VALIDATING THE EARLY CHILDHOOD SELF-ASSESSMENT TOOL FOR FAMILY SHELTERS

by

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ABSTRACT

Almost half of all children residing in federally funded shelter programs are under the age of six (Solari et al., 2017). Despite this fact, we know very little about the developmental friendliness of these housing programs. Because young children may be spending a considerable amount of time in the shelter environment, it is important to understand the experiences of young children in shelter. The Self-Assessment (2014) was designed to address both the environmental quality of emergency and transitional housing programs for children aged birth to five, and the shelter program's ability to make referrals to ECE programs. The current study addressed the psychometric properties of the Self-Assessment by engaging in a mixed methods validity analysis. Findings highlighted the importance of incorporating the perspectives of housing providers in the survey development process. Additionally, findings suggested that the original Self-Assessment did not provide enough flexibility to capture the diversity among housing programs. Based on the findings from Phase I, revisions were made to the Self-Assessment. The current study then assessed the factor structure of the revised Self-Assessment. Findings suggested a two-factor solution for the data. Factor loadings for each of the two factors clearly delineated those Self-Assessment items which were related to linkages to early childhood and family services, and those items related to more material-based ways to improve the shelter environment for young children. The items on the Self-Assessment related to each of these factors can help support housing staff in making critical decisions about how to invest resources to better support young children and their families.

Chapter 1

INTRODUCTION

The current project is a mixed methods study that seeks to validate the Early Childhood Self-Assessment Tool for Family Shelters (the Self-Assessment) (Administration for Children and Families, 2014). The Self-Assessment was designed to increase the awareness and capacity of shelter programs to provide high quality, developmentally appropriate environments and practices for infants, toddlers, and preschoolers experiencing homelessness. Currently, we know very little about the experiences of young children in shelter. Therefore, the intent of the Self-Assessment is to contribute to a broader understanding of the ecological impact of temporary housing use on young children. To date there is no evidence supporting the reliability and validity of this measure.

While temporary housing may present environmental factors that can be harmful to young children, it also affords the opportunity to incorporate protective factors to foster positive developmental outcomes. For example, shelters may provide in-house social services (i.e. case management) to address families' immediate needs, as well as refer families to community resources (i.e. domestic violence services, job supports, and health care) (Holtrop, Chaviano, Scott, & McNeil Smith, 2015). For families with young children, referrals to high quality early care and education (ECE) programs can be particularly impactful. Despite this fact, very little is known about the relationship between housing and ECE and the practices of connecting young children experiencing homelessness to high quality early learning.

Therefore, the present study employs a mixed methods framework to validate the Self-Assessment. Measurement validity, or the ability of items on a specific measure to meaningfully capture the construct of interest, is a crucial step in survey development (Adcock & Collier, 2001). In this exploratory sequential design, two data collection and analysis phases are conducted sequentially over time to assess the validity of the Self-Assessment. Phase I includes qualitative and quantitative analyses of cognitive interviews from providers completing the Self-Assessment measure. Phase I is followed by revisions to the Self-Assessment tool that reflect the findings from the first phase of analysis. Phase II includes quantitative analysis of the revised Self-Assessment scores from a nationally representative sample of providers.

The Early Childhood Self-Assessment Tool for Family Shelters

Given that we know very little about the experiences of young children in shelter, the Administration for Children and Families developed the Early Childhood Self-Assessment Tool for Emergency Shelters (the Self-Assessment) which aims to improve the quality of shelter environments for young children, including increasing knowledge of early childhood development and ECE services (Administration of Children and Families, 2014) (Please see appendix A to view the items on the Self-Assessment). On the Self-Assessment the quality of the environment is measured by addressing the physical space within the shelter, and the service coordination with, and referral to early childhood services. The assessment contains 52 items gauging key characteristics of settings appropriate for young children. The tool is divided into five sections: (1) health and safety, (2) wellness and development, (3) workforce standards and training, (4) programming, and (5) food and nutrition. Included in the measure are eight items that refer to the coordination, and referral process for enrolling young

children in ECE programs (e.g. “We have procedures in place for collaborating with local early care and education programs - Head Start, child care, IDEA part C early intervention, and part B preschool, etc.”). These questions related to the referral process are embedded into three of the five sections. The Self-Assessment process involves a detailed review of shelter facilities and policies relevant to young children. After rating each item, housing staff are asked to identify areas of greatest importance for improvement. Implementation of the Self-Assessment in Connecticut resulted in an overall increase in the child-friendliness of shelter environments, as well as increased enrollment of young children in both Early Head Start and Head Start programs (Hayes, Suchar, Rankin, & Peterson, 2015).

The Self-Assessment was developed as a collaborative effort across multiple national agencies to support the outreach efforts of the Early Childhood Sub-group of the Interagency Workgroup on Ending Family Homelessness in 2014. Given that this measure is relatively new, evidence to support the reliability and validity of the tool is needed. Therefore, the present study employs a mixed methods validation framework to better understand the psychometric properties of this tool. This process will ensure that the measure incorporates key aspects of practice that support early childhood development, and that it is useful to staff working in shelter environments who are typically not trained in early childhood development.

Theoretical Foundation

Bioecological Theory. Underlying the current study are two theoretical frameworks, the first is bioecological theory (Bronfrenbrenner, 2005). This perspective posits that development is influenced by both direct and indirect environmental factors (Paat, 2013; Swick & Williams, 2006). These influences are

categorized into a series of concentric circles. Most immediately children are impacted by their proximal environment, or microsystem. The microsystem constitutes the people that the child directly and frequently interacts with including parents, siblings, and peers at school. For children experiencing homelessness this microsystem acts as their reference point for understanding the rest of their world. For these young children who are disproportionately exposed to domestic violence, and the trauma of losing their home this influence can play a significant role in their development (Swick & Williams, 2006). Expanding beyond the most proximal environmental influences, the second level of influence, the mesosystem, refers to the interactions among the individuals in the microsystem. For example, this may be a case worker in a shelter that is available to assist a family with making housing appointments, while also being available to assist with child care during the appointment. Further environmental consequences such as the parents work environment, neighborhood level effects, and social services are referred to as the exosystem. For families experiencing homelessness, knowing that they have a young child may influence their decision to enter a shelter (Swick & Williams, 2006). Finally, development is also influenced by society's cultural views, and policies, or the macrosystem. Social policies that support families experiencing homelessness include those related to education, food access, and financial support are all part of the macrosystem. Ecological Systems theory places an emphasis on the child's interactions and environment, and therefore is useful in explaining the benefits and detriments of emergency and transitional housing on children.

Bronfrenbrenner (2005) expanded on the bioecological framework by including the chronosystem, which accounts for how people and their environments

evolve over time. Within this construct he developed the Process-Person-Context-Time (PPCT) model. The process component of this model refers primarily to the influence of proximal processes on development. For example, it considers that development occurs through regular, increasingly complex, interactions with others and the environment. In the case of families residing in federally funded shelter programs this may include the interactions with the shelter environment, housing staff, and other families. The second component, person, considers the personal attributes of the individual as they contribute to development. These include demand (e.g. age, gender), resource (e.g. access to shelter/housing, past experiences), and force (e.g. temperament, motivation) characteristics. The context component refers to the interplay between the interconnected systems discussed above (microsystem, mesosystem, exosystem, and macrosystem). Finally, the time component refers to the timing of interactions and development across the interconnected systems (Bronfrenbrenner, 2005). For young children experiencing homelessness, spending sensitive periods for development within the shelter system may have a greater impact on developmental outcomes.

While the bioecological framework has not been widely used with young children experiencing homelessness, it has been used to study other populations facing adversity (Paat, 2013). Understanding the impact of the physical environment of housing programs, as well as the connections to ECE, and the timing of homeless episodes will help to understand the influence of housing instability on children's development.

Cumulative Risk. Within this ecological frame, the present study draws on constructs of cumulative risk to understand the relationship between risk and

protective factors in the environments of children residing in shelter programs (Masten & Wright, 1998). Such that experiences of multiple adversities, including living in poor quality neighborhoods, overcrowded housing, spaces not designed for children, and limited access to high quality early childhood education, may result in poor developmental outcomes, and decreased well-being. However, it is also important to address the various protective factors, which serve to moderate the risk present in a child's life, and are associated with more positive outcomes. The present study conceptualizes resiliency as, "The capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development." (Masten, 2014, p. 7).

For children experiencing homelessness, there are several potential risk factors that may impact their development and well-being. Children experiencing homelessness are more likely to witness acts of violence, have a single parent, experience poverty, and go through multiple moves (Park, Fertig, & Metraux, 2011). Compounded by housing instability, and the loss of their home, children experiencing homelessness are likely to experience the higher end of the continuum of risks. The shelter environment itself may also confer risks. For example, emergency and transitional housing programs with lower quality environments (i.e. lack of child-proofing, overcrowding, presence of environmental hazards) may negatively impact children's well-being and development. Considering the potential for elevated levels of adversity, the Self-Assessment can act as an indicator of the cumulative risk that children are exposed to in shelter. Furthermore, it suggests that children in higher quality shelter environments, as measured by the Self-Assessment will have more positive outcomes compared to their peers in lesser quality shelters.

Chapter 2

LITERATURE REVIEW

Early Childhood Development and Homelessness

Developmental science underscores the importance of the first years of life. During these years, young children develop the foundational cognitive, social-emotional, and gross/fine motor competencies that they will need to successfully negotiate developmental challenges across the lifespan (Sroufe, Egeland, Carlson, & Collins 2005). These early years are also marked by increased vulnerability to traumatic events, including homelessness. According to the McKinney-Vento Homeless Assistance Act (2001), homelessness is defined by the absence of stable, adequate nighttime shelter. This includes the use of public shelters, doubled-up or shared housing, automobiles or other inadequate shelter, and substandard housing (42 USC 11431 et seq.). Children under six represent approximately half (49.6%) of all children in federally funded shelter programs (Solari, Shivji, de Sousa, Watt, & Silverbush, 2017). Furthermore, children are at greatest risk of entering the emergency housing system during the first year of life (Perlman & Fantuzzo, 2010).

Children and families in federally funded shelters are typically first placed in emergency housing. Emergency housing, as defined by the Department of Housing and Urban Development (HUD) refers to a short-term accommodation for individuals facing a homelessness crisis. Emergency Housing programs provide services to meet a family's basic needs. In addition to Emergency Housing, many families experiencing homelessness are also enrolled in Transitional Housing programs. HUD defines Transitional Housing as those programs which serve to facilitate the movement of families experiencing homelessness into more permanent housing. These programs

typically serve families with greater needs and may fall under one of three HUD priority populations including families exposed to domestic violence, youth-headed households (18-24 years old), and families who have a parent with mental or physical disabilities. Unfortunately, very little is known about the specific supports and services these housing programs provide for families with infants, toddlers, and young children.

This is problematic as these young children are perhaps the most vulnerable segment of our society. There are several plausible ways in which exposure to this type of environment may negatively impact development. Perhaps most notably, early exposure to adversity hinders neurological growth. In fact, the brain develops at an unprecedented rate during the prenatal and earliest years of life, with the brain more than tripling in size between birth and age two (National Research Council, 2000). Soon after conception, neural development begins and continues rapidly throughout early childhood (Nelson & Bosquet, 2000). Exposure to adversity or traumatic early experiences, such as homelessness, can negatively influence this neural development.

More broadly, literature on infants born into homelessness suggests that there are a variety of adverse health and education outcomes associated with episodes of housing instability. Children experiencing homelessness in the first few years of life are more likely than their permanently housed peers to have been born prematurely and at a low birth weight (Fantuzzo, LeBoeuf, Brumley, & Perlman, 2013). These infants are also more likely to experience a stay in a Neonatal Intensive Care Unit, have limited access to well-baby visits, and are less likely to be breastfed by their mothers (Little et al., 2005; Richards, Merril, & Baksh, 2011). Furthermore, these

babies and toddlers grow to experience higher rates of asthma and chronic ear infections than their peers (Grant et al., 2007).

In addition to adverse health outcomes, homelessness is associated with increased school problems, including poor academic achievement, and higher rates of behavioral problems (Gewirtz, Hart-Shegos, & Medhanie, 2008; Perlman & Fantuzzo, 2010). The loss of autonomy, and added stress associated with episodes of homelessness, can result in decreased well-being and developmental delay, perhaps most notably socio-emotional delay (Brumley, Fantuzzo, Zager, & Perlman, 2015; Coley, Leventhal, Lynch, & Kull 2013; Gargiulo, 2006; Park et al., 2011; Zima et al., 1997). Research demonstrates that environmental factors exert a unique influence on children's developmental outcomes. For children experiencing homelessness, this includes the environment of housing programs.

Quality of Environments in Emergency/Transitional Housing

All types of homelessness confer risk on young children, but the specific aspects of homelessness that may increase risk are less evident. Some risks may be intrinsic to institutional living in emergency or transitional housing shelters themselves. Some of the unique living arrangements for children in emergency housing include rules about guests, diet restrictions, curfews, and hygiene standards (Friedman & Clark, 2000). Additionally, emergency shelter systems are often inundated with families in need and face challenges with overcrowding (David, Gelburg, & Suchman, 2012; Friedman & Clark, 2000). This is problematic, as conceding to shelter guidelines, often within a chaotic environment, can be disruptive to a family's normative behavior and rituals (David et al., 2012). This results in a

high-stress environment for children already facing a time of crisis in the loss of their home.

Interacting with the Shelter Environment. Unlike their school-aged peers, infants and toddlers rely on a distinct set of perceptual cues to make sense of their environment. Young children are more likely to explore by crawling on the ground, and using their hands and mouths for sensory input (Le Cann et al., 2011). This places infants and toddlers in a unique position to be particularly susceptible to many contagions in their environment. Children living in poverty are more likely to be exposed to older, or substandard housing which presents an elevated risk for exposure to lead paint. Furthermore, housing programs tend to be clustered in older infrastructure, and were not built with children in mind. Therefore, poor housing quality markedly increases the risk for environmental contagions within these housing facilities. Additionally, if children are not enrolled in ECE programs, they may be spending most of their day in a shelter, increasing the dose of exposure to poor quality environments.

Importantly, there are several aspects of community or congregate living that are contributing to these health risks. Most notably, children in shelter programs are exposed to higher rates of crowding, as the demand for housing far outweighs the supply of emergency housing facilities. Inadequate resources lead emergency shelters to make the most of the limited living space they have available for families (Leventhal & Newman, 2010). Children in shelter are also exposed to elevated levels of noise as a result of the crowding. As one might imagine, high levels of noise can detrimentally impact a child’s attention, sleep patterns, and general focus throughout the day (Graham, Fisher, & Pfeifer, 2013). Furthermore, as parents grapple with the

trauma of losing their home, they may be transmitting their stress through verbal interactions with their young children. Infants display the ability to distinguish between anger and other more neutral or happy verbal tones and may internalize the tone of conversations around them (Graham et al., 2013).

The inherent chaos associated with experiences of homelessness also plays a role in shaping the development of young children. Chaos refers to confusion, clutter, ambient noise, instability (residential and relationship), and disorganization (Vernon-Feagan, Garrett-Peters, & Willoughby, 2016). In fact, there is evidence to suggest that home chaos is associated with both parent-level, and child-level outcomes. In a sample of low-income families, disorganized home environments were associated with decreased parenting skills (Vernon-Feagans et al., 2016). Furthermore, Coley and colleagues (2013) identified a relationship between home chaos and child outcomes such as developmental delay, poor health, and externalizing behaviors.

While the shelter environment appears to pose a series of potential risk factors for young children, it also provides an opportunity to incorporate protective factors to foster positive developmental outcomes. Shelters provide services such as parenting courses, career education, GED programs, as well as a variety of other daily living skills programs. Additionally, some housing facilities offer support with connecting young children to ECE programs through partnerships with local child care providers. These child care providers can provide a safe, and supportive environment for young children experiencing homelessness.

Home and Education Environments and Homelessness. Taken together, there is evidence to suggest the environments of both the home and early education programs that a child interacts with work in concert to impact developmental

outcomes. To illustrate this point, children in low quality home and child care environments incur the most cumulative risk compared to their peers in higher quality settings in either the home, or child care environment (Watamura et al., 2011). This indicates that for the best outcomes, the home and early education programs should be of high quality.

Access to Early Childhood Education (ECE)

High quality ECE programs can contribute to narrowing the achievement gap prior to kindergarten (Puma et al., 2012). As knowledge of the importance of early intervention improves, early childhood service providers are beginning to prioritize the needs of young children who experience homelessness (Perlman, 2014). Yet, findings from several reports indicate that numerous challenges and barriers may inhibit the number of young children without a stable home to access high quality early childhood programming. Findings suggest that there exist several barriers from both the providers' perspective, and from the family's (Perlman, Shaw, Kieffer, Whitney, & Bires, 2017). A national survey of housing providers identified several factors that hinder access to high quality ECE (Perlman, 2014). Examples of barriers include inadequate transportation, limited availability of ECE programs, mobility, and limited understanding of the policies and programming offered by various young child serving systems (Perlman et al., 2017).

Furthermore, in a case study examining the impact of a Head Start program which only served families experiencing chronic homelessness, several teachers indicated concerns about student attendance, and emotional stability in the classroom. As these teachers reported, the children in their classrooms were coming from very unstable home environments (Bullough, & Hall-Kenyon, 2015). The director of the

program in question even cited concerns about finding appropriate teachers to work in this environment, as the social emotional needs of these young children were far greater than the needs of other children in their Head Start programs (Bullough, & Hall-Kenyon, 2015).

A qualitative analysis of interviews with parents experiencing homelessness substantiates these findings (Taylor, Gibson, & Hurd, 2015). While 61% of parents in the sample of mothers experiencing homelessness enrolled their child in formal early education programs (pre-school, child care, or Head Start), there were several barriers that impacted or complicated this process. Parents reported that competing demands, concerns about mobility, difficulty navigating enrollment, lack of transportation, and concerns about costs, were all barriers to enrollment (Taylor et al., 2015). In fact, several parents cited a lack of support with the enrollment process from both the emergency housing system, and the public school system via the McKinney-Vento Liaison (Taylor et al., 2015). This leaves parents on their own to navigate a complex system, in addition to their other obligations including work requirements, and looking for adequate housing.

The cost of child care also appears to be one of the most significant barriers for families facing housing instability and homelessness (Costa Nunez, Anderson, & Bazerjian, 2014). To illustrate this point, a report from the Institute for Children, Poverty, and Homelessness report in 2012 identified that parents experiencing homelessness were less likely to have access to child care subsidy[1] than their low-

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[1] Financial assistance from state or federal funds available to low-income families who meet the state's income eligibility requirements. Subsidized care is available in licensed child care centers, family child care homes, and by license-exempt providers

income but stably housed peers. Furthermore, it may be the case that families with disproportionately higher numbers of risk factors are less likely to be accessing child care subsidy (Johnson, Martin, and Brooks-Gunn, 2011).

Given that families experiencing homelessness are on the higher end on the continuum of risk factors, it is probable these families would fall into this group. This indicates that the child care subsidy may be more difficult to navigate for families facing elevated levels of risk (Johnson et al., 2011). Despite these barriers, there are provisions in several federal policies that prioritize the needs of homeless children including the Child Care and Development Block Grant, the McKinney-Vento Homeless Assistance Act, the Every Student Succeeds Act, and the Head Start Act. The following sections will explore these federal policies.

Child Care and Development Block Grant Act (2014). The reauthorization of the Child Care and Development Block Grant (CDBG) in 2014 prioritized the child care needs of families experiencing homelessness. The CDBG legislation provides funds to increase access to ECE programs by requiring procedures for training education providers on how to identify, serve, and provide outreach to families experiencing homelessness. Several provisions in the current legislation support the unique needs of these families. Under the previous legislation, families experiencing homelessness had a challenging time meeting the work and education requirements for child care subsidy, finding and completing the appropriate paper work, and often could not afford the co-pays associated with child care subsidy use (Duffield, 2014). Additionally, given the highly transient nature of this population, attendance requirements were an additional concern.

The reauthorization of CCDBG addresses these barriers, by including several provisions specific to families experiencing homelessness. The legislation also provides a grace period for families facing homelessness, allowing their children to enroll while they gather the appropriate paperwork, including immunizations. A sliding fee scale is also mandated under the current legislation to ensure that there are no financial barriers for families receiving federal assistance. Once a child is enrolled in the program, there should be no change in eligibility for services for at least 12 months regardless of any fiscal changes the family may experience.

