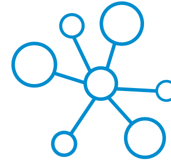
MAPPING THE FAMILY CHILD CARE NETWORK LANDSCAPE



Findings from the National Study of Family Child Care Networks

FULL TECHNICAL REPORT

JANUARY 2019

W. Clement & Jessie V. Stone FOUNDATION

PRITZKER Children's Initiative

Erikson Institute
Herr Research Center

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https://www.erikson.edu/research/national-study-of-family-child-care-networks/

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MAPPING THE FAMILY CHILD CARE NETWORK LANDSCAPE:

FINDINGS FROM THE NATIONAL STUDY OF FAMILY CHILD CARE NETWORKS

TABLE OF CONTENTS

I. INTRODUCTION 1

II. BACKGROUND

- Research on Family Child Care Networks 2
- Policy and Program Context 2
- Project Overview 4

III. RESEARCH DESIGN AND METHODS

- Research Questions 5
- Data Collection Methods 5
- Sample Description 6
- Data Analyses 8

IV. FINDINGS

- Organizational Characteristics 9
- Services Offered To HBCC Providers 12
- Staffing and Supervision 30
- Evaluation and Quality Assessment 37

V. DISCUSSION AND RECOMMENDATIONS

- Discussion 42
- Recommendations For Programs, Policy, and Research 43
- Conclusion 44

VI. REFERENCES 45

FIGURES & TABLES

- Figure 1 Location of Staffed Family Child Care Networks
- Table 1 Complete Sample of Organizations
- Table 2 Types of Staffed Family Child Care Networks and Organizational Platforms
- Table 3 Staffed Family Child Care Network Duration and Reach
- Table 4 Types of Providers Served by Organizations that House SFCCNs
- Table 5 Funding Sources
- Table 6 Systems Support
- Table 7 Visits to Provider Homes
- Table 8 Training Workshop Topics
- Table 9 Peer Support Services
- Table 10 Types of Curriculum Help
- Table 11 Business and Administrative Support
- Table 12 Incentives and Materials
- Table 13 Comprehensive Resources for Children and Families
- Table 14 Combinations of Services
- Table 15 Staff Positions
- Table 16 Staff Qualifications
- Table 17 Language of Service Delivery
- Table 18 In-Service Staff Training Topics
- Table 19 Staff Supervision
- Table 20 Evaluation and Quality Assessment
- Table 21 Summary Table of Significant Differences across Types of Staffed Family Child Care Networks

APPENDICES

- Appendix A Methods Detail: Survey Recruitment and Qualitative Methods
- Appendix B Profiles of Networks
- Appendix C Statistical Tables

INTRODUCTION

Millions of children, ages birth through five and not yet in kindergarten in the U.S., are cared for in home-based child care (HBCC). These settings include regulated family child care (FCC) as well as family, friend, and neighbor (FFN) caregivers who may or may not be legally-exempt from regulations. More infants and toddlers are cared for in HBCC than any other child care arrangement (NSECE, 2013) and children from low-income families are disproportionately cared for in HBCC arrangements (Laughlin, 2013). Many school-age children are also cared for in these settings (NSECE, 2016).

Concerns about the quality of HBCC care, especially for infants and toddlers, have led to the development of several recent federal policy initiatives. The 2014 re-authorization of the Child Care and Development Block Grant (CCDBG), the primary federal source of funding for reimbursement for providers who care for children from eligible families, included new regulations to enhance children's health and safety, to increase access to care, and to improve child care quality (Office of Child Care, 2016a). In the same year, the federal Offices of Child Care and Head Start launched the Early Head Start-Child Care Partnership program, an effort to increase the supply of high-quality infant-toddler child care that included FCC (U.S. Department of Health and Human Services, 2018).

Implementing quality improvement initiatives for HBCC at the state and community levels has been elusive because the research base to inform policy and program directions is limited (Bromer & Korfmacher, 2017). Some studies have examined the characteristics, needs, and interests of HBCC providers broadly, including both FCC and FFN (Layzer, Goodson, & Brown-Lyons, 2007; Morrissey, 2007; National Survey of Early Care and Education Project Team, 2013; 2015b; Susman-Stillman & Banghart, 2008). Other studies have focused specifically on the experiences of FCC providers (e.g., Lanigan, 2011; Tonyan, 2014) or FFN providers' perspectives on caregiving (e.g. Porter & Kearns, 2005; Thomas, Johnson, Young, Boller, Hu, & Gonzalez, 2015).

A small but increasing research base has examined initiatives to improve quality in HBCC (for reviews see Bromer & Korfmacher, 2017; Paulsell et al., 2010; Porter, Paulsell, Del Grosso, Avellar, Hass, & Vuong, 2010; Susman-Stillman & Banghart, 2011; Weber, 2013). Studies have examined the effectiveness of specific quality improvement strategies such as home visiting (McCabe & Cochran, 2008), mentoring (Abell, Arsiwalla, Putnam, & Miller, E. B., 2014), training and professional development (Boller et al., 2010; Burris & Fredericksen, 2012; Rusby, Jones, Crowley, Smolkowski, & Arthun, 2013), play and learn programs (Organizational Research Services, 2010; Porter & Vuong, 2008), and combinations of services such as coaching and coursework (Moreno, Green, & Koehn, 2015; Neuman & Cunningham, 2009), or coaching and video-feedback (Groeneveld, Vermeer, van Ijzendoorn, & Linting, 2011). Still other studies have explored the relationship between FCC participation in a Quality Rating and Improvement System (QRIS) and quality outcomes (Boller et al., 2015; Hallam, Hooper, Bargreen, Buell, & Han, 2017; Isner et al., 2011; Tonyan, 2013).

***STAFFED FAMILY CHILD CARE NETWORKS** are organizations that offer HBCC providers a menu of quality improvement services and supports including technical assistance, training, and/or peer support delivered by a paid staff member.*

The current study examines a specific quality improvement approach – family child care networks. For this study, we define a "staffed family child care network" as an organization that offers HBCC providers a menu of quality improvement services and supports including technical assistance, training, and/or peer support delivered by a paid staff member (Bromer & Porter, 2017). This report describes findings from a survey-based scan of the landscape of staffed family child care networks across the U.S. and draws on examples from in-depth interviews with a sub-sample of network directors. Findings from this study contribute new information about the types of services networks offer to providers and families and set the stage for future examination of network effectiveness.

BACKGROUND

RESEARCH ON FAMILY CHILD CARE NETWORKS

Two studies have systematically examined networks' effects on provider quality. The Family Child Care Network Impact Study (Bromer, Van Haitsma, Daley, & Modigliani, 2009), a quasi-experimental study of licensed FCC providers participating in 35 different networks in Chicago, found that providers who were affiliated with staffed networks that delivered a combination of on-going support services were more likely to offer higher quality care than unaffiliated providers. A more recent study, the 2014 evaluation of All Our Kin, a family child care network in Connecticut that offers a combination of intensive in-home consultation visits, training, and peer networking for FCC providers, also found that affiliated network providers offered higher quality care than a comparison group of unaffiliated providers (Porter & Reiman, 2016).

Qualitative studies find that networks help to ameliorate some of the barriers, such as isolation, that HBCC providers face, by connecting them to training opportunities and other providers (Buell, Pfister, & Gamel-McCormick, 2002; Hershfield, Moeller, Cohen & the Mills Consulting Group, 2005; Musick, 1996). Focus groups with providers in nine professional development networks in Washington State, for example, found that providers cited relationship-based support, networking opportunities with other providers, and respect for FCC as benefits of network participation (Lanigan, 2011).

