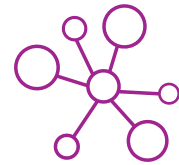


DELIVERING SERVICES TO MEET THE NEEDS OF HOME-BASED CHILD CARE PROVIDERS



Findings from the Director Interviews
Sub-study of the National Study of Family Child Care Networks



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For more information about this study, contact:

Juliet Bromer, Ph.D.
Herr Research Center
Erikson Institute 451 N. LaSalle Street, Chicago, IL 60654
Phone: (312) 893-7127 Email: jbromer@erikson.edu

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JULIET BROMER

Research Scientist

HERR RESEARCH CENTER

ERIKSON INSTITUTE

TONI PORTER

Principal

EARLY CARE AND EDUCATION CONSULTING

DELIVERING SERVICES TO MEET THE NEEDS OF HOME-BASED CHILD PROVIDERS:

FINDINGS FROM THE DIRECTOR INTERVIEWS
SUB-STUDY OF THE NATIONAL STUDY OF FAMILY CHILD CARE NETWORKS

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EXECUTIVE SUMMARY

OVERVIEW

Home-based child care (HBCC) encompasses non-custodial care provided by regulated family child care (FCC) providers and family, friend, and neighbor (FFN) caregivers, who may or may not be legally-exempt from regulation. It is the most common child care arrangement for children from birth through age five, caring for approximately seven million children (NSECE Project Team, 2016). More infants and toddlers are in these setting than any other child care arrangement (NSECE Project Team, 2013; Paschall, 2019) and low-income families working non-traditional schedules disproportionately use HBCC (Laughlin, 2013).

Two issues—improving HBCC quality and maintaining supply—have emerged as pressing questions for policy makers and program administrators across the country. While there is some evidence that both FCC and FFN providers engage in quality improvement initiatives, data about the effects of these initiatives are limited and the results are mixed (Bromer and Korfmacher, 2017; Douglass, Taj, Coonan, & Friedman, 2017; Hallam, Hooper, Bargree, & Han, 2017; Tonyan, Paulsell, & Shivers, 2017). Moreover, while the number of regulated FCC providers decreased by 46% in the past decade (NCECQA, 2019), there is a lack of data on supply-building strategies.

Some research suggests that family child care networks—organizations that provide a combination of services to HBCC providers delivered by a paid staff member—may be a promising approach for improving the quality and building the supply of HBCC (Bromer & Porter, 2019; Bromer, Van Haitsma, Daley, & Modigliani, 2009; Porter & Reiman, 2016).

***HBCC NETWORKS** are defined as organizations that have specialized staff who provide a menu of services (including visits to provider homes, training workshops, and/or peer support) specifically intended for a targeted group of regulated FCC providers and/or FFN caregivers, although the organization may also serve or house center-based programs.*

Within this broad category of HBCC networks, we also define “dedicated” HBCC networks, which are stand-alone organizations that exclusively serve HBCC providers.

RESEARCH QUESTIONS

1. What are director perceptions of providers' challenges and needs?
2. How do networks and other organizations that serve HBCC meet provider interests and needs?
3. How do networks and other organizations that serve HBCC providers implement services that are most likely to shape positive outcomes for HBCC providers, children, and families?
4. How do networks and other organizations that serve HBCC providers help them navigate licensing, subsidy, QRIS, and Head Start systems?

PURPOSE

The current report presents findings from qualitative interviews with a sub-sample of 47 directors of organizations drawn from the National Study of Family Child Care Networks (Bromer & Porter, 2019).¹ Building on the results of the national survey, the findings seek to clarify the definition of “family child care network” and to understand how networks and other organizations that support HBCC tailor services to meet the needs of HBCC providers and offer services that are most likely to shape positive quality outcomes.

SAMPLE

TYPES OF ORGANIZATIONS

- 70% of the organizations interviewed were categorized as HBCC networks
 - » 11 of these 33 HBCC networks were dedicated networks meaning they were stand-alone organizations that exclusively served HBCC providers; the other 22 networks were housed in larger umbrella organizations
- 30% of the interview sample were categorized as other organizations that serve HBCC providers but do not offer a menu of services to a targeted group of HBCC providers

PROVIDERS SERVED

- 57% of organizations served regulated FCC providers only; 32% served both FCC and FFN; 11% served only FFN caregivers.

SYSTEM AND POLICY ROLE

- 43% of organizations enforced regulatory and quality system standards (system enforcers); 47% supported providers within these systems (system supporters); 11% were not connected to any public regulatory or quality system

FINDINGS AND HIGHLIGHTS

Directors described challenges faced by providers including difficult working conditions, need for and access to information, and difficulty making a living.

- Isolation was the most commonly reported work-related challenge for HBCC providers.
- The most commonly reported topics where HBCC providers wanted more information were supporting children’s social-emotional development and working with families.
- Close to two-fifths of directors brought up providers’ lack of business skills as a major challenge.

Directors also described provider challenges meeting demands of regulatory and quality systems.

- Cross-system variation in requirements and complicated (often redundant) standards created confusion for many HBCC providers who participate in licensing, subsidy, or QRIS. Health and safety requirements in particular were burdensome for providers.
- Low reimbursement rates for providers participating in state child care subsidy systems were a disincentive for providers to participate in subsidy and quality systems.
- Directors reported that providers experienced discomfort using online technologies, faced language barriers with English-only content, and had limited access to online platforms.

“This is really lonely work.”

“They have no clue whatsoever what it means to actually balance the books or run a business.”

“The providers are so overwhelmed... All these different entities are asking them to do things, and they’re getting really confused as to who’s asking what, and who needs what paperwork where.”

“The ability to do all these sorts of things to get this low reimbursement rate ... is really breaking the back, and, frankly, driving out a lot of people who have a heart, and have the desire to take care of kids.”

¹ One organization housed two distinct family child care networks. Directors of both networks were included in the sample.

Provider needs and system demands drove strategies to support HBCC providers. Most organizations offered visits to provider homes, training workshops, and formal peer supports. Many offered business supports, and fewer offered financial assistance or any material resources.

- Visits to provider homes and training primarily focused on provider compliance with health and safety regulations. Visits and training also focused on quality caregiving including supporting children’s social-emotional development and planning activities for children.
- Visits and trainings were tailored to meet HBCC provider needs. Organizations that served providers in rural areas used visits in order to reach providers who could not travel to a training or class. Trainings were frequently held on evenings and weekends. Most directors reported using relationship-building and adult learning principles to guide visits and trainings.
- System enforcers were more likely to conduct compliance focused visits than system supporters. Organizations serving both FCC and FFN were more likely to differentiate training levels for providers.
- Peer supports included mostly provider-led and fewer staff-facilitated peer support groups, communities of practice, and peer mentoring.
- The most commonly offered business support was business workshops. Organizations also used coaching as well as enrollment of families, collection of parent fees, and back-office assistance to support providers with administrative tasks.
- Financial assistance and material resources were most often related to regulatory and quality system fees and requirements. System enforcers were more likely to pay for educational requirements while system supporters were more likely to offer financial assistance in general to HBCC providers.

The five organizations in our sample that exclusively served FFN caregivers tailored services to meet the needs of informal caregivers while the 15 organizations that served both FFN caregivers and FCC providers focused more of their service delivery on regulated FCC providers.

“Every visit requires walking through, indoors and outdoors, and checking for safety and for hygiene.”

“You’re trying to build that relationship. That makes us more successful over time.

“There are times within the month that are more stressful, and they need that support ... It’s a day that everybody comes and just talks about what they’ve done, what’s not working, what’s working. Just venting.”

“It’s actually really helpful to have someone not only teach you about record keeping, but come over and help you organize your files, or actually go through your contract with you one on one.”

“Our purpose is to make sure we’re taking away any barriers that people might have to certification, which includes the financial piece.”

RECOMMENDATIONS FOR PROGRAM, POLICY, AND RESEARCH

DIRECTIONS FOR HBCC NETWORKS

- Tailor content to the specific needs of FCC providers and FFN caregivers.
- Develop strategies to increase focus of visits to provider homes on support rather than compliance.
- Provide formal opportunities for peer support.
- Offer more business supports focused on financial management.
- Increase support for technology use.

DIRECTIONS FOR POLICY

- Align system requirements to reduce burdens on HBCC providers.
- Create more flexible options for required training.
- Provide adequate funding for organizations that meet the criteria for HBCC networks to maximize their potential for improving quality and increasing supply.

FUTURE RESEARCH

- Explore how peer support and business support help providers improve quality of caregiving for children and families.
- Study how visits to HBCC provider homes can shape positive outcomes for children and families.
- Examine the distinct needs of FFN caregivers and promising strategies for supporting them.
- Study local implementation and adaptation of HBCC network strategies for diverse provider populations working within different policy contexts.

INTRODUCTION

Home-based child care (HBCC) encompasses non-custodial care provided by regulated family child care (FCC) providers and family, friend, and neighbor (FFN) caregivers, who may or may not be legally-exempt from regulation. It is the most common child care arrangement for children from birth through age five. According to the National Survey of Early Care and Education (NSECE), approximately seven million children received care from close to four million HBCC providers in 2012 (NSECE Project Team, 2016). More infants and toddlers were in these setting than any other child care arrangement (NSECE Project Team, 2013; Paschall, 2019). Low-income families working non-traditional schedules disproportionately used HBCC (NSECE Project Team, 2015a); many families relied on these settings for school-age child care (Laughlin, 2013).

The NSECE data have heightened concern about HBCC quality, given the high proportions of very young children in these settings. Research indicates that there is wide variation in HBCC care, just as there is in center-based child care (Bassok, Fitzpatrick, Greenberg, & Loeb, 2016). Some data show that FCC providers have the same levels of observed quality as centers (Lipscomb, Weber, Green, & Patterson, 2016). Yet there is evidence that some providers, FFN caregivers, in particular, do not engage in formal learning activities that support children’s cognitive development (Layzer & Goodson, 2007; NSECE Project Team, 2015b). Measurement may not fully capture quality in HBCC settings, because many instruments have been designed for center-based care (Blasberg et al., 2019).

There have also been growing concerns about a national decline in HBCC supply since the 2012 NSECE data were released. Recent national data suggest a significant decrease in the number of regulated FCC providers by 46% between 2008 and 2017 (NCECQA, 2019). HBCC participation in the Child Care and Development Fund (CCDF) subsidy system mirrored this trend, with the number of FCC providers dropping by nearly half (49%) between FY2011 and FY 2016 (Office of Child Care, 2014, 2019).

These two issues—improving HBCC quality and maintaining supply—have emerged as pressing questions for policy makers and program administrators across the country. While there is some evidence that both FCC and FFN providers engage in quality improvement initiatives, data about the effects of these initiatives are limited and the results are mixed (Bromer and Korfmacher, 2017; Douglass, Taj, Coonan, & Friedman, 2017; Hallam, Hooper, Bargree, & Han, 2017; Tonyan, Paulsell, & Shivers, 2017). There are also limited data about effective strategies to build HBCC supply (Henly & Adams, 2018; NCECQA, 2019; Rohacek & Adams, 2017; Sandstrom et al., 2018).

A small body of research suggests that family child care networks—organizations that employ paid staff to deliver a combination of services to HBCC providers—may be a promising approach for improving quality (Bromer & Porter, 2019). Two studies that systematically examined networks’ effects found that FCC providers affiliated with networks were more likely to offer higher quality care than unaffiliated providers (Bromer, Van Haitsma, Daley, & Modigliani, 2009; Porter & Reiman, 2016). Several studies have also found that FFN participation in efforts that that may look similar to networks had positive effects on quality (ORS IMPACT, 2015; Shivers, Farrago, & Goubeaux, 2015). Findings from other qualitative research suggest that family child care networks can mitigate the isolation that is characteristic of providing HBCC (Buell, Pfister, & Gamel-McCormick, 2002; Hershfield, Moeller, Cohen & the Mills Consulting Group, 2005; Lanigan, 2011; Musick, 1996).

The current report presents findings from qualitative interviews with a sub-sample of 47 directors of organizations drawn from the National Study of Family Child Care Networks (Bromer & Porter, 2019).¹ Building on the results of the national survey, the findings seek to clarify the definition of “family child care network” and to understand how networks and other organizations that support HBCC tailor services to meet the needs of HBCC providers. Reports from directors highlight services that have the potential to support and meet the needs of providers, to improve quality, and to increase the supply of HBCC in the U.S. See Box 1 for a description of the broader National Study of Family Child Care Networks.

1 One organization housed two distinct family child care networks. Directors of both networks were included in the sample.

BOX 1. THE NATIONAL STUDY OF FAMILY CHILD CARE NETWORKS

The National Study of Family Child Care Networks was a three-year study, initiated in 2017, that sought to describe the landscape of network organizations in the U.S., the services and supports they offer to HBCC providers, and the implementation of services. The study consisted of four components: 1) a national survey of staffed family child care networks; 2) qualitative interviews with network directors about how networks implement services; 3) surveys of a sub-sample of providers and staff across networks and development of a measure of relationship-based support; and 4) in-depth case studies of two promising networks.

The first report from this study, *Mapping the Landscape of Family Child Care Networks* (Bromer & Porter, 2019) identified 156 organizations that were broadly defined

as networks and that were housed in a variety of organizations, including: child care resource and referral (CCR&R) agencies; Head Start, Early Head Start, and Migrant Head Start programs; and other types of early childhood, social service, and community development agencies.

This report focuses on qualitative data from in-depth interviews with 47 directors from the sample of 156 networks that completed the landscape survey. The report is intended as a complementary analysis to the landscape report. Analyses of director interview data allowed us to narrow our definition of networks and examine more closely how organizations implement service delivery strategies with HBCC providers.

BACKGROUND

The following sections briefly review existing research on supporting quality in HBCC and factors that may shape the way support services are delivered. These factors include individual provider demographics and characteristics, features of HBCC work, and publicly-funded regulatory and quality system requirements which all may contribute to challenges and opportunities for HBCC providers and the organizations that support them.

SUPPORTING QUALITY IN HOME-BASED CHILD CARE

A small research base has identified some of the core components of high-quality support for HBCC (for reviews see Bromer & Korfmacher, 2017; Hatfield & Hoke, 2016; Paulsell et al., 2010; Porter, Paulsell, Del Grosso, Avellar, Hass, & Vuong, 2010; Susman-Stillman & Banghart, 2011). Studies have examined the effectiveness of specific quality improvement strategies such as coaching or home visiting (Isner et al., 2011; McCabe & Cochran, 2008), training and professional development (Boller et al., 2010; Burris & Fredericksen, 2012; Rusby, Jones, Crowley, Smolkowski, & Arthun, 2013), and peer support (Doherty, Forer, Leo, Goelman, & LaGrange, 2006; Swartz, Wiley, Koziol, & Magerko, 2016).

Research suggests that coaching or consultation visits with HBCC providers that focus on quality caregiving may be an effective approach for improving quality (Bromer & Korfmacher, 2017; McCabe & Cochran, 2008; Porter, et al., 2010). Several studies also find an association between providers who receive training in early care and education and higher quality care in FCC settings (Fukkink & Lont, 2007; Porter, et al., 2010). Moreover, when combined with coaching or individualized technical assistance, training is more likely to positively shape quality outcomes than training workshops alone (Moreno, Green, & Koehn, 2015).

Some studies have found that peer support is related to FCC quality, because it has the potential to increase social support and reduce isolation, which in turn may enhance providers' mental and emotional well-being and responsiveness to children (Doherty et al., 2006; Forry et al., 2013; Gray, 2015; Porter & Reiman, 2016; Raikes, Raikes, & Wilcox, 2005; Swartz et al., 2016).

A recent conceptual model of quality in HBCC (Blasberg et al., 2019) identifies managing a child care business as a core component of quality. FCC providers who cannot sustain their programs may leave the field due to the stress of balancing program revenues and expenses. Such stress may also shape a provider's capacity to offer responsive and sensitive care to children (Østbye et al., 2015). Providers who learn to manage their business practices efficiently may find they have more time to focus on interactions with children and the learning environment.

