

An Important Partnership in Child Development: Child Care Providers and Screening Programs

SURVEY OF LICENSED CHILD CARE PROVIDERS IN MINNESOTA

September 2016

Authors and contributors

Katy Schalla Lesiak, MSN/MPH, APRN-CPNP, Child Health Consultant,
Minnesota Department of Health

Andrea Boh, MS, CCC-SLP, Doctoral Student/LEND Fellow, Department
of Educational Psychology, University of Minnesota - Twin Cities

Sheila Amenumey, PhD, Student Worker Para-Professional Senior,
Minnesota Department of Health

Sally Goodman, MS, Child Health Educator, Minnesota Department of
Health

Lora Kussman, MA, Professional Development Specialist, Minnesota
Department of Human Services

Diane Etling, MS, PHN, LSN, APRN-CPNP, Child care Health Consultant,
Minnesota Department of Health

Meredith Martinez, MPH, Early Childhood Specialist, Minnesota
Department of Education

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H25MC00276 and title Early Childhood Comprehensive Systems (CISS SECCS) for grant amount \$140,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



Maternal Child Health
www.health.state.mn.us
651-201-3760

Executive summary

This report summarizes findings of a 2015 survey of licensed child care providers in Minnesota regarding developmental and social-emotional screening and referral practices. Developmental and social-emotional standardized screening is an accurate and efficient way to identify infants, toddlers, and young children who may benefit from more evaluation and resources to address concerns, and to improve their health and learning outcomes later in life. Standardized tools have been tested in large, diverse populations of children to make sure that they accurately and reliably identify children that may need a closer look. In Minnesota's efforts to support universal screening of young children from birth through five years of age, it is clear that licensed child care providers may play an important role, since the majority of children in this age group spend time in child care outside of the home.

At this time, there are no state recommendations or requirements for child care providers to directly provide developmental or social-emotional standardized screening, although there are some other requirements related to child development in licensing and in the state's quality rating system, described later in this report.

Policy makers and early childhood leaders have different opinions about whether child care providers in Minnesota should be asked to provide standardized developmental and social-emotional screening. Child care providers obviously bring many strengths to any effort to support healthy child development: they have trusted relationships with families, they know the children they serve, and they may notice developmental and behavioral milestones or concerns in their daily interaction with these children.

However, there are some important questions to consider when thinking about whether child care providers can or should be asked to add screening to the list of services they provide. Does it make sense to add an additional layer of screening activity, or does it make more sense to encourage child care providers to connect young children to outside, existing screening providers such as clinics, schools, and public health? Are child care providers positioned and prepared to provide screening and referral services?

To answer these questions, a survey of licensed child care providers in Minnesota was conducted in the summer of 2015. At the time of the survey, there were about 10,850 licensed family and center-based child care providers in the state. Of these, 8,959 had an email address (to receive the electronic survey) and were not based in a Head Start or Early Head Start program. Nearly 19 percent (1,567) responded to the survey. This is too small a number to be considered representative of all licensed providers in the state, but their answers help guide maximizing the role of child care providers to support healthy child development.

Findings: The findings of the survey are summarized here. Further details are provided later in this report.

1. As in other professions and settings, there is some confusion among child care providers about what standardized screening means, and varying opinions about screening (to identify children who need more evaluation and possibly services) versus assessment (to identify an individual child's curriculum needs).

2. A relatively small percentage of licensed child care providers in Minnesota are currently providing standardized screening for children in their care. Approximately eight percent of respondents are providing developmental or social-emotional screening using a standardized instrument, most often with the Ages and Stages Questionnaires.
3. There is a wide range of opinions among child care providers about their role in screening.
 - Just over half of all respondents agreed that child care providers should provide screening. Of these, the vast majority agreed that they should partner with existing local screening programs to provide this service.
 - Conversely, almost half felt that screening is not the job of child care providers.
 - The majority of all respondents (73 percent) thought that it was best to have children screened at existing outside screening programs, or to partner with those programs to provide screening in the child care setting.
 - There were differing opinions between types of child care providers by setting (family/home-based care versus center-based care) and by Parent Aware status.
4. Child care providers have strong connections to some outside screening providers and programs, including Early Childhood Screening at the school district and child health care providers. However, fewer child care providers refer to local public health programs. The respondents provided information about what would make them more likely to refer children and families to these programs.
5. Whether or not they provide screening, the majority of child care providers indicated that they refer children with developmental concerns to the child's primary health care provider and to Help Me Grow or the local school district's early intervention program.
6. Some resources are used more than others by child care providers to learn more about child development. There are differences between family and center-based providers in which resources they use.
7. Child care providers identify specific needs related to child development. More than half said they needed more information on where to find support for parents and parenting programs, talking to families about developmental concerns, and where to send or refer children for social-emotional or behavioral concerns.

The survey responses clarify the views of child care providers about their role in screening, and their needs for training and support for child development. This information can help guide policy, professional development, screening program partnerships with child care, and other activities at the state and local level.

Recommendations based on the results may include the following. These recommendations are outlined in more detail in the Implications section.

For state child care policy, licensing, and regulation:

- While child care providers are certainly in an excellent position to identify developmental concerns, careful consideration should be taken before asking child care providers to add screening to their work, for reasons outlined in the Implications section of this report.

- Standardized screening is not well-understood (similar to other early childhood settings), and few child care providers currently are screening.
- There is a wide range of agreement – from strong agreement to strong disagreement - about whether screening should be the child care provider’s role. Opinions vary by setting and Parent Aware status.
- The majority of child care providers report already referring children to outside, existing screening programs.
- The majority of respondents indicated that it is best to partner with existing screening programs to provide this service in their setting.
- State policy and programs should encourage, support, and provide technical assistance for partnership between child care providers and existing local screening programs.
- While child care providers are interested and have a range of expertise in child development, and have strong relationships with families, they express challenges and an interest in training for particular areas related to child development. Many of these resources are already available, and so efforts should be made to increase awareness of and access to these resources.
- Child care providers have strong connections to multiple sources of information already, which may be used to help relay important information about screening and referral.
- Policies and statewide messaging about screening should emphasize the importance of and support routine, universal screening beginning in infancy and continuing periodically throughout early childhood.
- Increase awareness of child development resources available on www.HelpMeGrowMN.org; include additional resources for and connections with child care providers in the development of Minnesota’s expanded Help Me Grow system.

For screening program leaders at the state and local levels:

- Child care providers expressed a strong interest in partnering with existing local screening programs to ensure that children are screened.
- Child care providers would like to have materials to share with parents about screening and other child developmental resources available in their community.

For professional development:

- Key topics for training of child care providers include where to find support for parents and parenting programs, how to talk with families about developmental concerns, and where to send children for social-emotional or behavioral concerns.
- Training resources exist through multiple sources on a number of these topics; there may be an opportunity to make these resources better known to child care providers. These are outlined in more detail in the Recommendations section later in this report.
- For topics where training does not currently exist, there may be an opportunity to include this information in existing training methods, or to develop trainings and provide it through methods identified as important in the survey:
 - For family child care providers: through Child Care Aware training, the local child care association, or local licensors.

- For center-based child care providers: through Child Care Aware training, Child Care Health Consultant training, center supervisors or training directors, or local licensors.
- For Parent Aware Quality Coaches, who could then share this information with child care providers.

More detailed information is available in the following report about the survey development, distribution, findings and implications.

