materials developed could be leveraged by the broader ECE sector. ECE stakeholders also described the need for a multigenerational approach to trauma-informed care but suggested that agency territorial or administrative issues hinder this comprehensive approach.

RECOMMENDATION: Develop a systemwide approach to trauma-informed delivery. Stakeholders observed a lack of a systemwide approach to trauma-informed care, and broad inconsistency on the level of awareness among direct providers. They also noted the need to define alternative ways to discuss protective factors and resiliency, since some communities are not comfortable speaking directly about trauma.

⁸² National Technical Assistance Center for Children’s Mental Health, *Trauma-Informed Care: Perspectives and Resources* (Washington, DC: Georgetown University, 2015), https://gucchdtacenter.georgetown.edu/TraumaInformedCare/TraumaInformedCareGU_postcard091515.pdf.

⁸³ Ibid.

Coordination

As introduced in the Context chapter, cross-sector system coordination can result in improved service delivery and better outcomes through coordinated assessment, referrals, and connections to services. In this chapter, we present findings and recommendations related to early childhood system coordination from the perspective of caregivers accessing services and from the perspective of providers working with families. The analysis includes family and provider perspectives on:

- **Developmental screening** practices.
- How easily families **navigate the system** to get their children the help they need, and how well providers **coordinate referrals**.
- How well providers **coordinate care** when working with the same family.
- How providers **support transitions** from service-to-service, with a particular focus on the transition to kindergarten.
- The extent to which agencies **share data** and are otherwise using integrated data systems.

While the chapter assesses coordination issues across the early childhood system, it is primarily focused on early care and education (ECE) settings. Additional findings related to coordination within family support and healthcare settings are presented in Appendix F: Coordination.

Developmental screening

In this study, we define developmental screening as tools used within an SBIRT-like process (Screening, Brief Intervention, and Referral to Treatment) to identify children’s needs early and connect them to services and supports. Screenings are often completed by parents in a primary care or home visiting setting or providers in an ECE setting. The Bright Futures/American Academy of Pediatrics recommends universal developmental screening at identified intervals. Their Periodicity Schedule recommends screenings at 9, 18, and 30 months with autism-spectrum screening recommended at 18 and 24 months.

Developmental screenings are to be distinguished from assessments, which are often conducted in response to a concern identified in a developmental screen. Assessments seek to obtain more in-depth child outcomes over time, demonstrating a child’s growth and development. They may be conducted by professionals trained in assessment and specific to a particular condition or developmental need, such as physical, behavioral, or emotional health.

The focus of this section is on the use of developmental screening in ECE settings, although coordination with screenings occurring in the primary care or home visiting setting is a widely recognized best practice.

KEY FINDING: There is opportunity for more consistency in screening tools used statewide.

There are many different screening tools in use statewide and many providers do not use a validated instrument. Figure 38 shows the most common screening tools used by providers participating in the

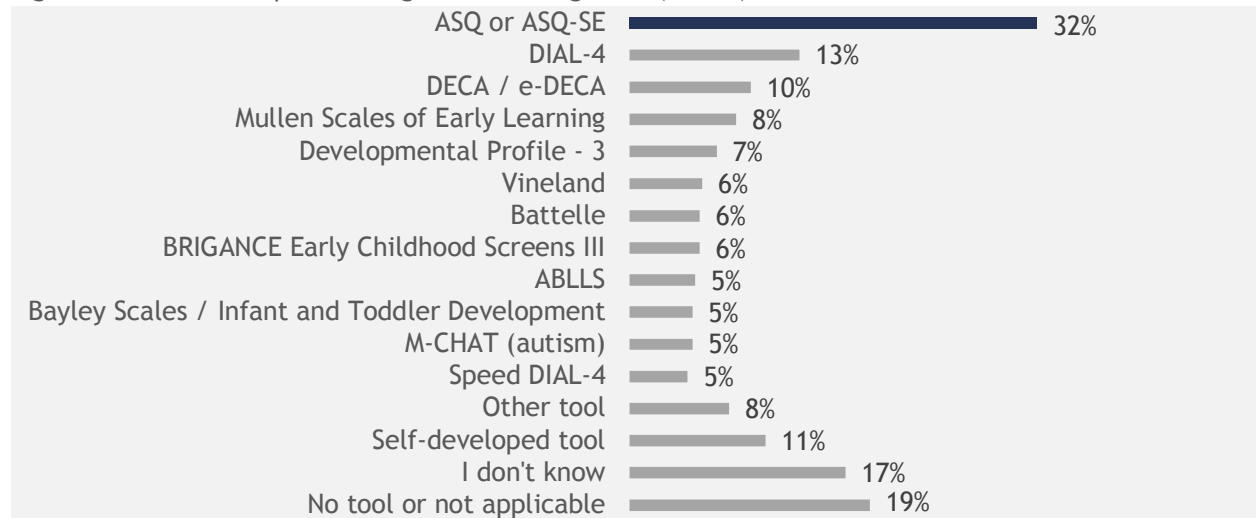
needs assessment survey.⁸⁴ Many different developmental screening tools are in use, including self-created (unvalidated) tools or informal assessments, and nearly one in five (19%) of provider survey respondents indicated they did not screen. Needs assessment participation from primary care was low, but qualitative input from healthcare providers suggests that pediatricians may be observing children during well child checks, looking for developmental “red flags,” but not necessarily administering or asking parents to complete a validated assessment.⁸⁵

Providers consider the lack of consistency in screening tools used to be the biggest challenge with respect to the current state of developmental screening. Different provider types (e.g. home visiting, ECE, Part C) may be screening children and not sharing results and/or using different tools, which makes a coordinated service and support response challenging. Stakeholders mused that a consistent tool may support improved family engagement in screening and any follow-ups needed.

ASQ is the most commonly used screening tool. Despite the lack of consistency in uptake and tools used, providers use the ASQ or ASQ-SE at a rate nearly three-times as high as the next most frequently used tool (DIAL-4 at 13%). Further, the ASQ was positively rated by STARS providers (see Appendix F: Coordination for these results) and the ASQ is relatively quick to administer, taking about 10-15 minutes for caregivers to complete and 2-3 minutes for professionals or program staff to score, which addresses providers’ identified concern of screening being too time-intensive (see Figure 39).⁸⁶

THE MOST COMMONLY USED SCREENING TOOL IS THE ASQ / ASQ-SE

Figure 38. Provider-reported usage of screening tools (N=519)



Source: Montana PDG B-5 Needs Assessment Provider Survey

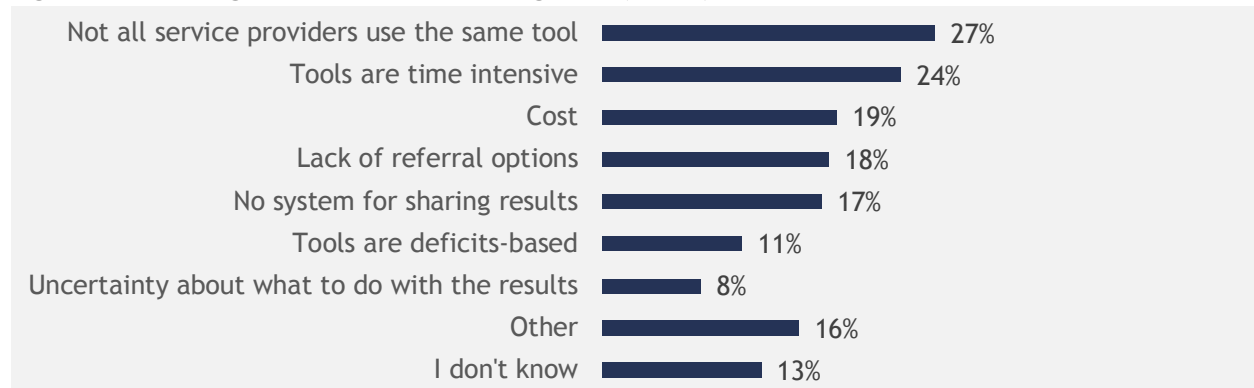
⁸⁴ The following screening assessments, not included in Figure 38, were used by 5% of provider organizations: ABLLS (Assessment of Basic Language and Learning Skills), Bayley Scales of Infant and Toddler Development, M-CHAT (autism), and Speed DIAL-4.

⁸⁵ BBAC Advisory Council Meeting, April 23-24, 2019.

⁸⁶ *Ages & Stages Questionnaire*, Paul H. Brookes Publishing, Accessed on September 17, 2019, <http://support.agesandstages.com/kb/article/262-how-long-does-it-take-to-administer-asqse2/>.

LACK OF CONSISTENCY IN SCREENING TOOLS USED IS BIGGEST CHALLENGE

Figure 39. Challenges with current screening tools (N=332)



Source: Montana PDG B-5 Needs Assessment Provider Survey

RECOMMENDATION: Adopt the ASQ/ASQ-SE as the preferred developmental screening tool statewide. The critical mass of ASQ/ASQ-SE users, combined with the positive attributes of the ASQ and provider motivation for consistency in screening tools, could provide an entrée for the statewide adoption of the ASQ/ASQ-SE as the preferred screening tool. Some providers interviewed expressed frustration with “homemade” or frequent changes to tools and assessment. Selection of the ASQ/ASQ-SE, as a validated tool, and a commitment to using the tool for an extended period, would address this concern. The state can take steps to encourage the use of the same tool by all early childhood service providers, including health care providers, home visitors, and ECE providers. Montana’s early childhood service agencies can consider incentivizing the administration of a consistent tool by: providing manuals, training, training videos, and/or technical assistance to providers; and covering ASQ/ASQ-SE assessment costs for a defined period of time, particularly for family-based child care providers which may have more limited resources.

KEY FINDING: State falls short of universal developmental screening.

Developmental screening rates in early childhood service settings – including ECE, home visiting, and primary care – are well under the goal of universal screening. Just 27% of parents participating in the needs assessment whose child was in ECE in the past five years reported that the ECE provider screened their child for developmental delay.⁸⁷ Among ECE providers responding to the survey, most (69%) indicated their agency used a tool, either validated or self-created, to screen children.⁸⁸ The reported higher rate may signal that providers are assessing children without clearly communicating this to parents, and/or not asking parents to complete a tool, such as the ASQ. Without a developmental

⁸⁷ The figure was higher for families participating in home visiting (59%) or who had visited a primary care doctor in the past five year (52%). For more needs assessment results on screening in the healthcare and home visiting settings, see Appendix F: Coordination.

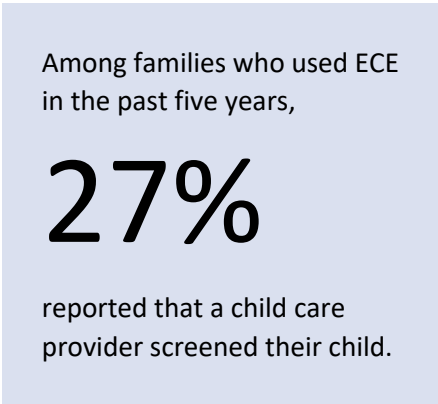
⁸⁸ This calculated percentage may include duplication if respondents from the same organization responded to the survey.

screening registry or clear requirements for conducting screenings, children may be screened multiple times, or not at all. Outside of specific programs, such as Head Start, these data are not available.

Needs assessment participants noted the negative impacts of an early childhood system that does not universally screen young children. As one provider explained, if a child has needs that aren't caught before age three, they miss the Part C funding and then it can take a long time to connect to Part B services. *"It's those kids who fall through the cracks and a lot of those kids are some of your most vulnerable, they may have parents with challenges themselves who wouldn't know how to advocate [for Part B services]."*

Tools are time intensive and costly. Some providers felt that administering screening tools is time intensive and costly, which may contribute to spotty administration.

Some providers cited a lack of referral options and no system for sharing results (Figure 39). This lack of clarity around what to do with results may make it challenging to take the next step from screening to further assessment and/or referrals. Or it may disincentivize providers from doing a screening in the first place if they don't feel they will be able to do anything with the findings.



RECOMMENDATION: Conduct further research on ways Montana can track rates of screenings at the recommended intervals and reduce duplication. Among research activities, investigate the feasibility of a statewide developmental screening registry, which would record screening frequency, intervals, findings, referrals (if needed), and connection to services for each child. A screening registry is a key strategy used by many states to track screenings across different settings and ensure families are getting connected to services. This helps reduce duplication – or omission – of screening, as well as provides policymakers with data that enables them to understand how well they are making progress toward universal screening and getting the children who need intervention into services. States use different strategies to implement statewide developmental screening registries, including Help Me Grow, QRIS, or other resources. Further research may include best practices for successful deployment and use of a developmental screening registry, such as pairing it with existing statewide immunization registries, building into an agency's data system integration and expansion plans, and ensuring that healthcare providers are reimbursed adequately by public and private insurance plans (and informed the reimbursement is available). Investigate alternative strategies to improve tracking of developmental screenings in the event a developmental screening registry is not preferred or feasible in the foreseeable future.

RECOMMENDATION: Increase public awareness for parents, as well as providers, regarding the importance of developmental screening. Informed and engaged families and providers are more likely to request screenings from the providers they work with. Various strategies can be employed to increase public awareness, such as community health workers conducting outreach, maternity ward providers sharing information with new parents, and billboards and other print collateral. Conduct further research into effective campaigns.

RECOMMENDATION: Offer technical assistance on Part B and C eligibility and referral pathways for healthcare providers. Provide information and training on how and where to refer, particularly concerning developmental and mental health screening results.

KEY FINDING: ECE providers can play an important role in increasing the rate and quality of developmental screening.

In focus groups, providers discussed the increased use of developmental screening tools in ECE settings. While pediatric care settings are a natural place to promote universal developmental screening, since nearly all children access medical care, in focus groups, providers and parents discussed the limitations of pediatricians and primary care providers in terms of interpreting and acting on the results of developmental screenings. As one mental health provider explained, *“People, including some providers, don’t know what is/is not appropriate within infant or early childhood mental health. For Child Find, I get no mental health referrals or social-emotional referrals.”* A few parents shared experiences of pediatricians not catching developmental delays and *“red flags”* thus not being identified. ECE providers, as well as home visitors, have an advantage in that they observe children closely over a longer period of time than clinicians in a primary care setting, which could reveal previously undetected issues.

Head Start is viewed as a leader in terms of developmental screening administration. As one parent explained, *“Our Head Start teacher was the first one that made me feel like I wasn’t crazy...I love teachers that can sit there and say, ‘okay, we’re seeing it too, you’re not crazy.’”* Additionally, ECE providers must comply with federal law (IDEA/Child Find) that requires them to have process for identifying and evaluating children for developmental or academic delays. Providers also discussed how helpful it has been for some ECE providers to receive training through the CRRs in the use of certain assessment tools to at least provide initial screenings.

We’ve been able to—and I know Head Start does, too—implement screening, using tools like the DECA or the ASQ in the child care setting, so that we are recognizing children’s needs earlier on, not just when they get into school or later, much later. - ECE provider

Public school settings can be a limited stop-gap for previously unidentified developmental concerns. In focus groups and interviews, providers and state-level administrators highlighted the opportunities and challenges with screening and assessment for children ages 3 to 5 in public school settings. Some communities are implementing screenings during their kindergarten roundup events, to identify needs before children enter the classroom. This is helpful in terms of tracking children into Part B services and developing IEPs when appropriate. However, public schools should not be considered a primary provider of developmental screening because their scope is limited; they are only focused on developmental concerns that impact learning and they cannot diagnose. As one provider explained, parents don’t always understand that *“as a school, we have to do what is educationally relevant. I think*

there is a lack of understanding because we can't do the medical piece at school...and [...] actually identify if a child has special needs. Not everyone can give a child a diagnosis."

RECOMMENDATION: Implement lessons learned from the Head Start and LAUNCH models to increase developmental screening in ECE settings. Scaling developmental screening in broader ECE settings should be informed by lessons learned from Head Start ([link to Head Start policies and regulations pertaining to screening](#)) and see Appendix F: Coordination for additional data from Head Start on screening and assessment program information) and Project LAUNCH, which expanded use of ASQ/ASQ-SE as a screening tool across early childhood providers. Non-Head Start/non-LAUNCH ECE providers can use this model and these lessons to guide their own screening processes. Alternatively, providers can administer screening tools before, during, and at the end of a child's tenure in a program, not only as a way to screen the child for developmental or socioemotional needs, but as a way to begin a conversation between the family and the ECE provider. As a starting point for ECE providers that are new to screening, screening could be added as a regular part of the enrollment protocol.

RECOMMENDATION: Provide professional development and technical assistance to ECE providers on how to screen children and what to do if a need is identified, from how to talk to parents to how to refer for services. Implementation of this recommendation can be linked to the recommendation for enhanced and expanded care coordination by training ECE providers on how to connect families to system navigators or care coordinators, and how to stay involved in care coordination once referred. Increased supports for ECE providers to better serve children with special needs, including scaling of IECMHC, may include a focus on developmental screening.

System navigation, referrals, and care coordination

A high-functioning early childhood system is one that reaches families with the help they need, where there is “no wrong door” for families seeking services, and where services and supports are coordinated among the various providers. The ultimate goal is improved outcomes for children and their families. The need for coordination is highly relevant to many families. Needs assessment results show that cross-sector service use is common – fully 55% of needs assessment family survey respondents (N=651) indicated they worked with more than one organization to get the help their child needed. In focus groups, families (as well as providers) talked about three related but distinct steps in the path to getting and using services across the early childhood system: 1) identifying and orienting to resources (system navigation); 2) accessing specific services, either through referrals or parent-directed outreach; and 3) participating in those cross-sector services over time. Overall, families in the focus groups expressed a need for more information for themselves and for point people who can support parents as they navigate the system. They also expressed a need for more support managing care when many different providers are involved, particularly at periods of transition from one agency's care to another, or when service needs are especially complex.

