

**Evaluation of Erikson Institute Family Child Care  
Specialist Training Program Phase II**

**Final Report**

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## Introduction and background

Approximately half of all young children spend some time in the care of home-based child care providers while their parents work or are in school. Home-based child care includes both regulated family child care providers (FCC) who offer group care to children in the provider's home, as well as unregulated family, friend, and neighbor child care (FFN)<sup>1</sup>. Home-based child care providers have the potential to nurture young children's development and support low-income working families (Bromer & Henly, 2009; Porter et al., 2010). Moreover, many FCC homes are run as small businesses and may serve as economic and social assets to their communities (Bromer, 2006; Gilman, 2001). Increasing recognition of home-based child care as a viable early care and education (ECE) option is reflected in recent federal and state policy initiatives targeting quality improvement in this sector (Porter et al, 2010). FCC is now an official option of both Head Start and Early Head Start and is included in most states' Quality Rating and Improvement Systems (QRIS) (Morrissey, 2007; Tout et al., 2010). As a result of these trends, a variety of child care and social service agencies in communities across the country have developed programs to support home-based child care providers (Hershfield, Moeller, Cohen, & the Mills Consulting Group, 2005; Porter et al., 2010). Agency specialists deliver a range of services to home-based child care providers including training and support groups and visits to provider homes focused on monitoring compliance to standards, nutrition and healthy food consultation, and quality supports.

Yet, despite the increased attention to family child care, there are relatively few evidence-based models designed to improve quality in these arrangements. A small body of research suggests that relationship-based services to providers, such as coaching and consultation, visits to provider homes, and one-on-one technical assistance, may be promising strategies for improving care in home-based child care arrangements (Bromer, VanHaitma, Daley, & Modigliani, 2009; Bryant et al, 2009; McCabe & Cochran, 2008; Ota & Austin, 2013; Ramey & Ramey, 2008). Bromer et al. (2009) found that FCC providers affiliated with a community-based, agency-run support network that delivers services to providers (i.e., visits to provider homes and training through network staff with *specialized training*) offered significantly higher quality care than unaffiliated FCC providers or providers in networks without specially-trained staff. Unlike center-based child care providers who work under the guidance of a director or supervisor, most home-based providers work alone and may be more likely to benefit from support and guidance offered by a skilled agency specialist. Investing resources into developing a highly-qualified and skilled workforce of specialists who work with providers over time has the potential to improve and sustain the quality of care offered to children and families across a wide array of home-based child care programs.

### The Family Child Care Specialist Training Program

The Family Child Care Specialist Training Program is part of an ongoing effort to improve the quality of home-based child care through relationship-based training for child care and social service

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<sup>1</sup> National studies estimate that up to 22% of children under age 5 in non-parental care spend some time each week in FCC settings (Capizzano, Adams, & Sonenstein, 2000; Laughlin, 2010), and close to half of all young children under age 5 spend time in the care of FFN providers, the majority of whom are grandmother caregivers (Laughlin, 2010). Moreover, one third of children receiving government-subsidized child care through the federal Child Care & Development Fund (CCDF) are cared for by home-based child care providers (U.S. Child Care Bureau, 2009).

agency staff who work with family child care providers and is based on a successful pilot (phase I) that was recently completed at Erikson Institute. Evaluation findings from the pilot suggest that a unique set of skills and knowledge related to child development across the age span (most home-based child care providers care for mixed-age groups of children), as well as adult development and learning styles, is critical for agency staff who work with home-based child care providers and that relationship-based training is a promising approach to improving the quality of support services to providers (Bromer & Korfmacher, 2012).

The second phase of the *Family Child Care Specialist Training Program* was conducted from July, 2012 through May, 2013 with a diverse cohort of eight specialists from six agencies in the city of Chicago. The training also included two supervisors and one family child care provider although this report focuses on the experiences of the eight specialists who worked directly with home-based child care providers. Training participants attended weekly in-person two-hour seminars at a centrally located agency over an 11-month time period during 2012-2013. Seminars were held during the work-day and were considered part of the specialists' regular job hours. Two conference calls were scheduled for agency program directors over the course of the training in order to update them on topics covered and to answer any questions about how participants were using the training in their work.

### **Evaluation overview**

A process evaluation of the training program was conducted in order to 1) describe a variety of agency approaches to supporting home-based child care providers and agency specialists' experiences delivering support services to providers, and 2) examine how staff training helps agencies improve the quality of support services to providers. This report summarizes findings from the evaluation.

### **Evaluation methods and research design**

A mixed-method approach was used for this evaluation and data were collected from multiple sources including agency specialists who participated in the training, agency directors who supported their staff throughout the training, family child care providers who received services from the specialists participating in the training, and the program facilitator. Approval for this research was provided by Erikson Institute's Institutional Review Board.

#### ***Data collection and analysis procedures and protocols***

##### ***Agency Specialists***

Interviews. Two in-person interviews were conducted with each training participant. The first interview was conducted at the beginning of the training program (July, 2012) and the second interview was conducted at the end of the training program (May-June, 2013). In addition, at the end of each interview, participants were asked to respond to a series of vignettes about hypothetical situations they might encounter in their work. Interviews lasted approximately one hour.

Interviews consisted of open-ended questions about participants' job roles, motivations for participating in the training, and current approaches to working with providers. End of program interviews focused on participants' experiences in the training program and changes in their work that may have resulted from the training. Interviews included vignettes about challenging situations with providers. The goal of the vignettes was to assess how the training may have impacted attitudes and approaches toward working with providers

All interviews were audio-taped and transcribed. All interview transcripts were entered into NVIVO, a qualitative software analysis program. Coding schemes were developed based on interview questions and on themes that emerged from the interviews. The Principal Investigator and a research

assistant independently coded transcripts and then reached consensus on areas of disagreement. Summaries of codes were developed and used for analyses of common themes.

Vignette responses were assessed using a set of four 5-point rating scales developed by the research team. The scales measure four areas of relationship-based and family child care-focused practice: 1) the specialists' approach to offering guidance and support, 2) the specialists' understanding of opportunities for mixed-age groups of children, 3) the specialists' recognition of individual and cultural differences, and 4) the specialists' articulation of self-awareness and reflection. Each scale was given a score from one to five and detailed descriptions and examples guided the scoring process. The PI and co-PI independently rated each vignette and then compared their scores. All discrepancies were within one point. Discrepancies were reconciled through discussion until consensus was reached.

On-line survey. An on-line survey was distributed to specialists in the training program via email. Surveys took approximately 20 minutes to complete. The survey was developed by the research team and its purpose was to gather data on specialists' work with providers, attitudes towards their work, and challenges and rewards of their jobs. Demographic information was also collected.

Video observations. Participating specialists were asked to collect and share video observations of their visits to provider homes. Video observations were chosen as they offer in-depth information about staff practices with providers. Participants were instructed to videotape themselves during a typical visit to a provider's home at the beginning and end of the training. Video observations lasted between 30 and 60 minutes and focused on staff-provider interactions and not on specific children in care. However, as children in care occasionally appeared on videos, consent was obtained from parents of any children in a video prior to that video being watched. Written consent was also obtained from providers before videotaping was conducted. Specialists were also asked to complete a short questionnaire about each video they completed to inform researchers about the context of the visit. A total of 12 videos of typical visits were collected from six specialists<sup>2</sup>.