POLICY & PROGRAM CONTEXT

Staffed family child care networks operate within a broader policy context that includes state licensing, federally-regulated child care subsidy systems, state or local QRIS initiatives, and in some communities, federally-funded and locally implemented Head Start, Migrant Head Start, and Early Head Start programs. Each of these systems and programs incorporates regulations and requirements for HBCC providers. The 2014 Child Care and Development Block Grant (CCDBG) regulations include new training topic requirements for HBCC providers who participate in the subsidy system (Office of Child Care, 2016a). Relative providers are exempt from these regulations, although some states do not take the exemption and require relative caregivers to complete required training.

In 2016, the Office of Child Care, an office of the Administration for Children and Families, singled out family child care networks as a quality improvement strategy for helping HBCC providers comply with the 2014 federal CCDBG standards for improving quality (Office of Child Care, 2016a). Eighteen states, the District of Columbia, and the territory of Puerto Rico indicated that they intended to establish or expand networks in their 2016-2018 CCDBG plans (Office of Child Care, 2016b).[1]

One strategy used by states is to develop contracts with family child care networks to deliver subsidized child care to low-income families. For example, Massachusetts has the longest running state-wide support for FCC through what it calls "family child care systems." MA systems are like networks that offer a menu of supports and services to providers who serve families in the subsidy program (Adams & Katz, 2015). New York City also delivers subsidized child care to families through family child care networks that are part of the EarlyLearn initiative (Banghart & Porter, 2016; Hurley & Shinn, 2016).

1 These states included AL, CA, CT, DC, FL, GA, IN, ME, MA, MS, NM, NY, OR, PR, SC, VT, WA, WY (Office of Child Care, 2016b).

STATE LICENSING AND CERTIFICATION

State licensing or certification systems are intended to protect the health and safety of children through requirements for providers such as: 1) the number of children in care; 2) qualifications of providers and required training; and 3) environmental health and safety features (National Center on Early Childhood Quality Assurance, 2017). State licensing is inter-related with other systems such as child care subsidy assistance programs for low-income families and Quality Rating and Improvement Systems.

Some states have utilized family child care networks as a vehicle for increasing participation of FCC providers in QRIS. For example, Oregon has 15 "focused family child care networks" throughout the State that help providers improve quality of care through a cohort-based training and coaching model (Oregon Department of Education, 2018).

QUALITY RATING AND IMPROVEMENT SYSTEMS (QRIS)

QRISs have dual goals of improving the quality of the early childhood workforce through: 1) helping families choose high-quality care; and 2) providing professional development tied to ratings with financial incentives for providers. Of the 44 QRISs, 41 included HBCC (Build Initiative & Child Trends, 2017). The vast majority (36) of the QRISs that included HBCC require FCC providers to be licensed as a threshold for participation, and 18 of these states use licensing as the first rating level (Build Initiative & Child Trends, 2017).[2]

Some Early Head Start-Child Care Partnerships may operate like staffed family child care networks in which staff offer a menu of services to regulated FCC providers in the context of the Head Start Performance Standards. Staffed family child care networks also interact with the federal Child and Adult Care Food Program (CACFP) and accreditation offered by the National Association for Family Child Care (NAFCC). CACFP provides reimbursement for meals and snacks for eligible children in care. NAFCC accreditation sets standards of high quality for FCC and recognizes providers who meet these standards. NAFCC accreditation is used by a third of the QRISs as the highest FCC rating (Build Initiative & Child Trends, 2017). In addition, some cities such as Philadelphia include FCC providers in their publicly-funded preschool or pre-kindergarten programs. Participating providers are usually required to meet a set of locally-developed early learning program standards.

HEAD START

Head Start has offered a family child care option since 1995. In 2014, the federal Office of Head Start and the Office of Child Care created the Early Head Start-Child Care Partnership program, which aims to bring together Early Head Start and child care programs, including regulated or licensed FCC, to provide low-income families access to full-day, full-year, high-quality child care and comprehensive services. Of the 220 Early Head Start-Child Care Partnership programs that responded to a recent national survey, 39% served FCC providers as well as centers, and 7% served FCC only (Del Grosso & Thomas, 2018).

2 Eight states also allow participation of license-exempt providers (BUILD Initiative & Child Trends, 2017).

PROJECT OVERVIEW

Erikson Institute's National Study of Family Child Care Networks aims to address the gap in the knowledge base about staffed family child care networks. Launched in 2017, with support from the Pritzker Children's Initiative and the W. Clement and Jessie V. Stone Foundation, the project intends to inform policy and programs about network models that support HBCC providers. The three-year exploratory study consists of four primary components: 1) a national survey of staffed family child care networks; 2) in-depth interviews with a sub-sample of network directors about services implementation; 3) surveys of a sub-sample of providers and staff across networks; and 4) in-depth case studies of two promising networks.

This report presents findings from the national survey of family child care networks and includes examples of network services and strategies from the qualitative interviews with directors. The report is organized into three sections. The first section introduces the research design, including research questions and methods. The second section presents findings about the organizational characteristics, services, staffing, and kinds of evaluation across the networks in our sample. The report concludes with a discussion of, and implications for, program and policy directions and future research.

RESEARCH DESIGN & METHODS

RESEARCH QUESTIONS

The network survey and subsequent director interviews sought to explore the following research questions:

1. What is the range of organizational platforms, geographic areas served, types of providers served, and funding of staffed family child care networks?
2. What types of services and supports do staffed family child care networks offer providers and how are these services and supports implemented?
3. How does implementation of services vary across types of staffed family child care networks?

DATA COLLECTION METHODS

The following section describes survey recruitment, procedures, and protocols. Detailed methods for the qualitative interviews with directors are included in Appendix A. Survey and interview protocols are available upon request from Erikson Institute.

IDENTIFICATION AND RECRUITMENT OF FAMILY CHILD CARE NETWORKS

For this exploratory study, we cast a wide net, seeking to identify organizations that might house or operate family child care networks as well as networks that might be free-standing (housed in organizations whose only function was providing network services to HBCC providers). Given the lack of research on family child care networks as well as lack of consensus about definitions, we used a broad definition of family child care networks for the survey. We sought to identify organizations that offer a menu of supports and services to HBCC providers through paid staff. These organizations included: 1) child care resource and referral (CCR&R) agencies that help parents find child care and offer providers quality improvement support; 2) Head Start programs, including Early Head Start and Migrant Head Start; 3) child care centers; and 4) a variety of other social service agencies. We also included shared services alliances or programs that use shared services, an approach that offers providers back-office administrative and business support, bulk purchasing, and training (Opportunities Exchange, 2018).

Family child care associations and unions were also included in our sampling strategy. Associations are voluntary provider-run membership organizations that offer peer and professional supports (see Bromer et al., 2009). We hypothesized that family child care associations might have grants or other funding to hire staff who offer training and help their members achieve NAFCC accreditation. We included unions because local chapters may offer training and other professional supports for members in addition to representing them in collective bargaining agreements.[3]

We used three primary strategies to identify organizations that might fit our working definition of networks (see Appendix A for detail):

- identified organizations that support HBCC providers from key informants;
- partnered with national organizations to publish the survey link in their newsletters; and
- conducted internet searches, using terms such as “family child care networks,” “family child care systems,” “family child care hubs,” and “family, friend, and neighbor support.”

3 The Service Employees International Union (SEIU) was the first union to successfully negotiate a collective bargaining agreement on behalf of HBCC providers in Illinois (Blank, Campbell, & Entmacher, 2013). Since then, SEIU and its fellow union, the American Federation of State, County and Municipal Employees (AFSCME) have won the right to represent HBCC providers in 14 states, including CT, IL, IA, KS, MD, MA, NJ, NM, NY, OH, OR, PA, RI, and WA.