Additionally, the reauthorization of CCDBG mandates service coordination between early childhood programs providing services to children experiencing homelessness. This would include programs providing temporary housing that support young children. Finally, the current legislation requires programs to collect and submit data on children who are homeless receiving federal child care assistance. The intent by doing so, is to have a better picture of the scope of services provided to families experiencing homelessness.

Notably many of barriers families experiencing homelessness face during enrollment in ECE, are not yet addressed by the current legislation. Building a relationship between early education providers and emergency housing staff will help to address these barriers by helping to educate both families, and providers on the necessary steps for successful enrollment. One way to assess these barriers is through the use of an environmental rating scale, such as the Self-Assessment. This measure is well aligned with the current policy landscape, including the reauthorization of the CCDBG by filling a practice gap to connecting ECE and housing programs. The Self-Assessment tool may aid in this process by asking emergency housing staff to think

about their referral processes, and the policies their programs have in place that may also serve as a barrier for enrollment.

In a 2014 report assessing how states meet the childcare needs of homeless families, the Institute for Children, Poverty, and Homelessness (ICPH) made several policy recommendations concerning the allocation of CCDF funding to families experiencing homelessness. These recommendations include prioritizing families experiencing homelessness, and including homelessness status as categorically eligible for care due to a need for protective services. By doing so, this would allow families to qualify for assistance without the need to fulfill work requirements. Additionally, the ICPH report (Costa Nunez et al., 2014) recommends easing the restrictive documentation requirements of CCDF funding, including immunization records, and birth records. For families experiencing homelessness it can be difficult to access these records. Other recommendations include adding housing search as an eligibility activity, reducing the cost of care, increasing provider reimbursement rates to match the child care needs of this special population, and promoting continuity of care for these highly mobile families (Costa Nunez et al., 2014).

The McKinney-Vento Homeless Assistance Act (2001). The McKinney-Vento Homeless Assistance Act aims to eliminate some of the barriers young children experiencing homelessness face when enrolling in education programs. In addition to the education provisions, the McKinney-Vento legislation funds transitional housing programs, work programs, and the creation of other programs to support homelessness. McKinney-Vento Homeless Liaisons are identified by districts as being the dedicated staff member to assist children experiencing homelessness in their schools. Unfortunately, current research suggests that many of these liaisons may be

unaware of their elected position, as well as reporting many other job titles in addition to liaison (Taylor Wilkins, Mullins, Mahan, & Canfield, 2015). Additionally, it appears that there is great variability in the implementation of the policy by level of collaboration and awareness between McKinney-Vento liaisons and teachers (Taylor Wilkins, et al., 2015).

Therefore, while there are provisions in place to support access and enrollment in high quality ECE, there remains a gap in our understanding of how these policies are supporting this process. It is fundamental to the development and well-being of young children experiencing homelessness that the barriers to enrollment, as well as the coordination of services be better understood. There currently exists only a small sample of literature that explores the barriers to enrollment, and none to the author's knowledge that explore the coordination of services, or referral to early education programs. Of the limited work, parents have identified that they are not familiar with their local McKinney-Vento Homeless Liaison, and that their emergency and transitional housing programs only provide a limited amount of support for enrollment (Taylor et al., 2015). This is problematic for several reasons, most notably; this results in a limited understanding of how these policies can support emergency and transitional housing staff, as well as families, in the enrollment process. Therefore, it is crucial to measure the coordination of early education services, and referral processes in emergency and transitional housing programs.

Every Student Succeeds Act (2015). The Every Student Succeeds Act (ESSA), signed into law December 2015, amends the McKinney-Vento Homeless Assistance Act with an increased focus on the needs of young children experiencing homelessness. The ESSA specifically added language to include preschools under the

guidance concerning school of origin, affording young children access to the same preschool they attended prior to their homelessness episode. This includes providing transportation if other children in the school are afforded the same benefit. In addition, the ESSA clarified the local McKinney-Vento liaison's role. These liaisons are now required to ensure that young children experiencing homelessness have access to all needed early childhood services offered to their stably housed peers including, Head Start, Early Intervention Program for Infants and Toddlers with Disabilities (Part C of Individuals with Disabilities Education Act (IDEA), and other publicly funded preschool programs. The ESSA also increased language about the collaboration and coordination with other social services such as child care providers and operators of emergency and transitional housing facilities.

Head Start Act (2007). The Head Start Act provides federally funded early education to low-income families to promote school readiness. These programs work to support the mental, social, and emotional development of children by partnering with local agencies to provide high quality early childhood services. Head Start's programming consider the importance of engaging parents as part of the early education process, and provide a variety of services to best fit each family's needs. Services provided by head start include home visiting, center-based care, or school based care.

In 2016 Head Start revised their performance standards, which now include children experiencing homelessness as a priority population. In fact, the Head Start Act requires the identification as well as prioritization of children and families experiencing homelessness in both Head Start and Early Head Start programs. The 2016 Head Start Program Performance Standards (HSPPS) outline provisions which

are aligned with both McKinney-Vento and Every Student Succeeds legislation. The new standards specifically address barriers to enrollment for children experiencing homelessness. For example, families are required to produce a letter of residency for enrollment purposes, however, under the new standards families experiencing homelessness have flexibility in terms of the type of documentation needed to meet this requirement. Families may provide a letter from their housing program, the family they are staying with if doubled up, or they can provide a self-declaration through a written letter. In addition, the new standards provide grace periods for receiving health and other documentation needed for enrollment. For example, children who are homeless can attend for up to 90 days without records or immunizations. The performance standards allow programs to reserve up to 3% of the funded enrollment, or at least one spot, for pregnant women and children experiencing homelessness for 30 days. Finally, to address family mobility, Head Start programs provide transition supports and services to aid parents in finding Head Start programming in the event they move outside of the area.

The number of children experiencing homelessness served by Head Start has substantially increased over the years. In fact, there was an almost 8% increase in the number of children experiencing homelessness enrolled in Head Start programs from 2007 to 2010 (Costa Nunez, Adams, & Harris, 2011). However, it is also important to highlight the fact that there are limitations to enrollment in the current model of Head Start. For example, Head Start policy requires that all grantees operate at 100% enrollment and maintain a wait list. Grantees with enrollment below 97% may be placed on corrective action and subject to fiscal penalties (Head Start Act, 2007). Given the transient nature of this population it could be a significant risk to a grantee

to serve them in the traditional Head Start model. We need more responsive program models to ensure that homeless children and families access these important services while grantees meet their regulatory mandates to funders.

Head Start and Homelessness

There is limited evidence on the impact of ECE on the development of young children experiencing homelessness. In fact, to the author's knowledge, the only analyses exploring the impact of ECE programs on young children experiencing homelessness involve students enrolled in Head Start programming. For children facing housing instability, the comprehensive services provided by Head Start may be of particular benefit. In a nationally representative sample of families enrolled in their first year of Head Start, Costa Nunez and colleagues (2011) identified several gains for children in temporary housing or homeless living situations. Children experiencing homelessness entered Head Start significantly behind their stably housed peers in social-emotional and cognitive outcomes. However, after participation in Head Start for one year, children experiencing homelessness show substantial gains in many social-emotional outcomes. The gains were greater for children experiencing homelessness than for their stably housed peers on several measures including children's attitudes towards learning, and both internalizing and externalizing behaviors. However, for other indicators of social-emotional development despite gains, there remained a gap between homeless and stably housed students. In terms of cognitive development, again children experiencing homelessness show several gains over their year of participation in Head Start, particularly in language, and math skills. The gains in cognitive developmental outcomes were more limited, with over half of the indicators of cognitive development showing statistically significant differences

between the housed and homeless samples at the end of participation in Head Start (Costa Nunez et al., 2011).

In a case study of a Head Start program specifically serving young children experiencing chronic homelessness and their families, several teachers reported the need for ECE programs to address the social-emotional needs of young children experiencing homelessness (Bullough, & Hall-Kenyon, 2015). However, currently the Head Start model emphasizes increasing academic performance over other program goals. Importantly the authors argue the importance of focusing on the social-emotional needs of young children experiencing homelessness. In fact, in several examples, the authors highlight the specific needs of these young children who have experienced abuse, neglect, and maltreatment all within the context of housing and care taker instability (Bullough, & Hall-Kenyon, 2015).

It is also important to note that there is mixed evidence on the impact of Head Start particularly for families experiencing homelessness. Koblinsky and colleagues (2000) identified losses in social-emotional outcomes for children experiencing homelessness after participation in Head Start. However, there are several limitations to this study that may be impacting their results. The authors highlight that on average the children experiencing homelessness in their sample were absent for more than half of their days in their school year. This is important to note, as continuity in care is an important factor impacting the efficacy of this type of program. Additionally, the authors report a large amount of attrition for their sample of children experiencing homelessness, resulting in a very small sample size of only 38 homeless preschoolers. Given the small sample size, and other notable limitations, caution should be used when interpreting these results.

Early Education/Child Care and Trauma/Adversity

Given that there is limited research supporting the efficacy of high quality ECE programs on children experiencing homelessness, it is important to draw on literature from other populations of children experiencing trauma and adversity. Indeed, several studies highlight the positive impact that Head Start has on developmental outcomes of children experiencing maltreatment, and community violence. This is important to note, as children experiencing homelessness likely have experiences of trauma and adversity. Furthermore, in general the population served through Head Start programming is disproportionately more likely to have experiences of trauma, and family violence. In fact, in a small sample of 188 children served by Head Start, 75% reported at least one traumatic event, while 27% had been exposed to family violence (Roberts, Campbell, Ferguson, & Crusto, 2013).

Using a subsample of the Early Head Start Research and Evaluation Project, Green and colleagues (2014) found that participation in Early Head Start decreased the likelihood of physical and sexual abuse, and experiencing subsequent maltreatment experiences. Children enrolled in Early Head Start had fewer overall maltreatment experiences than their peers who were not enrolled in the program at ages five and nine (Green et al., 2014). Furthermore, in a nationally representative sample of children in the child welfare system, exposure to ECE had a positive impact on early language development (Merritt & Klein, 2015). Additionally, in their review of ECE programming, Mortenson and Barnett (2016) identified several ways in which child care can support the emotional regulatory needs of children who experienced maltreatment.

For children exposed to violence, Head Start also has a positive effect. This is particularly important as families experiencing homelessness are at an elevated risk for

domestic, and neighborhood violence (Swick, 2004). Recent work also highlights the impact of family violence on the parent-child relationship. In fact, in a sample of 188 Head Start participants, family violence was significantly associated with child mental health, such that parenting stress mediated the relationship between family violence and child mental health (Roberts et al., 2013). However, there are several artifacts of Head Start that can support the needs of families exposed to violence. In a sample of children exposed early to violence, Head Start attendance showed higher levels of positive approaches to learning, and lower levels of hyperactivity (Lee & Ludington, 2016).

Finally, for children in out-of-home placement, such as foster care or group home care, Head Start exposure had a modest direct short-term effect, and indirect longer-term effects on school-readiness outcomes (Lipscomb, Pratt, Schmitt, Pears, & Kim, 2013). Using the Head Start Impact Study data, Lee (2015) found that there was no main effect of foster care on reading and math scores; however, there was an interaction with gender and caregiver age. Girls, and those cared by older caregivers enrolled in Head Start and foster care obtained higher reading and writing scores (Lee, 2015). However, in a sample of Head Start directors, several noted that while they prioritize children with foster care involvement, there are several barriers to providing ECE to these families (McCrae, Brown, Yang, & Groneman, 2016).

One gap in the literature on the importance of high quality ECE for young children experiencing homelessness and trauma is a lack of evidence supporting the referral and enrollment process. The Self-Assessment tool offers an opportunity to further explore the referral and enrollment process. However, the psychometric properties of this measure are not well understood.

Early Childhood Survey Development and Validation

Currently, a variety of early childhood measures are being employed without appropriate documentation of reliability and validity (Bordignon & Lam, 2004). This has important implications about how these tools are being used in diverse populations and settings (Goldstein, & Flake, 2016). When a program seeks to understand their environment, it is critical that the tool they are using can accurately and appropriately measure the quality of their program's environment. The Standards for Educational and Psychological Testing (2014) define validity as the, "degree to which evidence and theory support the interpretations of test scores entailed by the proposed use of tests" (p.9). Therefore, under this framework, the Self-Assessment should be able to distinguish between lower quality and higher quality shelter environments for young children.

Unfortunately, early childhood assessments tend to be fraught with measurement error. According to Goldstein and Flake (2016), this error emerges because of the nature of early childhood development, and the factors that influence development. For example, children tend to be spending time in several different settings, such as ECE programs, with relatives, and in home-based care, unlike school aged children who may be spending much of their time in school-based settings. Therefore, measuring the quality of environments young children interact with can be difficult considering the variability in these environments. In the case of young children experiencing homelessness, it is plausible to expect that children are spending much of their time in emergency and transitional housing, or ECE programs. Therefore, a measure of the housing environment would be crucial in understanding the day to day interactions of these young children and how they impact development.

Validation Using Mixed Methods. There are several models that highlight the significance of using a mixed methods framework for the validation process, including within early childhood measurement (McWayne & Melzi, 2014). The use of mixed methodologies for establishing construct validity is still in its infancy (Daigneault & Jacob, 2014). Mixed methods research refers to the meaningful integration of both qualitative and quantitative data analysis to increase the depth and breadth of data interpretation (Creswell & Planko, 2011). In fact, for the present study no one single data source can answer all the research questions. Therefore, the use of multiple methodologies, such as cognitive interviewing and factor analysis, aid to strengthen the validation of a measure.

According to the *Standards for Educational and Psychological Testing*, there are several steps that are integral to the validation process (American Education Research Association, American Psychological Association, National Council on Measurement in Education, & Joint Committee on Standards for Educational and Psychological Testing, U.S., 2014). A first step in the validation process is to understand the internal structure of the existing measure. More specifically, to what degree does each item relate to the broader construct they are aiming to measure (Morell & Tan, 2009). While this is typically done through quantitative measures, the present study addresses the internal structure of the measure through cognitive interviewing.

Cognitive interviewing is one technique used to glean a better understanding of the response process for each of the items in the measure (Morell & Tan, 2009). Shelter staff are not typically trained on early childhood development, or ECE, therefore, it is important to ensure that the measure is designed in a way that is easily

interpretable and functional for shelter staff. The addition of cognitive interviewing to understand the response process will help to substantiate the more traditional ways of assessing validity, such as concurrent validity measure (Willis, 2004).

Cognitive Interviewing. While the *Standards for Educational and Psychological Testing* (American Education Research Association, American Psychological Association, National Council on Measurement in Education, & Joint Committee on Standards for Educational and Psychological Testing, U.S., 2014) indicate the importance for understanding the response process to measure items, they do not offer clear guidelines for how to do so. One way to gather this type of information is through cognitive interviewing. This process entails interviewing participants while they complete a measure to understand their response process (Wilson & Miller, 2014). This application of cognitive interviewing has been widely supported as an effective strategy for early validation of a variety of measures (Wilson & Miller, 2014). However, there are a few potential drawbacks in that this methodology including a lack of objectively and consistency across interviews (Padilla, Benitez, & Castillo, 2013). Despite these potential limitations, this strategy remains as an effective way to gauge participant response processes.

Importantly, the validation process recommended by *Standards for Educational and Psychological Testing* also involves the mixing of methods to best capture the validity of a measure (American Education Research Association, American Psychological Association, National Council on Measurement in Education, & Joint Committee on Standards for Educational and Psychological Testing, U.S., 2014). Therefore, a mixed methods framework, such as the method for the present study, is well aligned with the best practices for psychometrics.

Present Study

Through creating an understanding of the psychometric properties of the tool, the present study aims to strengthen the tool, and increase its functional use within shelter environments. This in turn will increase the accessibility and usability of the tool to create a more appropriate space for very young children in shelter. Having a better understanding of the ways in which shelters can build on their current strengths to serve their youngest clients will ensure that action can be taken to increase the protective factors available to young children in shelter. To this end, the present study aims to answer the following research questions:

1. How do emergency and transitional housing program staff interpret the items on the Self-Assessment?
2. What is the factor structure of the revised Self-Assessment tool?

The following chapters will present the research design, methodology, and results for the present study. The methodology and results will be presented separately for Phase I and Phase II of the study.

Chapter 3

METHODOLOGY: PHASE I

Research Design and Methodology

The present study aims to explore the measurement validity of the Self-Assessment tool, or how the items on this measure meaningfully capture what it means to have a developmentally appropriate space for young children in shelter. Therefore, measurement validity is achieved when scores from any given item can be interpreted and understood in terms of the underlying concept (Adcock & Collier, 2001). The data sources and analyses for this study are presented in Table 1.

Table 1 Data Sources, Analysis Plan, and Research Phase by Research Question

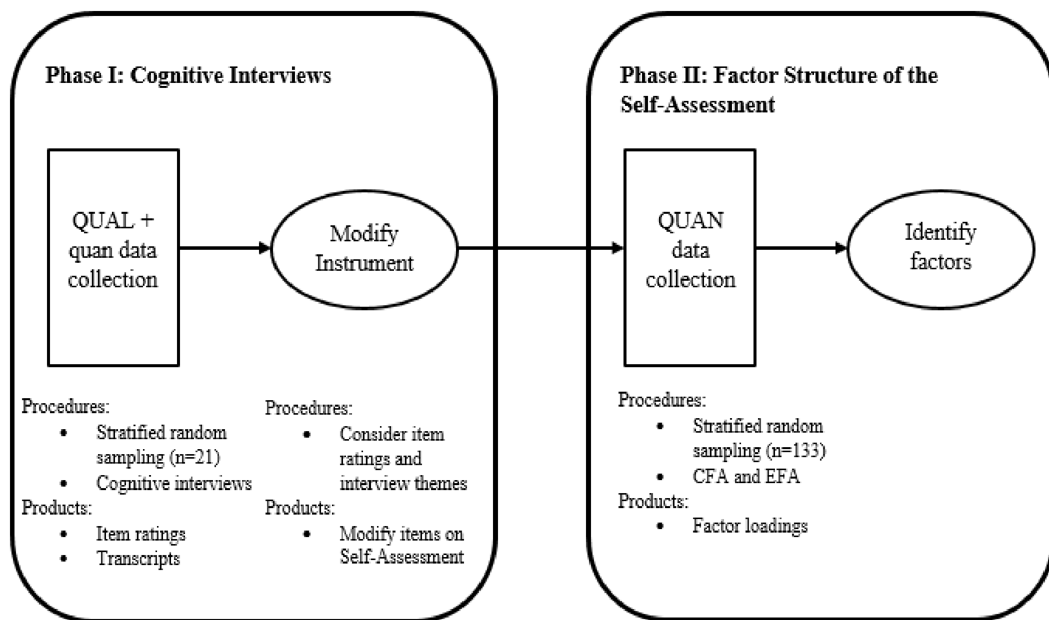
Research Question	Data Source	Analysis Plan	Phase
How do emergency and transitional housing program staff interpret the items on the Self-Assessment?	Cognitive Interviews	Grounded Theory, Descriptive Statistics	I
What is the factor structure of the revised Self-Assessment tool?	Self-Assessment data from a nationally representative sample	Confirmatory Factor Analysis and Exploratory Factor Analysis	II

Research Design

In this multiphase design, there were two data collection and analysis phases conducted sequentially. Phase I included qualitative and quantitative analysis of cognitive interviews with emergency and transitional housing staff while they completed the Self-Assessment measure. Results from Phase I resulted in revisions to

the existing measure. Phase II included quantitative analysis of the revised Self-Assessment scores from a nationally representative sample of emergency and transitional housing staff. As proposed by Creswell and Planko (2011), it is useful to provide a visual diagram of the proposed mixed methodologies. Therefore, a visual diagram for procedures in this mixed methods design and the alignment with the research questions are presented in Figure 1.

Figure 1 A visualization of the mixed methods multiphase design



The following section will describe the sample selection, data collection procedures, measures, and analyses for each of the two sequential project phases.

Phase I

Phase I of the study addressed the following question: (1) How do emergency and transitional housing program staff interpret items on the Self-Assessment? The following describes the sample, measures, procedures and analytic plan for the first phase of the study. This will be followed by a description of the results and revisions to the Self-Assessment from Phase I.

Sample. The data for Phase I come from a random sample of 21 emergency and transitional housing staff from each of the ten HUD regions. The HUD regions were chosen to signify a nationally representative sample of housing providers. Given the existing structure and proximity of states within each of the HUD regions, the current study drew on these geographic regions for sampling purposes. For a list of the states within each HUD region please see Table 2.

