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Supporting Quality in Home-Based Child Care

THIS ISSUE AND WHY IT MATTERS

The most common nonparental child care arrangement for infants and toddlers takes place in a home. ZERO TO THREE's 2009 national parent survey, *Parenting Infants and Toddlers Today* (Hart Research Associates, 2010; Powers, 2010) found that 14% of parents used center-based care, while 36% relied on family members or other in-home providers. Parents of infants and toddlers often choose home-based care over center-based care because they believe a home environment can offer smaller groups of children, more individualized care, increased flexibility, and consistent relationships over time. The two primary types of home-based child care include family, friend, and neighbor (FFN) care and family child care (FCC). FFN care tends to be informal and is largely unregulated and highly variable in terms of the context of care (e.g., where it is provided, the number of hours, and whether the caregiver is paid). In contrast, FCC homes are regulated by the state or local community and must follow licensing laws and regulations that stipulate safety and quality standards.

Although FFN care and FCC homes share the intimacy of a home environment as the setting for child care, each offers unique benefits and challenges. Efforts to support the quality of care offered in the home environment have focused on increasing professionalism and skill-building through training, networks of support, and targeted services to caregivers. The articles in this issue of *Zero to Three* synthesize the research on home-based child care and describe some of the recent quality initiatives around the country. Articles describe the development of the national accreditation process offered through The National Association for Family Child Care, FCC within the U.S. Department of Defense child development system, an examination of the emerging literature on FFN care, and research exploring the relationship between support network affiliation and quality in family child care. Also described in this issue is a new collaborative initiative of the Office of Head Start and the Office of Child Care—The Early Head Start for Family Child Care Project—which seeks to understand how existing resources at the federal, state, and local levels can be combined and coordinated to leverage comprehensive services for children in low-income families.

The voices of the providers who are caring for children in their homes provide an important perspective on the implementation of "best practices" and the day-to-day reality of home-based child care. An interview with three providers participating in a professional network of FCC providers partnering with Early Head Start reveals the opportunities and complications of their work with children and families. It will take the collective interest and careful attention of researchers, policymakers, educators, parents, funders, and providers to preserve the special qualities of home-based child care while at the same time ensuring that all children receive enriching early care and education experiences.

Stefanie Powers, Editor
spowers@zerotothree.org

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Developing Initiatives for Home-Based Child Care

Current Research and Future Directions

TONI PORTER
Bank Street College of Education

DIANE PAULSELL
Mathematica Policy Research

When you went back to work after your baby was born, what kinds of child care arrangements did you make for her? If you turned to your mother, your sister, a close friend, or a family child care provider, you made the same decision that thousands of parents do. These kinds of arrangements are often called "home-based child care," because the care is offered in the home of the caregiver.

After the passage of welfare reform in the mid-1990s, home-based child care (regulated family child care and family, friend, and neighbor care that is legally exempt from regulation) emerged as a significant issue for federal and state policymakers (Porter & Kearns, 2005). In large part, the interest in these kinds of child care arrangements was related to two factors: increasing recognition that many families who used publicly funded child care subsidies relied on these caregivers; and growing concern about the quality of care that children received in these settings (Porter, Paulsell, Del Grosso, et al., 2010). These issues are significant because a large proportion of young children, especially infants and toddlers, are in home-based child care, and existing research on its quality is mixed.

Background

Research indicates that home-based child care is a prevalent type of child care and that quality varies widely across settings. Since 2000, many initiatives have been developed to improve quality in these settings, but little rigorous research evidence exists about their effectiveness.

The Prevalence of Home-Based Child Care

Studies estimate that the majority of children less than 5 years old in nonparental child care are in home-based child care (Johnson, 2005), although estimates vary by study. Nearly 40% are cared for by relatives (Johnson). Home-based child care is a common arrangement for infants and toddlers (children less than 3 years old): One study estimated that nearly 72% of children in nonparental care are in these settings (Brandon, 2005). Although families across income and ethnic spectrums rely on this kind of child care, research indicates that it is more commonly used by families of color (Snyder & Adelman, 2004) and families with low incomes (Boushey & Wright, 2004; Capizzano, Adams, & Sonenstein, 2000; Johnson).

The Quality of Home-Based Child Care

Studies of quality in home-based child care suggest that there is considerable variation (Porter, Paulsell, Del Grosso, et al., 2010). The mixed results may be related to the measures that were used in the research (see box Quality Studies by Type of Instrument).

Some research with the Family Day Care Environmental Rating Scale (Harms & Clifford, 1989) or its updated version, the Family Child Care Environmental Rating Scale (Harms, Cryer, & Clifford, 2007)—both

Abstract

Home-based child care accounts for a significant share of the child care supply in the United States, especially for infants and toddlers. A synthesis of the home-based care research literature and information about recent home-based care quality initiatives points to a critical need for more systematic efforts to develop and test quality initiatives for this type of child care. This article summarizes key findings on the prevalence and quality of home-based child care, caregiver characteristics, and quality initiatives and then makes recommendations for future directions.

commonly used observational instruments—show poor to moderate quality. Research with other instruments such as the Quality of Early Care and Education Settings: Caregiver Rating Scale (Goodson, Layzer, & Layzer, 2005) and the Child Care Assessment Tool for Relatives (Porter, Rice, & Rivera, 2006) find that settings are safe and healthy and that caregivers are responsive, nurturing, and engaged with the children, although levels of cognitive stimulation may be low.

Initiatives for Home-Based Caregivers

In the past decade, a growing number of state and local agencies across the country have created initiatives to support home-based caregivers. Many of these initiatives are funded with public dollars such as Child Care Development Fund quality improvement funds; others are supported through private philanthropy such as the United Way (O'Donnell et al., 2006; Pittard, Zaslow, Lavelle, & Porter, 2006; Porter & Kearns, 2005).These initiatives are offered by a variety of organizations—child care resource and referral agencies, family resource centers, institutions of higher education, and government agencies. The Administration for Children and Families has also been engaged in efforts to improve home-based child care. It funded the Early Head Start Enhanced Home Visiting Pilot program, which aimed to support family, friend, and neighbor caregivers who were providing care to children enrolled in Early Head Start (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006).

Regardless of their funding source, home-based child care initiatives aim to improve quality in these settings (Porter & Kearns, 2005; Porter, Nichols, et al., 2010). To achieve their goals, these efforts rely on a wide range of strategies. Many initiatives document their results by collecting some kind of data, but, for the most part, these data focus on implementation.

Lessons From Research

Only a limited number of initiatives have conducted evaluations to determine whether the intended outcomes have been achieved or whether the initiative has had an impact on the intended population (Porter, Nichols, et al., 2010; Porter, Paulsell, Del Grosso, et al., 2010). What can be learned from these few studies to inform the design and development of future efforts? This article reports on some of the findings from a 2-year research project, Supporting Quality in Home-Based Child Care, sponsored by the Office of Planning, Research, and Evaluation in the Administration for Children and Families in the U.S. Department of Health and Human Services. Conducted jointly by Mathematica Policy

Photo: Marilyn Nolt

Home-based providers often provide care for school-age children and preschoolers, as well as infants and toddlers.

Quality Studies by Type of Instrument

Examples of studies that used different instruments to measure quality in home-based child care settings are listed below.

***Family Day Care Environmental Rating Scale* (Harms & Clifford, 1989) and *Family Child Care Environmental Rating Scale* (Harms, Cryer, & Clifford, 2007)**

- 17 Early Head Start research sites nationwide (Administration for Children and Families, 2004)
- Regulated family child care homes and family, friend, and neighbor care used by low-income families in Boston, Chicago, and San Antonio (Coley, Chase-Landsdale, & Li-Grining, 2001).
- Regulated family child care homes and family, friend, and neighbor care in four urban counties in Indiana (Elicker et al., 2005)
- Regulated family child care homes and family, friend, and neighbor care used by families with mothers in welfare-to-work programs in Connecticut, Florida, and California (Fuller & Kagan, 2000; Loeb, Fuller, Kagan, & Carrol, 2004)
- Regulated family child care homes and family, friend, and neighbor care in North Carolina, Texas, and California (Kontos, Howes, Shinn, & Galinsky, 1995)
- Family, friend, and neighbor care in North Carolina (Maxwell & Kraus, 2005)
- Regulated family child care homes in White Center and Yakima, WA (Paulsell, Boller, Aikens, Kovac, & Del Grosso, 2008)
- Regulated family child care homes in North Carolina (Peisner-Feinberg, Bernier, Bryant, & Maxwell, 2000)
- Family, friend, and neighbor care in Los Angeles (Shivers, 2006)

***Quality of Early Care and Education Settings: Caregiver Rating Scale* (Goodson, Layzer, & Layzer, 2005)**

- Regulated family child care and family, friend, and neighbor care in Los Angeles County, CA; Hamilton County, OH; Harris County, TX; King County, WA; and Franklin County, MA (Layzer & Goodson, 2006)
- Family, friend, and neighbor care in Minnesota (Tout & Zaslow, 2006)

***Child Care Assessment Tool for Relatives* (Porter, Rice, & Rivera, 2006)**

- Family, friend, and neighbor care in 17 Early Head Start programs nationwide (Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006)

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An effort that aims to improve professionalism among family child care providers could include support for obtaining a CDA credential.

Research and Bank Street College of Education, the project included four components: a literature review of more than 135 articles on topics related to home-based child care (Porter, Paulsell, Del Grosso, et al., 2010); a compilation of 96 home-based child care initiatives based on a scan of the field (Porter, Nichols, et al., 2010); a compendium of detailed profiles of 23 of these initiatives (Porter, Paulsell, Nichols, et al., 2010); a paper on options for designs and evaluations (Paulsell et al., 2010); and an executive summary (Paulsell et al., 2010).

The literature review identified only 17 studies of the effects of home-based child care initiatives (Porter, Paulsell, Del Grosso, et al., 2010). Most of these studies lacked rigor. Thirteen used descriptive or correlational designs, and four used random assignment; in many cases, sample sizes were small. A search for initiatives that were being implemented in the field also found that most had not been rigorously evaluated. Of the 96 initiatives that we identified through this search, fewer than half (40) reported that an evaluation had been conducted (Porter, Nichols, et al., 2010). Most (28) of the evaluations focused on effects on caregiver knowledge or practice and used pre–post designs without a comparison or control group. These types of descriptive outcome studies are useful for examining implementation and suggesting results, but they do not allow us to understand if effects were related to the initiative (correlational outcome studies) or whether it caused them (conclusive outcome studies). In summary, because of a lack of rigorous methods to isolate the effects of the initiatives and small sample sizes, the research team could not draw conclusions about the effectiveness of different strategies for improving the quality of home-based care.

The research on these service delivery approaches, however, provides important descriptive information about caregivers and initiatives that can be used as a starting point to develop and test future quality improvement initiatives for home-based care. To identify the potential approaches for improving home-based child care, we have organized the initiatives identified through the literature review and the search for initiatives in the field into eight categories of service delivery approaches: home-based technical assistance, professional development, training workshops, Play and Learn, peer support groups, grants to caregivers, materials and mailings, and reading vans (see Table 1).

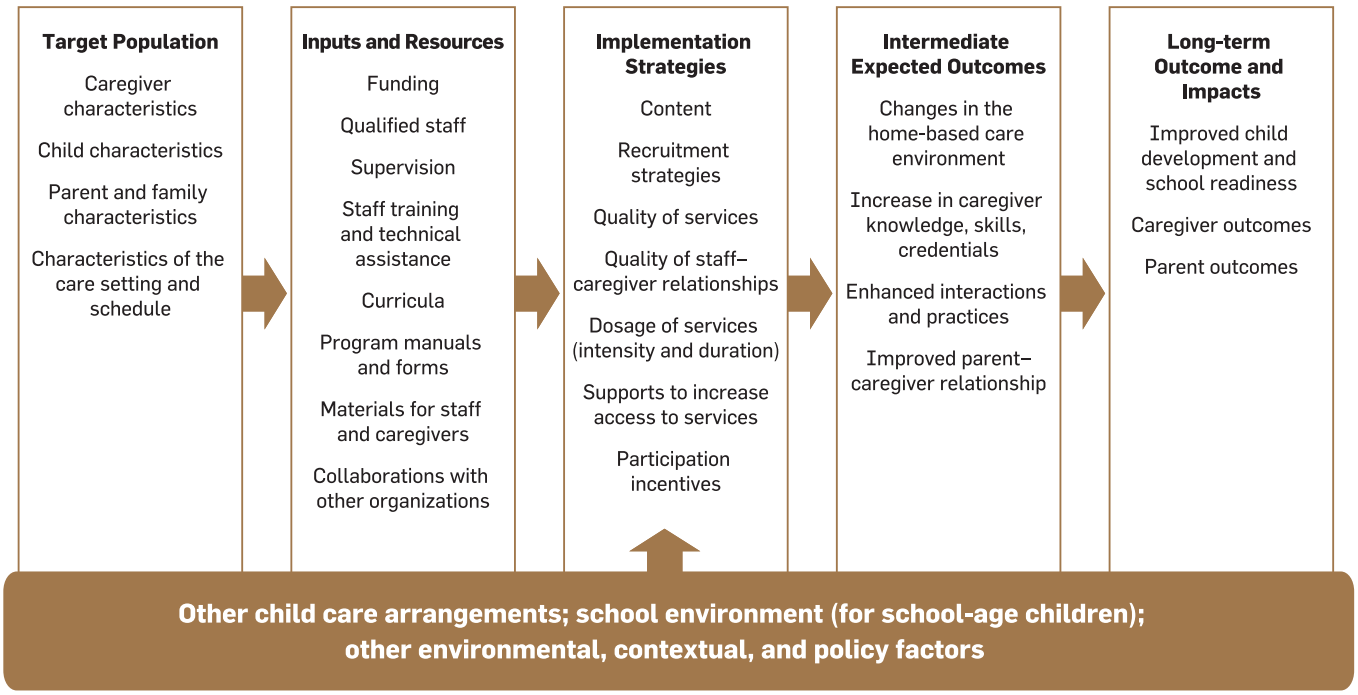
We present the project's findings in the context of a logic model for initiatives that aim to support quality in home-based child care (Paulsell et al., 2010; see Figure 1). The

Table 1. Service Delivery Strategies for Home-based Child Care

Type of strategy	Definition	Studies in the literature review	Evaluations in the scan of the field
Home-based technical assistance (home visiting, coaching, consultation)	Technical assistance and other services to caregivers in their homes using coaching, consultation, and home visiting approaches	3	27
Professional development through formal education	Credit-bearing courses, as well as financial assistance and supportive services to help caregivers access professional development opportunities	1 2 additional studies reported in the Design Options report	2
Training through workshops	Workshops to improve caregiver knowledge and skills, either as stand-alone offerings or in a series	8	40
Play and Learn	Drop-in events in which caregiver–child dyads interact in a range of activity centers; staff model the activities for caregivers	3	5
Peer support	Group meetings in which caregivers discuss shared experiences and exchange ideas, information, and strategies	3 related studies 2 additional studies reported in the Design Options report	8
Grants to caregivers	Monetary grants to caregivers for enhancing the quality of the home-based care environment or funding caregiver training	None 1 additional study reported in the Design Options report	3
Materials and mailings	Dissemination of information such as newsletters or activity sheets, as well as items such as books, toys, fire extinguishers, or first aid kits to enhance the care environment or caregiver knowledge	None	5
Reading vans	Visits by mobile reading vans to distribute children's books, other literacy materials, and information for caregivers	None 1 additional study reported in the literature review	2

Sources: Paulsell et al., 2010a; Porter, Paulsell, Del Grosso et al., 2010; Porter, Nichols et al., 2010

Figure 1: Illustrative Model for a Home-Based Child Care Initiative



logic model provides a useful approach for developing an initiative because it defines the specific aspects of the initiative and shows how they are interrelated. Articulating specific and concrete outcomes for an identified target population, as well as developing a clear, detailed strategy for delivering services, can increase the likelihood that the initiative will achieve its intended outcomes. The model can, and should, draw on research findings because they point to directions for possible effects that can be produced and strategies for achieving them.

We begin with a discussion of the kinds of long-term and intermediate outcomes that might be expected from initiatives for regulated family child care providers and family, friend, and neighbor caregivers. The next section discusses the characteristics of the target population of caregivers for whom such initiatives might be appropriate. The third section focuses on service delivery strategies. We conclude with some suggestions for future work.

Using a Logic Model to Develop and Initiative for Home-Based Caregivers

In this section, we illustrate how a logic model can be used to develop an initiative for home-based child care. Figure 1 shows the components that should be considered. They include: (a) long-term outcomes and impacts for children, caregivers, and parents; (b) intermediate and expected outcomes; (c) target population; (d) implementation strategies; and (e) inputs and resources.

Child Outcomes

We begin with the right-hand side of the model, "Long-Term Outcomes and Impacts" (Paulsell et al., 2010). These outcomes are those that one would expect to produce for children, caregivers, and parents when the initiative for home-based caregivers is complete. Table 2 identifies a range of possible child outcomes that could be expected, depending on the content of the initiative (Porter, Paulsell, Del Grosso, et al., 2010). To some extent, the anticipated outcomes for children in home-based child care are similar to those for other settings—improved cognitive development, improved language development, improved health, and reduced injuries. There are, however, some child outcomes—improved social–emotional development, positive racial and social identification, and reduced behavior problems—that may be particularly salient for home-based child care in which there are typically a small number of children, the children in care are often related to the

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Training workshops may have potential for improving quality.

caregiver, and the children often share the caregiver's race and ethnicity (Porter, Paulsell, Del Grosso, et al., 2010).

We found six studies of initiatives that reported on child outcomes. Three studies examined home-based technical assistance initiatives, two examined training workshops, and one examined a Play and Learn initiative. The three evaluations of home-based technical assistance—Partners for Inclusion (PFI), which used consultation as a primary strategy (Bryant et al., 2009); Right from Birth (RFB), which used coaching (Ramey & Ramey, 2008); and Caring for Quality (CFQ), which used home visiting (Cochran & McCabe, 2008; McCabe & Cochran, 2008)—found no statistically significant impacts on children in their randomized controlled trial evaluations, although CFQ reported some suggestive evidence that children in the family child care program group showed greater improvements on language development and self-regulation than those in the control groups (McCabe, 2007). All of these studies had small, selected samples. An evaluation of a training workshop series for family child care, a pre–post design, reported higher attachment among infants whose caregivers had participated in workshops on infant and toddler development (Howes, Galinsky, & Kontos, 1998). Another study, a pre–post evaluation of Tutu and Me, a Play and Learn initiative, found significant gains in language development for children 3 years and older; there were also improvements for 3- and 4-year-old children in sociopersonal, language and literacy, physical development, and mathematical thinking (Tutu and Me, 2008). These findings from pre–post studies, however, are only suggestive, because rigorous designs were not used to isolate the effects of the initiatives.

Caregiver Outcomes

Like child outcomes, caregiver outcomes that were anticipated for home-based care, reflect, in many respects, those that can be identified for initiatives to improve quality in other settings. Caregiver outcomes can be viewed as long-term or intermediate, depending on the ultimate result the initiative aims to achieve (Porter, Paulsell, Del Grosso, et al., 2010; see Table 2). For example, improvement of caregivers' knowledge and skills, as well as their interactions and practices, are reasonable long-term outcomes in themselves; they can also serve as intermediate outcomes if the initiative is intended to have effects on child outcomes as well.

Studies also suggest some possible outcomes that are more closely associated with specific aspects of home-based care. Initiatives for family, friend, and neighbor caregivers can aim to help them become licensed as a long-term outcome, or as an intermediate outcome if the initiative then intends to improve quality of care. Initiatives can identify enhancing caregivers' professionalism by helping them obtain a child development associate (CDA) credential or degree as a long-term outcome, or as an intermediate outcome if they intend to achieve some other outcome such as accreditation by a professional child care organization.

Caregiver outcomes were the focus of 18 evaluations, including those reported in the literature review and those we identified in the scan. The findings suggested that some approaches might have an effect on environmental quality or on specific aspects of quality such as caregivers' knowledge and skills. For example, home-based technical assistance appears promising: three random assignment studies (PFI, RFB, and CFQ) showed significant increases in Family Day Care Environmental Rating Scale (Harms et al., 2007) scores on most subscales for family child care providers.

Training workshops may also have potential for improving quality, but findings are only suggestive. Four of the eight studies of training workshops in our literature review found that participation in workshops was associated with increased Family Day Care Environmental Rating Scale (Harms et al., 2007) scores for family child care providers (Bromer, van Haitsma, Daley, & Modigliani, 2009; Kansas Association of Child Care Resource and Referral Agencies, Infant/Toddler Project, 2003; Norris, 2001; Peisner-Feinberg et al., 2000), but self-selection (providers who participated may have been more motivated to improve their care) may have been a factor in these results.

There is some indication that Play and Learn initiatives may influence quality as well. Evaluations of Tutu and Me (2008) and Step-Up using the CCAT-R in pre–post tests (Choices for Children, n.d.; Porter & Vuong, 2008) found significant improvements in caregivers' support for language development for children less than 3 years

Table 2: Menu of Potential Target Caregiver, Parent, and Child Outcomes for Initiatives to Support Quality in Home-Based Care

Caregiver outcomes	Parent outcomes	Child outcomes
Improved relationships with parents	Improved knowledge of child development	Improved social–emotional development (e.g., social skills, self-regulation)
Increased knowledge of child development	Increased satisfaction with child care arrangements	Reduced behavior problems
Improved caregiving skills	Improved relationship with caregiver	Improved language and literacy development
Improved health and safety of the home	Greater ability to balance work and family	Improved cognitive development
Increased professionalization	Reduced stress	Improved health status
Improved satisfaction with role as caregiver	Reduced work absenteeism	Positive racial and ethnic socialization and identity
Improved access to social support		
Reduced isolation		
Improved psychological well-being		
Increased income		
Increased access to health insurance		
Reduced social service needs		

Source: Porter, Paulsell, Del Grosso et al., 2010

old, improvements in caregivers' support for cognitive development (Tutu and Me) and improvements in support for social–emotional development (Step-Up). Again, because these studies did not use rigorous designs, these findings should be considered suggestive but not conclusive.

There is also some suggestive pre–post evidence that initiatives may be able to produce effects on caregiver knowledge and skills. Several evaluations have found changes in caregiver knowledge. One study of an initiative that used professional development as a primary strategy found increased knowledge of developmentally appropriate practice and environment in pre–post tests among family child care providers who had participated in college courses (Adams & Buell, 2002), and parents and caregivers in the evaluation of Seattle's Play and Learn program reported that they had increased their knowledge about child development and how children learn through play (Organizational Research Services, 2008). Two of the peer support initiatives, the Arizona Kith and Kin Project and the Bridgeport Kith and Kin Project, also reported improvements in caregiver knowledge about child development in pre–post evaluations.

Evaluations of other initiatives point to possible changes in caregiver practice. One of the training workshop evaluations found increased sensitivity among family child care providers in pre–post tests (Howes et al., 1998), whereas the other found increased use of effective behavior management practices in a random assignment study (Rusby, Smolkowski, Marquez, & Taylor, 2008). The third workshop initiative, a media literacy-related effort, used a random assignment design in its evaluation. The study found few statistically significant impacts on participants' self-reported viewing of television (Boller et al., 2004).

Very little research is available on mailings and materials, as well as on mobile reading vans, and study designs are weak. Caregivers in the Family, Friend and Neighbor Care Orientation program, which distributed a one-time kit to subsidized caregivers, reported in a pre–post survey that they read to the children more often and that they had more books in the home (Rider & Atwater, 2009). One small descriptive study found that caregivers reported increased knowledge about interactive reading skills and reading to their children more often (Tanabe et al., 2005).

Parent Outcomes

The notion of improving parent outcomes as an aspect of child care quality has not often been considered in initiatives (Bromer et al., 2011). Research suggests that quality improvement initiatives, including those for home-based caregivers, might consider identifying outcomes for parents in an initiative, because positive provider–family relationships may lead to improved outcomes for children (Bromer et al.).

Table 2 lists some possible long-term outcomes for parents, which could be viewed as intermediate outcomes if the initiative specified child outcomes as long term. For example, an initiative could aim to enhance parents' knowledge about child development through the caregiver, which may result in improved parenting practices or shared knowledge of child-rearing practices that may, in turn, create greater consistency across settings for the child. An intended parental outcome of improved satisfaction with care may contribute to reduced stress and improved parental mental health, which can have a positive effect on children's social–emotional development. Through strengthening provider–family relationships, an initiative might aim to enhance parents' ability to balance work and family issues, which may contribute to positive employment outcomes such as reduced absenteeism.

Almost no research exists on peer support strategies. We did not find any studies on the effectiveness of peer support for home-based caregivers in our review of the literature (Porter, Paulsell, Del Grosso, et al., 2010), but one of the peer support initiatives that we identified, the Arizona Kith and Kin Project, indicated that it had conducted an evaluation. In a pre–post survey, approximately 80% of the caregivers reported that they had made changes in their practices with children (Porter, Nichols, et al., 2010).

Characteristics of the Target Population

Here we move to the column on the far left of the logic model (Figure 1). Taking into account the characteristics of the caregivers, children, and families in care is essential in developing an initiative because it will not succeed if the resources and implementation strategies are not appropriate for the population and not sufficient to achieve the target outcomes or if services do not fit caregivers' needs, interests, and backgrounds.

Caregivers. Specifying the target population of home-based caregivers is complicated because research indicates that there are wide variations in their motivations for providing care and their interests (Porter, Paulsell, Del Grosso, et al., 2010). For many family, friend, and neighbor caregivers, for example, an initiative that has licensing as a goal may not be appropriate because they provide child care to help out their families and friends and they are not interested in child care as a profession, nor may they be attracted to initiatives that use training workshops as a strategy. Home visiting, peer support groups, or Play and Learn programs may be more appealing to these caregivers (see box, The Arizona Kith and Kin Project).

Regulated family child care providers, on the other hand, may be interested in initiatives that offer opportunities for professional development (and related increases in reimbursement rates) because they often provide care to earn income. In addition, regulated family child care providers are often required to complete a specific number of training hours to obtain or maintain their regulated status. For them, training workshops or credit-bearing courses may be attractive.

Initiatives should take into consideration other caregiver characteristics such as educational backgrounds and experience. Materials should correspond to caregivers' educational levels, literacy levels, and home language so that caregivers will be comfortable using them and can understand the content. These characteristics may also influence the choice of service delivery strategy—whether to use approaches such as home visiting, coaching, and consultation rather than classroom-based training.

Other characteristics. Among the other target population characteristics that initiatives should consider are those of the children in care, the parents, and the care setting. Clearly, the age of the children in care is a primary factor for the content of the initiative. A focus on infant–toddler care might be not only appropriate but also relevant for home-based caregivers, because children in this age group

The Arizona Kith and Kin Project

The Arizona Kith and Kin Project offers a 14-week series of 2-hour support group sessions for Spanish-speaking family, friend, and neighbor caregivers. Most sessions are offered during the day at various Head Start centers, churches, and local community centers that have an adjoining space for child care. When the 14-week training session ends, participants receive a certificate that indicates the number of training hours they received. The peer support group topics include the following: guidance and discipline, daily schedule planning, nutrition, parent–caregiver relationships, environment, language and literacy (including a Reading Is Fundamental book event and distribution), brain development, health and safety, first aid, and CPR. The Kith and Kin Project also provides a range of safety-related materials such as outlet covers, smoke detectors, and fire extinguishers in conjunction with an annual health and safety conference.