Combined, these strategies helped us identify a total of 505 organizations in 50 states and the District of Columbia as well as some tribal communities.

Invitations to complete the survey were sent between March and June 2017 through Qualtrics, an on-line survey tool. Directors of networks were asked to complete the survey and consult with key staff about questions that focused on service delivery. Snowball sampling strategies were also used with key informants who forwarded the invitations because they did not want to share what they perceived as confidential contact information or because they were sensitive to possible cultural concerns about participating in research.

During each of four waves of survey distribution, we provided a $25 Amazon e-gift card to the first 50 survey participants who completed the survey. All procedures and protocols were approved by Erikson Institute's IRB prior to data collection.

SURVEY PROTOCOL

The 20- to 25-minute survey consisted of approximately 50 questions about organizational characteristics, network services, staffing and supervision, and data collection and evaluation. Survey questions were adapted from protocols developed by the authors from previous studies (Bromer & Weaver, 2016; Bromer et al., 2009; Porter, Nichols, Del Grosso, Begnoche, Hass, Vuong, & Paulsell, 2010). A Frequently Asked Questions page allowed for informed consent before completing the survey.

Organizational characteristics included the numbers and types of providers served, budget and funding sources, the number of years networks had been in existence, and the types of organizations in which networks were housed. Questions about network services focused on home visits, training workshops, peer support, business and systems help, and comprehensive resources for families and children. The survey also included questions about staff roles, qualifications, and supports for staff (including in-service training and supervision). In addition, the survey asked about types of data collected by networks and the use of child care quality assessment instruments. (The survey protocol is available upon request.)

SAMPLE DESCRIPTION

We received a total of 275 survey responses, but 71 were eliminated because they either did not provide the name of the organization, were individual providers rather than organizations, or were spurious responses. Our initial sample consisted of 204 organizations that reported supporting HBCC providers. Of the 204 respondents, 25 only provided information about type of organization and did not provide information about services.[4] Two respondents did not fit our broad definition of networks as offering a menu of supports: one was a web-site and the other an advocacy organization.

The complete sample consisted of 177 responses (Table 1: Complete Sample of Organizations). Of this total, 156 met our definition of a staffed family child care network (SFCCN). Eighteen identified as family child care associations: two of these associations reported having paid staff and a menu of services for providers and were included in the 156 SFCCN sample. Five organizations identified as unions. This report describes findings related to the 156 SFCCNs.

TABLE 1: COMPLETE SAMPLE OF ORGANIZATIONS

	N=179
Staffed family child care network (SFCCN)	87% (156)
Family child care association[a]	10% (18)
Union that represents family child care	3% (5)

[a]Two associations were also categorized as SFCCN because they reported having paid staff.

4 The majority of these 25 incomplete responses were from organizations that may have met our definition of SFCCNs but did not provide enough information to report on service delivery strategies.

WHAT TYPES OF SFCCNS WERE IDENTIFIED?

The sample of SFCCNs consists of three sub-samples: 1) CCR&R agencies; 2) Head Start, Early Head Start, or Migrant Head Start programs that deliver services through FCC providers; and 3) Other organizations that did not identify as CCR&Rs or Head Start programs. This third category of SFCCNs comprised a mixed group of agencies that were difficult to categorize.

Two-fifths (42%) of the SFCCNs in our sample were operated through CCR&Rs (Table 2: Types of Staffed Family Child Care Networks and Organizational Platforms). Only 13% of the SFCCNs were part of programs that delivered Head Start, Early Head Start, or Migrant Head Start through licensed or regulated FCC providers. Most of these Head Start programs indicated that they were Early Head Start-Child Care Partnership projects. The remaining 44% of other SFCCNs in our sample did not fit into any one category. Twelve of these other SFCCNs reported that they were not part of any larger organization or program, indicating they may have been free-standing family child care networks.[5]

Many of the SFCCNs, including CCR&Rs and Head Start programs, were housed in larger umbrella organizations such as social service agencies, youth and family support organizations, public school districts, universities, and child care centers. Five SFCCNs identified as shared services alliances.

Given the exploratory nature of this study, we cannot assume that our sample is representative of the universe of networks that support HBCC in the U.S. For example, Child Care Aware reports that there are more than 400 CCR&R agencies in the U.S. (Child Care Aware, 2018) but only 66 responded to our survey. Similarly, there are 86 Early Head Start-Child Care partnership sites that deliver services through FCC providers (Del Grosso & Thomas, 2018), but only 19 in our sample. Given these small sample sizes, findings about differences across types of SFCCNs in our sample are only suggestive.

TABLE 2: TYPES OF STAFFED FAMILY CHILD CARE NETWORKS AND ORGANIZATIONAL PLATFORMS

	N=156
Child care resource & referral agency (CCR&R)	42% (66)
Early Head Start-Child Care Partnership project	12% (19)
Head Start/Migrant Head Start programs	1% (2)
Other SFCCNs	44% (69)
ORGANIZATIONAL PLATFORMS FOR NETWORKS[a]	**N=156**
Institute of higher education	8% (13)
Child care center	6% (10)
Public school district	5% (8)
Shared services alliance	3% (5)
Family child care association	1% (2)

[a]Categories are not mutually exclusive. Some CCR&R networks were also part of larger organizations such as institutes of higher education. Some Head Start programs were part of school districts. Some Head Start programs were also shared services alliances.

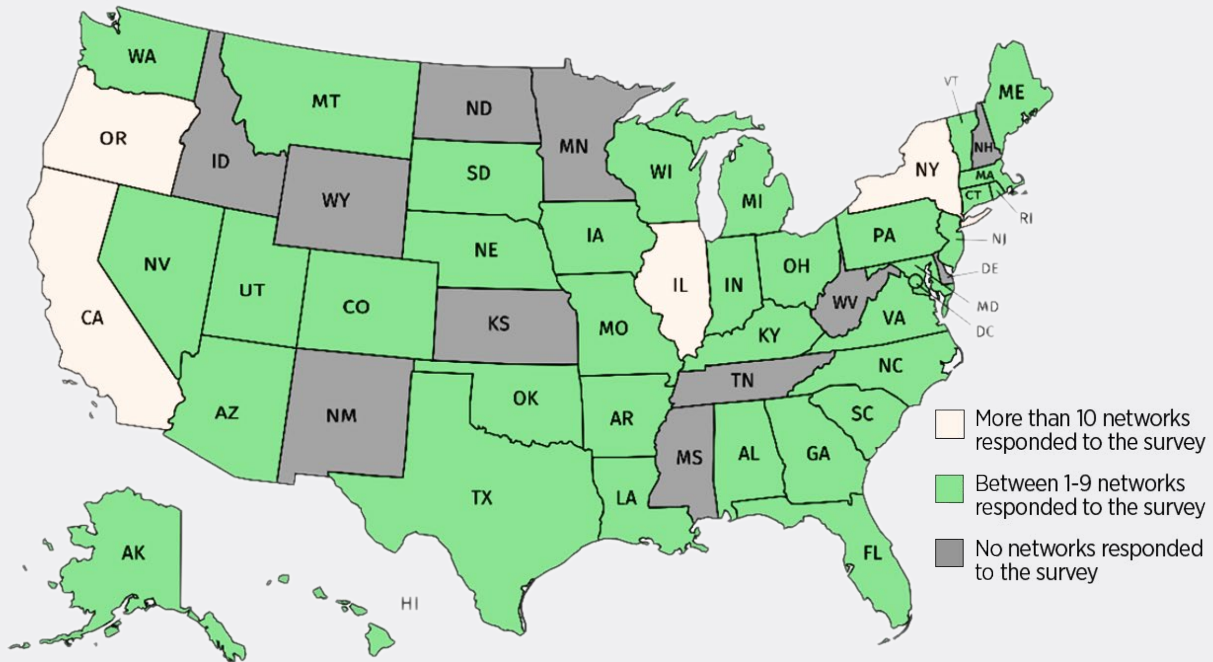
5 Our survey data for whether an SFCCN was housed in a larger organization or was free-standing are not reliable because the language in the survey question about organizational structure was not well defined. However, we know that there were at least a small number of free-standing networks in our sample of 156 based on the sub-sample of director interviews.