KEY FINDING: Lack of up-to-date, comprehensive, and centralized information about early childhood services hinder both assisted and self-directed system navigation.

Across communities, families, and specific types of needs, the consistent message is that it is very hard to find information because people don't know where to look and there are not centralized resources.

While some families prefer to find out information on their own, many parents expressed how nice it would be to have a person help them navigate the system. Many focus group participants highlighted that there could be more effective use of social media, Facebook, or text message-based reminders.

Pediatrician's offices provide an opportunity for the dissemination of a comprehensive resource guide for the benefit of families, but also providers. Families and providers noted the missed opportunity of not providing more comprehensive resource guides through pediatricians' offices, since the majority of families interact with the health system. A few communities are using the 211 system to maintain updated resource guides, and many others talked about how useful the Project LAUNCH resource guide has been. These resources can help families navigate the system themselves, but they are also important sources of information for providers. Providers noted that it is hard for them to keep up with all of the possible resources that are out there, which emphasizes for them how hard it must be for families to navigate the initial stages of system engagement: *"If we don't know about them as professionals, how will families know about them?"* Families confirm this gap in provider knowledge influences their ability to get needed referrals from pediatricians: *"They do care, at the least the doctors I have had. They care and they tried to help, but they were very limited in knowing what to do [in this case, for an autism diagnosis]."* With better information, providers would have knowledge of a wide range of resources that they can recommend in targeted ways to specific families when appropriate, either in-person or through electronic media.

Parentingmontana.org and the state's early childhood portal are being improved and expanded. Through this grant, the state is building out parentingmontana.org with information for 0-4 year olds and enhancing the early childhood education portal to share information about state programs and quality ECE. These can be great resources for families with Internet access.

RECOMMENDATION: Improve up-to-date and available early childhood service resource information for families and providers. Consider the following strategies:

- Work with and capitalize on existing information resources such as Project LAUNCH.
- Hire specialized information coordinators to keep information up-to-date and disseminated at the local level.
- Disseminate information in new baby packets sent home with parents after the birth of a child and/or at well-child visits.
- Use texting and social media communication strategies, while recognizing that not all families have Internet access.
- Take steps to keep the providers who work with families up-to-date on resources available and eligibility criteria, since busy families may still need assistance with navigation in spite of clear resource guides (e.g. ensure maternity ward providers know about home visiting resources so they may refer families; ensure primary care providers know what early intervention resources are available).
- Invest in the best practice of universal post-partum, in-hospital family screening (bedside screens) to share information and determine the need for home visiting services.
- Explore additional creative methods and venues for information sharing should be explored (dentist offices, grocery stores, billboards).

RECOMMENDATION: Analyze approaches to supporting early childhood system navigation for families needing connections to multiple agencies or programs. Consider piloting system

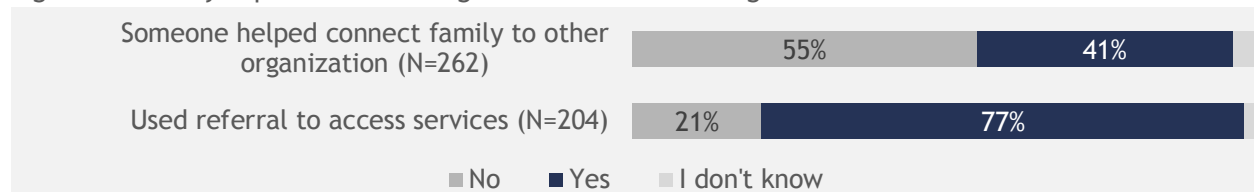
navigation positions in selected early childhood system sectors that do not already have system navigators. For example, families accessing only EPSDT or child care subsidy services do not have case management or care coordinator services available to them, but they may benefit from support navigating the broader system. Some stakeholders recommended using a single point of entry model alongside the navigator role. Others see the navigator as independent – regardless of the door a family enters the system through, everyone is connected to a navigator.

KEY FINDING: More often than not, families working with more than one organization report that they did not receive referrals between the organizations, but providers report that they usually provide them.

There is a disconnect between families and providers in terms of perceptions about referrals. As shown in Figure 40, 41% of families working with more than one organization reported that someone helped them get connected to another organization (for example, by referring them to the organization or getting them an appointment).

ONLY 41% OF FAMILIES REPORT SOMEONE HELPED CONNECT THEM TO ANOTHER ORGANIZATION

Figure 40. Family experiences working with more than one organization

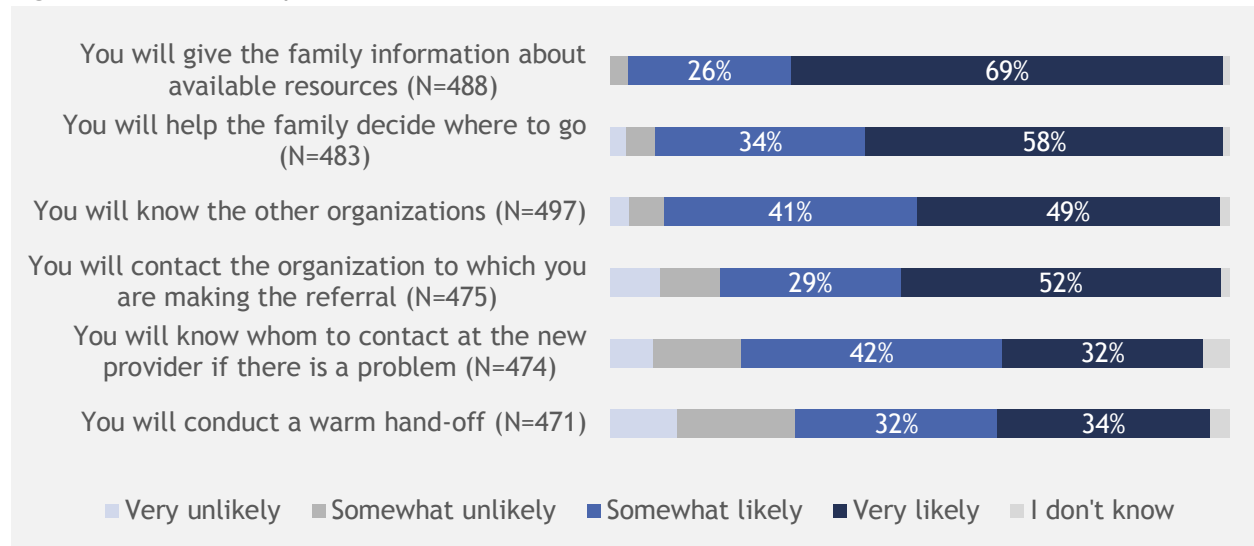


Source: Montana PDG B-5 Needs Assessment Family Survey

Interestingly, providers report they are more likely to provide this type of referral assistance (Figure 41). For example, providers were given a scenario in the survey in which a family in their care needs services outside of their organization, or ages out of services. In this scenario, most providers indicated they would give the family information about available resources (95%) or help the family decide where to go (92%). Most (82%) said that in this scenario, they would also contact the other organization on behalf of the family. Fewer said they would conduct a warm-hand off, such as accompanying the family to the new provider, or getting everyone on the phone together.

PROVIDERS LIKELY TO GIVE INFORMATION; “WARM HANDOFFS” LESS LIKELY

Figure 41. Provider responses to referral scenario



Source: Montana PDG B-5 Needs Assessment Provider Survey

The disconnect between family perspectives and provider perspectives on referrals may stem from different expectations and definitions of what constitutes a referral. To a provider, a “referral” may be defined as offering the family a business card or name of an organization for the family to contact. Whereas families may consider a “referral” something that is more akin to a warm hand-off, where the current provider calls the new organization, sets up an appointment for them, and/or helps them fill out forms. The disconnect may also stem from families’ seeking out their own services, without provider assistance.

RECOMMENDATION: Clarify for providers what constitutes a referral while taking steps to move providers toward the best practice of a warm hand-off, particularly for vulnerable families. This recommendation can be paired with the recommendation under Developmental screening to provide technical assistance to ECE providers on their role in screening and resources available for referral, as well as care coordination recommendations below.

KEY FINDING: When a referral is made, families reported using the referral and finding it helpful.

The vast majority of families found referrals helpful. While there were inconsistencies between family and provider survey responses with respect to the frequency of receiving a referral, when a referral was made, fully 77% of families said they used the referral to access services and 95% found the referral to be helpful. However, the ease with which families access services – or providers refer to services – varied somewhat by the type of service they were seeking.

Overall, families encounter the most difficulties accessing service referrals made as a result of child and family services

Families reporting that a referral made by a provider was very or somewhat helpful:

95%

involvement and early care and education, while providers have difficulties referring and coordinating with child and family services and mental health care. Appendix F: Coordination provides needs assessment detail on the ease or difficulty families encountered in accessing specific services to which their child was referred. Families reported that it was most difficult accessing services from child care providers (36% had difficulty) and child welfare (25% had difficulty). These results were largely the same for families who did or did not have a child in the vulnerable group (see page 15 for the definition of vulnerable). It is probable that families indicating difficulty with child welfare referrals may be indicating challenges with connecting to services to which Child and Family referred the child and family. For providers, the survey revealed it was most difficult to refer and coordinate with mental health care providers (32% had difficulty) and child welfare (26% had difficulty). Head Start service referral data show a 117% increase between 2014 and 2018 in the number of families referred to mental health services and a 259% increase in the number of families referred to child abuse and neglect services.⁸⁹ Focus group participants also noted challenges with referrals from the Indian Health Services.

The triple-digit increases in referrals to these services by Head Start provide a clue to the underlying reality that some of the referral difficulties result from increased demand, inadequate supply, long waitlists, and staff workload. Some of the difficulty may also be related to ineligibility or inadequate insurance coverage. But some of the challenges may be due to broken or non-existent cross-sector referral pathways. For example, some ECE providers noted that they are comfortable telling parents that they feel their child should be assessed for developmental delay, but they see referring directly to the healthcare provider as outside of their role. Other ECE providers thought it would be very nice to be able to reach out to specific providers, especially mental health and developmental specialists, to learn how to provide support in the ECE setting. Most ECE providers expressed a desire for something in the middle of these two options, with the ability to provide families with referrals to the health system that are appropriate and formalized, and that do not put additional burden on the ECE provider.

Regardless of cause, referral difficulties can lead parents to give up, which is why seeking out root causes behind the difficulty accessing services is important.

RECOMMENDATION: Conduct further research to determine the root causes behind the difficulties accessing services within, or referring to, different sectors, with a particular focus on Child and Family Services-referred services, mental health, early care and education, and Indian Health Services. Determine whether the results point to insufficient access to services, insufficient resources, broken referral pathways for families and/or providers, family/provider education/awareness, or some other cause. Couple this research with the exploration of care coordination and cross-sector electronic referral and data systems (see recommendations below).

KEY FINDING: Cross-sector care coordination is rare, but when in place and done well, it is valued by families and providers alike.

When a need is identified, families are often on their own to manage their child's care across different providers. Care coordination, especially when families need services from different agencies or providers, is rare – but needed. Needs assessment participants discussed children and families

⁸⁹ For more information on TANF and Head Start service referrals, including types of referrals and trends, see Appendix F: Coordination.

interacting with multiple case managers, care coordinators, resource and referral coordinators, family engagement coordinators, and home visitors and resultant issues including families not receiving needed services, family experiencing confusion, fatigue, and frustration, and providers also experiencing confusion and frustration.

In focus groups, families discussed how beneficial it was to have ‘point people’ whose job requires them to know all of the possible resources and the basic eligibility requirements or appropriateness of specific services for specific needs. As one parent explained, *“There almost needs to be an ombudsman.”* But, this type of cross-sector case management is not generally available.

In absence of comprehensive case management, some families reported using Offices of Public Assistance as point people. Others have relied on family support specialists in public preschool settings, case managers in organizations that support children with special needs, and case workers in pediatricians’ offices. The common thread from families is that they appreciate having individuals whose jobs are dedicated to being ‘in the know.’ However, many providers, especially those in the ECE system, noted that it is difficult for providers who have some other primary responsibility to take on much in the way of coordination. Consequently, in most communities, if cross-sector care coordination is happening at all it is because there are dedicated case managers who take on that role.

One challenge for implementing cross-sector care coordination is how to pay for it when there are many different funding streams and/or no discrete funding available for care coordination. Several focus group participants spoke about creative solutions to overcome this barrier. For example, reducing “no shows,” which are costly for programs, is one benefit of care coordination and could help backfill care coordination costs.

Another significant challenge is the limited scope of most cross-sector care coordination. Needs assessment stakeholders reported that care coordination is often siloed, where two agencies recognize the need to collaborate, but not all of the agencies a family works with are included in the care coordination. A comprehensive care coordination model requires holistic family assessment so that the full range of family strengths and needs can be taken into account. This approach may require interfacing with agencies typically considered outside of the early childhood system, such as substance use disorder services, adult mental health services, or criminal justice.

A renewed commitment to cross-sector case management, particularly for vulnerable families, could help Montana make progress on Code 52-2-301. [Montana Code 52-2-301](#) calls for the state “to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available.”

Lessons learned from several models of cross-sector care coordination could be used to craft an expansion.

- KMA (Kids Management Authorities) was a federal grant-funded initiative from the early 2000’s which provided wraparound case management services for children with serious emotional disturbance. KMA was grant funded, which impacted its longevity. A thorough review of the

program in 2010 identified specific challenges that could be addressed in any sort of redeployment.⁹⁰

- OneHealth in Miles City is an example of integrated healthcare and family support services, and their merge with other federally qualified health centers (FQHCs) has increased the potential for integrated and coordinated care.
- A foster child health program in Missoula, Great Falls, and Billings, originally called Follow the Child, connects public health nurses to children when they enter the foster system to establish a medical home. Missoula's program is now considered a promising practice. The program has struggled with funding sustainability, and services stop with reunification or adoption. Additional research could be done to explore continuity of services, perhaps through home visiting.

RECOMMENDATION: Encourage the use of a common, expanded social determinants of health family screening and assessment tool, similar to the TANF Family Bridge model,⁹¹ to understand the breadth of child and family needs. Care coordinators should be charged with knowing the associated resources available to local families and ensure connections to needed services occur. This would be aided by the implementation of the recommendation to improve up-to-date service information.

RECOMMENDATION: Increase access to, and quality of, cross-sector care coordination for young children and families. Cross-sector care coordination improvements will need to be part of a broader effort on the part of local and state early childhood systems to take steps to identify opportunities to improve connections, such as between ECE and primary care, or ECE and early intervention services, or child welfare and any other service. This could occur through several different or parallel strategies. Consider the following:

- Pilot system navigation positions in selected early childhood system sectors that do not already have system navigators. When a family enters the system through any door, test whether they will be helped to get the services they need, even if those needs are within a different organization (also recommended above in system navigation).
- Pilot cross-sector care coordination positions in selected early childhood system sectors that do not already have care coordinators to manage care on an ongoing basis for families – particularly vulnerable families – participating in services with more than one agency. Ensure a broad, social determinants of health perspective that, if needed, would bring into the care coordination agencies typically viewed as outside of the early childhood system.
- Clearly define care coordinator roles and responsibilities, possibly centralizing care coordination in complex cases. In cases where multiple people are charged with coordinating, managing, or otherwise overseeing service provision, there should be clarity in who does what, including which provider is ultimately responsible to ensure

⁹⁰ John Talbot, *System of Care Report to the Montana Legislature Report & Recommendations as Recommendations as Required by House Bill 243*" (Gettysburg, PA: Open Minds, 2010), leg.mt.gov/content/Committees/Interim/2009_2010/Children_Family/Meeting_Documents/August%202010/hb243-report-powerpoint.pdf.

⁹¹ See Appendix F: Coordination for more information on the TANF Family Bridge model.

the child's/family's full needs are met in a tiered system. For example, an algorithm could be developed, such as "if x, y, and z services are used, provider z is responsible for broad-based coordination." Improved information technology through the MPATH (Montana Program for Automating and Transforming Healthcare) project could allow for one "master" care coordinator who has a holistic view of children's needs and services to more effectively and efficiently manage all of the child's needs. This could be a large efficiency gain for families, providers, and the state in cases of children with complex needs accessing services and supports from a variety of programs. "Centralized" or "master" care coordination could be piloted for a subset of children with complex needs and/or in a community or region. This is an area for additional research. The reinstatement of targeted case management services provides an opportunity to pilot possible approaches.

- In any care coordination deployment, consider lessons learned from the implementation of the [Kids Management Authorities](#) (KMA). For example:
 - Identify a stable funding source for wraparound case management services.
 - Identify strategies to overcome barriers to funding for services for children receiving services from multiple agencies which are funded by different funding streams that may have their own rules, including prohibitions to blend funding.
 - Implement at the local level with sufficient state support to ensure fidelity to the model and to realize economies of scale, while also being responsive to local needs and preferences.
 - Employ strategies to increase attendance at interdisciplinary team meetings by providers with authority to make funding and care decisions.
 - Codify the program in agency- and systemwide practice so that a change in leadership or staff would not disrupt program implementation.
- Consider expanding the foster child health program from Missoula, Great Falls, and Billings for children/families in the child welfare system.

KEY FINDING: There is limited utilization of Medicaid-funded, school-based medical services.

Medicaid can fund school-based services. Schools can bill Medicaid for allowable school-based medical services for Medicaid-eligible children ages 3-20 receiving special education services through an individualized education plan (IEP). These services may include, but are not limited to, physical therapy, occupational therapy, speech pathology or therapy services, psychological counseling, nursing, and eligible transportation services. Services do not need to be performed by Medicaid enrolled providers in order to bill for these services. Interview findings reveal that approximately half of Montana school districts do not participate in this program.