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Through strengthening provider–family relationships, an initiative might aim to enhance parents' ability to balance work and family issues.

represent such a large proportion of children in these settings. Content about working with mixed-age or sibling groups is appropriate as well because home-based providers often provide care for school-age children and preschoolers, as well as infants and toddlers.

The characteristics of the parents are another factor to consider because work schedules might inhibit participation in a parenting component or other program activities. In addition, the hours in which children are in care should be taken into account. Differences in schedules—full-time care versus part-time care, traditional hour care versus shift work or nighttime care—may affect caregivers' ability to participate in the program and the kinds of content they want or need.

Delivering the Initiative

Now we move to the middle of the logic model, the columns that relate to the components of the initiative (Figure 1). "Implementation Strategies" encompasses the actual service delivery (content, recruitment, dosage of services, supports, and incentives for participation), whereas "Inputs and Resources" includes the components that make the delivery of the initiative possible (e.g., funding, qualified staff, curricula, materials for staff and caregivers, and collaboration with other organizations). These two columns represent broad categories in the logic model, but a fully developed model will be detailed and specific, linking all of the components to the outcomes.

Implementation strategies. The first step in delivering an initiative should be the choice of the mode of service delivery. This decision should be related to both the intended outcome of the initiative and the target population of caregivers, as well as their interests and needs. An initiative that aims to improve the health and safety of the environment in family, friend, and neighbor care, for example, can provide equipment such as first aid kits and fire extinguishers. If the intention is to improve caregivers' knowledge about health and safety for infants and toddlers, the initiative could provide information about practices through peer support groups, home visiting, or Play and Learn programs.

The initiative's content is also related to its intended outcomes. The content—the curricula, the activities, and the materials for caregivers—must focus on the changes that the initiative aims to achieve. An initiative that is intended to improve family, friends', and neighbors' knowledge of how to support infants and toddlers could include topics on early brain development, social–emotional needs of infants and toddlers, and language development, as well as other related topics, whereas an effort that aims to improve professionalism among family child care providers could include information about and support for obtaining a CDA (see box, The Infant–Toddler Family Day Care Network).

Dosage of services refers to intensity and duration. These, too, are related to the intended outcomes because initiatives may require different levels of services depending on what they aim to achieve. Helping caregivers who provide care to subsidized children to understand subsidy policies and regulations may only require one short workshop, but improving caregivers' knowledge of infant development will most likely require a series of workshops that are offered regularly; for example, weekly for several months. Research can guide some of the decisions about how often and how long a period will be effective for achieving goals (Paulsell et al., 2010).

Other issues that should be considered in the logic model are recruitment and incentives for participation. The identified target population should influence the kinds of recruitment strategies that an initiative includes because caregivers will be more likely to respond to a program that meets their needs (Powell, 2008; Shivers & Wills, 2001; Todd, Robinson, & McGraw, 2005). Research suggests a variety of different strategies depending on whether the caregivers are family, friends, and neighbors or family child care providers (Paulsell et al., 2010; Porter, Paulsell, Del Grosso, et al., 2010). In addition, initiatives may include a range of incentives—informational, financial, social, or public and professional recognition—to encourage participation and maintain engagement (see box All Our Kin).

Inputs and resources. Clearly, the available funding for the initiative will influence its design, including staffing levels,

The Infant–Toddler Family Day Care Network

The Infant–Toddler Family Day Care Network began as an effort to meet the need for infant–toddler child care in Northern Virginia. The network serves predominantly immigrant women who seek to become licensed family child care providers. New network members must complete 100 hours of preservice training workshops annually, including 12 hours of training on medical administration (with CPR and first aid) and other topics related to infant development (e.g., early brain development, professionalism, parent communication, and English as a Second Language) and 40 hours of mentoring with an approved network provider.

All Our Kin

All Our Kin in New Haven, CT, aims to achieve the dual goals of supporting high-quality child care and supporting the economic viability of child care as a business. It offers three primary services: (a) the Toolkit in a Box project, which takes individuals through the licensing process and provides training materials; books about the business aspects of providing care; health and safety materials; and books, blocks, a parachute, and articles about curriculum; (b) family child care mentorship, which provides support to new providers through 3 months of home visits; and (c) the Family Child Care Network, which provides training on a variety of topics, such as CDA training, support for National Association for Family Child Care accreditation, monthly network meetings, and an annual conference.

qualifications, and training, as well as the dosage of services. If an initiative is implemented without the necessary resources, it may not be delivered as intended or be able to achieve the anticipated results. Staffing is an essential aspect of initiative design because the staff members are the "face" of an initiative. Although we lack evidence of specific educational qualifications needed for initiatives that use different strategies, staff relational skills may be important for home visitors, consultants, and coaches, and workshop trainers and peer support group facilitators should have an understanding of adult learning principles (Paulsell et al., 2010; Porter, Paulsell, Del Grosso, et al., 2010). One study of family child care networks, for example, found that staff training had a significant relationship to higher quality care (Bromer et al., 2009). Staff training should also be considered in developing the logic model, especially if the initiative intends to use a published curriculum that requires it. Staff may also benefit from in-service training and supervision to strengthen their knowledge and skills and to improve their work with caregivers (Powell, 2008).

Future Directions

Our research points to three directions for strengthening initiatives to improve quality in home-based child care. One direction relates to the design of initiatives on the basis of intended outcomes, target population, content, and supports. The second direction relates to the potential of achieving specific outcomes for caregivers, children, and parents. The third is about the need for additional research.

Many of the initiatives that we identified used multiple strategies, combining a primary strategy of training workshops or home visiting, for instance, with distributing materials. A more systematic approach might be to create a continuum of services based on several criteria: level of service intensity, training or education, or interest in professionalism. One example is offering weekly home visits or consultation along with monthly workshops for family child care providers and peer support groups for family, friend, and neighbor caregivers. Another example is offering support for a CDA or credit-bearing courses for family child care providers who are interested in enhancing their professionalism; still another example is offering peer support groups for those who may not be interested in child care as a career.

Another option for combining services is tailoring services to individual caregivers' needs. This approach consists of offering a core service, such as training workshops, with a range of other services, such as grants, materials, peer support groups, and even home visits, depending on the caregivers' interests.

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Initiatives may be able to produce effects on caregiver knowledge and skills.

Although all of the strategies for home-based child care initiatives aim to improve quality, they vary in their potential to produce effects on caregivers' knowledge, skills, and practices that can positively influence child and parent outcomes. To a large extent, this variation is related to the intensity of service delivery and the degree to which these services can be individualized to meet the interests and needs of caregivers. We suggest that the eight service delivery strategies (delineated in Table 1) can be categorized depending on these characteristics.

Two strategies—home-based technical assistance and professional development—have a high potential for intensity and individualization. Home-based technical assistance initiatives can offer frequent home visits for a long period, such as a year. These visits can provide in-depth content, and because the consultant, coach, or home visitor uses strong relational skills one on one with a caregiver, they can be tailored for individual needs. Likewise, a professional development initiative may provide multiple courses with in-depth content from which the caregiver can choose. Each of these strategies can enhance the likelihood that caregivers' new knowledge and skills will be translated into practice, a necessary precursor for producing positive child outcomes.

We suggest that training through workshops, peer support, and Play and Learn have a moderate potential for intensity and individualization. Typically, initiatives that rely on these strategies offer content through a limited set of group activities. Some workshop initiatives provide a single session or a short series; Play and Learn and peer support may not require regular participation. The initiative content may not correspond to the individual interests of the caregivers because it is delivered to the group as a whole.

Learn More

Supporting Quality in Home-Based Child Care Reports
www.acf.hhs.gov/programs/opre/cc/supporting_quality/index.html

Supporting Quality in Home-Based Child Care
www.researchconnections.org
For products from the *Supporting Quality in Home-Based Child Care* project, as well as many of the studies cited in this article

W. K. Kellogg Foundation
www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf
For a detailed description of a logic model, *The W. K. Kellogg Foundation Logic Model Development Guide* (W. K. Kellogg Foundation)

Bank Street College of Education, Institute for a Child Care Continuum
www.bankstreet.edu/iccc/toolkit.html
A Toolkit for Evaluating Initiatives to Improve Child Care Quality provides a framework for understanding and conducting an evaluation of child care quality improvement initiatives, a general description of summative and formative evaluations, and a set of generic evaluation instruments.

Child Care & Early Education Research Connections
www.researchconnections.org/location/13403
For information about existing measures of quality in early care and education, *Quality in Early Childhood Care and Education Settings: The Compendium of Measures* (compiled by Child Trends, Inc., for the Office of Planning, Research, and Evaluation Administration of Children and Families, U.S. Department of Health and Human Services)

In addition, it may not fit caregivers' learning styles unless the trainers, the facilitators, and the Play and Learn staff understand adult learning principles.

By contrast, grants to caregivers, materials and mailings, and mobile reading vans have low potential for intensity and individualization. These initiatives provide information—newsletters or children's books, for example—to caregivers. Interactions with staff are limited, and there is often little support from staff about how to use the information or the resources in practice.

Finally, additional research on strategies for supporting quality in home-based child care is essential for moving the field forward in improving the quality of child care for our nation's youngest and most vulnerable children. A full range of research and development activities—including research to specify models and potential adaptations for different populations of caregivers, assess feasibility of implementation, develop and test fidelity standards, describe implementation and outcomes, and assess the effectiveness of well-developed models—is urgently needed. The findings from this project, coupled with future research, can contribute to the creation of initiatives with promise for improving quality in home-based child care by supporting the development of well-specified initiatives grounded in detailed logic models that link services to expected outcomes; adapt initiatives to meet the needs of this highly diverse group of caregivers; and identify the strategies, dosage of services, and staffing configurations needed to improve quality, support caregivers and parents, and promote children's optimal development in home-based child care settings.

Toni Porter, *MA, is the director of the Institute for a Child Care Continuum at Bank Street College of Education. She was the principal investigator on the Supporting Quality in Home-Based Child Care project, as well as a 3-year federal Child Care Bureau study of initiatives to improve child care quality. She has also conducted several studies of family, friend, and neighbor child care, including research on the interests and needs of these caregivers and initiatives to support them.*

Diane Paulsell, *MPA, is a senior researcher and an associate director of human services research at Mathematica Policy Research with expertise in early education, child care, and employment programs and policies for low-income families. She directed Supporting Quality in Home-Based Child Care, a project funded by the Office of Planning, Research, and Evaluation, Administration for Children and Families, to identify promising strategies for supporting home-based child care providers who serve children from low-income families.*

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"Who Says What Is Quality?"

Setting Quality Standards for Family Child Care

KATHY MODIGLIANI
Family Child Care Project
Arlington, Massachusetts

"Who says what is quality?" This important question was asked by a family child care (FCC) provider at the beginning of a project to develop a new accreditation system for the National Association for Family Child Care (NAFCC). Indeed, who should set the quality standards for child care?

Twenty years ago the answer would have been "the experts," the recognized researchers and early childhood professional leaders. But few of these experts were very familiar with FCC. And most of them represented the U. S. cultural mainstream, even though FCC is our nation's most culturally diverse form of early education and care.

In the mid-1990s, every existing assessment instrument for home-based child care programs had been developed by researchers who simply modified an instrument they had already designed for child care centers. There was an uneasy sense in FCC circles that none of these instruments truly captured the special and surprisingly different nature and unique opportunities of home-based care. For example, they did not assess the way the provider works with the mixed-age groups of children that are found in most homes, nor the way that the older and younger children interact with each other. There was little recognition of the challenges and opportunities resulting from a single caregiver working alone, nor for a child care environment that was shared with the provider's own family. Many people in the FCC field believed that the comfortable informality and "homey-ness" of a home is ideal for very young children, compared to the institutional feeling of the infant and toddler rooms in many child care centers. But the field needed a definition of quality and a mechanism to motivate providers to implement it.

The Family Child Care Project (FCCP) at Wheelock College in Boston, with the support of the NAFCC Board, wanted to design an assessment to take into account the views of the providers themselves and the families they served. Further, we wanted to consider cultural differences in child-rearing values and diverse ways that a caregiver might be able to achieve the desired outcomes. Who says that mainstream early education values are the only ones that can result in benefits for children?

The Family Child Care Accreditation Project

For these reasons, the (FCCP set out to design quality standards for FCC "from scratch." In 1995, we were funded to design a new accreditation system for NAFCC, the professional association for home-based providers (parallel to the National Association for the Education of Young Children [NAEYC], but much smaller). The FCCP launched the 4-year Family Child Care Accreditation Project (the Accreditation Project) with funding to study how diverse FCC providers and parents, as well as researchers and other experts, defined high quality in home-based child care. The Accreditation Project set out to develop our own quality standards to capture the characteristics that promoted children's

Abstract

This article tells the story of the 4-year consensus-building process to design quality standards for the field of family child care. Working with the National Association for Family Child Care, the Family Child Care Project at Wheelock College was funded to create an accreditation system for home-based child care programs using innovative methods to gather information from providers and parents as well as from experts in the field. The author describes conflicts that arose between the values of providers and parents and the research findings, and their resolution; some of the differences that emerged among cultural groups and how the project chose to reconcile differences and reach consensus; and how the quality standards were developed into an accreditation assessment.

development and well-being while meeting the needs of their families. Later we would develop instruments to reliably assess these standards and procedures to administer the accreditation.

Careful attention to defining FCC quality was important for several reasons. Most trainers and policymakers, as well as providers and parents, had only vague notions of what high quality in home-based care could look like—we heard comments like "I never thought about the idea that there could be quality in *family* child care!" The goals of the Accreditation Project were to:

- Define standards of quality for the field of FCC,
- Promote providers' self-assessment and quality improvement,
- Help parents and policymakers recognize high-quality programs, and
- Serve as a cornerstone in state professional development systems.

In hindsight, one can add two more benefits that were gained by having clearly defined quality standards:

- Define concrete goals for training, coaching, and mentoring; and
- Earn the respect of other early childhood professionals and policymakers who tended to see FCC as the poor stepchild of child care.

Developing the Standards

My colleague Juliet Bromer and I identified four stages of work needed to develop the standards: gathering information, analyzing the information, resolving conflicts and reaching consensus, and converting the quality standards into an assessment system.

Stage 1. Gathering Information

Over the 4-year project, we gathered information from three sources: relevant research, invited Community Workgroups, committees of national and state/community-level experts, and a paper-and-pencil survey. We paid special attention to cultural differences in child-rearing values.

REVIEW OF RESEARCH AND BEST PRACTICE

First, at Wheelock College we began compiling possible standards from the research literature in child development, best practices in early childhood education, health and safety, cultural differences in child-rearing values, and small business administration. We had lengthy interviews with leading experts in particular areas of interest, such as child development, teacher education, cultural sensitivity and respect, health and safety, business practices, and public health and pediatrics.

COMMUNITY WORKGROUPS

To gather authentic and original information from the field to complement, supplement, and perhaps contradict the findings from research and best practice, the Accreditation Project devised a method to hear from FCC providers, parents, and others in their communities. We circulated a request for proposals for Community Workgroups of 8–12 people who would commit to holding four meetings over a 2-year period. The request stated that selection preference would be given to "diverse groups that can speak for under-represented voices in FCC," without specifying what we meant by these terms. People were surprisingly interested in helping with this process: The task struck a chord, and the applications poured in.

We selected 52 Workgroups involving nearly 500 people. Participants included FCC providers, parents, support agency staff members, and other community professionals. The Workgroups were categorized as all White, all Black, all Spanish-speaking, or mixed in race and culture. There were several kinds of heterogeneous groups including one that included FCC providers, a licensing staff member, resource and referral agency staff, local college professors, and their NAEYC affiliate. Participants lived in urban, suburban, or rural communities across the country. Thanks to the outreach methods in circulating the request for proposals, the resulting groups slightly over-represented Spanish speakers and African-Americans.

Each Workgroup had a facilitator who was paid a small sum to document the group's responses to each of four tasks: one focus group to define FCC quality, another to brainstorm possible accreditation procedures, and two rounds of commenting on successive drafts of the standards.

Facilitators received brief but effective information on how to conduct focus groups. They tape-recorded the conversations or took careful notes and wrote detailed reports of their findings, for which they were paid $100. Pilot research revealed that most people had trouble answering an abstract question such as "How would you define good quality in child care?" So the focus groups asked more specific questions, such as "If a friend or family member asked you what to look for in child care for their baby, what would you say?"

Despite the minimal funding, most Workgroups were enthusiastic and welcomed the opportunity to contribute to the cause. Of the 52 groups, 48 made meaningful contributions to the standards and procedures. As described in the section Thematic Analysis of the Focus Groups below, the central organizing structure of the new standards emerged from these focus group findings, as did a wealth of other useful data.

Photo: Marilyn Nolt

Many people believe that the comfortable informality and "homey-ness" of a home is ideal for very young children.

PROJECT COMMITTEES

Two committees were convened to add additional expertise. A Steering Committee of leading national experts came together to suggest standards, critique the first two drafts of the new standards, and help us think about how to position NAFCC accreditation within the wider field of early childhood professional development. A larger Advisory Committee assembled diverse provider leaders, community agency staff, and other community-based experts who had been working with FCC quality improvement. These two committees responded to successive drafts of the standards and procedures. The Advisory Committee, which met at three national conferences over 2 years, was particularly useful in struggling through to consensus wherever conflicts arose over the standards. Both committees provided key publications and contributed suggestions for standards in their areas of expertise.

Stage 2. Analyzing the Information

Analysis of the data consisted of three steps: a thematic analysis of the focus groups, a survey to rate the importance of proposed standards in the first draft and suggest ways to improve the wording of standards, and consideration of how to respect diverse cultural values while setting standards to apply to all FCC programs.

THEMATIC ANALYSIS OF THE FOCUS GROUPS

The thematic analysis of the first focus group to define FCC quality yielded the fundamental structure that framed the outline for the new accreditation standards:

- Relationships
- The Environment
- The Activities
- Developmental Learning Goals
- Safety and Health
- Professional and Business Practices

This organization has carried through until today, except that "The Activities" and "Developmental Learning Goals" have been integrated into one section because their content areas overlapped. The next few paragraphs describe some issues that were identified by the Community Workgroups.

A fairly clear consensus emerged immediately, with diverse respondents agreeing that the most important characteristic of a high-quality FCC program is "a warm, loving, nurturing provider." But this imperative posed a potential problem. The sense among researchers at the time was that traits such as "warm," "loving," and "nurturing" were considered too subjective to be measured with reliability.

On the other hand, recent research findings in several areas including early brain development, resiliency, and the prevention of violence all argued for the importance of sensitive, responsive relationships for children's well-being as well as for their learning. At the time, the National Research Council's study—later published as *From Neurons to Neighborhoods* (National Research Council & Institute of Medicine, 2000)—confirmed the centrality of nurturing relationships as the foundation and context for children's learning. We decided to define high-quality relationships and then to write the most objective measures we could for this dimension and see how these measures fared. See the box Selected Quality Standards Emerging From the Research for a few examples.

Several of these relationship standards were subsequently used by the research firm Abt Associates in Cambridge, Massachusetts, with "good inter-rater reliability" (C. Creps, personal communication, May, 2001). Unfortunately, there has been never been a major research study that has been able to test the reliability of NAFCC accreditation because there have never been enough accredited providers in a study sample.

THE "KITCHEN SINK" SURVEY

The first draft of the quality standards was compiled from the hundreds of possible standards suggested by the literature, the focus

Selected Quality Standards Emerging From the Research

Following are a few of the quality standards that emerged in combining the research and the focus group findings. When the quality standards were too general or abstract to be observable, we later developed objective observer standards that could be assessed with reliability—they are indented and marked OS.

Relationships

1.1 The provider cares about and respects all the children and is committed to helping them develop to their full potential.

1.2 The provider shows affection to children through a gentle touch, kind words, and/or a special look. The provider holds babies frequently.

1.4 The provider seems to like children and to enjoy being with them.

OS 2.1 The provider shows interest in what children say and do and listens attentively to them most of the time.

OS 2.2 The provider responds frequently to children's language and babies' vocalizations.

OS 2.3 The provider has conversations with each child.

OS 2.4 The provider shows affection to each child in some way.

OS 2.14 The provider holds or carries babies frequently, depending upon the babies' individual preferences.

1.20 The arrangement of space and use of materials are balanced to meet the needs of both the child care program and the provider's family.

The Environment

2.1 The areas of the home used by children are welcoming and friendly, appearing like a family home, a small preschool, or a combination of the two. [That is to say that a high-quality FCC environment does not have to look like a little preschool.]

2.8 Outdoors, the play area has open space for active movement, some play equipment and materials, and places for open-ended explorations. [That is to say that the home does not need to have a traditionally furnished play yard—it does not even need to have any yard if there are other possibilities such as a park nearby. This standard accommodates urban dwellings that do not have back yards.]

Developmental Learning Activities

3.13 The provider takes advantage of and builds upon the many natural learning experiences and "teachable moments" associated with daily life in a home.

3.17 The provider usually maintains a consistent sequence of daily events, while the flow of activities is adapted to the individual and developmental needs of each child and the changing group.

3.67 Children learn math and science concepts in the context of every-day activities, such as setting the table, preparing food, sorting the mail, cooking, gardening, and playing games....

3.74 If there are children age 3 and older, the provider values children's work by displaying some of it (such as on the refrigerator or closet doors, in photo albums, scrapbooks, portfolios, ...). [In other words, children's work does not have to be displayed on the walls in the family's living area.]

3.80 If children watch television or videos, the provider limits their viewing time to no more than 1 hour per day and one full-length movie per week. Children under 2 are not encouraged to watch television or videos. Alternate activities are available for all children.

OS 3.24 Television, video, and DVD use is limited to no more than 1 half hour during the observation [4–5 hours]. Children under 2 are not encouraged to watch television or videos. Alternate activities are available for all children.

For the complete list of today's NAFCC Accreditation standards, see http://nafcc.net/index.php?option=com_content&view=article&id=289&Itemid=325

The National Association for Family Child Care (2005b). Reprinted with permission.

groups, and consultations (we called it the "Kitchen Sink Draft" to acknowledge that it was a hodgepodge). We developed this draft into a survey for respondents to rate whether each of the possible standards should be "required" or was "very important," "somewhat important," or "not important." Then we asked the respondents if they could re-word the standards to improve their meaning or clarity . We mailed the survey to approximately 800 people including the above Workgroups and committees. Approximately 400 complete responses were returned.

Again we were delighted by the quality of information obtained with these rather unconventional methods. Most respondents thought we had too many standards in the sections on Activities and Developmental Learning Goals (Juliet and I were both ex-teachers steeped in the nuances of NAEYC theory and practice). We consolidated many detailed standards in curriculum areas into just a few. See the box Examples of Cultural Differences in Child-Rearing Values for other feedback from this survey.

The approximately 16,000 suggestions for how to reword the standards provided invaluable feedback. Thanks to computer sorting we usually had a manageable 5 to 15 suggestions for the unsatisfactory standards. Typically we learned that people did not like a particular term or phrase and usually supplied better wording in their suggestions. Also, the suggestions identified jargon that professionals took for granted and helped to identify the words that nonprofessionals use to describe a particular quality.

RESPECTING CULTURAL DIFFERENCES IN DEFINITIONS OF QUALITY

Culture may be defined broadly as the values, beliefs, behavioral patterns, and traditions of a group. Culture evolves constantly, and often it is unconscious, as is said, as invisible to people as water is to a fish. We were determined to identify cultural differences in child-rearing values and to write standards that permitted a broad range of practice in the support of desired outcomes.

There were enough African-American and Latino respondents in the survey to permit a statistical analysis of the differences in importance ratings among those groups and the White respondents. Compared to Whites, both Latinos and African Americans thought the first draft of the standards placed too much emphasis on each individual child, while they gave more importance to standards pertaining to the group of children and their relationships with each other. They also gave more importance to standards related to involvement in the neighborhood and community. The literature about cultural differences in child-rearing values indicates that many—probably most—cultures around the world value interdependence in contrast to the mainstream U.S. emphasis on independence. We were guilty of this ourselves in the first draft. Fortunately, the survey results suggested eliminating the phrase "each individual child" from several standards and adding more emphasis on the children cooperating, empathizing with, and taking care of each other (see box Selected Quality Standards Emerging From the Research).

PHOTO: KIWI STREET STUDIOS

The most important characteristic of a high-quality family child care program is "a warm, loving, nurturing provider."

Although patterns of variations are found across cultural groups, it is important to recognize that there may also be significant value differences within one subgroup and even within one family. Further, an individual may value both sides of a dimension—for example a provider might value helping children become independent by teaching self-help skills and individualizing activities while also building interdependence, teaching children to empathize with and take care of each other.

To bring the concept of value differences to a concrete and meaningful level, providers in various conference sessions and meetings were asked to identify value differences they had observed among families they had known. Frequently they began by saying that the families in their programs were culturally homogeneous (usually it turned out that they were focusing on race), but often they changed their minds by the end of this exercise. See the box Examples of Cultural Differences in Child-Rearing Values.

EXAMPLES OF CULTURAL DIFFERENCES IN CHILD-REARING VALUES

- Academic teaching (e.g., phonics, math) versus child-directed play and social skills
- Breast versus bottle feeding
- Caregiver's name (Ms. or Mrs., first name, or Auntie)
- Child's role in the family
- Cleanliness and hygiene
- Competition versus cooperation
- Discipline—strict or permissive, physical punishment, shaming, talking and explaining
- Eye contact
- Food—what is appropriate for children, religious restrictions, using food as a reward, natural versus "junk" food
- Gender issues—dress-ups, role-playing, appropriate chores
- Holding and carrying a baby versus placing unrestricted on the floor vs. cradle board or other restraint
- Holidays—what and when to celebrate
- Lifestyle, family composition
- Manners
- Messy activities
- Privacy around toileting
- Religion—prayers and religious teaching or not
- Schedule—predetermined versus flexible
- Showing affection to children—amount and style
- Storytelling, the role of stories in teaching
- Talking about human bodies, sex
- Toilet training timing and techniques
- Tone of voice—loud or quiet
- Use of pacifiers, age of weaning

Stage 3. Resolving Conflicts and Reaching Consensus

The FCCP used the information about value differences to re-examine the draft standards. We could easily accept diversity of practice in the use of storytelling or pacifiers, and set no standards in such areas. But conflicts arose in other areas where there was compelling research to argue that one approach was better than others.