WHERE WERE SFCCNS LOCATED?

SFCCNs in our sample were located in 38 states and the District of Columbia (Figure 1: Location of Staffed Family Child Care Networks). More than 10 networks each responded from Oregon, California, Illinois, and New York. Nearly 40% of the CCR&R networks were located in three of these states (California-9, New York-8, and Oregon-10), and half of the 21 Head Start SFCCNs were in California, Illinois, and New York. In many cases, however, there were only two or three responses from each state. We also received responses from seven tribal communities.

It is possible that the high response rates from Oregon, California, Illinois, and New York are related to public policies in these states that support family child care networks. We received responses from 14 states and the District of Columbia (D.C.) out of the 18 states and D.C. that indicated using family child care networks to increase infant-toddler child care in their 2016-2018 State CCDBG plans.

FIGURE 1: LOCATION OF STAFFED FAMILY CHILD CARE NETWORKS (N=156)



DATA ANALYSES

We used non-parametric Chi Square tests to analyze differences across the types of SFCCN sub-samples for specific variables, such as funding sources and service delivery. Adjusted residuals were calculated to measure the strength of statistically significant differences between observed and expected values. Additionally, Cramer's V was calculated as a proxy for effect size.

In describing findings, we report on the differences that meet the criteria for statistical significance (i.e. $p < 0.05$), as well as those that indicate at least a moderate effect size (i.e. medium ranging from 0.17 to 0.3 and large ranging from 0.29 to 0.5, depending on the degrees of freedom) (Cohen, 1988; 1994). Findings that indicate a moderate or greater effect size, the focus of our reporting, are shown in bold throughout the tables. Detail for all statistically significant findings including those with a small effect size are included in Appendix C.

FINDINGS

The following section focuses on the 156 SFCCNs and includes findings in four areas: 1) SFCCN organizational characteristics; 2) SFCCN services; 3) SFCCN staffing and supervision; and 4) SFCCN evaluation and quality assessment.

ORGANIZATIONAL CHARACTERISTICS

WHAT IS THE DURATION AND REACH OF SFCCNS?

Close to half of the SFCCNs in our sample indicated a long-term commitment to serving HBCC providers, reporting that they had been providing services for at least 20 years (Table 3: SFCCN Duration and Reach). A much smaller proportion reported being in operation for fewer than five years.

Many SFCCNs reported serving local communities and small numbers of providers. Only a fraction (12%) indicated that they offered services statewide; notably, geographic size of the state did not determine state-wide services. Similarly, only 12% served more than 500 HBCC providers (the 19 networks were not the same as those that provided statewide services). CCR&Rs were more likely to serve more than 1000 providers and to offer services across multi-county areas compared to Head Start SFCCNs that were more likely to serve local communities and fewer than 50 providers.

Close to half of the SFCCNs served urban providers compared to slightly fewer than three in ten that served rural and suburban providers respectively. This finding suggests that providers who live in rural, or even suburban, areas, may be harder to reach, and may require more agency resources such as transportation and staffing to deliver services.

TABLE 3: STAFFED FAMILY CHILD CARE NETWORK DURATION AND REACH

NETWORK DURATION	ALL SFCCN N=126	CCR&R SFCCN N=51	HEAD START SFCCN N=16	OTHER SFCCN N=59
20 to <50 years	48% (60)	57% (29)	31% (5)	44% (26)
5 to < 20 years	37% (47)	29% (15)	31% (5)	46% (27)
1 to <5 years	15% (19)	14% (7)	38% (6)	10% (6)
GEOGRAPHIC REACH	**N=156**	**N=66**	**N=21**	**N=69**
Local	46% (72)	39% (26)	**67% (14)****	46% (32)
Multi-County	42% (65)	**55% (36)****	28% (6)	33% (23)
Statewide	12% (19)	**6% (4)****	5% (1)	**20% (14)****
AREAS WHERE PROVIDERS LIVE	**N=154**	**N=66**	**N=20**	**N= 68**
Urban	45% (69)	**32% (21)****	65% (13)	51% (35)
Suburban	28% (43)	33% (22)	**0% (0)****	31% (21)
Rural	27% (42)	35% (23)	35% (7)	**18% (12)****
NUMBERS OF HBCC PROVIDERS SERVED	**N=146**	**N=60**	**N=21**	**N=65**
1 to 50	42% (62)	**28% (17)***	**67% (14)***	48% (31)
51 to 100	15% (22)	18% (11)	19% (4)	11% (7)
101-500	31% (45)	33% (20)	**9% (2)***	35% (23)
501-999	3% (4)	5% (3)	5% (1)	0% (0)
>1000	9% (13)	**15% (9)***	0% (0)	6% (4)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

WHAT TYPES OF PROVIDERS DO ORGANIZATIONS THAT HOUSE SFCCNS SERVE?

Just over a third of organizations that house SFCCNs in our sample reported that they exclusively served HBCC providers (Table 4: Types of Providers Served by Organizations that House SFCCNs), while the majority reported that they served both HBCC and center-based providers. Our survey data do not indicate whether the services for HBCC providers were specifically tailored for HBCC providers or whether the implementation of HBCC services differed from that of services for centers. All but five of the 156 SFCCNs served regulated FCC providers and close to half served FFN caregivers. Five SFCCNs served exclusively FFN caregivers.

CCR&R networks were more likely to serve a mix of HBCC and center providers than other networks. Head Start and other networks that were neither CCR&R nor Head Start were more likely to serve only HBCC providers, which may suggest a specific focus on services that meet the distinct needs and interests of these providers.

TABLE 4: TYPES OF PROVIDERS SERVED BY ORGANIZATIONS THAT HOUSE SFCCNS

TYPES OF PROVIDERS	ALL SFCCN N=153	CCR&R SFCCN N=64	HEAD START SFCCN N=21	OTHER SFCCN N=68
Serves both HBCC and centers	61% (93)	**78% (50)***	**38% (8)***	**51% (35)***
Serves only HBCC providers (no centers)	39% (60)	**22% (14) ***	**62% (13) ***	**49% (33) ***
Serves regulated FCC providers only and/or centers (no FFN)	56% (86)	53% (34)	**90% (19)**	49% (33)
Serves any FFN providers (and/or FCC and/or centers)	44% (67)	47% (30)	**10% (2)***	51% (35)
Serves exclusively FFN providers	3% (5)	2% (1)	0% (0)	6% (4)
Serves both regulated FCC providers and FFN caregivers (and/or centers)	41% (62)	45% (29)	**10% (2)**	46% (31)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

HOW ARE SFCCNS FUNDED?

The vast majority of SFCCNs in our sample reported some kind of public funding (Table 5: Funding Sources). Funding from state contracts was the most commonly reported (60%). A fifth reported blending public and private foundation funding. CCR&R networks were more likely to report state contracts, suggesting their involvement in state systems such as a QRIS as described later in this report.