Cost is a barrier for school districts. The primary reason cited for why schools do not participate is because of the resource investment required to file claims for Medicaid services. Some school districts contract out to private or nonprofit billing service providers to file their claims or do so through their special education cooperative. Larger school districts will bill out of their billing office for all of their schools. Others decide the cost is not worth their effort, particularly when serving a small number of children in their district.

Complying with privacy laws is a barrier. A secondary reason is concern over sharing information between the Office of Public Instruction (OPI) and Medicaid. The school district (if they are doing the billing themselves) or the billing contractor need to be able to show they are compliant with the Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

Tribal education agencies tend to have lower utilization of school-based Medicaid services. The source of this underutilization may be lack of awareness that they can access this Medicaid funding, and/or trying to operate with Indian Health Services funding rather than access Medicaid. Concerns over the cost of billing Medicaid and/or privacy requirements may be other factors contributing to the low utilization.

RECOMMENDATION: Provide support to increase billing of Medicaid for eligible school-based services. There is an opportunity for DPHHS, OPI, and tribal education agencies to collaborate to support the cost of billing Medicaid for eligible services/students. This will allow for more children with disabilities to be served in schools and provides a funding match opportunity for agencies.

KEY FINDING: Early childhood agencies working with homeless or housing insecure families operate under different definitions of “homeless,” leading to underutilization of services.

Homeless definitions vary in their inclusion of families sharing housing. There are different federal definitions for homelessness used by agencies within Montana’s early childhood system, which causes confusion when a housing-insecure family is attempting to access services from agencies with different definitions. The two definitions are similar except that U.S. Department of Housing and Urban Development’s (HUD) does not include families living doubled- or tripled-up with another family due to economic hardship as being homeless, while McKinney-Vento does. Most ECE programs (Head Start, CCDF, and OPI) use the definition for homelessness codified in the McKinney-Vento Homeless Assistance Act of 1987 (McKinney-Vento). CFSD is responsible for assessing the safety of children. Housing conditions can vary greatly without CFSD formal intervention. Understanding the different definitions of homelessness and resources available to children and families is essential to improving outcomes for children. If a CFSD caseworker receives a call about a potential homeless child and determines s/he is not because of being doubled up, there is not a process to refer the child to the school for homeless/stability services.

RECOMMENDATION: Improve CFSD-OPI coordination related to homelessness. Child and family services caseworkers could call schools when they see a child meeting the McKinney Vento homeless definition and a homeless liaison could be used to help alleviate the stress, and hopefully prevent further child welfare involvement. Housing coordinators can connect children and families to broader supports throughout school and the community. An automatic referral process could be used to ensure school homeless liaisons are contacted whenever children are investigated in the child welfare system to support connection to prevention, early intervention, and family support community services.

RECOMMENDATION: Conduct further research on whether homelessness definitions could be aligned. If the state has an option of which homeless definition to use within its early childhood system programs, it should select a common one that best serves the interests of children and families experiencing homelessness or housing insecurity.

Transition support

Smooth transitions to kindergarten are a key component of kindergarten readiness. The transition from preschool to kindergarten is supported by making personal connections, aligning practices, engaging authentically with parents in the planning process, and sharing child data. Kindergarten readiness assessments (KRA) provide a method for teachers, service providers, parents, and policymakers to monitor kindergarten readiness statewide, improve practices at the school-level, and determine appropriate instruction for individual children. For additional detail on kindergarten transition and assessment best practices, see Appendix F: Coordination.

This section discusses needs assessment findings and recommendations pertaining to kindergarten transitions and kindergarten readiness assessments, specifically. To a lesser extent, we present findings related to provider and family experiences with transitions more broadly, including transitions between different agencies or services.

KEY FINDING: Some families feel “dropped” when their child ages out of services or they need to access services from another agency.

The shift of services when a child transitions (because of age or change in needs) – due to different laws, agencies, and funding governing the child’s services – can be abrupt for both families and the child.

Needs assessment survey results reveal that most providers (64%) work with families to soften the transition, but not all families get this support. A significant barrier is who is responsible for a child at a specific age; unless transition services are explicitly funded and allowed, it is difficult for an agency that is responsible for a child up to a certain age or within a certain program to participate in transition meetings or services with the child outside of their explicit scope of responsibility.

KEY FINDING: Certain kindergarten transition best practices have been widely adopted, while others are yet to be widely implemented.

Meeting the kindergarten teacher and visiting the classroom is a near universal practice. Nearly all parent survey respondents that had a child transition to kindergarten in the past five years reported that they met their child’s kindergarten teacher (89%) and visited the classroom (87%) before their child started (Figure 42). Home visits by the kindergarten teacher or individual visits to the kindergarten classroom by the family were cited by parents in focus groups as important for smooth transitions.

According to parents, formal transition plans are rare, but providers report otherwise. Most ECE providers indicated they create individualized transition plans for children “always” or “usually” (60%), while less than a quarter (24%) of families reported they had a formal transition plan for their child. The disconnect may point to definitional differences; what providers consider a transition plan may be different from what parents consider a transition plan. Or it may signal the need for more robust, authentic family engagement practices. Fully 70% of ECE providers report “involving families closely in transition process...through collaborative planning” (see Figure 43), but these efforts may be lost on families; less than half of family respondents (49%) indicated they participated in a transition meeting (see Figure 42).⁹² Stakeholders participating in a needs assessment meeting focused on transitions

⁹² See Appendix G: Family Engagement for more detail on family engagement needs assessment results.

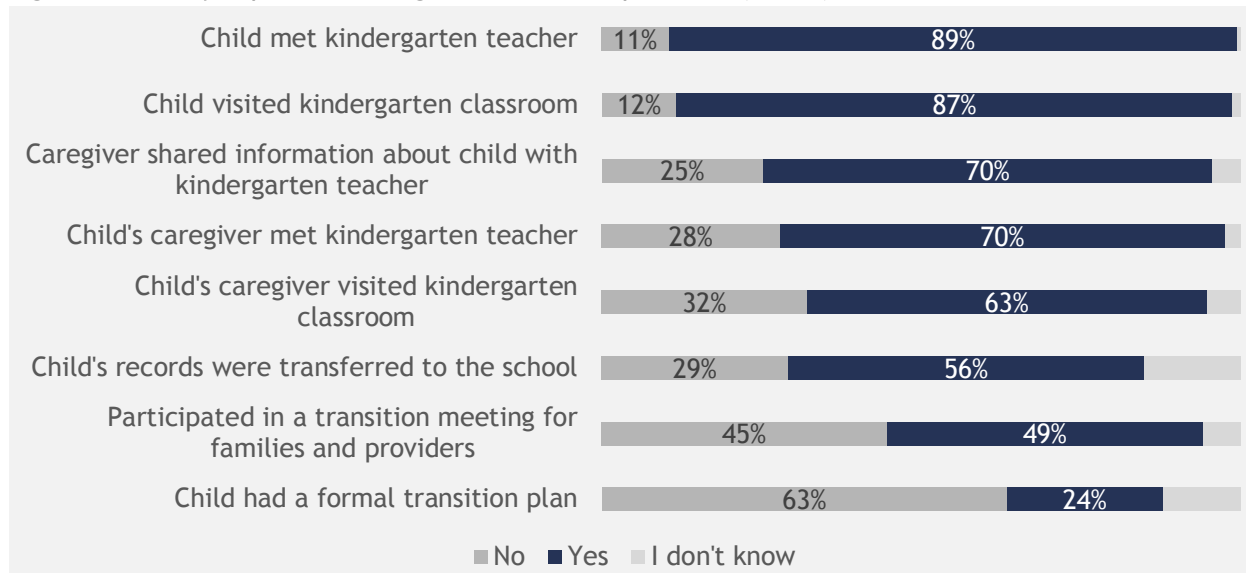
confirmed these findings, stating that family engagement in the transition process is challenging and inconsistent.

Providers recognize the need to engage in additional kindergarten transition planning efforts for vulnerable families. While the extent of formal transition planning occurring remains unclear, providers appear somewhat more likely to report that they create transition plans “always” or “usually” for a child who may be struggling (68%), compared to 60% for all children. These provider perspectives were supported by the family survey. There were two significant differences in kindergarten transitions reported by families whose child had a vulnerability compared to those whose children did not have a vulnerability (see page 15 for the definition of vulnerability): children with one or more vulnerability were more likely to have a formal kindergarten transition plan (28% vs. 19%) and were more likely to have records transferred to the school (64% vs. 45%).

Kindergarten transition best practices that have yet to be adopted widely include those around continuous quality improvement and alignment of ECE and K-12 programs (see Figure 43). Members of the Best Beginnings Advisory Council (BBAC) developed the BBAC Kindergarten Readiness Tool, currently in draft form, which includes the best practices listed in Figure 43 and other best practices for smooth and successful kindergarten transitions (see following Key Finding).

MOST CHILDREN VISITED THE KINDERGARTEN CLASSROOM PRIOR TO ENTERING KINDERGARTEN

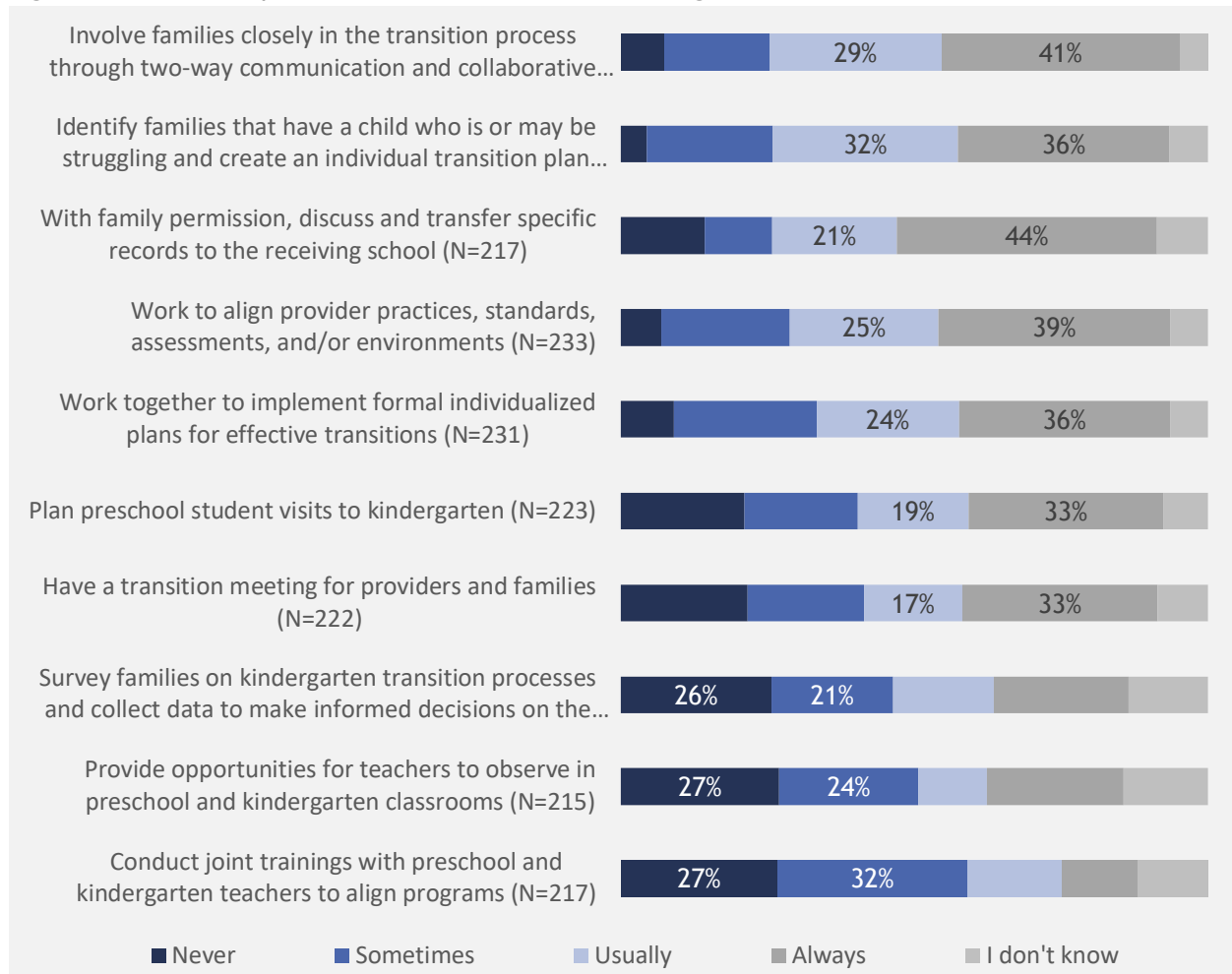
Figure 42. Family-reported kindergarten transition practices (N=352)



Source: Montana PDG B-5 Needs Assessment Family Survey

PROVIDERS REPORTED INVOLVING FAMILIES AND DEVELOPING TRANSITION PLANS

Figure 43. Transition practices for the transition to kindergarten



Source: Montana PDG B-5 Needs Assessment Provider Survey

RECOMMENDATION: Work with communities to take steps to expand the types of transition best practices in place. This could include taking steps to bridge the gap between ECE and K-12 through language, culture, communication, and professional development efforts. For example, in terms of language, adopting the term “P-12” rather than “K-12” can help ECE and school districts view a child’s education as an integrated continuum from early care to high school graduation. Cultural barriers include the perception of lower status of ECE teachers compared to primary school teachers, evidenced by lower pay among ECE teachers. These perceptions can impact the value school districts place on working collaboratively with ECE providers. Integrated professional development is a strategy that can positively impact a child’s school readiness and transition to kindergarten, as well as push back against negative perceptions. An important first step toward implementing these strategies to bridge the gap is increased awareness of transition best practices; early care and education serving agencies can play a role in communicating transition best practices to ECE and K-12 providers. Other transition best practices are included in Appendix F: Coordination.

KEY FINDING: Montana lacks a statewide kindergarten readiness assessment (KRA) and transition process.

Montana is among the 17 states as of 2018 that does not have a kindergarten readiness assessment specified in statute, regulations, or policies.^{93,94} Locally, many regions and programs conduct developmental screenings, but few implement KRA.⁹⁵ Some schools and school districts have developed transition processes, but there is no statewide standard. However, there is progress being made in these directions. First, the state defined the 2015 Montana Early Learning Standards (MELS), which includes domains aligned with many kindergarten readiness definitions, including: emotional and social development; physical development; communication; and cognition. Second, the state is taking strides in the area of kindergarten readiness outreach to families and caregivers. The BBAC developed the draft Kindergarten Transition Tool which is “intended to be a reference for those supporting school readiness. It is written for families, communities, early learning programs, and schools.”⁹⁶ The tool is designed to align with the MELS. OPI has also developed transition materials. Further, some communities are piloting kindergarten entry/readiness assessments and processes including piloting of the Kindergarten Observation Form in Missoula and a home-grown tool and process in Kalispell.

RECOMMENDATION: Leverage existing resources including kindergarten transition pilots, draft transition tools, best practices, and Head Start materials⁹⁷ to create a Montana guide for quality kindergarten transitions. To encourage broad adoption, particularly among programs not currently engaging in kindergarten transition planning, consider creating a stepped or leveled version of the tool, where programs commit to increasing intensity of transition activities as their capacity grows. Eventually, the state should move toward the adoption of a statewide kindergarten readiness assessment and process. A single statewide assessment provides many economies of scale, enabling streamlined technical assistance and staff resources. It also enables statewide assessment of readiness at the local level, allowing localities to compare their region’s performance to statewide or even national averages and benchmarks.

⁹³ State Education Reforms, *Table 5.2. Early childhood school readiness definitions, assessments, and interventions for children not meeting expectations, by state* (Washington, DC: National Center for Education Statistics, 2018), https://nces.ed.gov/programs/statereform/tab5_2.asp.

⁹⁴ *50-State Comparison, State Kindergarten-Through-Third-Grade Policies: Are kindergarten entrance assessments required?*, Education Commission of the States, June 2018, <http://ecs.force.com/mbdata/MBQuest2RTanw?rep=KK3Q1811>.

⁹⁵ Montana PDG B-5 Needs Assessment Kick-Off Forum, January 24, 2019.

⁹⁶ Tara Ferriter Smith and Montana Office of Public Instruction, *Kindergarten Transition Tool (Draft)*, email to author, May 28, 2019.

⁹⁷ Blanca Enriquez, *Head Start Early Learning Outcomes Framework, Ages Birth to Five* (Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, 2015), <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/elof-ohs-framework.pdf>.

Shared data systems

Best practices for data systems design, deployment, and management in early childhood systems all focus on utilizing existing and ever-improving data gathering, analysis, and interpretation technology to:

- Increase coordination within the early childhood system (horizontal data systems).
- Improve understanding of long-term impacts and outcomes of early childhood policy and programming (longitudinal data systems).

As discussed in greater detail in Appendix F: Coordination, well-designed and comprehensive early childhood integrated data systems (ECIDS) share many features that improve horizontal and longitudinal capacity with the intent to improve workflows, service quality, and, ultimately, outcomes for children and their families.

This section presents data system-related findings from the needs assessment, including stakeholder perceptions about sharing data and utilization of current systems, and recommendations based on best practices and stakeholder input.

KEY FINDING: Child and family data are in multiple, primarily disconnected systems, making the unique identification of children not possible at present time.

Montana has numerous information technology systems across DPHHS and OPI programs. Montana, like many states, supports a multitude of information technology systems to implement targeted services or processes. The table below outlines the data systems containing client information for those participating in early childhood services and supports.