Within each HUD region there exist many continuum of care programs (CoC). CoC's represent a community commitment and effort to end homelessness through the delivery of housing services, as well as other preventative measures to end and prevent returns to homelessness (HUD, n.d.). Each CoC works closely with emergency and transitional housing providers within their geographic area. Therefore, the current study worked with CoC's to distribute information about the study for recruitment purposes. Contact information for each CoC is made publicly available at https://www.hudexchange.info/programs/coc/. An invitation to participate was sent to

each CoC, who forwarded the request to a random sample of emergency and transitional housing programs in their geographic region. The present study also drew on national organizations to aid with recruitment such as The Bassuk Center, and ACF.

Table 2 HUD Regions by State

HUD Region	States
1	Connecticut, Vermont, Massachusetts, Maine, New Hampshire, Rhode Island
2	New York, New Jersey
3	Pennsylvania, Virginia, West Virginia, Maryland, Delaware, Washington D.C.
4	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Puerto Rico, U.S. Virgin Islands
5	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
6	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
7	Kansas, Iowa, Missouri, Nebraska
8	Colorado, Montana, North Dakota, South Dakota Utah, Wyoming
9	California, Arizona, Hawaii, Nevada
10	Washington, Alaska, Idaho, Oregon

Within each of the ten regions, special attention was paid to stratified housing programs based on type of housing (emergency, or transitional), family configuration (in-tact families, mothers and children only), and geographic region (urban, suburban, rural). A total of 21 staff were interviewed for phase I. Shelter staff who participated received a $30 gift card[2] for their participation.

[2] Gift cards were purchased by the author, without financial support of funds from any of the organizations mentioned in the current study.

Measures. Cognitive interviewing is one way to understand a participant's response process. This process is helpful in identifying items on an existing measure that are invalid or unreliable (Beatty & Willis, 2007). Additionally, participants can respond to questions that are difficult to answer, or potentially misleading. Cognitive interviewing involves recording participants' interpretations and perceptions to items on a survey as it is being administered. As such, the present study relied on the interpretivist paradigm for cognitive interviewing. The interpretivist paradigm is best for eliciting the respondent's interpretations of questions, and moves away from understanding cognitive processes within a socio-cultural context (Wilson, & Miller, 2014). In this vein, we are not asking respondents to be experts in survey design; rather we are relying on participants to describe and explain their own experience, providing more authentic information about their response process (Wilson, & Miller, 2014). There are two key tenets to the cognitive interviewing process: (1) capturing participant verbal responses while completing the Self-Assessment, and (2) researcher probes to encourage participant responses (Beatty & Willis, 2007). Therefore, the semi-structured interview allows for the interviewer to be an active participant in the interview process, while simultaneously allowing flexibility to reflect on the individual response pattern of the respondent.

Prior to the cognitive interview, each respondent was asked to complete a demographic survey describing their position, organization, and background (please see Appendix B for additional information). A total of 18 participants completed the demographic survey. Three participants declined to complete this survey.

A 45- 90-minute semi-structured interview was also conducted over the phone (Please see Appendix C for the interview protocol). During the semi-structured

interview, housing staff were asked to concurrently complete the Self-Assessment tool, and were asked a series of questions after they completed each item. Participants were probed to provide additional details with questions such as ("tell me what you are thinking…how did you come up with your response?"). All interviews were recorded and transcribed.

Analysis. To analyze the data from Phase I, thematic content analysis was conducted using NVivo, a software program for mixed methods data analysis. To ensure reliability of the codes, the author and a doctoral student summarized data and identified key themes on a subset of the interviews. After the initial themes were identified, the author and the doctoral research assistant developed codes by consensus (Flick, 2014). The research assistant audited the author's code application for 10% (n=3) of the interviews. Qualitative data were analyzed using a grounded theory approach, where key themes were identified across interviews.

All subsequent qualitative data were coded by the author of the present study. Quantitative data in the form of Self-Assessment scores were analyzed separately. Means and standard deviations were calculated based on the participant's response to each item on the measure using SPSS.

Chapter 4

RESULTS: PHASE I

Phase I

Demographic Results. Participants in phase I included 21 emergency and transitional housing providers. Participants were from 17 states, representing at least two housing programs from each of the ten HUD regions. Participants were from a wide range of housing programs, though the majority (83.3%) represented emergency housing programs, that predominantly serve families only[3] (72.2%). Respondents were also representative of several distinct positions within these housing programs including case managers (44.4%), executive staff (16.7%), administrative staff (11.1%), and direct support staff (5.6%). Please see Table 3 below for additional detail.

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[3] Housing programs may choose to only serve special populations, including families. The current study asked whether the housing programs *only* served families, women and children, or whether they served all individuals experiencing homelessness.

Table 3 Demographic Survey Results

Survey Item	Response *n* (%)
Staff position	
Exec	3 (16.7)
Admin	2 (11.1)
Direct Support	1 (5.6)
Case Management	8 (44.4)
Other	4 (22.2)
Length of time in position	
Less than one	5 (27.8)
1 to 3	3 (16.7)
3 to 5	3 (16.7)
5+	7 (38.9)
Primary population served	
Families	13 (72.2)
Single women and children	3 (16.7)
All individuals experiencing homelessness	2 (11.1)
Type of housing program	
Emergency housing	15 (83.3)
Transitional housing	2 (11.1)
Permanent supportive housing	1 (5.6)
Primary special populations served	
All families	15 (83.3)
Families who have experienced DV	3 (16.7)
Veterans	0
Youth	0
Location	
Urban	12 (66.7)
Suburban	4 (22.2)
Rural	2 (11.1)
Room styles	
Dorm	2 (11.1)
Single	16 (88.9)
Multi-family	0

Self-Assessment. Providers were asked to score themselves on each Self-Assessment item as (1) needs action, (2) improving, or (3) accomplished (please see Table 4. for means and standard deviations for each Self-Assessment item). Across Self-Assessment items, providers felt that they had accomplished, or were improving on most items. However, there were also several instances where providers either felt that a Self-Assessment item did not apply to their housing program, or they did not provide a specific response.

Table 4 Self-Assessment Scores

Self-Assessment Item	Descriptive Statistics	
	N	*M (SD)*
We meet all Emergency Solutions Grant health and safety standards.	17	3.00(0)
We discuss emergency response plans (for natural disasters, lost children, active shooters, etc.) with residents and post them publicly.	18	2.11(0.68)
We have sanitary diaper changing stations.	18	2.78(0.55)
We practice and encourage frequent hand washing.	20	2.85(0.49)
We prevent harmful exposure to blood and other dangerous bodily fluids.	20	2.95(0.22)
We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers.	18	2.83(0.38)
We encourage parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.	20	2.75(0.55)
We maintain an appropriate temperature in the shelter and allow residents with young children to stay inside when needed and/or desired.	19	3.00(0)
We have rules regarding visitation by non-residents to ensure the safety of residents.	20	2.90(0.31)
We mandate that all residents, staff, volunteers, and other shelter guests sign in and out of the facility.	17	2.82(0.39)

Self-Assessment Item	Descriptive Statistics	
	N	*M (SD)*
Infants, toddlers, and preschoolers are under supervision by parents and/or staff/volunteers at all times, following staff/child ratio requirements.	20	2.90(0.31)
We encourage and incorporate parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers.	20	2.60(0.60)
We follow safe sleep practices as outlined by the NIH to reduce the risk of Sudden Infant Death Syndrome (SIDS) and provide parents with this information.	17	2.35(0.79)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers.	20	2.60(0.50)
We have age appropriate first aid materials on hand (including EpiPens, Children's Benadryl and Tylenol, band aids, etc.).	20	2.50(0.76)
We provide age appropriate hygiene materials (i.e. baby soap, baby shampoo, sunscreen).	19	2.95(0.23)
We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.	16	2.88(0.34)
We have separate, private rooms for each family with infants, toddlers, and preschoolers.	20	2.85(0.49)
We have child abuse safeguards throughout our facility (low walls, vision panels, and reflective security mirrors) and have written process and training for reporting child abuse.	20	2.3(0.80)
We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans.	17	2.53(0.72)
We offer referrals to Part C and Part B of IDEA for evaluations to determine the need for IDEA services such as speech, physical therapy and special education. We offer referrals for infants, toddlers, and preschoolers (i.e. mental health, home visiting).	18	2.44(0.86)
We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, Head Start, IDEA Part C early intervention or Part B preschool or other early care and learning programs.	20	2.90(0.31)

Self-Assessment Item	Descriptive Statistics	
	N	*M (SD)*
We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs.	19	2.95(0.23)
We have and maintain age and developmentally appropriate toys and learning materials (books, games, etc. that are cleaned, repaired, etc.).	20	2.95(0.22)
We have space available for women to breastfeed privately.	19	2.68(0.67)
We have space available for parents to spend time with infants, toddlers, and preschoolers that is clean, well-maintained, and family friendly.	20	2.95(0.22)
We have space available for parents to eat with infants, toddlers, and preschoolers.	20	3.00(0)
We have indoor and outdoor play space available for infants, toddlers, and preschoolers that is safe, clean, and well-maintained and family friendly.	20	2.90(0.45)
We train our staff on the effects of homelessness on the development of young children and on how they can support the healthy development of infants, toddlers, and preschoolers.	19	2.58(0.51)
We train our staff to recognize and respond to adverse drug and allergic reactions.	19	2.16(0.76)
We have procedures in place for collaborating with local early care and education programs (Head Start, child care, IDEA Part C early intervention and Part B preschool, etc.).	19	2.89(0.32)
We collaborate with the local McKinney-Vento Homeless Education Liaison and post contact information in the shelter.	17	2.94(0.24)
We train our staff on recognizing domestic violence and the process for referring families to community-based services and hotlines.	19	2.84 (0.50)
We train our staff in trauma-informed care.	19	2.63(0.68)
We have at least one staff who is trained in CPR/First Aid for adults, infants, toddlers, and preschoolers present at all times.	19	2.74(0.65)
We run background checks on all of our staff to ensure they pass all child abuse clearances.	19	3.00(0)

Self-Assessment Item	Descriptive Statistics	
	N	*M (SD)*
We have staff and/or consultants who can address the developmental, educational, and nutritional needs of infants, toddlers, preschoolers and knows process for making referrals to IDEA Part C and Part B programs for infants, toddlers and young children with disabilities for early care and learning programs.	20	2.60(0.82)
We encourage and support family connections to Head Start, Child Care, TANF, LIHEAP, public education, IDEA Program, SNAP, WIC, Summer Food Service Program, CHIP & Medicaid, etc.	20	3.00(0)
We connect families with home visiting services and provide space for home visits to occur in our shelter.	18	2.78(0.55)
We have a clear process to receive feedback and/or file grievances relating to the shelter's policies and practices concerning infants, toddlers, and preschoolers.	20	2.80(0.41)
All rules, policies, programming, and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter.	16	2.19(0.91)
We have on-site early childhood enrichment programming for infants, toddlers, and preschoolers.	18	2.50(0.79)
We offer (not require) classes on topics such as parenting, nutrition, financial literacy, etc. to support the parents of infants, toddlers, and preschoolers.	20	2.75(0.44)
We comply with local, state, and federal food safety standards.	14	3.00(0)
We do not serve foods that are choking hazards to infants, toddlers, or preschoolers.	15	2.47(0.83)
Our residents always have access to safe drinking water.	20	3.00(0)
We follow CDC guidelines for storing human milk.	11	2.90(0.30)
We warm bottles with warm tap water, NEVER the microwave and publicly post this practice.	10	2.50(0.71)
We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.	16	2.88(0.50)
We take advantage of the Child and Adult Care Food Program.	8	3.00(0)
We provide snacks and meals with attention to children's allergies and dietary restrictions.	14	2.86(0.53)
We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers.	14	3.00(0)

Cognitive Interviews

Cognitive interviews revealed several aspects of the Self-Assessment that could be improved to facilitate housing staff's use of the tool. Findings from the first phase of data collection highlighted several questions in the Self-Assessment that were misunderstood by, or confusing to housing providers. Findings also suggest that there are several questions which are not universally applicable across housing programs. Finally, respondents indicated that there are several strengths of the Self-Assessment, as well as areas for improvement. Key themes from the interviews include; (1) misinterpreted words or phrases, (2) multi-part questions, (3) item does not apply, (4) strengths of the Self-Assessment, and (5) areas for improvement. Table 5 below provides a list of the items where at least three responses (> 10% of respondents) included one of the key themes. The following describes each of the themes in more detail, along with a discussion of the perceived strengths and general feedback on areas for improvement.

Table 5 Frequencies of Key Themes

Self-Assessment Item	n (%)
Respondents only answered a portion of the question	
We discuss emergency response plans (for natural disasters, lost children, active shooters, etc.) with residents and post them publicly	9 (42.86)
We maintain an appropriate temperature in the shelter and allow residents with young children to stay inside when needed and/or desired	7 (33.33)
We encourage and incorporate parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers	6 (28.57)
We have child abuse safeguards throughout our facility (low walls, vision panels, and reflective security mirrors) and have written process and training for reporting child abuse	4 (19.05)
We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs	4 (19.05)
We have indoor and outdoor play space available for infants, toddlers, and preschoolers that is safe, clean, and well-maintained and family friendly	10 (47.62)
We train our staff on the effects of homelessness on the development of young children and on how they can support the healthy development of infants, toddlers, and preschoolers	7 (33.33)
We collaborate with the local McKinney-Vento Homeless Education Liaison and post contact information in the shelter	10 (47.62)
We have a clear process to receive feedback and/or file grievances relating to the shelter's policies and practices concerning infants, toddlers, and preschoolers	15 (71.43)

Self-Assessment Item	n (%)
We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.	7 (33.33)
Misinterpreted words or phrases	
Infants, toddlers, and preschoolers are under supervision by parents and/or staff/volunteers at all times, following staff/child ratio requirements	3 (14.29)
We follow safe sleep practices as outlined by the NIH to reduce the risk of Sudden Infant Death Syndrome (SIDS) and provide parents with this information	4 (19.05)
We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.	6 (28.57)
We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans	4 (19.05)
We offer referrals to Part C and Part B of IDEA for evaluations to determine the need for IDEA services such as speech, physical therapy and special education. We offer referrals for infants, toddlers, and preschoolers (i.e. mental health, home visiting).	3 (14.29)
We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, Head Start, IDEA Part C early intervention or Part B preschool or other early care and learning programs	5 (23.81)

Self-Assessment Item	n (%)
We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs	3 (14.29)
We collaborate with the local McKinney-Vento Homeless Education Liaison and post contact information in the shelter	3 (14.29)
We train our staff on recognizing domestic violence and the process for referring families to community-based services and hotlines	3 (14.29)
We connect families with home visiting services and provide space for home visits to occur in our shelter	8 (38.10)
We have on-site early childhood enrichment programming for infants, toddlers, and preschoolers	3 (14.29)
We follow CDC guidelines for storing human milk	5 (23.81)
We take advantage of the Child and Adult Care Food Program	12 (57.14)
Does not apply	
We have sanitary diaper changing stations	3 (14.29)
Infants, toddlers, and preschoolers are under supervision by parents and/or staff/volunteers at all times, following staff/child ratio requirements	9 (42.86)
We have age appropriate first aid materials on hand (including EpiPens, Children’s Benadryl and Tylenol, band aids, etc.)	4 (19.05)

Self-Assessment Item	n (%)
We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans	3 (14.29)
All rules, policies, programming and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter	3 (14.29)
We comply with local, state, and federal food safety standards	8 (38.10)
We do not serve foods that are choking hazards to infants, toddlers, or preschoolers	6 (28.60)
We follow CDC guidelines for storing human milk	5 (23.81)
We warm bottles with warm tap water, NEVER the microwave and publicly post this practice	10 (47.62)
We identify and maintain records of food allergies and other special dietary needs of infants and toddlers	5 (23.81)
We take advantage of the Child and Adult Care Food Program	3 (14.29)
We provide snacks and meals with attention to children's allergies and dietary restrictions	5 (23.81)
We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers	6 (28.60)

Misinterpreted words or phrases. In several instances, housing staff misinterpreted words or phrases within the Self-Assessment. These misinterpretations hindered the housing staff's ability to understand specific Self-Assessment items, or lead to confusion as to whether or not a program is currently implementing the item.

The following exemplars highlight several examples of these misinterpretations. Each response is preceded by the associated Self-Assessment item.

> Self-Assessment Item: We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.
>
> Response: *We do post information I wouldn't, we don't particularly, we don't provide the transportation like if it was preschoolers and they're enrolled in a public preschool then it something where the buses would come and get them but we don't provide the transportation ourselves.*

> Self-Assessment Item: We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans.
>
> Response: *So, because I don't even know what that means, I would probably say no.*

> Self-Assessment Item: We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs.
>
> Response: *So, yes, I'm going to say yes. That being said, I don't know exactly what some of those are that you said. If I went up to my office door and looked on the outside of it that is in the hallway, some of that stuff will be posted, if I walk through the building some of that stuff will be posted. I don't know what like part C is…or what IDEA….*

Two or multi-part questions. In addition to these misinterpretations, several Self-Assessment items included multiple sub-questions. In these instances, housing staff frequently only partially answered questions, focusing on the aspect of the question that was most salient to their housing program. In several instances housing providers reference only one piece of the stem question in their response.

Self-Assessment Item: We discuss emergency response plans (for natural disasters, lost children, active shooters, etc.) with residents and post them publicly.

Response: *I want to say yes on that because I've had a lot of trainings on that stuff. But it's probably something that needs to be talked about more. Especially, like what do you do in an emergency, it's not something we talk about a lot. Active shooters come up a lot for us.*

Self-Assessment Item: We have child abuse safeguards throughout our facility (low walls, vision panels, and reflective security mirrors) and have written process and training for reporting child abuse.

Response: *Um so we have surveillance cameras everywhere except for inside the individual rooms and inside the bathrooms so I don't know…and I don't know that we have any reflective mirrors.*

Self-Assessment Item: We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.

Response: *Just because I know a lot of my clients are on county assistance or state assistance. So, they're always asking me about different PCPs and what should be different and what they should or shouldn't do. So, I'll kind of guide them to the common area board just because I know that has a lot more information than I could provide them.*

Item does not apply. There were also several questions where housing providers indicated that a Self-Assessment item did not apply to their housing program. However, there was no option to select "does not apply".

Self-Assessment Item: We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers

Response: *Um, I think that would be, I, I would say that does not apply because I know that there is, we have like a separate organization within our organization called [organization] and they do a lot of that training, and they go into the shelter. Now personally I don't know what they do when they do that, they may not. But I know on a peripheral level, I don't know that well enough to answer.*

> Self-Assessment Item: We provide age appropriate hygiene materials (i.e. baby soap, baby shampoo, sunscreen)
>
> Response: *Uh, we don't, but that's not really our intention. We have a great- so basically, we don't provide toiletries for anybody. Although we have a toiletry closet, but if a mom comes to us and says I need this, we can get it to her. But we don't across the board provide that, we do, we have our own, we have child sunscreen that put in certain children's groups and if they're going to go outside we will put on them.*
>
> Self-Assessment Item: We screen all infants, toddlers and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans.
>
> Response: *What came to mind is resources and skills. My staff does not have the skill to assess that and the resources don't exist in the community to provide that on site at the shelters. And the other thing that came to mind is that we're a shelter, folks are coming to us because they're homeless, not because their children need developmental assessments. So, it's outside of our mission.*
>
> Self-Assessment Item: We have staff and/or consultants who can address the developmental, educational, and nutritional needs of infants, toddlers, preschoolers and knows process for making referrals to IDEA Part C and Part B programs for infants, toddlers and young children with disabilities for early care and learning programs.
>
> Response: *It's a mission and a resource issue. If the resources were there, the families are there, so it would be great to have that service on site. But that's not something that anyone pays us to do.*

Strengths of the Self-Assessment. Data were also coded to reflect the respondent's perceptions of the strengths of the tool. Respondents indicated that the Self-Assessment is easy to use. As one respondent highlighted, "it was really clear cut". Several respondents also indicated that one strength of the Self-Assessment is that is that it is comprehensive, and covers a range of topics relevant to supporting young children experiencing homelessness in shelter.

> Exemplar 1: Everything down to the physical environment to recognizing the emotional environment that the child is going through with the assessments and such. I think that is a big strength in it. I think that is kind of an all-encompassing idea. Like oh person and environment that's what it's all about.