Permission was granted to develop a modified version of the Home Visiting Rating Scales – Adapted & Extended (HOVRS A+; Roggman, et al., 2008) to rate the quality of visits to provider homes captured in the videotapes. The HOVRS-A+ is an observation-based rating tool of home visiting quality with parents and was used in this study to assess the quality of visits to family child care provider homes by an agency specialist. The HOVRS A+ measures four dimensions of process quality (i.e. responsiveness to parents and children, relationships with parents and children, facilitation of parent-child interactions, and non-intrusiveness and collaboration) and three dimensions of effectiveness (i.e. parent-child interaction, parent engagement, and child engagement in the home visit). Items are rated on a 7-point scale ranging from 1 (inadequate) to 7 (excellent).

The PI and co-PI participated in training on how to reliably score the HOVRS-A+. For this project, the four process scales were modified to examine the specialists' responsiveness to the provider and children in care, relationship with the provider and children in care, facilitation of provider-child interactions, and non-intrusiveness and collaboration with the provider. In some cases, the facilitation of provider-child interactions scale was omitted because no children were present in the video. Only one effectiveness scale was used – provider engagement. The PI and co-PI independently rated each video, and compared scores. Discrepancies were reconciled through discussion until consensus was reached. A Spanish-speaking research assistant, who was also trained on how to reliably score the HOVRS-A+, independently completed the modified HOVRS-A+ ratings for videos that were in Spanish.

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<sup>2</sup>The remaining two specialists collected videos that were not focused on their work with providers. One specialist collected a video of her work with children in a provider's home without the provider's participation. Another specialist collected videos of a formal interview she conducted with a provider rather than a typical visit. These videos were not analyzed for this report.

A checklist was created by the research team to inventory the content and activities covered during the provider home visit. The PI and a research assistant completed the checklists for each video. Responses to the checklists were then compared, discrepancies were discussed, and consensus was reached. A Spanish-speaking research assistant independently completed the checklists for videos that were in Spanish.

Results from the on-line survey as well as the HOVRS, vignette rating scores, and video checklists were entered into SPSS, a quantitative software analysis program.

Examples of agency specialist practices were developed through combining data from all of the data collection sources (interview, video, survey). In order to protect the confidentiality of research participants and agencies, composites were created in which details across specialists who reported similar experiences were combined.

#### *Agency program directors*

Interviews. Program directors of participating agencies were asked to participate in two interviews. The first interviews took place in-person at the beginning of the training year (July-September, 2012). The second interview with directors took place on the telephone after the training was completed (September- October, 2013).

Interviews asked directors to describe their agency's structure and provider-focused programming and services. An inventory of network services provided by the agency was also given to directors to complete. Directors were asked to reflect on any changes in their agency's work with providers as a result of the training program and their perspective on their agency's participation in the program.

#### *Home-based child care providers*

Telephone interviews. Telephone interviews were conducted with home-based child care providers who worked with the specialists enrolled in the training program. Providers were recruited by the specialists and their contact information was given to the researchers. Providers were each sent a \$10 gift card for participating in the interviews which lasted about 30 minutes and were scheduled at a time convenient for the providers. The interview protocols were translated into Spanish. A Spanish-speaking research assistant conducted interviews with two providers in Spanish and interview transcripts were then translated back into English.

Interviews with providers gathered information about provider experiences working with their agency specialist and receiving agency services. Basic demographic and income data were also gathered. Providers were also asked questions from the *Strengths-Based Practices Inventory* (SBPI; Green, McAllister, & Tarte, 2004) which assesses the extent to which the providers felt they received relationship-based services from their agency specialist. The SBPI is a 16-item measure of strengths-based practices relevant to family support and early child care programs. With the author's permission, the language of this measure was slightly modified to elicit information about receiving services from an agency specialist. Items were scored on a 7-point likert scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Responses were then averaged to produce one overall score and four related factor scores: (a) Strengths, (b) Cultural Competency, (c) Relationship-Based Support, and (d) Staff Competence.

#### *Program facilitator and trainer*

The trainer of the professional development program was interviewed in-person after the program was complete. The interview focused on the facilitator’s experiences implementing the program and reflections on how the program could be modified for future cohorts.

**Sample description**

**Agencies**

Eight agency specialists from six agencies participated in the training (see table 1). All six agencies were located in the city of Chicago and worked with family child care providers serving families and young children. Four of the agencies operated the family child care option of the federal Head Start and/or Early Head Start program. Early Head Start (serves children 0-2) and Head Start (children 3-5) are federally-funded comprehensive early childhood programs for low-income families. These four agencies had “networks” of licensed family child care providers who contracted with the agency to provide Head Start and Early Head Start services to families and children in the community. In turn, these providers received training and support from the agency as well as monitoring visits. These programs required providers to meet a comprehensive list of quality and program performance standards including educational requirements and documentation of compliance. One of the other agencies in the training was a child care resource and referral agency that administers the federal child and adult food program (CACFP) among other child care-related services to both home and center-based providers, families, and children. Another agency was a privately run, fee-based network for home-based child care providers (both licensed and license-exempt) that was part of a broader University-community partnership.

**Table 1: Participating agencies and specialists**

	Agency	Specialists <sup>a</sup>	Program Type	Provider Type
	Child and youth care services agency	Maria	Head Start & Early Head Start	Licensed
	Family & child services agency	Loukeshia	Early Head Start	Licensed
	Family & child services agency	Susan	Early Head Start	Licensed
	Family & child services agency	Candace	Head Start & Early Head Start	Licensed
	Child care resource & referral	Linda Elena	Child and Adult Food Program	Licensed & license-exempt <sup>b</sup>
	University-community partnership	Jess Mary	Private FCC network	Licensed & license-exempt
<b>Total</b>	<b>6</b>	<b>8</b>		

<sup>a</sup> All names have been changed to protect the confidentiality of participants.

<sup>b</sup> In Illinois, providers caring for fewer than three unrelated children are exempt from licensing regulations.

**Agency specialists**

Specialists in the training program included agency staff who worked directly with family child care providers through visits to provider homes, training, technical assistance, coaching and mentoring (table 2). All the specialists were female and had an average age of 40 years. Three specialists identified their race/ethnicity as Black/African American, two identified as White/Caucasian, two identified as Latina/Hispanic, and one identified as bi-racial. Specialists varied in terms of highest degree earned and area of study. Three specialists had completed an associates’ degree, one had completed a bachelor’s degree, three had completed a master’s degree, and one had

completed a doctorate. Only one specialist had earned her highest degree in ECE; however, three others had earned their highest degree in a related field such as education, psychology, or social work. Four other specialists had earned their highest degree in an unrelated field. Specialists also varied in terms of their current job title and years of experience working with home-based child care providers. Half of specialists had worked with home-based providers for one to five years; however, three had worked with home-based providers for less than a year and one had worked with home-based providers for over six years. All names of specialists have been changed to pseudonyms for this report.