Figure 44. Montana early childhood-related data systems

Program or Service	System Name	Additional Information
Child and Adult Care Food Program	CACFP payment and grant management system	CACFP is used to manage applications, claims, and payments for the USDA Adult and Child Care food program
Child and Family Services	CAPS	CAPS is used for the overall management of child welfare including foster care, child abuse investigations, and case management. CAPS is a legacy Mainframe system.
Child Care Development Fund	Child Care Under the Big Sky (CCUBS)	CCUBS is used to manage the child care licensing and child subsidies. The system also is used to manage provider inspections, family eligibility determinations for subsidy and payment processes, federal error rates, quality assessments, quality improvement, and contract management. CCUBS is connected to the Early Childhood Project Practitioner Registry and the QRIS.
Child Care Licensing	SansWrite	The Child Care Licensing system provides information on ECE licensing to families seeking care options. SansWrite interfaces with CCUBS.
Child Care Referrals	Naccaraware	Naccaraware is Montana's online referral system.
Child Support	SEARCHS	SEARCHS is the Mainframe based case management and fiscal management system for Child Support Enforcement.

Program or Service	System Name	Additional Information
Children with Special Healthcare Needs	CHRIS	CHRIS is the Child Health Referral and Information System. It is used to manage providers and payments for certain services for eligible children identified to have a special health care need.
Developmental Disabilities	AWACS-DDP or DDP	DDP is used to manage developmentally disabled clients, services, individual cost plans, eligibility, and payments. DDP is actually four individual applications that are tightly integrated with the AWACS system.
Early Intervention, IDEA Part C	IDEA Part C	System is housed independently and is planned to move into the managed care system database within the MPATH project (new MMIS).
Education, including IDEA Part B	Statewide Longitudinal Data System (GEMS)	GEMS is the Office of Public Instruction's longitudinal data system the state's public education system.
Head Start	Program Information Report (PIR)	While not a system per se, the Office of Head Start's PIR provides comprehensive data on the services, staff, children, and families served by Head Start and Early Head Start programs.
Immunization	ImMTrax (Montana Immunization Tracking System)	imMTrax is used to register and track child immunization records across the state. Various health care providers and schools access the system to record and retrieve immunization records.
Maternal, Infant, Early Childhood Home Visiting (MIECHV)	MIECHV	MIECHV is used to manage the Maternal, Infant, and Childhood Home Visiting program.
Medicaid	Montana Medicaid Management Information System (MMIS)	MMIS is used to processes and pay Medicaid, CHIP, and Montana Mental Health Service claims for the State. It is a hosted legacy solution and is operated by Conduent.
Medicaid	Montana Program for Automating and Transforming Healthcare (MPATH)	MPATH is comprised modular data management systems using existing enterprise software and is in varying stages of procurement and implementation. Initial modules include a data warehouse and data analytics capacity.
SNAP and TANF eligibility and service delivery, and Medicaid/CHIP eligibility	Combined Healthcare Information and Montana Eligibility System (CHIMES)	CHIMES provides combined eligibility determination and case management for the Medicaid, SNAP, TANF, and Healthy Montana Kids (HMK or CHIP) programs. It is through this eligibility system that common client identifiers are being assigned
Vital Statistics	Vital Stats / VSIMS	VSIMS is used to manage and record birth, death, and marriage records for the State of Montana.
WIC	M-Spirit	M-Spirit is used to manage the WIC program including client eligibility, client services, food vendors, and expenditure tracking.

Program or Service	System Name	Additional Information
WIC	WIC-SIS	WIC-SIS is used by the WIC program to search for and verify a WIC applicant’s enrollment in other assistance programs such as SNAP, TANF, and Medicaid.

Source: DPHHS 2018 IT Plan

Existing data systems pose analysis challenges. Many of the existing systems are challenging to extract usable data from for analysis. Comparing data across systems in a valid way is extremely difficult. For example, in this assessment, researchers attempted to extract and combine data from and CCUBS and PIR. CCUBS data required significant cleaning to be useful and could not be compared/combined with PIR data because of system limitations.

KEY FINDING: The state is implementing new information technology infrastructure including a common client index, allowing for unique identification across data systems.

Montana’s Medicaid program is investing significant resources in MPATH project, which can be extended to include a broader early childhood focus. DPHHS has been working to replace the MMIS system through a modular approach, with procurement efforts beginning in 2017. A systems integrator is being used with master client and provider indices, meaning each individual is assigned a unique identifier so s/he can be identified, and outcomes analyzed across disparate systems through data analytics. The data warehouse and analytics are newly implemented, and currently contain Medicaid/CHIP claims and immunization registry information. Through this project, the state is analyzing how to include early childhood data, such as the data in CCUBS and other systems listed in Figure 44. The MPATH approach aligns with the fundamentals of an early childhood integrated data system (ECIDS), using the hybrid model, where early childhood data is managed in a federated approach but the mapping across data sets for integration is done in a persistent and standardized way (see Appendix F: Coordination).

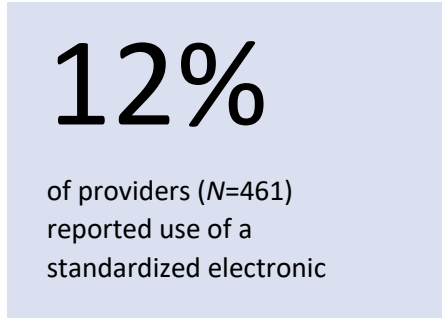
RECOMMENDATION: Develop early childhood system roadmap to support information technology planning. Include a governance framework defining criteria/priorities for system decision-making.

RECOMMENDATION: Build upon existing enterprise software and analytics tools being developed to uniquely identify children and families and measure outcomes across the early childhood system. The state should leverage the investment in systemwide infrastructure. MPATH was designed to include health/claims data, which is generally more complex than other early childhood data and is essential for understanding how the state supports children and families holistically. This approach aligns with the hybrid ECIDS model. This alternative provides all of the necessary capacity for an effective longitudinal data system and the approach could be integrated with a horizontal data (referral) system that follows best practices. To maximize success:

- Ensure consistent communication with all relevant stakeholders, both internal and external, in the early childhood system.
- The data warehouse and data analytics platforms should be made available, when appropriate, to stakeholders in the early childhood system.
- The advanced data analytics capacity within this alternative should be used when appropriate to assess and measure change over time in gaps, needs, and strengths in the early childhood system.

KEY FINDING: Electronic referral system participation is low.

Only one in eight, or 12% of providers responding to the needs assessment survey, use an electronic referral system. Of those who use such a system, most (82%) use CONNECT. The low participation rate in an electronic referral system like CONNECT is a barrier to its utility. To make the system more useful, it needs to be more widely used, but providers are less likely to want to use it until it is used widely enough to provide them the information they need. Many providers who work for smaller agencies expressed a feeling that horizontal data systems only work if large players, like Child and Family Services or the county public health department, are on board.



KEY FINDING: Providers appreciate aspects of CONNECT and see opportunities for improved utility.

In interviews and focus groups with providers who use CONNECT, there were several positives cited about using the system. For example, it was helpful in one community for ensuring children transitioning from preschool to kindergarten do not fall through the cracks. For the Chronic Disease Prevention and Health Promotion program, they administer the screening tool within CONNECT and if any referrals need to be made, they are made through CONNECT. For other providers, CONNECT is not used as referral tool, but it is valued for record keeping, which enables them to have comprehensive client data.

As a provider who uses CONNECT, I don't get the feedback I want from that system. So we use both. We still do a written referral and have a face-to-face conversation with the provider we are trying to connect with. CONNECT doesn't allow for us to build the relationship with the provider. -Provider

Some stakeholders expressed concerns about CONNECT's functionality and worry that the tool may encounter challenges as it scales, which would result in continued under-utilization. However, the system is being enhanced in response to these concerns, and many stakeholders remain interested in scaling CONNECT on the promise that doing so will allow them to efficiently and rapidly refer families to the appropriate provider regardless of where the family enters the system.

Current efforts to improve, expand, and integrate state data systems may overcome some of the identified barriers. The state is currently in the process of developing more integrated data systems. DPHHS is implementing modules of the MPATH system including a common client index, data warehouse, data analytics, and a care coordination module with a referral engine to support improved analysis, decision-making, and care coordination.

RECOMMENDATION: Ensure that efforts to improve, expand, and integrate data systems have a system-level approach and incentivize broad participation. Continue work toward the adoption of

a coordinated electronic referral and case management system by all child-serving agencies. Ensure that large agencies, including healthcare providers, are participating, to spur adoption more broadly. Provide incentives for smaller agencies, both public and private, to participate.

KEY FINDING: In the interest of better service delivery, most families are willing to have their data shared and most providers are willing to share their client’s data with other providers.

Sixty-one percent (61%) of providers reported that they would be willing to share information and data about the families they serve with other providers. One in five (20%) said that they would not be willing.

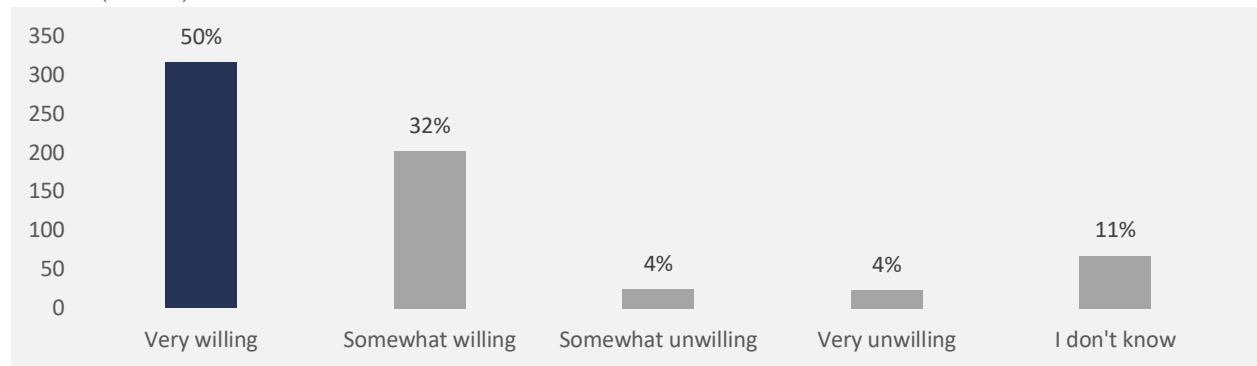
61%

of providers reported that they are willing to share client data with other providers.

A combined 82% of families would be very or somewhat willing to have their data shared. Figure 45 shows over 80% of the families who responded to the survey are very or somewhat willing to have their data shared. Where there was hesitation among focus group participants, it revolved around the notion of consent, with some families preferring to give consent to share on a case-by-case basis, rather than a blanket consent. Others expressed concerns that longitudinal data systems could act like a criminal record, where a child’s early developmental delay is tracked with them throughout their schooling, giving teachers preconceived ideas of a child’s potential.

MOST FAMILY SURVEY RESPONDENTS ARE WILLING TO HAVE THEIR DATA SHARED

Figure 45. Willingness of families who responded to the needs assessment survey to have their data shared (N=697)



Source: Montana PDG B-5 Needs Assessment Provider Survey

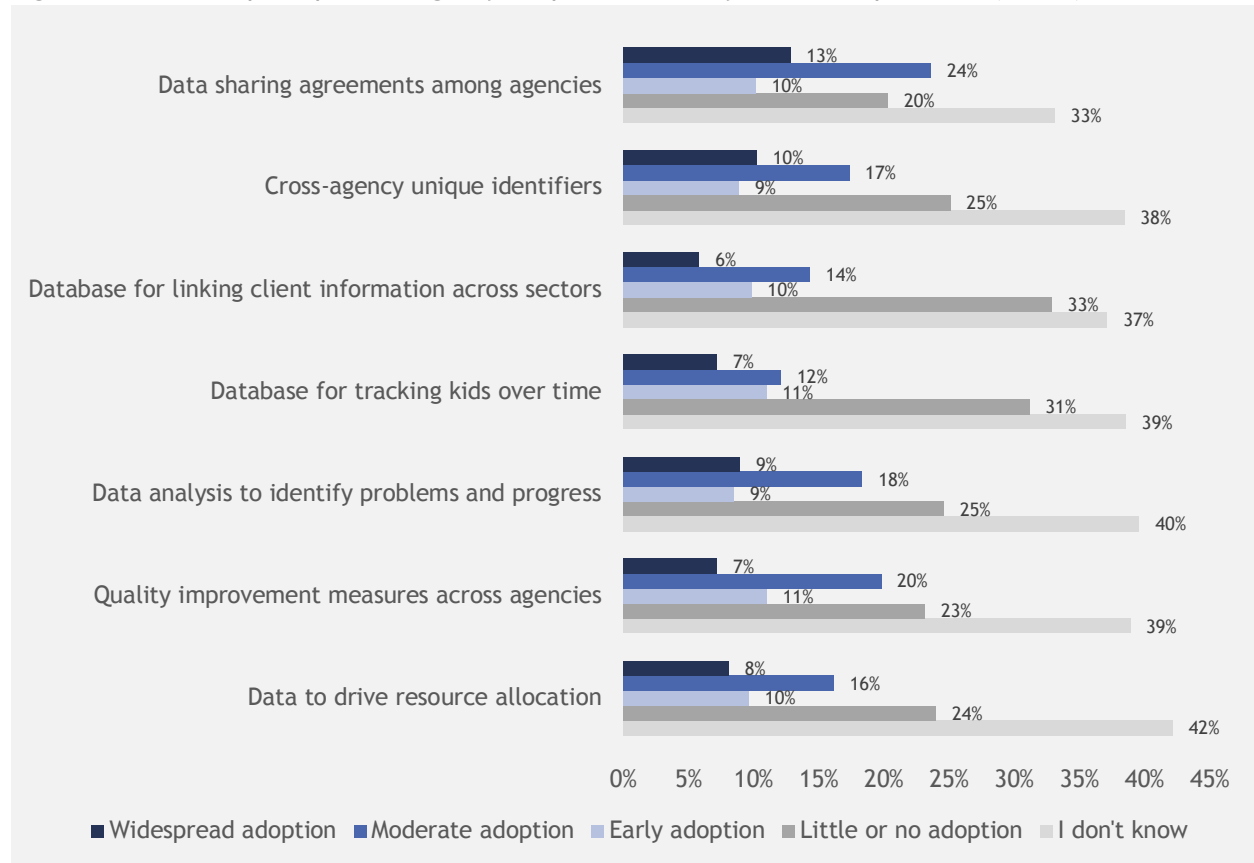
KEY FINDING: Data sharing agreements are relatively common, with some progress toward unique identifiers and quality improvement, but cross-sector (horizontal) databases and longitudinal databases are rarer.

Most providers are unfamiliar with their agency’s data systems practices, which perhaps points to the lack of significance data systems have in current cross-sector interactions and program improvement. Figure 46 shows that the most common response from providers across all data system best practices was uncertainty, with 33% to 42% selecting ‘I don’t know’ as their response to how much adoption has occurred. However, among those familiar with their agency’s practices, the most common best practice

is data sharing agreements, with 37% indicating widespread or moderate adoption. Very few providers have the perception that data systems best practices have been widely adopted in their local communities – only 8% to 13% across all data systems questions. Respondents most frequently found little or no adoption of databases that link client information across sectors (horizontal integration) or databases that track children over time, beyond their tenure with a particular agency (longitudinal integration).

MOST PROVIDERS DON'T KNOW IF THEIR AGENCIES ARE ADOPTING DATA SYSTEMS BEST PRACTICES

Figure 46. Provider perception of agency adoption of data systems best practices (N=450)



Source: Montana PDG B-5 Needs Assessment Provider Survey

Providers are positive about the potential horizontal data integration would have on their work and child outcomes. In terms of sharing data about the families they serve and the services they provide, most providers participating in focus groups expressed a perception that horizontal data systems would facilitate record-keeping, referrals, and follow ups, to the benefit families and providers. As one provider explained, it would be good to have “that universal referral system so you aren’t losing anybody [...] because a lot of the families move all over the place and you lose track of them. That would be so helpful, having those unified systems.” Leveraging successful existing systems was also cited as an opportunity. For instance, one Head Start provider suggested using the K-12 Infinite Campus system (which is run by the state) for Head Start, because of how well it works for K-12 schools to track children when they move.

Key barriers to data sharing expressed by providers were logistical barriers and the feeling that digital systems are necessary, but not sufficient, in creating an integrated and coordinated early childhood system. Creating data sharing memorandums of understanding (MOUs) when there are many different child-serving nonprofit agencies working in a region is one challenge. Without those formal agreements in place for a large number of organizations, the horizontal data systems, including those that facilitate referrals do not have a critical mass of users and thus are of limited use. As one provider explained, “the gist is that we do not have a formal referral system that is effectively used. It is relationship based and the onus is on the provider [to decide to use the system]. So, unless we create MOUs formally, then it’s not happening.”

Interviews with state-level providers revealed a general consensus about the need for both longitudinal and horizontal data systems that are both flexible and able to be integrated into even larger cross-agency initiatives going forward. For example, a best practice for longitudinal early childhood data systems is the ability to integrate with the K-12 systems run by departments of education. The hybrid approach being taken by DPHHS currently in building out both a data warehouse and analytics platform should lower the barriers to further cross-agency integration in the future, as well as for public-private partnerships like integrating with the Health Information Exchange (HIE) being developed by private medical providers. On the horizontal data system side, there seems to be general agreement at the state level about the need for a data system that can support both real-time information sharing and facilitate referrals. Especially of interest is the ability for all providers to see the results of developmental and social-emotional screenings for individual children regardless of where they were conducted (this is another early childhood data systems best practice).