> Exemplar 2: Oh, I think it's great. I mean it even is helping me think about some things like making sure that we are doing some things. But yeah, I think it's a wonderful tool, it's very comprehensive.

Another strength identified by respondents was that the focus of the tool was on children and families as clients, and not just adults.

> Exemplar 1: Well I certainly think it's a good idea, especially for family shelters. Because going through this it certainly has us looking at very specific things related to zero to five-year old's. Right? Um when our services were geared…we've always served families but it was easy to say that the adult or the head of household is the primary client, right? And this allows us or gives us the opportunity to really focus on doing the best thing to meet the youngest kid's needs.

Relatedly, the tool provides guidance on how to support young children, and raises the awareness of the importance of early childhood for housing providers.

> Exemplar 1: Again, the opportunity to look at things in ways that you might not look at. You know you have very specific questions about in very…in similar or different areas of focus and again to think about that and to reflect on it in ways that we may not because we're right in the middle of it. So sometimes, I'm not seeing what the assessment allows me to see because I'm not looking for it or it wasn't a priority.

> Exemplar 2: Uh, yeah, I mean it's a good tool for awareness about what you're, what you should be doing that you maybe haven't thought you should be doing. Like, um, and it you know, it made me think certainly about the difference sin the services that we provide to young children in shelter versus in housing. And it made me think about whether or not that should change. I don't know that it should, you know, given the kind of, the speed that we're trying to get them back out into housing. Yeah, I think it's great, I think it's really good for awareness.

> Exemplar 3: Well for me, like from our conversation it's been helpful to identify areas that might need action because you don't think about it, because when you work in a system, you usually think about an issue that needs attention when something happens. But the whole time we've been talking I've been taking notes

> Exemplar 4: um, I think overall um, for organizations that are serving children in this age range it at least will give you, make you think about what you do and don't have. And whether or not that is something that could be implemented or just maybe tweaked to be implemented in a certain way depending on the structure of the program

Finally, respondents indicated that the focus on the health and safety of young children in shelter is a strength of the Self-Assessment. As one respondent highlighted, "I think it is really focused on making sure the environment is safe and that is a really strong strength".

Areas for improvement. Finally, data identified potential areas for improvement on the Self-Assessment. For example, respondents indicated that the Self-Assessment could be strengthened by including information about cultural competency.

> Exemplar 1: You didn't really talk anything about language barriers too. You know, if you wanted to add things like that like there if there is Hispanic families, or different cultures…But it might be interesting to put something because a lot of cultures are different even in their bathroom habits to be truthful. It's just when you have different cultures…that could be something different to add into the assessment.

> Exemplar 2: I think that's a really important tool because I talk a lot about your organization and I actually hope we will start doing this training in our organization while we have a cultural competency council and a cultural competency training which we all have to do which is great and we also have trauma informed care teams they provide a billion trainings and we have our practice intervention trainings and all of our health-related trainings.

Respondents also felt that the Self-Assessment could be improved by adding items focused on resident finances.

> Exemplar 1: Yes, there is one thing that came to mind and it comes to mind a lot in my dealing with families and that is something that is cliff effect related because I see a lot of families really struggle to provide for their children because they lose benefits over one thing or another. And I don't know how much of that goes on in [your city] but in [my city] I've had families who became homeless because they went off the fiscal cliff when they lost services but got a better job.

Related to feedback on specific Self-Assessment items, some respondents felt that the tool was not applicable to all shelter programs. As one provider indicated, "I don't think it's a bad thing. I don't think it necessarily applies to every organization or every scenario but it could be a helpful guide". Or as another provider reported,

> I was thinking that yeah maybe it's more for a Head Start, or like our we really do, I don't know, I think of [organization] we really try to make it kind of like, it's not really home away from home, but that they can feel like it's a place where they can feel nurtured and they can grow.

Other respondents reported that some of the items in the Self-Assessment would benefit from additional context, or information.

> Exemplar 1: There are some questions that maybe could be a little bit more specific. Um, you know I understand with lots of different programs that's kind of hard to do that you have to be a little more general in questions but you know as far as when you're talking staff are you talking all staff, are you talking at least someone on staff, or someone whose there at all times. Just kind of a little more specific in what it is you're looking for because there's a lot still that's open for interpretation.

> Exemplar 2: I mean I think you could get like into more specifics about…I mean I guess not every community living situation is the same as ours…but like you know I know it talked about like is there individual rooms for the families but a little bit more specific about are the beds appropriate sizes for the children and things like that.

Recommendations

Based off the findings from Phase I, the author developed a series of recommended changes to the Self-Assessment. These changes incorporate the

feedback and comments from the cognitive interviews with housing providers. While some of the comments provided from housing staff are not reflected in the revised Self-Assessment, this is due to the fact that these comments fell outside of the scope of the current tool. For example, housing staff were interested in having a tool that was applicable to school-aged children as well. While such a tool would be beneficial, the focus of the current measure is on early childhood. The recommended changes aim to increase the clarity and usability of the Self-Assessment. These recommendations include the following (described in more detail below):

3. Providing definitions of commonly misinterpreted words/phrases.
4. Including additional response categories to reflect the diversity of responses across various housing programs.
5. Eliminating questions that are not relevant to the majority of housing programs.
6. Including a response option for programs where a specific item may not apply to their housing program.
7. Restructuring several questions for clarity.

There were several instances where housing staff misinterpreted words or phrases on the Self-Assessment. These phrases were typically associated with early childhood education policy, and services. Therefore, the revised Self-Assessment incorporates plain language, and definitions to ensure that staff unfamiliar with the early childhood field can interpret and respond to Self-Assessment questions. For example, on the original Self-Assessment stated, “We offer referrals for infants, toddlers, and preschoolers (i.e. mental health, home visiting).” For this particular item, the revised Self-Assessment provides examples of home visiting services as follows, “We offer referrals to infants, toddlers, and preschoolers for additional services such

as mental health, and home visiting programs (i.e. Early Head Start, Nurse Family Partnership, Parents as Teachers, Healthy Families America, etc.)."

To respond to the need to reflect diversity in how housing programs operate, the revised Self-Assessment has expanded upon the options for response categories. Instead of three universal responses across all items on the Self-Assessment (e.g. needs action, improving, accomplished), the revised Self-Assessment includes more nuanced response options for each individual item. Additionally, the revised Assessment allows the housing provider to select an option stating that an item does not currently apply to their housing program, or, "we do not do this now."

Finally, in the revised Self-Assessment several items were restructured for clarity. For example, there were several items that did not provide enough detail or context for housing providers to adequately respond. The revised Self-Assessment includes a total of 98 individual items (Please see Appendix D for the full measure). For an example of how the original Self-Assessment items compare to the revised items, please see Table 6 below. To revise the Self-Assessment, the author consulted with an early childhood expert to draft a set of revised items. These items were then shared with a former advisor within ACF for their feedback who worked closely on the development of the original measure. Once the final list of items was approved, they were developed into the revised Self-Assessment.

Table 6 Sample Comparison of the original Self-Assessment Items with the Revised Items

Original Self-Assessment Item	Revised Self-Assessment Item
We follow safe sleep practices as outlined by the NIH to reduce the risk of Sudden Infant Death Syndrome (SIDS) and provide parents with this information	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to always place their baby on his or her back to sleep, for naps and at night.

Chapter 5

METHODOLOGY: PHASE II

Methodology

Phase II of the study addresses the following question: (2) How do emergency and transitional housing program staff interpret items on the Self-Assessment?

Sample. The data for Phase II came from a random sample of housing staff from each of the ten HUD regions. CoC's were again asked to distribute information about the study for recruitment purposes. An invitation to participate was sent to each CoC, who forwarded the request to a random sample of emergency and transitional housing programs in their geographic region. To increase response rates, one reminder email was sent approximately four weeks after the initial invitations to participate were shared. Reminder emails were sent to each CoC. Shelter staff who participated were entered into a raffle to receive $30 gift card for their participation.

A total of 199 staff responded to the survey. To ensure only one response per housing program, responses were randomly selected when more than one participant from the same housing program completed the measure. Additionally, responses that were less than 50% complete were excluded from analyses. Therefore, the final sample for phase II included 133 housing staff. Staff in the final sample were from 35 states, representing all 10 HUD regions (please see Table 7 below for the number of respondents per HUD region). However, regions four and five were overrepresented in this sample, while regions one and eight were underrepresented. Please note that regions vary in terms of size and urbanicity. Regions one and eight both represent largely rural states.

Table 7 Phase II Respondents by HUD Region

HUD Region	n (%)
1	3 (2.26)
2	9 (6.77)
3	18 (13.53)
4	26 (19.55)
5	28 21.05)
6	9 (6.77)
7	6 (4.51)
8	2 (1.50)
9	16 (12.03)
10	16 (12.03)

Measures. The revised Self-Assessment was used to determine whether the proposed changes were aligned with the suggested factor structure of the original Self-Assessment (described below). Similarly, to Phase I, participants were also asked to respond to a number of demographic questions.

Analysis. The primary purpose of phase II was to evaluate whether the 98 items on the revised Self-Assessment combined to form five factors as suggested by the original Self-Assessment: (1) Health and safety, (2) wellness and development, (3) workforce standards and training, (4) programming, and (5) food and nutrition. Between 6 and 19 indicators were assumed to underlie each factor (please see the original Self-Assessment measure [https://www.acf.hhs.gov/ecd/interagency-projects/ece-services-for-homeless-children/self-assessment-tool-family-shelters] for additional information on which indicators were assumed for each factor).

Confirmatory factor analysis methods were used to determine whether the data fit with the original factor structure. The underlying assumptions for completing a confirmatory factor analysis using nominal data include a priori model specification (the current study will rely on the model specification offered through the original Self-Assessment tool), a sufficient sample size, and that the data come from a random sample. There are robust discussions concerning appropriate sample sizes for factor analysis. The minimum sample size recommended by Anderson and Gerbing (1984) is 100. While the current sample exceeds this minimum threshold, it is still relatively small. Therefore, Bayesian techniques are recommended to account for small samples, as is often the case in social science research (McNeish, 2016).

Factor correlations were freely estimated, error terms were uncorrelated, and metrics of the latent variables were set by fixing one path to unity. All models were assessed using the Mplus 8 program (Muthén, & Muthén, 1998-2017). Given that the indicators were all nominal, and the relatively small sample size, Bayesian (BAYES) estimation was employed to uncover underlying constructs. To assess the model fit, the Posterior Predictive p-value (PPP) was used (Muthen & Asparouhov, 2010). A lower PPP value may indicate a poor fitting model, while an excellent fitting model is expected to have a PPP value equal to or greater than .05.

Exploratory factor analysis was also employed because of the uncertainty surrounding the underlying structure of the revised Self-Assessment (Browne, 2001). To meet the underlying assumptions for exploratory factor analysis, variables in the analysis must be at least moderately correlated to one another. Again, to address the limitations of the sample size, Bayesian estimation was employed to uncover

underlying factors. For both theoretical and empirical reasons, it was assumed that retained factors would be correlated. Therefore, a promax rotation was employed.

To determine the number of factors to retain, several considerations were made. Most commonly researchers retain factors when eigenvalues are $\geq$ 1.0. However, relying on just one criterion can be problematic. In particular, relying solely on eigenvalues may overestimate the number of true latent dimensions when there are more than 20 observed variables, as is the case with the revised Self-Assessment (Henson & Roberts, 2006). Accordingly, each model was evaluated against the following three rules: (1) eigenvalues greater than 1.0 (Kaiser, 1974); (2) scree (Cattell, 1966), and (3) interpretability (Fabrigar et al., 1999; Gorsuch, 1983, 2003).

Chapter 6

RESULTS: PHASE II

Results

Demographic Survey. Housing staff represented a range of housing programs. Programs varied on the population served, though the majority (77%) served families of all configurations including, single mothers, fathers, and two parent households including same sex and grandparent lead households. Housing staff also represented several different positions within their respective housing programs, with the majority (34%) of respondents reporting their position as case manager. For additional information see Table 8.

Table 8 Phase II Demographics (n=133)

Survey Item	n (%)
Which of the following best describes your position?	
Executive	27 (19.71)
Direct Support	16 (11.68)
Case management	47 (34.31)
Administrative	18 (13.14)
Other	27 (19.57)
How long have you been in your current position?	
Less than 1 year	25 (18.25)
1-3 years	31 (22.63)
3-5 years	28 (20.44)
5+ years	50 (36.50)
What is the highest degree or level of school you have completed?	
Less than high school diploma	1 (0.73)
High school diploma or GED	7 (5.11)
Some college, but no degree	18 (13.14)
Associates degree	7 (5.11)
Bachelor's degree	57 (41.61)
Master's degree	43 (31.39)

Professional or doctoral degree	2 (1.46)
Which of the following best describe the population your program serves.	
Single women and children	24 (17.52)
Families	106 (77.37)
Youth	5 (3.65)

Self-Assessment. Providers were asked to score themselves on each of the revised Self-Assessment items (please see Table 9. for frequencies for each Self-Assessment item and response). Overall, providers indicated a range of responses to each Self-Assessment item. In comparison to Phase I, providers demonstrated a higher rate of variability in their responses.

Table 9 Revised Self-Assessment Frequencies

Revised Self-Assessment Results	
Survey Item	Response n (%)
We have the following emergency response plans: - Natural disasters	
We do not currently do this	30 (22.2)
We have a policy in place	42 (31.1)
We have a policy in place and share this information with residents	53 (39.3)
We have the following emergency response plans: - Lost children	
We do not currently do this	57 (42.2)
We have a policy in place	33 (24.4)
We have a policy in place and share this information with residents	35 (25.9)
We have the following emergency response plans: - Active shooters	
We do not currently do this	63 (46.7)
We have a policy in place	40 (29.6)
We have a policy in place and share this information with residents	22 (16.3)

Survey Item	Response n (%)
We have sanitary diaper changing stations.	
We do not currently have a diaper changing station	69 (51.1)
We have diaper changing stations available to all families,	25 (18.5)
We have diaper changing stations available to all families and have policies around cleaning and disinfecting the surface of the changing station.	31 (23.0)
We take measures to ensure the health of residents. - We practice frequent hand washing.	
We do not currently do this	26 (19.3)
We have procedures/guidelines in place to meet this recommendation	20 (14.8)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	81 (60)
We take measures to ensure the health of residents. - We prevent harmful exposure to blood and other dangerous bodily fluids.	
We do not currently do this	18 (13.3)
We have procedures/guidelines in place to meet this recommendation	23 (17.0)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	85 (63.0)
We take measures to ensure the health of residents. - We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers.	
We do not currently do this	18 (13.3)
We have procedures/guidelines in place to meet this recommendation	28 (20.7)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	80 (59.3)
We take measures to ensure the health of residents. - We support parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.	
We do not currently do this	32 (23.7)
We have procedures/guidelines in place to meet this recommendation	23 (17.0)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	70 (51.9)

Survey Item	Response n (%)
We take measures to ensure that families are not exposed to extreme weather or temperatures. - We maintain an appropriate temperature in the shelter.	
We do not currently do this	11 (8.1)
We have procedures/guidelines in place to meet this recommendation	7 (5.2)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	106 (78.5)
We take measures to ensure that families are not exposed to extreme weather or temperatures. - We allow residents with young children to stay inside when needed and/or desired.	
We do not currently do this	13 (9.6)
We have procedures/guidelines in place to meet this recommendation	15 (11.1)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	94 (69.6)
We have measures in place to ensure the safety of residents. - We have rules regarding visitation by non-residents to ensure the safety of residents.	
We do not currently do this	13 (9.6)
We have procedures/guidelines in place to meet this recommendation	7 (5.2)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	104 (77.0)
We have measures in place to ensure the safety of residents. - We mandate that staff sign in and out of the facility.	
We do not currently do this	61 (45.2)
We have procedures/guidelines in place to meet this recommendation	19 (14.1)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	43 (31.9)

Survey Item	Response n (%)
We have measures in place to ensure the safety of residents. - We mandate that volunteers sign in and out of the facility.	
We do not currently do this	23 (17.0)
We have procedures/guidelines in place to meet this recommendation	25 (18.5)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	74 (54.8)
We have measures in place to ensure the safety of residents. - We mandate that residents sign in and out of the facility.	
We do not currently do this	49 (36.3)
We have procedures/guidelines in place to meet this recommendation	11 (8.1)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	62 (45.9)
We have measures in place to ensure the safety of residents. - Infants, toddlers, and preschoolers are under the supervision by parents/staff/volunteers at all times.	
We do not currently do this	9 (6.7)
We have procedures/guidelines in place to meet this recommendation	8 (5.9)
We have procedures/guidelines in place and encourage families and staff to follow these procedures	108 (80.0)
We elicit parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers.	
We do not do this at this time	19 (14.1)
We encourage parent feedback more generally, but do not specifically ask about concerns around the safety and development of children	37 (27.4)
We encourage parent feedback regarding their children's safety and development	26 (19.3)
We incorporate parent feedback on their children's development and safety in our programming and policies.	43 (31.9)

Survey Item	Response n (%)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to always place their baby on his or her back to sleep, for naps and at night.	
We do not do this at this time	39 (28.9)
We do this sometimes	18 (13.3)
We do this all of the time	64 (47.4)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We always provide a firm sleep surface, such as a mattress in a safety-approved crib or pack and play covered by a fitted sheet.	
We do not do this at this time	20 (14.8)
We do this sometimes	9 (6.7)
We do this all of the time	90 (88.1)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to keep soft objects, toys, crib bumpers, and loose bedding out of their baby's sleep area.	
We do not do this at this time	28 (20.7)
We do this sometimes	16 (11.9)
We do this all of the time	75 (55.6)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to monitor the temperature in their sleep space, and not let their baby overheat.	
We do not do this at this time	40 (29.6)
We do this sometimes	12 (8.9)
We do this all of the time	66 (48.9)

Survey Item	Response n (%)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to only use pacifiers with no strings attached while their baby sleeps.	
We do not do this at this time	48 (35.6)
We do this sometimes	20 (14.8)
We do this all of the time	50 (37.0)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We discuss the dangers of co-sleeping with parents.	
We do not do this at this time	34 (25.2)
We do this sometimes	22 (16.3)
We do this all of the time	61 (45.2)
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We have space available for, and encourage parents to provide their infants with tummy time.	
We do not do this at this time	34 (25.2)
We do this sometimes	25 (18.5)
We do this all of the time	59 (43.7)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have child proof electoral outlet covers.	
We do not do this at this time	29 (21.5)
We do this in some spaces, but not throughout the whole shelter	29 (21.5)
We do this throughout the entire shelter	15 (11.1)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	48 (35.6)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - All toxic substances (i.e. cleaning supplies) are kept in locked spaces and are inaccessible to children.	
We do not do this at this time	14 (10.4)
We do this in some spaces, but not throughout the whole shelter	20 (14.8)
We do this throughout the entire shelter	27 (20.0)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	59 (43.7)

Survey Item	Response n (%)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - There are no openings that could entrap a child's head or limbs.	
We do not do this at this time	17 (12.6)
We do this in some spaces, but not throughout the whole shelter	23 (17.0)
We do this throughout the entire shelter	26 (19.3)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	53 (39.3)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have baby gates at the tops of stairs/ramps.	
We do not do this at this time	47 (34.8)
We do this in some spaces, but not throughout the whole shelter	19 (14.1)
We do this throughout the entire shelter	8 (5.9)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	39 (28.9)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure all furniture that has the potential to tip over (i.e. dressers, book shelves, etc.) are bolted to the wall to ensure they will not fall over.	
We do not do this at this time	39 (28.9)
We do this in some spaces, but not throughout the whole shelter	26 (19.3)
We do this throughout the entire shelter	14 (10.4)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	39 (28.9)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We keep any item that has the potential to be a choking hazard in a place that is inaccessible to children.	
We do not do this at this time	22 (16.3)
We do this in some spaces, but not throughout the whole shelter	30 (22.2)
We do this throughout the entire shelter	22 (16.3)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	44 (32.6)