**Table 2. Demographic characteristics of specialists (N=8)**

	M (SD)
<b>Age</b>	39.5 (12.7)
	<b>N</b>
<b>Gender</b>	
Female	8
<b>Race/Ethnicity</b>	
Black/African American	3
White/Caucasian	2
Latina/Hispanic	2
Bi-racial	1
<b>Highest level of education completed</b>	
Associates Degree	3
Bachelor's Degree	1
Master's Degree	3
Doctoral Degree	1
<b>Area of Study (Highest Degree)</b>	
Early Childhood Education	1
Related Field (Education, Psychology, Social Work)	3
Unrelated Field	4
<b>Years worked with home-based providers</b>	
< 1 year	3
1 to 5 years	4
6 to 10 years	1

**Agency program directors**

In each of the six agencies, a program director oversaw the work of each of the project specialists, although may not have been a direct supervisor. Four of the directors self-identified their race/ethnicity as Black/African American and two identified as White/Caucasian. One director had completed a bachelor's degree, four had completed a master's degree, and one had completed a doctorate. Half of the directors had completed their highest degree in ECE and the other half had completed their highest degree in a related field. Directors had been working in the ECE field for an average of 19 years and had been in their current positions for an average of five years.

**Home-based child care providers**

Ten home-based child care providers who received services from an agency specialist in the training program were interviewed including eight licensed family child care providers and two license-exempt family, friend and neighbor caregivers (table 3). The providers were all married women and, on average, 41 years old. Four providers self-reported their race/ethnicity to be Black/African-American, four identified as Latina/Hispanic, and two as Asian. Half of the providers identified their primary home language as English and of the other half, two identified Spanish, two identified multiple languages, and



one identified Bengali as her primary home language. Providers varied in their level of education and area of study. Two providers had completed a high school diploma or GED, three had completed some college classes or an associate’s degree, three had completed a bachelor’s degree, and two had completed some graduate courses or a master’s degree. Of those completing some college or higher, half completed their highest degree in ECE or a related field and the other half completed their highest degree in an unrelated area.

**Table 3. Demographic characteristics of providers (N=10)**

	M (SD)
Age	40.60 (7.07)
Number of children taken care of	7.20 (3.77)
<b>Race/Ethnicity</b>	
Black/African American	4
Latina/Hispanic	4
Asian	2
<b>Marital status</b>	
Married <sup>a</sup>	9
<b>Gender</b>	
Female	10
<b>Primary home language</b>	
English	5
Spanish	2
Multiple Languages	2
Bengali	1
<b>Highest level of education completed</b>	
HS Diploma or GED	2
Some College/Associates Degree	3
Bachelor’s Degree	3
Some Graduate Courses/Master’s Degree	2
<b>Area of study<sup>a</sup></b>	
ECE/Child Development/Preschool Education	4
Unrelated Field	4
<b>Licensing status</b>	
Licensed	8
License-exempt	2
<b>Type of agency affiliation</b>	
Head Start	6
CACFP	2
Private	2

<sup>a</sup> Missing data.

**Program description: Family Child Care Specialist Training**

The relationship-based training program for family child care agency specialists was developed at Erikson Institute. The 11-month program entailed advanced-level weekly seminars; curriculum focused on developmental principles across the age span; reflective practice and collaborative learning; and an emphasis on the unique context of home-based child care.

The program draws on a variety of theoretical and practice perspectives, including an emphasis on relationship-based practice (Heffron, 2005), adult learning theory (Mezirow & Associates, 1990), and the concept of skilled dialogue in early childhood settings (Barrera & Kramer, 2009). The training program is rooted in the notion of “parallel process” which refers to the idea that relationships formed in the training between the instructor and the participants shape how participants develop relationships with providers and ultimately how providers develop relationships with families and children. The

training offers participants a structured setting in which to “pause” in their week to reflect on their own experiences with others doing similar work, ask questions, and gain new perspective on their work with providers over time (Heffron, 2005).

### **Findings: How agencies work with home-based child care providers**

The first goal of the evaluation was to describe how agencies approach their work with providers and to learn more about the agencies and experiences of agency specialists who deliver support services to providers.

#### **Agency mission and home-based child care**

Five out of six agencies in our study primarily serve low income families in many of Chicago’s poorest neighborhoods. According to one agency’s mission statement, the organization aims to “empower families to be able to meet their own needs.” The sixth agency served providers in a middle class community.

Three of the six agencies embraced family child care providers as an integral part of the organization’s mission and work as the following directors reported:

“it is very important for us to have a collaborative relationship with the family child care providers. We see them not as an extension of the [the agency] but as a true part of [the agency]. We look to foster their growth.” - Family & child services agency director

“Make sure all children have access to quality child care. The majority of children, especially children in low income environments are found in home-based child care. One of our driving forces is to make sure those providers have exposure to things that can help them with developing children and making sure it’s quality care for them.” - Family & child services agency director

For the other three agencies, services to family child care providers were a small part of the organization’s work with families and children which focused more on center-based programming and family support services.

#### **Programmatic focus**

All but one of the agencies administered a federally funded and regulated program for child care providers and families including Head Start, Early Head Start, and the federal child and adult care food program (CACFP). The federal regulations and standards of these programs largely dictated the ways specialists carried out their jobs and the types of services and supports they were able to deliver to providers. In some cases, the agency may have valued relationship building and quality improvement yet the federal program’s requirements for monitoring and compliance to a strict set of federal standards limited opportunities for relationship-based work beyond the circumscribed set of regulations.

#### **Career trajectories of specialists**

Table 4 shows the career paths of the eight specialists in the study. With the exception of the two CACFP specialists (Linda and Elena), the specialists in this study came to this work from other early childhood-related jobs. Mary and Candace had been family child care providers themselves, others were preschool teachers or early childhood administrators, and still others had experience in early childhood home visiting programs with parents. Linda and Elena had no prior experience or training in early

childhood settings. Linda had been a receptionist and Elena had worked in a factory prior to their work with home-based child care providers. However, despite their apparent lack of intentionality regarding a career path, both women spoke passionately about wanting to continue working in the ECE field. These jobs seemed to serve as a possible entry point for them into a career in ECE.

**Table 4: Career trajectories of specialists**

	Current Job	Months in Current Job	Years in Field	Previous Job	Ever home-based child care provider
Linda	CACFP monitor	4	2	Receptionist	
Elena	CACFP monitor	72	6	Factory Worker	
Maria	Network coordinator	48	18	Preschool Teacher	
Jess	Family child care specialist	2	11	Social Work Intern	
Mary	Family child care specialist	0	4	FCC Provider	Yes
Loukesha	Family child care specialist	30	8	Home Visitor	
Susan	Network coordinator	9	34	Family Support Specialist	
Candace	Network coordinator	13	4	Provider Specialist	Yes
<b>Average</b>		<b>22</b>	<b>11</b>		

### **Working with home-based child care providers**

Regardless of programmatic focus or job description, all of the agency specialists in this study conducted regular visits to provider homes as part of their job. Much of the work with providers took place either in the provider homes or on the phone with providers between visits. Specialists in this study were clear about the purpose of their work with providers.