WHEN THE RESEARCH DISAGREED WITH RESPONDENTS' OPINIONS

The review of the research forced us to move beyond cultural relativism in many cases. Warily, we took a stand that some

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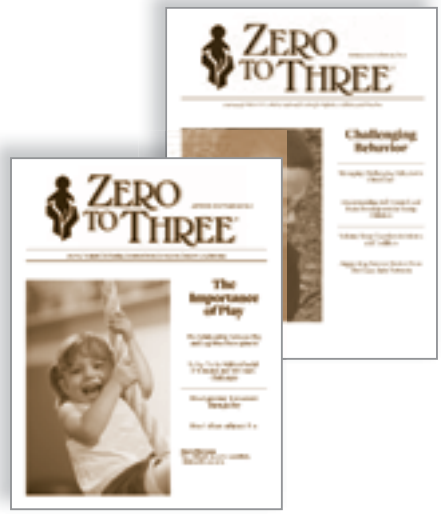

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cultural practices were better than others from an informed perspective. For example, in weighing the various approaches to discipline, we decided that the research was clear on the benefits of positive guidance versus punishment and built consensus around the wording: "No form of physical punishment or humiliation is ever used. The provider does not criticize, shame, tease hurtfully, threaten or yell at children and is not physically rough with the children" (NAFCC, 2005b, p. 16). Providers who come from cultures that believe that shaming or teasing should be used to correct misbehavior must learn and implement more positive approaches in order to become accredited.

A related area in which our interpretation of child development research trumped cultural tolerance was in toilet learning timing and techniques. Here we emphasized children's developmental readiness and providers and parents working together, restricting the range of practice in line with the discipline guidelines: "If a child is learning to use the toilet, parents and the provider agree on the toilet learning approach based on the child's developmental readiness, not on age. The process is free from punishment or power struggles" (NAFCC, 2005b, p. 15).

In some cultures the open expression of emotions is valued, while in others controlling one's emotions is desired. Here we went with the research that supported children's paying attention to what they are feeling and learning to express their feelings and their needs to others.

In other areas we chose a "both-and" rather than an "either-or" solution. We conceptualized an idea we called "the diversity of quality" and "many right ways" in which providers could range in their emphasis of a particular standard from 25% to 75% of the time—for example, they could lean toward interdependence or independence, but they couldn't ignore the other end of the continuum. Every provider needs to pay attention to, show affection to, and provide appropriate activities for each individual child, while also building the sense of the group of children and teaching cooperation, sharing, taking turns, empathy, and taking care of each other.

WHEN THERE WAS NO OBVIOUS SOLUTION

In the process of building consensus around the standards, we came to a point where we had a list of standards that were still controversial among our Community Workgroups and survey respondents with no obvious solution or compelling research base.

For example, best early childhood practice decreed that the adult should sit down with the children at meal times. But providers told us loudly and clearly, "No Way!" Their reasons were convincing. This became a clear example of how the situation in FCC is different from center-based programs. In most centers there is a cook or a second adult helping with the food, or the children bring lunch boxes from home. Most FCC providers supply children's meals and snacks. Also, the mealtime needs of babies, toddlers, and preschoolers are different, and accommodating mixed-age groups is more challenging than it is with the narrower age spans in most center classrooms. Why was it considered best practice to sit at the table? Could providers achieve a more basic goal (such as quality interactions with the children during meals) while not requiring them to sit down during meal times? In the end the standard simply said "There is pleasant conversation during meals and snacks."

Photo: ©iStockphoto.com/Quan Yin

Recent research findings argued for the importance of sensitive, responsive relationships.

Many providers did not like our initial approach to minimize children's television watching. They argued that letting the children watch television was the only way they could prepare lunch. After much discussion, the quality standard permitted up to 1 hour of television a day, as shown in the box Selected Quality Standards Emerging From the Research. This was a big improvement for some providers; others choose not to use television at all as the highest form of quality.

Many providers thought that it was unnecessary or even silly to read books to babies and toddlers. Because the research was clear, the standard remained. Another standard many providers resisted was the requirement to keep children less than 3 years old in sight at all times, but the excellent standards of the National Resource Center for Health and Safety in Child Care and Early Education (2002) offered compelling evidence that the need for safety was worth the providers' diligence.

With two additional drafts of the standards, we were able to reach consensus among the Community Workgroups and the Advisory and Steering Committees on the new quality standards. After all the back and forth, brainstorming, and arguing, the participants had come to a remarkably calm meeting of the minds and had truly captured the nature of quality in FCC.

Stage 4. Developing the Observation Standards and Procedures

Finally we were all satisfied with the quality standards, and the next step was to transform them into an assessment. The central part of the accreditation was to be an assessment by a trained observer. The center-based accreditation sponsored by NAEYC provided inspiration (NAEYC, 2007). Many of our community-based advisors were involved in supporting NAEYC accreditation and suggested similar strategies that were working well. NAEYC generously encouraged us to adapt their procedures as we liked, and in the end NAFCC's self-study and observation procedures were strongly influenced by NAEYC's.

Because every quality standard needed to be assessed in some way, we developed an *Observer Workbook* (NAFCC, 1999 [current edition 2005a]), compiling the standards that were observable. As described in the box *Selected Quality Standards Emerging From the Research*, some of the quality standards were too general or abstract to be observable. These were revised into observation standards that were objective in language, as shown in the

Photo: Marilyn Nolt

Providers argued that letting the children watch television was the only way they could prepare lunch.

indented examples in the box. Most of the quality standards were already written in concrete, objective language and were simply repeated in the *Observer Workbook*.

Some of the quality standards that addressed the experiences of parents and families were converted into a parent survey, to be completed by at least 80% of the families enrolled in a program. Other standards pertained to the provider's thinking and planning—these were assessed through scripted questions in the observer's interview with the provider at the end of the observation visit. A few standards that could not be reasonably assessed in any other way were made into Self-Certified Standards—these were added to the end of the providers' Self-Assessment, where they rated themselves on exactly the same standards that the observers used. And finally, the NAFCC national office assesses providers' licensing status, criminal records, and other written requirements.

Learn More

California Tomorrow
www.californiatomorrow.org/publications/print/index.php?cat_id=1
California Tomorrow worked to shape early childhood education and school readiness efforts to meet the needs of diverse communities. The organization ceased operations in December 2010 but their Web site offers resources and publications available to download.

To develop the numerous procedures, we compiled a first draft and returned to the consensus-building process. It proved to be much more straightforward and less complicated than when we were working on the quality standards. One of the key aspects of the final procedures that originated from this process is the numerous ways that respect and friendliness were built in to the procedures. Observers are required to have familiarity with FCC as well as knowledge of child development and early childhood education. An intensive 2-day training teaches them to write clear, specific, nonjudgmental observations to document the standards. Each standard is scored as "fully met," partially met," or "not met," giving evidence for their score and explaining exactly why any standard is scored as less than fully met. Additional procedures were developed during the pilot study and others have been added over the years as new situations and possibilities have presented themselves.

A year-long pilot study was conducted in four diverse communities across the country and at a U. S. Air Force base. The pilot study helped us fine-tune the procedures, adding considerations for the reality of daily life in FCC.

Launching NAFCC's New Accreditation

In 1999, NAFCC's new accreditation was introduced across the nation and throughout the Air Force. (The Army began to support it soon thereafter, as did the other branches of the services in the following years.) NAFCC and the FCCP have been gratified to learn that the standards were universally well received across all groups and, in fact, they have held up over the years. The few modifications that have been made in subsequent editions of the standards reflect new knowledge about early development, such as lead safety and putting babies to bed on their backs to reduce the risk of Sudden Infant Death Syndrome.

NAFCC Accreditation Today

Providers in all 50 states, the District of Columbia, and U.S. military abroad are accredited by NAFCC. If you look at a map of the United States with stars for every accredited home, you will see clusters where there are projects supporting providers through accreditation. The entire process is available in Spanish as well as English. Although individual providers may go through the process on their own, most benefit from training and support around the standards, the process, and the paperwork. Similarly, although some providers pay the full fees, most require some financial support.

Why Seek Accreditation?

Why would a provider seek accreditation today? They may want to:

- "Be the best that they can be" and challenge themselves to meet these high standards, or to keep up with or compete with their peers who are becoming accredited.
- Get paid the higher reimbursement rates or subsidies for quality child care as recognized by their state's quality rating system;
- Qualify for tax credits or deductions granted by some states through the Dependent Care Tax Credit, or for lower liability insurance rates granted by come companies;
- Market their program to parents looking for high quality; and/or
- Take advantage of training opportunities and material incentives offered by accreditation support initiatives.

The Need for Incentives

Unfortunately, many providers ask "Why should I bother?" If they do not have one or more of the incentives mentioned above, there may be no good answer for them beyond the personal, intrinsic satisfaction. From unpublished interviews with providers who have gone through the process, I am convinced that accreditation motivates almost everyone to improve their practice, often in very significant ways. They improve their curricula, pay more attention to details, focus on what the children are doing (as a means to add a form of outcome measures to the Observation, we included several standards about what the children are doing). But such improvements can be invisible to everyone but the providers and the children in their programs. For accreditation to grow, providers need incentives as well as training and sometimes coaching.

Looking toward the future, limited funding and the lack of an infrastructure at the state and community levels continue to present challenges. The goal is to build NAFCC affiliates in every state that can help providers through the process and can screen and train observers. These two functions cannot be performed at the national level, so it is imperative that states become involved to increase providers' participation and support.

Preparing for and maintaining accreditation has proven to be one of the most effective strategies for child care quality improvement in homes as well as in centers. Given the large numbers of young children in FCC—and the proportionately higher numbers of infants and toddlers, those from low-income families and immigrant families, and those from rural areas

where there are few available centers—greater resources need to be shifted to this important sector of our child care delivery system.

Kathy Modigliani, *EdD, leads the Family Child Care Project in Arlington, MA. She has studied FCC for 25 years, visiting more than 400 providers' homes and evaluating more than 50 community FCC initiatives. At Wheelock College, she led the development of the National Association for Family Child Care (NAFCC) Accreditation system. She has consulted with numerous national organizations, foundations, advisory boards, and governmental agencies; conducted research projects; taught at several colleges; and designed and implemented trainings for NAFCC, foundations, community Resource and Referral Agencies, and family child care networks.*

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Lessons Learned From Home Visiting With Home-Based Child Care Providers

LISA A. McCABE
Family Life Development Center, Cornell University

SHIRA M. PETERSON
AMY C. BAKER
Children's Institute, University of Rochester

MARSHA DUMKA
Rochester Childfirst Network, Rochester, New York

MARY JO BRACH
Family Resource Centers of Crestwood Children's Center, Rochester, New York

DIANA WEBB
Rochester Childfirst Network, Rochester, New York

Jenny[1] adores young children. When her own children were young, Jenny worked as a family child care provider and thoroughly enjoyed spending her days caring for and educating young children. When her own children got older, Jenny wanted to try something new; working as a home visitor for family child care programs was a perfect fit. Jenny loves the sight of three children jumping up and down exclaiming, "Jenny, Jenny what did you bring in your bag today?" Recently she brought pretend fire hoses made from paper towel tubes with shiny blue crepe paper strips taped to the end and played firefighter along with the children. She talked with Mary, the family child care provider, about how dramatic play can foster the children's self-regulation skills and how Mary can extend the play through books, discussions about fire safety, or a trip to the local fire station. As she left the home, Jenny hugged each child knowing that she has done something to help them grow and learn.

Deanna loves her job as a family child care home visitor. She feels like she really connects with each of her providers and is welcomed almost like a family member when she visits. She and the providers talk about what has happened since the last visit and then explore ways to expand the children's learning. She models activities with the children and likes the fact that the children get excited to try new things. Sometimes, providers share challenges they are experiencing. One provider was struggling with parents who did not pay their fees, causing the provider to fall behind on her rent. Deanna feels that she can support providers through these difficult challenges by listening, asking important questions, and offering information or resources. Deanna finds her work rewarding because she knows she's making a difference in the lives of the providers and the children in their care.

Jenny and Deanna, working as home visitors for home-based child care providers, share the same job title, but bring different strengths and passions to their work. One focuses more on the children, while the other focuses more on the provider herself. One approach isn't better than another. In their own ways, both Jenny and Deanna are supporting the provider and the children in her care. But their diverse experiences and perspectives reveal the complexities involved in home visiting programs. Their stories of working with home-based child care providers in upstate New York illustrate some of the successes and challenges experienced during home visitation and can inform other communities that may be implementing (or wish to implement) similar programs. These

[1] All names have been changed to protect the identities of program participants.

Abstract

Caring for Quality and Partners in Family Child Care are home visiting programs designed to improve the quality of home-based child care. This article describes the experiences of two different home visitors to demonstrate how programs such as these can help providers improve the overall quality of care, increase children's development, and lead to trusting relationships between providers and home visitors. Home visiting was less successful at promoting long-term changes in health and safety practices. The authors discuss the challenges that arose in assessing and supporting social–emotional development in young children, and how providers' "readiness to change" relates to home visiting outcomes.

experiences may also help shape state-wide quality improvement efforts, such as the Quality Rating and Improvement Systems now operating in 25 states (Tout et al., 2010).

The Value of Home Visiting

Home visiting programs for families have a long history with positive outcomes for both children and their parents (Daro & Cohn-Donnelly, 2001; DuMont et al., 2006; Kahn & Moore, 2010; Love et al., 2002; Olds, Sadler, & Kitzman, 2007). In recent years, the home visiting model has been extended to home-based child care settings (Hoffman & Perrin, 2009; McCabe & Cochran, 2008; Paulsell, Mekos, Del Grosso, Banghart, & Nogales, 2006; Porter, Nichols, et al., 2010). This expansion reflects the fact that home-based child care is the most common out-of-home care arrangement for children less than 5 years old (Johnson, 2005; Susman-Stillman & Banghart, 2008) and thus represents a key context for young children's development. Yet, despite the prevalence of home-based care, many studies have documented the poor quality of care that is often provided in these settings (Bigras et al., 2010; Fuller, Kagen, Loeb, & Chang, 2004; Kontos, Howes, Shinn, & Galinsky, 1995; Porter, Paulsell, et al., 2010). For these reasons, the next generation of home visiting programs will likely be designed to include home-based child care providers who are offering formal and informal care for both related and non-related children in their homes. Although home visiting with families and home-based child care providers may be similar, home visits within a child care context require some adaptations to the home visiting model. Our aim is to relay the experiences, successes, and challenges in extending the home visiting model to home-based child care settings.

Family Child Care Home Visiting in Rochester, New York

Since 2002, Rochester, New York, has offered some form of home visiting to home-based child care providers, reaching more than 150 home-based child care providers (and more than 900 children) including registered providers; license-exempt family, friend, and neighbor providers; and group family child care providers (2 providers and up to 12 children). The programs developed out of community collaborations that included professionals with expertise in working with family child care providers, national and local funders, and researchers. Although the details of program structure and content vary, the programs all offer professional development, support, and materials to enrich the quality of the family child care homes.

In this article, we profile two of these community collaborative programs. In the Caring for Quality (CFQ) program, both registered and license-exempt family child care providers received two home visits per month for up to 1 year. During each visit, trained home visitors met with a provider in her home while she cared for up to 6 children. The 90-minute visits were based on the Supporting Care Providers Through Personal Visits curriculum (Parents as Teachers National Center, Inc., 2002), a version of the Parents as Teachers Curriculum for family child care providers. This curriculum includes visit plans and activities as well as resources for providers and home visitors on topics such as child development, health and safety, and nutrition. Home visits were guided by the Family Development Credential (Forest, 2003) empowerment approach to training front-line workers. At each visit, home visitors interacted with children and partnered with providers around a theme (e.g., dramatic play), provided related materials and a book, and offered support and ideas for implementing and extending the theme in between visits.

The Partners in Family Child Care (PFCC) Program, which was open to group family child care providers, offered individualized professional development services to improve child care practices. Like CFQ, the heart of the program involved up to 10 months of intensive home visits based on the Parents as Teachers Supporting Care Providers Through Personal Visits curriculum (2002). But the PFCC program placed special emphasis on children's literacy and social–emotional development and so included research-based material from the local Early Literacy Project (Children's Institute, 2003) and WestEd's Program for Infant/Toddler Caregivers (2003). Home visits included home-visitor provider consultations along with hands-on activities with the children and providers. Providers received materials and a children's book to accompany the activity, curriculum materials, and supplementary materials (e.g., parent handouts, screening information). Home visitors were also trained to assist providers in screening children using the *Ages and Stages Questionnaire* (Bricker & Squires, 1999); *Get Ready To Read!* (Whitehurst & Lonigan, 2001), preschool children only; and the *Devereux Early Childhood Assessment – Infant/Toddler* (DECA-IT ; Mackrain, LeBuffe, & Powell, 2007). Home visitors referred providers to existing community services as needed.

Both programs also included small group meetings that offered training in topics such as screening, literacy, and child development. In addition, group meetings provided a forum in which providers could problem-solve as a community of learners to support each other in making improvements in child care quality. See box Home Visiting Program Evaluation Design for a summary of the evaluation efforts.

Home Visiting Successes in Family Child Care

The potential successes for home visits with home-based child care providers are many. Below are some examples of the positive ways two home visiting programs in home-based child care settings resulted in positive outcomes for providers, children's development, and the quality of care provided in these homes.

Increasing the Quality of the Environment

When Deanna first began visiting Charlene, the children spent a lot of time running around the living room. Deanna found this behavior stressful and wondered how Charlene could put up with it. Deanna noticed that although there were many toys, they were stacked along the wall, making it difficult for children to see what was there. Deanna talked with Charlene and found she was stressed by the noise too and glad to brainstorm ways to make the toys more inviting for children. She stored some of the toys in

Home Visiting Program Evaluation Design

CFQ was formally evaluated with two waves of providers ($n = 74$) who completed the program and a comparison group of providers waitlisted for the program ($n = 23$). Independent researchers, who were unaware whether providers were CFQ participants or in the comparison group, conducted pre- and post-observations that focused on overall program quality as well as on health and safety practices. Providers and home visitors completed surveys about their experiences with CFQ.

PFCC included three waves of providers ($N = 80$) who completed the program. As of the writing of this article, data from two waves of providers was complete and the third wave was underway. Researchers observed participating providers at the beginning and end of the year, using measures of overall child care quality and early literacy environment quality. At both time points, researchers also screened two children in each home (one 1–36 months old, and one 36–60 months old) on assessments of social–emotional skills, early literacy, and overall development.

Photo: Emily J. Rivera

Creating a safe and healthy environment for children is a critical piece of providing high quality care.

a closet and arranged the others so they were easier to see. Since these changes were made, the children are engaged more and running less, and Charlene is happy for the peace and quiet in her home. Deanna is thrilled to have helped Charlene make this improvement to her program.

Deanna saw the problem of environment through the providers' eyes. Because of her regular visits to Charlene's home, she was able to get a good sense of what challenges might be present—in this case the potential stress associated with spending the day with children who are excited, running, and noisy in a small, indoor space. Deanna's experience highlights one of the benefits to home visits: the home visitor can tailor the visits to the specific needs of an individual provider. As a result, home visiting programs can result in significant increases across many different aspects of child care quality (McCabe & Cochran, 2008). By the end of the CFQ program, participating providers as a group showed an increase in global quality. These changes were most significant on quality dimensions such as children's language and reasoning, learning activities, children's social development, and adult needs (all measured by the *Family Day Care Environment Rating Scale*; Harms & Clifford, 1989). Providers in CFQ also demonstrated some increases on health and safety standards such as having working smoke detectors in place and washing hands before meals (measured with a health and safety checklist; Modigliani & Bromer, 2002). Providers' own assessments of their knowledge and skills before and after participation in the CFQ program also indicated that they had grown in areas such as understanding child development and knowing more about how to set limits with children. Finally, home visitor observations of provider changes give additional evidence of the program's effectiveness. For example, home visitors observed and described providers who were better able to meet the needs of individual children and had a greater understanding of the importance of play for young children's development and learning. Together, these findings highlight the diverse changes CFQ providers made to improve the overall quality of their child care programs, and they suggest that home visiting can be an important method for supporting providers to improve the quality of care provided in their homes.

Increasing Children's Literacy Skills

"Price check! How much does this cereal cost?" asked Jenny. Four-year-old Tasha called out, "Ten, please. It says so right here," pointing to a grocery store receipt, part of the kit of materials Jenny had brought to Vicki's family child care for this home visit focused on literacy-enriched pretend play. Two-year-old Nick had scribbled on pieces of green construction paper to make play money, and Vicki had provided empty boxes and cans for the merchandise. Vicki and Jenny played along as the older children acted out their roles as shoppers, check-out workers, and price checkers, while Vicki's assistant Kenisha held 9-month-old Tommy who looked on with interest. "Oh no, I can't carry all this food. What can I do?" asked Jenny. "I do it!" shouted Nick. "You can use my bag," suggested Tasha. "We'll all help," offered Vicki, as all the players helped pack the groceries into the canvas shopping bag.

The PFCC program made use of the Early Literacy Project curriculum (Children's Institute, 2003), a research-based program designed to encourage children's motivation and enthusiasm for learning about language and print in their natural environment. Home visits encouraged and stressed the importance of responsive adult–child relationships in fostering young children's development of the language, attention, self-regulation, cognitive, social, and emotional foundations that prepare them for later success in learning to read and write. For young children, these responsive relationships created opportunities to participate in meaningful spoken and written language activities as well as to engage in pretend and other forms of play, in order to foster verbal comprehension, phonological awareness, and concepts about print that orient children to the "ways with words" they will encounter in written texts in school.

In the PFCC program, home visitor observations and provider interviews documented qualitative improvements in providers' use of developmentally appropriate practices to foster children's early literacy development. One provider remarked, "I make sure I continually offer opportunities for the children to talk, tell stories, sing, write letters and words, use their imagination and creativity." Several providers made changes in their environment to support children's engagement with language and literacy, as one home visitor noted: "[The provider] had set up a cozy corner with a low shelf displaying books. Samples of children's writing were displayed on the wall at the children's eye level."

Children of providers enrolled in the first two waves of the PFCC program (the third wave is still being evaluated) demonstrated growth substantially above developmental expectations in both early literacy and overall development (Peterson & Weber, 2010). A major finding of the program was the significant gains on the *Ages and Stages Questionnaire* (Bricker & Squires, 1999), particularly in the areas of Communication and Problem Solving. On the *Get Ready to Read!* assessment (Whitehurst & Lonigan, 2001), 3- and 4-year-old children increased their scores substantially above developmental expectations, compared with norms for children the same age. Over the course of the home visiting program, children's average score increased from "making progress" to "has mastered many skills."

Home visitors and providers noticed remarkable developmental gains in the children during the program. One provider

commented, "[The children have a] longer attention span. During play the children rhyme and sing more. [They are] learning the letters in their name and other words." Another provider observed, "They are more creative in what they do and how they think. Some of the children talk more about their ideas." These literacy gains suggest that home visiting in particular can help providers make specific programmatic changes that benefit children's language and literacy development.

The Home Visitor-Provider Relationship

Deanna really enjoys her home visits with Maria, a family child care provider. Whenever she arrives for a visit, Maria enthusiastically welcomes her in. Lately Maria has been telling Deanna stories of her struggles with her own son who has been in and out of jail for the past few years. His 16-month-old daughter (her granddaughter) is living with her, and is part of the child care program, but her son is threatening to fight for custody. Deanna can see the effect this has on Maria's program. Maria is distracted and constantly worried that her son will show up unannounced to take his daughter. Deanna has supported her through this challenge by listening and asking questions. Now and then she is able to provide information about resources that might be helpful to the family.

One of Deanna's strengths as a home visitor is her ability to create a relationship that blends professionalism, empathy, and a true understanding of the unique challenges that can result when caring for children takes place in a provider's home. In this way, she serves not simply as a source of new information, but also as a supportive and trusted confidant. This strong connection between home visitors and providers was often talked about as one of the best parts of the CFQ and PFCC programs. For home-based providers, who often work in relative professional isolation, having regular visits by another person knowledgeable about home-based child care filled a void for them. When the program ended, many providers expressed interest in continuing precisely because they valued their relationship with their home visitors.

But the value of these strong home visitor–provider relationships goes beyond simply helping to reduce the feelings of isolation so common to home-based child care providers. This ongoing, trusting relationship enables home visitors and providers to tackle complicated issues that affect program quality and that would be difficult to address with other shorter, less-intense programs. Deanna's support and empathy for Maria's complicated situation with her son and granddaughter may have been one reason why Maria continued with the program, despite personal challenges (Korfmacher, Kitzman, & Olds, 1998). And, by being responsive to individual needs over time, home visitors like Deanna were able to help providers overcome significant obstacles and make improvements in their child care programs.

PHOTO: MARILYN NOLT

Responsive relationships created opportunities to participate in meaningful spoken and written language activities.

Challenges in Family Child Care Home Visiting

DESPITE THE MANY successes of home visiting in family child settings, significant challenges also emerged through these pilot home visiting programs. Below are some of these challenges, along with suggestions for how they can be addressed in future work with home-based child care providers.

Maintaining Health and Safety Quality

When Jenny first started visiting Monique, she noticed that the smoke alarm had no batteries in it and that some of the outlets were not covered. Jenny was alarmed. The two toddlers were in danger of getting seriously hurt. She was so concerned she brought Monique batteries and outlet covers within a week. Monique seemed grateful, but, 8 months later, Jenny saw that the batteries and outlet covers were missing again. When she asked Monique about the missing items, Monique seemed embarrassed and said, "Yeah, I needed the batteries for a toy and I took the outlet cover off to do some vacuuming and I forgot to put it back in." Jenny is afraid for the children and frustrated that Monique seems unable to make sure these safety precautions are in place.

Jenny acted so quickly because she was concerned about the children. Creating a safe and healthy environment for children is a critical piece of providing high quality care for young children. At the beginning of the CFQ project, home visitors expressed concerns that basic health and safety issues were not being addressed in many of the homes. Evidence from the initial home observations, where many providers scored in the "minimal" range on health and safety *Family Day Care Environment Rating Scale* subscale (Harms & Clifford, 1989), provided further evidence that this was an area for concern. As a result, in the first year of CFQ implementation, one entire home visit was dedicated to the topic of health and safety. In addition, home visitors addressed safety issues whenever it seemed relevant during other visits. At the end of the first year of CFQ, however, providers as a group did not seem to have made any progress. In post-CFQ observations, many providers still scored at the "minimal" level on the *Family Day Care Rating Scale*. In addition, despite some general increases in the number of "met" items on the Health and Safety Checklist, there were still many items "not met" on the day of observation.

During routine meetings with home visitors, health and safety issues were a common topic for discussion. Jenny's experiences were typical in that home visitors often found providers willing to make changes to ensure a safer and healthier environment, but these

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The home visitor can tailor the visits to the specific needs of an individual provider.

changes were not implemented consistently over time. In response to these challenges, home visitors in the CFQ program decided to change how health and safety issues were addressed in the home visits. For the second wave of participating providers, health and safety was integrated as a feature of every home visit. The hope was that providers would become more vigilant in maintaining health and safety practices on a regular basis. Unfortunately, this change did little to effect long-term changes in health and safety. At the end of the second wave of the program, providers still demonstrated "minimal" scores on the health and safety subscale.

These challenges suggest that although quick health and safety changes are easy to implement (e.g., children wash hands before a meal or smoke detectors have batteries), making sure the standards are implemented on an ongoing basis is much more difficult. It may be that by referring to health and safety in each home visit the message got "diluted." It is also possible that providers do not buy in to or take time to process the benefits of the many health and safety regulations imposed on them. Although the home visits profiled here have not been successful in helping providers to maintain consistent environments when it comes to health and safety, this issue has surfaced as a common problem that is also not likely being addressed by other forms of training currently available to providers. More work needs to be done to explore potential ways to help providers create and maintain a safe and healthy environment for young children.