INDIVIDUAL PROVIDER AND PROGRAM CHARACTERISTICS

Provider characteristics are relevant for the types of services and supports networks and other organizations offer HBCC providers. The NSECE, a 2012 nationally representative survey of the early childhood workforce and households who use child care, offers a portrait of HBCC providers. It groups HBCC providers into three categories: 1) listed providers, who were identified through state lists such as licensing and are most likely FCC providers; 2) unlisted paid providers who were identified through a household survey and are mostly FFN caregivers, although the NSECE estimates that 22% may be FCC providers; and 3) unlisted unpaid providers who were also identified through the household survey and are most likely FFN caregivers (NSECE Project Team, 2016). In the summary below, we will refer to the NSECE listed providers as FCC and unlisted unpaid providers as FFN.¹

The NSECE data reveal some striking differences in the characteristics of FCC providers and FFN caregivers. Motivation for providing care is one. Nearly half of FCC providers (47%) in the NSECE regarded this work as a career or a calling. In contrast, more than three quarters of FFN caregivers reported that they provide child care to help children's parents; fewer than 10% saw child care as a career or calling.

¹ We do not include unlisted paid providers because the category includes a mix of FCC providers and FFN caregivers.

NSECE data also shed additional light on some of the challenges faced by HBCC providers. These challenges include isolation and long working hours, low income from doing child care, and low education levels. FCC providers often work alone; 60% of providers did not have a paid assistant (NSECE Project Team, 2016). Eight in ten FCC providers worked more than a 40-hour week and more than a third of them spent an additional 10 to 35 hours a week on child care related activities (NSECE Project Team, 2016). FFN caregivers may also work alone, without another adult in the household; four in ten of them were not married or living with a partner. They did not have paid assistants. They reported spending less time on child care work; only a quarter worked more than 40 hours a week, and nearly a third worked 20 or fewer hours a week.

Income from an FCC business may be essential for providers. Nearly half (47%) of FCC providers reported that they depended on their business revenues for half or more of their household income, despite the fact that 73% were married or living with a partner who may also contribute to family finances (NSECE Project Team, 2016). Yet nearly a quarter of FCC providers reported mean incomes of \$25,000, which was slightly above the 2012 federal poverty level for a family of four (Office of the Assistant Secretary for Planning and Evaluation, 2019). FFN caregivers are also poor; a quarter reported a mean income of \$17,000.

The NSECE data suggest that providers may lack the knowledge and skills to work with children, especially children across a wide age span. Approximately equal proportions of FCC providers (30%) and FFN caregivers (32%) held an AA or BA degree. But a two- or four-year degree does not necessarily mean that providers have formal knowledge of child development or quality child care. Only a third of FCC providers had an early childhood or related major.²

POLICY AND SYSTEM CHALLENGES

In the past several years, regulatory and quality systems have imposed new requirements on HBCC providers (see Box 2). Many organizations that work with FCC providers and FFN caregivers operate in the context of these publicly-funded systems, enforcing system requirements or helping providers meet them. Although the policy changes, such as the 2014 federal Child Care and Development Block Grant (CCDBG) regulations around subsidy eligibility, are intended to protect the health and safety of children and to improve the quality of care, some studies suggest that these changes may be having an impact on provider engagement in systems (Henly & Adams, 2018; Maxwell, Sosinsky, Tout, & Hegseth, 2016; NCECQA, 2019; Rohacek & Adams, 2017; Sandstrom et al., 2018). The findings point to onerous paperwork and requirements that are often confusing, complex, and challenging for providers to meet. Moreover, low reimbursement rates from state subsidy systems do not compensate for the increased burden of participating in subsidy or quality systems.

BOX 2. PUBLICLY-FUNDED CHILD CARE QUALITY AND REGULATORY INITIATIVES

Licensing or certification systems intend to protect the health and safety of children through requirements such as 1) capping the number of children in care, 2) minimum qualifications of providers and required training, and 3) features of the environment and provider practices.

The federal **Child Care and Development Block Grant (CCDBG)** provides subsidies to eligible families to obtain child care. Child care providers who are reimbursed to provide subsidized child care must comply with federal and state regulatory requirements.

Quality Rating and Improvement Systems (QRIS) have the dual goals of helping families choose high-quality care and helping improve child care quality through providing professional development opportunities for providers to increase their ratings and earn financial incentives.

Head Start/Migrant Head Start and Early Head Start-Child Care Partnerships provide high-quality early care and education for children and comprehensive supports for low-income families. Providers must comply with the Head Start Performance Standards.

² The NSECE does not report post-secondary education majors for unlisted unpaid providers.

LICENSING CHANGES

Close to half (46%) of states define licensed FCC as one individual who cares for children in her own home, although several states use the terms certification or registration (NCECQA, 2015). Licensing thresholds for numbers of children in care range from one to seven, and maximum group size for small FCC homes ranges from four to six or more, and sometimes includes the provider's own children. Between 2011 and 2014, half of the states made changes in their licensing requirements. Close to 60% of the states require providers to complete orientation training, and more than 80% require on-going training. All states now require at least one kind of background check (criminal history records, state/federal fingerprints, child abuse and neglect registry, sex offender registry); 16 require all of them. Nearly all states (90%) require inspections before granting a license, for routine compliance, or for license renewal; a third make unannounced visits for compliance (NCECQA, 2015).

SUBSIDY CHANGES

The 2014 CCDBG reauthorization also required changes. All FCC providers, whether small or large homes, as well as many FFN caregivers, must comply with state regulatory requirements in order to participate in the CCDF subsidy program. Providers who care only for children who are related to them are exempt from regulation (Office of Child Care, 2016). All other providers, both regulated and legally-exempt from licensing, must complete training hours in 10 topics, including CPR and pediatric First Aid, and are subject to inspection visits, with unannounced visits recommended for legally-exempt providers. Comprehensive background checks are required for CCDF-eligible providers; individuals residing in the home who are 18 and older are also required to complete background checks.

QRIS CHANGES

Many states have revised, or are revising, their QRIS standards with new requirements for FCC providers. Of the 44 QRISs, 41 include HBCC. The vast majority (36) of the QRISs that include HBCC require FCC providers to be licensed as a threshold for participation, and 18 of these states use licensing as the first rating level. Eight states allow participation of FFN caregivers. Ratings are based on compliance with standards. The most common standards for FCC providers include education and training, environment, and program administration. Other standards include health and safety, interactions, child assessment, curriculum, family partnerships, and accreditation (The Build Initiative & Child Trends, 2017).

HEAD START, MIGRANT HEAD START, AND EARLY HEAD START-CHILD CARE PARTNERSHIPS

Head Start has offered a family child care option since 1995. In 2014, the federal Office of Head Start and the Office of Child Care created the Early Head Start-Child Care Partnership program, which aims to bring together Early Head Start and child care programs, including regulated or licensed FCC, to provide low-income families access to full-day, full-year child care and the comprehensive services that Early Head Start provides for families. Of the 220 Early Head Start-Child Care Partnership programs that responded to a recent national survey, 39% served FCC providers as well as centers, and 7% served FCC only (Del Grosso et al., 2019).

Together, these changes have implications for services and supports intended to encourage HBCC provider participation in publicly-funded systems.

RESEARCH DESIGN & METHODS

The primary focus of the director interview sub-study was to unpack strategies for supporting HBCC providers. First, we sought to understand director perceptions of the challenges that providers face in doing child care work and the issues that providers confront when they engage in publicly-funded systems. Second, we aimed to examine in detail the services and supports that organizations offer to meet these needs. We also sought to gain insights into director perspectives on the benefits and challenges of delivering these services.

RESEARCH QUESTIONS

1. What are director perceptions of providers' challenges and needs?
2. How do networks and other organizations that serve HBCC meet provider interests and needs?
3. How do networks and other organizations that serve HBCC providers implement services that are most likely to shape positive outcomes for HBCC providers, children, and families?
4. How do networks and other organizations that serve HBCC providers help them navigate licensing, subsidy, QRIS, and Head Start systems?

DATA COLLECTION

RECRUITMENT

Participants were all directors whose organizations participated in the National Survey of Family Child Care Networks (Bromer & Porter, 2019). The survey included a question about willingness to participate in an interview. The positive responses served as the initial director recruitment pool. We used four criteria to select the sample of potential respondents: 1) the organization had paid staff who worked with HBCC providers; 2) the organization offered at least three services, one of which was home visiting or training; 3) the organization served 10 or more HBCC providers; and 4) the organization had been in operation for at least six months. We also purposively over-sampled organizations that were defined as "other" in the landscape report in order to learn more about their approach. As a result, there were fewer CCR&R agencies and Head Start programs in our final sample than in the national landscape survey sample of 156 organizations.³

We sent e-mail invitations to the directors of the 67 organizations which met these criteria, with follow-up phone calls. A total of 49 interviews were completed, with a response rate of 73%.⁴ Of the remaining 18 directors, 13 declined to participate and five never responded to requests for an interview.

TELEPHONE INTERVIEWS

We conducted telephone interviews during a five-month period from August through December 2017. Interviews typically lasted an hour and a half to two hours. Because we encouraged directors to include other staff who might be able to help answer the range of questions about specific services, multiple staff sometimes joined the interviews. With verbal informed consent, we audiotaped the interviews, which were then transcribed for analysis. All protocols and procedures were approved by Erikson Institute's IRB prior to data collection.

³ Fewer than 20% of the final director interview sample included child care resource and referral agencies or Head Start organizations.

⁴ Although the two child care unions met our criteria for the sample, we excluded these interviews because the directors were the only staff who provided direct services to more than 3000 providers.

DATA ANALYSES

Interview transcripts were coded using NVIVO, a qualitative analysis software program. Transcripts were randomly assigned for coding, and every 8th transcript was double coded for reliability. Codes were based on the interview protocol questions which asked about several key service dimensions including help with systems, visits to homes, peer support, business practices, and training. The thematic codes where reliability scores were below 0.8 were discussed and consensus was reached. Analytic sub-codes were then developed for each broad thematic area (e.g. content of visits; types of business supports). Constant comparative analyses looking across organizations as well as within sub-groups of organizations were used to generate narratives around each broad theme.

In addition to this qualitative approach, frequencies were calculated for all broad and analytic codes and entered into Stata 14.2 for quantitative analyses. Two-tailed Fisher's exact tests were used to analyze differences in the frequency of specific services offered across organizations. Fisher's exact test was selected because there were a small number of observations overall (n=47) and small expected cell counts of the two-way contingency tables. If a group had 5 or fewer observations overall (e.g. organizations that serve FFN providers only), it was excluded from that specific comparison.

SAMPLE DESCRIPTION

ORGANIZATIONAL TYPE

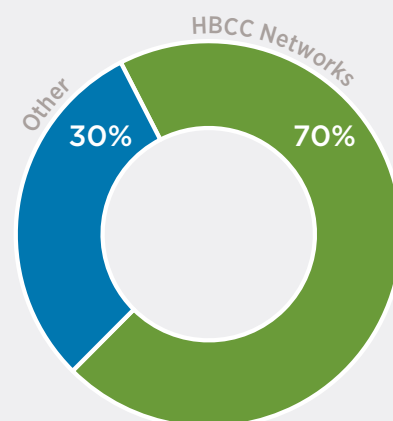
In-depth interviews with directors allowed us to hone our definition of networks. Although we referred to all 156 organizations in our landscape scan as "family child care networks" (Bromer & Porter, 2019), the in-depth director interviews in our sub-sample revealed that some organizations did not consider themselves to be networks but rather other types of organizations that support HBCC. We grouped the 47 organizations in our interview sample into two broad organizational types—*HBCC networks and other organizations that support HBCC providers*.⁵

HBCC networks are defined as organizations that have specialized staff who provide a menu of services (including visits to provider homes, training workshops and/or peer support) specifically intended for a targeted group of regulated FCC providers and/or FFN caregivers, although the organization may also serve or house center-based programs. HBCC networks may also have a specific budget for HBCC services and/or a specific set of services for HBCC providers that differs from services offered to center-based providers. This definition of HBCC networks is more inclusive than what the field refers to as "staffed family child care networks," because it includes networks that may offer services to FFN caregivers as well as to regulated family child care providers. By contrast, other organizations that support HBCC providers do not customize a menu of supports for HBCC providers, do not serve a targeted group of HBCC providers over time, and/or do not offer a combination of visits to provider homes and training and/or peer supports.

Slightly more than two-thirds of our interview sample were categorized as HBCC networks (see Figure 1). These included 11 dedicated and stand-alone networks that were not connected to a broader umbrella agency and that only served HBCC providers. The other 22 HBCC networks were housed in a variety of broader organizations including four child care resource and referral agencies, six Head Start Programs, and 12 other child and youth services agencies.

The other third of our interview sample included 14 organizations that support HBCC providers but did not meet our criteria for HBCC networks. These organizations included four child care resource and referral agencies, two Head Start programs, as well as other child and youth services organizations, family support agencies, and statewide professional development systems.

FIGURE 1: TYPES OF ORGANIZATIONS



HBCC networks - 70% (33)
Other organizations that support HBCC providers (not networks) - 30% (14)

⁵ One organization housed two distinct family child care networks. Directors of both networks were included in the sample.

PROVIDERS SERVED

The 47 organizations in our sample served a range of HBCC providers including licensed or regulated FCC providers and FFN caregivers (Table 1). Close to three fifths of all the organizations only served FCC providers; a third served both FCC providers and FFN caregivers; and five organizations served only FFN caregivers. HBCC networks were more likely to focus services on FCC providers only compared to other organizations that supported HBCC providers. Three of the five organizations that served only FFN caregivers (and not regulated FCC providers or centers) were dedicated HBCC networks.

TABLE 1: TYPES OF HBCC PROVIDERS SERVED

	All organizations N=47	HBCC networks ^a N=33	Other organizations that serve HBCC1 N=14
Regulated FCC providers only ^b	57% (27)	70%* (23)	29% (4)
FCC providers and FFN caregivers	32% (15)	21% (7)	57%* (8)
FFN caregivers only	11% (5)	9% (3)	14% (2)

^aFisher's exact test of significance does not include organizations that serve FFN only;

*** $p \leq .001$; ** $p \leq .01$; * $p \leq .05$; + $p \leq .10$

^bSome of these organizations also served center-based programs.

RELATIONSHIP TO SYSTEMS

We also categorized our sample by the role the organization played within local, state, or federally funded systems. A majority of the organizations in our sample were linked to licensing, subsidy, QRIS, and/or Early Head Start, Head Start, or Migrant Head Start (Table 2). The 42 organizations connected to a system were almost equally divided, regardless of network status or providers served, between those that could be considered system supporters versus system enforcers (Box 3). System supporters were contractually responsible for helping providers meet system requirements. System enforcers were contractually responsible for monitoring compliance with system requirements. All nine Head Start, Early Head Start, or Migrant Head Start programs in our sample were system enforcers.

BOX 3. SYSTEMS ROLE

System supporter: Organization is contractually responsible for helping providers participate and meet system standards and regulations.

System enforcer: Organization is contractually responsible for ensuring and monitoring compliance with system standards and regulations.

TABLE 2: SYSTEMS ROLE OF ORGANIZATIONS

	All organizations N=47	HBCC networks N=33	Other organizations that serve HBCC N=14
System supporters	47% (22)	48% (16)	43% (6)
System enforcers	43% (20)	42% (14)	43% (6)
Not connected to a system	11% (5)	9% (3)	14% (2)

No statistically significant differences between networks and other organizations.

FINDINGS

The following sections report on the results of the director interviews related to our primary study questions. The first section focuses on director perceptions of provider challenges around offering HBCC and meeting system demands. The second section presents findings about the strategies that organizations use to meet HBCC provider needs around offering child care and meeting system demands, including: 1) visits to provider homes, 2) training workshops, 3) peer and business supports, and 4) financial and material assistance.

Throughout the report we describe themes that emerged from director interviews. We also report on differences in service delivery strategies across types of HBCC providers served and system role of organizations. The report concludes with a discussion and recommendations for program, policy, and future research directions.

PERCEPTIONS OF PROVIDER NEEDS AND CHALLENGES

There is a growing acceptance in the early care and education field that HBCC has unique features that distinguish it from other types of non-parental early care and education arrangements (Blasberg et al., 2019; Forry et al., 2013; Lipscomb et al., 2016; NSECE Project Team, 2016; Porter et al., 2010; Susman-Stillman & Banghart, 2011; Tonyan, 2017). While some of these features – small numbers of children in care, homelike settings, and continuity of care from the same provider over time – may be a potential benefit for children, others may pose challenges for providers. Working alone for long hours without other adults, sustaining an income from a small child care business, and caring for mixed-age groups of children may create barriers to offering high-quality care as well as limit access to supports.