Survey Item	Response n (%)
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure any sharp edges or corners are covered or protected.	
We do not do this at this time	33 (24.4)
We do this in some spaces, but not throughout the whole shelter	29 (21.5)
We do this throughout the entire shelter	16 (11.9)
We do this throughout the whole shelter and monitor these items to ensure they are working and in good repair.	39 (28.9)
We have age appropriate first aid materials on hand including the following: - EpiPens or other Epinephrine Auto-injector	
We do not provide this to families	68 (50.4)
Only if the parents provide them, we keep them in a secure location	29 (21.5)
We keep these items stocked and have a policy in place to provide them to families in case of emergency	26 (19.3)
We have age appropriate first aid materials on hand including the following: - Children's Benadryl and Tylenol	
We do not provide this to families	45 (33.3)
Only if the parents provide them, we keep them in a secure location	20 (14.8)
We keep these items stocked and have a policy in place to provide them to families in case of emergency	57 (42.2)
We have age appropriate first aid materials on hand including the following: - Band aids, etc.	
We do not provide this to families	13 (9.6)
Only if the parents provide them, we keep them in a secure location	8 (5.9)
We keep these items stocked and have a policy in place to provide them to families in case of emergency	102 (75.6)
We have age appropriate hygiene materials on hand including: - Baby shampoo	
We do not provide this to families	21 (15.6)
We provide these items to families only when they are available from donations	41 (30.4)
We keep these items in stock for families to use	56 (41.4)
We keep these items on hand and re-stock the items as needed	3 (2.2)

Survey Item	Response n (%)
We have age appropriate hygiene materials on hand including: - Baby soap	
We do not provide this to families	20 (14.8)
We provide these items to families only when they are available from donations	41 (30.4)
We keep these items in stock for families to use	56 (41.5)
We keep these items on hand and re-stock the items as needed	3 (2.2)
We have age appropriate hygiene materials on hand including: - Baby sunscreen	
We do not provide this to families	23 (17.0)
We provide these items to families only when they are available from donations	44 (32.6)
We keep these items in stock for families to use	48 (35.6)
We keep these items on hand and re-stock the items as needed	4 (3.0)
We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We post contact information of local primary care providers.	
We do not do this at this time	24 (17.8)
We sometimes do this	23 (17.0)
We do this all of the time	75 (55.6)
We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We provide/support families in accessing transportation to and from appointments.	
We do not do this at this time	22 (16.3)
We sometimes do this	28 (20.7)
We do this all of the time	73 (54.1)
We have systems to ensure appropriate supervision. - We have safeguards in place such as low walls, vision panels, reflective security mirrors, or security cameras where appropriate.	
We do not do this at this time	50 (37.0)
We have this system in place	70 (51.9)

Survey Item	Response n (%)
We have systems to ensure appropriate supervision. - We have a written process and training for reporting child abuse.	
We do not do this at this time	18 (13.3)
We have this system in place	105 (77.8)
We screen all infants, toddlers, and preschoolers for developmental delays using a developmental screening tool (e.g. Ages and Stages, Brigance, etc.).	
We do not do this at this time	42 (31.1)
We do not do this on site, but can support families in connecting to other community organizations for developmental screenings	51 (37.8)
We provide on-site developmental screenings to all infants, toddlers, and preschoolers	7 (5.2)
We provide developmental screenings to all infants, toddlers, and preschoolers and can refer them to local Child Find, or other programs for young children with disabilities for additional services	20 (14.8)
We provide referrals to early learning services. - We offer referrals to special education services covered under the Individuals with Disabilities Education Improvement Act such as speech, physical therapy, and special education.	
We do not do this at this time	17 (12.6)
We sometimes do this	29 (21.5)
We do this all of the time	76 (56.3)
We provide referrals to early learning services. - We offer referrals to infants, toddlers, and preschoolers for additional services such as mental health, and home visiting programs (i.e. Early Head Start, Nurse Family Partnership, Parents as Teachers, Healthy Families America, etc.).	
We do not do this at this time	8 (5.9)
We sometimes do this	28 (20.7)
We do this all of the time	85 (63.0)

Survey Item	Response n (%)
We support families in enrolling in the following types of early learning programs: - Head Start	
We do not do this at this time	7 (5.2)
We do not offer referrals; however, we publicly post, or provide information to families about this program	10 (7.4)
We refer families to this program	19 (14.1)
We encourage families to enroll in this program and help address barriers to enrollment	87 (64.4)
We support families in enrolling in the following types of early learning programs: - Early Head Start	
We do not do this at this time	7 (5.2)
We do not offer referrals; however, we publicly post, or provide information to families about this program	10 (7.4)
We refer families to this program	20 (14.8)
We encourage families to enroll in this program and help address barriers to enrollment	85 (63.0)
We support families in enrolling in the following types of early learning programs: - Early Intervention for young children with disabilities	
We do not do this at this time	12 (8.9)
We do not offer referrals; however, we publicly post, or provide information to families about this program	12 (8.9)
We refer families to this program	17 (12.6)
We encourage families to enroll in this program and help address barriers to enrollment	82 (60.7)
We support families in enrolling in the following types of early learning programs: - Child Care subsidy	
We do not do this at this time	6 (4.4)
We do not offer referrals; however, we publicly post, or provide information to families about this program	12 (8.9)
We refer families to this program	21 (15.6)
We encourage families to enroll in this program and help address barriers to enrollment	83 (61.5)

Survey Item	Response n (%)
We support families in enrolling in the following types of early learning programs: - Child Care subsidy	
We do not do this at this time	6 (4.4)
We do not offer referrals; however, we publicly post, or provide information to families about this program	7 (5.2)
We refer families to this program	28 (20.7)
We encourage families to enroll in this program and help address barriers to enrollment	80 (59.3)
We support families in enrolling in the following types of early learning programs: - Home visiting programs	
We do not do this at this time	19 (14.1)
We do not offer referrals; however, we publicly post, or provide information to families about this program	10 (7.4)
We refer families to this program	23 (17.0)
We encourage families to enroll in this program and help address barriers to enrollment	69 (51.1)
We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, head start, or receive early intervention services.	
We do not currently do this	18 (13.3)
We do this sometimes	14 (10.4)
We do this all of the time	85 (63.0)
We have and maintain age and developmentally appropriate toys and learning materials.	
We do not do this at this time	23 (17.0)
We have these items available to families	53 (39.3)
We have and monitor these items in order to replace those that are in need of repair or damaged	42 (31.1)
We have a private space, that is not a bathroom, available for women to breastfeed privately.	
We do not have this at this time	34 (25.2)
Families have their own rooms, but we do not have any other dedicated space	65 (48.1)
We have a dedicated space, or that no one is able to enter while it is being used. The space has a comfortable chair and table for breastfeeding and/or pumping.	15 (11.1)

Survey Item	Response n (%)
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Indoor play space	
We do not have this at this time	29 (21.5)
We have this space available to families	27 (20.0)
We have this space available to families and have a policy regarding the cleaning and maintenance of this space	62 (45.9)
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Outdoor play space	
We do not have this at this time	25 (18.5)
We have this space available to families	31 (23.0)
We have this space available to families and have a policy regarding the cleaning and maintenance of this space	59 (43.7)
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Dining space	
We do not have this at this time	20 (14.8)
We have this space available to families	26 (19.3)
We have this space available to families and have a policy regarding the cleaning and maintenance of this space	69 (51.1)
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for napping.	
We do not have this at this time	36 (26.7)
We have this space available to families	28 (20.7)
We have this space available to families and have a policy regarding the cleaning and maintenance of this space	50 (37.0)

Survey Item	Response n (%)
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for Mommy/Daddy and me time.	
We do not have this at this time	51 (37.8)
We have this space available to families	22 (16.3)
We have this space available to families and have a policy regarding the cleaning and maintenance of this space	42 (31.1)
We train our staff on the following: - Child development	
We do not do this at this time	34 (25.2)
We do this, but not on a regular basis	26 (19.3)
We do this with some, not all staff on a regular basis	30 (22.2)
We do this will all staff on a regular basis	27 (20.0)
We train our staff on the following: - Recognizing and responding to adverse drug and allergic reactions	
We do not do this at this time	30 (22.2)
We do this, but not on a regular basis	27 (20.0)
We do this with some, not all staff on a regular basis	20 (14.8)
We do this will all staff on a regular basis	36 (26.7)
We train our staff on the following: - Recognizing and responding to domestic violence	
We do not do this at this time	10 (7.4)
We do this, but not on a regular basis	25 (18.5)
We do this with some, not all staff on a regular basis	24 (17.8)
We do this will all staff on a regular basis	58 (43.0)
We train our staff on the following: - Impacts of trauma on families and/or trauma-informed care	
We do not do this at this time	12 (8.9)
We do this, but not on a regular basis	16 (11.9)
We do this with some, not all staff on a regular basis	27 (20.0)
We do this will all staff on a regular basis	63 (46.7)

Survey Item	Response n (%)
We train our staff on the following: - CPR and First Aid for infants, toddlers, and preschoolers.	
We do not do this at this time	24 (17.8)
We do this, but not on a regular basis	18 (13.3)
We do this with some, not all staff on a regular basis	28 (20.7)
We do this will all staff on a regular basis	46 (34.1)
We collaborate with the following early care and learning programs: - Head Start	
We do not do this at this time	21 (15.6)
We have a contact in this program	52 (38.5)
We have a formal relationship with this program and engage in regular and communication with their staff	42 (31.1)
We collaborate with the following early care and learning programs: - Early Head Start	
We do not do this at this time	23 (17.0)
We have a contact in this program	51 (37.8)
We have a formal relationship with this program and engage in regular communication with their staff	41 (30.4)
We collaborate with the following early care and learning programs: - Child care programs	
We do not do this at this time	20 (14.8)
We have a contact in this program	47 (34.8)
We have a formal relationship with this program and engage in regular communication with their staff	47 (34.8)
We collaborate with the following early care and learning programs: - Early intervention programs for young children with disabilities	
We do not do this at this time	25 (18.5)
We have a contact in this program	52 (38.5)
We have a formal relationship with this program and engage in regular communication with their staff	39 (28.9)

Survey Item	Response n (%)
We collaborate with the following early care and learning programs: - Home visiting services such as Early Head Start, Nurse-Family Partnership, HIPPY, etc.	
We do not do this at this time	28 (20.7)
We have a contact in this program	45 (33.3)
We have a formal relationship with this program and engage in regular communication with their staff	43 (31.9)
We collaborate with the following early care and learning programs: - McKinney-Vento Homeless Education Liaison	
We do not do this at this time	15 (11.1)
We have a contact in this program	33 (24.4)
We have a formal relationship with this program and engage in regular communication with their staff	68 (50.4)
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Developmental	
We do not do this at this time	26 (19.3)
Yes, we have staff/consultants who can address this	90 (66.7)
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Educational	
We do not do this at this time	20 (14.8)
Yes, we have staff/consultants who can address this	97 (71.9)
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Nutritional	
We do not do this at this time	37 (27.4)
Yes, we have staff/consultants who can address this	80 (59.3)
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Social Emotional	
We do not do this at this time	20 (14.8)
Yes, we have staff/consultants who can address this	97 (71.9)
We run background checks on all of our staff to ensure they pass all child abuse clearances.	
We do not do this at this time	8 (5.9)
We do this all of the time.	109 (80.7)

Survey Item	Response n (%)
We support family connections to the following programs: - TANF	
We do not do this at this time	6 (4.4)
We refer families to this program	17 (12.6)
We publicly post, or provide information to families about this program	7 (5.2)
We support families with enrollment in this program and address any barriers to enrollment	89 (65.9)
We support family connections to the following programs: - LIHEAP	
We do not do this at this time	28 (20.7)
We refer families to this program	22 (16.3)
We publicly post, or provide information to families about this program	6 (4.4)
We support families with enrollment in this program and address any barriers to enrollment	56 (41.5)
We support family connections to the following programs: - Public Education	
We do not do this at this time	7 (5.2)
We refer families to this program	15 (11.1)
We publicly post, or provide information to families about this program	4 (3.0)
We support families with enrollment in this program and address any barriers to enrollment	93 (68.9)
We support family connections to the following programs: - SNAP	
We do not do this at this time	5 (3.7)
We refer families to this program	17 (12.6)
We publicly post, or provide information to families about this program	6 (4.4)
We support families with enrollment in this program and address any barriers to enrollment	91 (67.4)
We support family connections to the following programs: - WIC	
We do not do this at this time	5 (3.7)
We refer families to this program	21 (15.6)
We publicly post, or provide information to families about this program	5 (3.7)
We support families with enrollment in this program and address any barriers to enrollment	87 (64.4)

Survey Item	Response n (%)
We support family connections to the following programs: - Summer food service program	
We do not do this at this time	10 (14.8)
We refer families to this program	21 (15.6)
We publicly post, or provide information to families about this program	9 (6.7)
We support families with enrollment in this program and address any barriers to enrollment	67 (49.6)
We support family connections to the following programs: - CHIP & Medicaid	
We do not do this at this time	4 (3.0)
We refer families to this program	21 (15.6)
We publicly post, or provide information to families about this program	6 (4.4)
We support families with enrollment in this program and address any barriers to enrollment	87 (64.4)
We support family connections to the following programs: - Child Welfare	
We do not do this at this time	8 (5.9)
We refer families to this program	20 (14.8)
We publicly post, or provide information to families about this program	10 (7.4)
We support families with enrollment in this program and address any barriers to enrollment	81 (60.0)
We support family connections to the following programs: - Domestic Violence Services	
We do not do this at this time	5 (3.7)
We refer families to this program	19 (14.1)
We publicly post, or provide information to families about this program	9 (6.7)
We support families with enrollment in this program and address any barriers to enrollment	85 (63.0)

Survey Item	Response n (%)
We support family connections to the following programs: - Substance Use and Recovery Services	
We do not do this at this time	3 (2.2)
We refer families to this program	21 (15.6)
We publicly post, or provide information to families about this program	6 (4.4)
We support families with enrollment in this program and address any barriers to enrollment	88 (65.2)
All rules, policies, programming and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter or a copy is provided to each family.	
We do not do this at this time	37 (27.4)
We do this sometimes	18 (13.3)
We do this all of the time	56 (41.5)
We offer the following classes to parents of infants, toddlers, and preschoolers: - Parenting	
We do not offer this class at this time	42 (31.1)
We offer this class on an irregular basis	16 (11.9)
We offer this class on a regular basis	23 (17.0)
We offer this class and incorporate parent feedback into the development of future classes.	36 (26.7)
We offer the following classes to parents of infants, toddlers, and preschoolers: - Nutrition	
We do not offer this class at this time	46 (34.1)
We offer this class on an irregular basis	31 (23.0)
We offer this class on a regular basis	12 (8.9)
We offer this class and incorporate parent feedback into the development of future classes.	28 (20.7)
We offer the following classes to parents of infants, toddlers, and preschoolers: - Financial literacy	
We do not offer this class at this time	30 (22.2)
We offer this class on an irregular basis	24 (17.8)
We offer this class on a regular basis	25 (18.5)
We offer this class and incorporate parent feedback into the development of future classes.	37 (27.4)

Survey Item	Response n (%)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We comply with local, state, and federal food safety standards.	
We do not currently do this	14 (10.4)
We sometimes do this	2 (1.5)
We do this all of the time	95 (70.4)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We do not serve foods that are choking hazards to infants, toddlers, or preschoolers (i.e. hot dogs, grapes, peanut butter, popcorn, etc.).	
We do not currently do this	26 (19.3)
We sometimes do this	22 (16.3)
We do this all of the time	60 (44.4)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - Our residents always have access to safe drinking water.	
We do not currently do this	6 (4.4)
We sometimes do this	2 (1.5)
We do this all of the time	103 (76.3)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.	
We do not currently do this	28 (20.7)
We sometimes do this	10 (7.4)
We do this all of the time	72 (53.3)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We take advantage of the Child and Adult Care Food Program	
We do not currently do this	47 (34.8)
We sometimes do this	12 (8.9)
We do this all of the time	48 (35.6)

Survey Item	Response n (%)
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers.	
We do not currently do this	18 (13.3)
We sometimes do this	32 (23.7)
We do this all of the time	61 (45.2)
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide clean storage containers to parents for breast milk (i.e. screw cap bottles, hard plastic cups with tight caps, heavy-duty bags that fit directly into a bottle).	
We do not currently do this	60 (44.4)
We sometimes do this	16 (11.9)
We do this all of the time	31 (23.0)
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide refrigerator and/or freezer space for storing breast milk that easily accessible and safe for breast feeding mothers.	
We do not currently do this	31 (23.0)
We sometimes do this	7 (5.2)
We do this all of the time	70 (51.9)
We support families in following CDC guidelines for storing breast milk by doing the following: - We clearly label all breast milk with the date and name of parent.	
We do not currently do this	57 (42.2)
We sometimes do this	8 (5.9)
We do this all of the time	42 (31.1)
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide parents with information on proper storage of breast milk including the length of time it should be stored and at what temperature.	
We do not currently do this	53 (39.3)
We sometimes do this	13 (9.6)
We do this all of the time	42 (31.1)

Survey Item	Response n (%)
We warm bottles with warm tap water, never the microwave.	
We do not warm bottles for families	83 (61.5)
We publicly post or provide parents with information about bottle warming practices	11 (8.1)
We have a policy in place for warming bottles, and we share this information with parents and staff	10 (7.4)
We have a policy in place, and we monitor to ensure proper implementation of this policy	5 (3.7)

Confirmatory Factor Analysis. Fit indices, and estimates indicate that the data do not fit well with the suggested five factor solution (PPP <.001). Therefore, results indicate a lack of alignment with the original factor structure of the Self-Assessment tool. An inspection analysis? of factor loadings linking each variable to their respective factors revealed that the loadings varied considerably within each factor. Given that the five-factor structure does not adequately fit the data, an exploratory factor analysis was needed to determine the appropriate number of factors.

Exploratory Factor Analysis. One- through six-factor solutions were rotated. Kaiser's criterion, and scree both suggested that two factors be retained. However, the PPP was low (PPP <.001) for the two-factor solution. The PPP value is directly tied to the chi-square value, which is impacted by the relatively small sample size in the current study and is much less forgiving than more traditional fit indices such as CFI (Muthén & Asparouhov, 2010). While MPlus does not offer any other fit indices under Bayesian estimation, the current model satisfies Kaiser's criterion, scree criterion. The two-factor solution also satisfied requirements for simple structure in that most variables showed appreciable factor loadings and almost all variables loaded on only

one factor. By contrast, the three-factor solution revealed that multiple variables were loaded onto more than one factor. Therefore, based on the preceding statistical and substantive considerations, the two-factor solution was accepted.

The two factors were interpreted according to the magnitude and meaning of their salient pattern coefficients. All coefficients greater than or equal to .40 were considered appreciable. The first factor was characterized by high loadings on variables EMERA - EMERC, DIAP, HEALA - HEALD, WEATHA, WEATHB, SAFEA - SAFEE, SLEEPA - SLEEPG, SPROOFA - SPROOFG, FAIDA - FAIDC, HYGA - HYGC, DVA, DVB, SCHEDU, TOYS, BFEED, SPACEA - SPACEE, TRAINA - TRAINE, RULES, FOODA - FOODF, CDCA – CDCD, and BOTTLE (for a full list of variable names with corresponding measure items please see Appendix E). Consequently, the first factor was named *materials and environment*, demonstrating the focus on the physical building, and needs of families in shelter. The second latent dimension was defined by appreciable loadings from variables CONCTA, SCREEN, ECEA – ECEH, TRAIND, COLLABA – COLLABG, CONSULTA – CONSULTD, PROGA – PROGJ, CLASSA – CLASSC. Therefore, the factor was named *linkages with family and early childhood services*, reflecting the fact that these variables are related to providing social support to families in shelter (Please see Table 10 for factor loadings based on the two-factor solution).