Child care survey overview

Background

Standardized developmental and social-emotional screening is an effective and efficient method to identify children who may need further evaluation to detect potential delays or disabilities. It is estimated that 12 to 16 percent of children in United States experience at least one developmental delay, and half of those will not be identified before they enter kindergarten (Arunyanart, Fenick, Imjaijitt, Northrup, & Weitzman, 2012; Mackrides & Ryherd, 2011). Routine and periodic universal developmental and social-emotional screening is recommended at well child visits throughout early childhood, beginning in infancy (American Academy of Pediatrics, 2006).

However, children without health insurance, who were Hispanic or Black, and who had parents with less education were significantly less likely to receive well-child visits (Child Trends Data Bank, 2014). Even children who receive well child care may not receive the recommended screenings. According to Minnesota Medicaid billing data, less than half of children birth through 5 years of age receive developmental screening at recommended ages at their well child visits, and fewer than 10 percent receive social-emotional screening.

Other early childhood screening programs exist in Minnesota, in addition to health clinics. State statute requires comprehensive health and developmental screening before entry to public school kindergarten, to ensure that proper supports can be offered to promote school readiness. This preschool screening is provided by the Early Childhood Screening program, which is offered through local school districts beginning at 3 years of age. Head Start and Early Head Start programs also provide developmental and social-emotional screening to eligible children. Local public health programs in Minnesota, including the Follow Along Program and Family Home Visiting, provide developmental and social-emotional screening. In spite of these efforts, many of Minnesota's youngest children do not receive recommended screening, even though earlier identification of delays and intervention for young children is known to result in better outcomes.

Many states promote standardized developmental and social-emotional screening by child care providers to support universal reach and earlier identification. With their regular contact with children, child care providers are in a unique position to support standardized screening efforts. For example, child care programs and providers have multiple opportunities to observe child development in a variety of routines and activities; are experiencing increasing numbers of

infants, toddlers, and preschoolers within their setting; and have a range of training and experience in child development (Branson, Vigil, & Bingham, 2008; Pool & Hourcade, 2011).

With this in mind in Minnesota, questions have been raised regarding the role of child care providers in offering screening of young children:

- Many standardized screening programs already exist locally, including health care clinics, local public health programs, school district screening programs, and other programs such as Head Start: Would screening in child care add another layer of screening, and add to the coordination challenges that already exist between programs? How much do child care providers already know about screening, and the screening programs that are already available in their community?
- There is no data about screening in child care. How many child care providers already provide developmental or social-emotional screening in their programs?
- Child care providers have a range of training and experience. Are they interested and prepared to provide standardized screening, and to act on the results of screening?
- With or without screening, child care providers can play an important role in supporting families and their child's healthy development. What additional challenges or training needs do child care providers have for development and behavior for young children in their care?

There was no existing data source in the state to measure standardized screening or referral in the child care setting, outside of Head Start and Early Head Start.

It was determined that a survey of Minnesota's licensed center-based and family child care providers was the best method to establish a baseline understanding of current developmental and social-emotional screening and referral practices in child care, as well as learn about their connection with outside screening programs and actions taken when concerns arise. The survey could also provide information about child care providers' training needs specific to early childhood general and social-emotional development.

The survey authors did not make hypotheses about the results of the survey, given that the only information available on screening practices and opinions of child care providers was anecdotal. However, it was clear from conversations with many child care policy and program staff that it would be important to carefully define the term "screening", differentiating standardized screening from other types of developmental monitoring that commonly occur in child care settings, such as informal developmental milestone checklists and formal assessments for the purpose of curriculum development. For the purposes of this survey, standardized developmental screening was defined as the use of a brief, standardized (research-tested) tool to get basic information about a child's growth or development.

The purpose of the survey was to:

- 1. Help define the current practices of licensed Minnesota center-based and family child care providers related to:***
 - ***Standardized developmental and social-emotional screening:***

- To assess to what degree child care providers in Minnesota provide standardized screening, what screening instruments they use, and with what screening and referral protocols.
 - To assess child care providers' awareness of existing screening programs to which they could refer children, or with whom they could partner, to ensure developmental and social-emotional screening.
 - ***Referral of children with developmental or social-emotional concerns*** to early intervention (EI) and early childhood special education (ECSE) services, primary health care providers, mental health professionals, and other community resources and services.
- 2. Better understand licensed center-based and family child care providers':**
- ***Training needs related to early childhood development***, screening and referral.
 - ***Beliefs around their role*** in developmental and social-emotional screening and referral.

This survey was done as part of Minnesota's Early Childhood Comprehensive Systems (ECCS) federal grant, which has the broader goals of promoting early identification of and intervention for developmental and social-emotional concerns among young children in Minnesota, and increasing communication and collaboration across early childhood service sectors.

Methods

Development of the survey

Survey questions were developed by the ECCS Coordinator and a graduate LEND (Leadership Education in Neurodevelopmental Disorders) fellow from the University of Minnesota. The questions were based on awareness of Minnesota's current screening system, and on meetings and conversations between state, university, and child care resource and referral (Child Care Aware of Minnesota) staff with licensed child care expertise. The survey was developed with consultation from state Quality Rating and Improvement System (Parent Aware) staff, but was not funded by or part of the Parent Aware process.

An initial draft of the survey was reviewed by the Minnesota Department of Health (MDH) Child Care Health Consultant, Minnesota Department of Human Services (DHS) Child Development Services staff, Minnesota Department of Education (MDE) Early Learning Services staff, and the Child Care Aware of Minnesota director. Edits were made to clarify and shorten the survey.

Pilot testing

Given the broad potential reach of the survey and complexity of the content, the survey draft was tested prior to statewide distribution. Due to time and funding constraints, the ideal approach of using focus groups representing a broad range of licensed child care providers was not feasible. However, the pilot survey was distributed to two groups: a group of seven practicing licensed child care providers recruited by Child Care Aware of Minnesota and the Minnesota Tribal Resources for Early Child care (MN TRECC), and a group of graduate-level

early childhood special education students at the University of Minnesota. The pilot groups tested the survey and found it to be understandable, and easy to complete within 15 to 20 minutes. Minor edits to the survey content and wording were made based on their input.

The final survey included a maximum of 35 questions, including optional demographic questions. Survey questions involved a variety of question types, from multiple choice, yes/no, rating scales, and open ended questions. The total number of questions an individual answered depended on their answers, with skip logic incorporated into the electronic survey to lead them to the appropriate next question.

Survey distribution

The intended audience of the survey was the director or lead provider for every licensed center-based and family child care setting in Minnesota, excluding Head Start and Early Head Start programs (for which screening and referral practices are reported at the federal level). For ease of circulation and analysis of responses, the survey was developed and distributed electronically. According to Child Care Aware, there were 10,850 licensed child care providers in Minnesota as of May 2015. The list was narrowed to exclude Head Start providers and providers who did not list an email address.

The survey was sent by email to a total of 8,959 licensed family and center-based child care providers in May 2015, via their Child Care Aware regional contact. While this allowed recipients name recognition when the survey link was sent out, it also resulted in some duplication of emails across regions. These duplicate responses were weeded out from the final results. If more than one survey was started, the most complete result was included in analysis. After all duplicates and undeliverable emails were removed, the potential number of respondents was narrowed to 8,367 licensed child care providers. Because programs may have had more than one individual that could have responded, the lead individual within the family-based or center-based program was asked to complete the survey. This allowed only one response per program. Survey instructions informed respondents that all responses were voluntary and anonymous.

Analysis

After identifying information was removed and duplicate responses were identified, the LEND fellow from the University of Minnesota provided initial analysis. Further analysis of findings was provided by a Master's level student worker at MDH. Survey response data was analyzed using R Console and Microsoft Excel. Given the small sample size of child care providers, statistical significant tests for relations between variables were conducted using Fisher Exact Tests and Chi-Square Analyses, depending on the levels within a variable.