SFCCNs across the three categories reported federal funding, but more Head Start networks reported federal funding because Head Start is a federal program. Some of the other federal funding reported in our sample may have been Child Care Development Block Grant funds through state contracts.

Although few SFCCNs in our sample charged providers a fee for services, CCR&Rs were more likely to report this practice.

TABLE 5: FUNDING SOURCES

FUNDING SOURCES	ALL SFCCN N=152	CCR&R SFCCNS N=63	HEAD START SFCCNS N=21	OTHER SFCCNS N=68
Any public funding (federal, state, or other)	94% (143)	98% (62)	**100% (21)***	**88% (60)***
State contract	60% (91)	**73% (46)***	43% (9)	53% (36)
Federal funding[a]	40% (61)	41% (26)	**90% (19)[a]*** **	**24% (16)*****
Funded by any fees (parent or provider)	27% (41)	24% (15)	33% (7)	28% (19)
Private foundation	25% (38)	27% (17)	19% (4)	25% (17)
Blended public/private funding	22% (33)	25% (16)	19% (4)	19% (13)
Provider fees for network services	14% (21)	**22% (14)***	5% (1)	9% (6)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]*Two of the Head Start programs did not report federal funding. This may be due to a sub-contract with a larger grantee agency.*

SUMMARY OF ORGANIZATIONAL CHARACTERISTICS

- Most SFCCNs in our sample were housed in umbrella organizations that serve both HBCC and center-based providers.
- Nearly half of the SFCCNs had operated for more than 20 years.
- Most SFCCNs were local or county-focused, served fewer than 50 providers, and served providers living in urban areas.
- Many SFCCNs operated in states that have policies and public funding that support HBCC quality improvement.

SERVICES OFFERED TO HBCC PROVIDERS

In this section we describe the reach, frequency, and content of services offered by SFCCNs to HBCC providers. We also look at combinations of services that SFCCNs in our sample reported. Within each service delivery type, we report on differences found across types of SFCCNs. We also offer examples of services in action from our interviews with with 17 out of the 46 SFCCN directors.

In part, services reported by SFCCNs appear to be driven by funding requirements and programmatic standards. CCR&Rs, for example, are often funded by state contracts to administer the subsidy program and a QRIS's professional development for early care and education providers. Head Start program services are defined by the Head Start Performance Standards (HSPS) that require comprehensive service delivery around technical assistance, curriculum use, and resources for children and families. These HSPS drive the supports offered to providers by Head Start networks.

HOW DO SFCCNS HELP PROVIDERS NAVIGATE PUBLICLY-FUNDED SYSTEMS?

The three most commonly-reported types of public systems support in the SFCCN sample were help with licensing, the child care subsidy program, and QRIS participation (Table 6: Systems Support). CCR&R networks were more likely to report helping providers participate in a QRIS than other types of networks. In addition, two-thirds of the SFCCNs reported providing help with the federal Child and Adult Care Food Program (CACFP). Administering the CACFP may be one of the ways SFCCNs help providers become interested in additional quality improvement activities. A third of SFCCNs reported helping providers achieve National Association for Family Child Care (NAFCC) accreditation. Our survey data do not indicate if SFCCNs offered help with systems to providers on an as-needed basis or if this was a primary goal of the network.

TABLE 6: SYSTEMS SUPPORT

HELPS PROVIDERS PARTICIPATE IN:	ALL SFCCN N=156	CCR&R SFCCNS N=66	HEAD START SFCCNS N=21	OTHER SFCCNS N=69
Licensing/certification	81% (127)	88% (58)	76% (16)	77% (53)
QRIS	70% (109)	**83% (55)****	62% (13)	**59% (41)** **
Subsidy system	70% (109)	73% (48)	67% (14)	68% (47)
CACFP	62% (97)	67% (44)	71% (15)	55% (38)
NAFCC accreditation	34% (53)	36% (24)	33% (7)	32% (22)
Public Pre-k	17% (26)	18% (12)	0% (0)	20% (14)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

BOX 1: EXAMPLES OF SYSTEMS SUPPORT

Some research indicates that participation in early childhood systems may pose challenges for HBCC providers (Rohacek & Adams, 2017; Henly & Adams,2018). These burdens can include extensive and complicated paperwork and compliance requirements that may be particularly difficult for HBCC providers to complete, especially those who do not have staff to help with administrative paperwork.

HELP WITH LICENSING AND CHILD CARE SUBSIDY PROGRAMS

Bethel Child Care Services, a Massachusetts family child care system which serves FCC providers in Boston and the surrounding areas, helps providers navigate the licensing system through visits to provider homes. Many of its providers are non-English speakers, some with low levels of education, who live in low-income communities. The Massachusetts' regulations document is 77 pages in 14 sections (https://www.mass.gov/how-to/apply-for-a-family-child-care-provider-license).

Bethel serves as a buffer between the State and the providers by ensuring that the providers understand and comply with regulations to avoid violations. FCC specialists help providers make sense of what can sometimes be unclear requirements ("He's walking but he's not 15 months") or reasons for forms ("Oh, that's why I'm supposed to get the medical"). They play an important role in providing up-to-date information on changes: "[We're someone] to keep them in the loop. Because . . . they're out there on their own and . . . things change. Information isn't always disseminated in a great way." As the program director puts it, "If we as a system have a relationship with the State, and we don't always get that information, do you think educators, many of whom are not computer savvy, are getting it?"

The Association for Supportive Child Care's Niños en Mi Casa program in Arizona helps providers meet Department of Economic Security (DES) certification requirements to participate in the subsidy system. Providers come to the program with a variety of questions: "What does it mean to be a certified provider and what does it mean for my family? Is it beneficial? What will it offer me that being an unregulated provider won't?" Niños staff help providers understand the requirements and how to prepare for certification: "Our purpose is to make sure we're taking away any barriers that people might have to certification, which includes the financial piece of that and understanding the process, thinking through some of the challenges they might find in their home."

The program consists of three primary components: 1) a minimum of three home visits during the initial 90-day certification process; 2) 12 hours of health and safety training and six hours of developmentally-appropriate practice and CPR/First Aid in the 90 days post-certification, and; 3) financial assistance for the required TB tests for all household members, finger-printing and background checks for all household members 18 and older, liability insurance, health and safety equipment, and materials for the provider's program. In the first visit, staff help providers understand the health, safety, and environmental features that they will have to meet for the DES inspection. The second follow-up visit is another walk-through "to talk about how it's going to work out for their family, because we want to make sure that when they're setting up new systems in their home, it's not going to make it impractical for the family to continue to live there." The third visit is with the DES certification specialist; Niños staff help the providers with any issues that might arise.

Niños also offers providers the opportunity to obtain phone and e-mail support from mentors, who have been certified and in good standing for a year. Mentors reach out to providers to invite them to networking meetings and other professional development activities.

HELP PROVIDERS PARTICIPATE IN A QRIS

The Children's Council of San Francisco's Family Child Care Quality Network (FCCQN) is housed in a larger CCR&R agency and is one of two networks in San Francisco that offers supports to providers in the City's QRIS. Providers who participate in the City's subsidy program, Early Learning Scholarships, must commit to reaching a Tier 3 of the 5-Tier QRIS matrix within three years. The FCCQN is also developing a pathway to support

providers across stages of development from those who are interested in becoming licensed to those who are licensed but not part of the subsidy or QRIS system.