Table 10 Factor loadings based on an exploratory factor analysis with varimax rotation for the items on the revised Self-Assessment

	Materials and Environment	Linkages with Family and Early Childhood Services
We have the following emergency response plans: - Natural disasters	0.553	
We have the following emergency response plans: - Lost children	0.717	
We have the following emergency response plans: - Active shooters	0.541	
We have sanitary diaper changing stations.	0.705	
We take measures to ensure the health of residents. - We practice frequent hand washing.	0.498	
We take measures to ensure the health of residents. - We prevent harmful exposure to blood and other dangerous bodily fluids.	0.590	
We take measures to ensure the health of residents. - We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers.	0.659	
We take measures to ensure the health of residents. - We support parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.	0.561	0.363
We take measures to ensure that families are not exposed to extreme weather or temperatures. - We maintain an appropriate temperature in the shelter.	0.872	
We take measures to ensure that families are not exposed to extreme weather or temperatures. - We allow residents with young children to stay inside when needed and/or desired.	0.854	

We have measures in place to ensure the safety of residents. - We have rules regarding visitation by non-residents to ensure the safety of residents.	0.844	
We have measures in place to ensure the safety of residents. - We mandate that staff sign in and out of the facility.	0.746	
We have measures in place to ensure the safety of residents. - We mandate that volunteers sign in and out of the facility.	0.805	
We have measures in place to ensure the safety of residents. - We mandate that residents sign in and out of the facility.	0.624	
We have measures in place to ensure the safety of residents. - Infants, toddlers, and preschoolers are under the supervision by parents/staff/volunteers at all times.	0.910	
We elicit parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers.	0.471	0.487
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to always place their baby on his or her back to sleep, for naps and at night.	0.898	
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We always provide a firm sleep surface, such as a mattress in a safety-approved crib or pack and play covered by a fitted sheet.	0.903	
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to keep soft objects, toys, crib bumpers, and loose bedding out of their baby’s sleep area.	0.930	

We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to monitor the temperature in their sleep space, and not let their baby overheat.	0.902	
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to only use pacifiers with no strings attached while their baby sleeps.	0.834	
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We discuss the dangers of co-sleeping with parents.	0.780	0.325
We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We have space available for, and encourage parents to provide their infants with tummy time.	0.738	
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have child proof electoral outlet covers.	0.881	
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - All toxic substances (i.e. cleaning supplies) are kept in locked spaces and are inaccessible to children.	0.889	
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - There are no openings that could entrap a child's head or limbs.	0.945	

We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have baby gates at the tops of stairs/ramps.	0.846
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure all furniture that has the potential to tip over (i.e. dressers, book shelves, etc.) are bolted to the wall to ensure they will not fall over.	0.865
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We keep any item that has the potential to be a choking hazard in a place that is inaccessible to children.	0.949
We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure any sharp edges or corners are covered or protected.	0.910
We have age appropriate first aid materials on hand including the following: - EpiPens or other Epinephrine Auto-injector	0.796
We have age appropriate first aid materials on hand including the following: - Children's Benadryl and Tylenol	0.665
We have age appropriate first aid materials on hand including the following: - Band aids, etc.	0.774
We have age appropriate hygiene materials on hand including: - Baby shampoo	0.683
We have age appropriate hygiene materials on hand including: - Baby soap	0.668
We have age appropriate hygiene materials on hand including: - Baby sunscreen	0.684

We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We post contact information of local primary care providers.	0.546	0.441
We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We provide/support families in accessing transportation to and from appointments.	0.343	0.659
We have systems to ensure appropriate supervision. - We have safeguards in place such as low walls, vision panels, reflective security mirrors, or security cameras where appropriate.	0.786	
We have systems to ensure appropriate supervision. - We have a written process and training for reporting child abuse.	0.772	
We screen all infants, toddlers, and preschoolers for developmental delays using a developmental screening tool (e.g. Ages and Stages, Brigance, etc.).	0.378	0.489
We provide referrals to early learning services. - We offer referrals to special education services covered under the Individuals with Disabilities Education Improvement Act such as speech, physical therapy, and special education.		0.639
We provide referrals to early learning services. - We offer referrals to infants, toddlers, and preschoolers for additional services such as mental health, and home visiting programs (i.e. Early Head Start, Nurse Family Partnership, Parents as Teachers, Healthy Families America, etc.).		0.762
We support families in enrolling in the following types of early learning programs: - Head Start		0.994
We support families in enrolling in the following types of early learning programs: - Early Head Start		0.992

We support families in enrolling in the following types of early learning programs: - Early Intervention for young children with disabilities		1.001
We support families in enrolling in the following types of early learning programs: - Preschool programs		0.956
We support families in enrolling in the following types of early learning programs: - Child Care subsidy		0.976
We support families in enrolling in the following types of early learning programs: - Home visiting programs		0.902
We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, head start, or receive early intervention services.	0.514	
We have and maintain age and developmentally appropriate toys and learning materials.	0.817	
We have a private space, that is not a bathroom, available for women to breastfeed privately.	0.666	
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Indoor play space	0.800	
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Outdoor play space	0.717	
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Dining space	0.822	

We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for napping.	0.862	
We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for Mommy/Daddy and me time.	0.835	
We train our staff on the following: - Child development	0.663	0.389
We train our staff on the following: - Recognizing and responding to adverse drug and allergic reactions	0.688	0.301
We train our staff on the following: - Recognizing and responding to domestic violence	0.435	0.365
We train our staff on the following: - Impacts of trauma on families and/or trauma-informed care		0.586
We train our staff on the following: - CPR and First Aid for infants, toddlers, and preschoolers.	0.535	0.294
We collaborate with the following early care and learning programs: - Head Start		0.872
We collaborate with the following early care and learning programs: - Early Head Start		0.881
We collaborate with the following early care and learning programs: - Child care programs		0.795
We collaborate with the following early care and learning programs: - Early intervention programs for young children with disabilities		0.857
We collaborate with the following early care and learning programs: - Home visiting services such as Early Head Start, Nurse-Family Partnership, HIPPY, etc.		0.850

We collaborate with the following early care and learning programs: - McKinney-Vento Homeless Education Liaison		0.488
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Developmental		0.761
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Educational		0.624
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Nutritional		0.751
We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Social Emotional		0.679
We run background checks on all of our staff to ensure they pass all child abuse clearances.	0.350	0.411
We support family connections to the following programs: - TANF		0.918
We support family connections to the following programs: - LIHEAP		0.631
We support family connections to the following programs: - Public Education		0.963
We support family connections to the following programs: - SNAP		0.900
We support family connections to the following programs: - WIC		0.912
We support family connections to the following programs: - Summer food service program		0.898
We support family connections to the following programs: - CHIP & Medicaid		0.922

We support family connections to the following programs: - Child Welfare		0.886
We support family connections to the following programs: - Domestic Violence Services		0.951
We support family connections to the following programs: - Substance Use and Recovery Services		0.912
All rules, policies, programming and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter or a copy is provided to each family.	0.589	0.303
We offer the following classes to parents of infants, toddlers, and preschoolers: - Parenting		0.694
We offer the following classes to parents of infants, toddlers, and preschoolers: - Nutrition	0.336	0.686
We offer the following classes to parents of infants, toddlers, and preschoolers: - Financial literacy		0.711
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We comply with local, state, and federal food safety standards.	0.917	
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We comply with local, state, and federal food safety standards.	0.809	
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - Our residents always have access to safe drinking water.	0.866	

The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.	0.704	0.338
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We take advantage of the Child and Adult Care Food Program	0.541	
The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers.	0.810	
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide clean storage containers to parents for breast milk (i.e. screw cap bottles, hard plastic cups with tight caps, heavy-duty bags that fit directly into a bottle).	0.621	0.401
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide refrigerator and/or freezer space for storing breast milk that easily accessible and safe for breast feeding mothers.	0.658	0.334
We support families in following CDC guidelines for storing breast milk by doing the following: - We clearly label all breast milk with the date and name of parent.	0.711	
We support families in following CDC guidelines for storing breast milk by doing the following: - We provide parents with information on proper storage of breast milk including the length of time it should be stored and at what temperature.	0.742	0.335

We warm bottles with warm tap water, never the microwave.	0.705	0.328

Chapter 7

DISCUSSION

Almost half of all children residing in federally funded shelter programs are under the age of six (Solari et al., 2017). Despite this fact, we know very little about the developmental friendliness of these housing programs. Previous research indicates that young children experiencing homelessness are at a greater risk for several adverse health and educational outcomes (Fantuzzo et al., 2013; Little et al., 2005; Richards & Smith, 2007). Furthermore, a recent study found that children residing in shelter programs had lower overall developmental functioning scores on the Ages and Stages questionnaire in comparison to the normed sample (Haskett, Armstrong, & Tisdale, 2015).

Because young children may be spending a considerable amount of time in the shelter environment, it is important to understand the experiences of young children in shelters – both in terms of the physical environment but also the ways in which shelters interface with the larger ECE community. Within the bio-ecological framework (Bronfrenbrenner, 2005), it is important to consider the influence of children's proximal environment on their development. Within the shelter context this may include attributes of the physical space, as well as the staff and other families they interact with daily.

In addition to the physical space, the bioecological model also considers the connections young children have in their community, such as ECE programs (Bronfrenbrenner, 2005). For children birth to five, access to high-quality ECE can help promote positive developmental outcomes (Puma et al., 2012). Furthermore, for children experiencing homelessness, the impact of these programs may be especially

beneficial (Costa Nunez et al., 2011; Bullough, & Hall-Kenyon, 2015). Shelter programs can help families in facilitating connections to ECE programs.

Access to stable ECE supports families in finding and maintaining employment, by providing access to child care. As housing models continue to transition from largely service based, to focusing more explicitly on access to stable housing through programs such as rapid rehousing, it will become even more important for families to be well connected to community resources. Unfortunately to date there is very little information available on how housing programs connect families to early childhood services.

Within the bioecological context, the relationship and interactions between community resources and shelter services may provide an important context for supporting young children's educational needs. In fact, work with school aged children highlights that longer-term interaction with residential programs results in increased access to community resources (Miller, 2015). Furthermore, housing programs appear to be well poised to support students in accessing educational opportunities through partnerships and collaborations with local schools (Miller, 2011). While these findings have not been replicated for children in early childhood, it is plausible to assume similar results given the relative connectedness of shelter programs in their local communities.

The Self-Assessment (2014) was designed to address both the environmental quality of emergency and transitional housing programs for children aged birth to five, and the shelter programs ability to make referrals ECE programs. The original iteration of the Self-Assessment focused on the developmental needs of young children and included constructs related to supporting the health, and positive

development of young children experiencing homelessness. While Self-Assessment was developed by early childhood professionals, the psychometric properties of the tool were unknown.

The current study addressed the psychometric properties of the Self-Assessment by engaging in a mixed methods validity analysis. First, the present study aimed to explore the ways in which housing staff interpret the items on the Self-Assessment. The first phase of the study aimed to answer the following research question; (1) How do emergency and transitional housing program staff interpret the items on the Self-Assessment?

Findings from the first phase of the analyses included key themes from cognitive interviews with housing staff as they completed the Self-Assessment. These findings highlighted the importance of incorporating the perspective of housing providers in the survey development process. For example, several questions required further clarification to ensure that housing staff interpreted those questions the way they were intended to be understood. Additionally, findings suggested that the original Self-Assessment did not provide enough flexibility to capture the diversity among housing programs. It is important to ensure that the items on the Self-Assessment are being interpreted as intended so that housing staff can make appropriate and meaningful decisions about how to modify their programs to better support the developmental needs of young children. In fact, there were several instances where items that were included on the Self-Assessment were misinterpreted, or misunderstood by housing staff, resulting in responses that did not truly answer the root of the question of interest. Therefore, housing staff were missing some of the key information on how to promote positive environments for young children in shelter.

Despite this fact, housing staff felt that the Self-Assessment was useful and comprehensive. In fact, this tool is the first of its kind to attempt to address the developmental needs of young children in shelter, and therefore provides broad contributions to the larger field.

Respondents also indicated that housing programs are diverse in terms of their missions, priorities, and populations served. To illustrate this point, participants represented a variety of housing programs including those that provided limited case management, to those with much more comprehensive services. Housing programs also ranged in size, with some programs serving less than five families at a given time, to those that serve well over 300 families at a time. Therefore, the Self-Assessment tool needs to provide a level of flexibility to account for the diversity in housing programs.

Based on the findings from Phase I, revisions were made to the Self-Assessment. These revisions included adding clarity, refining questions, and providing opportunities for housing programs to better reflect the diversity of services they provide. The goal of these revisions was to increase the utility and clarity of the tool for housing staff interested in increasing the developmental friendliness of their housing program.

The current study also assessed the structure of the revised Self-Assessment. The second phase of the study aimed to answer the following research question; what is the factor structure of the revised Self-Assessment tool? Therefore, the second phase included a confirmatory and exploratory factor analysis of the revised Self-Assessment items.

While the confirmatory factor analysis found that the data did not support the a priori five-factor structure of the original Self-Assessment tool, findings did suggest a more parsimonious two-factor structure. Furthermore, the factor loadings for each of the two factors clearly delineated those Self-Assessment items which were related to linkages to early childhood and family services, and those items related to more material-based ways to improve the shelter environment for young children. However, it may be useful for staff to have more than two categories to describe the various components on the Self-Assessment tool, and to better understand the specific constructs that impact young children's development. Therefore, it may be useful to continue to explore how the items on the Self-Assessment may be categorized to support staffs understanding of these components.

The two-factor structure is notable given that shelter programs have historically been responsible for supporting the immediate housing needs of families, and have indicated that families competing demands for housing and economic security outweigh their desire to find ECE programs for their children (Perlman et al., 2017). Furthermore, this is well aligned with underlying theory, most notably Bronfrenbrenner's bioecological theory (2005). It is important to consider the fact that families are turning to emergency and transitional housing in order to have a safe place to sleep, while receiving adequate nutrition. Case managers are tasked with supporting parents as they search for stable housing and employment. In fact, parents experiencing homelessness have indicated that they receive very limited support from shelter staff in finding high-quality ECE (Perlman et al., 2017).

The two-factor solution is also well aligned with previous literature which suggests that poor physical environments can detrimentally impact children's

development (Le Cann et al., 2011), and that access to high-quality ECE can mitigate some of the risk associated with adversity in early childhood (Puma et al., 2012). The items on the Self-Assessment related to each of these factors can help support housing staff in making critical decisions about how to invest resources to better support young children and their families. Furthermore, by supporting access to these programs, shelters can also help to support the economic security of families in their programs.

Limitations

It is important to note that there are several limitations to the current study. The current study was limited to a relatively small sample of emergency and transitional housing providers (n=133) and may not generalize to all types of shelter environments. However, respondents represented all 10 HUD regions across the United States, as well as a variety of positions within these housing programs. It is important to note that housing staff are often faced with limited resources, and overburdened homeless service systems, such that they have limited time to complete tasks above and beyond the intervention supports they provide to families (Baker, O'Brien, & Salahuddin, 2007). Additionally, to the author's knowledge this is one of the first studies collecting data from a nationally representative sample of housing staff. While the sample size was limited, statistical techniques were employed to account for the relative size of the sample.

Another limitation of the current study is that validation efforts were employed after the Self-Assessment tool was already designed. The current study relied on a hybrid approach of survey development and validation. However, the author had support from the tool developers to revise the Self-Assessment. Therefore, revisions were incorporated prior to completing an analysis of the factor structure of the tool.

Finally, it should be noted that there were several suggestions from housing providers that were not incorporated into the revised Self-Assessment tool. These include suggestions that did not fit the scope of the tool (e.g. information about school aged children), however, there were other suggestions that should be considered in future research on the Self-Assessment. For example, one respondent highlighted the importance of incorporating cultural competency measures into the tool. While this was outside of the scope of the current project, it is an important consideration for future iterations of the Self-Assessment.

Future Directions

The current study provides valuable information concerning the psychometric properties of the Self-Assessment (The Self-Assessment Tool, 2014). While it is important that measures are valid, it is also important that these tools be implemented consistently over time (Halle, Metz, & Martinez-Beck, 2013). For example, research is needed to explore the feasibility or process of using a tool such as the Self-Assessment. More specifically, metrics are needed to assess the amount of time and resources it takes to complete the Self-Assessment, and which staff members are best suited for completing the measure. The respondent or group of respondents should be addressed in future implementation research. In this study each housing programs decided who would complete the Self-Assessment, and the respondents represented a wide range of positions within each housing program. Respondents included executive staff, administrative staff, case managers, and direct service workers. However, it will be important for future research to answer the following questions. Should the measure be completed by a group of staff members, or by one staff member? And who is best suited from the staff to complete the measure? Understanding who within the

organizational structure has the appropriate knowledge, skill, and resources to complete the Self-Assessment will be important to understanding how to best support the implementation of the tool (Metz et al., 2013).

Understanding this aspect of implementation is important both for considering the accuracy of the responses on the Self-Assessment, as well as gaining support from the program to implement changes based on the results of the assessment. For example, responses from various staff members should be compared to understand whether the perception of housing program quality varies by staffing type or level. This would have implications for understanding how differences in perceptions across staff types (i.e. executive, administrative, and direct service) influences families. For example, if executive staff are not aware that resources are needed in a particular program, they may not be directing funding, or staff time to address that particular need.

Exploring staff's perceptions of the utility of the tool is also an important consideration. Staff buy-in is related to effective implementation (Wang, Christ, & Chiu, 2014). Therefore, it is important to understand whether staff are looking at the Self-Assessment as a compliance measure, versus an actionable tool. For example, research is needed to assess how staff use their scores from the Self-Assessment. Are staff using the Self-Assessment to direct resources in their shelter programs? Given that the present study did not assess the long-term outcomes associated with completing the Self-Assessment, it is not clear at this time if staff are relying on their scores to develop actionable steps to address the development friendliness of their shelter programs.

In addition to these questions concerning implementation, the current study did not address how variance in shelter quality as measured by the Self-Assessment is related to children's development. Future work should consider the extent to which scores on the Self-Assessment are related to positive or negative developmental outcomes for children in shelter programs. As the early childhood field continues to focus on the impact of quality ECE on children's outcomes (Puma et al., 2012), so should other early childhood measure related to child health and well-being do the same thing. Furthermore, future research should consider whether housing staff and parents perceptions of quality are related to items on the revised Self-Assessment.

It will also be important for the items of the Self-Assessment to be shared with a panel of experts to ensure that the items are capturing the most prudent components of shelter programs for supporting positive development (American Education Research Association, American Psychological Association, National Council on Measurement in Education, & Joint Committee on Standards for Educational and Psychological Testing, U.S., 2014). In addition to experts in early care and education, experts in housing, community development, cultural competency, and health should be engaged to ensure that the items that are included on the revised Self-Assessment are adequate. Furthermore, experts may assist in developing or expanding upon existing constructs within the tool. For example, is it enough to ask whether housing staff make referrals to ECE programs, or is there a way to structure questions around the concept of providing a warm hand off for families to these programs. To this end, it will also be important to consider the perspectives of the other service providers involved in the referral process. For example, how does the ECE community work to

support enrollment into their programs? How do they develop relationships with housing programs?

It will also be important to consider the level of technical assistance or supported needed by staff to complete the tool. The revised Self-Assessment does not currently include a training manual. This will be a critical component to ensuring the successful implementation of the tool. Additionally, it will be important to consider other technical assistance that will support the use and uptake of this tool. For example, should technical assistance be provided to develop action plans, or actionable items after completing the Self-Assessment, and who should provide this support?

Conclusion

In conclusion, the revised version of the Self-Assessment tool takes into consideration the perspectives of a nationally representative sample of housing providers. The revised tool responded to the need to provide clarity, and to capture the diverse circumstances of housing programs. Therefore, the Self-Assessment is now better poised to support housing providers in making decisions on how to create more developmentally friendly spaces for young children in emergency and transitional housing programs.

. The revised Self-Assessment includes questions concerning the health and safety of young children, in addition to questions pertaining to their social emotional development. Furthermore, the revised Self-Assessment will help to illuminate opportunities for housing staff to connect with ECE programs, a much-needed resource for families. By using this tool, housing staff can better support the early

developmental needs of young children and help to support positive outcomes for this vulnerable population.

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Appendix A

ITEMS FROM THE EARLY CHILDHOOD SELF-ASSESSMENT TOOL FOR FAMILY SHELTERS

1. We meet all Emergency Solutions Grant health and safety standards.
2. We discuss emergency response plans (for natural disasters, lost children, active shooters, etc.) with residents and post them publicly.
3. We have sanitary diaper changing stations.
4. We practice and encourage frequent hand washing.
5. We prevent harmful exposure to blood and other dangerous bodily fluids
6. We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers
7. infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.
8. We maintain an appropriate temperature in the shelter and allow residents with young children to stay inside when needed and/or desired.
9. We have rules regarding visitation by non-residents to ensure the safety of residents.
10. We mandate that all residents, staff, volunteers, and other shelter guests sign in and out of the facility
11. Infants, toddlers, and preschoolers are under supervision by parents and/or staff/volunteers at all times, following staff/child ratio requirements
12. We encourage and incorporate parent feedback regarding our facility’s policies towards the safety and development of infants, toddlers, and preschoolers

13. We follow safe sleep practices as outlined by the NIH to reduce the risk of Sudden Infant Death Syndrome (SIDS) and provide parents with this information
14. We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers
15. We have age appropriate first aid materials on hand (including EpiPens, Children's Benadryl and Tylenol, band aids, etc.)
16. We provide age appropriate hygiene materials (i.e. baby soap, baby shampoo, sunscreen)
17. We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.
18. We have separate, private rooms for each family with infants, toddlers, and preschoolers.
19. We have child abuse safeguards throughout our facility (low walls, vision panels, and reflective security mirrors) and have written process and training for reporting child abuse.
20. We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans.
21. We offer referrals to Part C and Part B of IDEA for evaluations to determine the need for IDEA services such as speech, physical therapy and special education. We offer referrals for infants, toddlers, and preschoolers (i.e. mental health, home visiting).