Family Engagement

The United States Children’s Bureau defines family engagement as “the systematic inclusion of families in activities and programs—including planning, development, and evaluation—that promote children’s development, learning, and wellness.”⁹⁸ Family engagement falls along a continuum from relatively simple practices such as making families feel welcome to more sophisticated practices such as involving and supporting family members in policy and governance issues. All along this continuum, a persistent feature of family engagement is that it is relationship-based. Key principles of best practices for family engagement include:⁹⁹

- All stakeholders are welcomed and supported.
- Relationships between program staff and families are genuine, reciprocal, and empathetic, and are built on mutual trust and respect.
- Communication between families and staff is bi-directional, effective, and available in multiple formats.
- Families are included in decision making and goal setting for their child.
- Programs provide learning activities for the home and in the community.
- Programs are culturally responsive.
- Programs address family needs.
- Program staff and families share power and responsibility.
- Programs promote social connections among families.
- Programs invite families to participate in program-level decisions and early childhood education advocacy efforts.
- Programs develop and implement inclusive, comprehensive plans (including funding) to promote family engagement.

Family engagement in children’s early learning has been demonstrated to have positive effects in areas such as language, cognition, social-emotional development, and school readiness,¹⁰⁰ and supporting

⁹⁸ *Policy statement on family engagement from the early years to the early grades*, U.S. Department of Health and Human Services and U.S. Department of Education, May 5, 2016, <https://www2.ed.gov/about/inits/ed/earlylearning/families.html>.

⁹⁹ These principles represent those found in reports from: California Department of Education; Illinois State Board of Education; Maryland Family Engagement Coalition; Massachusetts Parent and Community Education and Involvement Advisory Council of the Massachusetts Board of Elementary and Secondary Education; National Association for the Education of Young Children; and U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, National Center on Parent, Family, and Community Engagement.

¹⁰⁰ Melissa Dahlin, *State approaches to family engagement in Pre-K programs* (New Brunswick, NJ: Center on Enhancing Early Learning Outcomes, 2016), http://ceelo.org/wp-content/uploads/2016/03/ceelo_policy_brief_family_engagement_2016_03_final_web_updated_2016_11.pdf, 31.

Karen Bierman, Pamela Morris and Rachel Abenavoli, *Parent Engagement Practices Improve Outcomes for Preschool Children* (State College, PA: Edna Bennett Pierce Prevention Research Center, Pennsylvania State University, 2017), https://www.peopleservingpeople.org/wp-content/uploads/2017/02/Parent_Engagement_Preschool_Outcomes.pdf.

family engagement during a child’s early years prepares families for engagement throughout their children’s school careers. While family involvement and family engagement both involve interactions between families and staff, family engagement is distinguished by the ongoing, collaborative nature of the interactions.

Family well-being is reliant on financial stability, housing stability, physical health, mental health, and access to basic resources such as food and clothing. Because a family’s well-being strongly predicts a child’s readiness for school, effective family engagement addresses the needs and interests of the family unit, not just the child.¹⁰¹

The content, context, and characteristics of family engagement vary depending on the needs and interests of the family, the needs of the child, and the family engagement practices in a given organization. That is, family engagement does not consist of a “one-size-fits-all” set of practices; rather, best practices for family engagement lie upon a continuum of practices.

Family engagement cuts across all of the areas of focus in the early childhood needs assessment – access, quality, workforce, coordination, and governance. Families need to be engaged for the early childhood system to optimally function. Family engagement findings and recommendations are included in all of these chapters. Additionally, Appendix G: Family Engagement has detailed data from the survey regarding family and provider perceptions of family engagement practices by early childhood sector and service area.

KEY FINDING: Family engagement is not consistently valued across the early childhood system, with many perceiving family interactions as primarily transactional.

The state’s early childhood system lacks a shared definition of family engagement, and providers may not universally value its importance. Montana does not have a single cohesive definition of family engagement between early learning and development, family support, and health sectors, or a plan for increasing engagement.

Some best practices of family engagement—such as welcoming families, respecting cultures, meeting language needs, and inviting families to share with providers about their child—occurred with regularity according to needs assessment survey results. The more substantive best practices of family engagement—such as including families as leaders, including family input on programs and governance, and including families in the evaluation of activities—occurred less frequently, and there were differences in the frequency of these types of engagement among different types of programs.

Lack of family interest and challenges with family availability were commonly cited challenges to family engagement, noted through needs assessment survey data, interviews, and focus groups. Research indicates that implicit bias and an understanding of trauma’s impacts play a role in a provider’s ability to effectively engage families.

Policy statement on family engagement.

Nicole Sharpe, Breanna Davis, and Mimi Howard, *Indispensable policies and practices for high-quality pre-K: Research and Pre-K standards review* (Washington, DC: New America, 2017), 52.

¹⁰¹ *Policy statement on family engagement.*

Head Start and home visiting (including IDEA Part C) are models for successful family engagement. For the ECE sector, Head Start has created numerous resources related to family engagement that could be adapted and/or more widely implemented as the state operationalizes its definition. The Head Start family engagement framework includes subjects such as engaging fathers, using social media to engage families, enhancing parents' advocacy and leadership skills, goal setting with families, and supporting early childhood transitions.¹⁰² For the family support sector, high levels of satisfaction from families receiving home visiting services bodes well for increased engagement through this service.

Providers perceive more family engagement efforts on their part than do families. Detailed data in Appendix G: Family Engagement demonstrates how provider and family perceptions of family engagement practices used across early childhood sectors differ, with providers perceptions being more positive.

RECOMMENDATION: Continue to develop and implement a shared family engagement definition across the early childhood system. The BBAC family engagement workgroup has created a draft family engagement definition for the ECE system and is working to operationalize the definition and make it consistent and applicable across early childhood sectors. The workgroup should continue to refine/ operationalize the definition of family engagement and developing a plan for increasing involvement collaboratively with Head Start providers and other cross-sector stakeholders. Implementation will include ongoing professional development to support a culture change around provider perspectives of family engagement value.

RECOMMENDATION: Evaluate service delivery models through a family engagement lens. Some families may be uncomfortable participating in activities in places that they associate with negative prior experiences. It may be helpful to meet somewhere other than school grounds. Families may also be uncomfortable inviting a stranger into their home, so home visiting providers may consider setting up initial meetings in a coffee shop, library, or other neutral place. Consider providing more virtual or telehealth-type programs given challenges with transportation.¹⁰³ To the extent possible, go to families where they live and/or offer services in multiple venues.

RECOMMENDATION: Train providers to recognize and correct implicit bias. Providers should receive training in examining and addressing unconscious biases that may negatively impact the way they interact with families.

KEY FINDING: Families expressed a desire for increased connection to peers.

Parents expressed a desire for peer-to-peer support, in informal settings as well as formally when navigating specific parts of the early childhood system (for example, peer support for CPS-involved families was identified by many parents as a need).

RECOMMENDATION: Explore options for peer/support mechanisms at local and state level. Early childhood community coalitions could invest in parent support groups. Explore, as well, the

¹⁰² See *Family Engagement*, Head Start Early Childhood Learning and Knowledge Center, Accessed on September 17, 2019, <https://eclkc.ohs.acf.hhs.gov/family-engagement>.

¹⁰³ Colorado is using telehealth to deliver Part C early intervention services. See *Colorado Enables Use of Telehealth in Part C Early Intervention, Zero to Three*, March 10, 2017, <https://www.zerotothree.org/resources/1737-colorado-enables-use-of-telehealth-in-part-c-early-intervention>.

possibility of more formal peer-support services for families and children with specific special needs, like the Parent Partner Program implemented through Children and Youth with Special Healthcare Needs.

Governance

The past two decades have seen a growing recognition among state legislatures and governors' offices that early childhood systems are fragmented. In most states, funding for early childhood programs is spread inefficiently across state programs, services are of uneven quality and sometimes duplicative, and the systems of services are confusing for families to navigate. Many states report that data collection and management are uncoordinated and unreliable, leading to a siloed view of child and family outcomes. States are acknowledging that early childhood systems need to better acknowledge families' overlapping needs and be more trauma informed.

In response, states are evaluating, streamlining, and reforming the statewide systems and governance structures that support young children and families from birth through third grade (the early childhood system). Steps toward system reform look different state to state, but the need to unify services for young children and their families was acknowledged nationally as early as 1994 in a Government Accountability Office (GAO) study examining the fragmentation, duplication, and lack of coordination of states' early childhood systems.¹⁰⁴ More recently in 2017, the GAO released new findings that while improvements are marked, fragmentation, overlap, and potential duplication among early childhood programs still exist.¹⁰⁵

A clear, transparent, robust governance structure will help states achieve their child and family outcomes through the careful use of authority, partnership, and informed decision making.¹⁰⁶ The 2017 GAO report found that "effective coordination can help mitigate the effects of program fragmentation and overlap and potentially help bridge service gaps."¹⁰⁷ However, there is not a great deal of evidence for whether any one governance model is most effective in terms of outcomes for children and families because the early childhood landscape varies state to state.¹⁰⁸ In part due to the fragmented data collection and management systems among early childhood programs, it is difficult for states to measure how structural changes have impacted child and family outcomes. However, researchers and advocates in this space agree that any effort to identify an optimal system structure and governance model should be driven by a shared understanding that the current system is not meeting the needs of young children and their families as evidenced (as much as possible) by child and family outcomes.

¹⁰⁴ Linda Morra, *Early Childhood Program: Many Poor Children and Strained Resources Challenge Head Start*, (Washington, DC: United States General Accounting Office, 1994).

¹⁰⁵ Cindy Brown Barnes, *Early Learning and Child Care: Overview of Federal Investment and Agency Coordination*, (Washington, DC: United States General Accounting Office, 2017).

¹⁰⁶ Elliot Regenstein and Katherine Lipper, *A Framework for Choosing a State-Level Early Childhood Governance System* (Boston, MA: BUILD Initiative, 2013).

¹⁰⁷ Barnes, *Early Learning*.

¹⁰⁸ Bruce Atchison and Louisa Diffey, *Governance in Early Childhood Education* (Denver, CO: Education Commission of the States, 2018).

Linda Smith, Megan Campbell, Sarah Tracey and Arabella Pluta-Ehlers, *Creating an Integrated Efficient Early Care and Education System to Support Children and Families: A State By State Analysis* (Washington DC: Bipartisan Policy Center, 2018).

The majority of early childhood system governance reform nationally has been focused on formal early care (child care and preschool) and education, and has not broadly included other areas of early childhood supports including those found in family support and health programs. However, this is shifting as more states look to fold together early learning and development, physical and mental health, and social services.

The graphic to the right displays the Build Initiative model of early childhood systems, showing that they are comprised of three, overlapping sectors of early learning and development, health, and family leadership

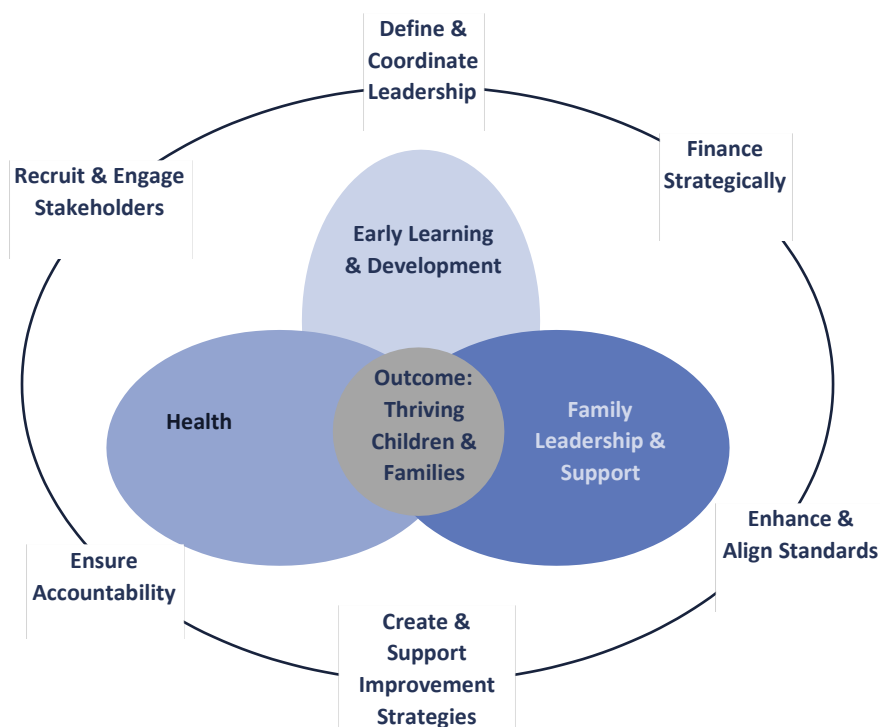
and support, which collectively support thriving children and families. The diagram shows how young children and families at the center often interact with multiple early childhood sectors. Families are best supported when there is coordination across these sectors. Doing so improves assessment, referrals, and connections to services, which can in turn improve outcomes.

Build defines six key strategies to improve the functioning of a comprehensive early childhood system as: 1) recruit and engage stakeholders; 2) define and coordinate leadership; 3) finance strategically; 4) enhance and align standards; 5) create and support improvement strategies; and 6) ensure accountability. A lead, organizing entity would define and implement these strategies to support a well-functioning, continuously improving early childhood system.

The statewide administration of early childhood programs and services typically occurs through one of three structures:

1. **Coordination** of programs within and across different state agencies, usually through the use of memorandums of understanding or formal agreements. This is considered the status quo for most states' early childhood governance structures.
2. **Consolidation** of existing programs previously under different agencies under the umbrella of one entity. Often this is overseen by a division or office within an agency.

Figure 47. Diagram of early childhood system coordination and six roles of a lead, organizing entity



Source: Build Initiative, *The Early Childhood Systems Working Group* (www.buildinitiative.org)

3. **Creation** of an entirely new agency, often through pulling existing programs together from education, health, and human services agencies.¹⁰⁹

State agencies operating in the early childhood space are typically departments of health and human services, and education agencies, supported by the state’s Early Childhood Advisory Council and sometimes other private sector partners.

Montana’s early childhood system within state government is currently structured as a loose collaboration and coordination of programs within DPHHS and OPI. Because most of Montana’s early childhood programs and services are already housed within DPHHS, which also houses the Best Beginning’s Advisory Council (BBAC), the state is well positioned to better coordinate and consolidate those programs, include health and human services programs, and do so through a trauma-informed lens.

This section covers three areas of findings and recommendations related to system governance:

1. Statewide Structure and Governance
2. Local Structure and Governance
3. Statewide Early Childhood Funding

The section concludes with a set of best practices and lessons learned regarding the change management lift associated with early childhood governance reform.

Statewide Structure and Governance

System Structure is the placement and administration of programs and services within the early childhood system.

System Governance is the allocation of authority for decisions around budgeting, resource allocation, data management, and the development of policies, programs, and regulations governing the early childhood system.¹¹⁰

¹⁰⁹ Atchison, *Governance*; Regenstein, *A Framework*.

¹¹⁰ Regenstein, *A Framework*.

Statewide structure and governance findings and recommendations

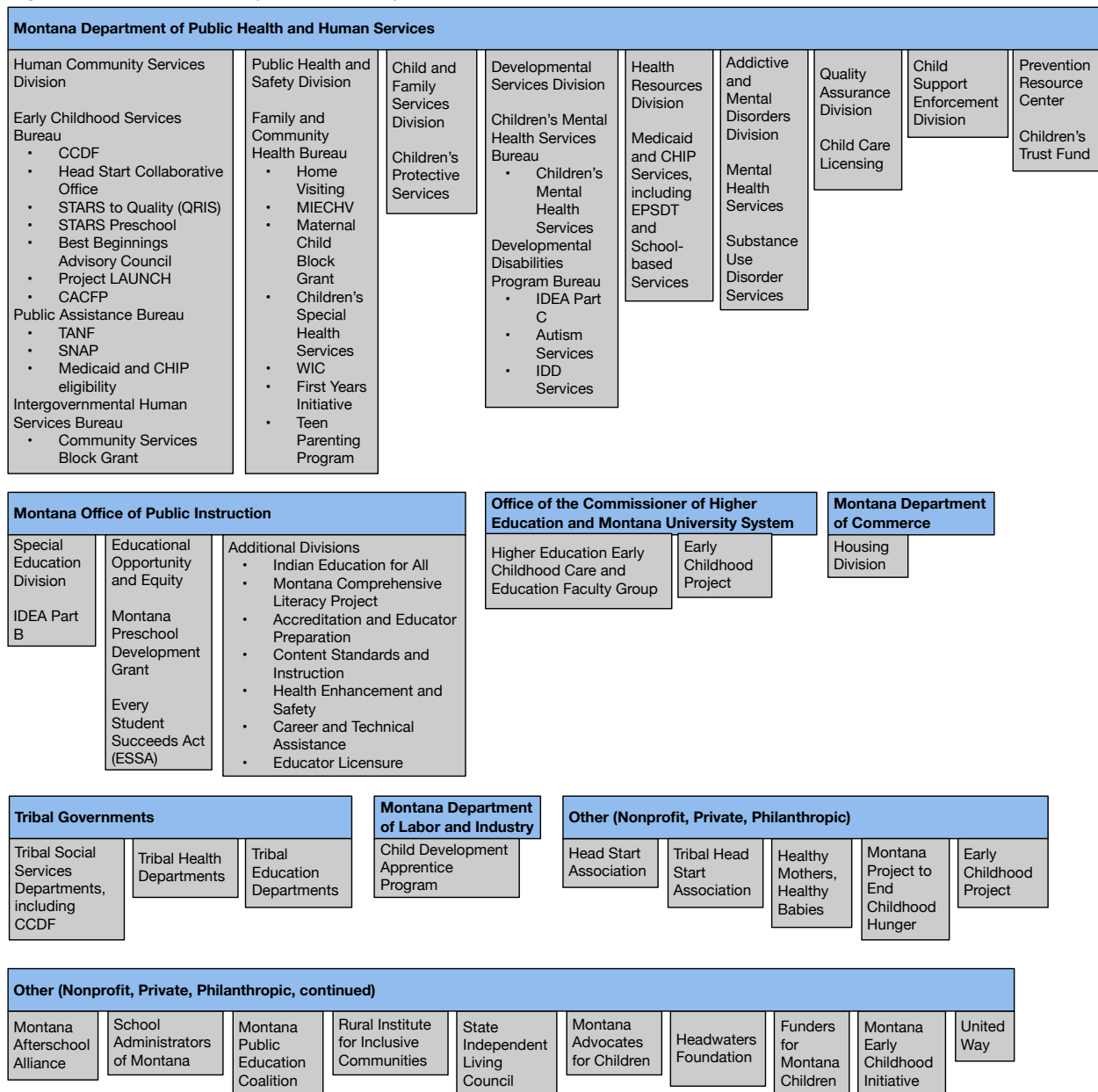
KEY FINDING: Many of Montana’s early childhood programs and services are housed with one agency but fragmented across divisions, bureaus, and levels within that agency.