The FCCQN views its work as building a community of providers through integration of the licensing, subsidy, and QRIS systems. "Strengthening our communication with all providers, getting some support to sustain their businesses and enhance the quality of their program is big. Licensing for family child care in California is very, very different than participating in a quality system. It's like a gigantic leap. . . We also have to navigate the subsidy system. We've brought providers together across languages. Usually you were siloed out by language and our four basic ones are English, Spanish, Cantonese, and Mandarin."

The FCCQN stresses a relationship-based approach, starting with sending the providers a bio and picture of the quality consultant who is assigned to work with them. The quality consultants build a "level of trust" with providers, because they share the same culture, speak the same language, and have life experience with family child care ("We have people whose mothers were providers"), as well as having degrees in child development. The consultants help providers develop a quality improvement plan that aligns with the QRIS matrix based on assessments and the areas which the provider aims to improve. The plan can range from rearranging the environment and observing children to implementing the required Ages and Stages Questionnaire and California's Desired Results Developmental Profile assessments. The FCCQN also provides funding for materials to improve the environment.

The FCCQN's training is aligned with the QRIS elements and California's Early Childhood Education Competencies. In addition to its own staff, the FCCQN turns to other Children's Council departments to offer inclusion and nutrition training. It brings in community partners such as University of California Davis to offer training as well.

HELP WITH THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

Illinois Action for Children, the CCR&R agency which serves Cook County, IL, offers the CACFP to regulated FCC providers and license-exempt providers. It follows the initial monitoring visit with a "resource visit" to engage providers in other program activities. "We're going to get them involved in either a cohort for quality or a cohort for infant and toddlers or literacy or maybe a path for licensing or maybe just a pair of learning groups."

HOW DO SFCCNS IMPLEMENT VISITS TO PROVIDER HOMES?

Nearly all the SFCCNs in our sample reported some level of visits to provider homes. Yet, only half indicated they offered at least one visit to most (75% or more) of their providers, and fewer than a third reported having long-term relationships with providers that involved making repeated visits to homes for over a year (Table 7: Visits to Provider Homes).

A small percentage of SFCCNs (17%) reported high-frequency visits to providers – two or more times a month. Compared to CCR&Rs, Head Start SFCCNs were more likely to conduct visits with a majority of their providers and offer high-frequency visits.[6] By comparison, only 5% of CCR&Rs and 11% of other SFCCNs reported high-frequency visits to provider homes.

A fifth of the SFCCNs did not report a specific visiting schedule but instead reported conducting visits on an "as needed" basis. CCR&Rs were most likely to schedule these types of ad hoc visits that may be in response to a specific provider need rather than a programmatic or curricular goal.

TABLE 7: VISITS TO PROVIDER HOMES

	ALL SFCCN N=156	CCR&R SFCCNS N=66	HEAD START SFCCNS N=21	OTHER SFCCNS N=69
Visits to provider homes	97% (151)	97% (64)	100% (21)	96% (66)
PERCENTAGE OF PROVIDERS WHO RECEIVE A VISIT	**N=149**	**N=62**	**N=21**	**N=66**
1-24%	23% (34)	31% (19)	10% (2)	20% (13)
25-49%	11% (16)	14% (9)	10% (2)	7% (5)
50-74%	13% (20)	18% (11)	4% (1)	12% (8)
75-100%	53% (79)	**37% (23)***	**76% (16)***	61% (40)
TIME PERIOD FOR VISITING	**N=149**	**N=62**	**N=21**	**N=66**
A year or less	40% (59)	40% (25)	38% (8)	39% (26)
More than one year	28% (42)	21% (13)	43% (9)	30% (20)
Depends on provider needs and interests	32% (48)	39% (24)	19% (4)	30% (20)
FREQUENCY OF VISITS	**N=151**	**N=64**	**N=21**	**N=66**
High-frequency visiting (more than monthly)	17% (26)	**5% (3)*****	**76% (16)*****	11% (7)
Weekly visits	5% (8)	**0% (0) *****	**19% (4)*****	6% (4)
Every other week	12% (18)	**5% (3)*****	**57% (12)*****	**5% (3)*****
Monthly	25% (38)	**14% (9)*****	14% (3)	**39% (26)*****
1 to 6 times a year	36% (55)	**48% (31)*****	**10% (2)*****	33% (22)
As needed	21% (32)	**33% (21)*****	**0% (0)*****	17% (11)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

6 Head Start Performance Standards require FCC providers to receive technical assistance visits weekly or every other week.

BOX 2: EXAMPLES OF VISITS TO PROVIDER HOMES

Provision of technical assistance around quality improvement in providers' homes may allow SFCCNs to shape quality outcomes in ways they could not accomplish through training or other services. Research suggests that coaching or consultation visits with HBCC providers that focus on quality caregiving may be an effective and promising approach for improving quality (Bromer & Korfmacher, 2017; McCabe & Cochran, 2008; Porter, et al., 2010). These visits may include help to providers around a range of topics depending on program focus, providers served, source of financial support, and the policy context. Some studies also find that the dosage of visits is related to quality with frequent visits associated with higher-quality care (Bromer et al., 2009; McCabe & Cochran, 2008).

BUILD RELATIONSHIPS WITH PROVIDERS AND THEIR FAMILIES

All Our Kin is a free-standing SFCCN that operates in the metropolitan areas of New Haven, Bridgeport, Norwalk, and Stamford, CT. Educational coaches, who are experts in both early childhood and adult learning, work individually with licensed FCC providers through coaching visits every other week. In addition to creating comfort and familiarity ("sitting, drinking tea, talking"), these visits focus on "shared goal-setting" that is "co-created" with providers: "Providers self-direct their learning and the vision of their program, shaping the process with the support of a responsive, strength-based, relationship-based, non-judgmental coach." The program hires staff who understand how to build these strong professional relationships: "I think the dance is between the responsiveness to what's happening in the moment and then this bigger set of goals that have already been established with the provider." The strengths-based approach is what keeps providers engaged in the network: "We really look for people who can go into a program and see what's good, and see what's working, and what's positive, and recognize, and celebrate that, and then build from it. That, I think, more than anything else, is what makes our work successful, because it's what makes family child care providers excited about engaging with us." Coaches model interactions for providers around developing meaningful relationships with children: "Our coaches are modeling lessons, and they're self-talking about what they're doing with the kids in the same way that providers learn to self-talk. They're talking about what they're doing, why they're doing it, how it might be supporting children's development. They're observing family child care providers as well, and reflecting back what they see about the practice."

Instituto Familiar de la Raza in San Francisco, CA, is a support agency for the Chicano/Latinx immigrant community that provides early childhood mental health consultation services for Hispanic licensed FCC providers. Monthly visits to provider homes focus on observations of children. The Instituto uses a strengths-based, culturally-responsive approach with providers to build trust and create opportunities for deeper reflection: "Our cultural lens is a core component in how we view support. We honor and affirm the inherent cultural strengths of our FCC care providers as they learn to also navigate the system and integrate new practices that are being taught through the QRIS. We're very strength- based. When we're doing visits, we're really trying to look for what's working as well, because they don't get feedback around how wonderful their care is." When a provider is not comfortable with an observation visit, staff will start off visiting when children are gone at the end of the day: "We have to honor and respect that, even though, of course, we'd love to see what's happening. We need to start there with them." For providers who are willing to be observed, staff take a hands-on approach, integrating themselves into the home: "When they come in to visit, they don't just sit and observe. They'll sit and pour milk and sit at the table and talk and be part of the milieu. I think that's a really important piece to the work, too. You got to be able to sit on the floor and in circle time. That's obvious. For some folks, it's not always so obvious. "

Visits to homes also allow staff to get to know providers' own families and the families of children in care. As Instituto's early intervention program manager explains: "The other part of home visiting is that you are interfacing with their families as well, and I mean their own personal families. How one attends to and builds those relationships is an

important part of the work. For example, there's a provider I used to work with . . . The husband would come help when he could. He worked night shifts, so he usually slept. He was an important person for us to know. Grandma would come and help out, we knew her. When issues came up with some of the kids . . . you're a little bit attending to the family needs, too, and the family relationships. Some might be more private, and you have less exposure, but I would say the majority-it's kind of a family approach. We pretty much know everyone in the family by now."