Findings

Demographics and response rates

Of the nearly 8,367 child care providers contacted, 1,565 were returned, unduplicated, for a response rate of 18.7%. Due to the low response rate, the results gathered from this survey cannot be generalized to all licensed child care providers in the state of Minnesota. However, the breakdown by child care provider type held relatively consistent with proportions statewide: approximately 75 percent of responses came from family child care providers, and 25 percent came from center-based providers.

In order to uphold anonymity, demographic questions were optional for respondents. Eighty percent of respondents completed the demographic portion of the survey. Responses came from 82 of 87 counties in the state, and 10 of 11 tribal nations and communities. Most respondents (62 percent) were not rated and were not seeking rating in Parent Aware, Minnesota's Quality Improvement Rating System for child care. Of the 38 percent that reported being Parent Aware rated or in the process of applying, 5 percent were rated at 1 star, 6 percent at 2 star, 1 percent at 3 star, and 11 percent at 4 star level. These demographics demonstrate broad inclusion of child care providers by statewide geography, setting (family vs. center-based care), and Parent Aware rating status.

Screening practices

Respondents were provided with definitions of general developmental and social-emotional screening, in contrast with informal developmental checklists and formal assessment processes. They were then asked to respond "yes" or "no" to a series of questions about different ways of checking the development for children in their care. Results are summarized in Table 1.

TABLE 1: WAYS OF CHECKING DEVELOPMENT OF CHILDREN IN THEIR CARE

Method used	Percent that responded "yes"
Checklist that we created	31 %
Checklist that we got from somewhere else (another program, website, or organization)	41 %
Developmental and/or social-emotional screening with a standardized tool *Refer to paragraph below for caveats.	16 %*
Assessment tool(s) to help make curriculum decisions	47 %

What percentage of child care providers provide standardized screening?

While 16 percent of respondents (254) indicated that they provide standardized developmental and/or social-emotional screening in their child care setting, further analysis (described below)

revealed that only about half of these respondents were using an instrument that was standardized and designed for developmental or social-emotional screening. Thus, *approximately 9 percent of responding child care providers actually provided standardized developmental and social-emotional screening.*

If respondents selected “yes” for developmental or social-emotional screening, they were directed to select which instrument(s) they used from a list of recommended standardized screening instruments (taken from the list of [recommended instruments](#) from the Minnesota Interagency Developmental Screening Task Force), or an “other” option. When asked to identify which instrument they use for screening, 48 percent of those reporting developmental screening and 36 percent of those reporting social-emotional screening identified the instrument used as “other” (not one of the listed standardized screening instruments). The vast majority of those who selected “other” wrote in tools that are either informal developmental milestone checklists or formal assessment tools designed for ongoing assessment or curriculum individualization. Thus, *just over half (55 percent) of respondents who said they provide screening are actually using a validated screening tool.*

Those who *are* using standardized screening tools are using the Ages and Stages Questionnaires (ASQ-3 for general development and ASQ:SE for social-emotional development) at much higher rates than other tools. The percentage and number of respondents that indicated “YES” to the use of various standardized screening instruments is displayed in Tables 2 and 3 below.

TABLE 2: STANDARDIZED DEVELOPMENTAL SCREENINGS USED BY RESPONDENTS

Standardized <i>developmental</i> screening	Percent (number) that responded “yes”
ASQ-3 (Ages and Stages Questionnaires, 3 rd Ed.)	44% (91)
PEDS (Parent’s Evaluation of Development)	10% (21)
BDI-2 (Batelle Developmental Inventory, 2 nd Ed.)	4% (9)
Bayley-III Screening Test (Bayley Scales of Infant and Toddler Development, 3 rd Ed.)	6% (13)
Brigance Early Childhood Screens	11% (23)
DIAL-4 (Developmental Indicators for Assessment of Learning, 4 th Ed.)	11% (23)
ESI-R (Early Screening Inventory-Revised, 2008 Ed.)	11% (23)
MPSI-R (Minneapolis Preschool Screening Instrument, Revised)	5% (11)
Other	48% (98)

TABLE 3: STANDARDIZED SOCIAL-EMOTIONAL SCREENINGS USED BY RESPONDENTS

Standardized <i>social-emotional</i> screening	Percent (number) that responded “yes”
ASQ:SE (Ages and Stages Questionnaires: Social-Emotional)	46% (96)
BITSEA (Brief Infant Toddler Social Emotional Assessment)	8% (18)
PCS (Pediatric Symptom Checklist)	8% (18)
Other	35% (73)

Differences in screening by setting type and Parent Aware Status

The survey results indicated differences in screening practices between child care setting types: center-based setting or family (home) setting. *Center-based respondents were five times more likely than family child care respondents to conduct standardized screening (OR=0.1930, $\alpha = 0.05$, $p < 0.001$).* A sizable number (309) of respondents did not provide setting information in the demographic section. Individuals who did *not* provide setting information were 2.1 times more likely to report that they conduct standardized developmental screening than individuals who *did* provide setting information.

A quantitative analysis was performed to determine an association between standardized screening and Parent Aware (PA) status of providers. Respondents that reported applying for PA rating were grouped with those that were PA rated, in order to have large enough numbers for analysis. The level of commitment required to apply for PA rating makes this group more similar to those who are rated than to those who are not. Results revealed a positive relationship between standardized screening and PA status ($OR = 6.2$, $\alpha = 0.05$, $p < 0.001$). In other words, providers who were applying or PA rated are 6.2 times more likely to report conducting standardized screening than those who were not.

Reasons child care providers do not provide screening

Among those child care providers who reported that they do not provide screening, many reasons were identified. Respondents were asked to respond “yes” or “no” to whether each possible reason applied to them. Table 4 shows the breakdown of responses. A majority of respondents said that they prefer to send children to outside agencies for screening (73 percent) or that the children in their care had already been screened elsewhere (61 percent). More than half of respondents identified practical reasons for not screening: no access to screening tools or lack of proper training. Forty-four percent of respondents indicated that screening was not part of their role as child care providers.

Of those that selected “other” as a reason, some mentioned the availability of external programs at schools or primary care as having the responsibility and expertise to provide screening.