Within DPHHS, early learning and development, health, and family support programs are scattered across multiple divisions and bureaus, and subject to different policies, business processes, evaluation criteria, and program leadership. According to a recent evaluation report by the Bipartisan Policy Institute, Montana ranks 8th in the nation for coordination of early childhood services because they are housed within only two state agencies, DPHHS and OPI. Additionally, unlike many other states, DPHHS is inclusive of both health programs and human service programs.¹¹¹ From the outside, Montana appears highly coordinated. However, within DPHHS, Montana’s early childhood system is fragmented, with services for children and families administered and provided across a number of programs within the same agency. Figure 48 shows the location of Montana’s early childhood system programs and services across state, tribal, and nonprofit agencies. Nine out of DPHHS’ 12 divisions within all three branches house early childhood programs.

¹¹¹ Smith, *Creating an Integrated*.

MONTANA'S EARLY CHILDHOOD SYSTEM IS WIDELY SPREAD THROUGHOUT DPHHS DIVISIONS AND OTHER STATE, TRIBAL, AND NONPROFIT ORGANIZATIONS

Figure 48. Montana early childhood system structure



The fragmentation of early childhood programs within DPHHS impacts children, families, and providers. Previous assessment chapters discussed impacts of the fragmented system in terms of access, quality, workforce, and coordination.

State staff are overtaxed because they are running early childhood programs equally complex as those in states with higher populations, but with significantly less staff. Montana's population in general, and early childhood system constituency in particular are smaller than most states, but the program management and compliance requirements are the same as states with larger populations. The number

of state staff to run those programs matches the system population rather than the complexity of the programs, so Montana’s state staff are doing the same work but with fewer resources.

Montana DPHHS’s agency strategic plan emphasizes collaboration and coordination of services across agency branches, providing an incentive to better coordinate and consolidate early childhood programs that are currently scattered across agency divisions and bureaus. See Goal 5: “Ensure core business services are efficient, innovative, and transparent.” See also the associated Objective 5.2: “Strengthen coordination and collaboration across branches, divisions, and programs.”¹¹²

RECOMMENDATION: Improve cross-program/bureau/division collaboration and coordination.

System stakeholders discussed the benefits of bringing Child Care Licensing, IDEA Part C, and the Children’s Trust Fund into one bureau. This consolidation would continue to broaden the focus of the Department’s Child Care Development Fund work to being about children’s learning and development, in addition to serving as a work support for parents. It would provide an opportunity for Child Care Licensing to be better coordinated with broader provider supports and quality initiatives and for IDEA Part C to be blended and braided throughout the early learning and development system to support more infants and toddlers.

RECOMMENDATION: Consider the benefits of consolidating early learning and development, health, and family support programs that are currently scattered across DPHHS into an Early Childhood Division.

If a state’s early childhood system governance structure can be measured against the efficient use of public funds and improved access to services,¹¹³ consolidation of the multiple health and human services programs within DPHHS that serve and support young children and their families would be an effective choice. Consolidation of early childhood programs and supports in Montana would require the establishment of a new division or bureau within DPHHS. A consolidated Early Childhood Division would ensure that its bureaus are working toward a set of coordinated goals, not driven by the requirements of separate grants. Such a consolidation or reorganization would not require legislation.

Many states focus primarily on child care and early learning actors within their early childhood systems as a first move toward consolidation.¹¹⁴ These often have the clearest funding streams that can be easily blended. Many states also house their early learning and development, health, and family support programs across several state agencies. Montana, with a single agency for health and human services programs, is uniquely positioned to consolidate early childhood programs across the system without the need to create a new agency.

States interviewed for this report offered some considerations for consolidation of programs:

The **Pennsylvania OCDEL** has five bureaus that consolidate early learning and development and some family supports:

1. Certification Services (includes Licensing)
2. Policy and Professional Development

¹¹² 2019-2024 Strategic Plan, Montana DPHHS, 2018, <https://dphhs.mt.gov/Portals/85/Documents/DPHHSStrategicPlan2019-2024.pdf>.

¹¹³ See Smith, *Creating an Integrated*.

¹¹⁴ For example, Washington focused first on early care and learning in the creation of DEL, and a decade later folded in health and family support programs, including Child Welfare in the expansion to DCYF.

3. Early Learning Center Operations and Monitoring
4. Early Intervention and Family Support Services (includes IDEA Part C and some child abuse prevention funding that requires collaboration with Child Welfare)
5. Finance and Planning

Interviewees noted that the state aims to fold in both physical and behavioral health programs, which are currently housed in separate agencies. As a pathway, the state is improving training and professional development to better coordinate with these programs and increase the bench of professionals supporting young children’s mental health issues.¹¹⁵

Georgia’s Department of Early Care and Learning (DECAL) is a separate agency focused mainly on child care and early education, but interviewees noted that separating IDEA Parts C and B is challenging from a service perspective. However, each program is protective of their respective funding streams. Part C is tied with maternal screening, infant screening and similar services so they expressed that it could be hard to tease them apart, although an argument could be made that maternal and infant screening are part of a comprehensive early childhood system. DECAL interviewees mentioned that the state could be more successful serving children with disabilities in inclusive environments and transitions if there was better coordination between IDEA Part B and Part C.¹¹⁶

Washington’s Department of Children, Youth, and Families (DCYF) includes both early learning and development and child welfare services:

- Child Protective Services’ Investigations
- Family Assessment Response
- Licensed Foster Care
- Adoption Support
- Early Childhood Education and Assistance Program for preschoolers
- Working Connections Child Care
- Home Visiting

Juvenile Rehabilitation and Juvenile Justice will be consolidated next. Interviewees from DCYF indicated that not only is the consolidation creating efficiencies in terms of funding streams and access to services, but is also raising the visibility of the intersections between early learning and development and child welfare.¹¹⁷

RECOMMENDATION: Increase staffing resources for early childhood system. State early childhood programs would benefit from full staffing.

KEY FINDING: Montana has an opportunity to better educate legislators about the needs of children and families in the early years, and the solutions available to meet those needs.

In part because of the 2019 preschool bill failure, there is opportunity for early childhood system leadership to better define the vision for Montana’s young children and their families and communicate that vision to legislators, partners, and the general public. The Center for the Study of Social Policy’s

¹¹⁵ Official of Pennsylvania Office of Child Development and Early Learning in discussion with authors, April 10, 2019.

¹¹⁶ Official of Georgia Department of Early Care and Learning in discussion with authors, April 19, 2019.

¹¹⁷ Official of Washington Department of Children, Youth, and Families in discussion with authors, April 19, 2019.

(CSSP) Early Childhood Systems Performance Assessment Toolkit is a set of guidance and tools for assessing the reach and coordination of early childhood services, as well as the commitment to those services and how well they advance equity and inclusion. The Toolkit's inclusion of *commitment* as a key component of a successful early childhood system looks at efforts to engage stakeholders and raise awareness about the importance of supporting young children and their families. Commitment is measured by efforts to foster public understanding, engage multisectoral leaders within the system, and advocate for policy change.¹¹⁸

RECOMMENDATION: Educate the public and decision makers about the importance of early childhood. Montana's failed legislative efforts to implement early childhood programs and state funding of early childhood priorities demonstrate that the state has an opportunity to improve public outreach and education about early childhood priorities through engaging system leaders in a conversation about the best paths to improving child and family outcomes. Opportunities for improved education include:

- Child development best practices and current gaps in Montana's system.
- The need for/lack of state investment in preschool (outside of the STARS preschool pilot, which was not refunded in the 2019 session), Part B 619 (special education preschool), and Head Start.
- What high-quality early care and education programs are and how to measure them.
- Who the system actors are today, including those within DPHHS, OPI, local communities, providers, and parents.

KEY FINDING: Public-private partnerships in Montana exist and are working to support children and families in the early years, but priorities and approaches are currently disjointed.

There are a few distinct groups focusing on funding for early childhood programs and services on the state level. The most prominent include: the Montana Healthcare Foundation, the Headwaters Foundation, and Funders for Montana's Children. At the local level, United Ways support early childhood services through coalitions and other supports. While well intentioned and in many cases successful at focusing funding for early childhood programs, some state level early childhood system stakeholders interviewed for this assessment indicated that collaboration is still in an infancy stage. Headwaters is a new organization with a new 0-5 initiative. Funders for Montana's Children has a goal of generating a network of early childhood champions across the state. Montana Healthcare Foundation approaches early childhood through a healthcare lens and generally on a project-basis. Continuing to engage private and philanthropic partners in developing a statewide coordinated early childhood system will help align system actors toward shared goals for child and family outcomes.

While there are a few organizations that are active in an advocacy role for early childhood issues, including those referenced above, advocacy is not yet coordinated or leveraged in focus of a unified vision. Coordinating and leveraging the advocacy power of the private and philanthropic sectors is a critical opportunity for Montana's early childhood system. The Montana Advocates for Children (MAC)

¹¹⁸ *Shared Results: Outcomes and Metrics*, The Center for the Study of Social Policy, Accessed on September 17, 2019, <https://cssp.org/our-work/projects/shared-results-outcomes-metrics/>.

works in this area; stakeholders felt their work has not been significantly effective at garnering public commitment around early childhood issues.

We don't have the power of thousands of parents or thousands of providers saying this is what we need, this is the funding we need - so it doesn't happen. -Assessment Interviewee

Montana does not have a history of actively engaging the business community in advocating for the early childhood system. When the business community is engaged it is often in conversations about employer sponsored child care or family leave policies. In other states this takes the form of business coalitions coming together to advocate and lobby for early care and education and family supports that underpin the current workforce and develop future employees. Funders for Montana's Children and Family Forward Montana are emerging leaders in this space. Funder's for Montana's Children's goal is to engage the business community as private sector champions for early childhood priorities across the state.¹¹⁹ Family Forward Montana was established in 2019, and is providing businesses with tiered options to invest in ECE.

Montana's ECE system has some robust partnerships with private and academic organizations to provide professional development to ECE providers. The state partners with the Early Childhood Project at MSU to work within higher education on a provider registry, early childhood career path, and certifications.¹²⁰ Montana contracts out ECE training in the field to CRRs. The state also subcontracts for support for coaching and mental health consultation for local providers. CFSD partners with the University of Montana for coaching services.

RECOMMENDATION: Coordinate and coalesce public private partnerships around Montana's early childhood system priorities. With multiple private and philanthropic organizations focusing on funding and advocacy for early childhood issues, Montana's statewide system has an opportunity to engage these partners in a coordinated effort. Once a governance structure is identified and goals for the state's early childhood system are in place, consider ways to bring together state and local organizations to define how each might contribute to realizing a systemwide vision. For example:

- Sponsor a conference for early childhood system partners.
- Develop a shared strategic plan that includes public and private sector roles and responsibilities.
- Use a collective impact framework with shared outcomes and responsibilities for stakeholders.
- Involve the business community.

Because efforts to engage the business community in Montana are still growing, consider developing a communication plan to educate business leaders about the importance of early care,

¹¹⁹ See: *Who We Are*, Funders for Montana's Children, Accessed on May 25, 2019, <https://fundersformontanaschildren.org/who-we-are/>.

¹²⁰ See: *Home*, Montana Early Childhood Project, Accessed on May 25, 2019, <https://mtecp.org/>.

education, and family supports to their current and future workforce. Look to Pennsylvania’s Early Learning Investment Commission for ideas.

KEY FINDING: The advisory function of Montana’s BBAC may be impacted by the council’s growth.

The BBAC was established in 2011 through a grant from the federal Administration for Children and Families (ACF). It was formed as an enhancement to the original Montana Early Childhood Advisory Council (MECAC), which was established in 1996 to advise the State on CCDF activities, the Early Childhood Comprehensive Systems grant, the CACFP and the Head Start State Collaboration grant. In moving from MECAC to the BBAC, Montana expanded the scope of the council’s work to include a broader focus on systems impacting children and families. The council is intended to improve collaboration and coordination across the spectrum of governmental and non-profit organizations providing early childhood services.¹²¹

The role of the BBAC is primarily advisory. However, because so many federal grants in the early childhood space require an advisory council, BBAC membership grows with every grant for which the state applies. Additionally, local coalitions are invited to send up to two members to meetings, and although these members are committed to the goal of the council, this practice further grows the size of the meetings. The council has multiple workgroups.

RECOMMENDATION: Focus the role of the BBAC on a representative advisory role within Montana’s early childhood governance structure. If Montana pursues a consolidated early childhood governance structure within DPHHS, the Best Beginnings Advisory Council (BBAC) should play an advisory role based on its representative composition. Montana should re-examine the composition of the council to ensure it is streamlined and not too large as to be unwieldy. BBAC should focus on providing guidance and guard rails for the early childhood system.

Local structure and governance

Local structure and governance findings and recommendations

Within a state’s early childhood governance model, regional and local governance structures play an important role in advancing the state’s goals for the early childhood system. At the same time, the success and reach of regional governance structures depend on state-level support.

The statewide governance structure should:¹²²

- Determine the level of regionalization necessary for successful governance, in terms of empowering local communities to plan, implement, and monitor initiatives in the early childhood space.

¹²¹ Kirsten Smith, *Early Childhood Needs Assessment. Report to DPHHS Early Childhood Services Bureau* (Bozeman, MT: Bloom Consulting, 2013).

¹²² Regenstein, *A Framework*.

- Define the authority delegated to regional structures (i.e., funding allocation, decision making).
- Leverage regional structures' ability to hold local programs and services accountable to the goals of the state's early childhood system.
- Consider regional input into statewide policies.

KEY FINDING: Montana's regional definitions are not aligned across the various actors within the state's early childhood system or within DPHHS.

Because Montana's early childhood system is led by a number of entities that are accountable to different leadership, funding streams, and priorities, the state's regional structure is subject to a variety of overlapping and misaligned definitions. A representative, but not exhaustive, list of DPHHS early childhood programs with differing regional definitions includes:

- CCRRs
- Child Care Licensing
- IDEA Part C
- Public Health
- CFSD
- Prevention (substance use)

Among the most significant misalignments is Child Care Licensing and CCRRs because both programs work with the same providers but support them differently. Licensing works with providers through a regulatory lens, and CCRRs through a quality lens. The regions for these two programs used to be aligned and continue to coordinate, but with the reduction of regions there is no longer full alignment.

RECOMMENDATION: Align regional definitions. Changes to regional definitions can be defined and implemented with change management processes associated with program coordination and consolidation efforts.

KEY FINDING: Local coalitions serve a range of essential functions in Montana's early childhood delivery system.

In Montana, the community coalition structure has been leveraged to preserve the value of local control, to efficiently allocate centralized grant dollars, and to enhance cross sector collaboration and engagement. In addition to efforts associated with this grant, programs in the early childhood delivery system that rely on a local coalition structure to implement programming in Montana are the Best Beginnings Councils, Montana Advocates for Children, and the 0-5 Initiative.

Coordination and collaboration in local communities through local coalitions is a strategy that a broad range of DPHHS programs rely on to engage with local stakeholders across the state to deliver programming. A few examples include the DPHHS Prevention Resources Center, Addictive and Mental Disorders Division, and Public Health and Safety Division. Communities may also have coalitions to address hunger, homelessness, and substance abuse.

Due to the widespread reliance on coalitions across early childhood and health, evaluation studies have attempted to identify the key components in an effective local coalition. Across topical areas, the key elements are consistently defined as: strong leadership, clear governing procedures, active participation,

diverse membership, and multisectoral engagement.¹²³ The best practices within coalition capacity support, however, can be a challenge for local leaders, as the burden of the dedication to create a successful and sustained coalition can often be unfair and challenging, especially in rural communities.¹²⁴ One identified source of this burden is that it is not uncommon for individuals in key leadership roles to be asked to participate in multiple local coalitions, across multiple topical areas.¹²⁵ The burdens of local coalitions can be reduced, when funding is available to support the inclusion of a coalition coordinator¹²⁶ and when technical assistance and training of coalition members has been carefully aligned with the findings of community needs assessments.¹²⁷

Within the context of this project, local early childhood coalitions have been vital partners, participating in different ways, including: 1) supporting assessment and planning work; 2) enhancing coalition coordination and family engagement work; or 3) significantly increasing focus on family engagement. In locations where we held focus groups, local coalitions were essential in recruiting participants and supporting the logistics required for both the parent and provider focus groups. During the provider focus groups, we heard from coalition members about the functioning of their coalitions as well as the challenges that they face. From the survey of providers, we understand that funding sources and extent of involvement among those who are providers in the early childhood system.