#### ***Focus on program administration and monitoring***

The six specialists whose job involved implementing federal programs were clear about the administrative requirements needed for home-based child care providers to meet federal guidelines. Much of their work with providers focused on completing paperwork for their home-based programs and entering child and program data for monitoring or funding purposes. In these administrative tasks, specialists felt competent and clear about their jobs as the following suggest:

“A typical day is monitoring, making sure that they're inputting observations for the new system that we're using to assess children's development. Making sure that they are on top of their license and their physicals... So it's really a lot of monitoring.” - Maria

“My position, it entails... making sure that lesson plans are implemented on a weekly basis, making sure assessments are done, checkpoints are done, observations are completed.... making sure the standards are being followed in the home.” - Loukesha

The focus on child care quality improvement and provider support, however, was less clear for these specialists. Maria said she felt unsure if she was doing enough to support providers, and noted: “I

don't know if I actually am doing it the way I'm supposed to do it." Candace said she felt clear about her administrative duties with providers but less clear about how to improve family child care. Several specialists made clear that they were monitors but not supervisors of the providers. Yet they felt less clear about how to support providers while also monitoring compliance:

"Your role is more of a support role. If you're supporting somebody, then how could you not wonder, what can I do? How can I help? The challenge, though, has been I don't want to do it for you. I want you to have some ownership in this also, so it's a joint effort. If you're willing to work with me, I want to work with you and we can do this together." - Candace

None of the specialists reported focusing visits to provider homes on aspects of caregiving unique to family child care such as managing and working with mixed age groups of children.

### ***Focus on home-based provider support***

Jess and Mary, the two specialists in an agency that was not implementing a federally regulated program, felt less conflicted about their role with providers and talked about being a "resource," a "mentor," and a "moral support." Other specialists also talked about the need to offer this emotional support in addition to the monitoring and administrative requirements of their jobs:

"I have some providers they may if they're feeling overwhelmed and it's affecting their work that they're doing. I just kind of sit down – most of the time they just need somebody you know, a listening ear, okay. And very seldom do they need the advice but just to kind of vent a little bit and kind of just take a step back because they're around kids all day." - Loukesha

"I'm a mentor. I'm an advisor. I'm a shoulder to cry on occasionally. And I take that very seriously....They trust me. I've gained their trust." - Susan

Some of the specialists conducted regular group meetings for providers either at the agency or in provider homes in addition to individual visits to provider homes. These specialists reported that they often felt more comfortable in group meetings to discuss quality issues than during individual visits. Mary talked about role playing with providers' difficult situations with families, offering suggestions and problem solving specific issues about children. As Loukesha described, the providers were more open with each other and with her in group meetings than during individual sessions. These group meetings allowed them to learn from each other and share ideas about child care:

"We kind of take turns at each provider's home every month, just to give the providers an opportunity to see each other's home, get ideas, get feedback, things like that. It kind of helps them build that trust, you know that communication. So that's why we do that. It's been working. They love it." - Loukesha

Observational data confirms that specialists' visits to provider homes were primarily focused on completion of paperwork and data entry tasks with providers related to the administration of federally regulated programs such as Head Start, Early Head Start, and CACFP (See table 5). Visits were focused on the provider and often conducted during nap time or after hours when children were not present. Specialists focused their discussions with providers on health and nutrition, physical development, cognitive development, and developmental stages and milestones of children in care. None of the specialists focused on provider-child relationships or social-emotional development of children. Only Mary spent any time during a visit facilitating provider-child interactions or modeling interactions with

children. This specialist was from an agency that did not administer a federally regulated program for providers and so had more flexibility in how she structured her visits to provider homes.

**Table 5. Specialists' areas of focus during visits to provider homes (N = 12 observations <sup>a</sup>)**

<b>Activities conducted by specialists during visits to provider homes</b>	<b>% (n)</b>
Provision of information or education	75 (9)
Administrative/Paperwork	50 (6)
Bring materials for provider	42 (5)
Goal setting and planning	42 (5)
Model or demonstrate interaction with children	33 (4)
Play with children	33 (4)
Bring materials for children	25 (3)
Quality assessment or observation	25 (3)
Problem solving	25 (3)
Facilitate provider-child interactions	17 (2)
Observation of provider-child interactions	8 (1)
Provision of emotional support to provider	8 (1)
Evaluation or feedback on provider-child interactions	0 (0)
<b>Topics covered by specialists during visits to provider homes: Primary focus</b>	
<b>Child health and development</b>	
Nutrition and health	50 (6)
Developmental stages/milestones and appropriate expectations	50 (6)
Cognitive development	42 (5)
Physical/motor development	36 (4)
Literacy and language development	17 (2)
Social-emotional needs and development	0 (0)
<b>Home environment</b>	
Materials and equipment	33 (4)
Routines	8 (1)
Home safety and licensing compliance	8 (1)
Child care set up and flow	0 (0)
<b>Relationships in care</b>	
Provider-parent relationships/family involvement	25 (3)
Provider-child relationships	0 (0)
<b>Provider health and well-being</b>	
Goal setting	8 (1)
Social support ; Mental health, coping, and well-being; Physical health; Substance use	0 (0)
<b>Community connections</b>	
Emergency/crisis intervention; Referral to community services for child, parent, or provider ; Housing and/or transportation	0 (0)
<b>Professional development</b>	
Head Start/Early Head Start	33 (4)
Help with food program	25 (3)
Accreditation/ QRIS/ Licensing help	0 (0)

<sup>a</sup> Twelve video observations were collected from six specialists.

### **Quality of visits to provider homes**

Observational data on the quality of visits to provider homes (table 6) also found that specialists scored low on responsiveness and facilitation of provider-child interactions yet performed higher on relationship-building with both providers and children in care. Specialists were observed to be relaxed and warm with providers, familiar with the child care environments, and non-judgmental in their interactions with providers. Overall, providers were engaged in visits from specialists. Specialists in jobs that implemented federally regulated programs scored lower across quality dimensions than other

specialists whose jobs may have allowed them more freedom to develop relationships and quality improvement implementation, although this is an area for further investigation since we do not know what other factors may have contributed to variations in quality ratings.

**Table 6. Observed quality of visits to provider homes** (N = 12 observations<sup>a</sup>)

Home Visiting Rating Scales (HOVRS – A+)	Average score (1-7)
Specialist responsiveness to provider and children	2.8
Specialist-provider and children relationship	4.2
Specialist facilitation of provider-children interaction <sup>b</sup>	1.6
Specialist non-intrusiveness & collaboration	2.6
Provider engagement during visit to provider home	4.3

<sup>a</sup> 12 video observations were collected from six specialists.

<sup>b</sup> Four videos were not rated for this item as there were no children present.

### ***Working with families***

The Head Start and Early Head Start specialists worked with the parents in the child care homes in addition to working with the providers. They helped families access resources, mediated discussions between providers and families, and served as a support to families around their child’s development. Loukesha shared a story of her experience with a homeless family. With her help, the family agreed to meet with her and the provider in order to share resources as well as discuss their child’s development. According to Loukesha, “the success of it is that this parent started going back to college for her nursing degree. She was able to find a home. She got the part time job.” While Loukesha saw herself as a resource to families, other specialists did not see their work as encompassing parents. Their work focused exclusively on helping providers comply with regulations or on helping providers with their own programmatic needs.