22. We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, Head Start, IDEA Part C early intervention or Part B preschool or other early care and learning programs.
23. We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs.
24. We have and maintain age and developmentally appropriate toys and learning materials (books, games, etc. that are cleaned, repaired, etc.).
25. We have space available for women to breastfeed privately.
26. We have space available for parents to spend time with infants, toddlers, and preschoolers that is clean, well-maintained, and family friendly.
27. We have space available for parents to eat with infants, toddlers, and preschoolers.
28. We have indoor and outdoor play space available for infants, toddlers, and preschoolers that is safe, clean, and well-maintained.
29. We train our staff on the effects of homelessness on the development of young children and on how they can support the healthy development of infants, toddlers, and preschoolers.
30. We train our staff to recognize and respond to adverse drug and allergic reactions.
31. We have procedures in place for collaborating with local early care and education programs (Head Start, child care, IDEA Part C early intervention and Part B preschool, etc.).

32. We collaborate with the local McKinney-Vento Homeless Education Liaison and post contact information in the shelter.
33. We train our staff on recognizing domestic violence and the process for referring families to community-based services and hotlines.
34. We train our staff in trauma-informed care.
35. We have at least one staff who is trained in CPR/First Aid for adults, infants, toddlers, and preschoolers present at all times.
36. We run background checks on all of our staff to ensure they pass all child abuse clearances.
37. We have staff and/or consultants who can address the developmental, educational, and nutritional needs of infants, toddlers, preschoolers and knows process for making referrals to IDEA Part C and Part B programs for infants, toddlers and young children with disabilities for early care and learning programs.
38. We encourage and support family connections to Head Start, Child Care, TANF, LIHEAP, public education, IDEA Program, SNAP, WIC, Summer Food Service Program, CHIP & Medicaid, etc.
39. We connect families with home visiting services and provide space for home visits to occur in our shelter.
40. We have a clear process to receive feedback and/or file grievances relating to the shelter's policies and practices concerning infants, toddlers, and preschoolers.
41. All rules, policies, programming, and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter.

42. We have on-site early childhood enrichment programming for infants, toddlers, and preschoolers.
43. We offer (not require) classes on topics such as parenting, nutrition, financial literacy, etc. to support the parents of infants, toddlers, and preschoolers.
44. We comply with local, state, and federal food safety standards
45. We do not serve foods that are choking hazards to infants, toddlers, or preschoolers
46. Our residents always have access to safe drinking water.
47. We follow CDC guidelines for storing human milk.
48. We warm bottles with warm tap water, NEVER the microwave and publicly post this practice.
49. We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.
50. We take advantage of the Child and Adult Care Food Program.
51. We provide snacks and meals with attention to children's allergies and dietary restrictions.
52. We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers

Appendix B

DEMOGRAPHIC SURVEY

Please check the box next to your answer, or follow the directions included in the question.

1. What is the full name of your housing program/organization?

   ____

2. Which of the following best describes your position?
   - o Administrative
   - o Executive
   - o Direct Support Staff
   - o Case Management
   - o Other ______________________________

3. How long have you been in your current position?
   - o Less than 1 year
   - o 1 – 3 years
   - o 3 – 5 years
   - o 5 or more years

4. What is the highest degree or level of school you have completed?
   - o Less than high school diploma
   - o High school diploma or GED

- Some college, but no degree
- Associates degree
- Bachelor’s degree
- Master’s degree
- Professional or doctoral degree

5. Which of the following best describe the population your program serves. Please choose all that apply.
   - **Only** single women and their children.
   - Two (or more) adult families such as those that may include fathers, mothers, same-sex parents, or grandparents as caregivers.
   - Unaccompanied youth
   - **Only** single adults, no children are served by our program.
   - Veterans
   - Other ___________________________________

6. Which of the following best describes your housing program? Check all that apply.
   - Emergency housing
   - Transitional housing
   - Permanent supportive housing
   - Other _________________________

7. Some housing programs serve special populations. Which of the following describes the population of families you serve in your program? (Check all that apply.)
    - o Individuals identified as domestic violence victims.
    - o Youth (ages 18-24).
    - o Veterans.
    - o Chronically homeless.
    - o Native American/American Indian.
    - o We serve all families experiencing homelessness regardless of special circumstance.
    - o Other ______________________

8. Which of the following best describes the location of your housing program?
    - o Rural
    - o Urban
    - o Suburban
    - o Other ________________________________

9. Approximately how many families are currently in your housing program? (If you do not know the exact number, please use your best estimation).

    ____

10. Which of the following best describes the living arrangements in your program? Check all that apply.

- o Dormitory style rooms (multiple families in an open living space)
- o Single family rooms (only one family per room)
- o Shared family rooms (2 or more families per room)
- o Other ________________________

11. Approximately how many children 0-5 are currently in your housing program? (If you do not know the exact number, please use your best estimation).

    ____

Appendix C

COGNITIVE INTERVIEW PROTOCOL

Introduction:

Thank you for agreeing to speak with me today, as I mentioned my name is Sara Shaw and I am a Doctoral Student at the University of Delaware. I am currently working with national partners, like you, who work with families experiencing homelessness. This interview is part of a study validating the *Early Childhood Self-Assessment Tool for Family Shelters.* The purpose of the study is to learn about the design, delivery, and effectiveness of the *Self-Assessment*.

You are being asked to complete the survey because you are a housing provider working with families experiencing homelessness. Your contact information (name and address) was provided by your local Continuum of Care.

The purpose of the interview is to get your opinion about the *Self-Assessment tool* and to learn about your experience working with young children in shelter.

Completing this interview is your choice. You do not have to answer any questions you do not want to answer. Your feedback may be used to improve future iterations of the *Self-Assessment*.

The interview will take about 45-60 minutes to complete. It asks for some demographic information like your name, position and organization. This identifiable

information will be kept confidential. We will report results only in the aggregate. If you have any questions, please feel free to stop me at any time to ask. I will begin by introducing the *Self-Assessment* tool, after which we will begin the interview. Do you have any questions before we begin?

The Self-Assessment: Family shelters provide essential services to infants, toddlers, and preschoolers during a difficult time in their lives. As you work to connect families to permanent housing, you can ensure that your shelter environment assists the physical, socio-emotional, and intellectual development of children ages 0-5 to support these children through their experience of homelessness. Creating this safe, developmentally appropriate environment will assure that the infants, toddlers, and preschoolers in your shelter have the best possible start to a bright future, as they exit homelessness into permanent housing.

The Early Childhood Self-Assessment Tool for Family Shelters is specifically designed to help shelter staff members create shelter environments that are safe and developmentally appropriate for infants, toddlers, and preschoolers. In this tool, you will find recommendations and information on how your shelter environment, programming, policies, and staff can support early childhood safety and development. Similar tools have been developed and implemented with much success in child care, early learning, and early childhood development settings.

This tool is just one of several resources that the Administration on Children and

Families (ACF) created to support the healthy and safe development of children experiencing homelessness.

How do you use the tool?

ACF recommends that shelter staff use this tool first to do an initial assessment of their facility, noting whether each recommendation has been accomplished, is improving, or needs action. Based on the results of the initial assessment, operators and/or staff then can use the included resources to identify strategies to best provide a safe and developmentally appropriate setting for infants, toddlers, and preschoolers. These strategies can then be translated into an action plan.

ACF suggests that staff members use this tool to re-evaluate the shelter's progress at least once during the implementation process and once after the process's completion. Also, because of the complex and changing nature of each family's experience with homelessness, it may be helpful to consistently engage residents, especially parents with young children, throughout the process of improving the facility's policies and practices related to infants, toddlers, and preschoolers.

This tool is not intended to serve as comprehensive guide to programming in shelters or as a guide for ensuring the full education needs of young children. It is simply a mechanism to guide shelter staff as they begin the process to improve the safety and developmental appropriateness of their facility for young children.

Question protocol:

53. We meet all Emergency Solutions Grant health and safety standards.
    a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

54. We discuss emergency response plans (for natural disasters, lost children, active shooters, etc.) with residents and post them publicly.

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

55. We have sanitary diaper changing stations.

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

56. We practice and encourage frequent hand washing.

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

57. We prevent harmful exposure to blood and other dangerous bodily fluids.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

58. We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

59. We encourage parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

60. We maintain an appropriate temperature in the shelter and allow residents with young children to stay inside when needed and/or desired.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

61. We have rules regarding visitation by non-residents to ensure the safety of residents.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

62. We mandate that all residents, staff, volunteers, and other shelter guests sign in and out of the facility

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

63. Infants, toddlers, and preschoolers are under supervision by parents and/or staff/volunteers at all times, following staff/child ratio requirements

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

64. We encourage and incorporate parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

65. We follow safe sleep practices as outlined by the NIH to reduce the risk of Sudden Infant Death Syndrome (SIDS) and provide parents with this information

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

66. We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

67. We have age appropriate first aid materials on hand (including EpiPens, Children's Benadryl and Tylenol, band aids, etc.)

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

68. We provide age appropriate hygiene materials (i.e. baby soap, baby shampoo, sunscreen)

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

69. We connect infants, toddlers, and preschoolers to primary care providers by posting information, providing transportation, etc.

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

70. We have separate, private rooms for each family with infants, toddlers, and preschoolers.

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

71. We have child abuse safeguards throughout our facility (low walls, vision panels, and reflective security mirrors) and have written process and training for reporting child abuse.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

72. We screen all infants, toddlers, and preschoolers for developmental delays, refer them to Part C and B of IDEA child find programs in each State if needed, and follow any existing special care plans.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

73. We offer referrals to Part C and Part B of IDEA for evaluations to determine the need for IDEA services such as speech, physical therapy and special education. We offer referrals for infants, toddlers, and preschoolers (i.e. mental health, home visiting).

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response]**?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

74. We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, Head Start, IDEA Part C early intervention or Part B preschool or other early care and learning programs.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
75. We publicly post enrollment materials for, refer families to, and encourage participation in Head Start, Early Head Start, IDEA Part C early intervention or Part B preschool, child care subsidy programs, preschool, and other early care and learning programs.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
76. We have and maintain age and developmentally appropriate toys and learning materials (books, games, etc. that are cleaned, repaired, etc.).
    a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
c. *Can you tell me why you answered* ***[insert response]****?*
d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

77. We have space available for women to breastfeed privately.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
78. We have space available for parents to spend time with infants, toddlers, and preschoolers that is clean, well-maintained, and family friendly.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
79. We have space available for parents to eat with infants, toddlers, and preschoolers.
    a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered* ***[insert response]****?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

80. We have indoor and outdoor play space available for infants, toddlers, and preschoolers that is safe, clean, and well-maintained.

    a. *What came to mind as I asked you this question?*

    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

    c. *Can you tell me why you answered* ***[insert response]****?*

    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

81. We train our staff on the effects of homelessness on the development of young children and on how they can support the healthy development of infants, toddlers, and preschoolers.

    a. *What came to mind as I asked you this question?*

    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

    c. *Can you tell me why you answered* ***[insert response]****?*

    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

82. We train our staff to recognize and respond to adverse drug and allergic reactions.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

83. We have procedures in place for collaborating with local early care and education programs (Head Start, child care, IDEA Part C early intervention and Part B preschool, etc.).

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

84. We collaborate with the local McKinney-Vento Homeless Education Liaison and post contact information in the shelter.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

85. We train our staff on recognizing domestic violence and the process for referring families to community-based services and hotlines.
    a. *What came to mind as I asked you this question?*
    b. Can you give me an example from your program that you were thinking of when you gave your answer?
    c. *Can you tell me why you answered **[insert response**]?*
    d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*
86. We train our staff in trauma-informed care.
    a. *What came to mind as I asked you this question?*
    b. Can you give me an example from your program that you were thinking of when you gave your answer?
    c. *Can you tell me why you answered **[insert response**]?*
    d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*
87. We have at least one staff who is trained in CPR/First Aid for adults, infants, toddlers, and preschoolers present at all times.
    a. *What came to mind as I asked you this question?*
    b. Can you give me an example from your program that you were thinking of when you gave your answer?
    c. *Can you tell me why you answered **[insert response**]?*
    d. ***If answered accomplished/improving:** What types of resources do you use to meet this goal?*

88. We run background checks on all of our staff to ensure they pass all child abuse clearances.

    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response***]*?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

89. We have staff and/or consultants who can address the developmental, educational, and nutritional needs of infants, toddlers, preschoolers and knows process for making referrals to IDEA Part C and Part B programs for infants, toddlers and young children with disabilities for early care and learning programs.

    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response***]*?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

90. We encourage and support family connections to Head Start, Child Care, TANF, LIHEAP, public education, IDEA Program, SNAP, WIC, Summer Food Service Program, CHIP & Medicaid, etc.

    a. *What came to mind as I asked you this question?*

  b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
  c. *Can you tell me why you answered* ***[insert response]****?*
  d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

91. We connect families with home visiting services and provide space for home visits to occur in our shelter.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
92. We have a clear process to receive feedback and/or file grievances relating to the shelter's policies and practices concerning infants, toddlers, and preschoolers.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
93. All rules, policies, programming, and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

94. We have on-site early childhood enrichment programming for infants, toddlers, and preschoolers.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

95. We offer (not require) classes on topics such as parenting, nutrition, financial literacy, etc. to support the parents of infants, toddlers, and preschoolers.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

96. We comply with local, state, and federal food safety standards

a. *What came to mind as I asked you this question?*

b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
c. *Can you tell me why you answered* ***[insert response]****?*
d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

97. We do not serve foods that are choking hazards to infants, toddlers, or preschoolers
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
98. Our residents always have access to safe drinking water.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*
    c. *Can you tell me why you answered* ***[insert response]****?*
    d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*
99. We follow CDC guidelines for storing human milk.
    a. *What came to mind as I asked you this question?*
    b. *Can you give me an example from your program that you were thinking of when you gave your answer?*

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

100. We warm bottles with warm tap water, NEVER the microwave and publicly post this practice.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

101. We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

102. We take advantage of the Child and Adult Care Food Program.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered **[insert response**]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

103. We provide snacks and meals with attention to children's allergies and dietary restrictions.

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response*** *]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

104. We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers

a. *What came to mind as I asked you this question?*

b. Can you give me an example from your program that you were thinking of when you gave your answer?

c. *Can you tell me why you answered* ***[insert response*** *]?*

d. ***If answered accomplished/improving:*** *What types of resources do you use to meet this goal?*

The final set of questions are about your overall response to the Self-Assessment process.

105. Overall, what do you think about this tool?

106. What are the strengths of the Self-Assessment tool?

107. What is missing from the tool that you think should be included?

108. Do you have any closing, or final thoughts you would like to add?

Appendix D

REVISED SELF-ASSESSMENT

Q1 We have, discuss, and post publicly the following emergency response plans:

	We do not currently do this.	We have a policy in place for this event.	We have a policy and share this with residents.	We have a policy that is shared with residents and monitor implementation of the policy.
Natural disasters	❍	❍	❍	❍
Lost children	❍	❍	❍	❍
Active shooters	❍	❍	❍	❍
Other	❍	❍	❍	❍

Q2 We have sanitary diaper changing stations.

❍ We do currently do this.
❍ We have diaper changing stations available to all families.
❍ We have diaper changing stations and disposable paper liner available to all families.
❍ We have changing stations with disposable liners and have policies around cleaning and disinfecting the surface of the changing station.

Q3 We practice and encourage frequent hand washing.

❍ We do not currently do this.
❍ We have a policy in place.
❍ We have a policy in place and publicly post this information.
❍ We encourage parents and monitor the implementation of this policy.

Q4 We prevent harmful exposure to blood and other dangerous bodily fluids.
❍ We do not currently do this.
❍ We have a policy in place.
❍ We have a policy in place and publicly post this information.
❍ We encourage parents and monitor the implementation of this policy.

Q5 We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers.
❍ We do not currently do this.
❍ We have a policy in place.
❍ We have a policy in place and publicly post this information.
❍ We encourage parents and monitor the implementation of this policy.

Q7 We encourage parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.
❍ We do not currently do this.
❍ We have a policy in place.
❍ We have a policy in place and publicly post this information.
❍ We encourage parents and monitor the implementation of this policy.

Q6 We take measures to ensure that families are not exposed to extreme weather or temperatures.

	We do not do this at this time.	We have a policy in place.	We have a policy and share this information with families.	We have a policy and monitor to ensure implementation is being met.
We maintain an appropriate temperature in the shelter.	❍	❍	❍	❍
We allow residents with young children to stay inside when needed and/or desired.	❍	❍	❍	❍

Q8 We have rules regarding visitation by non-residents to ensure the safety of residents.

- ❍ We do not currently do this.
- ❍ We have a policy in place.
- ❍ We have a policy in place and publicly post this information.
- ❍ We encourage parents and monitor the implementation of this policy.

Q9 We mandate that the following individuals sign in and out of the facility:

	We do not do this at this time.	We have a policy in place.	We have a policy and share this information with families.	We have a policy and monitor to ensure implementation is being met.
Residents	❍	❍	❍	❍
Staff	❍	❍	❍	❍
Volunteers	❍	❍	❍	❍

Q12 Infants, toddlers, and preschoolers are under the supervision by parents/staff/volunteers at all times. When staff/volunteers are watching children, we follow our state's child ratio requirements.

	We do not do this at this time.	We have a policy in place.	We have a policy and share this information with families.	We have a policy and monitor to ensure implementation is being met.
Parents	❍	❍	❍	❍
Staff	❍	❍	❍	❍
Volunteers	❍	❍	❍	❍

Q13 We encourage and incorporate parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers.

- We do not do this at this time.
- We encourage parent feedback more generally, but do not specifically ask about concerns around safety and development of children.
- We encourage parent feedback regarding their children's safety and development.
- We incorporate parent feedback on their children's development and safety in our programming and policies.

Q14 We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information.

	We do not do this at this time.	We have a policy in place.	We have a policy and share this information with families.	We have a policy and monitor to ensure implementation is being met.
We encourage parents to always place a baby on his or her back to sleep, for naps and at night.	❍	❍	❍	❍
We always provide a firm sleep surface, such as a mattress in a safety-approved crib covered by a fitted sheet.	❍	❍	❍	❍
We encourage parents to keep soft objects, toys, crib bumpers, and loose bedding out of your baby's sleep area.	❍	❍	❍	❍
We encourage parents to monitor the temperature in their sleep space, and not let their baby overheat.	❍	❍	❍	❍

We encourage parents to only use pacifiers with no strings attached while their baby sleeps.	❍	❍	❍	❍
We discuss the dangers of co-sleeping with parents.	❍	❍	❍	❍
We have space available for, and encourage parents to provide their infants with tummy time.	❍	❍	❍	❍

Q15 We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers.