TABLE 4: REASONS CHILD CARE PROVIDERS ARE NOT SCREENING

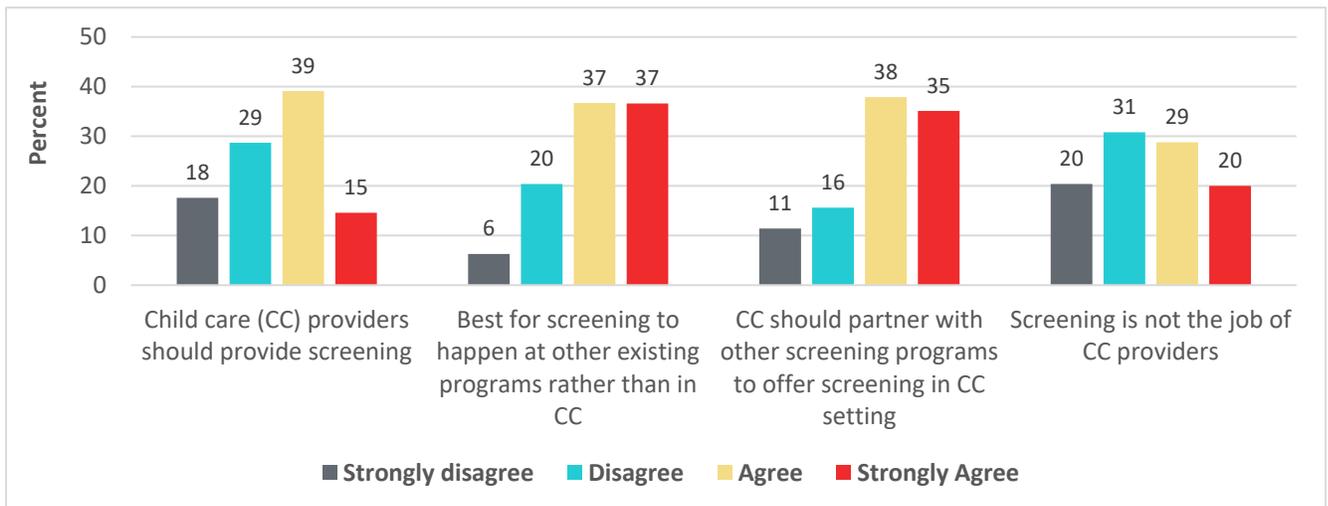
Reasons for not screening	Percent (number) that responded “yes”
We prefer to refer children to other screening programs/professionals.	73% (862)
We do not have the screening tools.	69% (814)
We do not have enough training to do screening.	62% (730)
Children are already screened by another agency.	61% (718)
This is not my/our job, role or expertise.	44% (526)
Not enough time.	31% (372)
Other	15% (177)

How do child care providers view their role in screening?

There were strong and varied opinions about whether child care providers should or should not perform screening. Respondents were asked whether they *strongly agree*, *somewhat agree*, *somewhat disagree*, or *strongly disagree* with the following statements:

- *Child care providers should provide screening.*
- *It is best for screening to happen at other existing screening programs, rather than in child care.*
- *Child care providers should partner with other screening programs (like clinics, schools or public health) to offer screening in the child care setting.*
- *Screening is not the job of child care providers.*

The bar graph below (Chart 1) summarizes the answers of all survey respondents, ranging from “strongly disagree” on the left to “strongly agree” on the right, for each of the four statements. While over half (54 percent) of respondents agreed or strongly agreed that child care providers should offer screening, there was stronger agreement (73 percent) that it was best to have children screened at outside existing screening programs or partner with existing outside screening programs. There were considerable differences in opinion as to whether screening was “the job of child care providers,” with responses spread evenly across disagree and agree options.

CHART 1: HOW MUCH DO ALL RESPONDENTS AGREE WITH THE FOLLOWING STATEMENTS?

Review of the open comment fields of the survey provided further insight on child care provider opinions about their role in screening. Some respondents indicated interest in screening and requested training.

“I would like to be able to offer screening at our preschool but I didn’t know that I could. If I had access to the tools I would do it here.”

Some respondents indicated that they are screening, although their process is not by definition standardized screening.

“We screen but with our own tool and prefer to refer them to the school district.”

However, other respondents felt that screening was not their job, for a variety of reasons, or that the screening need was met outside of child care:

“I have more than enough to do with the children that are in my child care. Everyone wants something done. There is not enough time!!”

“I am not educated to be able to screen children; this should be left to someone who has extensive education in this area.”

“As a child care and developmental program we use and need an assessment tool [rather than a screening tool], to provide and develop ‘emergent’ curriculum.”

“I don’t screen in the ways you have described. I go by my years of experience and if there is a child I feel is developmentally struggling, I make the parents aware. They then make the choice to have their child observed by other professionals.”

“All of our children are screened by the physician and the school district.”

Another common theme, which indicates an important area for future training, was the idea that screening is not appropriate for infants and toddlers. There were many references to Early Childhood Screening at the school districts, and the sense that screening was only allowable in that setting. This implies that there is a misperception among some respondents that infants and toddlers do not need screening, and that screening is only for preschool children.

"I serve only toddlers, so no need to screen."

"Our school district does the [preschool] screening and that is all that is accepted as far as I am aware."

Differences in opinions about screening by Parent Aware status and setting

Data were analyzed to assess differences in opinion on screening by PA status and setting (family vs. center-based care). There were notable differences in opinion between those providers who are PA-rated or applying versus those who were not. Charts 2 through 5 show the level of agreement with each statement by PA status and setting type.

Child care providers that were PA rated or applying were much more likely to identify a strong role for their agency in the screening process. Whether they believe their own center should be performing screening internally, or partnering with an external agency for direct referral, they commonly agreed that screening should be a part of their role as child care providers. As indicated in Chart 4, 86 percent of PA rated or applying respondents agreed that they should partner with other screening programs. Non-PA rated agencies were less inclined to agree, but still over half (64 percent) felt that they should partner with other screening programs.

There were also significant differences in opinion by setting type: family child care vs. center-based child care vs. setting not specified ($\chi=81.77$, $p<0.001$). As shown in Chart 2, center-based child care providers were more likely to agree that child care providers should provide screening, compared to family providers (70 versus 50 percent). Not surprisingly, family providers were more likely to agree that screening was best provided at existing outside programs, as shown on Chart 3, compared to center-based providers (78 versus 55 percent). On Chart 4, both center-based and family providers were more likely to agree that child care providers should partner with other, existing screening programs to offer screening in the child care setting. Chart 5 shows that family providers were more likely to agree that screening is not the job of child care providers than center-based providers (53 versus 30 percent).

Regardless of PA status or child care setting, *90 percent of those that agreed that screening was within the role of child care providers also agreed that child care providers should partner with other screening programs to provide this service.*