Our interviews with directors focused on service delivery strategies and did not specifically ask about challenges faced by HBCC providers although we did ask directors which topics or issues providers wanted addressed. During the course of the interviews, directors reported several challenges which they perceived providers faced. We grouped perceived challenges into two primary categories: 1) challenges around the work of providing child care; and 2) challenges around navigating the demands of participating in publicly-funded early care and education systems—licensing, subsidy, QRIS, and Head Start. Our data suggest that perceived provider challenges drive the ways in which both networks and other organizations implement services and tailor them to meet provider needs. We report on these challenges and related needs in the sections below.

CHALLENGES DOING HOME-BASED CHILD CARE WORK

The directors in our sample pointed to what they saw as provider challenges related to HBCC (Table 3). Among these challenges were working conditions – isolation, long hours, role burden, and work-family balance. Directors also reported on providers' requests for information about how to care for young children or work with families and the obstacles they faced around accessing information. For organizations that served only regulated FCC providers (mostly HBCC networks), directors talked about FCC providers' lack of skills around managing a child care business and general need for support around making a living from doing child care.

WORKING CONDITIONS

Isolation. Provider experiences of isolation emerged as the most commonly reported challenge by directors. One director stated the issue concisely: “This is really lonely work.” Others emphasized providers’ lack of contact with adult colleagues: “They don’t have adult interaction, and everybody needs that.”

Long hours and role burden. Long hours as well as role burden, especially for regulated FCC providers, were other challenges reported by directors. As one network director explained, FCC providers are “the administrator, the teacher, the activity planner, the driver, the cook.” Another director of a network described the burdens of doing family child care:

- “It takes a strong person to be able to open your doors at 6:00 a.m., sometimes going until midnight, taking in one, two, three children of varying needs, abilities. Oh, my goodness, everything. You’re mopping, you’re cooking, you’re changing diapers, you’re providing experiences and activities.”

Work-family balance. Directors also described providers’ challenges around balancing child care work with caring for their own families. These challenges included providers’ efforts to address their own children’s needs while caring for other people’s children, and managing family crises while maintaining a child care program.

NEED FOR INFORMATION ABOUT WORKING WITH YOUNG CHILDREN

Directors cited providers’ specific needs for information about aspects of working with young children and families. Two directors used the same language — “hunger for knowledge” — to describe providers’ motivation for joining their programs.

Supporting children’s social emotional development. The most commonly reported need around working with children was how to support children’s social-emotional development. As one network director noted:

- “A lot of times [the questions] are about trying to understand the child’s emotions and how to work with a child ...There’s a lot of ‘What do I do when she won’t stop crying? Why is he biting? Please help us connect with these children.’”

Another reported need was provider requests for information about caring for children with diagnosed special needs.

Working with families. Almost a third of directors reported that HBCC providers wanted information about working with families. A network director described her FCC providers’ and FFN caregivers’ lack of skills for supporting families, especially communication around difficult situations:

- “They need strategies and they need a lot of help in developing that communication [to discuss issues with parents]. Some of it is around how you establish that you’re operating a child care program as a professional. [But], in some cases, you’re a friend, family, and neighbor caregiver and you’re still dealing with the struggles of communicating with parents and being respected.”

Child care environments and curricula. Fewer directors mentioned other areas where providers needed help, including how to arrange a child care environment and how to implement a curriculum. Directors also discussed providers’ lack of knowledge about early care and education in general:

- “They want to learn how to teach children. They’re interested in seeing the children thrive... Most of them are not educated in the early childhood field. We bring in curriculum and teach them how to use it.”

Health and safety. Six directors mentioned providers’ needs for information about health and safety issues and most of these examples were around specific health practices. A network director elaborated on FCC providers’ interests in health and nutrition practices:

- “They want to know how to administer certain medicines. They want to know when and how to keep something refrigerated – they don’t have a refrigerator. They want to know about the physicals – how to learn to read the language within the physicals. Same things for menus. They want to know how to do the label-reading.”

Working with mixed-age groups. Supporting a wide range of ages of children is a unique challenge for HBCC providers. Six network directors noted that caring for mixed-age groups was often difficult for providers, and that finding information about this was even more difficult because most trainings were geared towards center-based, age-specific programs. One director of a dedicated network that only served FCC providers captured this perception: “Some [providers] want to go on and learn more—focus on child development or working with mixed ages, because their homes are mixed-age groups versus just one age group.”

OBSTACLES AROUND ACCESS TO EDUCATION AND TRAINING

Beyond specific child development and child care information, directors described obstacles faced by providers who were trying to access education and training: low education and literacy levels. These factors created both logistical and emotional barriers to participation as these directors' comments about provider fears and anxieties indicate:

- “The average age of our provider is in her mid-50’s and hasn’t been back in school in 30 years.”
- “We have some ladies that [have] no formal education, not even GED.”

Language was another barrier for providers accessing training and professional development. Most of the organizations in our sample served providers whose first language was not English. A network director described the challenge of supporting monolingual Spanish-speaking FCC providers and FFN caregivers:

- “You have huge populations of non-English speaking, monolingual Spanish speakers... They don’t come into training because they feel that they don’t have the skills, or that they don’t speak the language well, or they can’t read. They’re not sure how that’s gonna be received on the training end.”

MAKING A LIVING FROM CHILD CARE

Directors saw providers' needs for earning an income from their child care business and related lack of skills around managing these small child care businesses as significant issues.

Income. A fifth of directors cited providers' needs for a consistent source of income and the revenue that the FCC business would provide for their families. One director described this focus on making a living among providers: “We have a large cadre of people who look at providing subsidized child care to be their business model ...They are solely reliant on us to actually pay their bills.” Another expanded on this theme:

- “People are looking to be as creative as possible in generating revenue for their families to take care of their business ...They get additional money from being a part of our network ... They recognize that it may be more work, [and] it may be not worth the money that we give them. People need as much as they can get.”

Business skills. Nearly two-fifths of directors discussed providers' needs for business skills. Directors recognized that some people enter the field because they want to help children or because they want to earn an income while staying home with their own children, but they know little about managing a small business. One director characterized providers' lack of business skills this way: “They have no clue whatsoever what it means to actually balance the books or run a business.” Another director explained:

- “They don’t view it as a business. Changing their mindset really is part of the work. That’s an important piece, because they are operating a business. That’s something that we still struggle with our providers. You have to understand how to effectively be an owner and an operator and manage a business.”

The lack of business recordkeeping, marketing, and accounting skills had consequences. It sometimes meant that providers would leave the field because, as one director noted, providers “didn’t realize this is what [they were] getting into.”

SUMMARY

HBCC providers face multiple challenges doing the work of caring for children in their homes. From their experiences engaging and supporting providers, directors in our interview sample articulated many of these challenges and needs.

- Directors described difficult working conditions among HBCC providers. Isolation was the most commonly reported work-related challenge.
- Directors reported HBCC providers' need for information about working with children and families. The most commonly reported topics were supporting children’s social-emotional development and working with families. Directors also described obstacles providers face trying to access education and training, including language and literacy barriers.
- Directors mentioned providers' challenges around making a living from doing HBCC. Close to two-fifths of directors brought up providers' lack of business skills as a major challenge.

TABLE 3: CHALLENGES DOING CHILD CARE**All organizations****N=47**

WORKING CONDITIONS	
Isolation	60% (28)
Long hours and role burden	21% (10)
Balancing work and family	21% (10)
NEED FOR INFORMATION AROUND WORKING WITH CHILDREN AND FAMILIES	
Supporting children's social-emotional development	36% (17)
working with families	28% (13)
Child care environments	17% (8)
Curriculum and activities	15% (7)
Health and safety	13% (6)
Working with special needs children and inclusion	13% (6)
Working with mixed-age groups of children	13% (6)
MAKING A LIVING DOING HOME-BASED CHILD CARE	
Need for income	21% (10)
Need business skills	38% (18)

CHALLENGES MEETING SYSTEM DEMANDS

The 42 directors in our sample whose organizations worked within publicly-funded early childhood systems (licensing, subsidy, QRIS and Head Start), emphasized the demands of these systems as challenges for HBCC providers. Three major themes about system challenges emerged (Table 4). First, system requirements such as new CCDBG health and safety training, licensing and QRIS standards that were not HBCC-friendly, and general lack of alignment across systems posed challenges for HBCC providers. Second, low subsidy reimbursement rates for both FCC and FFN providers did not compensate for the added burden of compliance with requirements nor did the rates cover the cost of providing quality care. Third, technology requirements were challenging for HBCC providers who may not have had the requisite skills or access to online technology.

CHALLENGES MEETING SYSTEM REQUIREMENTS

Lack of alignment across systems and changing regulations, specific standards, required background checks, and paperwork made meeting system requirements difficult for HBCC providers. Two thirds of the directors talked about the challenges HBCC providers faced in meeting requirements. Directors described several aspects of requirements that were burdensome for providers, including: 1) cross-system variation and lack of alignment; 2) confusing and difficult licensing, subsidy, and QRIS standards; 3) background checks; 4) mandated training; and 5) paperwork.

Cross-system variation. Variation in requirements across systems created confusion for HBCC providers, especially if the information from system monitors or inspectors was conflicting. As one director of an organization that provided licensing, subsidy, and QRIS support for providers said: “Providers might want to do the right thing... but nobody can clearly and consistently describe what the right thing to do is.” A director of an Early Head Start and Head Start network described the conflict between Head Start and state child care licensing this way:

- “We heard from the providers, when the [state licensors] were coming into the homes, and we guide them to do certain things that they had to do for the Early Head Start program, [the state licensors] will say, ‘No. This is the way we do it’ or ‘I’m the one that gives you the license, so you have to listen to me.’”

Confusing and difficult standards. Specific system requirements were hard for HBCC providers to meet; failure to comply could result in loss of licensure or subsidy receipt. Understanding and keeping track of requirements such as ratios, immunizations, and attendance were challenging. Required ratios, for example, could be confusing for providers:

- “There’s ratios of how many children, the ages. If it’s one person, how many children under two you can have? Then, within that, under two, you can’t have more than three under 15 months. It’s difficult for some people to grasp and understand.”

Requirements around health and safety practices were another area where directors reported that providers struggled. Some talked about providers’ basic lack of awareness of what might constitute a safety issue: “The knife that’s hanging off the counter,” “the nail that’s sticking out of the log,” or “the hairspray that’s in the bathroom.” An Early Head Start and Head Start network director explained the challenges her FCC providers faced in trying to meet Head Start Performance Standards that were stricter than licensing:

- “The providers, for many years, have been used to the very, very basics, when it comes to licensing, and they didn’t really have to do not even half of what they do now... helping them understand why do you have to have your three feet in between cots? Why should children not have blankets, or pillows, or toys in the crib? Why should a baby not be holding the bottle by themselves? Why do we have to label everything?”

Directors indicated that QRIS requirements, in particular, were challenging for providers who did not have the skills to comply or were not motivated to meet standards. As this director explained:

- “There is a series of assessments that the providers have to do. Some of them will say ‘I don’t know if I want to still do this,’ and their level of expectation and their level of commitment begins to wane. [It’s] the level of work and commitment that the provider is expressing; it becomes clear that they’re not really as interested as they once were.”

Criminal background checks. Three directors cited background checks required by the CCDBG rules for subsidy programs as a barrier for providers. A director of a network that supported FCC providers in the subsidy system explained:

- “We’ve run into child abuse record checks and fingerprinting issues for household members. We’ve had some husbands with things in their past – not really significant – but enough that warrant the program having to close and then go through a lot of legal issues to put their license back into place. It’s unfortunate that a woman be penalized for something her husband did when he was 18 or 19.”

Mandated training hours. Directors also talked about mandated training hours for subsidy or Head Start that were difficult for HBCC providers to obtain because their programs were open from early morning to late in the evening. Providers’ only option was to close, which would mean a loss of income for their own family and loss of child care for parents. A director of a network that served FCC providers in a rural state explained the problem:

- “This lack of understanding how difficult [the mandatory training] is... because these providers have private kids too, and all of our families work. There seems to be a misconception that, well, if you give parents enough time, they’ll figure out where to put their kids if you have to close.”

Paperwork. Thirteen directors cited paperwork burdens associated with subsidy, licensing, QRIS, and Head Start as a challenge for HBCC providers. A director of a network that monitored licensing and subsidy compliance described the effects on its FCC providers: “The providers are so overwhelmed... All these different entities are asking them to do things, and they’re getting really confused as to who’s asking what, and who needs what paperwork where.”

Directors pointed to providers’ need for support including how to navigate the “red tape” associated with systems, how to read lengthy applications, and how to understand confusing instructions around completing and submitting paperwork. A director of a network that monitored licensing compliance and worked with many immigrant FCC providers explained that “weeding through all the paperwork is a challenge for our very diverse providers.” Another director from a network that helped HBCC providers comply with subsidy requirements talked about the consequences of incomplete paperwork: “The state says, ‘We’re going to halt your money until you get better at reporting your number of children and your clock hours.’” Sometimes these challenges proved too much for providers. According to one director of an organization that offered mental health consultation for FCC providers, “For some providers it’s just too much trouble to work with the bureaucracies.”

LOW REIMBURSEMENT RATES

A quarter of directors cited low subsidy reimbursement rates as a factor in HBCC providers’ decisions not to participate in subsidy or QRIS. A director of a network that helped providers with licensing, subsidy, and QRIS compliance articulated this issue:

- “The reimbursement rate [in our state] is really one of the lowest in the nation ... The ability to do all these sorts of things to get this low reimbursement rate, and then the transactional parts of it are so complicated and so hard, it is really breaking the back, and, frankly, driving [out] a lot of people who have a heart, and have the desire to take care of kids. I think you’re moving to more underground child care providers ...”

ONLINE TECHNOLOGY

Nine directors described the increased reliance of systems such as licensing and subsidy on online technology as challenging for HBCC providers. They described three types of challenges: 1) discomfort with online technology; 2) limited access to online technology; and 3) language barriers. One director saw the broad implications of reliance on technology for HBCC providers:

- “The state is requiring them to submit all of their attendance and all of their reimbursement requests in the form of electronics, do it electronically. It’s a sink or swim world.”

Discomfort with online technology. Directors described providers’ discomfort and lack of skills around using online technologies. A director of a network that helped FCC providers comply with licensing and subsidy requirements summed up the challenge: “This [technology] is most of the family child care system. [The providers] are not technically savvy.” Another director noted: “Twenty-five percent of our license-exempt providers are computer illiterate.” Other directors talked about “unfriendly” systems that were hard to manipulate. A director of a network described the calls she received from her providers every Monday:

- “How do you get your iPad to come on? How do you login? ... Still, two and a half years later, those are the tech calls that we get: ‘I can’t get my password to work. My grandkids came over this weekend.’ And we’ll have a whole bunch of those happen tomorrow too. I mean, it’s just the nature of the game ... it takes so much time away from what we think is the more meaningful work.”

Limited access to technology. Related to this, directors described challenges providers face accessing technology. A director of a statewide organization that supported rural FCC providers and FFN caregivers described challenges for providers who had to access web sites on their phones:

- “If they’re a person who just doesn’t use a computer a lot or is trying to access ... on their phone ... it’s really hard. Imagine reading a three or four-page article on my phone, but I know people do it.”

Language barriers. Directors explained that technology challenges for providers whose first language was not English were compounded by English-only materials and websites. A director of a network responsible for enforcing subsidy requirements identified technology as especially hard for monolingual Spanish speakers:

- “This requirement for health and safety is done online. In Spanish, there’s no written curriculum that can be used to supplement the training and the classroom training. You have huge populations of non-English speaking, monolingual Spanish speakers who’ve never touched a computer before.”

SUMMARY

HBCC providers face multiple challenges navigating as well as participating in regulatory and quality improvement systems. Directors in our interview sample cited provider challenges with system demands including requirements, low reimbursement rates, and access to and use of online technology.

- Cross-system variation in requirements and complicated, often redundant, standards created confusion for many HBCC providers who participated in licensing, subsidy, or QRIS. In particular, health and safety requirements were burdensome for providers. Paperwork requirements including documentation of mandated training hours were also challenging.
- Low reimbursement rates for providers participating in state child care subsidy systems were a disincentive for providers to participate in subsidy and quality systems.
- Directors reported that providers experienced discomfort using online technologies, faced language barriers with English-only content, and had limited access to online platforms.