Early Childhood Assessment

Jenny has been visiting Emma for 3 months and is getting to know how the children will respond to the activities she plans to bring each month. She has enjoyed the children's enthusiastic greeting and affectionate hugs, but today she saw something that disturbed her. One of the toddlers, Jaylene, pushed another child away when he came for a hug. Jenny has done some reading on attachment and she's taken a few workshops on infant–toddler development and she thinks this toddler may have unmet emotional needs but she isn't sure she's right and doesn't know how to raise the subject with Emma.

Home visitors like Jenny are generally good observers of children but they don't always know how to act on what they see. In an effort help her and children like Jaylene, the PFCC home visitors were taught to use the DECA-IT; Mackrain et al., 2007), a tool that assesses children birth to 3 years old for attachment/relationships, initiative, and (in toddlers) self-regulation. This one-page measure is designed for use by people who work directly with children, rather than by clinicians. Its purpose is to help practitioners identify problems and prevent them from becoming more serious.

The PFCC home visitors estimated that 25–50% of the children they saw had weak attachment relationships, challenging behaviors, or difficulty regulating their emotions. The hope was that DECA–IT (Mackrain et al., 2007) assessments would enable home visitors to help individual children through early identification of individual needs. In the long term, these assessments could also help to document the scope of early attachment issues and the need for broader systemic supports. The newly trained home visitors helped the providers while they assessed the infants and toddlers in their care by clarifying questions such as "Did the child show affection for a familiar adult?" and "Did the child seek attention when a familiar adult was with another child?" The caregivers' assessments took us by surprise: according to the caregivers, every child was on a normal trajectory. They stated that it was just a question of time until the children "grew out of" behaviors that home visitors viewed as problematic.

We had hoped that the DECA-IT (Mackrain et al., 2007) would become a starting point for conversations between the providers and the home visitors, but the home visitors said they didn't feel qualified to question the providers' assessments of the children. They didn't have enough depth of understanding of infant and toddler social–emotional development, and two 1-hour home visits per month provided little more than a snapshot of children's behavior.

These findings pointed to new directions for supporting children from birth to 3 years old: professional development for home visitors that is focused on infants and toddlers, access to behavioral consultants who can offer informed second opinions on individual children, and ease of access to community resources when additional supports are needed.

Readiness to Change

Deanna was feeling nervous about the home visit scheduled for the next morning. The last time she had gone to Renee's home, no one answered the door, even though she had confirmed the appointment the day before. On her previous visits, Deanna had very gently suggested ideas to improve the environment to make it more appropriate for the children, but it was apparent Renee never made any changes which they discussed. Deanna wasn't even sure why Renee had signed up for this program. It didn't seem like Renee was interested in learning anything new or changing her behavior at all. The next morning, Deanna was relieved that Renee was home and she could proceed with the visit. But when Deanna began to lead the children in a fingerplay, Renee started to leave the room. Summoning up her courage, Deanna walked over to Renee and quietly said, "This won't work without you—will you please join us?" After the activity, she reminded Renee that "I am here to work with YOU, not just with the children." Feeling discouraged and more than a little irritated, Deanna worried that this provider would never change her practices. Going to Renee's home seemed like a waste of everyone's time.

Deanna's favorite part of home visits has always been connecting with providers. So when Renee seemed uninterested in participating, Deanna felt especially frustrated. Her experience with Renee, unfortunately, was not uncommon in that many home visitors have attempted to work with providers who seem "resistant" to change. Home visitors

bring a wealth of knowledge to share about child development and best practices in child care, but this information will be useful only if the provider is ready to receive it. In reality, providers are likely to be in very different starting points in terms of their readiness to change. Some providers (like Renee above) may be uninterested or unconcerned about the effect of their behavior on children and have little internal motivation to learn about different approaches. Others may believe there is something they need to change, but they may feel overwhelmed to the point where new information only increases their stress level. In either case, providers may not readily participate fully in the home visits. In the CFQ program, about one third (34%) of providers were described by their home visitor as "not at all", "a little", or only "somewhat" engaged during the home visits, and these providers were, in fact, much less likely to demonstrate changes in their child care programs (McCabe & Cochran, 2008).

Individuals like these are said to be not ready to change. In other words, they lack the internal and external resources necessary to support meaningful and sustained behavior change (Peterson & Baker, in press; Peterson & Valk, 2010; Peterson, Valk, Baker, Brugger, & Hightower, 2010). The Transtheoretical Model of change, widely used in fields such as health behavior counseling and mental health services, provides a framework for understanding the typical stages experienced by individuals with regard to an intentional shift in behavior (Prochaska & Velicer, 1997). The stages of change (see Table 1), are often experienced as a spiral: it is typical for individuals to move back and forth through the stages over the course of months, weeks, or even within a single day.

Home visiting approaches that introduce information and focus on changing practices are likely to be ineffective for changing practices of individuals who are in the early stages of change. In the PFCC program, providers were rated by their home visitors on the *Stage of Change Scale for Early Education and Care 2.0* (Peterson, Baker, & Weber, 2010) at the beginning and end of the program, and their readiness to change was compared with their score on a measure of the child care literacy environment (the *Child/Home Early Language and Literacy Observation*; Neuman, Dwyer, & Koh, 2007). Data from the first 2 years of the PFCC showed that providers who were initially rated as being in the "contemplation" stage actually showed decreases in quality, whereas providers rated in the "ready to change" range showed small, but significant increases in quality (Peterson & Weber, 2010).

Photo: Emily J. Rivera

This curriculum includes resources for providers and home visitors on topics such as child development, health and safety, and nutrition.

Home visiting can incorporate research about readiness to change through two potential directions. One direction is to target certain interventions to people who are ready to benefit from them. For example, a home visiting program could limit eligibility to providers who are "ready to change," as assessed by the home visitor after an initial "getting to know you" period of one or two visits. Providers who do not appear to be ready to change their behaviors could participate in a different intervention, such as group meetings or classes that focus on raising awareness of areas providers might want to change. A second direction is to design home visiting programs that can be tailored to meet the needs of providers in all stages of change. This approach would require training home visitors in techniques that focus on the "why" rather than the "how to" of change when working with people who are not ready to change. One evidence-based approach for doing this is Motivational Interviewing, which focuses on helping the learner identify her values, develop confidence in her skills and abilities, and begin to create a commitment to meeting her goals (Rosengren, 2009). In addition to home visitor training, a tailored home visiting program requires structures of support for staff at all levels of implementation, including supervision of home visitors and appropriate organizational structures (e.g., timelines, goal-setting, and paperwork). Both targeted and tailored directions for home visiting have the potential to ease home visitors' frustration, increase program effectiveness, and create a better fit between home visiting programs and providers' readiness to change.

Table 1. Description of the Five Stages of Change

Stage	Description
1: Precontemplation	Not ready to make a change
2: Contemplation	Thinking about change, but overwhelmed by obstacles
3: Preparation	Ready to change
4: Action	Actively engaged in change
5: Maintenance	Maintaining change with vigilance

Source: Peterson, Baker, & Weber, 2010

The of Future Home Visiting With Home-Based Child Care Providers

In home-based child care settings, where studies often call into question their quality (Bigras et al., 2010; Fuller et al., 2004; Kontos et al., 1995; Porter, Paulsell et al., 2010), it is essential for programs to support providers in their roles as early childhood caregivers and educators. Home visiting represents one such promising effort. Across the two new home visiting initiatives described here, we see the potential for home visiting to increase the quality of care provided, to encourage positive gains in young children's development, and to nurture trusting home visitor–provider relationships within which complex problems can be addressed.

These positive outcomes were seen across diverse home-based settings, including more informal arrangements in which a grandmother is caring for her grandchild, regulated family child care settings, and more formal group child care settings that include assistant teachers and larger groups of children. Home visiting has the potential to positively impact all of these home-based child care settings, and in turn, support the many children and families who use this type of out-of-home care. The development and funding of home-visiting initiatives would help to ensure that young children are receiving high quality care in home-based child care settings.

Yet, despite these positive findings, home visiting in home-based child care settings has its challenges. Results from these programs suggest that future work should explore better ways to ensure children's health and safety, which is a critical component of quality programs for young children and is often the focus of state regulating and oversight agencies. Future work should also identify better strategies to support young children's social–emotional development. Many challenging behaviors are rooted in relationships and attachments that develop during the first 3 years of life. Yet, our experiences show that family child care providers tend to view all the children in their care as normal and may be missing children who have social–emotional needs. Home visitors, at least in these home visiting programs, typically do not have the skills and confidence needed to change this perception. Behavioral consultants who are knowledgeable about the emotional development of infants and toddlers, and who have often been helpful to center-based child care programs, may also be an important resource for home-based child care providers. Finally, future home visiting programs need to address the fact that not every provider who participates in such programs will demonstrate positive outcomes. In the CFQ and PFCC programs, providers who were engaged, or "ready to change," were more likely to benefit from these home visiting programs. When providers did not demonstrate these characteristics, even an intensive and individualized program was not likely to result in positive changes. In fact, in the PFCC project, providers who were at the "contemplation" stage (i.e., thinking about change, but overwhelmed by obstacles) actually showed a drop in quality over time. Findings from the PFCC project in particular suggested that assessing a provider's readiness to change has the potential to better inform the development and implementation of future home visiting programs. Whether this means tailoring or targeting programs, or some combination of the two, is a question for future programming and research efforts. Knowledge about how best to proceed given providers' varying readiness issues has the potential to save resources, especially given the expensive and time-intensive nature of on-going home visiting programs.

Throughout this article we have heard the stories and perspectives of two home visitors, Jenny and Deanna. Jenny's strength is in working with young children, while Deanna's is being especially able to connect with home-based child care providers. In our work with home visitors, we have found that both skills are equally important and necessary for home visiting that meets the needs of providers and the children in their care. Although some home visitors navigate their complex job with ease, others struggle to successfully meet these dual roles. Training that recognizes and supports both sets of strengths will better enable home visitors to fulfill their work to promote high quality home-based child care settings for young children and the providers who care for them.

Lisa A. McCabe, *PhD, is a research associate at the Family Life Development Center at Cornell University (www.human.cornell.edu/fldc/). Dr. McCabe conducts research in the area of early care and education and specializes in program evaluation and young children's social and emotional development. She led the evaluation of the Caring for Quality program and has worked as a center-based child care provider for infants, toddlers, and preschoolers.*

Shira M. Peterson, *PhD, is a research associate at Children's Institute, Inc., University of Rochester (www.childrensinstitute.net/). Dr. Peterson directs the Partners in Family Child Care home visiting program. Dr. Peterson studies and evaluates programs for early educators and parents, with a focus on understanding caregivers' readiness to change their practices with children. Along with her colleagues, she offers training, consultation, and measurement tools for administrators and support staff to identify and respond to caregivers' stage of change.*

Amy C. Baker, *MA, is a clinical analyst at Children's Institute, Inc., University of Rochester (www.childrensinstitute.net/). Ms. Baker is a nationally recognized expert in family child care and certified trainer for WestEd's Program for Infant/Toddler Caregivers (PITC). She is co-author with Lynn A. Manfredi-Petit of* Circle of Love: Relationships Between Parents, Providers and Children in Family Child Care *(Redleaf Press, 1998). With Shira M. Peterson, Amy Baker provides consultation, training, and support to programs interested in using a Stage of Change approach to early childhood professional development and parent education.*

Marsha Dumka, *MSEd, is executive director of Rochester Childfirst Network (RCN), a not-for-profit agency dedicated to advancing the quality of early care and education through leadership, advocacy, and direct services to children (http://rcn4kids.org/). RCN, through its Family Child care Satellites of Greater Rochester, served as a partner in the development of and was the lead agency in the implementation of Caring for Quality. RCN also serves as a partner in Partners in Family Child Care.*

Mary Jo Brach *is service director of Family Resource Centers (FRC) of Crestwood Children's Center, an affiliate of Hillside Family of Agencies (www.hillside.com/). FRC offers early childhood and parenting education and support in the Rochester community and has been providing Parents as Teachers-based home visits to both families and home-based child care providers for more than 14 years. FRC served as a partner in the development and implementation of Caring for Quality and Partners in Family Child Care.*

Diana Webb *is the coordinator for Family Child Care Satellites of Greater Rochester (http://rcn4kids.org/in-home-care-providers/) located at Rochester Childfirst Network. Diana has been in the field of Early Care and Education for more than 30 years. She represents the Satellites on interagency projects whose goals are to increase the quality of care offered in nearly 900 licensed and registered family child care homes. Diana serves on the board of the National Association for Family Child Care and is a workshop presenter at local, state, and national conferences.*

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Improving Support Services For Family Child Care Through Relationship-Based Training

JULIET BROMER
TONYA BIBBS
Erikson Institute

Abstract

Family child care (FCC) providers often experience isolation from other early childhood and child care professionals. Yet, research suggests that providers who network with other providers, engage with community resources, and belong to support groups tend to offer higher quality child care. For example, the Family Child Care Network Impact Study found that relationship-based network supports delivered by a specially trained staff person were associated with higher quality caregiving among network-affiliated family child care providers. The authors present the study and describe the dimensions and components of a relationship-based training program, developed based on the research findings, for support staff members who work with FCC providers.

Family child care (FCC) providers often experience isolation from other early childhood and child care professionals. They work long hours in their homes, often without much contact with other adults. Although many FCC providers report being well connected to family and neighbors in their immediate communities (Bromer, 2002), few report having connections with other FCC providers or support groups (Kontos, Howes, Shinn, & Galinksy, 1995). In addition, the decentralized nature of FCC makes it difficult to deliver training, supervision, and other support services to providers. These realities may serve as barriers to providers accessing support. Yet, research suggests that providers who network with other providers, engage with community resources, and belong to support groups tend to offer higher quality child care (Kontos et al.; Doherty, Forer, Lero, Goelman, & LaGrange, 2006).

This article results from a collaboration between a researcher and a program director at Erikson Institute. Our goal is to illustrate how a set of research study findings led to the development of a training model for support staff persons who work with FCC providers. First, we give a brief overview of what we know about the role of professional supports and FCC quality. Then we describe the Family Child Care Network Impact Study, which examined the relationship between support network affiliation and quality in FCC. In the second part of the article, we describe a professional development training model that emerged from the study findings and is currently being developed and piloted at Erikson Institute in Chicago.

Professional Support and FCC Quality

The few research studies that have examined the link between provider support groups and quality found that support from other providers and professionals has the potential to improve quality in FCC. Kontos et al. (1995) found that providers who were involved with other providers through provider associations and networks were more likely to deliver higher quality care.

A handful of other studies have documented similar findings regarding support and quality in FCC. In a study of Canadian FCC providers, Doherty et al. (2006) found that opportunities to network with other providers and access toy lending libraries and community resources were correlated with higher quality scores among providers.

By connecting providers to experienced and trained network staff, training opportunities, and other providers, staffed networks that offer a range of services through paid

staff members may help to ameliorate some of the barriers to quality and professionalism in FCC such as decentralization and isolation (Hamm, Gault, & Jones-DeWeever, 2005; Hershfield, Moeller, Cohen, & the Mills Consulting Group, 2005). Staffed networks may be a particularly effective strategy for improving FCC in low-income neighborhoods. Larner and Chaudry (1993) identified the following characteristics of staffed networks that had success working with low-income providers: financial and material resources to support home improvements and purchases of equipment, and learning materials; and one-to-one contact with staff members who have a background similar to the provider's own and who respect and can communicate easily with the providers.

In addition to improving quality of FCC, staffed networks may also have the potential to serve as a vehicle for low-income community development and infrastructure building (Gilman, 2001; Meyer, Smith, Porter, & Cardenas, 2003). Staffed networks are often housed in community-based organizations that may help increase community awareness and recognition of FCC as an important community service for families with young children (Gilman). Moreover, once staffed networks are well-established within a community, they may have the potential to extend their support services to other home-based providers in the community such as license-exempt providers.

The Family Child Care Network Impact Study

Building on these prior findings regarding the importance of support in quality improvement in FCC, the Family Child Care Network Impact Study sought to examine a particular type of support: staffed FCC networks (Bromer, Van Haitsma, Daley, & Modigliani, 2009). In Chicago, staffed networks offer a range of services to FCC providers, such as visits to provider homes by trained staff, training and education, support groups, mentoring, materials and equipment, and business assistance. Similar programs in other parts of the country deliver support services to providers and are referred to as systems, hubs, or satellites (Hershfield et al., 2005). Massachusetts, for example, has a long-standing public investment in FCC systems that deliver a range of services to providers. Volunteer-run provider associations also support providers but often have limited funding and no staff support, and they tend to focus on social support activities rather than quality improvement services such as home visits. Staffed networks that offer ongoing support and training are a community-based strategy that has the potential to improve the quality of child care for young children. Such networks may also be more effective at reaching low-income providers, particularly those who otherwise may not have access to services or resources. Through a network, a group of providers can meet and support each other, access training and professional development, and improve the quality of care they offer children and families.

Photo: Debbie Rappaport

Family child care (FCC) providers often experience isolation from other early childhood and child care professionals.

Networks in Chicago have been offering support services to FCC providers for many years. Some networks also deliver Head Start and Early Head Start services to families through FCC providers. However, the quality of such services has been unknown. The Family Child Care Network Study sought to understand whether networks are an effective quality improvement strategy for FCC and to identify specific features of networks that are most effective in improving quality.

At the time of data collection for the Network Study (2002), 35 staffed networks in Chicago served an estimated 674 FCC providers. The remainder of the city's FCC businesses—roughly 1,040 providers, or 60% of the total—were unaffiliated. Despite substantial funding from public sources, networks have few guidelines to follow or accountability standards to meet. Agencies that offer Early Head Start and Head Start services through FCC must meet some basic requirements, such as a minimum number of visits to provider homes, low coordinator-to-provider and provider-to-child ratios, and education requirements for network coordinators or support staff. Networks that support providers who do not have Head Start or Early Head Start slots do not need to meet such requirements, and the type and quality of services networks offer can vary widely.

This lack of standards for networks and the wider absence of research about the effect of networks on quality of care in FCC homes prompted the Network Study. The Network Study was the first study to take a detailed look at networks in a large urban community and to examine the particular characteristics and services of networks that are associated with higher quality child care. Researchers at Erikson Institute and University of Chicago who worked on the study asked three questions:

1. Do staffed networks contribute to higher quality child care among affiliated providers?
2. What characteristics and services of staffed networks are associated with higher quality care among member providers?
3. What policy recommendations can be made to improve the quality of services offered by staffed networks?

Study Participants

A total of 150 licensed FCC providers in the city of Chicago participated in the study, including 80 providers who were affiliated with networks and 40 providers who were unaffiliated. A third group of 30 licensed providers who belonged to voluntary, provider-run associations was also included. To better understand the particular influence of network affiliation on quality, the unaffiliated providers were matched to the network providers on key characteristics (e.g., race/ethnicity, experience, education). In Illinois, providers who care for more than three unrelated children in their homes

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must be licensed by the state. Providers (mostly grandmothers and other relatives or close neighbors) who care for fewer than three unrelated children are considered license-exempt.

Network coordinators—the staff members who deliver direct services to providers—and FCC providers were interviewed, and observations were conducted to assess quality of care in provider homes. The *Family Day Care Rating Scale* (Harms & Clifford, 1989) and the Arnett *Caregiver Interaction Scale* (Arnett, 1989), two popular measures of child care quality, were used to assess quality.

Two thirds of the providers in the study were African American (including Afro-Caribbean), and one third of the providers were Latina. Almost all of the providers lived in poor or working-class neighborhoods in the city of Chicago. Providers in the study were in their mid-40s and averaged just fewer than 6 years of experience in providing child care and had some college education but no degree. In addition, providers in the study offered group care to seven children, on average, and most had an assistant provider. More than half of the providers cared for babies.

Photo: ©iStockphoto.com/Christine Kublanski

Through a network, a group of providers can meet and support each other.

Findings From the Study

The study first examined whether providers in networks offered higher quality care than unaffiliated providers. Many other factors that may affect quality were considered, such as educational background, experience, and children's ages. The study found that network affiliation was associated with higher quality care for children, which confirmed earlier research about the importance of support in FCC. Next, the study examined specific features or types of services that were more effective in supporting quality than others. Several relationship-based service areas were associated with higher quality caregiving, including visits to provider homes by network coordinators focused on working with children and parents, trainings and workshops for providers at the network site, and regular opportunities for support and communication between network staff members and providers. All three of these service areas involved a network staff member (most often the coordinator) working directly with providers in the network. The relationship-building and trust that occurred between network coordinators and providers appeared to be central to how these networks supported higher quality care among their affiliated providers (Table 1).

Some network services did not appear to help providers offer high-quality child care. In particular, monitoring homes for licensing violations and health and safety regulations, referrals to external trainings and tuition reimbursement programs, and mentoring programs did not have a relationship to higher quality care—these services do not involve the key elements of interactions and relationship-building. However, they may still be important aspects of professional and business development in FCC, as suggested by provider reports of how these services helped their businesses. The study did not look at other outcomes that may be associated with higher quality care, such as income augmentation, stability, provider turnover, or job satisfaction.

Finally, the study examined the role of network coordinators in quality improvement, especially given the findings that demonstrate the importance of services that involve network–provider relationships and interactions. The study looked at several characteristics of network coordinators, including prior experience working in child care or FCC settings, education level, and job experience. A coordinator's prior experience and graduate-level education had a modest relationship to higher quality among the providers in the coordinator's network. However, in interviews with coordinators, we discovered that several of them had received specialized, advanced-level training in infant studies and FCC at Erikson Institute. Providers who received relationship-based services such as home visits, training, and provider meetings from networks with these specially trained coordinators had significantly higher quality scores than providers in other networks. Specially trained network coordinators turned out to be the key to quality in this study.

Table 1. Network Characteristics and Services and Family Child Care Quality

Effective characteristics and relationship-based services	Ineffective services
• Specially trained coordinator *and* direct services to providers: — On-site training at the network — Visits to FCC homes focused on working with children and parents — Regular network-provider communication • Regular meetings • Telephone help • Feedback opportunities	• Monthly visits to FCC homes focused on health/safety compliance • Referrals to external training • Peer mentoring • Material resources (e.g., lending libraries, free equipment) • Business services (e.g., tax preparation, enrollment of children, administration of subsidies)

A New Professional Development Training Model

Findings from this study point to the importance of highly qualified network coordinators and other agency staff (consultants, coaches, mentors, home visitors) who directly support FCC providers. The preparation and training of support staff are often overlooked or given scant attention in quality improvement initiatives. Staff

PHOTO: ©ISTOCKPHOTO.COM/JELANI MEMORY

Two thirds of the providers in the study were African American (including Afro-Caribbean), and one third of the providers were Latina.

training is often delivered in workshop format, over a couple of days, and rarely with follow-up or reflective supervision to help staff members refine and continue to develop their skills. Given the evidence of the importance of relationship-based work with FCC providers, it makes sense that it would be beneficial to offer support staff members opportunities to think through issues and concerns that arise in their work with providers. The additional findings demonstrating the importance of specialized, intensive training for coordinators led us at Erikson Institute to pilot and evaluate a new relationship-based training model for all support staff working with FCC providers, based on the specialized training that had been offered at the time of the Network Study.

At Erikson Institute, we are currently piloting the year-long training program with one of our community partners, a large child care advocacy and resource and referral agency that delivers services to home-based providers, including license-exempt caregivers and licensed FCC providers. The current cohort in the training consists of 12 staff members who work with FCC providers in a range of jobs including infant–toddler specialists, quality rating system specialists, and specialists who help providers with the federal food program and local services and resources. Despite differences in job definitions, all of the direct-service staff members conduct visits to provider homes and workshops for providers. In addition to these 12 staff persons, four supervisors are participating in the cohort. Two-hour seminars are held weekly at the agency and once a month at Erikson Institute.

The authors are working in collaboration to refine the professional development model for replication with future cohorts of support staff members who work with FCC providers (home visitors, consultants, network coordinators, coaches). The project includes an evaluation of the training, which entails the development of research protocols to examine the dimensions of relationship-based training and practice and relational approaches to working with providers. The evaluation will inform the further development of the model. The features in Table 2 can be thought of as the spokes of the model. As we learn more from the evaluation, we will be able to provide a hub that conceptually holds the spokes together and forms a complete model. The following sections describe the three dimensions of the professional development program and use examples from the seminars to illustrate their respective features.

Dimensions of Professional Development

We have conceptualized three primary dimensions of the professional development program—content, process, and context—as represented in Table 2 and described below.

Content

The content dimension refers to the "what" that participants learn in the training, such as child development information and issues in FCC. Content knowledge provides the theories, principles, and concepts of a particular discipline (Schulman, 1992), and participants are asked to use this knowledge to arrive at an understanding of the appropriate customs and practices of child care in a given setting. Adult learning theory says that individuals' own customs, acquired through personal and professional experiences, are as influential as content knowledge on their practices (Mezirow, 1990). Thus, the content of the professional development program integrates three components including: curriculum, the importance and use of participant customs, and dialogue skill building.

CURRICULUM

The program curriculum includes four content areas, each briefly described below:

The principles of thinking developmentally. Content knowledge moves participants beyond information about developmental stages and milestones to help them become developmental thinkers in their everyday work with providers through learning to interpret the behavior, practices, and goals of providers, children, and families. Learning about child development helps participants support FCC providers' work with children. For example, understanding crying, feeding, and sleeping can help staff members support FCC providers who often feel confused and helpless in their interactions with the infants in their care.

Table 2. Dimensions and Components of Erikson Institute Relationship-Based Professional Development Program for Support Staff Members Who Work With Home-Based Child Care Providers

Content	Process	Context
• Graduate-level curriculum focused on development from birth to age 12 years; key principles of adult learning and family engagement processes • Participant customs • Dialogue skill building	• Cohort togetherness: collaborative learning and development of a learning community among participants • Reflective practice: seminars and individual consultation help participants think about their work	• Adapted to specific job roles of participants • Agency support of professional development

The processes of development across domains. The seminars use observation assignments to help participants understand how infants and children integrate domains of development in everyday life and role-plays to help them learn how to communicate this information to providers.

The history and environment of FCC. Through readings and inclusion of FCC provider guest speakers, the seminars increase participants' understanding of FCC as a unique milieu.

Assessing quality in FCC. The seminars ask participants to think about the diverse aspects of quality in FCC, including the importance of strong provider–family relationships.

PARTICIPANT CUSTOMS

Participant customs refers to how participants' own experiences influence their engagement with the curriculum; this dimension of the professional development program also prepares participants to work with FCC providers' own customs around caregiving and content knowledge.

In order to create a learning space that is both reciprocal and collaborative, the seminars give equal consideration to customs of child care and child development knowledge. Staff members' own child-rearing experiences and practices often lead them to rely on folk theories of child development. When staff members discuss how they might support a provider's work with children, they often reference their own experience (e.g., "When I was a child, we . . . ," "With my child, I . . .") as much as they reference the seminar content. Initially, the seminars helped participants develop their awareness so that they could identify the source of their thinking. As the year progresses, the seminars help participants reflect on the degree to which their life experiences enhance and limit their work with providers.