Among providers who completed the survey, 61% report the existence of a community coalition for addressing issues related to early childhood system sectors. Responders were also asked to identify areas of focus for their coalitions across early childhood system. Across coalitions, 45% include a focus on early childhood learning and development, 40% a focus on childhood health, 43% a focus on family support, and 31% a focus on trauma.

Local coalitions in the Montana early childhood system reflect the broad characteristics of all local coalitions. They face challenges with communication, attendance, burnout, and governance. With 26% reporting that they receive funding for their activities, it is not a stretch to assume that some of these challenges are in part due to the reliance on volunteer time for the execution of the coalition tasks.

¹²³ Jomella Watson-Thompson, Vicki Collie-Akers, Nikki Keene Woods, Kaston D. Anderson-Carpenter, Marvia D. Jones and Erica L. Taylo, "Participatory Approaches for Conducting Community Needs and Resources Assessments," in *Community psychology: Foundations for practice*, edited by Victoria Chien Scott and Susan M. Wolfe (Thousand Oaks, CA: SAGE Publications, 2015).

¹²⁴ Sarah Flicker, Robb Travers, Adrian Guta, Sean McDonald, and Aileen Meagher, "Ethical Dilemmas in Community-Based Participatory Research: Recommendations for Institutional Review Boards," *Journal of Urban Health* 84, no. 4 (2007).

¹²⁵ Cherisse L. Seaton, Nikolai Holm, Joan L. Bottorff, Margaret Jones-Bricker, Sally Errey, Cristina M. Caperchione, Sonia Lamont, Steven T. Johnson, and Theresa Healy, "Factors That Impact the Success of Interorganizational Health Promotion Collaborations: A Scoping Review," *American Journal of Health Promotion* 32, no. 4 (2018): 1095–1109.

¹²⁶ Kari Gloppen, Michael W. Arthur, J. David Hawkins, and Valeri B. Shapiro, "Sustainability of the Communities That Care Prevention System by Coalitions Participating in the Community Youth Development Study," *Journal of Adolescent Health* 51, no. 3 (2012).

¹²⁷ Jomella Watson-Thompson, Nickki Keene Woods, Daniel J. Schober, and Jerry A. Schultz, "Implementing the Capacity Building for Change Model with Substance Abuse Prevention Coalitions," *Journal of Community Psychology* 42, no. 6 (2014).

KEY FINDING: Local coalitions face challenges related to governance, funding, and communication.

Local coalitions can suffer from poor governance at the local level and be adversely impacted by state-level political processes. Interviewees reported that the relationships between existing local coalitions and new initiatives can be confusing, as local coalition leadership can be caught between multiple funding sources and political goals. Supporting this concern, 22% of survey respondents reported that there was more than one coalition/collaborative aimed at addressing issues related to the early childhood system in their local area. Effective governance within local coalitions was identified as a mechanism for managing the potential danger of a coalition becoming personality driven and beholden to local political pressures. Each of these political elements can adversely impact the coalition functions of increasing collaboration and expanding participation in the early childhood system.

In most coalitions, the effectiveness of the collaboration is tied to the willingness of participants to altruistically support the coalition and engage in coalition meetings and processes. When competition increases, or participation decreases, the effectiveness of the coalition can be compromised. Both concerns were identified by interviewees and focus group participants.

Well we have, I think it's up to 50 on our list that we will invite that knows our meetings are second Tuesday of every month and we give them lunch and we'll get eight to ten, maybe 12 people to a meeting and on a routing basis. [Interviewer: Why do you think they do not attend?] I don't know, it just seems like they are all just too busy or whatever. -Local Coalition Member

A key informant who is intimately involved in the delivery of health services through local coalitions reported a general concern that the state *“has to stop telling communities they need to create a coalition because it is driving them nuts.”* Rather than suggesting that communities create a new coalition, instead, *“join them or become a workgroup.”* This approach may minimize the general challenge of coalition involvement overly burdening local leaders.

The final challenge identified across interviewees and focus group participants was communication. State agency staff identified a need to communicate about existing coalition requirements in funding streams and to create an inventory of coalitions to support more effective collaboration at the state. A home-based childcare provider in the Great Falls focus group noted that she continues to struggle with effective communication from her local early childhood coalition.

I personally am feeling a little frustrated with the coalition, because one, even though I've attended several times, I never get notices about it even though I have asked multiple times to be added to the list. And so that is a clear communication problem in my opinion. And I'm not

really sure what they do even though I've been there several times. It feels like they meet, and then nothing happens. -Provider

KEY FINDING: Local coalitions identified multiple opportunities to increase effectiveness.

The coalition structure can enhance local capacity for acquiring grant funding. Survey respondents were asked if their early childhood coalition received funding to complete its activities, with 26% of respondents reporting that yes, they did receive funding. Expanding this funding support may be beneficial. One reason that funding via coalitions can be valuable is that coalitions can create efficiencies, for example, through co-location within a community center and sharing the costs of building upkeep.

Interviewees identified multiple constituencies that could be more fully integrated within local coalitions, including Part C providers, pediatricians, and the business community. This type of expanded integration could generate the type of value across local communities that was identified by a focus group participant in Billings, who shared the value of the Best Beginnings Council in increasing local collaboration.

The Early Childhood community in in Billings, has really coalesced in the past five years, and it's primarily right here with the Best Beginnings Council, because all of the key players are integrated right here. And hear a lot of the common concerns, problem solving, and have been willing to break down silos and help each other out. And so, I would say, I feel that our communication and understanding of early childhood agencies and who does what, is very strong. -Local Coalition Member

RECOMMENDATION: Support consolidated, coordinated local coalitions. State and local leaders can support a shared local coalition framework with a structure (e.g. subcommittees) allowing for deeper dives into focus areas (e.g. substance use prevention). A consolidated approach will better support efficient resource utilization and sustainability.

RECOMMENDATION: Increase communication and collaboration within local coalitions. To expand the effectiveness of local coalitions in Montana, interviewees and focus group participants identified the following needs:

- Increased involvement of employers.
- Ensuring effective communication.
- Protecting coalition members from burnout.
- Improved tracking and awareness of coalitions across sectors among state agency staff.

Early childhood system funding

The national movement to blend and braid early childhood funding streams in an effort to better coordinate and consolidate early childhood programs, is helping make headway toward reducing fragmentation and duplication of services across the system. Common federal funding used to support ECE programs include:

- CCDF expenditure
- Temporary Assistance for Needy Families (TANF) transfer
- TANF child care expenditure (direct)
- TANF Pre-K / Head Start expenditure
- Head Start Allocation, Head Start, Early Head Start
- Early Head Start – Child Care Partnership
- IDEA Part C allocation (infant/toddler)
- IDEA Part B Section 619 allocation (3-5 years)
- Preschool Development grants
- Striving Readers Comprehensive Literacy
- Child and Adult Care Food Program expenditure
- Race to the Top, Early Learning Challenge

KEY FINDING: There are greater opportunities for Montana to maximize state investment in early childhood programs

Key informant interviews reported Montana does not maximize state general fund investment in early learning and development, including preschool, Early Head Start, Head Start, Early Intervention, and Special Education Part 619. Stakeholders feel the lack of investment is related to the lack of historical public and leadership commitment in early childhood discussed earlier. Limited state investment is directly related to supply/capacity constraints experienced by families statewide, particularly for infants/toddlers and children with special needs, workforce infrastructure deficits, pay disparity, and overall deficits provider support (i.e. lack of support for facility/environmental costs).

State funding for early childhood services and programs shows a state investment in the system. Many states invest state general funds into early learning programs beyond federally required match or maintenance, especially Pre-K programs. Forty-four states support Pre-K with state funds. State investment in ECE programs is a measure of early childhood system success according to the Bipartisan Policy Center.¹²⁸

Pennsylvania invests state (commonwealth) funds in their early childhood system, bringing in increased funding for preschool and home visiting programs. Pennsylvania OCDEL also shares some funding with Youth and Family Services.¹²⁹

¹²⁸ Smith, *Creating an Integrated*.

¹²⁹ Official of Pennsylvania Office of Child Development and Early Learning in discussion with authors, April 10, 2019.

Georgia earmarks \$370M of lottery dollars annually for Pre-K, in addition to some federal match dollars and funds for small projects within the agency.¹³⁰

Other methods for increasing state investment into early care and education in particular include applying governor discretion to move the administration of IDEA Part B (Section 619) funding to reduce the complexity and coordination challenges with Part B and Part C. (Note that Part B seems difficult to bring into a consolidated early childhood governance structure, even for states that have created a new comprehensive early childhood agency such as Washington’s DCYF.)^{131 132}

RECOMMENDATION: Work with partners to progress policy and funding priorities.

Recommendations throughout this and previous sections address opportunities to address commitment through increased partnerships and outreach/education/advocacy to increase commitment and investment in early childhood.

KEY FINDING: Montana’s early childhood funding streams could be blended and braided to reduce fragmentation and duplication.

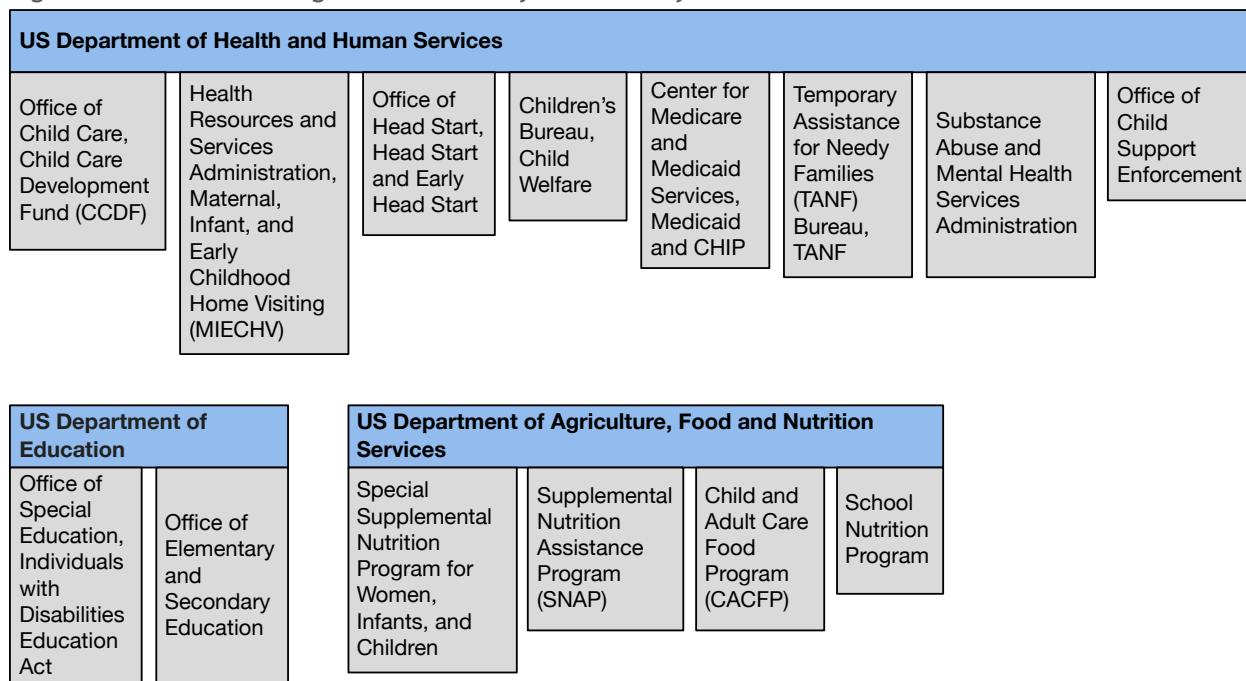
Disparate federal funding requirements, disaggregated information technology systems, and siloed/uncoordinated state early childhood systems, and worries about perceived misuse of funds are barriers to funding coordination. Montana’s early childhood system is funded through a variety of federal sources through Health and Human Services, Education, and Agriculture departments, as shown in Figure 49.

¹³⁰ Official of Georgia Department of Early Care and Learning in discussion with authors, April 19, 2019.

¹³¹ Official of Washington Department of Children, Youth, and Families in discussion with authors, April 19, 2019.

¹³² See: Smith, *Creating an Integrated*.

Figure 49. Federal funding sources for early childhood system



Stakeholders discussed varied barriers to blending/braiding funds contrasted with the need or desire to do so to make services/programs sustain. Examples of targeted case management funds used to sustain home visiting, child and family services and home visiting, and Part B and Medicaid, were shared by stakeholders as examples of current blended/braided funding efforts.

RECOMMENDATION: Explore opportunities to blend/braid funds through structural changes to coordinate/consolidate early childhood programs. Stakeholders expressed a desire for additional work in this area, including: analysis of funding options for infant early childhood mental health consultation through mental health and CCDF funds; cross-program/sector case management/care coordination and system navigation; increased integration of health and ECE services; increased coordination of licensing and quality work with ECE providers; integrating behavioral health and primary health for high-risk children and families; and others. Strategies will be developed through broader structural work on the state’s early childhood system.

KEY FINDING: The Family First Prevention Services Act provides a funding opportunity for prevention services.

The Family First Prevention Services Act (FFPSA) provides a new funding reimbursement for states to provide prevention services to avert foster care placement. The FFPSA was signed into law on February 9, 2018. The purpose of FFPSA is, “to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services.”¹³³

¹³³ Bipartisan Budget Act of 2018, Pub.L. 115-123 (2018), Title VII-Family First Prevention Services Act, Subtitle A-Investing in Prevention and Supporting Families, Sec. 50702.

One of the primary goals of the FFPSA is to shift the child welfare system from one that is primarily responding to crises to one that is able to avert crises by strengthening individuals, families, and communities. This shift in the child welfare system from a response to a prevention and strengthening focus is profound and should significantly impact the structure and functioning of child welfare and the broader early childhood and family support system. Through FFPSA, children and families who are determined to be at-risk for removal are eligible for evidence-based models of: 1) mental health services; 2) substance use disorder services; and 3) in-home parenting skill-based programs. Prevention services are not income tested. The theory is that prevention services should keep more children successfully at home and in their communities, lessening need/demand for foster care placement.

States have the option of using federal Title IV-E funding for evidence-based prevention services for children at risk of foster care placement and their families. Funding for prevention services is intended to augment, not supplant, state funding for prevention services; Maintenance of Effort (MOE) requirements exist. In general, states may provide behavioral health (mental health and substance use disorder) services and in-home parent skill-based programs for up to 12 months. Specific services/programs must be trauma-informed and promising, supported, or well-supported in the Title IV-E Prevention Services Clearinghouse. There is no limit on how many times a child and family can receive prevention services; new prevention plans may begin another 12 months for children/families identified as candidates again.

The FFPSA also supports evidence-based kinship navigator programs and enhances support under Title IV-B by eliminating the time limit for family reunification services while the child is in foster care and allowing 15 months of reunification services when a child returns home from foster care.

RECOMMENDATION: Explore how to use the Family First Prevention Services Act to support prevention service provision. Montana is in a position to determine candidacy and eligibility criteria for access to Family First Prevention Services reimbursement. This is a significant opportunity to leverage entitlement funding for evidence-based prevention services.

Summary of Findings and Recommendations

Montana’s early childhood system comprehensive statewide needs assessment highlights findings (strengths and gaps) and recommendations related to access, quality, workforce, coordination, family engagement, and governance in early learning and development, family support, and health. The table below summarizes needs assessment findings and recommendations.