TABLE 4: SYSTEM CHALLENGES

Director reports of provider challenges with systems (licensing, subsidy, QRIS, Head Start)	All organizations that work within systems
	N=42
Challenging system requirements	60% (25)
Low subsidy reimbursement rates	19% (8)
Navigating online technology required by systems	21% (9)

SERVICE DELIVERY STRATEGIES THAT RESPOND TO HBCC PROVIDERS' NEEDS AND SYSTEM DEMANDS

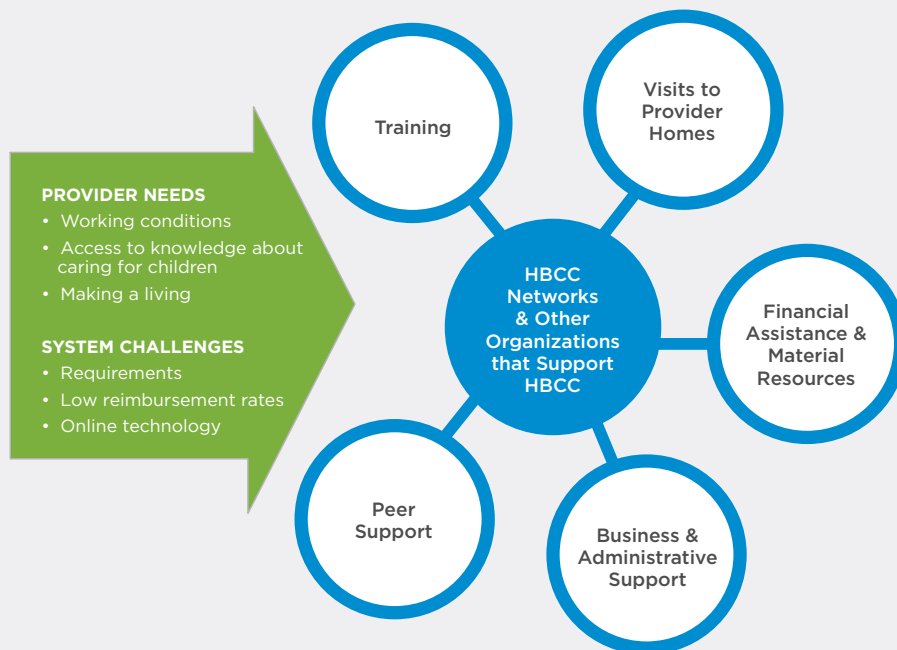
In the following sections, we describe how strategies to support HBCC providers were driven by the provider needs and system demands described above. Strategies included visits to provider homes, training, peer support, business and administrative supports, and financial assistance and material resources (see Figure 2).

Directors in our sample often framed discussions about their HBCC strategies by describing the tension between monitoring providers and supporting providers. Directors of organizations that were system enforcers talked about needing to support providers, and those of organizations that were system supporters talked about the high stakes associated with compliance. One director articulated how difficult it was to offer services in the context of enforcement: “[We have to serve] as a buffer between people who are just wanting to take care of kids, and the state, [which has] a very prescriptive rule, a very rules point of view.” Another director described the difficulty of helping providers understand her organization’s role as providing help rather than monitoring. She gave this example of how the state licensing agency referred providers to her organization to help with licensing violations:

- “Licensing does sometimes say to a program, ‘You need to call [us].’ That puts us in a little different arena. We have to work hard to make sure that they realize that we’re not licensing. We’re not monitoring that, but we are interested in quality. Then we get the call saying, ‘I’ve been written up. Apparently, I need to call you.’ Then it just takes time for the provider to realize that we’re in it to support them.”

Throughout the following sections, we describe service delivery approaches across the 47 organizations in our interview sample. We examine differences by types of providers served and systems role (enforcer vs. supporter).

FIGURE 2: STRATEGIES THAT RESPOND TO PROVIDER NEEDS AND SYSTEM CHALLENGES



VISITS TO PROVIDER HOMES

Visits to provider homes have the potential to offer providers support, technical assistance, and professional connections that they may not otherwise receive. Visits may help to reduce some of the social and professional isolation HBCC providers experience as well as provide a practical and hands-on approach to helping them put knowledge into practice. According to the NSECE data, approximately a third of FCC providers participated in a coaching visit during the year (NSECE Project Team, 2016). Yet we know little about how visits are conducted with HBCC providers across programs and agencies.

Directors in this study shed new light on the variation in approaches to visiting providers. All HBCC networks and all but two other organizations in our interview sample used visits to provider homes (Table 5). Terminology around visits was inconsistent. Directors referred to visits as coaching, mentoring, consultation, or technical assistance, and described a range of goals and topics covered by these visits. None of the directors described specific coaching models or curricula to guide visits. Both system enforcers and supporters offered visits beyond any required contact or prescribed dosage to support provider needs and interests.

When asked to describe the different types and purposes of visits, some directors, especially those that were directors of organizations that were not networks or were networks embedded in larger organizations, reported having multiple staff who conducted visits to HBCC provider homes. These included staff across different content areas and programs including food monitors for the Child Care and Adult Food Program, QRIS specialists, infant toddler specialists, nurse and mental health consultants, curriculum and resource specialists, disabilities specialists, and family engagement staff.

VISITS FOCUSED ON MONITORING AND COMPLIANCE

Close to three quarters of directors reported conducting visits to provider homes focused on compliance and monitoring, specifically around health and safety regulations. The 2014 CCDF regulations required annual inspection visits to all child care providers who receive reimbursement for providing subsidized child care. Not surprisingly, organizations that were tasked with enforcing these new regulations were more likely than system supporters to report focusing visits on monitoring and compliance. Monitoring visits often focused on documentation and paperwork. A director of a network that was a system enforcer and had a state contract to manage participation in the subsidy system described how visits were the vehicle for assuring providers adhered to subsidy regulations:

- “Those visits, we are looking for things that are part of our contracts that they need to follow, because we have our own on-site eligibility. In order to do that, there’s a lot of rules that we have to follow, or that they have to follow, to be part of our program to receive payment from the state. They have to be signing out all the parents. They have to do daily attendance forms so that we know what children are there, what days and what hours they’re there.”

In Head Start, Migrant Head Start or Early Head Start-Child Care Partnership programs, health and safety checks could happen on every visit to a provider’s home: “Every visit requires walking through, indoors and outdoors, and checking for safety and for hygiene.”

Part of a monitoring visit included completing required paperwork and documentation. Directors described how visitors tried to lessen the burden of paperwork for providers through completing forms during visits, using visits to collect forms so providers did not have to mail or submit them, or translating forms for providers whose first language was not English.

VISITS USED FOR TRAINING CREDIT

Six organizations reported using visits to deliver required training hours. Organizations that served providers in rural areas used visits as training in order to reach providers who could not travel to a training or class. Visits were a way of bringing “training to you in your home.”

An organization that operated an Early Head Start program brought modules to FCC provider homes that could be counted towards training hours required for licensing. A director of a network that was a system supporter reported that her FCC providers could use two hours of a visit towards training hours. As another example, a director of an organization that was responsible for enforcing systems requirements in provider homes talked about using visits as training to respond to licensing violations:

- “We are asked by the licensers to go in and to work with that program around a specific thing, so sometimes it is corrective action, and sometimes it’s for training. If a family child care provider is behind on their training and will affect their license, we will go in and do one-on-one training.”

State rules and regulations prevented some organizations from using visits as training. Two network directors reported that the state would not give credit for trainings conducted in the child care home. A director of a network that was a systems enforcer and served only FCC providers explained her state’s policy: “The training cannot be offered in home and count. If we did the training on their sidewalk, it would count, because it’s not in their home.”

VISITS FOCUSED ON SUPPORTING CAREGIVING PRACTICES

Directors described visit topics that ranged from a broad focus on quality improvement to specific topics. A quarter of directors reported using the Family Child Care Environment Rating Scale-Revised (FCCERS-R: Harms, Cryer, & Clifford 2006) to guide the focus of visits to provider homes. Close to half of directors mentioned a focus on supporting children's social emotional development and behavior, and two fifths reported that visits focused on helping providers implement curriculum or activities with children including lesson planning, math, science, and literacy activities.

Working with families. Close to a third of directors reported that visits could include a focus on working with families. Many of these were Head Start or other comprehensive services programs that had family engagement staff who worked with FCC providers. Only a handful of directors mentioned that their organizations helped providers conduct screenings, although QRIS often include child assessment as a standard, and providers may lack assessment and screening skills.

Supporting unique features of HBCC quality. Home environments and mixed-age groups of children are two features of HBCC that look different from other ECE settings (Blasberg et al., 2019). Close to a third of directors reported that helping providers improve their child care home environments was a goal of visits. One director of a network described helping a provider rearrange her environment to better meet the needs of a mixed-age group of children:

- “I was at a provider this week, and we were talking about room arrangement. I was showing her how she had a large enough space where she can actually have two spaces, one for the infants and the other space for the preschool children. I told her especially for the crawlers and the kids that need tummy time. That would be so much better. We moved the big couch into the middle of the floor.”

Seven directors also mentioned using visits to help providers offer quality caregiving to different age groups of children. An Early Head Start and Head Start network director explained making multiple visits to an FCC provider in order to help her problem solve how to implement routines for mixed-ages:

- “The provider might say ‘You know, this routine is not working out, because now I have children of different ages’... Sometimes, we have to go two, three days in a row, just trying to figure out what will be the best way to help them create those routines, because since they have children six weeks to 12 years old ... that’s when it becomes more difficult to keep up with a routine, to create a different lesson plan for the different ages they have.”

APPROACHES TO VISITS

Many directors described regulatory requirements that determined the frequency and timing of visits. For example, CCDF regulations require unannounced visits and Head Start programs are required to conduct biweekly visits to FCC homes. In contrast, some directors of system supporter networks reported conducting visits in response to provider requests for support. A director of a network that supported provider participation in QRIS explained how visits were driven by HBCC provider requests:

- “Each provider invites me as many times as they want to their home. They even dictate basically our level of interaction up to a point ... I go when it’s most convenient to them. It’s on their schedule, and that’s a benefit because that was not always how assistance has been provided in the past to them ... It’s not a 9 to 5 workday kind of a thing.”

Relationship-based approach. Relationships were described as a core component of effective provider visits by close to three quarters of directors regardless of providers served or system role as enforcers or supporters. Directors explained that developing rapport with providers, acknowledging their strengths, and building trust and respect were essential components of high-quality support.

For organizations that were system enforcers, developing relationships with providers was critical to building trust and engagement in systems, and led to greater compliance and goal completion. System supporters also used a relationship-based approach to help providers comply with regulations:

- “When we have a new child care specialist, I always say to them build a relationship first. You don’t go in and be Ms. Regulator right off. You go in and you slowly ease into it. If there’s an issue, of course, you acknowledge it. You’re trying to build that relationship. That makes us more successful over time.”

VISITS WITH FFN CAREGIVERS

Of the five organizations that served FFN caregivers exclusively, three conducted visits to caregiver homes. For example, a network that used staff-facilitated peer support groups as a primary strategy also offered a separate literacy home visiting program for caregivers who completed the 14-week group sessions. Another network used visits to help FFN caregivers become certified for the subsidy program as the director explained:

- “We have initial visits where we go in to do the first home visit, which is where we help providers take a look at their home to see what [the State] might be looking for, and what needs they might have for securing different things in their homes so children can’t have access to them, what they might need to make their home safe.”

All 15 organizations that served both FCC providers and FFN caregivers also offered visits to providers. Yet not all of these organizations delivered services equally across these different provider types. Half of these organizations did not offer visits at all to FFN caregivers or offered less intensive and intentional visiting. In one network, for example, FFN caregivers were offered a toolkit around licensing but were not eligible for coaching visits until they were licensed. Some directors whose organizations served a range of HBCC providers viewed FFN caregivers as having less attachment to the work or a need for intensive coaching or quality support as this director described:

- “Family, friend and neighbor are a little different. We do coaching, but it’s a little bit more instructional and information giving than it is with a family child care provider. It’s not to the same level of commitment because they’re typically, they’re with us for less time.”

Other directors explained that they didn’t often extend visits to FFN caregivers because they felt there was a “wariness factor” that made it hard to proactively reach out to them. One director noted that her organization had only visited one FFN caregiver for this reason.

SUMMARY

All HBCC networks and all but two other organizations that supported HBCC providers used visits to child care homes to deliver ongoing monitoring around compliance with regulatory requirements and quality standards, and/or provide information and coaching around caring and educating young children.

- Visits to monitor compliance to health and safety regulations were the most common type of visits reported.
- Visits also focused on helping providers support children’s social-emotional development as well as helping providers implement curriculum and activities for children.
- Networks, in particular, conducted visits to help providers with some of the unique features of HBCC including the home child care environment and caring for mixed-age groups of children.
- Relationship-based approaches to visits were used across organizations as a strategy to engage providers in systems participation (including compliance with regulations) and quality improvement efforts.
- Visits and coaching were not offered as frequently to FFN caregivers in organizations that served both FCC and FFN providers. Directors perceived FFN caregivers as less interested or open to agency visitors, and time and resource-intensive one-on-one coaching visits may have been reserved for licensed providers.

TABLE 5: VISITS TO PROVIDER HOMES

	All Organizations (N=47)	Type of Organization N=47		Who Served (N=47) ^a			System Role (N=42)		Not Connected N=5
		HBCC Networks (N=33)	Other organizations that serve HBCC (N=14)	FCC Only (N=27)	FCC and FFN (N=15)	FFN Only (N=5)	Enforcer N=20	Supporter N=22	
Conducts any visits to provider homes	96% (45)	100% (33)+	86% (12)	100% (27)	100% (15)	60% (3)	100% (20)	100% (22)	60% (3)
Visits to support system requirements									
Compliance-focused visits (health and safety, paperwork, monitoring)	73% (33)	76% (25)	67% (8)	81% (22)	60% (9)	67% (2)	95% (19)**	59% (13)	33% (1)
Visits are used for training credit	13% (6)	12% (4)	17% (2)	15% (4)	7% (1)	33% (1)	15% (3)	14% (3)	0% (0)
Visits to support quality caregiving									
Visits based on the Family Child Care Environment Rating Scale	24% (11)	27% (9)	17% (2)	26% (7)	27% (4)	0% (0)	30% (6)	18% (4)	33% (1)
Visits focus on helping providers support children's social emotional development; behavior, and/or special needs and inclusion	47% (21)	45% (15)	50% (6)	56% (15)	33% (5)	33% (1)	50% (10)	45% (10)	33% (1)
Visits focus on helping providers with curriculum and/or activities	40% (18)	42% (14)	33% (4)	37% (10)	40% (6)	67% (2)	40% (8)	36% (8)	67% (2)
Visits help providers work with families	33% (15)	39% (13)	17% (2)	56% (15)***	0% (0)	0% (0)	40% (8)	32% (7)	0% (0)
Visits focus on helping providers with the HBCC environment	29% (13)	30% (10)	25% (3)	22% (6)	33% (5)	67% (2)	20% (4)	27% (6)	100% (3)
Visits help providers care for mixed-age groups of children	16% (7)	18% (6)	8% (1)	22% (6)	7% (1)	0% (0)	25% (5)	9% (2)	0% (0)
Visits are used to conduct child screenings and assessments	16% (7)	18% (6)	8% (1)	22% (6)	7% (1)	0% (0)	20% (4)	14% (3)	0% (0)
Approaches to conducting visits									
Directors emphasize relationship-building in approach to visits	71% (32)	70% (23)	75% (9)	67% (18)	80% (12)	67% (2)	65% (13)	77% (17)	67% (2)

^aFisher's exact test of significance does not include organizations that serve FFN only or organizations that are not connected to a system; ***p≤.001; **p≤.01; *p≤.05; +p≤.10

TRAINING

Similar to visits to provider homes, training workshops were offered across all but one of the 47 organizations in our sample (Table 6). Training workshops are a low-intensity strategy for delivering professional development and quality improvement content to early care and education providers. According to the NSECE, two thirds of listed FCC providers had participated in a single workshop during the past year, and one third in a workshop series (NSECE Project Team, 2016). The sections below describe director reports about the content of training workshops as well as the approach to training.