The ability to draw on a wide range of personal experiences (see box Participant Customs and Child Care Quality) is particularly important for staff members working in FCC homes where there is also great variation in caregiving and child-rearing approaches. Staff members may work with grandmothers who care for a grandchild and perhaps one other child, young mothers who have become FCC providers so they can stay home with their children, and women who see themselves as community caregivers, taking care of the neighborhood's children. The seminars use the staff members' own experiences and memories of caregiving to help them think about care from a child's perspective; this encourages them to think about what providers might be trying to accomplish with their practices.

Participant Customs and Child Care Quality

In an exercise in one seminar, the instructor asked participants to think back to their own experience of receiving quality care. After the participants created individual narratives about this relationship, the instructor led the seminar participants in a group discussion to aggregate their stories. A construct of quality caregiving emerged that included: feeling secure, nurturing with favorite foods, doing things to make a child feel special, making time for a child, balancing being stern with nurturing, making a child feel wanted, showing interest in a child, and providing a lot of strong sensory moments that could be cherished. Seminar participants used this exercise to step back from pen-and-paper assessments of quality and consider how an infant or child might experience a quality caregiving relationship.

DIALOGUE SKILL BUILDING

One of the benefits of FCC is that children are more likely to be cared for in a milieu that is proximal to their home culture (Kontos, 1994). Home visitors must be able to enter into and understand a number of distinct cultural milieus. One goal of the seminars is to improve participants' capacity to work with diverse children and families. As such the curriculum includes attention to the ways in which professionals interact with one another and with families. To help participants develop their capacity in this area, the seminars use *skilled dialogue* developed by Barrera and Kramer (2009) and skills labs developed by the instructor. Skilled dialogue is an approach to communicating with people who are culturally different from the speaker. Barrera and Kramer's approach to transformation focuses on dispositions people use to approach interpersonal interactions, such as valuing a provider versus being in control of an interaction with a provider, and the strategies one uses to achieve these dispositions. The seminars use skilled dialogue concepts both to strengthen staff persons' ability to relate to providers and assist providers in strengthening their relationships with the families of the children in their care.

Skills labs build on a guided reading of the skilled dialogue text and give participants assignments to "try out" the principles in their everyday lives. The skills labs focus on developing capacity in the areas of artfully asking questions, making empathic statements, and giving supportive feedback (see box Dialogue Skills Labs). In the lab sessions participants focus not only on learning the skills, but also on considering the relationship of the skills to practice, in the hopes that they will internalize and use these skills in their interactions with providers.

Process

The process dimension of the training program focuses on how participants learn and interact with the seminar content. Cohort togetherness and reflective practice are key components of the process dimension.

COHORT TOGETHERNESS

Cohort togetherness refers to the ways participants interact with each other during the seminars. Because the staff members in this cohort work in different job roles, including supervisors, the cohort has the potential for interdisciplinary learning experiences and shared learning across different hierarchical positions.

Seminar discussions encourage participants to work in interdisciplinary reading groups to encourage them to learn from each other and interact with colleagues in different job roles. Many of the participants have a background in education and have worked with school-age children, and their ideas about development are largely formed by their experience with children in this age group. In a seminar on literacy, the group dialogue focused on reading comprehension; the presence of infant–toddler specialists helped shift the dialogue to early literacy and the experience of reading. The discussion encouraged the participants' conception of "literacy," originally restricted to "teaching reading," to expand to include the relational and social dimensions of reading. It also gave participants another opportunity to view infants as actively constructing their own

Dialogue Skills Labs

1. Introduce the skill (e.g., making empathic statements). Provide a definition of the skill and an explanation of its role in relationship-based practice.
2. Situate the skill in everyday practice. How do you use it in everyday conversations? How do you benefit when others use it? How do you feel when people don't use it?
3. Discuss the barriers that might occur to using the skill (in general and with regard to a home visitor's particular personal resonance issues).
4. Provide an opportunity to practice the skill and process the experience.

Photo: ©iStockphoto.com/Jo Unruh

A construct of "quality" caregiving emerged that included showing interest in a child and providing a lot of strong sensory moments that could be cherished.

development.

Expanding expertise across developmental periods is particularly important for staff members who work with FCC providers. Unlike providers at child care centers, which typically separate children into classrooms by age, FCC providers are likely to work with mixed-age groups of children that often include newborns, infants, toddlers, and school-age children, as well as preschoolers. A collaborative learning process helps staff members learn relevant developmental knowledge from each other.

REFLECTIVE PRACTICE

Reflective practice refers to stopping, stepping back, and thinking about one's practices. Supporting FCC providers is rewarding and challenging work. Support staff persons work with a variety of people and encounter a new circumstance every time they step into a provider's home. They describe issues of community violence and housing conditions that affect both their comfort with visiting FCC homes and providers' comfort with providing services. They also describe circumstances that are common among other home visitors—for example, providers who often feel isolated share personal information with support staff persons. In addition, staff persons have to manage the daily minutiae of working "on the road"—managing an office in the car, maintaining healthy eating practices without a staff refrigerator, finding a clean bathroom, and working alone. The reflective practice component of the seminars acknowledges these challenges and invites participants to slow down and reflect on their work.

The program includes two ongoing opportunities for reflective practice: group reflective practice seminars, and individual supervision for staff members on visits to provider homes followed by reflective consultation sessions with the instructor. Reflective practice seminars are held at Erikson Institute, away from the activity of participants' everyday routines and in a welcoming environment. The reflective sessions occur in three groups composed of same-job-category colleagues and their supervisor. Although this configuration sacrifices the interdisciplinary possibilities of the larger group, it gives the participants opportunities to strengthen their reflective capacity as a work group. Furthermore, the supervisors are in an apprentice role that will eventually lead to them conducting the reflective groups after the training is completed. Both the group configuration and the supervisor role anticipate the importance of sustaining growth and continuing practices when the training ends.

In paying attention to the physical space in which we conduct the trainings and the social configuration of the groups, the seminars aim to promote cohort togetherness and enhance staff persons' experience of support in their job roles. One-on-one supervision and consultation sessions, which are discussed further in the following section, help staff members extend their content knowledge within the context of their day-to-day work with providers.

Context

The context dimension of the professional development program refers to the factors that influence the implementation of the program. Although multiple factors may have an impact on how the program is delivered, we focus on how the participants' job roles and agency support shapes the program.

SPECIFIC JOB ROLES

The findings of the Network Study highlight the need for support staff members who work with providers to have specialized training in how to support the unique needs of FCC providers through visits to provider homes and other one-on-one technical assistance supports. The professional development program offers participants an opportunity to receive consultation on their direct practice with providers. The instructor accompanies participants on some of their visits to provider homes, which are followed by individual reflective sessions.

Individual observation and consultation sessions deepens the goal of supporting staff job roles, by encouraging the participants and the instructor to use the physical setting of provider homes to elaborate on topics discussed in seminars and clarify gaps in applied knowledge. The one-on-one post-visit reflection sessions enable each participant to cultivate individual learning goals that are limited by the group format.

AGENCY SUPPORT

Agency support for professional development is a key to successful implementation of this kind of intensive staff training. The agency that undertook the training demonstrated its commitment to developing its staff's capacity to provide services to FCC providers by giving staff members work time to attend the seminars over the course of a year and by providing space for the trainings, both important components of successful training. Direct supervisors and directors participated in the training program, further demonstrating the agency's investment in addressing development and change at all levels of programming. The authors at Erikson and the community partner facilitate this ongoing relationship by meeting periodically to discuss the status of the professional development program. These meetings enable us to incorporate their feedback into the evolution of the trainings and invite the agency to think about how it will help staff members sustain their development in their everyday practice. Therefore, both members of the collaboration are engaged in a process of growth.

Conclusion

Research findings led to the development of a training program for support staff members who work with FCC providers, which is being currently piloted and has now become the focus of research itself. At Erikson Institute, we are currently conducting an in-depth evaluation of the program in order to understand how this kind of intensive training helps staff members gain the knowledge and skills to deliver effective support to FCC providers. Our experiences designing the training program and conducting the research are teaching us about the knowledge and skills support staff members need to engage in relationship-based practices and deliver effective services to providers. This research is also leading to innovative methods to appropriately assess these developing skills. The term *relationship-based* is often used in the early childhood and home visiting fields, yet we lack clear definitions and models for what skills and training are needed to build and sustain professional relationships in quality improvement projects.

FCC is a unique context for child care and, as many experts in the field have pointed out (Porter et al., 2010), FCC providers may need support that is specifically targeted to the unique characteristics of home-based settings. There is clearly a need for more research on the types of supports that are most effective in helping providers improve quality. The study findings and training program dimensions reported here are one example of how a relationship-based approach to professional development for support staff may lead to improved delivery of support services to providers and better outcomes for providers and the families and children in their care.

Juliet Bromer, *PhD, is an assistant research scientist at the Herr Research Center for Children and Social Policy at Erikson Institute. Her research examines the family and community support roles of child care providers, family-sensitive caregiving in early childhood settings, and the role of relationship-based support and professional development in quality improvement in home-based child care.*

Tonya Bibbs, *MSW, is a director and trainer in Erikson Institute's professional development department. She is a licensed clinical social worker and is currently a doctoral student in child development at Erikson Institute. Prior to her current position, Tonya served as a director of Erikson Institute/Illinois State Board of Education's Infant and Early Childhood Mental Health Consultation Project.She is an adjunct faculty at Erikson Institute and serves on the board of the Illinois Association for Infant Mental Health.*

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Family Child Care Programs Within the Military System of Care

CAROLYN S. STEVENS
U.S. Department of Defense, Washington, DC

Family child care is one of the four main components that make up the U.S. military's child development system of care. The system also includes child development centers, school-age care programs, and resource and referral programs. The U.S. Department of Defense (DoD) defines family child care as home-based child care services that are provided for service members and DoD civilians by an individual who is certified by a designated representative for the DoD as qualified to provide those services. The individual provides those services for 10 hours or more per week per child on a regular basis for compensation (DoD, 1993). Care provided in the child's home by a relative or care provided through a cooperative arrangement among parents is not classified as family child care.

Family child care within the military's child development system is typically provided in the government-owned, -leased, or -privatized housing home by certified providers; however, care may also be provided in affiliated homes located off the installation. These affiliated family child care providers agree to abide by DoD standards for operation in addition to their state's requirements for family child care. In general, each family child care home may care for no more than six children, including the provider's own children who are enrolled in the program, at any one time. There are approximately 5,000 licensed and trained family child care providers located both on and off installations (DoD, 2010). According to the National Association of Child Care Resource & Referral Agencies (NACCRRA), each week more than 1.7 million children less than 5 years old are in family child care arrangements (NACCRRA, 2010). On average, children of working mothers spend about 36 hours each week in child care (NACCRRA, 2010).

The Need for Family Child Care

The U.S. military is a primarily a young force, and close to 44% of active duty members have children. According to the Office of the Deputy Under Secretary of Defense (2010) report *Demographics 2009: Profile of the Military Community*, active duty service members parent approximately 273,000 children less than 3 years old; Reserve component members parent almost 90,000 children in this age group.

The DoD system of care has evolved to become the largest employer-sponsored program in the country and is designed to meet the specific child care needs of DoD working families. This child development system serves more than 200,000 children (newborns through 12 years old) daily in full-day, part-day, and hourly child care; part-day preschools; and before- and after-school programs. Extended hourly care that includes nights, weekends, and care for shift workers is also offered. Child care is offered in a variety of settings where military families

Abstract

Military families face challenges not found in other work environments. Shifting work schedules that are often longer than the typical 8-hour day, as well as the ever-present possibility of being deployed anywhere in the world on a moment's notice, require a child care system that is flexible but maintains high-quality standards. The U.S. Department of Defense child development system aims to accommodate the youngest members of the military community by providing quality, affordable child care for infants, toddlers, preschoolers, and school-age children. This article focuses on the family child care component within the Defense Department's system of child care and the programs each military service branch operates to ensure that quality care is available to and affordable for the approximately 940,000 children (from birth to 12 years old) of military personnel.

live, including overseas locations and DoD-sponsored community-based programs in centers as well as family child care homes.

Despite the growth of facility-based care, family child care continues to be an integral component of the military's child development system. Estimates derived from national surveys indicated that from 10% to 25% of children are cared for in a family child care setting (Johnson as cited in Bromer, 2009). DoD family child care homes are an important alternative to center-based care. Many families choose family child care for their younger children because of its flexibility and homelike setting (Bromer, 2009). Still others rely on family child care because of its flexible hours of operation which may include night, weekend, and unusual hourly care, such as shift work. In addition, many families prefer family child care because of the small group sizes and the ability for siblings to be cared for together.

Photo: Kiwi Street Studios

Active duty service members parent approximately 273,000 children less than 3 years old.

A Systematic Approach to Quality in Family Child Care

The DoD's child development system is well regarded for its comprehensive approach to providing child care. The National Women's Law Center publication *Be All That We Can Be: Lessons From the Military for Improving Our Nation's Child Care System* (Campbell, Appelbaum, Martinson, & Martin, 2000) noted that the military's child development system required quality child care from all of its providers—centers, family child care homes, and school-age programs—through a systematic approach that encompassed basic standards of health and safety in addition to ongoing training and compensation tied to demonstrated competency. The 2004 follow-up report (Palmer, Blank, Campbell, & Schulman, 2004) concluded that the DoD's system of care continued to demonstrate improvement. National accreditation is required of child development programs by the Military Child Care Act (National Defense Authorization Act for Fiscal Year 1996). And, although the DoD does not require family child care providers to become accredited, providers are encouraged to seek national accreditation. The military services provide some financial assistance to achieve accreditation and provide additional compensation if the provider achieves and maintains accreditation (Palmer et al., 2004).

To be certified, individuals applying to become a family child care provider must complete a specialized orientation training prior to caring for children. This training includes pediatric cardiopulmonary resuscitation and first aid training, child abuse identification and reporting, developmentally appropriate practices, and business practices. In addition, each provider must complete a 15-module training program that covers core competencies such as developmentally appropriate activities, guidance techniques appropriate to children of different ages, and child abuse identification and reporting. They are required to complete additional training each year, similar to the training required of the child development center employees. There is no cost to the family child care provider for the preservice and module training, and in some cases, providers may earn college credit for completed training.

Developmentally appropriate practice is supported through a lending library program that ensures the home has access to developmentally appropriate materials and supplies. A wide variety of materials are available for loan such as small-muscle development toys, music materials, language skill supplies, arts and crafts materials, books, and games. Also available for loan are larger items such as cribs, sleep mats, and small, portable playground equipment. Access to these supplies and materials reduces the out-of-pocket expenses of starting up a family child care home.

A Systematic and Intentional Approach to Oversight

Licensure requirements for family child care providers vary dramatically from state to state. Today, 34 states require some form of licensure of family child care providers who care for at least four children. However, three states have no requirements for family child care homes. All of the states have more rigorous requirements for center-based care than for family-based care (Buettner & Andrews, 2009). One strength of the DoD family child care program is the rigorous system of program oversight which ensures that quality standards are met and maintained.

In recent years, NACCRRA has assessed state policies for small family child care homes (i.e., where up to six children are cared for in the home of the provider for compensation). Overall, NACCRRA has found that state standards and monitoring efforts remain weak and that there have been limited improvements since the 2008 NACCRRA report on the status of family child care in the United States (NACCRRA, 2010).

All family child care programs that serve military families must either be certified by the DoD and meet comprehensive standards akin to the state licensing process or be state licensed. Providers must meet comprehensive health and safety standards including background checks for the provider, substitutes, and family members over 12 years old; child abuse prevention procedures; training and provider qualifications; and parent involvement. Standards that promote developmentally appropriate practices and environments are also enforced. Specific adult-to-child ratios, including standards governing the provider's own children, ensure an operational standard of care.

Family child care homes are monitored quarterly and in some cases monthly. The family child care administrative office and a number of randomly selected homes are subject to four unannounced inspections per year. These inspections include a comprehensive fire and safety inspection, a health and sanitation inspection, a multidisciplinary inspection that includes parents as a component of the team, and an inspection conducted by members of the Service

Photo: Kiwi Street Studios

Family child care continues to be an integral component of the military's child development system.

Headquarters Children and Youth Program office (National Defense Authorization Act for Fiscal Year 1996).

Role of the Individual Military Service

The Army, Marine Corps, Navy, and Air Force provide operational oversight to their respective family child care programs (referred to as "child development homes" in the Navy). Each military service certifies the child care home as meeting appropriate standards. The certification process includes preservice training, home inspections, and background checks prior to the home offering care for children. Family child care providers who live off the installation and are state licensed may provide child care by becoming certified.

Military installations' family child care programs are supported by a program director or coordinator who is responsible for the overall management of the day-to-day operation of the family child care program. The program director, together with the community, ensures that each provider can work independently within a network of support.

The military services rely on the flexibility of the family child care system to offer a diverse array of approaches to provide nontraditional child care, available to support families outside of typical duty schedules and in geographically separated areas:

- All of the military services provide respite child care for deployed service members throughout the deployment cycle. This type of care is offered to the primary caregiver while the service member is deployed, resulting in a break or respite from the demands of parenting while the spouse is deployed. (Air Force Services Family Child Care, n.d.; Marine Corps Community Services, 2007; U.S. Army Family Child Care Homes, n.d.; U.S. Navy Child and Youth Programs, 2010)
- The military services offer programs that include 24-hour and long-term care during mobilization and training exercises, evening and weekend care, and care for children with special needs and mildly ill children.
- The Army and Navy provide care in group homes that are open 24 hours each day to meet the needs of shift workers in a home-like setting. These settings typically offer care for a group of 20 children and operate under the auspices of the child development program rather than family child care.
- The Air Force addresses the need for around-the-clock child care in a myriad of formats through its robust Expanded Child Care Program, which includes the Air Force Extended Duty Care Program that assists members who are experiencing a temporary shift change, the Air Force Returning Home Care program that supports airmen returning from deployment, the Air Force Home Community Care program that supports Air National Guard/Air Force Reserve families during their drill weekends, and the Air Force Missile Care program that provides child care for those required to work consecutive 24-hour shifts at missile sites. In addition, the Air Force is now piloting the Air Force Supplemental Child Care program, which augments a member's existing child care arrangement by providing care at the beginning or end of a 12-hour or longer shift.

Learn More

Military One Source
www.militaryonesource.com/
Military OneSource is a U.S. Department of Defense program that provides resources and support, including information about child care, to active-duty, National Guard, and Reserve service members and their families.

National Association of Child Care Resource and Referral Agencies
www.naccrra.org/military programs
NACCRRA is working with the U.S. Military Services to help those who serve in the military find and afford child care that suits their unique needs.

A Commitment to Families

Care for young children is a critical workforce issue for military families with a direct impact on their effectiveness and readiness. A focus on accessible, affordable, quality care allows service member parents to concentrate on their job knowing that their child is cared for in a safe, nurturing, and age-appropriate environment. Family child care is an arrangement of choice for many military families.

Carolyn S. Stevens, *MPA, is a senior program analyst in the Office of Family Policy/Children and Youth at the U.S. Department of Defense. She has more than 30 years of experience working with children, youth, and families. Her experience includes working in county-level social services, nonprofit recreational programs, and for-profit and federal child care systems. Her work within the federal system includes direct care and management experience in home-based and center-based child development programs at the installation level. She served as the first child and youth specialist for the Air Force Reserve Command Headquarters prior to assuming her current position with the Department of Defense.*

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Choosing Quality Child Care
www.zerotothree.org/choosingquality
What are the hallmarks of quality child care? And how do parents select an appropriate caregiver? ZERO TO THREE has established some basic principles that define quality care for infants and toddlers.

Parenting and Professionalism: The Myth of Having It All
By Robin B. Thomas, PhD, RN
www.zerotothree.org/parenting_professionalism
This classic article from the *Zero to Three* Journal describes the challenge of adapting to parenthood and how the workplace needs to become more supportive of the transition to, and the experience of, parenthood among professionals.

Family, Friend, & Neighbor Care
www.zerotothree.org/ffn
To help you provide the best care possible for the children and families you serve, with generous support from the Annie E. Casey Foundation, ZERO TO THREE held focus groups around the country with family, friend, and neighbor (FFN) providers to learn about the kinds of resources that would be most useful in your work. Feedback from these groups served as the foundation for this special section of our Web site which includes resources designed specifically to meet your needs.

The Minnesota Family, Friend and Neighbor Grant Program

AMY SUSMAN-STILLMAN
KAREN STOUT
JENNIFER CLEVELAND
VICKI HAWLEY
Center for Early Education and Development
University of Minnesota

Traditionally, professional development for child care providers has been targeted toward the members of child care community who provide what is termed "licensed care" in center- and home-based (family child care) settings. However, the most common form of nonparental care in the United States is not provided by licensed centers or licensed family child care caregivers, but by what are termed family, friend, and neighbor providers (FFN). The definitions and state regulations surrounding FFN caregiving vary by state, but a general definition of FFN care is home-based care provided in the child or caregiver's home by relatives, friends, neighbors, and babysitters or nannies. FFN care is generally unlicensed care, although in some cases it is subject to minimal regulation.

FFN care is distinct from licensed center and licensed family child care in a number of ways. There is wider variation in the caregivers, the location of care (child's or caregiver's home), the mix of children (related and unrelated), the expectations for payment, the timing and amount of care (weekend and nontraditional hours, overnight), and the reasons for providing care (to help the family, to generate extra income). FFN providers tend to be relatives, most commonly, but not exclusively, grandmothers; however, different strategies for classifying relative and nonrelative caregivers in demographic studies have made it more difficult to accurately estimate the prevalence of other relative and nonrelative caregivers (Susman-Stillman & Banghart, 2008).

Families and FFN providers recognize that FFN providers play a critical role in meeting the demand for child care, particularly infant–toddler care. Families of all socioeconomic backgrounds use FFN care, although low-income families are more likely to rely on it as their primary source of child care and so are families with children less than 3 years old (Chase & Valorose, 2010; Susman-Stillman & Banghart, 2008). Infants and toddlers living below the poverty line are more likely to be in relative care than nonrelative or licensed care (Mulligan, Brimhall, West, & Chapman, 2005). Among children of employed parents, infants and toddlers are just as likely as preschool-aged children to be in full-time relative care (at least 35 hours per week; Snyder & Adelman, 2004). Parents often report choosing FFN care for their infants and toddlers for both practical and personal reasons. They are more comfortable leaving their very young children with family members and want them to experience the family's particular cultural caregiving. Parents choosing FFN care for their infants and toddlers also appreciate the convenience and cost, because the care usually takes place in the caregiver's home,

Abstract

In 1997, Minnesota became the first state in the nation to pass legislation establishing an education and support program for family, friend, and neighbor (FFN) care providers. This article describes the Minnesota Family, Friend and Neighbor Grant Program and findings from an evaluation of the programs and a curriculum scan of materials used in the programs. The authors discuss lessons about program implementation and offer recommendations for continued program development. The authors also describe caregiver-reported activities as a result of program participation and share experiences of a unique and prominent group of FFN caregivers—grandmothers.

close to the parents' home, when the parents need it (often nontraditional hours) and it is more affordable than center-based infant care (Porter & Kearns, 2005).

Despite the common use of FFN caregiving, until recently, FFN caregivers were largely unrecognized by the formal child care community for the critical role they play in meeting the demand for child care and supporting families. With the advent of public policies emphasizing parental choice, an increased emphasis on providing quality early care and education for all children—and on promoting school readiness, particularly for low-income children—FFN care is receiving increased attention from researchers, practitioners, and policymakers.

Demographics of FFN Providers

Now there are national and state demographic studies describing the FFN caregiving population and patterns of care provision (Boushey & Wright, 2004; Brandon, Maher, Joesch, & Doyle, 2002; Chase, Arnold, Schauben,& Shardlow, 2006; Chase & Valorose, 2010; Maher & Joesch, 2005; Mulligan et al., 2005; Snyder & Adelman, 2004). FFN providers are notably heterogeneous in terms of ethnicity, language background, and amount of time they care for children, but do share some common characteristics. They are most frequently relatives (grandmothers), and often match the ethnic background of the children for whom they care, even when they are not related to the children. They tend to have incomes similar to the families for whom they care, and low levels of formal education. They have a wide range of experience caring for children, and little formal or specialized training related to caregiving. FFN providers are usually located in close geographic proximity to the children for whom they care, and they provide care during both traditional and nontraditional working hours (Susman-Stillman & Banghart, 2008). FFN providers report notable stability in their caregiving relationships—at least 12 months or more (Susman-Stillman & Banghart, in press).

A small number of studies examined the quality of FFN caregiving (Susman-Stillman & Banghart, in press). Taken together, this limited literature shows that, depending upon the measure of quality used and the populations studied, caregiver–child interaction is a strength of FFN care. FFN providers enjoy a low child:adult ratio, and report strong, positive relationships with parents. The use of television, opportunities for teaching and learning, and supports for social–emotional development, however, could be strengthened.

FFN providers do not generally view themselves as "caregiving professionals," nor do they want to become licensed caregivers. However, they report a strong commitment to caring for children and express an interest in learning more about how best to care for children (Porter & Kearns, 2005; Susman-Stillman, 2003). An analysis of FFN providers in Minnesota, for example, indicated that approximately 80% of providers were amenable to continued learning opportunities and that 56% had previously participated in some kind of parenting education (Chase et al., 2006).

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FFN providers tend to be relatives, most commonly, but not exclusively, grandmothers .

This growing body of research on FFN care reinforced the significance of FFN providers as a population of caregivers in demand. They are interested in learning more about how to best care for children, and in need of resources to support them in their caregiving activities.

Theoretical Perspectives Guiding Research and Practice

The literature on FFN care continues to grow. Two conceptual frameworks have been used to guide research on FFN care—a child developmental perspective and a family support perspective. The child developmental perspective emphasizes a focus on children's development and outcomes in the context of FFN care and views the FFN context from a framework based on the conditions of licensed, regulated care (Li-Grining & Coley, 2006), with less consideration of family or caregiver needs or the context in which FFN care is provided.

Although a family support perspective—recently also formulated as family sensitive caregiving (Bromer et al., 2011)—includes an appreciation for a focus on children's development, it also emphasizes responsiveness to the family's needs, strengths, and goals. Furthermore, a family support perspective promotes strategies for educating and supporting families (Kreader & Lawrence, 2006). The Strengthening Families approach, which describes five protective factors to build family resilience, is an example (Horton, 2003). A family support perspective may be more closely aligned with the nature and purpose of FFN caregiving, as it emphasizes unique components of FFN care, such as close family and community relationships, as well as the role FFN caregivers play in daily family life. Although some prefer a family support perspective because it more aptly captures the unique nature of FFN caregiving, it seems most useful to consider both a child development perspective and a family support perspective. Together, they include the compatible goals of supporting children's growth and development as well as promoting effective caregiving practices and supports for families.