CHART 2: CHILD CARE (CC) PROVIDERS SHOULD PROVIDE SCREENING, BY PARENT AWARE (PA) STATUS AND SETTING TYPE

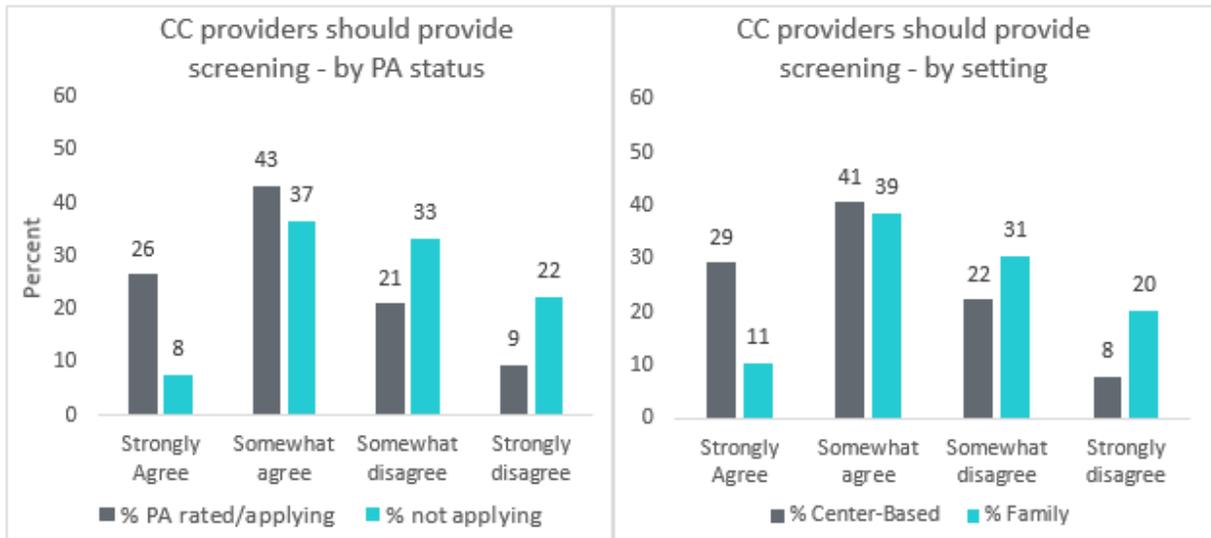


CHART 3: OTHER PROGRAMS SHOULD PROVIDE SCREENING, BY PARENT AWARE (PA) STATUS AND SETTING TYPE

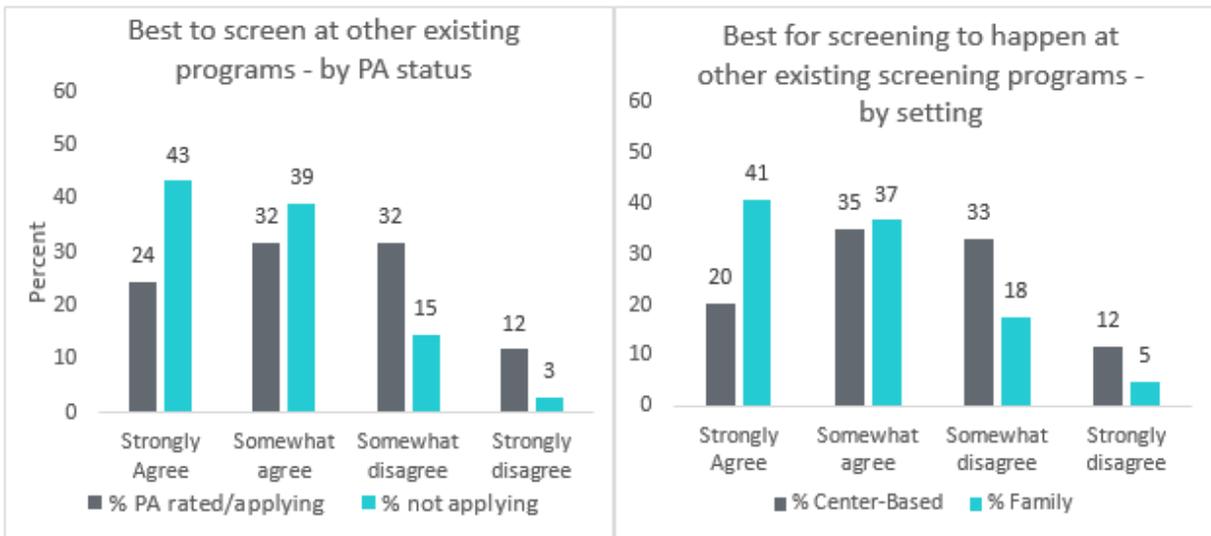


CHART 4: CHILD CARE (CC) PROVIDERS SHOULD PARTNER WITH OTHER SCREENING PROGRAMS, BY PARENT AWARE (PA) STATUS AND SETTING TYPE

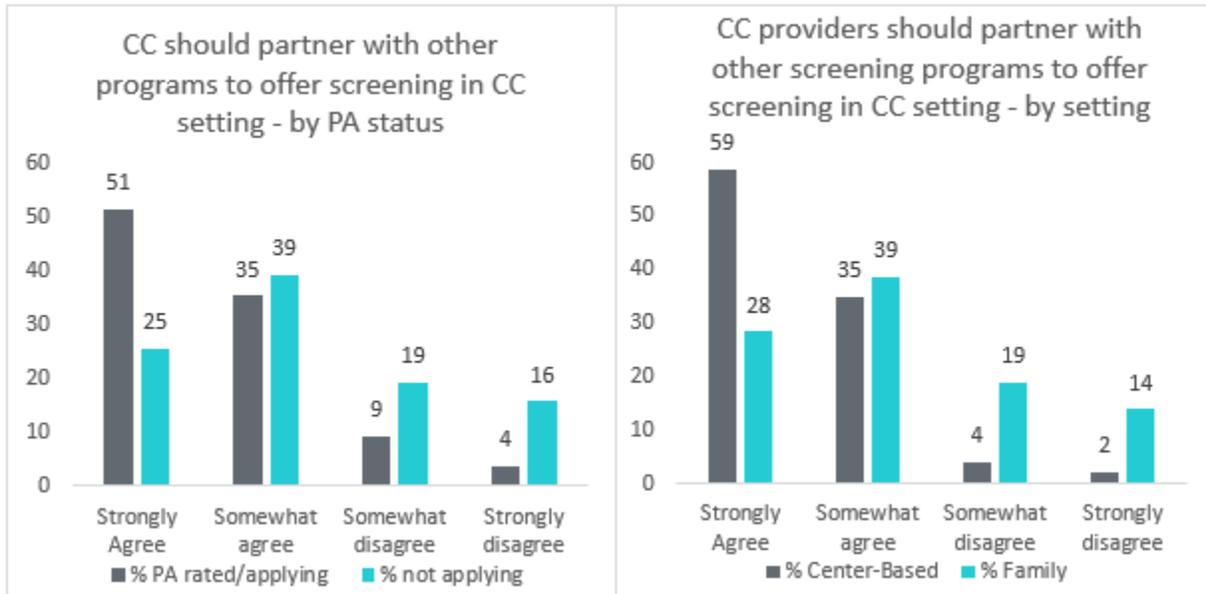
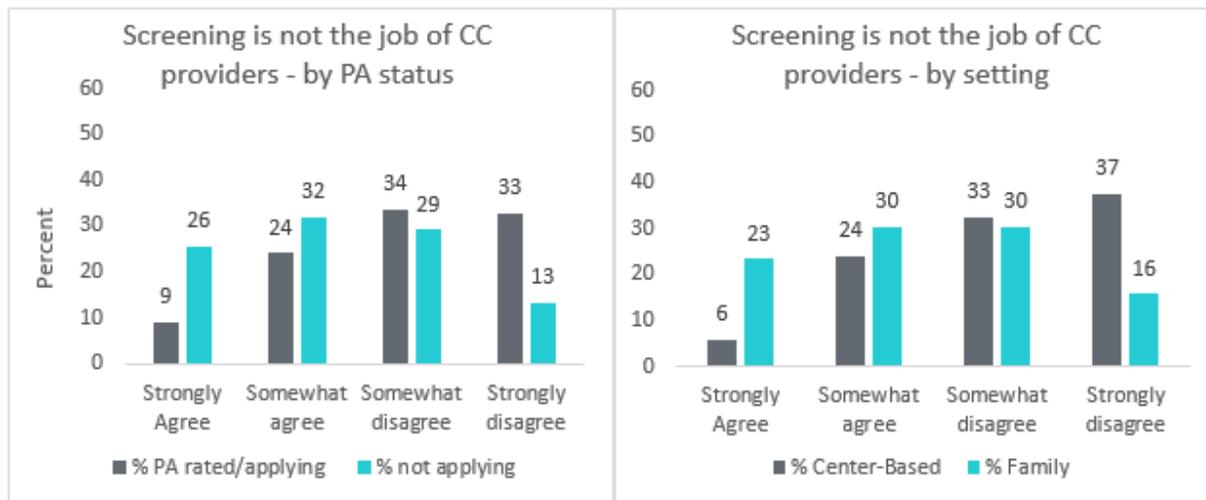


CHART 5: CHILD CARE (CC) PROVIDER OPINIONS ABOUT SCREENING BY PARENT AWARE (PA) STATUS AND SETTING TYPE



Connection to outside screening programs

An important goal of this survey was to discover how aware child care providers are of outside screening programs, and referring children to them. Results indicate that child care providers are regularly making connections to outside screening programs. The majority (92 percent) of respondents refer children to local school district preschool Early Childhood Screening

programs. Most respondents (88 percent) indicated that they refer children age 0 to 2 years or 3 to 5 years to the local school district's Early Intervention or Early Childhood Special Education program. Most respondents (82 percent) also refer children to their health care provider for screening. Fewer child care providers reported referring children to Head Start or local public health programs for screening. Table 5 provides a breakdown of connections to screening programs.