	We do not do this at this time.	We do this in some spaces, but not throughout the whole shelter.	We do this throughout the entire shelter.	We monitor these items to ensure they are working and replace any broken or missing pieces.
We have tamper-resistant electoral outlet covers.	❍	❍	❍	❍
All toxic substances in locked spaces and are inaccessible to children.	❍	❍	❍	❍
There are no openings that could entrap a child's head or limbs.	❍	❍	❍	❍
We have baby gates at the tops of stairs/ramps.	❍	❍	❍	❍
We ensure all furniture that has the potential to tip over (i.e. dressers, book shelves, etc.) are bolted to the wall to ensure they will not fall over.	❍	❍	❍	❍

We keep any item that has the potential to be a choking hazard in a place that is inaccessible to children.	❍	❍	❍	❍
We keep any other potentially hazardous item out of children's reach.	❍	❍	❍	❍
We ensure any sharp edges or corners are covered or protected.	❍	❍	❍	❍

Q16 We have age appropriate first aid materials on hand including the following:

	We do not do provide this.	We have these only if the parents provide them. We keep these items in a secure location.	We keep these items stocked and have a policy in place to receive parent approval to provide them to families in case of emergency.	We keep these items on hand and re-stock the items as needed. We monitor our policy to ensure family's needs are being met.
EpiPens or other Epinephrine Auto-injector	❍	❍	❍	❍
Children's Benadryl and Tylenol	❍	❍	❍	❍
Band aids, etc.	❍	❍	❍	❍

Q17 We have age appropriate hygiene materials on hand including:

	We do not do provide this.	We provide supports to parents in purchasing these items.	We keep these items in stock for families to use.	We keep these items on hand and re-stock the items as needed.
EpiPens or other Epinephrine Auto-injector	❍	❍	❍	❍
Children's Benadryl and Tylenol	❍	❍	❍	❍
Band aids, etc.	❍	❍	❍	❍

Q18 We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics by:

	We do not do this at time.	This is provided to parents.	This is provided to parents, and encouraged by case management or other shelter staff.	Information/services are updated and monitored to ensure family's needs are being met.
Posting contact information of local primary care providers.	❍	❍	❍	❍
Providing/supporting transportation to and from appointments.	❍	❍	❍	❍

Q19 We protect against child abuse by having the following in place:

	We do not do this at this time.	We have this in place.	We have this in place and communicate this to families.	We have this in place and monitor to ensure family's needs are being met.
We have safeguards in place such as low walls, vision panels, reflective security mirrors, or security cameras where appropriate.	❍	❍	❍	❍
We have a written process and training for reporting child abuse.	❍	❍	❍	❍

Q20 We screen all infants, toddlers, and preschoolers for developmental delays using a developmental screening tool.

❍ We do not do this at this time.

❍ We do not do this on site, but can support families in connecting to other community organizations for developmental screenings.

❍ We provide developmental screenings to all infants, toddlers, and preschoolers.

❍ We provide developmental screenings to all infants, toddlers, and preschoolers and can refer them to local Child Find, or other programs for young children with disabilities for additional services.

Q22 We offer referrals to special education services covered under the Individuals with Disabilities Education Improvement Act such as speech, physical therapy, and special education.

- ❍ We do not currently do this.
- ❍ We have a policy in place.
- ❍ We have a policy in place and provide parents with this information.
- ❍ We encourage parents to discuss concerns with their case manager and monitor the implementation of this policy.

Q23 We offer referrals to infants, toddlers, and preschoolers for additional services such as mental health, and home visiting programs (i.e. Early Head Start, Nurse Family Partnership, Parents as Teachers, Healthy Families America, etc.).

- ❍ We do not currently do this.
- ❍ We have a policy in place.
- ❍ We have a policy in place and provide parents with this information.
- ❍ We encourage parents to discuss concerns with their case manager and monitor the implementation of this policy.

Q25 We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, head start, or receive early intervention services.

- ❍ We do not currently do this.
- ❍ We have a policy in place.
- ❍ We have a policy in place and provide parents with this information.
- ❍ We encourage parents to discuss concerns with their case manager and monitor the implementation of this policy.

Q26 We support families in enrolling in the following types of early learning programs:

	We do not do this at this time.	We publicly post or provide families with enrollment information.	We refer families to this program.	We encourage families to enroll in this program and help address barriers to enrollment.
Head Start	❍	❍	❍	❍
Early Head Start	❍	❍	❍	❍
Early Intervention for young children with disabilities	❍	❍	❍	❍
Preschool programs	❍	❍	❍	❍
Other early care and learning programs	❍	❍	❍	❍

Q27 We support families in connecting with child care subsidy programs (state and federal programs that help low-income families pay their child care fees).

- ❍ We do not do this at this time.
- ❍ We publicly post or provide families with this information.
- ❍ We refer families to this program.
- ❍ We encourage families to enroll in this program and help address barriers to enrollment.

Q28 We have and maintain age and developmentally appropriate toys and learning materials.

- ❍ We do not do this at this time.
- ❍ We have these items available to families.
- ❍ We have these items available to families and have a policy for cleaning and maintaining these items.
- ❍ We monitor these items and replace those that are in need of repair or damaged.

Q29 We have a private space, that is not a bathroom, available for women to breastfeed privately.

- ❍ We do not have this at this time.
- ❍ Families have their own rooms.
- ❍ We have a dedicated space, or that no one is able to enter while it is being used. The space has a comfortable chair and table for breastfeeding and/or pumping.
- ❍ We have a dedicated space and policy to support breastfeeding mothers. We monitor this space and ensure that is clean and in good repair.

Q30 We have spaces available for parents to spend time with infants, toddlers, and preschoolers including the following:

	We do not have this at this time.	We have this space available to families.	We have this space available to families and ensure it is family friendly.	We have this space available to families have a policy regarding the cleaning and maintenance of this space.
Indoor play space	❍	❍	❍	❍
Outdoor play space	❍	❍	❍	❍
Dining space	❍	❍	❍	❍

Q31 We train our staff on the following:

	We do not do this at this time.	We do this, but not on a regular basis.	We do this with some, not all staff on a regular basis.	We do this will all staff on a regular basis.
Child development	❍	❍	❍	❍
Recognizing and responding to adverse drug and allergic reactions	❍	❍	❍	❍
Recognizing and responding to domestic violence	❍	❍	❍	❍
Trauma informed care	❍	❍	❍	❍
CPR and First Aid for infants, toddlers, and preschoolers.	❍	❍	❍	❍

Q32 We collaborate with the following early care and learning programs:

	We do not do this at this time	we have a procedure in place to collaborating with this program.	We collaborate with this program on an as-needed basis.	We regularly communicate with and collaborate with this program.
Head Start	❍	❍	❍	❍
Early Head Start	❍	❍	❍	❍
Child care programs	❍	❍	❍	❍
Early intervention programs for young children with disabilities	❍	❍	❍	❍
Other preschool programs	❍	❍	❍	❍

Q33 We collaborate with the local McKinney-Vento Homeless Education Liaison.

- ❍ We do not do this at this time.
- ❍ We publicly post the contact information of the McKinney-Vento Homeless Education Liaison in the shelter.
- ❍ We have a procedure in place for collaborating with the McKinney-Vento Homeless Education Liaison and do so on an as-needed basis.
- ❍ We regularly communicate with and collaborate with the McKinney-Vento Homeless Education Liaison.

Q34 We run background checks on all of our staff to ensure they pass all child abuse clearances.

- ❍ We do not do this at this time.
- ❍ Yes, we run background checks on all staff.

Q35 Click to write the question text

	We do not do this at this time.	We publicly post, or provide information to families about this program.	We refer families to this program.	We support families with enrollment in this program and address any barriers to enrollment.
TANF	❍	❍	❍	❍
LIHEAP	❍	❍	❍	❍
Public Education	❍	❍	❍	❍
SNAP	❍	❍	❍	❍
WIC	❍	❍	❍	❍
Summer food service program	❍	❍	❍	❍
CHIP & Medicaid	❍	❍	❍	❍

Q36 We encourage participation in home visiting services such as Early Head Start, Nurse-Family Partnership, HIPPY, etc.

- ❍ We do not do this at this time.
- ❍ We provide space for home visits for families who are already connected to services.
- ❍ We publicly post, or provide families with information about home visiting programs and provide space within the shelter for these to occur.
- ❍ We collaborate with, and refer families to home visiting services and provide space for these visits to occur in our shelter.

Q37 All rules, policies, programming and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter or a copy is provided to each family.

- ❍ We do not do this at this time.
- ❍ Yes, every family receives this information.

Q38 QUESTION ABOUT EARLY CHILDHOOD ENRICHMENT PROGRAMMING- WAITING ON RESPONSE FROM MARSHA AND WILL UPDATE.

- ❍ Click to write Choice 1
- ❍ Click to write Choice 2
- ❍ Click to write Choice 3

Q39 We offer (not require) the following classes to parents of infants, toddlers, and preschoolers:

	We do not offer this class at this time.	We offer this class on an irregular basis.	We offer this class on a regular basis.	We offer this class and incorporate parent feedback into the development of future classes.
Parenting	❍	❍	❍	❍
Nutrition	❍	❍	❍	❍
Financial literacy	❍	❍	❍	❍
Other	❍	❍	❍	❍

Q40 We comply with local, state, and federal food safety standards.

- ❍ We do not serve food to families. Families are responsible for their own meals.
- ❍ We have policies around food safety.
- ❍ We have and monitor policies around food safety.
- ❍ We are audited by a government entity for food safety standards.

Q41 We do not serve foods that are choking hazards to infants, toddlers, or preschoolers (i.e. hot dogs, grapes, peanut butter, popcorn, etc.).

- ❍ We do not serve food to families. Families are responsible for their own meals.
- ❍ We educate parents about potential choking hazards, but they are responsible for ensuring their children do not consume these foods.
- ❍ We have alternative meal options available for families with infants, toddlers, and preschoolers that do not include choking hazards. Families are responsible for requesting these meals.
- ❍ We have a meal plan that takes into account each residents age and provide age appropriate meals to everyone.

Q42 Our residents always have access to safe drinking water.

- ❍ We do not do this at this time.
- ❍ Yes, all residents always have access to safe drinking water.

Q43 We support families in following CDC guidelines for storing breast milk. by doing the following:

	Click to write Scale point 1	Click to write Scale point 2	Click to write Scale point 3
We provide clean storage containers to parents that are breast feeding (i.e. screw cap bottles, hard plastic cups with tight caps, heavy-duty bags that fit directly into a bottle).	❍	❍	❍
We provide refrigerator and/or freezer space for storing breast milk that easily accessible and safe for breast feeding mothers.	❍	❍	❍
We clearly label all breast milk with the date and name of parent.	❍	❍	❍
We provide parents with information on proper storage of breast milk including the length of time it should be stored and at what temperature.	❍	❍	❍

Q44 We warm bottles with warm tap water, never the microwave.
- We do not warm bottles for families.
- We publicly post or provide parents with information about bottle warming practices.
- We have a policy in place for warming bottles, and we share this information with parents and staff.
- We have a policy in place, and we monitor to ensure proper implementation of this policy.

Q46 We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.
- We do not do this at this time.
- We ask parents at intake for this information.
- We have a procedure in place for regularly updating the food allergy list.
- we monitor the food allergy list and provide snacks and meals with attention to Children's dietary restrictions.

Q47 We take advantage of the Child and Adult Care Food Program
- We do not serve food to families. This does not apply to our program.
- We do not take advantage of this at this time.
- Yes, we use the Child and Adult Care Food Program.

Q48 We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers.
- We do not serve food to families. This does not apply to our program.
- We do not do this at this time.
- When available, we provide these items to families.
- We maintain a stock of these items and have them readily available to families.

Appendix E

VARIABLE NAMES

Variable Name	Self-Assessment Item
EMER1	We have the following emergency response plans: - Natural disasters
EMER2	We have the following emergency response plans: - Lost children
EMER3	We have the following emergency response plans: - Active shooters
DIAP	We have sanitary diaper changing stations.
HEAL1	We take measures to ensure the health of residents. - We practice frequent hand washing.
HEAL2	We take measures to ensure the health of residents. - We prevent harmful exposure to blood and other dangerous bodily fluids.
HEAL3	We take measures to ensure the health of residents. - We take precautions to limit the spread of contagious diseases among infants, toddlers, and preschoolers.
HEAL4	We take measures to ensure the health of residents. - We support parents of infants, toddlers, and preschoolers to immunize their children and keep track of these immunizations.
WEATH1	We take measures to ensure that families are not exposed to extreme weather or temperatures. - We maintain an appropriate temperature in the shelter.
WEATH2	We take measures to ensure that families are not exposed to extreme weather or temperatures. - We allow residents with young children to stay inside when needed and/or desired.
SAFE1	We have measures in place to ensure the safety of residents. - We have rules regarding visitation by non-residents to ensure the safety of residents.
SAFE2	We have measures in place to ensure the safety of residents. - We mandate that staff sign in and out of the facility.
SAFE3	We have measures in place to ensure the safety of residents. - We mandate that volunteers sign in and out of the facility.
SAFE4	We have measures in place to ensure the safety of residents. - We mandate that residents sign in and out of the facility.
SAFE5	We have measures in place to ensure the safety of residents. - Infants, toddlers, and preschoolers are under the supervision by parents/staff/volunteers at all times.
FEEDBACK	We elicit parent feedback regarding our facility's policies towards the safety and development of infants, toddlers, and preschoolers.
SLEEP1	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this

	information. - We encourage parents to always place their baby on his or her back to sleep, for naps and at night.
SLEEP2	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We always provide a firm sleep surface, such as a mattress in a safety-approved crib or pack and play covered by a fitted sheet.
SLEEP3	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to keep soft objects, toys, crib bumpers, and loose bedding out of their babies sleep area.
SLEEP4	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to monitor the temperature in their sleep space, and not let their baby overheat.
SLEEP5	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We encourage parents to only use pacifiers with no strings attached while their baby sleeps.
SLEEP6	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We discuss the dangers of co-sleeping with parents.
SLEEP7	We follow safe sleep practices as outlined by the NIH o reduce the risk of Sudden Infant Death syndrome (SIDS) and provide parents with this information. - We have space available for, and encourage parents to provide their infants with tummy time.
SPROOF1	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have child proof electoral outlet covers.
SPROOF2	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - All toxic substances (i.e. cleaning supplies) are kept in locked spaces and are inaccessible to children.
SPROOF3	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - There are no openings that could entrap a child's head or limbs.
SPROOF4	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We have baby gates at the tops of stairs/ramps.
SPROOF5	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure all furniture that has the potential to tip over (i.e. dressers, book shelves, etc.) are bolted to the wall to ensure they will not fall over.

SPROOF6	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We keep any item that has the potential to be a choking hazard in a place that is inaccessible to children.
SPROOF7	We have safety proofed all rooms and common spaces for infants, toddlers, and preschoolers. - We ensure any sharp edges or corners are covered or protected.
FAID1	We have age appropriate first aid materials on hand including the following: - EpiPens or other Epinephrine Auto-injector
FAID2	We have age appropriate first aid materials on hand including the following: - Children's Benadryl and Tylenol
FAID3	We have age appropriate first aid materials on hand including the following: - Band aids, etc.
HYG1	We have age appropriate hygiene materials on hand including: - Baby shampoo
HYG2	We have age appropriate hygiene materials on hand including: - Baby soap
HYG3	We have age appropriate hygiene materials on hand including: - Baby sunscreen
CONCT1	We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We post contact information of local primary care providers.
CONCT2	We connect infants, toddlers, and preschoolers to primary care providers, doctors, or medical clinics: - We provide/support families in accessing transportation to and from appointments.
DV1	We have systems to ensure appropriate supervision. - We have safeguards in place such as low walls, vision panels, reflective security mirrors, or security cameras where appropriate.
DV2	We have systems to ensure appropriate supervision. - We have a written process and training for reporting child abuse.
SCREEN	We screen all infants, toddlers, and preschoolers for developmental delays using a developmental screening tool (e.g. Ages and Stages, Brigance, etc.).
ECE1	We provide referrals to early learning services. - We offer referrals to special education services covered under the Individuals with Disabilities Education Improvement Act such as speech, physical therapy, and special education.
ECE2	We provide referrals to early learning services. - We offer referrals to infants, toddlers, and preschoolers for additional services such as mental health, and home visiting programs (i.e. Early Head Start, Nurse Family Partnership, Parents as Teachers, Healthy Families America, etc.).

ECE3	We support families in enrolling in the following types of early learning programs: - Head Start
ECE4	We support families in enrolling in the following types of early learning programs: - Early Head Start
ECE5	We support families in enrolling in the following types of early learning programs: - Early Intervention for young children with disabilities
ECE6	We support families in enrolling in the following types of early learning programs: - Preschool programs
ECE7	We support families in enrolling in the following types of early learning programs: - Child Care subsidy
ECE8	We support families in enrolling in the following types of early learning programs: - Home visiting programs
SCHEDU	We follow a schedule that allows infants, toddlers, and preschoolers to attend child care, head start, or receive early intervention services.
TOYS	We have and maintain age and developmentally appropriate toys and learning materials.
BFEED	We have a private space, that is not a bathroom, available for women to breastfeed privately.
SPACE1	We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Indoor play space
SPACE2	We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Outdoor play space
SPACE3	We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Dining space
SPACE4	We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for napping.
SPACE5	We have spaces available which are age-appropriately furnished and maintained for parents to spend time with infants, toddlers, and preschoolers including the following: - Quiet space for Mommy/Daddy and me time.
TRAIN1	We train our staff on the following: - Child development
TRAIN2	We train our staff on the following: - Recognizing and responding to adverse drug and allergic reactions
TRAIN3	We train our staff on the following: - Recognizing and responding to domestic violence
TRAIN4	We train our staff on the following: - Impacts of trauma on families and/or trauma-informed care

TRAIN5	We train our staff on the following: - CPR and First Aid for infants, toddlers, and preschoolers.
COLLAB1	We collaborate with the following early care and learning programs: - Head Start
COLLAB2	We collaborate with the following early care and learning programs: - Early Head Start
COLLAB3	We collaborate with the following early care and learning programs: - Child care programs
COLLAB4	We collaborate with the following early care and learning programs: - Early intervention programs for young children with disabilities
COLLAB5	We collaborate with the following early care and learning programs: - Home visiting services such as Early Head Start, Nurse-Family Partnership, HIPPY, etc.
COLLAB6	We collaborate with the following early care and learning programs: - McKinney-Vento Homeless Education Liaison
CONSULT1	We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Developmental
CONSULT2	We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Educational
CONSULT3	We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Nutritional
CONSULT4	We have staff and/or consultants who can address the following concerns and can make referrals when needed: - Social Emotional
BGCHECK	We run background checks on all of our staff to ensure they pass all child abuse clearances.
PROG1	We support family connections to the following programs: - TANF
PROG2	We support family connections to the following programs: - LIHEAP
PROG3	We support family connections to the following programs: - Public Education
PROG4	We support family connections to the following programs: - SNAP
PROG5	We support family connections to the following programs: - WIC
PROG6	We support family connections to the following programs: - Summer food service program
PROG7	We support family connections to the following programs: - CHIP & Medicaid
PROG8	We support family connections to the following programs: - Child Welfare
PROG9	We support family connections to the following programs: - Domestic Violence Services
PROG10	We support family connections to the following programs: - Substance Use and Recovery Services

RULES	All rules, policies, programming and feedback processes regarding infants, toddlers, and preschoolers are posted publicly in the shelter or a copy is provided to each family.
CLASS1	We offer the following classes to parents of infants, toddlers, and preschoolers: - Parenting
CLASS2	We offer the following classes to parents of infants, toddlers, and preschoolers: - Nutrition
CLASS3	We offer the following classes to parents of infants, toddlers, and preschoolers: - Financial literacy
FOOD1	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We comply with local, state, and federal food safety standards.
FOOD2	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We comply with local, state, and federal food safety standards.
FOOD3	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - Our residents always have access to safe drinking water.
FOOD4	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We identify and maintain records of food allergies and other special dietary needs of infants, toddlers, and preschoolers.
FOOD5	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We take advantage of the Child and Adult Care Food Program
FOOD6	The following describes food safety practices. Please select the rating that best reflects your programs current practices. - We always have a supply of formula, baby food, and age-appropriate nutritious snacks available to parents of infants, toddlers, and preschoolers.
CDC1	We support families in following CDC guidelines for storing breast milk by doing the following: - We provide clean storage containers to parents for breast milk (i.e. screw cap bottles, hard plastic cups with tight caps, heavy-duty bags that fit directly into a bottle).
CDC2	We support families in following CDC guidelines for storing breast milk by doing the following: - We provide refrigerator and/or freezer space for storing breast milk that easily accessible and safe for breast feeding mothers.
CDC3	We support families in following CDC guidelines for storing breast milk by doing the following: - We clearly label all breast milk with the date and name of parent.
CDC4	We support families in following CDC guidelines for storing breast milk by doing the following: - We provide parents with information on

	proper storage of breast milk including the length of time it should be stored and at what temperature.
BOTTL	We warm bottles with warm tap water, never the microwave.

Appendix F

IRB HUMAN SUBJECTS APPROVAL LETTER

RESEARCH OFFICE

210 Hullihen Hall
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DATE:	January 9, 2018
TO:	Sara Shaw
FROM:	University of Delaware IRB
STUDY TITLE:	[1015361-5] Validating the Early Childhood Self-Assessment Tool for Family Shelter
SUBMISSION TYPE:	Continuing Review/Progress Report
ACTION:	Approved for Data Analysis Only
APPROVAL DATE:	January 9, 2018
EXPIRATION DATE:	January 30, 2019
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # *(9)*

Thank you for your submission of Continuing Review/Progress Report materials for this research study. The University of Delaware IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

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