Figure 50. Summary findings and recommendations

Findings	Recommendations
Access	
1. ECE capacity does not meet demand 2. ECE capacity varies greatly by county <ol style="list-style-type: none"> <i>Rural counties lack ECE providers</i> <i>Native American communities face greater child care access challenges</i> <i>Most counties with limited access were low-income communities</i> 	1. Increase supply of ECE statewide, with targeted focus on the most significant child care deserts in rural, tribal, and poorer counties
3. Families use a variety of methods to find child care providers in Montana	2. ECE stakeholders recommended increased cross-disciplinary efforts and technological improvements to support ECE awareness and referrals
4. Child care centers are providing an increasing proportion of ECE services	3. Explore additional approaches for recruiting new ECE providers
5. Infant and toddler capacity supply is extremely limited	4. Explore financial assistance to infant providers
6. Providing infant and toddler care can be cost-prohibitive for ECE providers	5. Support additional research to identify sustainable solutions that address the cost of infant/toddler care 6. Study Early Head Start-Child Care Partnership/Expansion grants to identify critical factors of partnership success

Findings	Recommendations
<p>7. Families of children with special needs face additional barriers to accessing child care</p> <p>8. Supply of providers able to care for children with special needs is insufficient</p> <p>9. Part B and Part C services are not optimized for supporting children with special needs in ECE settings</p> <p>10. Utilization of Best Beginnings special needs subsidies is limited</p>	<p>7. Provide ongoing training and technical assistance to build capacity to care for children with special needs</p> <p>8. Provide mental health consultation to support providers within and outside of the STARS to Quality system</p> <p>9. Increase incentives to encourage providers to work with these families</p> <p>10. Increase communication between Part C early intervention specialists, physicians, psychologists, and ECE providers support value of early intervention and facilitate provision of early intervention services in child care settings.</p> <p>11. Conduct further research to understand the process by which children are referred to, assessed by, and deemed eligible for Part B services</p> <p>12. Increase outreach and capacity building to school district leaders to increase awareness of preschool special education options</p> <p>13. Increase capacity of trained providers and awareness of subsidy availability to expand subsidy utilization</p>
<p>11. Health access issues and limited integration of health and early learning sectors exacerbate ECE access issues for children with special needs</p>	<p>14. Conduct additional research and planning on how to better integrate health services in ECE settings</p> <p>15. Increase family and provider education around disability</p>
<p>12. ECE cost is a key barrier to participation</p> <p>13. Child care subsidies do not reach all low-income children</p>	<p>16. Increase outreach to families to inform them of subsidy availability</p> <p>17. Improve subsidy eligibility process</p>
<p>14. Pervasive waitlists produce a false set of demands on the system and perpetuate barriers to care among families with low incomes</p>	<p>18. Expand eligibility for child care subsidies to include median income families</p> <p>19. Study the impact of recent policy changes that provide graduated child care subsidy eligibility for Montana families</p>
<p>15. Cohesive funding of ECE as a system is needed to address underlying cost margins of delivering ECE services</p>	<p>20. Increase public awareness and support of sustained ECE funding</p>
<p>16. Further research on ECE funding models could contribute to development of effective ECE funding and increased cost accessibility</p>	<p>21. Conduct further research on diverse funding models, including Head Start, to better align funding structure with service expectations</p>

Findings	Recommendations
	22. Explore options to increase access to co-operative models or shared services, including those offered by the state, to help offset providers costs and expand capacity
17. Families need more flexible ECE schedules to accommodate work demands	23. Expand high-quality child care capacity available during non-traditional work hours 24. Stakeholders discussed opportunities to adjust regulations to support more after hour care
18. Child care availability impacts workforce participation 19. Families face multiple barriers to accessing child care, including lack of availability for infants and toddlers, cost, and lack of care for children with special needs	25. Conduct further research on the impact of child care accessibility on statewide workforce, employment, and income outcomes
Quality	
20. Families participating in ECE services report quality program implementation 21. ECE programs use a variety of assessment tools to measure progress 22. Quality measures of ECE programs are improving over time across ECE initiatives	26. Conduct additional research on linking outcomes to practices in IDEA Parts C and B
23. Programs are pursuing quality through continuous improvement 24. The share of child care capacity served by STARS to Quality providers is increasing 25. High-quality ECE capacity is limited 26. STARS to Quality providers appreciate the focus on professional development and program improvement 27. STARS to Quality training requirements may dissuade program participation	27. Provide a more graduated entry into STARS to Quality requirements
28. Lack of alignment between Head Start and STARS to Quality requirements and training content limits Head Start participation in STARS to Quality	28. Review other states' policies regarding Head Start coordination with QRIS
29. Provider compensation varies by provider type 30. ECE provider compensation impacts workforce stability and professionalization	29. Continue to work toward credential-based compensation more consistently across the birth to elementary continuum
31. Lack of public consensus on the importance of quality ECE provision limits access to high-quality care	30. Increase public and family awareness on the benefits of high-quality care

Findings	Recommendations
32. Lack of universal licensing requirements impacts the number of children in low quality care and creates an unlevel playing field for providers	31. Eliminate exemptions to licensing requirements across providers
33. Inflexible or inconsistent licensing regulations can deter prospective providers from entering the system	32. Evaluate support structures and incentives to help providers come into compliance with licensing requirements 33. Provide greater guidance to programs when onboarding into licensing 34. Examine opportunities for more responsive and frequent communication related to licensing for providers 35. Continue to pursue licensing reciprocity between state CCDF, tribal CCDF, and Head Start ECE programs
34. Lack of coordination between licensing and STARS to Quality creates inefficiencies and confusion among providers	36. Increase coordination between STARS to Quality and licensing 37. Provide greater guidance to programs when onboarding into STARS to Quality
Workforce	
35. Most registry participants are at low registry levels 36. STARS to Quality program staff are likely to have some college or a Bachelor's degree 37. ECE providers participate in diverse professional development activities 38. The P-3 and Leadership Financial Assistance Project supported participation in early care and education coursework	
39. Apprenticeship and pre-apprenticeship programs are an untapped resource	38. Increase promotion of apprenticeship and pre-apprenticeship programs with students and providers
40. Professional Development Specialist trainers are limited in eastern counties	
41. Professional development recognition may overlook relevant training 42. ECP approved broad training opportunities; the majority were directed at beginning level practitioners	39. Target training requirements and increase connection between training options and staff education background
43. Lack of alignment of training requirements across programs creates duplication	40. Increase training coordination and reciprocity across ECE initiatives
44. Cross-sector trainings increase efficiency and communication	41. Increase cross-sector training and skill alignment

Findings	Recommendations
	42. Consider increasing Early Childhood Partnership registry infrastructure for broader early childhood professions
45. Distance learning options increase professional development flexibility	43. Expand opportunities for high-quality distance learning
46. Increased centralization of training development can improve access and facilitate cross sector utilization	44. Refine the process to create and implement ECE professional development content
47. Additional training is needed to support children with special need	45. Provide additional training and technical assistance to support children with special needs
48. Multiple coaching initiative support ECE professional development 49. Coaching content and delivery vary 50. Coaching impact is limited by capacity and staff turnover	46. Continue to improve coaching infrastructure and implementation
51. ECE learning community uptake is not widespread in Montana, but implementation appears to be of high-quality	47. Increase implementation of learning communities
52. Infant early childhood mental health consultation can improve provider quality and job satisfaction 53. Stakeholders noted need for more mental health consultation capacity across the state	48. Continue to pursue opportunities to increase Infant and Early Childhood Mental Health Consultation capacity in the state
54. Additional capacity building can support delivery of trauma-informed care and attention to secondary caregiver trauma	49. Develop a systemwide approach to trauma-informed delivery
Coordination	
55. There is opportunity for more consistency in screening tools used statewide	50. Adopt the ASQ/ASQ-SE as the preferred developmental screening tool statewide
56. State falls short of universal developmental screening	51. Conduct further research on ways Montana can track rates of screenings at the recommended intervals and reduce duplication 52. Increase public awareness for parents, as well as providers, regarding the importance of developmental screening 53. Offer technical assistance on Part B and C eligibility and referral pathways for healthcare providers
57. ECE providers can play an important role in increasing the rate and quality of developmental screening	54. Implement lessons learned from the Head Start and LAUNCH models to increase developmental screening in ECE settings

	55. Provide professional development and technical assistance to ECE providers on how to screen children and what to do if a need is identified, from how to talk to parents to how to refer for services
58. Lack of up-to-date, comprehensive, and centralized information about early childhood services hinder both assisted and self-directed system navigation	56. Improve up-to-date and available early childhood service resource information for families and providers 57. Analyze approaches to supporting early childhood system navigation for families needing connections to multiple agencies or programs
59. More often than not, families working with more than one organization report that they did not receive referrals between the organizations, but providers report that they usually provide them	58. Clarify for providers what constitutes a referral while taking steps to move providers toward the best practice of a warm hand-off, particularly for vulnerable families
60. When a referral is made, families reported using the referral and finding it helpful	59. Conduct further research to determine the root causes behind the difficulties accessing services within, or referring to, different sectors, with a particular focus on Child and Family Services-referred services, mental health, early care and education, and Indian Health Services
61. Cross-sector care coordination is rare, but when in place and done well, it is valued by families and providers alike	60. Encourage the use of a common, expanded social determinants of health family screening and assessment tool 61. Increase access to, and quality of, cross-sector care coordination for young children and families
62. There is limited utilization of Medicaid-funded, school-based medical services	62. Provide support to increase billing of Medicaid for eligible school-based services
63. Early childhood agencies working with homeless or housing insecure families operate under different definitions of “homeless,” leading to underutilization of services	63. Improve CFSD-OPI coordination related to homelessness 64. Conduct further research on whether homelessness definitions could be aligned
64. Some families feel “dropped” when their child ages out of services or they need to access services from another agency 65. Certain kindergarten transition best practices have been widely adopted, while others are yet to be widely implemented	65. Work with communities to take steps to expand the types of transition best practices in place 66. Leverage existing resources including kindergarten transition pilots, draft transition tools, best practices, and Head Start

Findings	Recommendations
66. Montana lacks a statewide kindergarten readiness assessment (KRA) and transition process	materials to create a Montana guide for quality kindergarten transitions
67. Child and family data are in multiple, primarily disconnected systems, making the unique identification of children not possible at present time 68. The state is implementing new information technology infrastructure including a common client index, allowing for unique identification across data systems	67. Develop early childhood system roadmap to support information technology planning 68. Build upon existing enterprise software and analytics tools being developed through MPATH to uniquely identify children and families and measure outcomes across the early childhood system
69. Electronic referral system participation is low 70. Providers appreciate aspects of CONNECT and see opportunities for improved utility 71. In the interest of better service delivery, most families are willing to have their data shared and most providers are willing to share their client’s data with other providers 72. Data sharing agreements are relatively common, with some progress toward unique identifiers and quality improvement, but cross-sector (horizontal) databases and longitudinal databases are rarer	69. Ensure that efforts to improve, expand, and integrate data systems have a system-level approach and incentivize broad participation
Family Engagement	
73. Family engagement is not consistently valued across the early childhood system, with many perceiving family interactions as primarily transactional	70. Continue to develop and implement a shared family engagement definition across the early childhood system 71. Evaluate service delivery models through a family engagement lens 72. Train providers to recognize and correct implicit bias
74. Families expressed a desire for increased connection to peers	73. Explore options for peer/support groups at local and state level
Governance	
75. Many of Montana’s early childhood programs and services are housed with one agency but fragmented across divisions, bureaus, and levels within that agency	74. Improve cross-program/bureau/division collaboration and coordination 75. Consider the benefits of consolidating early learning and development, health, and family support programs that are currently scattered across DPHHS into an Early Childhood Division 76. Increase staffing resources for early childhood system

Findings	Recommendations
76. Montana has an opportunity to better educate state leaders about the needs of children and families in the early years, and the solutions available to meet those needs	77. Educate the public and decision makers about the importance of early childhood
77. Public-private partnerships in Montana exist and are working to support children and families in the early years, but priorities and approaches are currently disjointed	78. Coordinate and coalesce public private partnerships around Montana’s early childhood system priorities
78. The advisory function of Montana’s BBAC may be impacted by the council’s growth	79. Focus the role of the BBAC on a representative advisory role within Montana’s early childhood governance structure
79. Montana’s regional definitions are not aligned across the various actors within the state’s early childhood system or within DPHHS	80. Align regional definitions
80. Local coalitions serve a range of essential functions in Montana’s early childhood delivery system 81. Local coalitions face challenges related to governance, funding, and communication 82. Local coalitions identified multiple opportunities to increase effectiveness	81. Support consolidated, coordinated local coalitions 82. Increase communication and collaboration within local coalitions
83. There are greater opportunities for Montana to maximize state investment in early childhood programs	83. Work with partners to progress policy and funding priorities
84. Montana’s early childhood funding streams could be blended and braided to reduce fragmentation and duplication	84. Explore opportunities to blend/braid funds through structural changes to coordinate/consolidate early childhood programs
85. The Family First Prevention Services Act provides a funding opportunity for prevention services	85. Explore how to use the Family First Prevention Services Act to support prevention service provision

Abbreviations

ACA	Affordable Care Act
ACF	Administration for Children and Families
AMDD	Addictive and Mental Disorders Division
BAS	Business Administrative Scale
BBAC	Best Beginnings Advisory Council
BCBA	Board Certified Behavior Analyst
BSB	Big Sky Bonanza
BSW	Big Sky Waiver
CACFP	Child and Adult Care Food Program
CANS	Child and Adolescent Needs and Strengths
CCDBG	Child Care Development Block Grant
CCDF	Child Care and Development Fund
CCL	Child Care Licensing
CCRR	Child Care Resource and Referral Agency
CFC	Community First Choice
CFS or CFSD	Child and Family Services, or Child and Family Services Division
CHIP	Children's Health Insurance Program
CMHB	Children's Mental Health Bureau
CoE	Center of Excellence for Infant and Early Childhood Mental Health Consultation
CPS	Child Protective Services
CSCT	Comprehensive School and Community Treatment
CSED	Child Support Enforcement Division
CSEFEL	Centers on the Social and Emotional Foundations for Early Learning
CSHS	Children's Special Healthcare Services
CTF	Children's Trust Fund
DCYF	Washington Department of Children, Youth, and Families
DD	Developmental Disabilities
DDP	Developmental Disabilities Program
DEL	Washington Department of Early Learning

DPHHS	Department of Public Health and Human Services
DSD	Developmental Services Division
ECE	Early Childhood Care and Education, or Early Care and Education
ECERS-R	Early Childhood Environment Rating Scale Revised
ECIDS	Early Childhood Integrated Data System
ECP	Early Childhood Project
ECSB	Early Childhood Services Bureau
EDI	Early Development Instrument
EEC	Massachusetts Department of Early Education and Care
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FERPA	Family Education Rights and Privacy Act
FES	Family Engagement and Support
FCCERS-R	Family Child Care Environment Rating Scale Revised
FFPSA	Family First Prevention Services Act
FICMMR	Fetal, Infant, Child, and Maternal Mortality Review
FPL	Federal Poverty Level
FSS	Family Support Specialist
FQHC	Federally Qualified Health Center
HBCC	Home Based Child Care
HCBS	Home and Community Based Services
HCSA	Human Community Services Division
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HMHB	Healthy Mothers, Healthy Babies
HMK	Healthy Montana Kids
HRD	Health Resources Division
HS-EHS	Head Start – Early Head Start
HUD	US Department of Housing and Urban Development
IDEA	Individuals with Disabilities Education Act
IDD	Intellectual and Developmental Disabilities
IECMHC	Infant and Early Childhood Mental Health Consultation
IEFA	Indian Education for All

IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IHS	Indian Health Service
KRA	Kindergarten readiness assessment
LAUNCH	Linking Actions for Unmet Needs in Children’s Health
LEA	Local Education Agency
MAC	Montana Advocates for Children
MCH	Maternal and Child Health
MECAC	Montana Early Childhood Advisory Council
MECHEC	Montana Early Childhood Higher Education Consortium
MHCF	Montana Healthcare Foundation
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MPDG	Montana Preschool Development Grant
MPEC	Montana Public Education Coalition
MTAA	Montana Afterschool Alliance
MTAEYC	Montana Association for the Education of Young Children
MT-PECH	Montana Project to End Childhood Hunger
MTSS	Multi-Tiered Systems of Supports
NFP	Nurse Family Partnership
NSCH	National Survey of Children’s Health
NTI	National Training Initiative
OCC	Office of Child Care
OCDEL	Pennsylvania Office of Child Development and Early Learning
OPA	Office of Public Assistance
OPI	Office of Public Instruction
PAB	Public Assistance Bureau
PAS	Program Administration Scale
PAT	Parents as Teachers
PBS	Positive Behavioral Support
PDG B-5	Preschool Development Grant Birth through Five
PDS	Professional Development Specialist
PHSD	Public Health and Safety Division

PRAMS	Pregnancy Risk Assessment Monitoring System
PRTF	Psychiatric Residential Treatment Facility
QAD	Quality Assurance Division
QRIS	Quality Rating Improvement System
SAC	State Early Childhood Advisory Council
SAM	School Administrators of Montana
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMS	Safety Assessment Management System
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SLTCD	Senior and Long-Term Care Division
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPOT	Teaching Pyramid Observation Tool
TPITOS	Teaching Pyramid Infant Toddler Observation Scale
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WIM	Wyoming, Idaho, and Montana Tracking

Glossary

ECE availability (or access)	ECE availability means that “parents, with reasonable effort and affordability, can enroll their child in an arrangement that supports the child’s development and meets the parents’ needs.” ¹³⁴ Factors that impact ECE availability include location, consumer information, transportation options, schedule alignment between work hours and program operation, cost of high-quality care, and limited specialized treatment for children with special needs.
Provider	“Provider” is used throughout the needs assessment to refer to people working directly with children or in administrative/management roles in diverse child-serving activities, including early care and education (ECE), home visiting, healthcare, child welfare, and any other areas of the early childhood system.
Quality ECE	High-quality early care and education is based on strong organizational foundations and effective practice implementation. Key components of quality ECE programs include effective instructional leaders, collaborative teachers, involved families, a supportive environment, and ambitious instruction.
Rural	The needs assessment uses the Center for American Progress three-level index to define rurality, where a score of 1 is the least rural (urban), a score of 2 is somewhat rural (suburban) and a score of 3 is the most rural (rural). The measure is based on household density, or the number of occupied households per square mile.
System	The term system, or early childhood system, refers to the partnerships between interrelated and interdependent agencies and organizations representing physical and mental health, social services, families and caregivers, and early childhood education to develop seamless systems of care for children from birth to kindergarten entry. ¹³⁵
Sector	A component of the larger early childhood system, such as the early care and education sector, the family support sector, or the healthcare sector.
Vulnerable/underserved	Montana defines children as being vulnerable and/or underserved when they experience any of the following: have a disability, identified developmental concern, or behavioral health issue; have special healthcare needs (such as food allergies, asthma, diabetes, special dietary restrictions, on extended prescribed medication, etc.); are an infant age 0-19 months; are an enrolled tribal member or reside on tribal lands, are children of teenage parent(s); are low income; are children of migrant families; are homeless or at risk of becoming homeless; are English language learners (ELL) or dual language learners (DLL); have experienced trauma or maltreatment, including children in foster placements;

¹³⁴ Friese, *Defining and Measuring*.

¹³⁵ *Early Childhood Comprehensive Systems*, Health Resources and Services Administration (HRSA), Accessed on September 17, 2019, <https://mchb.hrsa.gov/earlychildhoodcomprehensivesystems>.

	have a parent or guardian that is active in the military; and/or live in rural and underserved areas.
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