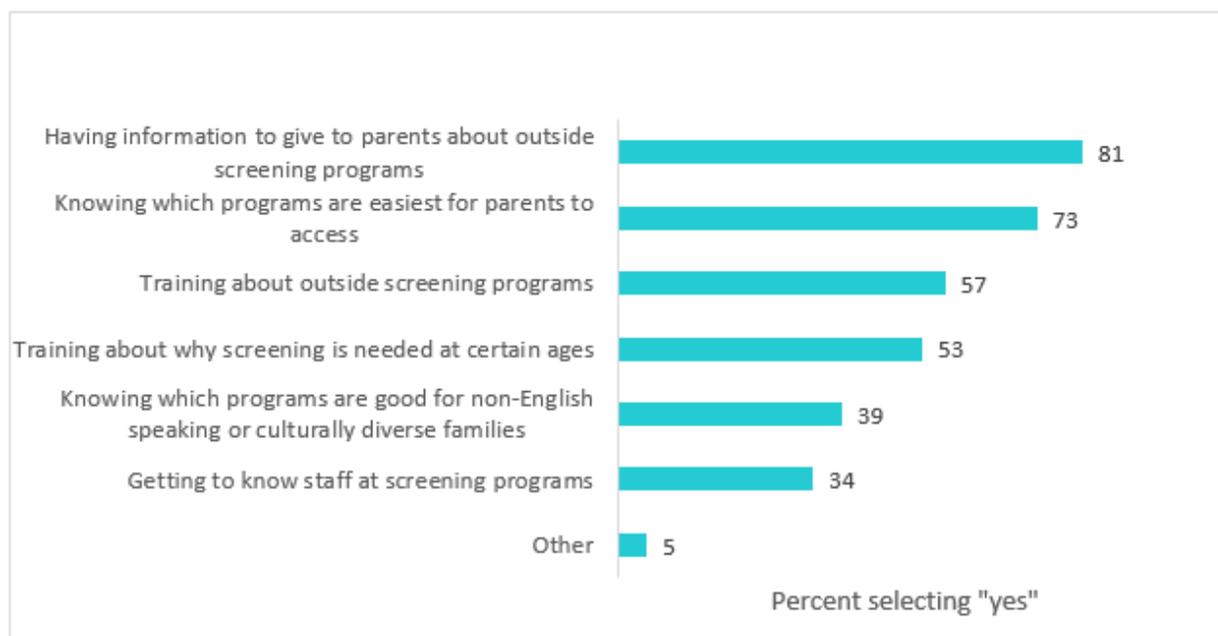
TABLE 5: EXTERNAL SCREENING PROGRAMS TO WHICH CHILD CARE PROVIDERS REFER

Outside screening program	Percent (number) that responded "yes"
Early Childhood Screening at school district (ages 3-5)	92% (1,214)
Local school district's Early Intervention or Early Childhood Special Education Program	88% (1,159)
Child's clinic/primary health care provider	82% (1,090)
Head Start or Early Head Start	45% (596)
Local county/Tribal public health program (such as Follow Along)	28% (372)
Other	8% (111)

Statistically significant differences were noted between center-based and family child care providers regarding where they referred children for screening ($\alpha=0.05$). Family child care providers were about half as likely to refer a child to the local Early Intervention or Early Childhood Special Education program for screening (OR=0.481, $\alpha=0.05$, $p=0.003$), but 1.45 times more likely to refer children to local public health (OR=1.449, $\alpha=0.05$, $p=0.020$) and 2.53 times more likely to refer to Head Start or Early Head Start programs (OR=2.353, $\alpha=0.05$, $p<0.001$). There was no significant difference between family and center-based respondents in referral to Early Childhood (preschool) Screening or to health care providers.

When asked what things would make them more likely to refer children in their care to outside screening programs, respondents were able to answer "yes" or "no" to all options. Chart 6 summarizes their responses. The majority indicated that it would help to have screening program information to share with parents and know which programs are easiest to access. About half of respondents thought that training about the screening programs or the importance of screening would make a difference in their referral practices. Fewer responded that it would help to know which screening programs were good for non-English speaking or culturally diverse families, or that it would help to get to know the staff at the outside screening programs.

CHART 6: OPTIONS THAT WOULD MAKE CHILD CARE PROVIDERS MORE LIKELY TO REFER CHILDREN FOR SCREENING AT OUTSIDE PROGRAMS



For those who selected "other" for this question about increasing referral to outside screening programs, the following quotes represent themes that emerged:

"I already recommend that parents get the normal public school and doctor wellness screening and I don't think I need further encouragement."

"Recommending screening at outside programs is a very touchy issue for parents."

"What I think would be most helpful is... language to use with parents."

"I don't feel that I know of all the agencies that are available. I make referrals as the director, but it is always good to know if there are new programs or resources available that I may not know about."

When concerns are identified

Referral to health care or Help Me Grow for concerns

Regardless of child care providers' opinions or practices related to screening, an important objective of the survey was to find out what action they take when they identify concerns about a child's development or behavior. A child care provider does not necessarily need to be formally trained in developmental or social-emotional assessment or screening to observe the need for such services in the children they serve. The majority of respondents indicated that they ask parents to bring up concerns with the child's primary health care provider (92 percent). The next most common first step is to urge parents to contact their local school district or Help Me Grow for Early Intervention (79 percent). Both of these actions are

consistent with national and state recommendations to ensure both medical and educational (early intervention) evaluation when there are developmental concerns.

The data were analyzed to look for differences in referral practices when concerns were identified, based on provider type. There was no significant difference between family providers versus center-based providers in referral to health care providers. However, family child care providers were half as likely as center-based providers to recommend that parents call the local school district (OR=0.48, $\alpha=0.05$, $p<0.001$) and less than half as likely to recommend a child get a screening (OR=0.414, $\alpha=0.05$, $p<0.001$). In addition, family child care providers were much less likely to make a direct referral to Help Me Grow/Early Intervention, rather than simply asking the parent to call (OR=0.185, $\alpha=0.05$, $p<0.001$).

Talking with parents about concerns

Anecdotal responses from respondents provided insight into how child care providers talk with parents about screening and concerns. Many highlighted the importance of open communication with parents to discuss behavior and developmental observations. They also emphasized the importance of parent-led decision making when there are concerns.

“Open communication with parent - talk to them to see if the same things are happening at home as they are happening at daycare. Communication is very important when there are concerns with a child.”

“I speak directly with the parents about my concerns and give them the information on screening facilities so they can make the best choices possible for their family.”

Other respondents noted the challenges of talking with parents about concerns, particularly the challenge of bringing up a sensitive topic with parents:

“My biggest concern is when I speak to parents, they do not take me seriously. And I have a Master's degree in special education, so I tend to see signs of concern, but parents often tell me that they are happier to be unaware than know if there is a problem. I talk to them about Early Intervention, and it doesn't seem to matter to them. I feel like parents need more information on early intervention and that it is not shameful to have your child assessed.”

“When I try to speak to parents about development, they are often unconcerned about things I am concerned with, and I feel that they will not want to share with me accurate information in these screenings, or they will not see the concerns that I see.”

“Parents get very upset if you have any negative information about their child.”