Current Findings About Implementing FFN Programs

Recently, various programs have emerged that aim to provide support to both licensed and unlicensed home-based providers (for a detailed survey, see Porter et al., 2010) Practice with FFN providers is largely based on what is known from reports of programs and practices from community-based organizations that have worked with FFN providers and, to a much lesser extent, on what has been shown to work via rigorous program evaluations. Currently there is more collective wisdom

Photo: Debbie Rappaport

Almost 90% of caregivers reported that they frequently played with the child, praised the child, and taught basic manners.

from the reports of community-based program than from well-designed evaluations of program implementation and impact (Porter et al., 2010; Powell, 2008). Yet, slowly but surely, the research and practice literatures are growing, and it is helpful to review current findings regarding successful program implementation for FFN caregivers.

Findings from community-based program reports and studies of program implementation converge on the following points. FFN providers are a diverse group, and they are notoriously hard to reach. They are outside the mainstream of typical early care and education opportunities, namely those for licensed caregivers, as well as educational efforts targeted at parents. Taking part in education and support activities is unfamiliar to them. Thus, recruitment and engagement of providers is an enormous challenge but one that can be overcome by use of targeted techniques: patient and time-intensive outreach from trusted community members, relationship building, and consistency in program offerings (Porter et al., 2010).

FFN Education and Support Programs

Variety in service strategy is a clear theme across the education and support programs that serve FFN caregivers (Porter, et al., 2010; Powell, 2008). Programs differ in their approaches. Some may offer one, others offer multiple services. Typical service strategies include reaching providers (a) in-home via home visiting or group activities in an apartment complex, (b) via community-wide events, (c) through group activities focused just on the adult caregivers, or (d) through group activities that focus on the caregivers and children together.

Program goals also vary from specific to general. Although a few have a specified curriculum (McCabe & Cochran, 2008), the majority piece together program content as they assess the interest, needs, and wants of their particular group of FFN providers (Powell, 2008). Intensity of service also varies greatly across projects, from weekly drop-in programs to biweekly home visits, to monthly community events. Rather than a "one size fits all" model, flexibility across service delivery and program offerings is an essential characteristic of FFN education and support programs.

Three recent evaluations (Maher, Kelly, & Scarpa, 2008; McCabe & Cochran, 2008; Porter & Vuong, 2008) examined the impact of a specific service strategy (e.g., home visiting, grandparent groups) on relevant caregiver and child outcomes. The outcomes measured were quality of care, caregiver–child interactions, and child growth and development. Positive program impacts were found: small growth in the quality of the child care setting, some improvements in the quality of interactions between caregiver and child, and greater caregiver knowledge about play and other aspects of child development.

In sum, the literature briefly reviewed provides some useful context and guidance regarding the nature, intent, and implementation of FFN programs. However, there is still much to learn about successful program development and implementation for FFN providers.

Minnesota's FFN Initiatives

A more focused, formal interest on FFN caregiving began developing about a decade ago in Minnesota. Since then, multiple collaborative efforts from a cross-section of Minnesota philanthropies, local and state organizations, and researchers resulted in demographic studies, focus groups with ethnically diverse FFN caregivers, and observations of FFN quality. Community-based organizations launched pilot education programs which included targeted training and outreach efforts through the Child Care Resource and Referral Network, the development of a statewide strategic action plan for the provision of services and supports to FFN caregivers (with technical assistance provided by ZERO TO THREE and the National Child Care Information Center), and, most recently and significantly, a state-funded education and support grant program for FFN caregivers.

In 2007, the Minnesota State Legislature became the first in the nation to pass legislation that specifically focused on providing education and support to FFN caregivers, establishing a Family, Friend and Neighbor Grant Program. The purpose of the FFN Grant Program was to "promote children's early literacy, healthy development, and school readiness [for children cared for by FFN providers], and to foster community partnerships to promote school readiness" (Laws, 2007, Chapter 147, Article 2, Section 48).

These grants, totaling $750,000, were awarded through a competitive grant process administered by the Minnesota Department of Human Services. Community-based organizations, nonprofit organizations and American Indian tribes received funds to implement early literacy programs and to support families' health, mental health, economic, and developmental needs. The grant also encouraged collaboration with community-based organizations that support early childhood development and learning. The programs initially received funding for 2 years. In 2009, the Grant Program was appropriated an additional $750,000 from the federal child care development American Reinvestment and Recovery Act (2009) funds. The funds were targeted for quality and expansion and infant–toddler care for fiscal years 2010–11 to continue existing projects or fund new ones (see box Collaborative FNN Projects Across Minnesota).

The legislation also called for an evaluation of the FFN Grant Program that included gathering information about the participating caregivers and the extent to which they demonstrated knowledge or practice about early child development and school readiness. The Center for Early Education and Development at the University of Minnesota was asked to conduct the evaluation. As part of the evaluation, information about program implementation

Collaborative FFN Projects Across Minnesota

The FFN Grant Program in Minnesota funded six collaborative projects across the state:

- **Neighborhood House** in St. Paul collaborated with Common Bond Communities, Prevent Child Abuse Minnesota, the Children's Museum, and Resources for Child Caring to develop culturally relevant services, interactive activities, outreach, and on-site programming and support-group meeting opportunities at low-income housing sites.
- **The Early Childhood Resource and Training Center** in Minneapolis focused on American Indian providers and the children they care for using trainers who spoke specifically to American Indian issues and who visited homes to deliver participant-driven services. This program connected participants with urban centers, clinics, and libraries. Its partners included the All Nations Early Education Center, Franklin Library, Native American Community Clinic, a University of Minnesota pediatrician, and the Minnesota Indian Women's Resource Center.
- **Resources for Child Caring**, the child care resource and referral agency for Hennepin and Ramsey Counties, coordinated efforts to develop and implement a community outreach model using current immigrant care providers and their families as community "ambassadors" to connect with other members of their communities. In addition, the Alliance for Early Childhood Professionals implemented their Hands on Teach to Learn curriculum. Other partners included Minneapolis Public Schools and the Northwest Hennepin Family Services Collaborative in offering practice preschool opportunities for FFN caregivers and the children in their care. Key resource providers were the City of Minneapolis Department of Health and Family Support, Hennepin County Child Care Licensing, and the Hennepin County Medical Center.
- The **Northland Foundation** in the Duluth area received a grant to fund a collaborative project in five communities. These include the Duluth Public Schools Early Childhood Programs, Carlton County Prenatal/Early Childhood Coalition, Hermantown/Proctor Early Childhood Programs and Coalition, and the Lake Superior School District, along with the Lake County and Silver Bay Early Childhood Coalitions. These groups worked in partnership support with the Northland Foundation as well as Child Care Resource & Referral–Region 3, the Duluth Public Library, Arrowhead Library System, United Way of Greater Duluth, Arrowhead Area Agency on Aging, and the University of Minnesota Duluth. Strategies included home visits, sharing of educational materials, a public awareness campaign, and training opportunities to help FFN providers gain access to a wealth of child development information and other resources.
- **Thorson Memorial Library** in Elbow Lake had as partners Early Childhood Family Education educators, Head Start, Public Health, Lakes & Prairies Child Care Resource & Referral, ELEAH Medical Center, University of Minnesota Extension, and The Child & Youth Council. This project developed Caregiver Toolkits, provided Play and Learn groups with training for caregivers and activities for children, and created Ready to Learn backpacks that were made available through the library system.
- The **White Earth Indian Reservation** developed monthly trainings and a home visiting program. Totes with materials on seasonal topics were assembled and checked out by FFN providers through the Bookmobile system. Local collaborators included organizations such as Even Start and White Earth Early Childhood Initiative, White Earth Home Health, Mahnomen/Becker/Clearwater Counties, White Earth Head Start, Shooting Star Casino/HR, Indian Health Service, White Earth Child Care Assistance Program, and White Earth Child Care Program/Early Childhood Training.

to gauge program fidelity, implementation successes, and challenges to implementation was also collected. Additional support from a local foundation allowed the Center for Early Education and Development evaluation team to enhance the required evaluation through interviewing grandmother FFN caregivers. The goals of these interviews were to learn more about the grandmothers' experiences in the FFN programs and to continue to gauge program impacts. The following section details findings from the evaluation.

Evaluation of the Minnesota FFN Grant Program

Program evaluation included interviewing program staff, holding grantee meetings, conducting site visits, and performing a curriculum scan of program materials to gather information about implementation fidelity. The goal was not to make any hard-and-fast determinations about whether or not programs reached a certain standard of implementation fidelity. Rather, because these programs were new and piloting their own new ways to work with FFN providers, the aim of the evaluation was to provide a useful synthesis of program implementation themes that can be used by programs and policymakers in future phases of FFN support and education initiatives.

Program Development and Implementation

Five themes related to program development and implementation, with features unique to FFN programming, emerged:

1. Raising awareness,
2. Building trust and community,
3. Connecting and collaborating,
4. Responding to context for program planning and delivery, and
5. Teaching/training grounded in experience.

RAISING AWARENESS

A common refrain we heard from program staff was the need to define FFN and build a general understanding of FFN caregivers and FFN caregiving. Program staff discovered that they themselves needed more knowledge about FFN caregiving, its rhythms, and the unique features of the FFN caregivers they were planning to serve. For example, they came to learn that having a predictable, regular schedule was important, even though caregiving schedules were often fluid and attendees were not always the same. They also discovered that FFN providers rarely recognized or acknowledged the critical role they play in caring for children and families, and they were surprised to learn that there was a term for their caregiving. FFN providers often understated the significance of their work and their contributions, saying, for example, "I'm just taking care of my grandchildren," or "I'm helping out my daughter." There is an intimate connection between awareness and recruitment. The need to raise awareness of FFN made identifying providers more difficult than was initially anticipated. Recruitment became a longer process as a result. Program staff acknowledged the significant amount of time needed to identify and recruit providers and also the ongoing nature of that endeavor. They noted several methods that were most successful in recruiting FFN providers including when they used individual, personalized contacts; when participants talked to other potential participants; when staff could take time to build and nurture relationships; when staff could offer a consistent schedule for activities; when staff used an existing program to recruit; and when incentives were part of the program throughout.

Photo: ©iStockphoto.com/Michael DeLeon

FFN care is the preferred type of care arrangement for infants and toddlers.

BUILDING TRUST AND COMMUNITY

Program staff also discussed building trust and community as an important component of raising awareness, as well as key to successful implementation and engagement. Building trust and community was observed in two ways: between program and providers and between providers themselves. Programs varied in the barriers they needed to overcome related to building trust and community. Those serving caregivers who were English language learners or immigrants also found themselves needing to allay fears about not reporting income for care provided or about reporting immigrant status to the authorities . However, programs described success in cultivating a more consistent group of participants once fears were alleviated. They also reported greater use of community organizations, such as the library, by FFN program participants.

Program staff reported a sense of community and connection between providers as well, saying that the programs "allowed providers to make connections for the children and for themselves that they would not have been able to make previously. Group activities allowed them to meet other people caring for children like they were." Many caregivers reported surprise, as well as pleasure, at learning about others like them who were also providing care. Cultivating a sense of community with the diverse groups that were part of the Minnesota FFN Grant Program brought unanticipated challenges to some of the programs. For example, a couple of the programs held group sessions that brought together members of African tribal groups with historical tensions. The programs did successfully develop acceptable solutions for maintaining involvement and connection.

CONNECTING AND COLLABORATING

The Minnesota FFN Grant Program required collaboration among community organizations. Although programs noted many benefits of the collaborations, namely in the form of resources, curricular materials, and stabilizing weaker organizations so the proposed programs could still be implemented, they also mentioned that there were differences in knowledge and experience working with FFN providers within different organizations. Programs reported some unclear lines of communication across the collaborating agencies, and, for a couple of the programs, challenges in cohering the set of activities put forth in the grant proposal once implementation began.

RESPONDING TO CONTEXT FOR PROGRAM PLANNING AND DELIVERY

All the FFN programs faced the enormous challenge of how to understand and then create meaningful programs for the participating FFN providers. Each program handled this issue a bit differently. While all were bound to the tenets of the legislation, which mandated a focus on school readiness and literacy, they were quite conscious of the need to gauge and respond to FFN providers' interests. Some surveyed participants, others asked in an ad-hoc way about interests, others made note of interests (e.g., around Ojibwe culture) and brought in materials, curriculum, or other resources as they saw fit. Overwhelmingly, caregivers sought new activities to engage in with the children. They also wanted to learn about a wide range of topics, including child development, discipline, health and safety, and getting children ready for school. An interesting request for healthy recipes came from FFN providers who were English language learners, who were concerned about obesity in the American culture and what one participant termed "big eating."

Programs intentionally and thoughtfully responded to caregiver interests. Across the programs, an extensive set of topics and activities were covered. All programs included the following topics: everyday learning, make-and-take activities, child development, language and literacy, school readiness, socio-emotional development and behavior, and health and safety (including safety hazards, CPR, and nutrition). Roughly half the programs also covered topics related to culture, use of television, parent–caregiver communication, and environments. A couple of programs also included why caregiving matters, caregiver stress and mental health, brain research, and becoming licensed.

Programs often reported that unexpected needs arose—whether for information or resources. "If there aren't resources and supplies, be ready to build a collection of resources or inventory," one agency director said, "we almost have a cottage industry going of developing bags of supplies." Several programs talked about the physical supplies that are now highly valued and frequently accessed by the FFN community, such as literacy kits at the libraries.

All of the FFN programs reported some degree of self-designed, emerging curriculum. In some cases, they use curricula that are backed up by research (e.g., Parents as Teachers). In other cases, they describe a curriculum that is a merging of content, approaches, and strategies. For example, some programs used an explicit curriculum approach and then adjusted it as FFN caregivers responded (positively or less positively) to particular parts of the curriculum. Other programs did not have an identified curriculum but rather a framework that guided their work (e.g., Minnesota Parent Education Curriculum Framework, University of Minnesota, 2008).

Program activities and curricular adaptations were related to the program's goals. However, programs varied in the extent to which they explicitly matched specific activities to goals. Some programs had an explicit set of goals that drove all content. For instance, one of the projects planned topics and activities that were purposefully matched with a protective factor and expected outcomes. Other programs offered activities and content that related to more general goals.

For instance, all of the programs offered support and training that fit under the general goals of school readiness or early literacy, but did not necessarily map onto explicit outcomes. Again, programs fell along a continuum. At one end were curricula with clear goals that drove all of the activities of the curriculum (e.g., increase caregiver–child reading time), and at the other end, the curricula functioned as a loose collection of topics and activities with less explicit goals (e.g., support oral language development).

In general, project personnel felt that they were able to adapt curriculum as needed. They attributed their adaptability and flexibility to the fact that they had several years of experience in working with a variety of adults and children. Some project personnel described the significance of their work. "We were giving caregivers with a limited educational background really basic and fundamental information and examples, especially about play." Another stated, "The whole idea of getting ready for school was a new thing. A lot for the first time were coloring and singing songs, using scissors, understanding the importance of different skills to get ready for school."

Program staff also reported making some changes as they implemented the programs. Examples of changes were:

- Shortening the number of weeks a cohort group would meet in order to increase the number of cohort groups overall
- Adding a parent educator to provide more information about activities with children
- Bringing in other resources from outside organizations
- Offering home visits as an alternative to the classroom program
- Altering the schedule of community events.

TEACHING/TRAINING GROUNDED IN EXPERIENCE

Program directors noted that they looked for project personnel who knew the community and who had experience working with both children and adults. Program personnel came from a variety of backgrounds, which included librarians, Early Childhood Family Education teachers, Head Start teachers, early education trainers, child care lead teacher, social worker, family worker, and the Peace Corps. In some cases, existing staff members were used.

Very little specific training for working with FFN providers was given. One director said, "They were specialists in their own work. We didn't train because most had presentations they gave." Staff was stable, and most favored experience over training as what was necessary to do this work well. Some spoke several languages and had home visiting experience. Meeting the needs of FFN providers in these programs required a diverse set of tasks and staff skills, so the wide range of experiences and backgrounds seemed necessary and appropriate. Even so, staff still reported learning unique to their work with FFN providers. Some examples include the time it took to build trusting relationships; the unpredictability of caregivers' schedules affecting their availability to participate in programs; and the interests, needs, and learning styles of the FFN caregivers. Staff who had regular meetings to debrief appreciated that opportunity, saying that sharing insights with one another really helped, so there "wasn't a constant [reinvention of] the wheel." They acknowledged that "this is unusual work, and having the basic support and opportunity to talk about it was important."

When asked about the characteristics of staff most effective at working with FFN caregivers, respondents consistently reported the same "must have" traits. All of those interviewed identified the ability to build trust in relationships as a key skill. A second common response was similar to trust: respectful flexibility. When asked to talk more about what these interpersonal traits looked like, respondents made comments like "flexible, no matter what is going on she can be calm and caring," "unflappable," or "someone who is able to suspend judgment, whether the environment is messy or clean, whether the caregiver knows what she is doing or is having a bad day." All but one interviewee talked about "being able to go where you don't expect the topic to go…to follow the needs of the caregiver."

The other consistent "must have" answer was that the persons delivering curricula have early childhood expertise. In some cases, program partners did not have this expertise, and so they found new partners who did have this background, even if that was not part of the original plan. Both library FFN programs specifically talked about needing to either hire part-time staff from Head Start or Early Childhood Family Education or else partner formally with an early childhood entity. In some cases where FFN facilitators did not have formal degrees or early childhood licensure, they were well-trained through the child care quality enhancement training curricula (e.g., literacy curriculum training).

Half of the programs identified early literacy expertise as a necessary part of the person's background (likely due to the legislation specifying literacy as a program goal). Half also mentioned that people needed to be willing to "bring themselves into the work." When asked to say more about that, interviewees talked about the need to share one's own background of adjustment to a new country, grandparenting experiences, working with one's own child with special needs, or coping with difficult childhood backgrounds.

Several other responses were mentioned by at least two of the programs: having an outgoing personality ("not afraid to strike up conversations with total strangers"); being well versed in the Minnesota Early Childhood Indicators of Progress (early learning standards); representing home culture and language; and being organized, self-directed, and able to take initiative.

Program directors and staff were also asked about the extent to which cultural factors such as language barriers or lack of knowledge about specific cultural child-rearing practices affected their work with FFN providers. The programs served at least six different cultural groups, including Caucasian, African American, Native American, Somali, Hmong, and West and East Africans. At least 50% of the programs served FFN providers from multiple ethnic backgrounds. Having translators was viewed as key and an absolute necessity. Surprisingly, however, program staff did not report lack of knowledge of specific cultural practices—or cultural issues in general—to be barriers in working with the FFN providers either onsite or in their homes or apartment buildings.

In sites where multiple ethnic groups participated, program personnel noted that having a multicultural staff enabled them to address and respond to any issues related to culture. One staff member talked about the challenges for new immigrant families around the topic of discipline and around general concepts of child and adult development; others acknowledged the "newness" of the concept of school readiness and the need to move slowly when introducing new information, and to keep reviewing ideas and concepts. One program specifically noted how they gathered information about African life and incorporated culturally specific information into the practice preschool sessions, and that the African grandparents responded by bringing in traditional African music and teaching dance.

Other respondents acknowledged particular philosophical issues: know curriculum goals well, make things practical and hands-on, be resourceful, and know the community. One respondent talked about the need to be reflective, to ask "How was that for you?" and then listen well. Although project personnel clearly demonstrated areas of competence and felt comfortable working in these programs, it was rare to find individual staff who had experience and training in the multiple

areas of early education, adult learning, FFN caregivers, and specific cultural perspectives. Clearly, this is a new arena for cultivating staff competencies. Meaningful staff development within the context of FFN education and support programs requires further discussion and development. Developing educational programming for staff working with FFN providers that incorporates many of the lessons learned from the Grant Program and other FFN initiatives around the nation may help programs get up to speed more quickly and easily and improve their effectiveness.

Learning From the FFN Providers

We obtained two sources of information from caregivers about their participation and learning as FFN program participants: a caregiver survey that 134 FFN providers across the six programs completed, either online or in-person, independently or with assistance and/or language translation; and interviews with 40 grandmothers who agreed to provide more in-depth information about their experiences in the FFN Grant Program (see box FNN Providers in Their Own Words). Because FFN caregivers, particularly grandmothers, are unlikely to have participated in education and support programs in the past, these interviews were conducted as a way to use the perspective of the participants to better understand what it meant to participate in programs like these and to gauge program impacts.

The caregiver survey included questions about the FFN caregiver's background and education, their activities with children, and their relationships with the children's parents. It was translated into Spanish, Somali, and Hmong. FFN caregivers identified by program staff as consistent participants were asked to complete the survey. FFN grandmothers were recruited for the interviews in a similar way. When necessary, translators helped us conduct the interviews.

Caregivers who completed the survey represented the diversity of participants in the FFN program. Almost half were immigrants (non-Caucasian) and spoke a language that was not English. Educational backgrounds varied, with about two thirds having completed high school or some college. The majority of survey respondents completed their education in the United States. Almost half of the caregiver respondents were grandmothers, followed by close friend FFN caregivers. The largest group of children they cared for was infants and toddlers, followed by preschool age children.

Almost 90% of caregivers reported that they frequently played with the child, praised the child, and taught basic manners. They also reported engaging in a wide range of activities with children to support socioemotional, cognitive, and literacy development. Many of these were activities discussed in their individual programs. Examples include frequently talking, telling stories, practicing language activities such as teaching names, and reading. They also reported frequently providing crayons, pencils, and paper for drawing or coloring; giving them simple tasks to do (e.g., clean up toys, follow directions) and playing finger and rhyming games. Caregivers often referenced using materials they received through participation in their grant program (e.g., backpack from the library, toys from home visit). They were much less likely to take children to organized lessons or activities.

FFN Providers in Their Own Words

Interviews with the diverse group of grandmothers who participated in the FFN Grant Program provided more detail about their experiences. Across the board, they describe important realizations about caring for infants and toddlers.

We'd play, but we didn't know how to make it fun. Like if you're getting ready to learn your numbers or your alphabet or something like that and you use things around the house, stuff you have and you don't even have to go spend money, common day stuff. And you can teach them with everyday stuff, "Okay, go get the red ball," not just, "Go get the ball." You know things that you don't—really come in your mind sometimes—that was really helpful.

My granddaughter who has just turned 2 has always loved reading. We read 5 books before nap. One time I tried to put her to bed without reading [to] her and that didn't work. We had to read, then we had to lay down. And my grandson who is 6 months gets in on that too.

The babies learn a way for us to teach them. They look at us with those eyes like, "What comes next?"

My friend's baby calls me Grandma and he is only 10 months old and I teach him milk *and* more *[sign language] and I notice the more you teach them, the faster they learn. If you talk all day to the children, the more they will be a professional. The more words you put in their vocabulary, the better for their future.*

When we were talking about finger play and talking about the importance and I thought the song "Where is Thumbkin?" is primarily to teach children which finger is your thumb, pointer, etc. And she [the home visitor] had pointed out that actually it's to promote the development of their fine motor skills.

Synthesis and Recommendations

Our evaluation findings suggest that the Minnesota FFN Grant Program offers promising examples for successfully serving FFN providers. They offered a diverse array of services to a unique group of caregivers for the first time. As is to be expected with new program development, there were important lessons and unexpected challenges to overcome. It took time to define and identify FFN providers, build trust and relationships and develop consistency in program and participation, and provide appropriate, relevant content. Adaptability, patience, and flexibility were recognized as key to program success. And although it did take time, relationships were built, more consistent groups of participants formed, and both program staff and FFN caregivers learned.

Our results across the program staff interviews, caregiver survey, and grandmother interviews offer a coherent picture of program activities and participant experiences. The FFN participants were an eager group. Activities to do with children were a high priority for caregivers, and programs genuinely responded to that request. Caregivers reported engaging in activities outside the program that they learned or became aware of through their participation in the program, and detailed examples of their lessons about child development, literacy, and overall

Learn More

Research Connections
www.researchconnections.org

Minnesota Resources for FFN Caregivers
www.mnchildcare.org/ffn/resources.php

Minnesota' Ready for K Initiative
www.ready4k.org/index.asp?Type=B_BASIC&SEC={C2C1E3F7-E149-484C-AE5E-8814D7808399}

National Child Care Information Center
http://nccic.acf.hhs.gov/; specifically, http://nccic.acf.hhs.gov/resource/understanding-and-supporting-family-friend-and-neighbor-child-care

caregiving. They reported positively about their experiences and continue to voice enthusiasm for learning.

The following recommendations were offered to enhance program success.

1. Foster learning and support opportunities, such as a network for FFN providers. Caregivers reported high levels of activities with children and high interest in learning more activities to do with children. Providers desire and need multiple kinds of supports, including:
   - Information about child development and school readiness,
   - Methods for strengthening their community connections, and
   - Education about family-friend relationship issues and communication.

2. Clearly define and effectively target FFN providers. There are limited resources and a vast FFN population. Developing strategic understanding and targeting of groups of FFN providers (e.g., grandparents, those receiving subsidies) will likely result in greater uptake of programs, higher quality implementation, greater program effectiveness, and more effective use of funds.
3. Continue program development with attention to program goals, content, and effectiveness.
   a. Clarify program goals for child development and caregiver–family support, and ensure coherence with program content and services offered (e.g., perhaps primary and then secondary services).
   b. Examine more closely the extent to which the content that formed the basis for program information matched and met the goals of the program and of the caregivers.
   c. Explore connections between program goals and cultural perspectives.

4. Develop education and support for professionals working with FFN providers.
   a. Create and disseminate materials to guide successful program implementation and develop trainings so that programs can start off at a higher level of implementation. Programs will be more efficient, needing to do less adaptation at the delivery level, and will likely increase their quality and effectiveness.
   b. Cultivate a community of practice for professionals working with FFN providers. Offer staff development specific to working with FFN caregivers and cultivate the multiple competencies required to successfully support FFN caregivers.

More children are cared for by unlicensed FFN caregivers than by formal, licensed programs. FFN care is the preferred type of care arrangement for infants and toddlers, and most common for low-income children. FFN caregivers report seeing themselves as "helping out," not as a teacher or educator. However, they are eager to learn. There is much to gain by reaching out and providing supports to them. FFN caregivers can "help out" while at the same time provide enriching early care and education experiences for their grandchildren, neighbor children, and friends' children. The Minnesota FFN Grant Program provides examples of promising programs for a diverse range of FFN providers.

Amy Susman-Stillman, *PhD, is co-director of the Center for Early Education and Development (CEED) at the University of Minnesota. Her work focuses on improving the quality of early care and education across all settings and professional development of early care and education providers. She has written literature reviews on the demographics and quality of FFN care, and is the principal investigator of the Minnesota FFN Grant Program evaluation and the Sharing the Wisdom FFN Grandmother Project.*

Karen Stout, *PhD, is a research associate for the Institute on Community Integration at the University of Minnesota. She is interested in research on policy enactment and model development to improve persistence and retention of K–12 and postsecondary students. She also conducts program evaluations in educational settings and shares a personal and professional interest in FFN caregiving.*

Jennifer Cleveland, *MSW, is program coordinator at the Center for Early Education and Development (CEED) at the University of Minnesota. She specializes in coordinating research projects within the field of applied research in early care and education, including the Sharing the Wisdom FFN Grandmother Project. She enjoys interviewing child care providers and hearing about caregiver experiences. .*

Vicki Hawley, *MS, is a program coordinator for a variety of professional development initiatives at the Center for Early Education and Development (CEED) at the University of Minnesota. Her areas of emphasis are early language/literacy development and infant–toddler care, and evaluating professional developmental models that use assessment to support teachers and children. Vicki spent her early professional life working directly with young children and their families in various settings (preschool, home visiting, and family life education) followed by 16 years in statewide training and training development. Before coming to CEED, she coordinated the Minnesota Reading Corps AmeriCorps project at the Minnesota Literacy Council and the Program for Infant-Toddler Care and Parents as Teachers statewide initiatives at North Dakota State University.*

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Working With Family, Friend, and Neighbor Caregivers

Lessons From Four Diverse Communities

DOUGLAS R. POWELL

Editor's Note: This article is excerpted from *Who's Watching the Babies? Improving the Quality of Family, Friend, and Neighbor Care* by Douglas R. Powell (ZERO TO THREE, 2008).