OBSERVE PROVIDERS AND CHILDREN IN ACTION

Carole Robertson Center for Children and Families in Chicago, IL, runs a Head Start and Early Head Start network of FCC homes as well as a child care center and family support program. Head Start Performance Standards mandate visits to provider homes every other week focused on monitoring and support. Visits are seen as an opportunity to observe providers in action and show them a different lens on their daily activities, something that may be difficult for providers to do on their own when their child care program is their home. The network coordinator explains: "When I go into my home every day, I don't notice that scratch of paint that's missing on the wall anymore, because it's my home and I go there every day and I kind of see it and I don't see it. Somebody else comes into my home, they might see it right away. It's a different lens. We're not going in to police what they're doing, although we have requirements. When they're not meeting their requirements, we want to know, how can we help you? What do you need? Why aren't you able to do this? What's preventing you from being successful in what it is that's required? What is it that you want to do?"

Providers see these visits as valuable and even ask staff to observe specific situations or children where they need support: "They look forward to the visits, they look forward to conversation, they look forward to the opportunities our presence provides to have someone else take a look at what it is they're doing. When we visit their homes, it's the norm for us to hear comments such as, 'I want you to see what this child has done. I want you to see what my assistant has done. Let me run this by you. I want to do this.'"

INDIVIDUALIZE LEARNING AND SUPPORT FOR EACH PROVIDER

Great Start to Quality Northeast Resource Center in Michigan connects professional development classes with individualized monthly coaching in provider homes. As the coordinator explains: "Face-to-face visits are very beneficial, and so are professional development opportunities. When these two services are combined, which is what Michigan is doing, we see providers' quality increase." She describes the process of how specialists visit providers in the Infant Toddler Learning Communities of Practice to translate classroom-based workshop content into practice: "The information that they're receiving in a professional development class, they're actually able to take back and have assistance with the specialist to implement in their settings and talk through, 'Did I understand this correctly?' or, 'Am I doing this right?' or, 'I'm doing this, but I'm still struggling. I'm doing A, but I'm struggling with B. How do I fix it?' Well, here's B, the additional option that you have. It really makes professional development that much more beneficial and deep for them."

WHICH TOPICS ARE COVERED IN TRAINING WORKSHOPS?

A large majority of SFCCNs in our sample reported offering training workshop topics for providers related to early care and education (Table 8: Training Workshop Topics). Fewer, but still a majority, reported offering training for providers on managing a business, stress management, child care licensing, and topics required by the CCDF subsidy requirements. Nearly all of the Head Start SFCCNs reported offering training workshops across topics. CCR&Rs were more likely than non-CCR&R and non-Head Start networks to offer training on systems participation including CCDF-required health and safety topics and licensing regulations.

Our survey focused on the content of training rather than the format or the training approaches that SFCCNs used. Our survey also did not allow us to distinguish the quality of training offered by SFCCNs. SFCCNs that were not housed in CCR&Rs or did not offer Head Start, however, appeared to approach training with a focus on provider needs. For example, these networks were more likely to offer child care during training sessions than CCR&Rs or Head Start programs. They were also less likely than CCR&Rs to charge providers a fee for training.

TABLE 8: TRAINING WORKSHOP TOPICS

	ALL SFCCN N=154	CCR&R SFCCNS N=65	HEAD START SFCCNS N=20	OTHER SFCCNS N=69
Offers any training for HBCC providers	97% (149)	98% (64)	100% (20)	94% (65)
TOPICS OFFERED	**N=147**	**N=64**	**N=20**	**N=63**
Social and emotional development/guiding children's behavior	97% (142)	95% (61)	100% (20)	97% (61)
Principles of child development	95% (140)	94% (60)	100% (20)	95% (60)
Curriculum	93% (136)	91% (58)	100% (20)	92% (58)
Child care home environments	90% (132)	91% (58)	100% (20)	86% (54)
Nutrition and physical activity	90% (132)	94% (60)	100% (20)	**83% (52)***
Early literacy	88% (129)	88% (56)	90% (18)	87% (55)
Cultural responsiveness	87% (128)	89% (57)	100% (20)	81% (51)
Partnerships with families	85% (125)	91% (58)	95% (19)	**76% (48)***
Caring for mixed-age groups	83% (123)	81% (52)	85% (17)	86% (54)
Observation and assessment	83% (123)	81% (52)	95% (19)	83% (52)
Inclusion and working with special needs learners	84% (124)	86% (55)	90% (18)	81% (51)
CCDF-required health and safety topics	80% (118)	**89% (57)****	90% (18)	**68% (43)****
Managing a child care business	77% (113)	86% (55)	70% (14)	70% (44)
Licensing regulations	73% (107)	**81% (52)****	85% (17)	**60% (38)****
Stress management	73% (107)	72% (46)	75% (15)	73% (46)
Working with dual language learners	59% (87)	66% (42)	70% (14)	49% (31)
Charges a training fee to providers[a]	29% (43)	**48% (31)*****	**0% (0)*****	**18% (12)*****
Offers child care during training[b]	17% (26)	**8% (5)***	14% (3)	**27% (18)***

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]N=149 for this variable
[b]N=151 for this variable

BOX 3: EXAMPLES OF TRAINING WORKSHOPS

Several studies have found that specialized early childhood training is associated with higher quality care in family child care (Fukkink & Lont, 2007; Porter, et al., 2010). Research also finds that training combined with coaching or individualized technical assistance is more likely to affect quality outcomes than training workshops alone (Moreno, Green, & Koehn, 2015).

TRAINING TAILORED TO FCC PROVIDERS

Central California Migrant Head Start in Santa Cruz County, CA, works with Spanish-speaking licensed FCC providers who deliver Migrant/Seasonal Head Start in their homes. All training is offered in Spanish. Head Start requires many training topics leaving little flexibility in the content of what is offered to providers: "By the time we cover all the health and safety, the new forms, literacy, mathematics, infant/toddlers, social emotional, special needs, there's not too much time for other topics." However, training approaches are tailored to the unique contexts of FCC and reflect the home child care environments: "We're doing a training Friday night on math, so they're taking pictures of the math activities in the homes to share at the trainings. That would be an example of connecting with the reality what's going on in the child care with the trainings." When required trainings are offered on Saturdays, the network cannot pay providers additional stipends for attending so they build in incentives: "What we do try to do is make the trainings interesting and pleasant —we fuss over them. We give them catered lunches. Every time they come to a training, they get an incentive. They get a book, or they get a safety/hygiene item—a first aid kit or organic disinfectant. They get something practical because we can't pay them for attending trainings. We try to make sure that they get something useful for their work to show them that we appreciate their time and their motivation to keep learning."

The Alabama Department of Human Resources Family Child Care Partnerships at Auburn University, a statewide network in Alabama, builds training sessions around issues and content that arise from mentor visits: "So if the mentor has four or five people on the caseload that are struggling with the same issue, or trying to accomplish the same goal, she might want to use that module, turn it back into the workshop, and do a two-hour workshop at night or on Saturday morning, or whatever's responsive to the needs of the family child care community that she serves, because they're not all the same."