CONTENT OF TRAINING

Organizations in our sample offered training workshops on topics required by systems such as QRIS, licensing, subsidy, and Head Start as well as trainings on how to navigate and participate in the systems themselves. In addition, organizations reported offering training on topics focused on how to support children's behaviors, activities to offer children, supporting families, and provider-focused topics around self-care. Directors of networks and other organizations offered many examples of tailoring training workshops specifically for HBCC providers. Yet for organizations that served HBCC providers as well as centers, and those that were not networks in particular, directors noted that trainings were often open to all: "We don't have trainings that are specifically for the family providers, so they come to these calendar of trainings that we offer to everybody."

Training on topics required by systems. The high stakes associated with 2014 CCDF requirements put pressure on directors to be sure that providers were completing the 10 training topics required for eligibility to serve subsidized families. Two thirds of directors reported offering health and safety training for HBCC providers. These mandated trainings around health and safety often constrained directors from offering other topics of interest to providers. One director explained the trade-off: "We are overwhelmingly training on basic health and safety. The creativity and innovation have sort of gone bye-bye." Another director described how she would like to develop and offer trainings that respond to provider interests but instead she explained:

- "We're not just able to go out and do something ... we're spending our time, and energy, and efforts to develop trainings that are either required by the State, and/or approval by a third party ... that approval can get a little complicated sometimes, and difficult to achieve."

In addition to offering training on required topics, directors reported offering workshops to help providers navigate aspects of systems such as understanding subsidy eligibility guidelines or completing a subsidy application. Workshops also provided information about changing regulations and requirements.

Training on quality caregiving. Licensing, QRIS, and Head Start standards require providers to meet different levels of quality including training and education in child development and child care practices. Directors described offering training topics that fulfilled these system standards and that also responded to provider interests. A quarter of directors reported that trainings broadly adhered to the FCCERS indicators, which are commonly used to assess FCC quality in QRIS.

A more frequently reported practice, however, was using provider feedback to develop training content. More than half of the directors reported surveying providers for this information. An Early Head Start and Head Start network director said:

- "We hear from everyone. We hear from the providers, we hear from the assistants, and we hear from the parents what they need, what they want, what are their needs. Then we decide, as a group."

Overall, directors reported that the most popular topics among HBCC providers were health and safety, curriculum or activities, and supporting children's social-emotional development and behavior, topics that aligned with provider needs and were similar to those discussed in visits. Approximately two thirds of directors reported training on social-emotional development and curriculum or activities, including math and literacy. Among the health and safety topics, directors noted that practical workshops (such as first aid and CPR, diapering procedures, medication administration and disaster preparation) were the most popular.

Fewer directors mentioned offering training on working with families or setting up the child care home environment, which may have been addressed during visits to homes. A handful of directors mentioned training on diversity and cultural responsiveness. Organizations that were tasked with enforcing regulations were more likely to report training on how to support families. This may have been related to Head Start programs (all were enforcers) that require providers to engage families in their programs.

Training on provider-focused topics. A handful of organizations also met provider needs through training content that directly aligned with issues and concerns of immediate importance to the provider community. Two networks that served mostly Latinx providers offered training on immigration issues. One network brought in attorneys to lead a training on the rights of undocumented families in the U.S., and to help providers be prepared if families and children in their care or in their own family

were deported. In addition, four networks and an early childhood mental health organization offered training on stress reduction and self-care for providers.

APPROACHES TO TRAINING

In addition to content, directors described how training workshops were implemented, including logistics, format, and approaches to working with adult learners.

Logistics of training. To accommodate the long working hours experienced by most HBCC providers, nearly all the directors reported holding trainings during evenings and/or on weekends. Directors also reported offering trainings for non-English speaking providers. Some used interpreters or simultaneous translation for providers who spoke Spanish, but few could meet the language needs of all providers. A network that was a systems enforcer and worked with many immigrant FCC providers, for example, had to conduct all of its trainings in English, because state law required all child care providers to speak, read, and write English.

Format of training. Many publicly-funded systems deliver training via online platforms. Slightly less than a quarter of the organizations in our sample that offered training provided help with online training, including offering their own online training for providers as well as providing help with required trainings.

Directors described online trainings for HBCC providers as an opportunity to provide a menu of options that could meet providers' logistical needs and allow for a choice of topics:

- “They pick and choose what works best for them.”
- “Anybody can enroll at any time. The sky’s the limit.”
- “We have a group of educators who have young children themselves and really have difficulty getting out in the evenings. Those are the folks that are doing more of the webinars.”

For many directors, the expansion of required online trainings by state systems presented new challenges around engaging FCC providers who, as described earlier, faced obstacles around internet access. One director noted: “The fear is that we use too much of that and we’ll lose that one-on-one, person-to-person contact.” To address this issue, some organizations combined online and in-person training. Others offered training webinars connected to a live trainer: “They are connecting with a trainer giving feedback and the trainer is helping the group move along in the module.” Organizations also offered technical support around accessing online trainings, through evening and weekend computer labs at their office sites or through individual assistance on the phone.

Training linked to visits. In our sample, we found that close to a third of organizations connected training to provider visits although most of these connections were informal rather than intentional. Directors talked about common goals and standards for visits and training that connected these supports. Some organizations had the same staff conduct visits and training with the same providers. Organizations that implemented coaching with providers beyond monitoring visits described ways that coaches could help providers implement what they had learned in a specific training. One director of a small Early Head Start and Head Start network that served a group of 10 providers explained how weekly visits from a coach could help providers implement lesson plans after a training: “There’s constant follow up. You just received the trainings, and we’re gonna help you implement what you just learned in your program.” Another network director explained that coaches were available to follow up with providers around trainings topics: “It’s nice to have training and then go back and try and apply it at home. Then you have somebody to come and check with you how things are going or if you need a little bit more information.”

Adult learning approaches. Directors viewed adult learning principles as particularly important when designing trainings for HBCC providers, because providers have such varied educational backgrounds and child care experiences. Two fifths of the directors talked about grounding their training in adult learning principles that included interactive and “hands-on” approaches, opportunities for providers to learn new information, reflect on their own experiences, and apply new knowledge. As one director of a state-wide organization that offered supports for HBCC providers noted, “When you have a trainer who is facilitating and incorporating the thoughts and the day-to-day actions of what’s happening with the child care provider into their training, it may be more effective than a trainer who stands in front of the room talking about a topic.”

TRAINING FOR FFN CAREGIVERS

Differentiating trainings for providers by experience, level of knowledge, and role was reported by 12 directors as another strategy for meeting the needs of adult learners. Organizations that served both FCC and FFN providers were more likely to report offering different kinds of training depending on provider type and different levels of education: "You have a portion of the FFN providers who don't want to get licensed, but actually do want to get more skills and be more professional and to go to trainings to learn how to play and to read with children." A network that served all HBCC providers described structuring trainings where providers could go into smaller break-out sessions by level, noting a recent need to make sure that all providers across levels of experience received "quality" trainings. She went on to explain the benefits for relative caregivers:

- "What I have found is that they love it, even the grandparents who you would think wouldn't. They don't miss a thing. They're at every training. Grandma and grandpa come together. They see it as this education that they never received and now they get to learn all of this, and they get to go back and do these things with their grandchildren and make a real impact, and the family child care providers, as well."

She went on to note that her organization did not make a distinction between these two types of providers:

- "Really, they all sit in all of the same trainings. They all talk support and network with each other without even 'oh, you're just a grandmother and I'm a family childcare provider.' We don't see that. We don't create that."

Of the five organizations that served FFN caregivers exclusively, four offered training workshops. Like the other organizations in the sample, the content often focused on health and safety, social-emotional development, activities, and working with families. One network included topics related to stress.

SUMMARY

Nearly all HBCC networks and other organizations in our sample offered training workshops on topics required by systems as well as topics that responded to provider needs around caring for and educating young children.

- Training on systems requirements most frequently focused on health and safety practices, curriculum and activities, and supporting children's social-emotional development and behavior.
- Provider feedback from surveys was used by organizations to develop and plan training workshop content. Nearly all organizations reported tailoring training logistics to meet the specific needs of HBCC providers – evening and weekend trainings. Some organizations used interpreters or simultaneous translation to help non-English-speaking providers, but few could meet the language needs of all providers.
- Adult learning principles including interactive and hands-on approaches that accommodated providers' varying education and experience levels were used by fewer than half of networks and other organizations.
- Training that was directly aligned with coaching or visits to provider homes, an approach to help providers put knowledge into practice, was used by fewer than one third of organizations.
- Organizations that served both FCC providers and FFN caregivers differentiated training workshops for these different types of HBCC providers.

TABLE 6: TRAINING WORKSHOPS

	All Organizations (N=47)	Type of Organization N=47		Who Served (N=47) ^a			System Role (N=42)		Not Connected N=5
		HBCC Networks (N=33)	Other organizations that serve HBCC (N=14)	FCC Only (N=27)	FCC and FFN (N=15)	FFN Only (N=5)	Enforcer N=20	Supporter N=22	
Any training workshops	98% (46)	100% (33)	93% (13)	100% (27)	100% (15)	80% (4)	100% (20)	100% (22)	80% (4)
Topics around systems requirements									
Health and safety	63% (29)	64% (21)	62% (8)	67% (18)	53% (8)	75% (3)	70% (14)	59% (13)	50% (2)
Topics around caregiving									
Training focuses on domains of quality in the Family Child Care Environment Rating Scale	26% (12)	33% (11)	8% (1)	30% (8)	27% (4)	0% (0)	25% (5)	27% (6)	25% (1)
Collects provider feedback to inform training topics	59% (27)	52% (17)	77% (10)	59% (16)	60% (9)	50% (2)	65% (13)	55% (12)	50% (2)
Curriculum and activities	65% (30)	64% (21)	69% (9)	44% (12)	93% (14)**	100% (4)	50% (10)	73% (16)	100% (4)
Supporting children's social-emotional development, behavior, and/or special needs and inclusion	61% (28)	58% (19)	69% (9)	59% (16)	60% (9)	75% (3)	55% (11)	64% (14)	75% (3)
Working with parents/families	22% (10)	24% (8)	15% (2)	22% (6)	13% (2)	50% (2)	35% (7)+	9% (2)	25% (1)
HBCC environments	13% (6)	15% (5)	8% (1)	11% (3)	13% (2)	25% (1)	5% (1)	23% (5)	0% (0)
Topics around provider-focused needs									
Managing stress; self-care	11% (5)	12% (4)	8% (1)	11% (3)	7% (1)	25% (1)	5% (1)	9% (2)	50% (2)
Immigration issues	4% (2)	6% (2)	0% (0)	7% (2)	0% (0)	0% (0)	5% (1)	5% (1)	0% (0)
Approaches to training									
Trainings are offered at times that are convenient for HBCC	83% (38)	82% (27)	85% (11)	78% (21)	93% (14)	75% (3)	80% (16)	86% (19)	75% (3)
Help with required online trainings or offers trainings online	24% (11)	18% (6)	38% (5)	11% (3)	47% (7)*	25% (1)	35% (7)	18% (4)	0% (0)
Training workshops are formally linked to visits/coaching	28% (13)	30% (10)	23% (3)	22% (6)	40% (6)	25% (1)	30% (6)	23% (5)	50% (2)
Adult learning principles are used to implement training	41% (19)	45% (15)	31% (4)	44% (12)	40% (6)	25% (1)	40% (8)	45% (10)	25% (1)
Differentiated training offered for HBCC providers	26% (12)	18% (6)	46% (6)+	19% (5)	47% (7)+	0% (0)	30% (6)	23% (5)	25% (1)

^aFisher's exact test of significance does not include organizations that serve FFN only or organizations that are not connected to a system; ***p≤.001; **p≤.01; *p≤.05; +p≤.10

PEER SUPPORT

Peer support strategies that bring providers together to share and network with each other were reported by four fifths of the directors in our interview sample (Table 7). Peer support was primarily used to address the working conditions of HBCC providers, particularly the isolation that many directors described hearing from providers. Formal support strategies included provider-led or staff-led peer support groups, learning cohorts and/or Communities of Practice (CoP), peer-to-peer mentoring, and use of social media to connect providers to one another.

PEER SUPPORT GROUPS

Formal peer support groups – either provider-led or staff-facilitated – were commonly used to bring providers together to foster “camaraderie” through the creation of both personal and professional friendships and opportunities for providers to share their experiences with each other. A director of a network explained the validation that providers experienced in such groups: “It helps them to know that, ‘Okay, I’m not out here on my own, and other people have this problem.’” Some directors described peer support groups as “safe places ... where [providers] are not judged and that they can just bring their problems.”

Peer support groups also offered opportunities for providers to learn from peers – “someone who’s been in the trenches every day” – which some directors viewed as potentially more effective than formal training workshops. One director of a network that was part of a statewide initiative put it this way:

- “Sometimes having somebody who you’re comfortable with, who has the same stories, you can hear better first from than you can hear it from me who’s standing in the front of the room, and being that official person that’s telling them something. When they hear in somebody else’s voice who they might be more comfortable with or who’s having some of the same experiences, sometimes they’re heard better.”

Provider-led support groups. Close to half of the organizations that offered formal peer supports relied on provider-led peer support groups. These groups often emerged from providers networking at a training. A network director who worked with FCC providers talked about how a provider-initiated support group grew out of work required for QRIS:

- “When they were going through the (QRIS) process, I think that’s when they really became a family, because they were at each other’s homes like one or two nights during the week, helping each other with those binders, and the paperwork, and the implementation they needed. So, they’ve been not just waiting for us. They just take the initiative to do it themselves.”

Staff-facilitated support groups. Staff-led peer support groups, a strategy for connecting providers to each other and to agency support, were less commonly reported by directors. An Early Head Start and Head Start network director who worked with FCC providers explained how she intentionally scheduled support groups during stressful times of the month:

- “There are times within the month that are more stressful, and they need that support ... It’s a day that everybody comes and just talks about what they’ve done, what’s not working, what’s working. Just venting.”

Staff-facilitated support groups also helped providers meet system demands. A director of an organization responsible for monitoring licensing and subsidy participation cited an example of using a staff-facilitated peer support group to help providers with changes in licensing procedures:

- “Currently, we’re having a little bit of trouble with licensing and the new licensing supervisor here and they’re doling out violations, literally. There’s concern around that, so, we’ll get together and talk about that.”

In general, peer support groups typically met once a month. Some were held during the day, others in the evenings. Locations varied from a community space such as a library to the provider’s home. Often the providers brought pot-luck meals. The number of participants was usually small, ranging from five to 20 providers.

COHORTS AND LEARNING COMMUNITIES

Two fifths of the organizations that offered peer support used cohorts, learning communities, or CoPs. Like peer support groups, CoPs offered opportunities for providers to learn from, and with, one another. CoPs, in particular, were structured to deepen learning around a single topic. For some organizations, CoPs counted towards required training hours.

One director of a state-wide professional development system that served both FCC and FFN providers explained how CoPs were

opportunities for the organization to tailor topics to provider interests:

- “Sometimes they’re wanting to talk specifically about infant care. There’s a lot of conversations about how to work with parents. Always, the child behavior topic comes up. Environment is also a topic that comes up a lot. For family child care ... the business aspects of, how do you get this all accomplished in a days’ time or weeks’ time?”

Some organizations also used learning cohorts or CoPs to help providers reach a specific goal such as completing the Child Development Associate (CDA) credential process or moving up levels in QRIS.

PEER-TO-PEER MENTORING

Peer-to-peer mentoring connects providers to each other one-on-one, allowing for more individualized support. Over one quarter of the organizations which offered peer support reported offering formal peer mentoring opportunities for providers.

Peer mentoring was formalized by staff matching an experienced provider with one who was new to the field or linking providers with similar concerns. Three networks used mentors in paid staff roles. Seasoned providers made home visits to new providers, contacted them on a regular basis through phone calls and e-mails, and offered training in the home. These kinds of individual peer connections held benefits for both the mentor and the mentee. This network director explained the benefits for mentors and mentees:

- “We really see that very deep friendships form. We’ve been doing work where family child care providers are visiting each other’s programs to see what they’re doing and learn from each other’s strategies. That’s something that’s been incredibly successful. They end up supporting each other in any number of ways.”

Networks also used peer-to-peer mentoring to help providers meet system requirements such as licensing or QRIS. Two network directors used experienced providers as mentors to help new providers get their homes ready for licensing.