Culture and development

Respondents were asked about challenges related to developmental concerns, including whether “knowing how culture might affect child development or behavior, or how I can best work with the child or family” was a challenge. For those that responded “yes”, common themes included language and communication issues; non-alignment of family rituals and child care center practices, including differences in parenting and discipline strategies at home

compared to the child care setting; and an interest in training to understand and honor cultural differences. Some thoughts about cultural differences are captured in the quotes below:

“Discuss with the parents how they are handling the situation and ask them how they would like our staff to handle it. Partner with them: try to guide them in using our knowledge but also taking into consideration their beliefs, values, and cultural norms.”

“Distinguishing whether or not something is a concern or simply a cultural difference.”

“Understanding cultural expectations, values, views, etc.”

“There is a lack of cultural diversity training in our region. We NEED more...”

Sources of information about child development

Respondents were asked how and where they get information about general and social-emotional development. Table 6 below lists the percent of providers who identified each entity as a source of child development information, broken down by family versus center-based providers. The five most used resources are Child Care Aware (74 percent), School District (68 percent), Health Care Provider (51 percent), Help Me Grow (47 percent), and Local Child care Association (41 percent). Many respondents wrote in their child care licenser as a source of information, as it was not listed as an option in the survey. Differences exist between family versus center-based providers in their use of these information sources, some of which may relate to licensing requirements.

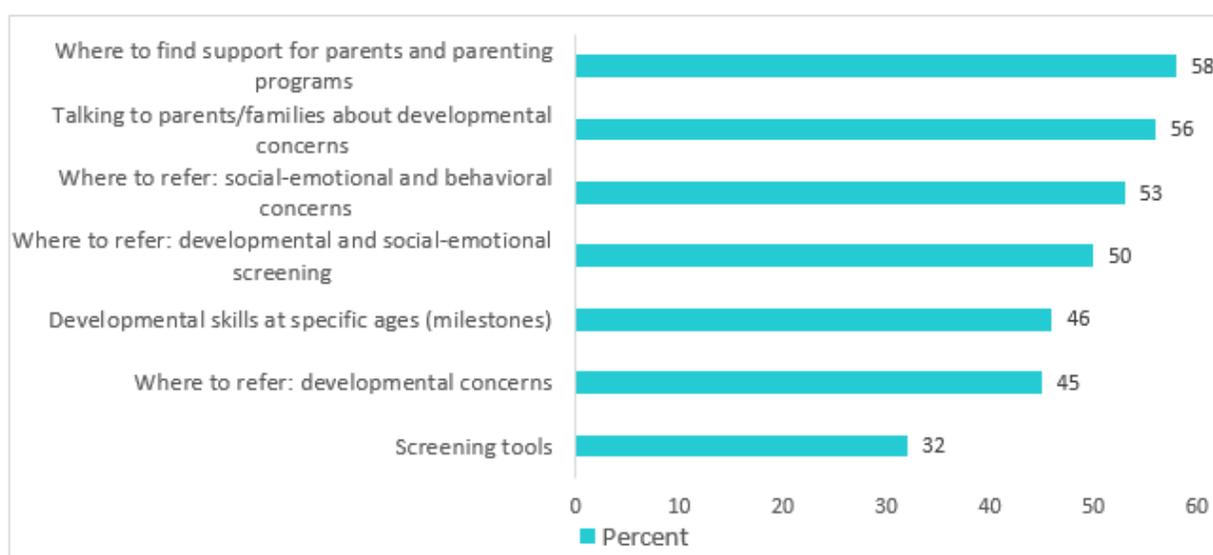
TABLE 6: RESOURCES RESPONDENTS USE FOR INFORMATION ABOUT CHILD DEVELOPMENT

Resources	% of family providers	% of center-based providers
CDC Learn the Signs, Act Early (www.cdc.gov)	23.1	29.2
Center for Inclusive Child Care (CICC) Consultant	15.7	29.6
The child’s health care provider or clinic	45.5	69.1
Child Care Aware Training	72.3	81.1
Child Care Health Consultant	12.5	69.8
Head Start	20.6	21.0
Help Me Grow (www.HelpMeGrowMN.org)	43.6	61.9
Local Child care Association	41.5	38.9
Mental Health Consultant	8.9	28.9
Minnesota Tribal Resources for Early Childhood Care (MN TRECC)	2.4	2.8
Parent Aware Quality Coach	23.1	37.8
School District	63.1	83.5
Supervisor or co-worker	14.8	71.8
Zero to Three (www.zerotothree.org)	22.0	31.6

Training needs

Respondents were asked about their training needs related to child development and screening. They were given a list of possible training topics and were able to reply “yes” or “no” to each, and to list others. Chart 7 captures the training needs identified by respondents. The top two responses were “where to find parenting support” and “talking to parents about concerns.” Respondents wanted to learn how and where to connect for referrals. There was less interest in learning about specific screening tools, which demonstrates the importance of relationships between child care providers and screening programs. Recommendations for highlighting and promoting existing trainings and developing new trainings will be discussed later on in this report.

CHART 7: TRAINING NEEDS IDENTIFIED BY CHILD CARE PROVIDERS



Discussion

Implications

Child care providers have routine contact and trusted relationships with young children and families (Branson, Vigil, & Bingham, 2008). Thus, they could play a key role in providing screening or connecting young children in their care to routine developmental and social-emotional screening. Some child care providers already fill these roles. However, there are significant differences among child care provider opinions on how and where screening should occur for children in their care.

Potential implications of the survey results include:

- Child care providers, like many other early childhood professionals and service providers, do not clearly understand screening, as evidenced by the fact that almost half of those who reported that they were providing screening were not using a validated

screening tool. More information about the purpose and practice of screening is needed.

- While many respondents reported agreement that providing screening was within the role of child care providers, the vast majority of those felt that this would best be done in partnership with outside existing programs. The state agencies, Child Care Aware, and Minnesota Interagency Developmental Screening Task Force could collaborate with child care providers to explore feasible options.
- Child care providers across the state of Minnesota would benefit from more support to address developmental, social-emotional, or behavioral concerns – including how to talk with parents about concerns.
- The survey revealed that respondents tend to be connected to outside referral sources regardless of type of facility they operate. However, center-based facilities tend to be more ready to act through a formal and active referral process. Family child care providers could be better supported to help link families to needed services.
- Child care providers demonstrate a need for training in the following areas. In some cases this training exists; in others it may need to be developed or expanded. Training for child care providers should include:
 - clarification of the purpose and importance of screening, in comparison to informal developmental monitoring and formal assessment
 - an emphasis on screening beginning in infancy and throughout early childhood;
 - support in connecting families to and partnering with existing, outside screening programs; and
 - potential ways that child care providers can help link young children and families to early intervention health and educational services.

Recommendations

Recommendations based on the results of this survey may include the following:

For state child care policy, licensing, and regulation:

- Currently, no state-level policy or recommendation exists for screening by child care providers. While child care providers are certainly in an excellent position to identify developmental concerns, careful consideration should be taken before asking child care providers to add screening to their work, for the following reasons:
 - Few child care providers are currently providing standardized developmental or social-emotional screening, and many do not have a clear understanding of how standardized screening compares or fits in with formal assessments, which are required for Parent Aware rating.
 - There is a wide range of views about whether screening should be their role; while some providers demonstrate interest, many feel that it is not their role. Opinions range from feeling that screening is not needed (because of their ability to recognize child developmental concerns with their own experience and expertise), to feeling that they are not qualified to do screening.
 - The majority of child care providers report already referring children to outside, existing screening programs.