### **Rewards of working with home-based child care providers**

Specialists reported many positive and rewarding aspects of working with family child care providers including spending time with children and seeing them develop, helping providers develop their own skills, helping improve quality, relationship building with providers, and the flexibility inherent in working with providers in their homes. Six specialists reported the reward of seeing providers develop their own professional skills and improve the quality of their child care programs:

“What I like, what’s rewarding is when I do actually see that they take the suggestions and the comments that I provide to them and put it to use. I’ve seen it on their lesson plans. I’ve seen it in their home when I go in and I see it, that’s rewarding to me.” - Maria

“When I have a provider come to me: ‘I’m working on my star level three!’ Or ‘I’m going to get accredited! I’ve been motivated to get accredited!’ Those things are rewarding to me.”  
- Loukesha

“...the other thing I find really rewarding is seeing ... the providers really develop confidence and develop their own skills” - Jess

Given that most of the specialists came to this work from prior experience working with children, it’s not surprising that five out of eight specialists talked about spending time with children as a meaningful aspect of this work:

“Really the kids. Seeing the kids, seeing them, they’re happy to see me. Seeing them get really excited or interested by something that I’m doing, seeing them doing a skill that I’ve taught them.” - Jess

“I mean anytime you go to a provider’s house and the children open the door for you and says Ms. Susan is at the door, it feels good.” - Susan

“I leave here and I can go into the homes of providers and the children grab your legs. They’re so happy to see you and their faces when you read to them and when I am on the floor playing with them and even went I don’t even really get to do any activities with them and I’m just there.” - Candace

Four specialists also noted the personal connections and relationship-building with providers and families as an important and rewarding aspect of the job and two specialists noted the flexibility of the job.

### **Program barriers to supporting home-based child care providers**

Despite these rewards and positive aspects of this work, specialists reported agency-level barriers to supporting home-based child care providers. Specialists who worked in agencies that included many different programs for children and families including center-based child care classrooms and family supports, found it difficult to obtain recognition, support, or resources for their work with home-based child care providers. Specialists described their work with home-based child care providers as isolated from the other programs at the agency. As Loukeshia explained, she often had to perform the roles of several specialists with home-based providers:

“I’m not only responsible for the education piece, but the health piece for the children, the disabilities piece, and there are already managers in those roles but they don’t work directly with the family child care homes so they’re filtering through me... I didn’t major in disabilities, that’s not my expertise area, so I’m limited to what questions I can answer, whether they’re coming from the provider or whether they’re coming from the parent. I just don’t have anybody that I can go to or that’s even willing to really go out to the homes.”

Other specialists echoed this frustration when they described the limited efforts their agencies make to offer home-based providers specific programming and resources. Maria articulated how the isolation of the family child care network at her agency made it difficult to engage in quality work with home-based child care providers and to offer the range of supports these providers need:

“I wish [our program] could be combined more into the agency. It’s not there yet. I do the education piece. I do a little bit of the enrollment. I do the recruitment, the disabilities, so that’s a lot of programs in just that one family child care home.” -Maria

Federal program requirements may have also limited the types of visits specialists could conduct in family child care homes and the quality of relationships they could build with providers. Some specialists reported having large caseloads of providers and only being able to visit providers three times a year. Video data of visits to provider homes suggest that specialists whose work entailed implementing a federal program spent most of the visits completing paperwork or data entry and that very little

discussion occurred between the specialist and the provider beyond completion of checklists and compliance documents. As Candace, a Head Start specialist, described, there were few opportunities for discussion of quality practices or child development:

“So much of our visits are paperwork exchanges, information exchanges and what about this and what about this? It’s so much of that it takes away from the time that I would love to spend with them working with some of the developmental activities with the children.”

### **Other challenges faced by specialists**

Across agency types, specialists consistently identified several challenges to their abilities to work effectively with home-based child care providers. These challenges included resistant providers, poor working conditions, logistical challenges, and the difficulty of working in providers’ homes. In addition, safety concerns, trouble establishing personal boundaries, isolation, large caseloads, low-quality practices in home-based child care, and language barriers were cited as challenges.

In describing the challenge of working with resistant providers, specialists spoke of providers who resisted change and those who failed to follow through on requirements. Some specialists described providers who were set in their ways and did not trust outside advice or expertise. As Jess stated, “I think sometimes the challenges are getting people to try new things or to look at what they're doing in a different way.” Examples given of providers not following through on tasks included not staying on track with obtaining required academic credentials, not submitting paperwork on time, or failing to complete child observations required for Head Start and Early Head Start.

Specialists also described challenges stemming from their working conditions such as poor or irregular compensation and a lack of overtime, benefits, and growth potential. Further, some specialists described long and irregular work hours. For example, Maria described becoming “tired and drained” because of long work hours and the need to schedule provider meetings after her regular 9 to 5 work day or on Saturdays.

In addition to external challenges associated with this work, specialists also cited challenges related to their own abilities to establish personal boundaries with home-based child care providers who are often isolated from other adults and may view the specialist’s visit as an opportunity to talk about a range of personal issues. Specialists mentioned fielding provider phone calls outside of their established work hours. Linda described her commitment to her job and providers:

“I mean the job never ends. It's 24 hours. So I mean, you know, it definitely falls into when I’m not working, I’m working because I could start at five in the morning and be done at two, but of course I’m still getting phone calls at six, seven and eight, you know, of questions and things like that, which I never turn down.”

Additionally, safety concerns were raised by specialists as a challenging aspect of working in provider homes. Specialists were unable to know who besides the provider and children may be in the home or surrounding area. Three specialists – Linda, Elena, and Susan – noted they had concerns about their own safety and/or property while on visits. Elena spoke about being scared to go into certain neighborhoods but going anyway because it is part of her job: “I feel like, yeah, the neighborhood may be bad or in my eyes a bad neighborhood, but my provider still has to live there, so I still have to go see this provider.”



Finally, isolation was a challenge that some specialists mentioned. Specialists spent most of their work day visiting provider homes and, like the providers they worked with, were often isolated from their co-workers. Linda noted, “you really don’t have anyone to talk to 'cause you're always driving from home to home.” Elena explained that while her agency has monthly staff meetings, she did not feel as if this contact was frequent enough – “I don’t really work with other people.”

### **Supervision and support**

Participants in agencies where programs and services for home-based child care were central to the mission of the organization found that they received responsive support and understanding from their supervisors. Both Maria and Elena, the CACFP specialists, talked about having a supervisor who had herself been a home visitor: “She can relate, she’s done it, she’s awesome.” Maria, a specialist at a child and social services agency indicated that her supervisor had a “good understanding” of family child care and often accompanied her on visits to provider homes. Jess and Mary, specialists from an agency whose exclusive focus is on family child care providers, reported that their supervisor understands the nature of their jobs since she originally started the network: “She built this network from the ground up.”

Specialists working in agencies that were less focused on family child care and invested more resources into center-based care and other community services, reported receiving less supervision and support for their job. These specialists noted that their supervisors lacked an understanding of what their jobs entailed. Susan noted about her supervisor who had recently left the position: “I never developed a true relationship with her.” Candace talked about her supervisor’s lack of support: “I think that’s probably one of the things that frustrates me the most. I know that [she is] smart enough to understand my challenges, yet [she] totally ignore[s] them and the focus is the mission, the requirements, deadlines.” Loukesha explained that her supervisor is limited in how much she is able to provide support – “I think the majority of the time it’s me brainstorming with the providers and coming up with a solution.”