SOCIAL MEDIA

Six directors reported using social media as a strategy for connecting providers. Three talked about how they used Facebook or other online platforms to help providers share ideas about working with children, openings in their programs, provider events, or equipment needs. Three other directors cited online groups that providers had created to facilitate virtual provider meetings.

PEER SUPPORT FOR FFN CAREGIVERS

Four of the five organizations that served only FFN caregivers offered formal peer supports. These organizations developed innovative and specific strategies to reach these more informal caregivers, finding ways to combine peer support with delivery of child development content. One network used staff-facilitated provider peer groups as a primary strategy for delivering information about caregiving as well as offering caregivers opportunities to share their expertise with each other. She described the benefits of this approach:

- “We identify our format as a training/support delivery mechanism. It’s not a training lecture, ‘Oh, my gosh, everything you’ve been doing has been wrong.’ It’s much more of a back and forth between the trainer delivering the information and the trainer paying attention to teachable moments, letting the providers process how each of them is doing things in their home and what’s working, what’s not working. The support that comes from each other as peers with the help of the trainer is what gets people hooked. The support piece and knowing that they’re not doing this alone is huge, and keeps them just very attached to what’s being asked of them.”

Two of the five organizations that served FFN exclusively also used cohorts as a strategy to meet these providers’ needs. A director of a state-wide organization explained the rationale for the FFN cohorts it offered:

- “We developed 30 Early Learning Conversations, [on topics] like brain development and children’s development, home safety, early literacy – the same topics that we have for the Play and Learn groups. There is also a section on self-care. This grew out of a request from caregivers, where they felt that they wanted to have more time, adult time, just to talk about some of the topics that come up or that are introduced in a group. The [facilitators] hold a series however long they feel they want to do that.”

SUMMARY

Formal peer support strategies were implemented by the majority of organizations in our sample to help mitigate isolation as well as to enhance provider knowledge and skills around specific aspects of providing child care, supporting children's development, and meeting system requirements.

- Peer supports included mostly provider-led and fewer staff-facilitated peer support groups, CoPs, and peer mentoring.
- Networks that exclusively served FFN caregivers used innovative peer support strategies to both deliver child development information and reduce isolation by bringing caregivers together to share their experiences.

TABLE 7: PEER SUPPORT

	All Organizations (N=47)	Type of Organization N=47		Who Served (N=47) ^a			System Role (N=42)		Not Connected N=5
		HBCC Networks (N=33)	Other organizations that serve HBCC (N=14)	FCC Only (N=27)	FCC and FFN (N=15)	FFN Only (N=5)	Enforcer N=20	Supporter N=22	
Any peer support	83% (39)	79% (26)	93% (13)	81% (22)	87% (13)	80% (4)	80% (16)	86% (19)	80% (4)
Provider-led support groups	46% (18)	46% (12)	46% (6)	50% (11)	54% (7)	0% (0)	50% (8)	53% (10)	0% (0)
Staff-facilitated support groups	23% (9)	31% (8)	8% (1)	23% (5)	23% (3)	25% (1)	25% (4)	21% (4)	25% (1)
Cohorts/Learning Communities of practice (CoP)	41% (16)	31% (8)	62% (8)+	36% (8)	46% (6)	50% (2)	44% (7)	37% (7)	50% (2)
Peer-to-peer mentoring	28% (11)	35% (9)	15% (2)	36% (8)	15% (2)	25% (1)	19% (3)	37% (7)	25% (1)
Social media strategies to connect providers	15% (6)	15% (4)	15% (2)	14% (3)	23% (3)	0% (0)	6% (1)	21% (4)	25% (1)

^aFisher's exact test of significance does not include organizations that serve FFN only or organizations that are not connected to a system; ***p≤.001; **p≤.01; *p≤.05; +p≤.10

BUSINESS AND ADMINISTRATIVE SUPPORTS

Business support strategies address providers' needs to make a living doing child care and help to build sustainability of the HBCC workforce. Close to three quarters of the directors in our sample reported offering some type of business support to providers (Table 8). Business workshops were the most commonly used strategy, more than double business coaching or visits. Other supports for business included help with enrollment and collection of parent fees as well as shared services.

BUSINESS WORKSHOPS

Training workshops were the most commonly reported service delivery mechanism for business supports. Business issues, especially managing budgets, were a topic of workshops that was crucial for providers: "It's painful to learn about cash flow, and to take a good, honest look at what you make and what you're spending, and so that's pretty popular right now."

Workshop formats ranged from a single workshop on business "basics" to a 12-session series. One network offered a two-day intensive training with lawyers who had expertise in small businesses. Only a few directors reported a focus on specific business topics such as helping providers market their businesses to families, maintain records to keep track of enrollment and attendance, manage revenues and expenses, and/or tax preparation.

BUSINESS COACHING

Fewer organizations, close to a third, reported using coaching or visits to provider homes as a strategy for supporting providers' business needs. Five out of the 11 organizations that used coaching or visits for business support combined the coaching with workshops, which helped providers implement what they learned, as this network director explained:

- "We created a coaching piece to go along with [the business workshop curriculum], because we recognized that it's actually really helpful to have someone not only teach you about record keeping, but come over and help you organize your files, or actually go through your contract with you one on one."

ENROLLMENT AND COLLECTION OF PARENT FEES

Approximately one third of the organizations helped providers maintain full enrollment by placing children in their homes. Organizations that served FCC providers only and those that were system enforcers were more likely to report supporting providers with enrollment of families, not surprising since Head Start, Migrant Head Start and Early Head Start help families enroll in child care programs. Five organizations collected parent fees for providers, reducing the stress providers experienced around financial transactions with families.

SHARED SERVICES

Shared services is an approach to back-office supports that early care and education programs are increasingly using to reduce the administrative burden on child care providers (ELC TA, 2016; Stoney & Blank, 2011). Three organizations used this strategy with FCC providers, who paid a fee to obtain these services. One director described the approach:

- "We go out, we recruit them to join us, they sign a service agreement, and then we deliver the business services. Our mission is to improve the quality of child care and access for all parents to it. Everything is automated. It tracks all of the different meals for the food reporting and their attendance for licensing compliance and all of the different things. They can send out invoices to parents, etcetera. I think that they see the value. I think the return on investment shows that they have to pay, but they definitely get that back, plus more."

BUSINESS SUPPORT FOR FFN CAREGIVERS

Notably two of the five FFN-only networks offered business workshops for FFN providers. One director of a network that helped providers participate in the state's subsidy system explained the network's rationale for offering business workshops to FFN caregivers:

- "They want guidance, support in accomplishing that goal to open a child care business. We include business practices training to help them learn how to market their program, how to look at it from the business angle, as well as from the supporting children and families angle."

SUMMARY

Business support was offered by nearly three quarters of our sample, and mostly included workshops. In addition, organizations used coaching as well as enrollment of families, collection of parent fees, and back-office assistance to support providers with administrative tasks.

- Organizations that were system enforcers were more likely to report any business support, and enrollment of families specifically. These organizations were mostly those that delivered Head Start which requires enrollment of families.
- Two of the five organizations that served only FFN caregivers offered business workshops for providers who might consider opening an FCC program.

TABLE 8: BUSINESS & ADMINISTRATIVE SUPPORTS

	All Organizations (N=47)	Type of Organization N=47		Who Served (N=47) ¹			System Role (N=42)		Not Connected N=5
		HBCC Networks (N=33)	Other organizations that serve HBCC (N=14)	FCC Only (N=27)	FCC and FFN (N=15)	FFN Only (N=5)	Enforcer N=20	Supporter N=22	
Any business and administrative supports	72% (34)	73% (24)	71% (10)	81% (22)	67% (10)	40% (2)	95% (19)*	64% (14)	20% (1)
Training workshops	68% (23)	58% (14)	90% (9)	55% (12)	90% (9)	100% (2)	63% (12)	71% (10)	100% (1)
One-on-one visits or coaching focused on business support	32% (11)	38% (9)	20% (2)	41% (9)	20% (2)	0% (0)	37% (7)	29% (4)	0% (0)
Enrollment of families in family child care programs	32% (11)	38% (9)	20% (2)	50% (11)**	0% (0)	0% (0)	53% (10)**	7% (1)	0% (0)
Shared services offered: help with back-office support, administrative tasks, bulk purchasing, etc.	9% (3)	8% (2)	10% (1)	14% (3)	0% (0)	0% (0)	16% (3)	0% (0)	0% (0)
Collects parent fees for providers	15% (5)	17% (4)	10% (1)	23% (5)	0% (0)	0% (0)	11% (2)	21% (3)	0% (0)

¹Fisher's exact test of significance does not include organizations that serve FFN only or organizations that are not connected to a system; **p≤.001; *p≤.01; *p≤.05; +p≤.10

FINANCIAL ASSISTANCE AND MATERIAL RESOURCES

Many HBCC providers have limited financial resources, with households reporting incomes near the federal poverty level for a family of four (NSCEC Project Team, 2016). The lack of discretionary income may inhibit their participation in licensing, subsidy, or QRIS with their associated costs for fees, required environment standards, or professional development. Providers may also lack materials for children that would contribute to a high-quality program.

Close to half of the organizations in our sample addressed these issues by providing financial assistance to help offset HBCC providers' burdens with often costly requirements. Two fifths of the organizations offered materials and/or equipment for HBCC providers' programs (Table 9).

FINANCIAL ASSISTANCE

Financial assistance included helping providers cover the costs of workshop and conference fees, accreditation and credentialing fees, fees associated with licensing and subsidy participation, and liability insurance. System supporters were more likely to offer financial assistance of any kind to the HBCC providers they served, suggesting their focus on meeting provider needs around sustainability.

Costs of professional development. Organizations helped providers cover the costs of meeting required professional development standards. For example, system enforcers were more likely than supporters to offer financial assistance with the CDA credential (renewals and related workshops) and college tuition. Nine directors reported paying for NAFCC accreditation fees.

Four directors paid for workshops related to regulatory and quality system requirements, as this director of a network that helped FCC providers with compliance in licensing, subsidy, and QRIS explained:

- “We offer a lot of support in helping educators find what they need, registering for workshops and trainings, and then offering reimbursement. If they’re registering for ones outside of us, then we’ll pay for the educators. As long as they participate and pass, they can show us the receipt and their certificate, and we’ll reimburse it for them.”

In addition to these systems-related costs, seven organizations (six of them networks) paid fees for providers to attend early childhood conferences to enhance their professional development.

Business expenses. A handful of networks used financial assistance to help providers with business expenses such as liability insurance. One network offered zero-interest loans. One director described a general emergency fund for providers at her network:

- “Since our providers come from all over the world, on occasion, they have an emergency where they have to go back to their country, and other kinds of emergencies that may come up. We have money set aside that we can help them with that. We capped it at \$500 each time. We had a couple of providers who lost their husbands. They had to stop doing child care. At the time, we thought, ‘We need to try to help people.’”

MATERIAL RESOURCES

Two fifths of organizations helped providers purchase materials or equipment or provided these directly. Materials were mostly those needed by providers for general environment and program improvements – furniture, manipulatives, science or music materials, diapers, wipes, and formula for infants. Organizations also offered materials to support FCC business management such as file cabinets and calendars.

Sometimes provision of materials was intended to help providers comply with system requirements around safe environments for children. One director of an organization responsible for licensing compliance reported that she offered \$500 for purchasing required fences as well as an emergency fund to help providers replace materials that had been ruined in a flood; another director offered \$5000 in grants for storm shelters; and an Early Head Start network provided funds for tree removal and surface cushioning.

Two networks provided technology equipment to help providers comply with licensing and QRIS requirements. One network director explained that, “The state had asked that their lesson plans be printed off, posted physically in the space, so we bought printers for everybody.” This network also paid for the high-speed internet that was required for providers to access curriculum and data tools: “There’s no other way to do it. I mean, everybody has to use internet to use Teaching Strategies™.”

FINANCIAL ASSISTANCE AND MATERIAL RESOURCES FOR FFN CAREGIVERS

A network that helped FFN caregivers participate in the state's subsidy certification system paid for required fingerprinting and TB tests as well as liability insurance. As the director explained:

- “Our purpose is to make sure we’re taking away any barriers that people might have to certification, which includes the financial piece. We’ll write a check to the insurance company or if they send us something in the mail that shows us their insurance and what the difference is for adding liability insurance to their current homeowner’s policy, then we’ll just reimburse them the difference.”

Two other networks that served only FFN caregivers provided materials. One network offered car seats, bicycle helmets, fire extinguishers, smoke alarms, and outlet covers at its staff-facilitated support groups. It also offered a mini-grant for FFN caregivers who participated in a literacy-focused home visiting program. The other network offered basic health and safety household materials such as bath mats, door knobs, and fire extinguishers.

SUMMARY

Close to half of the organizations in our sample offered some type of financial assistance to providers and two fifths offered help with materials and equipment.

- System supporters were more likely to offer providers any type of financial assistance, perhaps in part, related to their focus on meeting provider needs.
- Much of the financial assistance offered by organizations was related to regulatory and quality system fees and requirements.
- Material resources were also related to helping providers meet system regulations around safe child care environments.
- The few networks serving only FFN caregivers used financial assistance and materials support to remove barriers for caregivers to participate in subsidy systems and to supply these caregivers with basic health and safety equipment.

TABLE 9: FINANCIAL ASSISTANCE & MATERIAL RESOURCES

	All Organizations (N=47)	Type of Organization N=47		Who Served (N=47) ^a			System Role (N=42)		Not Connected N=5
		HBCC Networks (N=33)	Other organizations that serve HBCC (N=14)	FCC Only (N=27)	FCC and FFN (N=15)	FFN Only (N=5)	Enforcer N=20	Supporter N=22	
Any financial assistance (not including help to purchase materials)	49% (23)	45% (15)	57% (8)	48% (13)	60% (9)	20% (1)	35% (7)	68% (15)+	20% (1)
Stipends for network participation, workshop participation	39% (9)	33% (5)	50% (4)	46% (6)	33% (3)	0% (0)	57% (4)	33% (5)	0% (0)
NAFCC fees/membership	39% (9)	47% (7)	25% (2)	38% (5)	44% (4)	0% (0)	29% (2)	47% (7)	0% (0)
CDA tuition/renewals	17% (4)	20% (3)	13% (1)	23% (3)	11% (1)	0% (0)	43% (3)+	7% (1)	0% (0)
Conference fees	30% (7)	40% (6)	13% (1)	46% (6)	11% (1)	0% (0)	43% (3)	27% (4)	0% (0)
Systems requirements fees: e.g. TB tests, fingerprinting, licensing fees, CPR training costs	17% (4)	20% (3)	13% (1)	8% (1)	22% (2)	100% (1)	0% (0)	20% (3)	100% (1)
Liability insurance	17% (4)	27% (4)	0% (0)	15% (2)	11% (1)	100% (1)	0% (0)	20% (3)	100% (1)
Help with college tuition	9% (2)	7% (1)	13% (1)	15% (2)	0% (0)	0% (0)	29% (2)+	0% (0)	0% (0)
Any material resources	40% (19)	45% (15)	29% (4)	41% (11)	40% (6)	40% (2)	50% (10)	36% (8)	20% (1)
Provides materials directly for child care home	89% (17)	93% (14)	75% (3)	100% (11)	83% (5)	50% (1)	90% (9)	88% (7)	100% (1)
Provides funds for purchasing equipment/materials	37% (7)	27% (4)	75% (3)	36% (4)	17% (1)	100% (2)	50% (5)	13% (1)	100% (1)

^aFisher's exact test of significance does not include organizations that serve FFN only or organizations that are not connected to a system; ***p≤.001; **p≤.01; *p≤.05; +p≤.10

DISCUSSION

Expanding on findings from the first report of the *National Study of Family Child Care Networks, Mapping the Family Child Care Network Landscape* (Bromer & Porter, 2019), this study provides new insights into the organizations that serve HBCC providers, the ways in which they deliver services, and the fit between those services and perceived needs of FCC providers and FFN caregivers through the lens of director interviews. It also provides a more refined characterization of HBCC networks, enabling us to better understand the potential of these kinds of organizations to improve HBCC quality and to increase HBCC supply.