- The majority of respondents indicated that it is best to partner with existing screening programs to provide this service in their setting (versus doing it on their own).
- If screening is to be encouraged in the child care setting, or for those child care providers that are currently interested in or providing screening, the following should be addressed:
 - Encourage, support, and provide technical assistance for partnership between child care providers and existing local screening programs.
 - Provide training and support to clarify screening versus assessment, use of recommended standardized tools, communicating with families about results, and appropriate and active/direct referrals when concerns are identified.
- Child care providers have strong connections to multiple sources of information already, which may be used to help relay important information about screening and referral. Some of the most important sources of information identified by respondents in the survey include Child Care Aware of Minnesota, Child Care Health Consultants (for center-based providers), local child care associations, Parent Aware (PA) Quality Coaches (for providers that are PA-rated or applying), and local child care licensors.
- Ensure that policies and statewide messaging about screening emphasize the importance of and support routine, universal screening beginning in infancy and continuing periodically throughout early childhood.

For screening program leaders at the state and local levels:

- Local screening programs – including public health and educational screening programs – can reach out to child care providers to partner around screening for children ages birth to kindergarten entry. Child care providers expressed a strong interest in partnering to ensure that children are screened, either by referral or by partnering with screening programs to provide the service in the child care setting.
- Child care providers are interested in having materials available for parents that explain what screening and child developmental services are available in their community.

For professional development:

- Key topics for training of child care providers include where to find support for parents and parenting programs, how to talk with families about developmental concerns, and where to send children for social-emotional or behavioral concerns.
- Additional topics with less (but still strong) interest include where to refer children for screening, developmental skills at specific ages, where to refer for general developmental concerns, and screening tools (where there is an interest in screening).
- Training resources exist through multiple sources on a number of these topics; there may be an opportunity to make these resources better known to child care providers.

- Important sources of existing training for child care providers in Minnesota include [Develop \(www.developtoolmn.org\)](http://www.developtoolmn.org) and the [Center for Inclusive Child Care \(CICC\) \(www.inclusivechildcare.org\)](http://www.inclusivechildcare.org). For screening, instrument-specific training is available from instrument publishers.
- The Minnesota Child Care Credential and the Minnesota Infant Toddler Credential both cover information on screening and referral, difficult conversations with families, child development and behavioral issues, and the difference between screening and assessment. This information is also included in the Social-Emotional Pyramid Model training, multiple Parent Aware courses and our 8 hour training specifically developed for Legal Non-Licensed providers. The Center for Inclusive Child Care, through a contract with the Minnesota Department of Human Services, also provides training, podcasts, self-paced learning, coaching/consultation and myriad other resources about the identified topic areas cited in the report for both parents and providers.
- A training module was developed by Generation Next and the Greater Twin Cities United Way, along with a number of community and state partners. It is available on Develop for hours toward licensing requirements: [Early Childhood Screening: What It's All About \(www.developtoolmn.org\)](http://www.developtoolmn.org). The training is designed to help child care providers better understand the preschool Early Childhood Screening program, and to support them in referring families to screening and to follow up on recommendations after screening. This training may serve as a model for other similar trainings, showing ways that child care providers could potentially support existing screening activities in addition to preschool screening.
- For topics where training does not currently exist, there may be an opportunity to include this information in existing training methods, or to develop trainings and provide it through methods identified as important in the survey:
 - For family child care providers: through Child Care Aware training, the local child care association, or local licensors.
 - For center-based child care providers: through Child Care Aware training, Child Care Health Consultant training, center supervisors or training directors, or local licensors.
 - For Parent Aware Quality Coaches, so that they can share information about Minnesota's screening and referral system with child care providers.

Limitations

While the survey offers a window into Minnesota's licensed child care providers' views and practices in developmental and social-emotional screening and referral, it has a number of limitations. Over 1500 center-based and family child care providers responded, but with less than a 20 percent response rate, this cannot be considered representative of the state's licensed child care providers. The survey did not capture the perspectives of family, friend and neighbor (FFN) providers. Given that FFN providers make up the largest portion of child care

providers across the state, particularly for infants and toddlers, it would be interesting to gain their perspective. Also, the survey was only distributed electronically, excluding providers without an email address or consistent internet connection. Further, the survey was only available in English, limiting participation and creating challenges for providers with limited English proficiency or literacy.

The survey was distributed on the heels of a required annual survey from Child Care Aware. Some potential respondents may have confused this survey as one they had already completed or may not have responded due to “survey fatigue.”

Additionally, based on phone and email correspondence, it appears that some respondents assumed an association with Parent Aware. Also, in spite of efforts to clarify this through the survey instructions, some thought that screening was being “pushed” by MDH. In this case, child care providers may have been dissuaded to complete the survey or may have answered questions less candidly.

Finally, more useful anecdotal information may have been captured if certain questions had options for free text responses. Particularly troublesome was the lack of an opportunity to provide comments on the item that asked about whether child care providers should provide screening, send children to other screening programs, partner with other screening programs, or whether screening was even “the job” of child care providers.

Next steps

With the information gathered in this report, the Minnesota Department of Health will work with the Minnesota Department of Human Services Child Development Services to explore ways to support licensed child care providers through training in connecting young children in their care to screening opportunities. It may be useful to incorporate information on connecting children to screening and intervention programs into Anytime Learning online modules available on [Develop \(www.developoptoolmn.org\)](http://www.developoptoolmn.org), which offer training hours that count toward licensing, or into other existing training modules with related content. Additionally, it may be useful to train Parent Aware quality coaches, given the greater interest among PA-rated and applying programs in screening.

In the future, it may also be useful to conduct focus groups or qualitative interviews with culturally and linguistically diverse child care providers to gain their perspective.

Conclusion

While the findings of this survey cannot be broadly generalized across all of Minnesota’s child care providers, the results provide valuable insight into ways that state agencies and local screening programs can partner with child care providers to ensure that all of Minnesota’s children birth to kindergarten entry receive appropriate screening and connection to services that support healthy development. Child care providers indicated a strong interest in partnering with existing local screening programs, and some are interested in providing screening themselves. There are opportunities to develop training materials on using screening

instruments, assist in connecting child care providers to existing local programs for screening and referral, and follow through to the next steps after screening. Training and tools can also be provided to assist child care providers in talking with parents about the importance of screening, how to connect to routine screening opportunities, and resources for developmental and social-emotional concerns.

References

- American Academy of Pediatrics. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics*, *118*, 405-420.
- Arunyanart, W., Fenick, A., Imjaijitt, W., Northrup, V., & Weitzman, C. (2012). Developmental and autism screening. *Infants & Young Children*, *25*(3), 175-187.
doi:10.1097/IYC.0b013e31825a5a42
- Branson, D., Vigil, D. C., & Bingham, A. (2008). Community childcare providers' role in the early detection of autism spectrum disorders. *Early Childhood Education Journal*, *35*(6), 523-530. doi:10.1097/IYC.0b013e31825a5a42
- Child Trends Data Bank. (2014). *Well Child Visits: Indicators on Children and Youth*.
doi:10.1017/CBO9781107415324.004
- Glascoe, F. (2005). Screening for developmental and behavioral problems. *Mental Retardation and Developmental Disabilities Research Reviews*, *35*(6), 173-179.
doi:10.1002/mrdd.20068
- Mackrides, P., & Ryherd, S. (2011). Screening for developmental delay. *American Family Physician*, *84*(5), 546-549.
- Pool, J., & Hourcade, J. J. (2011). Developmental screening: A review of contemporary practice. *Education and Training in Autism and Developmental Disabilities*, *46*(2), 267-275.