In addition, these specialists did not feel recognized or appreciated by their agencies and felt that their agency directors were not supportive of the home-based child care providers. Loukesha explained: “It’s very limited. To me, it seems they’re more concerned about the slots, the numbers, that’s the main focus at the end of the day. ... It’s always like we’re thought about second.” Candace talked about the disparate nature of family child care and the challenge of integrating home-based provider programs into the agency when these providers offer care and education off site and are rarely able to visit the agency: “We’re an afterthought...Because [here there are] buildings with several hundred children and families here every day all day and we’re not. We’re away and there are fewer of us.”

### **Home-based child care provider perspectives on agency support**

Home-based child care providers reported having positive relationships with their agency specialists and all ten providers interviewed rated their specialists high on strengths-based approaches including empowerment, cultural competency, sensitivity, and support with most rating their specialists as a six or seven on the seven-point Strengths-Based Practices Inventory. Four providers reported that they would like more frequent visits and support: “I feel more comfortable when I talk with her, I trust myself that I am doing well with the babies; that I am doing well with my daycare.” This statement underlies the potential importance of external support for home-based child care providers who often work in isolation without the daily support or validation of other caregivers and professionals.

Home-based child care providers reported changes they made in their child care programs as a result of working with an agency specialist. These included developing new routines and schedules, making changes to the child care environment, learning to see themselves as professionals, and learning how to interact with parents in more professional ways. Yet, provider perspectives on their visits from specialists also confirm the administrative rather than quality focus of agency supports. Providers emphasized that the visits focused on the specific monitoring goals and that most of the help received from a specialist was administrative rather than quality or development focused. Providers reported getting help entering observational data, learning to use a computer, and meeting specific program standards related to health, safety, and nutrition. However, providers also expressed needing materials and information related to literacy, books for children, helping parents understand the goals of their child care programs, and other materials for their programs.

The following example illustrates the tensions agency specialists experience between monitoring compliance to standards and developing relationships with providers focused on quality improvement and professional growth and development.

**Example of agency practices:  
The challenge of monitoring and supporting home-based child care providers**

Candace works in a community organization that has been serving home-based child care providers through their Family Child Care (FCC) Network for many years. The agency began including FCC providers in their service delivery in order to expand their programming into the community and “support the development of strong, well-educated, well-versed providers who have access to developmental screenings, ongoing assessment systems, and high quality curricula.” The FCC Network provides these services to low income families in several of Chicago’s poorest neighborhoods and receives funding from several federal programs (e.g., Early Head Start, Head Start, and Child Care Assistance Program). The FCC Network is small in comparison to other programs at the agency including center-based programming and family support services.

Candace began her career in an area unrelated to early childhood but joined her current organization after having her own children and working briefly as a home-based provider. She has worked at the organization for almost three years and has been in her current position for 13 months.

Candace has a caseload of four licensed providers and in addition to facilitating monthly provider meetings, she conducts visits to each provider’s home at least twice a month. When asked to describe her typical day, Candace indicates that the majority of her time is spent visiting providers, reaching out to parents and providers over the telephone, maintaining databases of children’s medical, dental, and developmental screening information, and attending meetings and workshops. Her visits with providers often focus on administrative tasks such as helping providers complete the paperwork and data entry requirements of the federal funding agencies. She reports that she rarely has time during visits to engage in or model child-focused activities with providers. In fact, Candace indicates that at times she feels like she is swamped with the administrative tasks of her job and does not have enough time in her work day to complete other, more relational activities with providers or developmental activities with children. Indeed, video observations of her work with a provider shows that despite her engaging and warm approach with the provider, Candace focused the visit on training the provider to enter child data into a computer. She notes that she has a certain level of discomfort around how to facilitate quality improvements beyond these administrative tasks, partially due to her lack of formal education in early childhood education: “I’m very direct when it comes to administrative things. When it comes to some of the other things related to child care maybe not as clear, but, and some of it is because of my lack of knowledge and some of it is because it is a very tricky thing going into someone’s home, their business, and pointing out to them some area that they could tweak, improve, it’s challenging.”

Candace enjoys her work with providers but feels frustrated with the lack of direct supervision and support she receives to do this work. While her supervisor seems to understand the nature of working with home-based child care providers on an intellectual level, Candace feels she does not get enough support around the challenging aspects of the work. In addition, Candace notes that her agency is not always able to prioritize the interests of the home-based providers, given other program priorities and demands. Candace attributes this lack of focus on the FCC network to the fact that the home-based providers and the children they care for are not visible to the agency directors in the same way the center-based providers and children are.

Despite all these challenges, Candace indicates that she is committed to her agency and reports numerous positive aspects of her job, notably working with children and being able to watch them learn and develop. Further, she reports having positive, close, and trusting relationships with her providers and indicates that most of her providers count on her for support.

All names were changed in the writing of this example. Details were combined across respondent reports to create a composite example of practice.

### **Findings: How training shapes agency practices with home-based child care providers**

The second goal of the evaluation was to understand how the *Family Child Care Specialist Training Program* for agency staff can help shape practices with home-based child care providers as well as agency systems and procedures that support providers. The evaluation examined the ways that this training was received and used within the context of agency structure and programmatic focus.

#### **Motivations for participating in training**

Prior to the training program, specialists reported several areas where they felt training would be helpful to their work with providers, including: adult learning, understanding family child care, coaching and consultation, school-age development, and developing a business. When asked to elaborate on their reasons for participating in the *Family Child Care Specialist Training Program*, specialists reported wanting to improve their skills working with providers and learn more effective ways to support quality in family child care homes. Loukesha articulated:

“I want to know that I am doing everything that I can to help this provider better her business as well as better herself. And in turn help the parents and the children. That’s my main thing 'cause sometimes I feel like I’m not doing enough or I’m kind of lost. I’m not sure about this or I’m not sure about that you know.”

Specialists also hoped to expand their professional networks and connections in order to provide better services and resources for their providers.

“I wanted to know what other individuals in my role were doing to help the providers. How they were implementing things. How that they support them, in what way and how did they do it, that was my main goal.” - Loukesha

“Maybe other ideas of what other coordinators do. Are they as involved in the home with the provider and the children or is it more like the administrator, you know, trying to look in and make sure that things are running well?” - Maria

“Meet other people who’ve been doing the work longer but didn't have the same kind of background that I did, I was just really excited about that.” -Jess

For Candace, who did not have a background in early childhood education, the training could fill a knowledge gap: “I don't make any secret of the fact that my EC background is not extensive. I make no secret about that at all... It's an opportunity increase my knowledge about child development and early childhood education.”

#### **Change experienced by participants**

##### ***Social and professional networking***

All eight specialists reported that the most valuable aspect of the training was the opportunity to network and share resources with other specialists who did similar work with providers in Chicago. As mentioned earlier, many of the specialists spoke about the isolation they feel in their jobs and at their agencies. They spend much of their work days in their cars driving to and from provider homes, and are

often the only person at the agency who works with family child care providers. The chance to talk with others who were also doing this work allowed them to vent, share, and feel validated in their challenges and rewards. As Linda explained:

“...with other people’s stories and knowing that they go through some of the same things, you know what I mean, these challenging visits, and the way that they handled them. So that would help.”