One Saturday morning on a cold winter day in Minnesota, a group of 12 women gathered in a meeting room at a community center to talk about their work in caring for very young children. Nine women were caring for grandchildren, and three women were caring for children of close friends or relatives. The women attended the meeting in response to a letter of invitation from the meeting organizer, a child care expert at a child care resource and referral (CCR&R) agency interested in launching a project to provide support for informal caregivers. The participants described their caregiving arrangements (e.g., from 1 to 9 children at different times) and why they do the work (e.g., "to help my daughter"). They generated a list of topics they'd like to learn more about. Infant–toddler development, early literacy, special needs, CPR, first aid, sudden infant death syndrome, and communicating with parents were quickly identified as some of the areas of shared interest. The listing of topics moved to a discussion of joys and frustrations in caring for other people's children. There was talk of difficulties in setting limits with the children's parents, getting strongly attached to the children, finding time each day for taking care of one's self, and differences between rearing grandchildren and their own children. Several cried. The participants agreed to meet twice a month on Saturday mornings, shared contact information so they could communicate between meetings, and wanted to know if they could invite others. This gathering occurred in one of four projects aimed at supporting family, friend, and neighbor (FFN) caregivers. The projects were initiated by the Archibald Bush Foundation of St. Paul, Minnesota, for the purpose of learning how to share information about the development and care of infants and toddlers with informal child care providers. Questions about program development and implementation strategies were at the forefront of the Bush initiative: How do programs and their host agencies prepare to work with the relatively unfamiliar population of FFN caregivers? What are effective ways to find and engage informal providers? What methods are useful in responding to the needs and interests of FFN providers? (See Table 1)

The intent was to ensure that projects incorporated the views and experiences of informal caregivers in generating a project design. Second, the projects were to work with individuals caring for at least one child 3 years old or younger for 10 or more hours per week in an informal (unlicensed) arrangement. Lastly, project staff—coordinators and their supervisors—were to document their efforts by maintaining daily journals of their project-related actions and reflections on the work. They also participated in periodic interviews with Bush consultants responsible for providing technical assistance to the initiative. Agencies were selected for developing a project through a grant proposal review process that began with agency submission of a letter of intent. Prior to inviting eligible agencies to submit a full proposal, Bush Foundation staff convened a meeting with representatives of interested agencies for the purpose of describing the planned parameters of the initiative. Population diversity was among the considerations in the Bush Foundation's decision-making process.

The projects received three types of support during the 18-month duration of the initiative. Bush consultants in early childhood organized and implemented four 1-day meetings of project coordinators and their supervisors for purposes of sharing current knowledge about supporting FFN providers and, importantly, facilitating discussion among project staff about their plans and experiences. These meetings were initiated with an orientation session prior to the beginning of project work. A focus of the orientation was the presentation and discussion of Bush Foundation-prepared

Table 1. Contrasting Approaches to Program Development in Supporting Family, Friend, and Neighbor Caregivers

Program Feature	Conventional Approach	Community-Based Approach
Main question	What needs or problems have you seen in the informal providers or the children they care for?	How can we support you in the important job you are doing with young children?
Key informant	Other professionals	Caregivers
View of caregiver	Has deficits	Has both resources and needs
Recruitment	Print (e.g., fliers, letters, posters)	Personal (e.g., word of mouth)
Helping process	Professional gives to caregiver	Professional adds to insights and resources shared by caregivers
Source of key words to describe program	Professional perspectives and terminology (e.g., training)	Caregivers' perspectives and language (e.g., "get together")
Methods of providing support	Modeling, newsletters, presentations	Determined with caregivers
Number of support strategies	Usually one dominant approach	Several
Focus of growth	Caregiver	Both professional and caregiver
Sponsoring agency role	Extend existing knowledge and skill base	Learn or refine new ways to provide information and support

summaries of available research on FFN caregivers and 11 state or local projects aimed at supporting the quality of FFN care through training or technical assistance. The 11 featured projects were identified in consultation with Bank Street College's Institute for a Child Care Continuum. One of the recurring features of each follow-up meeting was joint effort, through group discussion, to refine key elements of the community-based approach to program development as set forth in Table 1. Leaders of Bank Street College's Institute for a Child Care Continuum provided a 3-day training based on the curriculum described in chapter 3 (of *Who's Watching the Babies?*). Finally, a Bush consultant provided technical assistance and advice to each project coordinator. The frequency of these consultations varied across projects. Each project was encouraged to devote the first 3 months of the grant period to project planning, particularly in collaboration with pertinent leaders and members of the target community.

Below are brief descriptions of the four projects, their communities, and the caregivers they served.[1] Most providers cared for one or two children through an informal arrangement, although providers in the inner-city neighborhood project cared for an average of four children across various times of the day. Most providers cared for a preschool or school-age child or children in addition to one or more children less than 3 years old. Across the four projects, about one half of the participants had been FFN providers for between 1 and 5 years. The suburban community project served a sizeable number of women who had been FFN providers for less than 1 year (45%), whereas the inner-city neighborhood project served many FFN providers with 6 or more years of experience (50%). The number of program sessions with caregivers, in the form of group meetings or home visits, ranged from 7 to 10.

- **Inner-city neighborhood:** A CCR&R agency with a long history of training child care providers developed and implemented one of the projects for informal caregivers in an urban neighborhood with a substantial number of lower income and ethnically/racially diverse residents. A group method was employed. More than two thirds of participants were African American and 17% were Native American. A majority of caregivers were relatives of the child or children in their care (58%); others were friends/neighbors (25%) or cared for a mix of relatives' and friends' children (17%). One third had completed high school, and most others had some post-secondary education (42%) or college degree (17%). The project coordinator was an early childhood professional with experiences in a special project for recipients of welfare and in facilitating support groups
- **Urban Somali neighborhood:** An agency that provides training and technical assistance to early childhood personnel developed a project for women in an urban neighborhood comprised primarily of recent immigrants from Somalia. Most of the women lived in two adjacent apartment complexes. The project used a group format, with meetings held in a meeting room in one of the apartment complexes or at the agency's nearby offices (transportation was provided). All participants in the project were Somalian, most of whom had recently relocated to the United States. Most cared informally for children of friends or neighbors (53%); others cared for children of relatives (47%). The project coordinator was a recent immigrant from Somalia with extensive professional experiences and credentials as a community health worker.
- **Suburban community:** The project serving a large suburban county was based at an agency that provided child care resource and referral services plus a family support program for at-risk children. The project worked with Somali women, all recent immigrants to the United States, through a collaborative arrangement with a parenting education program in which the women were participating. One half of the women were informally caring for one or more children of relatives, and the other one half were caring for neighbors' children. The project also served a different set of informal caregivers through occasional consultation work, usually via telephone calls initiated by the providers. The latter group was mostly European American (80%) with college degrees (55%), primarily caring for children of friends or neighbors (55%) or serving as a nanny (15%). The project prepared and distributed a newsletter for FFN providers. Three staff persons assumed responsibility for different geographic areas of the county. One staff member had experiences in child care referral work, another was a seasoned early childhood professional with a background in training infant–toddler caregivers, and the third staff member had child care center teaching experiences. In this article, the terms suburban Somali and urban Somali are used to distinguish the two Somali groups reached in the initiative.
- **Native American reservation:** The project was developed by early childhood staff affiliated with an infant–toddler caregiver training program based at a tribal college. The project was targeted

[1] *Information on caregiver characteristics is based on the following numbers of participants who completed demographic questionnaires: 12 in the inner-city neighborhood project; 15 in the project serving urban Somali immigrants; and 28 in the suburban project (8 of whom were enrolled in the parenting education group serving Somali immigrant women). Demographic information was not secured from participants in the project serving a tribal community.*

to informal caregivers living on the tribe's reservation. The project provided home visits focused on early literacy and language development plus periodic group meetings. It also prepared and distributed a newsletter for the target population. This project ended several months early because of the departure of the project coordinator for another professional position on the reservation. The project coordinator was a teacher (licensed in early childhood and elementary education) with experiences in teaching infant–toddler development at the college level.

Finding and Engaging FFN Caregivers

The projects mostly found FFN providers with an existing connection to a formal support system for their caregiver role.

Each project initially identified prospective participants who were already linked to an established program focused on the care of young children. Most prospective participants were not receiving ongoing training and technical assistance for their informal caregiver role, however. Some participants had previously enrolled in child care training workshops or programs. This was especially the case with providers in the inner-city neighborhood project. Prior to participating in the Bush Foundation project, two thirds of participants in the inner-city neighborhood project had received child care training, ranging from 12 to 44 hours.

It was common for projects to find prospective participants through lists of legally unlicensed providers participating in a child care subsidy program as well as lists of self-identified unlicensed providers who had participated in one or more child care trainings such as a workshop.

The project serving an inner-city neighborhood also found FFN caregivers by word of mouth, through friends who attended the first group meeting, and through visibility at the community center where the project's group meetings were held (e.g., the receptionist regularly provided care for a friend's child on weekends).

Agency lists of unlicensed providers were not always an efficient, guaranteed path to FFN caregivers.

There were striking differences across the projects in whether contact with unlicensed providers identified through child care agency lists led to project participation. One project sent an invitation to a project orientation meeting to approximately 150 unlicensed providers who had received a child care subsidy administered by the agency or identified themselves as a legally unlicensed provider in registering for a child care training offered by the agency. The letter was accompanied by a stick of gum, enclosed as an attention-getting device. Twenty-five of the some 150 individuals who received the letter responded with an intention to attend the first meeting, and 12 of the 25 individuals attended the first meeting (described in the first paragraph of this article). The coordinator of the project serving urban Somali women was able to conduct a home visit with nearly all of the individuals on a list of current recipients of a child care subsidy for FFN providers.

In contrast, a third project encountered problems in conducting a telephone and mail survey with prospective participants by using agency lists of (a) unlicensed provider participants in the child care subsidy program, (b) persons expressing interest in providing child care, and (c) unlicensed providers who had attended child care trainings.

Difficult-to-reach FFN providers were most readily found through families.

Projects used several different outreach efforts to identify FFN caregivers who were "unknown" to the projects—that is, not on available lists of child care subsidy recipients, child care training participants, or existing programs such as the suburban parenting education group. This more invisible set of informal caregivers may have needs and interests that differ from those of informal caregivers who have found their way to subsidy programs and other forms of formal assistance such as a parenting program.

The project serving a tribal community found some of its participants through tribal college students who were parents. The project coordinator visited classes and approached students in campus gathering places (e.g., cafeteria) to ask if students had a child care arrangement with a relative or friend. Those who responded "yes" were told about the project and asked for permission to contact the relative or friend. Most of the informal providers identified through this method were not on lists of child care providers secured through other agencies. The project coordinator found that when she contacted providers via telephone, they were more receptive to talking with her than were providers she identified through agency lists. About one quarter of FFN caregivers identified through the college students enrolled in the project.

Projects also pursued print-based outreach efforts and personal contact with prospective participants via young children's programs at local libraries. The limited yield of these efforts is described next.

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A majority of caregivers were relatives of the child or children in their care.

Print-based community outreach generally was not successful in identifying FFN caregivers.

The use of print to publicize a new program is a common approach to promoting awareness of a community issue and an agency's response. This method helps introduce a new program to other agencies and professionals in a community, and provides yet one more reminder of a program's existence to individuals who have learned of the program through other means. Two of the projects initially attempted to identify caregivers primarily through print-based outreach strategies in their target communities. The efforts were not productive.

Not surprisingly, personal contact—eventually used by all of the projects—proved to be superior to impersonal means of connecting with FFN caregivers. However, personal contact was not uniformly effective, as described next.

Not all personal contact is the same. The quality of a project's personal exchanges with FFN caregivers seemed to influence decisions about project participation.

Some forms of personal contact were more useful than others. The most productive in-person exchanges with prospective participants generally permitted some focused discussion of the project. Specifically, it appeared beneficial for the setting of the exchange to be relatively free of distractions and for adequate time to be available for the project worker to provide a clear description of the project and to talk with the caregiver about her or his interests.

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Word of mouth was a highly productive means of finding FFN caregivers.

The project serving urban Somali women is illustrative of the conditions noted above. The coordinator identified FFN caregivers in the target neighborhood through agency lists of individuals receiving child care subsidies. She made the initial contact by mail and then a follow-up telephone call, when phones were available, aimed at scheduling a home visit. She also met prospective participants during visits to the apartment buildings where most providers resided or provided care. Word of mouth was a highly productive means of finding FFN caregivers in this Somali neighborhood once some initial contacts with caregivers were established. For example, on one of her first home visits, the coordinator met with 4 women who were informally providing care to infants and toddlers. The caregiver who originally was the sole focus of the home visit invited 3 other FFN caregivers to join the session. Each brought the child or children in their care. The coordinator described the FFN support project in some detail and led a discussion of the caregivers' experiences with the caregiver role by asking a series of questions (see next section). She also gave each woman a scarf, a highly valued item of cultural significance that could be used multiple ways (e.g., privacy shield for breastfeeding, protection from wind). Nearly all prospective project participants contacted in this manner became active members of the FFN support project. Existing ties among the caregivers may have been an influential form of peer support for project participation.

Methods for learning about FFN providers' interests were an integral part of engaging prospective program participants.

The important task of learning about the interests of prospective program participants was a core element of outreach to FFN providers. Information gathering and recruitment were merged functions. Information gathering from prospective participants focused primarily on their content interests, not their preferred methods of project participation (e.g., group sessions vs. home visit). Some examples are described below.

Discussions during the home visits to informal caregivers in the urban Somali neighborhood (described in the previous paragraph) were guided by a 12-item questionnaire the project coordinator developed with agency colleagues. Some questions were common to a generic needs assessment (e.g., preferred time and place of project gatherings), but other questions were specific to the population. One novel question that consistently generated a good deal of discussion with caregivers simply asked, "What's the challenge of caring for children here in the U.S. rather than at home?"

The project serving the tribal community generated and distributed a newsletter with information about the care of infants and toddlers to prospective program participants, identified primarily from lists of unlicensed providers receiving a child care subsidy. Focus groups of prospective participants were subsequently convened. As part of the discussion at group meetings, informal providers described what they found useful in the newsletters and what other types of information they would like to receive. An advantage of this arrangement is that providers were responding to concrete rather than abstract possibilities for program support of their caregiver role.

The inner-city neighborhood project had its first in-person contact with prospective participants at a group meeting convened by the project for purposes of learning providers' interests and describing parameters of the project. Prospective participants were identified through lists of informal providers receiving a child care subsidy. The invitation was extended via a letter. The session essentially became the first meeting of an ongoing information and support group (see next section). Attendees discussed their interests, agreed on a meeting schedule, and shared basic information about their caregiver work.

Two projects also attempted to learn the interests of informal caregivers by distributing surveys that were to be returned via U.S. mail. This was not a productive approach. Response rates were low, and some respondents did not complete all items.

Responding to Caregivers' Interests and Needs

Different methods of supporting caregivers—home visits, group meetings, newsletters, providing child care equipment and materials—were equally well received.

The literacy-focused home visits with informal caregivers on the reservation, the group sessions in urban and suburban communities, the child care materials and equipment provided by all projects, and the newsletters developed and distributed by two of the projects were well received by participants. We do not have information on whether some prospective participants declined participation in a project because a different service delivery method was preferred. None of the group-based projects offered a home visiting option. Providing home visits and group meetings as a combined delivery method was not successful on the reservation. Caregivers participated in the home visits but rarely attended the periodic group meetings. This pattern has been found elsewhere (see chapter 4 of *Who's Watching the Babies?*).

Across the four projects, participants expressed appreciation for a program that "says we're important." Recognition of the contributions of FFN caregivers to the growth and development of infants and toddlers was consistently identified by project participants as a valued feature of each project. Providers in the project serving the suburban community, for example, found the "Caring From the Heart" program title to accurately represent their approach to caregiving.

The opportunity to connect with peers was cited by participants in the group-based inner-city neighborhood project as a major benefit of involvement. Participants indicated that they valued the opportunity to find and form ties with other informal caregivers. Peer discussion of common interests appeared to

be as worthwhile to participants as the child care information provided by the project (e.g., "I get a lot of support from the other providers and I like the issues we discuss."). The peer support component of the two group-based projects serving Somali populations may have been less salient because the women had ties with one another that predated the project.

Food was a regular feature of group sessions across all projects. Provisions ranged from snacks and refreshments to full-fledged meals prepared by the project coordinator using culturally appropriate recipes.

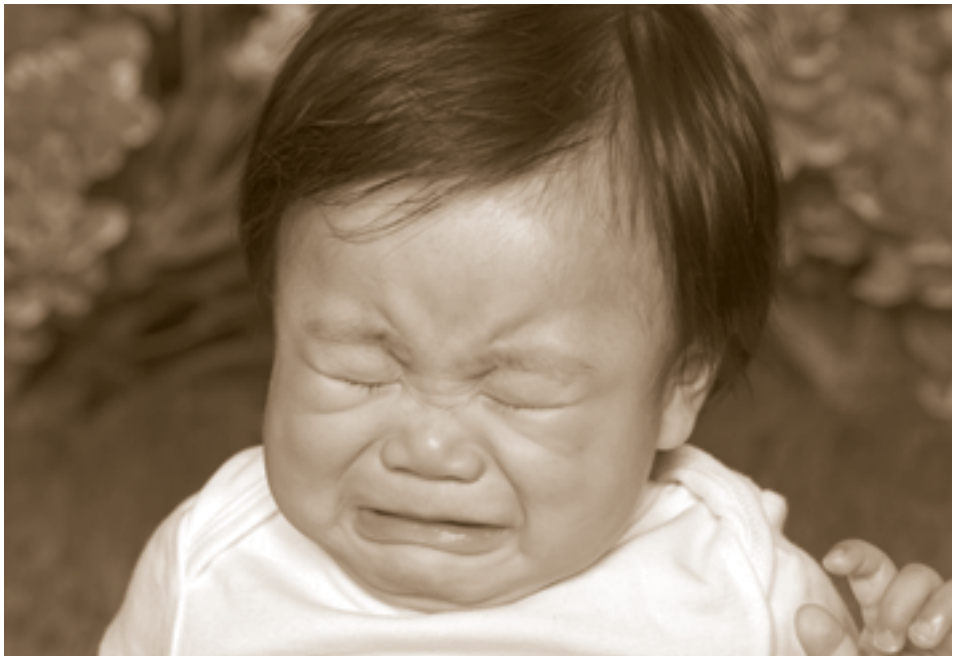
The safety items and child care materials provided by each project reportedly were put to good use. Reports of home visits conducted to recruit informal caregivers in the urban Somali neighborhood and in the tribal community indicated that some homes were void of routine safety provisions for infants and toddlers (e.g., no security gates on stairways) as well as manipulative objects. The children's books provided by the project serving the reservation were especially novel.

Projects differed in how equipment and materials were distributed. One project used items as incentives for project participation. Points earned by caregivers for attending sessions could be "exchanged" for child care items of interest to each participant. Another project placed project-selected toys for infants and toddlers on a table at each group session, and caregivers selected items in an equitable manner agreed on among themselves. The project did not impose rules or expectations about ownership of the items, and the project coordinator privately wondered if the items would remain with the child or the caregiver.

Most of the information shared with project participants was an adaptation of existing child care training resources.

With the exception of the project serving the reservation, the projects used existing child care training resources for conducting sessions with participants. It was common for guest experts rather than the project coordinators to make presentations at group sessions (e.g., a nutrition expert presented a session on feeding infants and toddlers, a nurse presented a session on sudden infant death syndrome, a bilingual firefighter conducted CPR training). Accordingly, in the three group-based projects, coordinators typically functioned as organizers of sessions (e.g., securing outside speakers) and less frequently as a primary source of expert information presented at a meeting. Interpreters were provided for the two groups serving Somali women.

The project serving the reservation worked with students enrolled in a child development associate's degree program at the tribal college to generate activity packets for distribution and use at home visits. Each of the activity packets focused on a theme related to a children's book and included toys (e.g., stacking rings) and materials to support the use of songs and a manipulative (e.g., recipe for play dough). The books were secured through corporate donations solicited by the project. The project coordinator was wary of using an existing curriculum, believing that materials developed on the reservation and for the reservation would be more credible with prospective users.



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Information on infant temperaments seemed to be of greatest interest, partly because this topic was new to most participants.

The infant–toddler focus was both a strength and a limitation.

In general, caregiver participants in each project welcomed the opportunity to learn more about the care of infants and toddlers. Information on infant temperaments seemed to be of greatest interest, partly because this topic was new to most participants. Many caregivers who participated in the project also cared for preschool- and school-age children, and often expressed stronger interest in learning more about the care of older children than in children less than 3 years old. Also, some prospective participants contacted by project staff did not care for infants and toddlers and communicated disappointment that a program of support was not available for informal caregivers of older children. The infant–toddler content boundaries of the projects seemed artificial in these instances, and led some project coordinators to believe that a multiage approach would be more responsive to the realities of family child care arrangements.

For immigrant populations, the projects served as cultural mediators.

In both the urban and suburban projects serving Somali women, group sessions typically addressed cultural differences in the care of young children. The women communicated pride and confidence in their child-rearing abilities. As one caregiver told a project coordinator, at an early age "our mothers taught us everything we will need for the future: cooking, cleaning, care for children, administration of the family and our traditional way of doing everything...and we helped our mothers care for the children, so when you grow up you already know how to take care of children." Nonetheless, the caregivers expressed feelings of isolation and uncertainty in caring for young children in the United States. They were puzzled by immunization practices (e.g., one caregiver described how breast milk and goat's milk were sufficient protection against diseases in her native land). They expressed many concerns about the children's safety and confinement to indoor spaces. They were accustomed to children being outside for most of the day, but viewed Minnesota weather as either too hot or too cold and the neighborhood's outdoor spaces as unsafe (e.g., worried about kidnapping). They thought the apartments were too small for children to spend their entire day.

Cultural differences in food were explored with considerable interest. Prepared and packaged foods in the United States were a particular curiosity (e.g., one caregiver described how camel milk, camel meat, and local crops were the nutritional mainstay

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A session that included an introduction to snacks commonly used with young children in the United States generated strong, negative reactions to "ants on a log."

in her rural Somalia). In the project serving the urban Somali group, for example, a session with a nutritionist ran well over the allotted time because participants had many, many questions and issues to discuss. In the suburban Somali group, a session that included an introduction to snacks commonly used with young children in the United States generated strong, negative reactions to "ants on a log" (which is typically celery stick, peanut butter, and raisins).

The content focus of the urban project serving Somali immigrants extended beyond child care issues. The project coordinator made arrangements for classes for English language learners to be held at a community center in the neighborhood where project participants resided. The project also helped several caregivers attend a nanny training program by providing interpretation services and, near the end of the project, helped two participants take steps to become licensed child care providers. The project coordinator received calls daily for assistance in making clinic appointments and in understanding and completing forms, including child care subsidy requests. She provided transportation to training sessions not held in the caregivers' neighborhood. She followed up with caregivers who did not attend training as anticipated (e.g., in one instance a schedule had been read incorrectly). Importantly, the coordinator, who was a recent immigrant herself, served as a role model for the caregivers regarding the process of becoming familiar with a new country. In a meeting with two caregivers interested in becoming licensed, for example, she showed a book on English grammar that she was studying herself and told where she had purchased the book.

Project participants differed widely in their goals and stability in the informal caregiver role.

Some participants were desirous of becoming licensed child care providers or credentialed to serve as an aide in a public school. This varied across projects. For example, about one third of participants in the inner-city project wished to pursue licensure at the conclusion of the project. Nearly all of the Somali women sought to enroll in a training program that led to a preschool aide credential. Child care licensing was out of reach for most of these women because their apartments did not meet licensing requirements. Other participants were happy with their current informal caregiver status, sometimes because the arrangement was viewed as temporary and other future work paths were of interest.

Project work contributed to changes in staff competencies and agency practices.

None of the projects fully implemented a community-based approach to program development as described in Table 1. Yet important progress was made on several fronts, particularly in understandings of informal care arrangements. An unintended outcome of the Bush Foundation initiative is that staff and agencies were better equipped to responsively serve FFN populations at the end compared to the beginning of their project. Consider the following examples. Several project coordinators became members of a state-level planning committee organized by a state agency to consider ways of strengthening supports to FFN providers. A child development expert who made a guest presentation at one of the FFN group sessions noted on a follow-up survey that "my biggest realization was that these women take their responsibilities seriously and are proud of the work they are doing. They are also hungry for information that will help them give quality care to children." One of the agencies added questions about child care arrangements to its routine intake procedures for a family support program. The supervisor of a project in another agency noted the effort had "stirred the waters ... related to our organization's intent to serve legally unlicensed providers more fully."

Future Directions for Capacity Building

The experiences across the projects described in this chapter reflect some unique differences, probably based in part on staffing and community factors. At the same time, there are striking similarities in the experiences of the four projects.

As training programs and researchers "unpack" the population of FFN providers, it is becoming clear that one size of support does not fit all caregivers. For some providers described in this article, project participation served as an "on ramp" to licensure training. Yet other providers had absolutely no interest in formalizing their role. Future work should consider efficient ways of enabling this self-sorting process to occur early in the engagement process, so providers can be matched to appropriate resources.

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The Early Head Start for Family Child Care Project

KIMBERLY STICE
SHERRIE RUDICK
ZERO TO THREE, Washington, DC

The U.S. Department of Health and Human Services (DHHS) oversees two of the country's largest programs for early childhood care and development for children in low-income families. The Office of Head Start (OHS), through the Early Head Start (EHS) program, promotes healthy prenatal outcomes, enhances the development of infants and toddlers, and promotes healthy family functioning. The Office of Child Care (OCC) administers the Child Care and Development Fund. This program assists with the affordability of child care (a) for low-income working families so that they can succeed in the workplace and (b) for families in which parents are engaged in education and training programs (see box Child Care and Early Head Start).

What would happen if these two funding streams came together to work toward increased quality for children in family child care (FCC)? OHS and OCC seek to answer this question through the Early Head Start for Family Child Care (EHS for FCC) project.

The EHS for FCC Project

The EHS for FCC Project, housed at ZERO TO THREE, operates under the auspices of both OHS and OCC. Collaboration is a complex process. The project seeks to understand the challenges and barriers inherent in creating partnerships at the state and local levels and also how existing resources can be combined and coordinated to leverage comprehensive services for all children.

The project has four long-term goals:

- Quality care for children in FCC homes;
- Coordinated, comprehensive services for families;
- Support to increase capacity for FCC providers; and
- Strong partnerships that support coordinated service delivery in communities.