Findings from our interviews confirm findings from the Network Landscape report that the majority of organizations in our sample offered visits, training, and peer support services to HBCC providers (Table 10). Prior research suggests that certain service delivery approaches may be more effective for improving quality than other strategies. For example, research indicates that training workshops alone are unlikely to improve quality in HBCC (Bromer & Korfmacher, 2017), and that training combined with coaching or visiting may have more potential to improve caregiving practices, particularly around provider-child interactions (Moreno, Green, & Koehn, 2015). Our finding that less than a third of organizations connected training with coaching, often informally, suggests an area for further development in HBCC networks. Moreover, most directors in this study reported that visits were focused on compliance and that this focus on regulation made it difficult to find time for a deeper focus on quality coaching around caregiving practices.

A majority of organizations in our sample also reported offering peer support, yet very little research exists on how peer support strategies shape quality outcomes in HBCC. Some research finds that staff-facilitated peer groups may lead to higher quality practices in FFN homes (Shivers, Farrago, & Goubeaux, 2015), suggesting that this is a promising direction for HBCC network service delivery strategies.

In contrast, fewer organizations in our sample reported offering business supports, and even fewer offered financial or material assistance to HBCC providers. Without strong financial management and business skills, FCC providers may not be able to sustain their small businesses. In fact, the current decline of regulated FCC in the U.S., up to 50% in some communities (NCECQA, 2019), may be partially due to the lack of supports available to providers around managing a small business including financial management, financial resources, and materials and equipment needed to comply with standards.

TABLE 10: PROPORTIONS OF ORGANIZATIONS REPORTING SERVICE DELIVERY STRATEGIES

N=47 ORGANIZATIONS	Over 75%	50-75%	25-50%
Visits to provider homes	X		
Training	X		
Peer support	X		
Business and administrative support		X	
Financial assistance			X
Material resources			X

We grouped the 47 organizations in our sample into two categories: HBCC networks, and other types of organizations that support HBCC but did not meet our criteria for networks. The primary differences between the two categories were related to staffing, providers served, and types of services offered. HBCC networks had specialized staff who delivered, at a minimum, visits, training and/or peer support to a targeted population of HBCC providers – FCC providers and/or FFN caregivers, although they may have also provided services for center-based providers. Other organizations, by contrast, did not have specialized staff, did not offer a combination of visits, training and/or peer support, and did not serve a specific group of HBCC providers. The 33 organizations categorized as HBCC networks accounted for slightly more than two thirds of our sample. Within this group, one third were dedicated networks that exclusively served HBCC providers.

We found few meaningful differences between HBCC networks and other organizations that serve HBCC providers (Table 11). The only statistically significant difference was that HBCC networks were more likely to focus services on regulated FCC providers than both FCC and FFN caregivers. Our findings suggest that organizations that served both FCC providers and FFN caregivers may not offer the same quality and intensity of supports to FFN caregivers that they offer to FCC providers. Visits and coaching in provider homes, for example, were offered less intentionally to FFN caregivers than to FCC providers in organizations that served both. By contrast, HBCC networks tailored their visits, training, and business supports for FCC providers, and the five organizations that exclusively served FFN providers offered training, peer support, financial assistance and materials services that were specifically intended to meet these caregivers' needs.

TABLE 11: SERVICES MOST LIKELY OFFERED BY ORGANIZATIONS SERVING FCC PROVIDERS ONLY VS. THOSE SERVING BOTH FCC AND FFN

N=42 Organizations	FCC only N=27	FCC & FFN N=15
Visits focused on helping providers work with families	X	
Enrollment of families	X	
Online training		X
Training on curriculum/ activities		X
Differentiated training for HBCC at different levels		X

Fisher's exact test of significance where p ≤ .10

Findings from our interviews also deepen our understanding of how organizations implement supports to meet the specific needs and interests of HBCC providers. Irrespective of organizational type, directors in our sample were attuned to the challenges that HBCC providers faced in their child care work, and provided services that were responsive to these needs. To mitigate the isolation related to working long hours alone, visits to provider homes used relationship-based approaches to connect with HBCC providers and to offer social support as well as connection to resources. Peer support groups facilitated by providers or agency staff as well as CoPs and peer to peer mentoring offered opportunities for providers to share their experiences, learn new content, and develop leadership skills. Training workshops were offered in the evenings or on weekends when providers could participate without closing their businesses, and some organizations based their workshops on adult learning principles to meet HBCC providers' varied educational backgrounds.

Service delivery content often aligned with providers' needs for information. Both visits and training workshops frequently focused on social-emotional development, the most commonly reported need. Many organizations offered workshops to help providers create and maintain a business that would generate a sustainable income from child care. There was, however, less attention in visits or training workshops to providers' need for information about working with families, and few organizations helped providers with the home environment or mixed-age groups, two distinctive features of HBCC.

Our findings also indicate that directors across all organizations were keenly aware of demands that HBCC providers faced in participating and navigating licensing, subsidy, QRIS, and Head Start systems. These demands included lack of alignment across program standards, cumbersome and often redundant paperwork, low reimbursement rates that did not compensate for system requirements, and systems' increasing reliance on technology.

To better understand the relationship between systems and the kinds of services that organizations which serve HBCC providers offer, we grouped the 42 organizations that were connected to a system into two categories: "system enforcers" – contractually responsible for monitoring licensing, subsidy, QRIS, and/or Head Start and Early Head Start compliance, and "system supporters" – responsible for supporting and preparing HBCC providers to participate in regulatory and quality systems. We found almost equal proportions of system enforcers and system supporters (Table 12). Of the five organizations that were not connected to a system, four served FFN caregivers exclusively.

TABLE 12: SERVICES MOST LIKELY OFFERED BY SYSTEM ENFORCERS AND SYSTEM SUPPORTERS

N=42 Organizations	System enforcers N=20	System supporters N=22
Compliance-focused visits to provider homes	X	
Training focused on working with families	X	
Enrollment of families	X	
Any business support	X	
Financial support		X
Tuition support for credentials and/or college	X	

Fisher's exact test of significance where $p \leq .10$

Directors across organizations emphasized how regulatory and quality systems such as licensing, subsidy, and QRIS shaped and constrained service delivery strategies regardless of the organization's contractual roles as enforcers or supporters within those systems. Almost all organizations used visits for monitoring health and safety practices although system enforcers were more likely to report emphasizing this as a goal. System enforcers reported enrolling families in FCC homes, likely due to requirements by Head Start. In addition, system enforcers were more likely to offer financial support for educational attainment (CDA or college tuition) related to Head Start or QRIS educational requirements. By contrast, system supporters may have had more flexibility in supporting providers. For example, supporters were more likely to offer any kind of financial assistance to providers, including assistance that was not required by regulations but that was essential for running a business, such as liability insurance.

Required training topics sometimes constrained organizations from offering other topics of interest to providers. Nearly two thirds of the organizations, for example, offered training on health and safety, in large part, in response to required Head Start and CCDF topics, and a quarter provided training workshops that were aligned with FCCERS indicators, which are commonly used in QRIS environmental standards. Similarly, organizations in our study focused support on helping HBCC providers navigate online technologies associated with regulatory and quality systems. To avert the high stakes consequences for providers who did not comply with standards or could not access required online technology, organizations often had to put additional supports focused on caregiving quality and provider-child interactions on hold.

LIMITATIONS

Although this is the first study to examine network directors' perceptions of the fit between services and the challenges that HBCC providers face, our sample is relatively small and non-representative. Our analyses and in-depth interviews with directors revealed that the original survey sample included many organizations that were not networks. Directors self-selected into the sample and their reports may not accurately reflect the full range of ways networks and other organizations deliver services. In addition, our study only includes director reports and lacks the perspective from providers themselves, who may have different views on these issues.

RECOMMENDATIONS

Our findings suggest several directions for programs, policy, and future research. We include recommendations for each of these areas below. Since the majority of our study sample consisted of HBCC networks, our recommendations are focused on future directions for HBCC networks.

IMPLICATIONS FOR ORGANIZATIONS THAT SERVE HOME-BASED CHILD CARE PROVIDERS

Our findings suggest that networks and other organizations that serve HBCC providers may have greater potential for supporting providers if they target their services and content to specific types of HBCC providers. In addition, our findings suggest that an increased focus on specific kinds of services —peer support, business support, and technology support – may be promising strategies for meeting provider needs.

TAILOR CONTENT TO THE SPECIFIC NEEDS OF FCC PROVIDERS AND FFN CAREGIVERS

Content around health and safety, child development across the domains, and environment, for example, is useful for any provider who cares for children, but modifying other topics may be warranted depending on the type of provider. Content on issues related to working with families, for example, may be different for FFN caregivers, who may be close to the families of the children they serve and have informal child care arrangements, as opposed to that offered to FCC providers, who have contractual relationships with families. Curriculum-related topics may be more relevant to FCC providers, particularly those who participate in QRIS, than for FFN caregivers, although gaining an understanding of activities that support child development may be helpful for them as well. Working with mixed-ages, too, may be more appropriate for FCC providers who are likely to care for a small group of infants, toddlers, preschoolers, and school-age children, than for FFN caregivers who may only care for one or two children.

DEVELOP STRATEGIES TO INCREASE FOCUS OF VISITS TO PROVIDER HOMES ON SUPPORT RATHER THAN COMPLIANCE

The findings about the juggling that organizations face in helping providers comply with system requirements and supporting providers' efforts to improve quality point to the need to redress the balance between these two often competing demands. Our data suggest that organizations should develop strategies to reduce the amount of time that staff must spend on compliance during visits. Such strategies could include completing necessary paperwork before visits and engaging providers in self-assessment about issues such as health and safety. Organizations should also consider using more intentional approaches to link training workshops and home visits to enhance opportunities for providers to apply what they have learned.

PROVIDE FORMAL OPPORTUNITIES FOR PEER SUPPORT

Our findings about peer support point to the need for an intentional focus on implementation of this strategy. Rather than relying on informal networking at training or attendance at conferences, organizations that serve HBCC providers may want to consider providing formal opportunities such as staff-led support groups for providers to get together as well as to offer content that meets providers' needs, whether these needs are related to systems compliance or enhancing practice. Organizations may also consider increased use of strategies that offer the combined benefits of specific content and peer support (such as cohorts, learning communities, or CoPs), because these may have greater potential for improving provider knowledge and skills.

OFFER MORE BUSINESS SUPPORTS FOCUSED ON FINANCIAL MANAGEMENT

Our findings also point to the role of business supports in helping regulated FCC providers remain in the field. Clearly, this issue is primarily relevant for FCC providers as small business owners. Organizations should consider offering more coaching and nuts and bolts training topics around business and financial management, budgeting, or marketing rather than broad-based workshops. Some kind of general business support might also be useful for FFN caregivers, who might consider becoming regulated providers.

INCREASE SUPPORT FOR TECHNOLOGY USE

A related issue is support for systems' increasing reliance on technology. To reduce this burden on HBCC providers who participate in licensing, subsidy, or QRIS, organizations should offer a variety of supports. These supports could include computer labs and technical assistance to help providers complete reporting forms as well as comply with online training requirements. In addition, organizations should consider providing computers, tablets, or even smart phones to enable providers to access relevant websites as well as to use social media to connect with one another for support. Hybrid online approaches that include contact with a trainer and/or other providers may be a promising strategy for conveying content.

IMPLICATIONS FOR POLICY

Our findings about the demands systems place on providers and organizations' efforts to alleviate these burdens suggest several policy directions, some of which have been identified in other research studies. Licensing, subsidy, QRIS and Head Start all create enormous administrative burdens on both providers and the organizations that serve them.

ALIGN SYSTEM REQUIREMENTS TO REDUCE BURDENS ON HBCC PROVIDERS

One strategy for reducing these burdens might be to simplify licensing and subsidy applications and documentation by developing some kind of common form like the common college application that might eliminate the need for redundant and duplicative information. For example, provider contact information, numbers of children in care, educational qualifications and documentation of inspections such as lead paint, which may be required by both licensing and subsidy, could be included in a single source available to both systems, with the capacity for updating the information for required renewals. A similar strategy could be developed to ensure better alignment for topics that are required across systems – that is, credit for completing health and safety training for licensing, for example, could be applied to subsidy and QRIS systems. Our data also suggest that required applications, reporting forms, and training materials should be available in languages other than English to meet the needs of the large number of HBCC providers who do not speak, write, or read English.

CREATE MORE FLEXIBLE OPTIONS FOR REQUIRED TRAINING

There is also a need for increased flexibility in required training hours for licensing and subsidy systems. Limiting approved hours to training workshops constrains both networks and providers. Rather, policy makers should consider alternative strategies—enabling organizations that serve HBCC providers to offer visits, cohorts, or even peer support groups as approved training. Such strategies have the potential for enabling providers to meet these requirements without closing their programs for the day and may have the potential for increasing systems participation while also improving quality.

PROVIDE ADEQUATE FUNDING TO ENABLE ORGANIZATIONS THAT MEET SPECIFIC CRITERIA FOR NETWORKS TO MAXIMIZE THEIR POTENTIAL

Our findings suggest that networks may be under-resourced compared to other organizations that serve HBCC providers. The non-network organizations in our sample, for example, appear to have a greater capacity to offer trainings for providers at different levels. Policy makers should consider expanding their support for organizations that meet the criteria for HBCC networks to maximize their potential for improving quality and increasing supply. Such support would enable networks to strengthen their service delivery to meet provider needs, including the costs that are associated with system requirements and high-quality programs.

Reimbursement rates have long been cited as a factor in engagement in the subsidy system (Adams, Rohacek, & Snyder, 2008). Our data support these findings, suggesting that low reimbursement rates may not compensate for the challenge of meeting system requirements and expectations.

IMPLICATIONS FOR FUTURE RESEARCH

The current study illustrates many challenges that HBCC providers face around delivering high-quality care and education to young children and their families, and that FCC providers face around remaining in the field. HBCC networks may be a promising strategy for addressing these issues. Future research that links specific network supports and combinations of supports to both quality and supply outcomes will be crucial for informing states around how to support this sector of the early childhood workforce.

EXPLORE HOW PEER SUPPORT AND BUSINESS SUPPORT HELP PROVIDERS IMPROVE QUALITY OF CAREGIVING FOR CHILDREN AND FAMILIES

Given the widespread use of peer and business supports for HBCC providers, additional research on how these strategies shape provider, child, and family outcomes will be a critical next step in informing development of evidence-based supports for HBCC.

STUDY HOW VISITS TO HBCC PROVIDER HOMES CAN SHAPE POSITIVE OUTCOMES FOR CHILDREN AND FAMILIES

The field lacks research on the approaches to visiting that are most effective with HBCC providers (Bromer & Korfmacher, 2017; Lloyd, Kane, Seok, & Vega, 2019). Findings from this study suggest that most visits focus on compliance to system standards and regulations and include help with paperwork and recordkeeping rather than quality caregiving. More research is needed on provider and staff perspectives about the approaches to visits that are most effective in improving caregiving quality.

EXAMINE THE DISTINCT NEEDS OF FFN CAREGIVERS AND PROMISING STRATEGIES FOR SUPPORTING THEM

Only five organizations in our sample served FFN caregivers exclusively, and the organizations that served both FFN and FCC offered fewer and less intensive services to FFN caregivers. Given the large numbers of unregulated HBCC providers caring for young children in the U.S. (NSECE Project Team, 2016), future research should examine the differences in challenges, needs, and interests across FFN and FCC providers as well as differentiated approaches to serving these populations of HBCC providers.

STUDY LOCAL IMPLEMENTATION AND ADAPTATION OF HBCC NETWORK STRATEGIES FOR DIVERSE PROVIDER POPULATIONS WORKING WITHIN DIFFERENT POLICY CONTEXTS

Findings from this study suggest that networks are a potential strategy for improving quality in HBCC. Given the diversity of the HBCC workforce and the variations across city, county, and state level policies, traditional approaches to evaluation (randomization) may not yield the most useful results (Lloyd et al., 2019; McCannon, Delgado, & Bisogno, 2019).

CONCLUSION

HBCC is the most common early childhood education setting for young children across the U.S. Many families turn to HBCC because these arrangements meet their non-traditional schedules, offer the opportunity for individual attention in a small group of children, are conveniently located in the neighborhood, and often match their culture. The children in these settings, many of them infants and toddlers, are among our most vulnerable. Yet policy makers and program administrators face challenges in engaging HBCC providers in quality improvement efforts as well as in maintaining the supply of regulated FCC providers.