At the end of the program year, specialists reported that they had already started relying on each other for resources and information sharing as well as problem solving as Loukesha describes:

“Those people will go with my reference books. I just, in talking to them I realized the wealth of information that they have here that I can draw on, and they were very open about whatever you need, however I can help, give me a call. So, yeah, they will be a part of my reference library.”

### ***Relationship-based practices***

Specialists reported ways that the training helped them change their support practices with providers. Specialists’ responses to vignettes describing challenging situations with providers at both the beginning and end of the training program, revealed improvements in relationship-based responses to such situations. Specialists were rated a two out of five possible points, on average, at the beginning of the training program and were rated a three out of five in their response to the same vignette at the end of the program. Although this suggests a small improvement in how they view their work, few specialists articulated approaches that included validating and empowering providers or an awareness of cultural differences, nor was there much evidence of understanding how to work with mixed age groups of children.

Interview data with specialists at the end of the year further suggest that specialists learned new ways of communicating and engaging with providers around quality improvement and compliance to standards and regulations. Specialists reported learning new perspective-taking strategies that helped them listen and ask open-ended questions to providers before trying to problem solve or give advice. Specialists referred to reflective practice that was emphasized in the training program and gave examples of how this helped them shift their approach to visiting providers. Elena said she realized that many providers are isolated in their work and that they often like to talk about their lives and experiences with a visitor. The training helped her recognize this perspective and learn how to shift her communication style to be more open to providers’ experiences. Susan noted that she learned how to approach problem solving in a more open-ended manner: “And I could not go in there and say okay ‘you must, you better, you have to,’ but more of the approach of, ‘have you thought about?’” This shift in communication style and perspective taking is also heard in Mary’s explanation of what she learned from the training:

“That was sort of my -- you’ve got a problem? I can solve it. That’s just antithetical to what the whole reflection, reflective supervision is about....to take a step back, not to just react without thinking, assuming that there’s more going on underneath whatever sentence just got spoken and being curious about what that more is.....But it’s that piece in myself that I’ve become really aware of, and it’s even helped me interact with some of our parents who sometimes have views or wants or desires with regard to their little ones that I think are misguided, and so I’ve learned to sort of take a step back and try to listen for what’s going on behind the sentence you just uttered..... ‘Tell me more about

that.’ That’s a great thing I learned from Erikson.”

These examples suggest how specialists’ experiences of sharing and collaborating with other specialists through the training process may have also helped them recognize and value the importance of collaboration and partnership for providers. Specialists described their work as similar to providers’ work with children in the way the work is isolated from other colleagues and adults. Perhaps as specialists learned how to communicate and share their own experiences with other specialists, they also learned how to be more aware of providers’ needs to share and collaborate.

### ***Supporting and monitoring***

In addition to new communication and perspective-taking skills, specialists who worked in agencies that administered a federally regulated program, reported that the training helped them find ways to offer providers support as well as perform the required monitoring tasks. Elena talked about learning to start a visit with providers by listening to their concerns rather than completing a checklist. Maria talked about modifying her directive approach with providers regarding Head Start compliance, and instead providing more information and explaining the reasons behind specific standards. She noted that she is learning “just to be a listener first, and then discuss whatever you have to discuss.” She noted that building strong relationships with providers is helping to improve provider compliance around the Head Start standards. Elena noted a similar balancing act between monitoring and supporting: “Even though I still do my monitoring job, as a monitor, because I still have to keep by the guidelines, I also keep in mind that they’re people and things happen and I do try to help as much as I can.”

Specialists also gave examples of new types of partnerships they developed with providers as a result of the training program. Maria noted that she had learned how to do more “hands-on” projects with her providers. She gave an example of helping a provider create a health bulletin board as opposed to just telling her it was a requirement she had to complete. She noted that the training “put it into perspective that they really do need hands-on guiding, showing, touching, and I think that’s what really got to me at the end, like, oh my goodness, I could have probably been doing this all along and wouldn’t have to be like, oh here I have to tell them again or here I have to show them again.”

### ***Career development***

Three specialists reported that the training helped them focus on their career goals. For Elena, a CACFP monitor, the training inspired her to go back to school and finish her degree. Jess, a specialist at the private network, said the training helped her re-think next steps in her educational and vocational aspirations. For Loukesha, the training helped her realize how much she had accomplished in her job and gave her the confidence to imagine new career pathways.

### ***Agency change***

One of the goals of the training program was to enhance the organizational capacity of agencies to support family child care providers and to integrate relationship-based practices into provider support services. This goal proved to be a challenging one in the six participating agencies due to organizational structures, funding limitations, and external program requirements. However, two of the agencies noted ways in which the training program helped the agency improve its approach to service delivery with providers. In one of the agencies that administered the CACFP, the program director noted that although she had emphasized the all-encompassing nature of the CACFP monitors’ jobs and had encouraged them to engage with providers beyond the narrow monitoring requirements of the food program, the training helped these specialists see their role as more expansive and related to quality

improvement. She noted that as a result of the training program, more specialists at the agency were collaborating and sharing ideas with each other. Linda, one of the CACFP specialists, confirmed this new approach to her job: "I pay more attention to what's going on and the reason -- you know as opposed to just coming for a review or for the visit. Now, I'm observing more, I'm paying attention to the children and their interaction with me or the provider's interaction with the children."

The following example illustrates how a specialist's personal and professional growth can help transform an agency's approach to working with providers.

### **Example of a specialist's change in practice:**

#### **The impact of training on leadership and advocacy development**

Susan is the family child care specialist at an agency serving families and children in several high poverty neighborhoods in Chicago. The agency runs two center-based Head Start and child care classrooms as well as a family support program. The agency's mission is to promote family self-sufficiency and empowerment. The agency was one of the first in the city to offer the family child care Early Head Start option and sees the program as a way to meet the needs of more families in the community, especially those families who are not able to access center-based programs. Yet despite the agencies commitment to the family child care network, at the beginning of the training year Susan is the only staff member who interacts with family child care providers at the agency and she reports feeling isolated in her work. Collaboration across programs at the agency is minimal. There is little understanding or recognition of what family child care is and limited time and staff to deliver resources and information directly to provider homes.

Susan feels overwhelmed by the expectation that she deliver support to providers in all areas. Although there are specialists at the agency in disabilities, health, and curriculum support, none of these specialists conduct visits to provider homes. As a result, she has to rely on her own knowledge in these specific areas. She reports focusing her work with providers on compliance to the Head Start standards yet she wishes she could do more.

At the beginning of the training year, Susan finds herself without a direct supervisor and, as the agency director reports, on the verge of burnout. The training program transforms her job experiences and her sense of efficacy as a professional. First, the program offers her a support network that both reduces her isolation as well as validates her experiences helping providers. Through the encouragement received from the instructor and her colleagues in the training, Susan begins to make her needs known at the agency (specifically her need for supervision and job clarity): "I'm able to communicate when I'm feeling overwhelmed...[I've] learned to sit down and talk to [my] supervisor about challenges and not be afraid of repercussions."