Twenty-two EHS sites which had been granted funds under the American Recovery and Reinvestment Act (H.R. 1—111th Congress, 2009) were selected to participate in this project. Located in rural, urban, and suburban settings in 17 states, these 22 programs will help OHS and OCC learn how partnerships at the local and state levels can help EHS programs everywhere improve the quality of family child care. In order to learn from programs at various stages of partnership, three different types of EHS grantees were encouraged to apply: those already serving children through an EHS FCC option, those beginning to partner with FCC through their American Recovery and Reinvestment Act-expansion funds, and those that had not previously partnered with FCC but were considering the option for families in their communities and service areas.

To apply, the EHS grantee began the partnership by completing the application with a child care partner (in many cases, a representative from a Child Care Resource & Referral agency). One representative from each agency comprised the two-member team (see box Early Head Start for Family Child Care Project Teams). Each team also identified a person who was embedded in the community and knowledgeable about community partnerships and family child care to serve as a consultant, referred to as a Child Care Partnership Coordinator (CCPC). CCPCs provide up to 52.5 hours of consultation per month to facilitate the work of the team. A stipend, managed by the CCPC, supports each team in the development of the partnership between the two agencies.

To guide the teams in their process, ZERO TO THREE developed a framework with short-term, medium-term, and long-term outcomes of the partnership defined at the local

Child Care and Early Head Start	
The Office of Child Care serves 488,790 infants and toddlers (DHHS, 2009).	The Office of Head Start serves 104,400 infants and toddlers (DHHS, 2010).
29% of the infants and 25% of the toddlers who receive child care subsidies are in family child care homes (DHHS, 2009).	2.5% of infants and toddlers in Early Head Start are served through the family child care option (DHHS, 2010)

Early Head Start for Family Child Care Project Teams

The 22 EHS programs in the EHS for FCC project represent a variety of communities, experience, and demographics. Characteristics of the teams participating in the EHS for FCC Project include:

- 17 different states represented
- 3 Migrant/Seasonal Head Start programs
- 1 tribal government
- Range in years of providing EHS: Less than 1 year to more than 10 years
- EHS program enrollment ranges from 40–367
- Represents rural, urban, and suburban settings
- 8 programs already using the EHS FCC option

and state levels. Teams used this framework to assess their current level of partnership by identifying those outcomes already achieved and new outcomes to approach during the 9 months of the project. Depending where the team entered the framework, their work plans addressed anticipated outcomes in areas of awareness, skills, knowledge, attitude, motivation, behaviors, practices, and policies.

Mathematica Policy Research, Inc., will conduct the evaluation of the project, informed by team applications and work plans; data collected and provided by the CCPCs; and telephone interviews with grantee staff, key partners, and parents. The evaluation will examine the characteristics of the teams and their communities, outcomes selected, the way work plans were implemented, and whether the activities to support the outcomes are sustainable in the programs and their communities.

Partnership Opportunities

In their work plans, teams identified a number of partnership opportunities to pursue. For example, many teams plan to link FCC providers to their state's Quality Rating Improvement Systems. Some plans include meetings and advocacy at the state level to address barriers such as the differences in the eligibility period between child care and EHS.

Several teams identified professional development as focus of their partnership efforts. Many plans include activities to establish networks for providers to connect to colleagues, to help FCC providers obtain their Child Development Associate (CDA) Credential or AA degree, or to strengthen FCC providers' practice through coaching or mentoring.

Three teams participating in the project are Migrant and Seasonal Head Start programs. Families in these programs face unique challenges because of mobility and nontraditional work hours. The continuity and consistency of child care for migrant and seasonal families who enroll their children in FCC is challenging. The participating Migrant and Seasonal Head Start partnership teams plan to work with families to assist them in understanding the procedures and benefits to applying for child care subsidies as they migrate. Like other teams, the Migrant and Seasonal Head Start partners are working on both establishing new FCC homes and increasing quality of existing homes.

Another team represents a tribal government; both EHS and child care funds flow directly to the tribe for their administration. In this case, the tribe determined that child care programs, including FCC, must meet the standards set forth by the Head Start Program Performance Standards, so the quality of provider care is quite similar whether FCC is funded through child care or EHS funds. For this team, the next steps involve developing a process to fully inform parents of the range of infant–toddler programs available to them and analyzing how funds can be blended to provide the range of comprehensive services through EHS.

Moving Forward

FCC can be an excellent choice for working families. It can also be a very rewarding career choice for providers when they are valued for their expertise, supported through networks, and given opportunities for ongoing professional development. A partnership between EHS and FCC can provide more comprehensive services for children and families while adding stability not only for children and families, but for FCC providers as well. For families using child care subsidy, the loss of a job, increase in wages, or change in educational program enrollment can mean the loss of the subsidy, resulting in a potential loss of a caregiver for the child and loss of income for the provider. A creative funding partnership can support families and providers through times of transition to prevent this loss and ensure continuity of care for the child and income for the provider. When child care and EHS funding comes together, children, families, providers, and communities all benefit and become stronger, leading to better outcomes for children, families, and the child care profession.

Kimberly Stice, *MA, is a senior writer/training specialist in the Early Head Start for Family Child Care Project at ZERO TO THREE. Ms. Stice has more than 20 years of experience in early childhood development and special education as a training coordinator, curriculum developer, and teacher. Her experience includes working on early childhood grants from both the Office of Head Start and the U.S. Department of Education including roles such as infant/toddler disabilities specialist for the American Indian and Alaska Native Early Head Start programs, program coordinator for StoryQUEST: Celebrating Beginning Language and Literacy, and assistant director of the National Head Start Family Literacy Center. Ms. Stice received her BS in special education from the University of Oklahoma and her MA in education, with a major in early childhood special education from the California State University, Northridge.*

Sherrie Rudick *is program manager in the Early Head Start for Family Child Care Project at ZERO TO THREE. She has more than 30 years of experience providing services to young children and their families. As training and development manager at East Coast Migrant Head Start Project, she oversaw the development of a peer mentor program, organized training conferences, and developed training materials for all Head Start service delivery areas. At the American Institutes for Research, she participated in the development of and training on the PRISM instrument and is co-author of* Putting the Pro in Protégé: A Guide for Mentoring in Head Start. *As director of training and director of special projects at Teaching Strategies, she helped write several publications, including* The Creative Curriculum for Infants, Toddlers & Twos, A Trainer's Guide to The Creative Curriculum for Infants, Toddlers & Twos, *and* The Creative Curriculum for Family Child Care. *She is also the co-author of eCDA, Teaching Strategies, Internet-based professional development program for the CDA Credential.*

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Strategic Planning for Family, Friend, and Neighbor Care

THE NATIONAL INFANT & TODDLER CHILD CARE INITIATIVE
@ ZERO TO THREE, Washington, DC

The National Infant & Toddler Child Care Initiative @ ZERO TO THREE (NITCCI), a project of the Office of Child Care, has created a strategic planning process and tools to assist states and U.S. territories with strategic planning to systematically support family, friend, and neighbor (FFN) caregivers. The strategic planning tool kit, developed with the participation of the Child Care and Development Fund Administrators and their teams in Maine, Puerto Rico, and the Virgin Islands, provides a comprehensive and collaborative process in three phases: data collection and analysis, strategic planning meetings, and a final report and action plan that will include both short- and long-term objectives to better support FFN caregivers to provide quality care.

The strategic planning process is designed to maximize involvement of planning committee members and other stakeholders while minimizing face-to-face meeting requirements. The process can be used to conduct a complete analysis of the support that a state or territory's early care and education system provides for infant and toddler child care, or to plan for the use of funds from the Child Care Development Fund (CCDF) that are targeted for infants and toddlers, or both. The process can also be used to address other specific issues such as the development of infant–toddler specialist networks or credentials for the infant–toddler workforce. It is recommended that two half-day sessions or a full-day be scheduled for an issue-specific planning process and 1½ to 2 days be allocated for an early care and education system analysis.

The tool kit, available online at http://nitcci.nccic.acf.hhs.gov/resources/FFN_toolkit.htm, includes:

- **CCDF Targeted Funds for Infants and Toddlers.** This fact sheet uses information submitted in Fiscal Year 2010-2011 State/ Territory Child Care and Development Fund (CCDF) Plans to present a national overview of how states and territories are using funds targeted for infants and toddlers. The information is organized using the ecological model of early care and education systems developed by the National Infant & Toddler Child Care Initiative.
- **Planning for CCDF Targeted Funds for Infants and Toddlers.** This publication was developed to support states and territories as they plan for the effective use of targeted funds. It discusses use of the funds, effects of the funds on quality, research on quality indicators, system planning, how to assess overall quality of care, the current and past use of funds, and planning for quality.
- **Key Elements of the Early Care and Education System for Infants and Toddlers**. This fact sheet lists key elements of a child care system that supports quality care for infants and toddlers, and describes the characteristics of each element. It also includes a graphic representation of the system that shows how the elements are inter-related and differentiates elements that impact direct services from those that are part of the child care infrastructure. NITCCI uses this model to help states and territories map their current system to inform their plans for future work around infant and toddler child care.

Note: This information is excerpted and adapted with permission from "The National Infant & Toddler Care Initiative FFN Strategic Planning Tool Kit Introduction" on the Web site of the Administration for Children & Families, U.S. Department of Health and Human Services (http://nitcci.nccic.acf.hhs.gov/resources/ffn09_toolkit_intro.pdf). The Web site also includes Webinars, handouts, and links to other resources highlighting some of the work being done to help states and territories support FFN care.

Tools:

1. Supporting FFN Child Care: Strategic Planning Process Overview.

This PowerPoint™ presentation provides an overview of the FFN strategic planning process. It can be used to explain the process to stakeholders, members of the planning design group, and strategic planning committee members.

2. Task Matrix

The Task Matrix is a table that provides a checklist of tasks that support the strategic planning process. It includes columns that list the task, who will complete it, when it will be completed, and a comment column.

3. Interview Questions for FFN Committee Members

The document provides sample questions for interviews with FFN committee members prior to the initial face-to-face strategic planning committee meeting. The strategic planning vision and mission provided in the document are examples and can be adapted for a particular state or territory.

4. FFN Key Elements Planning Tool

This tool provides a framework for thinking strategically about systems that support FFN care and quality for infants and toddlers in child care. It is intended to be used to develop a scan of the current, planned, and potential supports for infant and toddler child care in a state or territory. It is structured around key elements of the ECE system and offers opportunities to discuss the following topics for each element:

- Current status
- Questions for consideration
- Potential quality enhancements

An initial draft of the FFN Key Elements document is prepared by the planning design group prior to the first onsite strategic planning committee meeting. Changes can be made to it throughout the planning process and as strategies are implemented.

5. Strategic Planning Logic Model

This PowerPoint presentation provides an overview and guide for developing a logic model that can be incorporated into the strategic planning process to help states and territories define and track outcomes, outputs, strategic activities, inputs, and resources. It can be used to help define the type of information that must be collected to track the progress and evaluate the effect of the strategic planning efforts over time.

Photo: ©iStockphoto.com/Steve Debenport

A strategic planning process can help states and U.S. territories to systemically support family, friend, and neighbor caregivers.

6. Sample Infant–Toddler Logic Model

This resource provides an example of a state or territory logic model to help guide planning to achieve outcomes for infants and toddlers.

7. Blank Logic Model

The blank logic model provides a format a state or territory can use to develop their logic model.

8. Sample First Meeting Agenda

The sample agenda for an initial full committee meeting is designed for a 3-hour meeting but can be adapted for a longer meeting if desired. It can also be combined with the second meeting agenda for one full-day meeting; however, two meetings separated by 4 to 6 weeks are recommended. The first meeting includes an overview of the planning process, review of national and state or territory information about the topic, completion of planning process vision and mission, member interview results, and review of the draft key elements tool.

9. Sample Second Meeting Agenda

The agenda for the second full committee meeting is designed for a 4-hour meeting. It focuses on goal, strategy, and action plan development. NITCCI uses a process for these activities but a state or territory may use other goal, strategy, and action plan development processes as they desire.

10. Sample Full-Day Agenda

This sample agenda provides an option for a state or territory that wants to schedule a full-day meeting. It is recommended that two half-day or one full-day meeting be scheduled for an issue-specific planning process and 1½ to 2 days be allocated for an ECE system analysis.

11. Action Plan Example

The action plan example is separated into 3 sections: planned activities, back burner (activities that are delayed), and completed steps. It also provides an area to identify technical assistance needs. The example provided shows entries in all sections to help guide use of the document.

12. Blank FFN Action Plan

The blank action plan is designed to be used near the completion of the planning process meetings. It is intended to be reviewed and edited periodically.

13. Icebreakers

The sample icebreakers quiz can be used in the full committee meetings.

Voices From the Field

Family Child Care Providers in Their Own Words

BONNIE ARJONA
Fairfax County (Virginia) Early Head Start

Ada Lazo, Monica Villa, and Yajaira Hidalgo operate licensed family child care homes in northern Virginia, and participate in a network of family child care providers who are partnering with Early Head Start in their community (Stice & Rudick, this issue, p. 58). Ada, Monica, and Yajaira provide care both for children enrolled in the child care subsidy program and those whose families pay the full cost of care. Each provider also has at least one child in her care who is also enrolled in the local Early Head Start program, and all participate in the U.S. Department of Agriculture Child and Adult Care Food Program.

As part of the Fairfax County Office for Children partnership with Early Head Start programs, these providers have the opportunity to share professional development experiences, receive resources and materials that support their work, participate in cohort discussions about implementing the Head Start Program Performance Standards, and learn from Early Head Start specialists who visit their homes and support their work. Ada and Yajaira have been family child care providers for 5 years and Monica has been working with children in her home for 15 years. Each has a Career Studies Certificate in Infant and Toddler Care and the Child Development Associate (CDA) credential.

Bonnie Arjona, a child care specialist working with the Fairfax County Early Head Start program, had the opportunity to speak with Ada, Monica, and Yajaira to learn more about their perspectives on being family child care providers.

Why do you think family child care is a good option for infants and toddlers?

Ada: I think family child care is a good option because we build a close relationship with the children and families. We get to know each child and their strengths and weaknesses and can adjust our routines to accommodate that. I think parents feel secure knowing their child is with the same person all day, and not having different teachers throughout the day.

Monica: We have a strong relationship with our families and great communication. We have smaller ratios, and it is easier for us to individualize for each child. In our homes we have less children than centers, so we can be more flexible to meet the needs of each child. For example, we have meal times, but if a child is not hungry we can feed them on demand. If a child doesn't want to nap, we can use naptime to work one on one with a child. Or if a child naps earlier or later than others, we can accommodate that. Infants and toddlers need a routine, but also one that is flexible to meet their needs on any given day. Infants and toddlers also learn from others and in family child care they are with a mixed age group, and they can learn from the other children.

Yajiara: Some parents prefer a smaller group for their baby or toddler so they receive more attention. Infants and toddlers are also comfortable in the home environment. Family child care is also a good option for parents because the hours can be flexible. We often live close to the children in our care and that is convenient for parents.

How has being in a family child care network changed what you do? How do you do things differently now?

Ada: We are always learning something new by exchanging information with other providers. We learn from each other's experiences. We also share ideas for activities.

Monica: Through my classes with other providers and an excellent instructor, I learned more than academics. I learned more about understanding families. My classes gave me tools to work with my families and also to sometimes educate them without saying "I'm educating you." It completely changed my point of view. I used to be stricter in my rules, now I am much more flexible and my relationships have grown with my families.

Yajaira: I have gained more experience. I have made friends with other providers and we share ideas and meet for field trips. Being in a network has also allowed me to increase my education by providing training and guiding me through getting my CDA.

What do you feel you have gained by being regulated by Early Head Start Performance Standards and Child Care Assistance and Referral Program requirements?

Ada: I gained more knowledge in safety, health, and child development. I have had the opportunity to serve more diverse families. I've served families from many cultures which has helped me to understand the children better which also helps me strengthen my relationship with them. I also was given the chance to learn more about child development and earn my certifications.

Monica: It makes me more professional. By following standards, I have gained confidence when talking with all my families (private, and subsidy). I follow the same rules with all of them. I have consistency. When I have to follow a standard, they have to follow it too. For example, I have to make sure all the children's immunizations are kept up to date. I remind parents when it is time to get them, and they make the appointment. Some of the parents like this, because they don't remember when these are needed. Then by the time they have their second child, they understand what has to be done and when. When we have to follow a standard, we explain the standard to the parent and they understand. It is also great to have an enforcer. Parents sometimes get frustrated by our sick policies. But we explain that if it was another child sick, you wouldn't want them to come and pass the germs to your child or the provider and then we would have to close. It is nice to have Early Head Start and Child Care Assistance Specialists to reinforce this with parents.

Yajaira: Being regulated has pushed me to take more training, and increase my knowledge in child development. This gave me the opportunity to earn my CDA and my Infant / Toddler Career Studies Certificate.

Why do you continue to be a family child care provider?

Ada: It is a business that I enjoy and allows me to help provide for my family. It is a good choice for me because it allows me to balance work and family, by being home when my son gets home from school.

Monica: I love to work with children and their families. I enjoy being a part of their development. I have seen attitudes toward family child care providers change over the years. We used to be treated like babysitters, but now people are seeing us professionals as more of us are increasing our knowledge and partnering with programs like Early Head Start. I am very confident in what I do and each year it gets easier as I learn more. I know my job is important. Children are excited to come to care. They are ready to play, explore, and learn. I feel really good about this field and the growing recognition of family child care as a profession.

Yajaira: I love this job; I enjoy the lasting relationships I have built with the children, their families, and other providers. It is also important for me that I am available for my own children.

For more information about and to get the latest resources for the Early Head Start for Family Child Care Project, visit the Web site of the Early Childhood Learning Center at http://eclkc.ohs.acf.hhs.gov/hslc.

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Field Notes

ZERO TO THREE Fellows share news and information about research, policy, and practice innovations in their work with infants, toddlers, and families.

All Our Kin: Investing in Home-Based Child Care

Jessica Sager and **Jana Wagner**, All Our Kin, New Haven, Connecticut

Walter S. Gilliam, The Edward Zigler Center in Child Development and Social Policy, Child Study Center, Yale School of Medicine

Home-based providers play a crucial role as the teachers of the youngest and most vulnerable children. The majority of infants and toddlers are cared for in home-based settings, and children with socioeconomic risk factors are the most likely to be in home-based child care arrangements (Porter et al., 2010). All Our Kin (www.allourkin.org), based in New Haven, Connecticut, trains, supports, and sustains these child care providers at every stage of their development, from relatives and caregivers to professional educators and businesspeople.

All Our Kin provides materials, mentorship, and support to help unlicensed family, friend, and neighbor caregivers meet health and safety standards, fulfill state licensing requirements, and become part of a professional community of child care providers. When a child care provider becomes licensed by the state, that program meets health and safety standards and operates under state supervision. The result: more children spend the day in safe, healthy settings. Licensing is also transformative for providers. Their earnings increase; they gain pride and professionalism; and they are able to serve more children, and serve them better, with the equipment and training they need to provide safe, educational child care. Between 2000 and 2007, Connecticut lost more than 32% of its family child care programs. This translated into 7,500 fewer child care spaces for Connecticut's families. In New Haven, because of All Our Kin's efforts, the number of licensed family child care programs increased by nearly 27% during the same period.

Once a participant receives her family child care license, she begins work with a skilled master teacher who visits her program and offers individual coaching and support specifically for new child care providers. The mentor covers a range of basic educational topics, including an overview of how children grow and learn, how to design curriculum, choosing appropriate materials, and family engagement.

The provider then transitions to the Family Child Care Network, which offers educational mentorship, professional development, advocacy and leadership opportunities, and a network of relationships with other family child care providers. The Family Child Care Network is a high-touch program built on best practices in early childhood consultation and teacher mentoring. Early childhood consultants visit family child care centers to lead model lessons, demonstrate new strategies, and reflect with providers on their work. Consultants bring books and materials, professional articles, and curriculum ideas, and offer suggestions to enhance children's learning. Providers in the Network also come together for monthly meetings, workshops and trainings, including Child Development Associate training and college courses, and an annual professional development conference. They have access to a "warm line" they can call for advice at any time. All Our Kin offers zero-interest loans and grants, financial management and education training, and marketing and referral opportunities. All services are bilingual.

Through All Our Kin's child development classes, workshops, and hands-on educational program visits, family child care providers gain a greater knowledge of child development, and learn new strategies for supporting children and families. Providers become part of a wider professional community, with access to resources, information, and ongoing support. And most important, providers build high-quality caring, consistent, and nurturing relationships with infants and toddlers that last a lifetime.

Porter, Paulsell, Del Grosso, Avellar, Hass, & Vuong (2010). *A review of the literature on home-based child care: Implications for future Directions.* Princeton, NJ: Mathematica Policy Research.

A Multidisciplinary Approach to Early Care and Education Quality Improvement

Jane Bernzweig, Sujata Bansal, Lisa Erickson, and **Deborrah Bremond**, First 5 Alameda County, California

A growing body of knowledge shows that consistent, developmentally sound, and emotionally supportive early care and education (ECE) has a positive effect on children and families (Peisner-Feinberg et al., 2001). Because so many children were enrolled in ECE programs that lacked quality indicators, states began implementing quality improvement initiatives (Bryant et al., 2009). On-site consultation has become a widely implemented approach to quality improvement for ECE programs. A study by the Child Care Bureau showed significant gains in child care quality following on-site con-

sultation, especially in family child care homes (Bryant et al.). In 2001, First 5 Alameda County implemented Quality Counts (QC) which provides a full set of resources, including on-site consultation, nationally recognized assessment tools, collaborative planning, and group and one-on-one training in family child care homes.

This year, QC paired an ECE consultant who has expertise in health and safety, curriculum development, action planning, and implementing change with a mental health (MH) consultant who has expertise in social–emotional development, relationship dynamics, and facilitating reflective discussions. Together the consultants partner with family child care providers to build reflective capacity and thereby improve program quality. This multidisciplinary approach differs from traditional consultation models by allowing consultants to share expertise and skills that a single, disciplinary approach cannot. Following is an example of how an ECE and MH consultant worked together to improve the quality in one program:

Rhonda, a family child care provider in Oakland, California, employed her sister and daughter, who live with her, as co-teachers. The QC consultants immediately noticed that having related people living and working together constituted dual relationships that affected the adults' abilities to provide quality care for the children. Conflicts arose for Rhonda who was mother, sister, and supervisor to her adult daughter and sister. She doubted her ability to lead or create any structure or routine, critical components of a quality child care. While both consultants identified the problem, the MH consultant addressed the dual relationships by helping Rhonda to reflect on her feelings about leadership, maintaining boundaries around work and family roles, and managing interpersonal conflicts. The ECE consultant addressed ways for Rhonda to improve program structure and routines. As a result of her work with the consultants, Rhonda is better able to implement policies and procedures that have led to improved quality.

Multidisciplinary approaches allow consultants to use their unique expertise to identify and help solve problems. By following the QC model, consultants and family child care providers implement quality improvements.

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Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan. S. L., et. al. (2001). The relation of preschool child care quality to children's cognitive and social development trajectories through second grade. *Child Development, 72,* 1534–1553.

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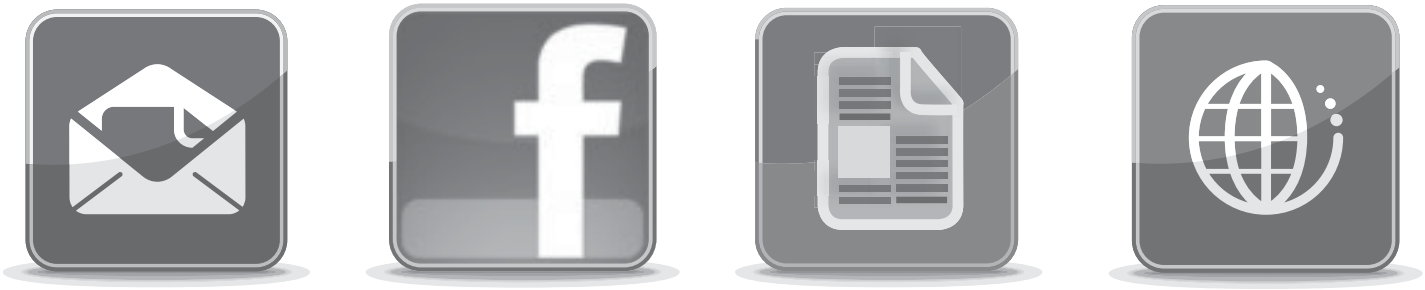

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The Baby Monitor is the ZERO TO THREE Policy Network's bi-weekly e-newsletter, focused on policy and advocacy news about infant–toddler issues. Stay updated on key federal and state policy issues and learn how you can get involved. ***The Baby Monitor*** also features publications, online resources, and advocacy tools that can help you be a big voice for little kids.

To sign up, join the Policy Network at **www.zerotothree.org/babymonitor**

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three,* we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	*What it means*
Family Child Care Accreditation	The National Association for Family Child Care sponsors a nationally recognized accreditation system designed specifically for family child care providers. The accreditation process examines all aspects of the family child care program, including relationships, the environment, developmental learning activities, safety and health, and professional and business practices. (Find it in Modigliani, page 14)
Family Child Care Networks	Family child care networks offer a range of support services to family child care providers such as visits to provider homes, training and education opportunities, support groups, mentoring opportunities, materials and equipment, and business assistance. Similar programs in other parts of the country deliver support services to providers and are referred to as systems, hubs, or satellites. (Find it in Bromer & Bibbs, page 30)
Family Day Care Environmental Rating Scale (FDCERS)	The FDCERS (Harms, Cryer & Clifford, 2007) is designed to assess family child care programs which are conducted in a provider's home for children from infancy through school-age. The rating scale consists of 37 items organized into 7 subscales: Space and Furnishings; Personal Care Routines; Listening and Talking; Activities; Interaction; Program Structure; Parents and Provider. (Find it in Porter & Paulsell, page 4)
Family, Friend, and Neighbor Care (FFN)	FFN care is home-based care provided in the child's or caregiver's home by relatives, friends, neighbors, and babysitters or nannies. FFN care is generally unlicensed care, although in some cases it is subject to minimal regulation. (Find it in Sussman-Stillman, Stout, Cleveland, & Hawley, page 42)
Skilled Dialogue	Skilled Dialogue (Barrera & Kramer, 2009) is a method for developing communication skills to be able to speak effectively with individuals who come from a different culture. Used with family child care providers, it can help providers learn new skills for communicating with the parents of children in their care. (Find it in Bromer & Bibbs, page 30)
U. S. Military Family Child Care	The U.S. Department of Defense (DoD) defines family child care as home-based child care services that are provided for service members and DoD civilians by an individual who is certified by a designated representative for the DoD as qualified to provide those services. The individual provides those services for 10 hours or more per week per child on a regular basis for compensation. Care provided in the child's home by a relative or care provided through a cooperative arrangement among parents is not classified as family child care. (Find it in Stevens, page 38)

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UPCOMING ISSUES

July: Case Studies—Stories From the Field
September: Supporting Competency Through Professional Development
November: Working Together to Address Challenging Behavior

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