This study builds on emerging evidence about the potential of HBCC networks and other organizations that serve HBCC providers as an approach for addressing these issues. The findings add to our knowledge about how HBCC networks, in particular, implement services that meet the distinctive individual needs of HBCC providers. The study provides insights into directors' perceptions of the challenges that providers face and the service delivery strategies that have promise for addressing them.

Questions remain, however, about networks' effectiveness in improving quality and maintaining supply. We lack data on outcomes for both FCC providers and FFN caregivers, and, equally important, whether networks can make a difference in child or family outcomes. Similarly, we do not fully understand the specific network components that contribute to positive effects, such as organizational structures and culture, or staffing and in-service supports. This study provides a gateway for further research to examine these issues.

REFERENCES

- Adams, G., Rohacek, M., & Snyder, K. (2008). *Child care voucher programs: Provider experiences in five counties*. https://www.urban.org/sites/default/files/publication/71331/411667_provider_experiences.pdf
- Bassok, D., Fitzpatrick, M., Greenberg, E., & Loeb, S. (2016). Within- and between-sector quality differences in early childhood education and care. *Child Development, 87*(5), 1627–1645. <http://dx.doi.org/10.1111/cdev.12551>
- Blasberg, A., Bromer, J., Nugent, C., Porter, T., Shivers, E.M., Tonyan, H., Tout, K., & Weber, B. (2019). *A conceptual model for quality in home-based child care* (Report No. 2019-37). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/ccepra_hbcc_conceptual_model_508b.pdf
- Boller, K., Del Grosso, P., Yumiko, R. B., Fortson, K., Paulsell, D., Lundquist, E., Hallgren, K., & Kovac, M. (2010). *The Seeds to Success modified field test: Findings from the impact and implementation studies*. Princeton, N.J.: Mathematica Policy Research. <https://files.eric.ed.gov/fulltext/ED511095.pdf>
- Bromer, J., & Korfmacher, J. (2017). Providing high-quality support services to home-based child care: A conceptual model and literature review. *Early Education and Development, 28*, 745–772. <https://doi.org/10.1080/10409289.2016.1256720>
- Bromer, J. & Porter, T. (2019). *Mapping the family child care network landscape: Findings from the national study of family child care networks*. Chicago, IL: Erikson Institute. https://www.erikson.edu/wp-content/uploads/2019/01/FCC-Network-Landscape_Executive-Summary_Erikson-Institute_Jan2019.pdf
- Bromer, J., Van Haitisma, M., Daley, K., & Modigliani, K. (2009). *Staffed support networks and quality in family child care: Findings from the Family Child Care Network Impact Study*. Chicago, IL: Herr Research Center for Children and Social Policy, Erikson Institute. https://www.erikson.edu/wp-content/uploads/fccnetwork_execsummary1.pdf
- The Build Initiative & Child Trends. (2017). A catalog and comparison of quality initiatives. <http://qualitycompendium.org/> on 4. 11.2019.
- Buell, M. J., Pfister, I., & Gamel-McCormick, M. (2002). Caring for the caregiver: Early Head Start/family child care partnerships. *Infant Mental Health Journal, 23*(1–2), 213–220. <https://doi.org/10.1002/imhj.10013>
- Burris, G., & Fredericksen, A. (2012, February 7). Training makes a difference: The experience of unionized family, friend, and neighbor child care providers in Washington State. *Economic Opportunity Institute*. <http://www.opportunityinstitute.org/research/post/training-makes-a-difference/>
- Del Grosso, P., Thomas, J., Makowsky, L., Levere, M., Fung, N., & Paulsell, D. (2019). *Working together for children and families: Findings from the National Descriptive Study of Early Head Start-Child Care Partnerships* (Report No. 2019-16). Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/ehs_ccpfinalreport508.pdf
- Doherty, G., Forer, B., Lero, D.S., Goelman, H., & LaGrange, A. (2006). Predictors of quality in family child care. *Early Childhood Research Quarterly, 21*(3), 296–312. <http://dx.doi.org/10.1016/j.ecresq.2006.07.006>
- Douglass, A., Taj, K., Coonan, M., & Friedman, D. H. (2017). Lessons from an urban school readiness initiative: Including family, friend, and neighbor care providers. *Early Education and Development, 28*(6), 640–654. <https://doi.org/10.1080/10409289.2017.1309628>
- Early Learning Challenge Technical Assistance (ELC TA) Program (2016). *Shared services as a strategy to support child care providers: State TA resources*. Washington, DC: Author. <https://files.eric.ed.gov/fulltext/ED583847.pdf>

- Forry, N., Iruka, I., Tout, K., Torquati, J., Susman-Stillman, A., Bryant, D., & Daneri, M. P. (2013). Predictors of quality and child outcomes in family child care settings. *Early Childhood Research Quarterly, 28*(4), 893–904. <https://doi.org/10.1016/j.ecresq.2013.05.006>
- Fukkink, R. G., & Lont, A. (2007). Does training matter? A meta-analysis and review of caregiver training studies. *Early Childhood Research Quarterly, 22*(3), 294–311. <http://dx.doi.org/10.1016/j.ecresq.2007.04.005>
- Gray, S. A. (2015). Widening the circle of security: A quasi-experimental evaluation of attachment-based professional development for family child care providers. *Infant Mental Health Journal, 36*(3), 308–319. <https://doi.org/10.1002/imhj.21513>
- Hallam, R., Hooper, A., Bargree, K., Buell, M., & Han, M. (2017). A two-state study of family child care engagement in Quality Rating and Improvement Systems: A mixed-methods analysis. *Early Education and Development, 28*(6), 669–683. <https://doi.org/10.1080/10409289.2017.1303306>
- Harms, T., Cryer, D., & Clifford, R.M. (2006). *Family child care environment rating scale (revised edition)*. NY: Teachers College Press
- Hatfield, B. & Hoke, K. (2016). *Improving the quality of family, friend and neighbor care: A review of the research literature*. Corvallis, OR: Oregon Child Care Research Partnership, Oregon’s Early Learning Division. <https://health.oregonstate.edu/sites/health.oregonstate.edu/files/occrp/pdf/improving-the-quality-of-family-friend-and-neighbor-care-2016.pdf>
- Henly, J. & Adams, G. (2018). *Increasing access to quality child care for four priority populations: Challenges and opportunities with CCDBG reauthorization*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/99150/increasing_access_to_quality_child_care_for_four_priority_populations_report_3.pdf
- Hershfield, B., Moeller, A., Cohen, A. J., & the Mills Consulting Group. (2005). *Family child care networks/systems: A model for expanding community resources*. New York: Child Welfare League of America.
- Isner, T., Tout, K., Zaslow, M., Soli, M., Quinn, K., Rothenberg, L. & Burkhauser, M. (2011). *Coaching in early care and education programs and Quality Rating and Improvement Systems (QRIS): Identifying promising features*. Washington, DC: Child Trends. <https://www.childtrends.org/wp-content/uploads/2013/05/2011-35CoachingQualityImprovement.pdf>
- Lanigan, J.D. (2011). Family child care providers’ perspectives regarding effective professional development and their role in the child care system: A qualitative study. *Early Childhood Education Journal, 38*, 399–409. <https://doi.org/10.1007/s10643-010-0420-2>
- Laughlin, L. (2013). Who’s minding the kids? Child care arrangements: Spring 2011. *Current population reports, (pp.70-135)*. Washington, D.C.: U.S. Census Bureau. <https://www.census.gov/prod/2013pubs/p70-135.pdf>
- Layzer, J. & Goodson, B. (2007). *National study of child care for low-income families care in the home: A description of family child care and the experiences of the families and children who use it: Executive summary*. Washington, DC: U.S. Department of Health and Human Services Administration for Children and Families. https://www.acf.hhs.gov/sites/default/files/opre/care_home_exsum.pdf
- Lipscomb, S. T., Weber, R. B., Green, B. L., & Patterson, L. B. (2016). *Oregon’s Quality Rating and Improvement System (QRIS) validation study one: Associations with observed program quality*. https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/research/oregons_qris_validation_study1report_withappendices_jan2017.pdf
- Lloyd, C.M., Kane, M., Seok, D., & Vega, C. (2019). *Examining the feasibility of using home visiting models to support home-based child care providers*. Washington, DC: Child Trends. https://www.childtrends.org/wp-content/uploads/2019/09/FCD-Full-Report_ChildTrends_Sept2019.pdf
- Maxwell, K. L., Sosinsky, L., Tout, K., & Hegseth, D. (2016). *Coordinated monitoring systems for early care and education* (Research Brief No. 2016-19). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/coordinated_monitoring_systems_in_early_care_and_education.pdf
- McCabe, L., & Cochran, M. (October, 2008). *Can home visiting increase the quality of home-based child care? Findings from the Caring for Quality project*. Cornell Early Childhood Program Research Brief, No. 3.

- McCannon, J., Delgado, P., & Bisogno, M. (2019, August 23). 10 lessons learned from health care on quality improvement. *Stanford Social Innovation Review*. https://ssir.org/articles/entry/10_lessons_from_health_care_on_quality_improvement
- Moreno, A. J., Green, S., & Koehn, J. (2015). The effectiveness of coursework and onsite coaching at improving the quality of care in infant-toddler settings. *Early Education and Development*, 26(1), 66–88. <https://doi.org/10.1080/10409289.2014.941260>
- Musick, J. S. (1996). *Uncovering the many sides of family child care: A study of the family child care connection*. Chicago, IL: YWCA of Metropolitan Chicago. <https://files.eric.ed.gov/fulltext/ED400940.pdf>
- National Center on Early Childhood Quality Assurance (NCECQA) (October 2019). *Addressing the decreasing number of family child care providers in the United States*. Washington, DC: Administration for Children and Families, Office of Child Care. <https://childcareta.acf.hhs.gov/resource/addressing-decreasing-number-family-child-care-providers-united-states>
- National Center on Early Childhood Quality Assurance (NCECQA) (2015). *Research brief #2: Trends in Family child care home licensing regulations and policies for 2014 (No. 315)*. Washington, DC: Administration for Children and Families, Office of Child Care.
- National Survey of Early Care and Education (NSECE) Project Team (2016). *Characteristics of home-based early care and education providers: Initial findings from the National Survey of Early Care and Education* (Report No. 2016-13). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/characteristics_of_home_based_early_care_and_education_toopre_032416.pdf
- National Survey of Early Care and Education (NSECE) Project Team (2013). *Number and characteristics of early care and education (ECE) teachers and caregivers: Initial findings from the National Survey of Early Care and Education* (Report No. 2013-38). Washington DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. http://www.acf.hhs.gov/sites/default/files/opre/nsece_wf_brief_102913_0.pdf
- National Survey of Early Care and Education Project Team (2015a). *Fact sheet: Provision of early care and education during non-standard hours* (Report No. 2015-44). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/factsheet_nonstandard_hours_provision_of_ece_toopre_041715_508.pdf
- National Survey of Early Care and Education Project Team (2015b). *Measuring predictors of quality in early care and education settings in the National Survey of Early Care and Education* (Report No. 2015-93). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/opre/measuring_predictors_of_quality_mpoq_in_the_nsece_final_092315_b508.pdf
- Office of Child Care. (2014). *FY 2011 CCDF Data Tables (Final)*. Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/occ/resource/fy-2011-ccdf-data-tables-final>
- Office of Child Care. (2016). *Overview of the 2016 Child Care and Development Fund final rule*. Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/occ/ccdf_final_rule_fact_sheet.pdf
- Office of Child Care. (2019). *FY 2017 CCDF Data Tables (Preliminary)*. Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/occ/resource/preliminary-fy2017>
- Office of the Assistant Secretary for Planning and Evaluation. (2019). *U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs*. Washington, DC: U.S. Department of Health and Human Services. <https://aspe.hhs.gov/2019-poverty-guidelines>
- ORS IMPACT (2015). *Summary of year-end Kaleidoscope Play & Learn participant survey results*. Seattle, WA: Author. https://www.childcare.org/ckfinder/userfiles/files/2015_Kaleidoscope_Play_%26_Learn_Evaluation_Results.pdf
- Østbye, T., Mann, C. M., Vaughn, A. E., Namemek Brouwer, R. J., Benjamin Neelon, S. E., Hales, D., Bangdiwala, S. I., & Ward, D. S. (2015). The keys to healthy family child care homes intervention: Study design and rationale. *Contemporary Clinical Trials*, 40, 81-89. <https://doi.org/10.1016/j.cct.2014.11.003>

- Paschall, K. (2019). *Nearly 30 percent of infants and toddlers attend home-based child care as their primary arrangement*. Washington, DC: Child Trends. <https://www.childtrends.org/nearly-30-percent-of-infants-and-toddlers-attend-home-based-child-care-as-their-primary-arrangement>
- Paulsell, D., Porter, T., Kirby, G., Boller, K., Martin, E. S., Burwick, A., Ross, C., & Begnoche, C. (2010). *Supporting quality in home-based child care: Initiative design and evaluation options*. Princeton, NJ: Mathematica Policy Research. https://www.acf.hhs.gov/sites/default/files/opre/supporting_options.pdf
- Porter, T., Paulsell, D., Del Grosso, P., Avellar, S., Hass, R., & Vuong, L. (2010). *A review of the literature on home-based child care: Implications for future directions*. Princeton, NJ: Mathematica Policy Research. https://www.acf.hhs.gov/sites/default/files/opre/lit_review.pdf
- Porter, T. & Reiman, K. (2016). *Examining quality in family child care: An evaluation of All Our Kin*. New Haven, CT: All Our Kin. <http://www.allourkin.org/sites/default/files/ExaminingQualityinFCC2016.pdf>
- Raikes, H. A., Raikes, H. H., & Wilcox, B. (2005). Regulation, subsidy receipt and provider characteristics: What predicts quality in child care homes? *Early Childhood Research Quarterly*, 20(2), 164-184. <https://doi.org/10.1016/j.ecresq.2005.04.006>
- Rohacek, M. & Adams, G. (2017). *Providers in the child care subsidy system: Insights into factors shaping participation, financial well-being, and quality*. Washington, DC: Urban Institute. <https://www.urban.org/sites/default/files/publication/95221/providers-and-subsidies.pdf>
- Rusby, J., Jones, L., Crowley, R., Smolkowski, K., & Arthun, C. (2013). Predictors of home-based child care providers' participation in professional development workshops and coaching. *Child & Youth Care Forum*, 42, 439-455. <https://doi.org/10.1007/s10566-013-9209-y>
- Sandstrom, H., Coffey, A., Henly, J., Bromer, J., Spalding, A., Thomas, W., Greenberg, E., & Derrick-Mills, T. (2018). *Learning from child care providers across settings: A critical step to improving the quality and stability of subsidized care*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/99519/learning_from_child_care_providers_across_settings_0.pdf
- Shivers, E. M., Farago, F., & Goubeaux, P. (2015). *The Arizona Kith and Kin evaluation, brief #1: Improving quality in family, friend, and neighbor (FFN) child care settings*. Phoenix, AZ: Indigo Cultural Center. <http://indigoculturalcenter.org/wp-content/uploads/2016/02/Indigo-ASCC-Kith-and-Kin-Evaluation-FNL-2016.pdf>
- Stoney, L. & Blank, S. (2011). *Delivering quality: Strengthening the business side of early care and education*. Palm Beach, FL: Opportunities Exchange. https://opportunities-exchange.org/wp-content/uploads/OpEx_IssueBrief2_BizSide-final.pdf
- Susman-Stillman, A. R., & Banghart, P. (2011). *Quality in family, friend, and neighbor child care settings*. New York, NY: Child Care & Early Education Research Connections. <https://doi.org/10.7916/D8R49ZR3>
- Swartz, R. A., Wiley, A. R., Koziol, N. A., & Magerko, K. (2016). Psychosocial influences upon the workforce and professional development participation of family child care providers. *Child & Youth Care Forum*, 45, 781-805. <https://doi.org/10.1007/s10566-016-9353-2>
- Tonyan, H. A. (2017). Opportunities to practice what is locally valued: An ecocultural perspective on quality in family child care homes. *Early Education and Development*, 28(6), 727-744. <https://doi.org/10.1080/10409289.2017.1303304>
- Tonyan, H. A., Paulsell, D., & Shivers, E. M. (2017). Understanding and incorporating home-based child care into early education and development systems. *Early Education and Development*, 28(6), 633-639. <https://doi.org/10.1080/10409289.2017.1324243>