Second, the program helps Susan find new ways of working with providers, especially in difficult or challenging situations. She talks about the difficulty of working with providers who are resistant to change. The focus on adult learning styles in the training helps her appreciate different ways of learning and take a "fresh outlook" on providers who are resistant to completing paperwork and other program requirements. In reference to one provider in particular, she notes that by "really listen[ing] to her challenges" and "just going step by step, letting her show me how she does it... I can kind of gauge okay, this is where the problem lies or this is what is being done wrong." As a result, she is able to help the provider find new ways of meeting program requirements. She describes the provider's reaction to this as "'Oh.' It was like a light bulb went off, 'oh okay I get it now.'"

Susan also reports changing her perspective and view of providers. Prior to the training, she would conduct her visits in a matter-of-fact manner without connecting personally with the providers. The training helps her balance providers' needs for sharing personal matters with her own need to cover a required agenda and tasks. "So the training has helped me ...acknowledge their concerns and let them know yeah you are valid in feeling this way, how can I help you, how can we continue to move forward. The training has taught me how to do that." The training has helped her value the importance of relationship-based practice and see her job as more than just a monitor: "The training showed me that's insensitive, you don't have to be that way. I may have some resources that the provider can benefit from. So it just opened my eyes to that."

Finally, the training helps Susan in her own career and professional development: "It has made me sit down and think about where do I want to go after this, what I want to do exactly?...It's made me look at what I do and say you should be proud of yourself because you do a lot, you have accomplished a lot." According to the agency director, Susan's increased confidence is visible in the way she now advocates for the Early Head Start provider program within the agency and speaks up on behalf of providers and the families and children in these home-based programs. The director notes that Susan "pushed us to pay more attention to providers - this is where our work needs to be done; it's not either/or but how do we connect to providers and improve quality in these settings?" The director also observes that the providers at the agency seem more empowered. They are more active at the agency and with Susan's help are able to voice their needs and agenda within the agency. Finally, according to the director, under Susan's leadership of the provider program, the agency has started to implement new organizational practices. For example, several of the specialists – including the nurse consultant – have started to make visits to family child care homes and there is more collaboration across content areas. Overall, Susan's participation in the training has helped her grow personally and professionally as a leader in her agency. The agency was ready for this change and recognized the importance of family child care in the community and was able to respond to Susan's developing advocacy and leadership role.



All names were changed in the writing of this example. Details were combined across respondent reports to create a composite example of practice.

## Summary

The second phase of the *Family Child Care Specialist Training Program* was conducted with a diverse cohort of family child care specialists who deliver support services to home-based child care providers through six agencies in the city of Chicago. This intensive year-long program aimed to help specialists acquire relationship-based skills and developmental knowledge to improve their delivery of support services to providers. A process evaluation of the training program was conducted in order to 1) describe a variety of agency approaches to supporting home-based child care providers and agency specialists' experiences delivering support services to providers, and 2) examine how staff training helps agencies improve the quality of support services to providers.

Findings suggest that specialists who work with family child care providers face unique challenges including isolation within their agencies, resistant providers, and having to navigate diverse home environments. Specialists who worked in agencies where home-based child care services were not integrated into other services at the agency received less supervision, support, and recognition for their work with providers compared to specialists in agencies in which those services were integrated. Additional challenges were reported around administrative and paperwork tasks related to monitoring federally-regulated programs. The focus on monitoring compliance with regulatory standards may have eclipsed opportunities to facilitate positive provider-child interactions and other relational dimensions of quality such as provider-family relationships, social-emotional development of children, and facilitation of learning and development within mixed-age groupings of children.

The *Family Child Care Specialist Training Program* offered specialists an opportunity to acquire and utilize new skills and knowledge to enhance their work with home-based child care providers. Training helped specialists practice new strategies for developing partnerships, taking provider perspectives, and communicating more effectively, which allowed them to both monitor *and* support home-based child care providers in their care and education of children and families.

Training also created new opportunities for sharing and collaboration across agencies. This networking reduced the isolation that many specialists described in their work and may have also helped them to bring new resources and networks to the home-based child care providers in their caseloads. The new collaborations that specialists developed across agencies during the training motivated some to take on advocacy and leadership roles around family child care within their agencies. In addition to individual skill and knowledge acquisition, the training program may have shaped agencies' approaches to service delivery for home-based child care, particularly in agencies that were ready for change and could accommodate new practices and approaches to supporting quality.

## Discussion and Implications

Most specialists in the study came to their current jobs from other early childhood-related positions. They reported that having the opportunity to positively influence children's experiences was one of the rewards of working with home-based child care providers. Specialists welcomed the chance to interact informally with children in child care homes – many noted that the children knew them by name and looked forward to their visits – yet few of the specialists focused their visits to child care homes on facilitating provider-child interactions. In fact, finding ways to help providers improve quality, while also monitoring their adherence and compliance to standards, was identified by specialists as an

ongoing challenge. The focus on administrative tasks rather than the quality of interactions may limit the effectiveness of visits in improving the quality of home-based child care. Research on home visiting programs suggests that high quality home visiting has the potential to impact child outcomes when it involves facilitation of provider-child interactions and relationships (Roggman , Boyce, & Cook, 2009). A similar focus on provider-child relationships during visits to family child care homes could potentially shape positive outcomes for children in these settings.

Findings from this study point to the need for more specific guidelines and standards around best practices for supporting family child care providers. Prior research finds that visits to family child care homes is a promising strategy for improving quality and child outcomes (Bromer et al., 2009; McCabe & Cochran, 2008) yet the field lacks guidelines for implementing high-quality visiting in family child care homes across diverse home contexts as well as other strategies for supporting quality such as mentoring and coaching. The lack of supervision and support that many specialists reported in this current study may be partially due to the lack of knowledge and information that agencies and agency supervisors have about family child care and how to support these providers. Integrating home-based child care services into agency service delivery systems will require greater understanding among staff throughout the agency about the unique context of family child care, how family child care differs from center-based care, the potential for quality in these settings, and the key elements of effective support that improve outcomes for children in family child care homes.

The current study identified isolation of agency specialists who work with home-based providers as a possible barrier to the delivery of high-quality support services. Prior research has identified isolation as a barrier to quality in family child care homes (Porter et al, 2010; Bromer & Korfmacher, 2012) and professional affiliation and support as predictors of quality family child care (Doherty, Forer, Lero, Goelman, & LaGrange, 2006; Forry et al., 2013). One study of organizational culture found that child care agencies classified as “relational” had higher quality partnerships with families than organizations classified as “conventional” in their approach to working with families (Douglass, 2011). Delivery of high quality supports to providers may require a similar type of relationship-based organizational culture that values the development of partnerships with family child care providers and views home-based child care as a positive option for families and children. Future research should focus on dimensions of an agency’s organizational culture and practice that are associated with high quality support practices and ultimately high quality care in affiliated provider homes.

Collaboration and sharing across agencies around family child care quality improvement initiatives and programs may further reduce the isolation of specialists and providers as well as create new communities of practice and learning around family child care and quality support. Networking among specialists who do this work may lead to enhanced advocacy on behalf of family child care. A majority of young children in non-parental child care are cared for in home-based child care settings, yet early childhood education policy and research initiatives have largely focused on center-based care. Increasing understanding of the potential benefits of home-based child care for families and children and communicating these benefits to the public could help bring this sector of child care out of the shadows and into the broader public discussion about high-quality early childhood education. Specialists who understand the unique potential for quality and positive outcomes in family child care homes can communicate within their agencies and to the public, the value of these settings as a viable option for families and children.

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