TRAINING BASED ON PROVIDER LEVEL

Capital District Child Care Coordinating Council is a CCR&R in New York that differentiates training for HBCC providers from FFN to newly-licensed to more experienced educators. For FFN, the Council offers a six-part series on topics such as health and safety, activities for children, and child abuse and maltreatment. For providers who are just starting their businesses, additional trainings are offered on business practices, parent communication, and curriculum planning. Trainings on quality assessment tools such as the FCCERS appeal to more "seasoned providers who engage in that kind of work."

TRAINING COHORTS

Illinois Action for Children uses cohort-based training: "We are moving away from one-time trainings . . . because we really do see the impact, not only the impact of cumulative learning, but also the relationships that get built." Training cohorts are offered over three consecutive Saturdays. Cohorts bring providers together around specific training topics: "providers that have an interest in a particular topic area and are willing to be a part of a training series for an extended period of time." Action for Children also offers computer labs where providers can complete paperwork, coursework, and other administrative tasks.

WHAT PEER SUPPORT OPPORTUNITIES DO SFCCNS OFFER?

Most SFCCNs offered opportunities for providers to share and learn from each other, although more offered support groups for providers than one-on-one peer-to-peer mentoring opportunities (Table 9: Peer Support Services). Networks that were not housed in CCR&Rs or that did not offer Head Start were more likely to offer any type of peer support and, specifically, more likely to offer peer groups, suggesting a focus on meeting provider needs and interests. Many SFCCNs also offered conferences or provider recognition events. Fewer reported that they connected providers to local family child care associations which could be related to the lack of associations in some regions.

TABLE 9: PEER SUPPORT SERVICES

	ALL SFCCN N=154	CCR&R SFCCNS N=65	HEAD START SFCCNS N=20	OTHER SFCCNS N=69
Any support groups or peer mentoring	78% (120)	**65% (42)*****	70% (14)	**93% (64)*****
Staff- and/or provider-facilitated peer support groups	73% (112)	**60% (39)****	70% (14)	**86% (59)****
Provider recognition event	53% (82)	54% (35)	60% (12)	51% (35)
Annual conference	49% (76)	58% (38)	55% (11)	39% (27)
Peer mentoring	42% (65)	35% (23)	35% (7)	51% (35)
Links to a family child care association[a]	34% (51)	32% (20)	25% (5)	32% (20)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported;
****$p \leq .001$; **$p \leq .01$; *$p \leq .05$; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]N=151

BOX 4: EXAMPLES OF PEER SUPPORT

There is no consistent definition of peer support in the early childhood or child care literature, but, in general, peer support means opportunities for networking among providers (Mead & MacNeil, 2006). Some studies have found that peer support is related to FCC quality, because it increases social supports and reduces isolation, which in turn enhances provider mental and emotional well-being and availability to respond to children (Doherty, Forer, Leo, Goelman, & LaGrange, 2006; Swartz, Wiley, Koziol, & Magerko, 2016). Other studies have linked peer support to FCC providers' enhanced self-efficacy or confidence in their capacity and competence. These provider characteristics have been associated with higher quality caregiving (Gray, 2015; Porter & Reiman, 2016). Still other research has found that peer support is related to providers' sense of professionalism, which is also associated with quality (Forry et al., 2013; Raikes, Raikes, & Wilcox, 2005).

STAFF-LED PEER SUPPORT GROUPS

The Association for Supportive Child Care – Kith and Kin Project uses a facilitated support group approach to improve the quality of FFN care in Arizona. The support groups aim to meet the needs of an "isolated population whose desire for support is huge. Their motivation . . . is typically the attachment they have for the children in their care, wanting those children to do better, to have better outcomes."

The 14-week two-to-four-hour sessions are offered in schools, community centers, and Head Start programs at the times that the partners indicate work best for the providers. Most sessions are offered at 8:30 or 9:00 in the morning after school drop-offs, although some sessions are offered in the late afternoon, in the evenings, or on the weekends. Child care is provided.

Trained bilingual Spanish-speaking staff facilitate the sessions with an interactive approach intended to help providers "process what's working and what's not working in their homes . . . through supporting each other." Session topics include: parent/caregiver relationships; positive discipline and guidance; nutrition; language and literacy; brain development; ages and stages of development; and an injury prevention component that focuses on pediatric first aid, pediatric CPR, home safe sleep, and car seat safety. One session includes a professional development exploration to help providers who are interested in participating in CACFP, becoming certified, or finishing a GED and to refer them to the appropriate sources. According to the division director, "The most prevalent topic is always guidance and discipline, or anything related to that. Even though we may come in today to talk about nutrition, we're going to end up talking about discipline, too. We may be talking about car seat safety, and we're still going to talk about discipline."

As part of the training, health and safety equipment (such as smoke alarms, fire extinguishers, and car seats) are provided for the participants.

PROVIDER-LED PEER SUPPORT GROUPS

Satellite Family Child Care System, a program of Reach Dane, uses a provider-led peer support group approach to help providers become accredited by the City of Madison, WI. Participation in the groups fosters "camaraderie . . . professional friendships, personal friendship . . . an opportunity to meet with other adults outside of their family childcare setting." The groups are also validating, because providers come to learn that: "I'm not the only person that has experienced this," or "I'm not the only person that uses this strategy."

There are two groups, Sojourn for English-speaking providers, and Acoris for Spanish-speaking providers. Sojourn, which is led by two providers, meets monthly in different providers' homes. Following a pot-luck supper, the providers discuss items that they have raised on a check-in sheet when they arrive. The discussion is highly structured: There is a specific amount of time for each provider to speak. "They're really good about making sure that if someone comes to the meeting . . . they have an opportunity to address something, and so, it's great for a provider who perhaps doesn't talk very often, because then they have just as much time as anybody else. It's presented as their need or question, or issue, or whatever it is, is just as important as the person that comes every

month . . . There's a great deal of safety, they're very careful to make sure that one person who happens to have a very strong opinion doesn't have all of the opinions and all of the talk time in the meeting." Acoris uses a slightly different format, bringing in an outside speaker for a one-hour information session.

Satellite staff rotate between the meetings, but they only participate in the discussions if a specific question is raised about what Satellite can do about an issue.

PEER-TO-PEER MENTORING

Infant Toddler Family Day Care is a free-standing SFCCN in Fairfax, VA. They use a structured peer-to-peer mentorship approach to help individuals through the approval process from the initial paperwork and background checks through the visit from the licensing agency. "It's all about relationships." The process begins with an initial home inspection by the Work Force Development Director. Then the mentees attend classroom training, CPR/First Aid, Medication Administration Training, and spend 40 hours over several weeks in a mentor's home. During their time in a mentor's home, providers learn health and safety routines such as hand-washing and proper sleep safety, and they participate in activities with the children, with a least one visit to observe drop-off and pick-up. At the end of the process, the mentor will conduct a home inspection of the new provider's home before the formal licensing visit.

Mentors must have been with Infant-Toddler for at least two years; have a CDA, a community college certificate or a degree in early childhood or a related field; and a recommendation from an Infant-Toddler child care specialist. With the Work Force Development Director, they complete a training that includes practicing a home inspection as well as an observation of the mentor's interaction in her home with the mentee. The mentor-mentee relationship often continues after the 40 hours are completed: "[The mentee] will call their mentor when they have questions. If they're getting ready to have an interview, many of them have called up the mentor and said, 'Oh, my gosh, I have my first interview. Can you help me? Remind me what we practiced.'"

HOW DO SFCCNS SUPPORT CURRICULUM USE IN HBCC?

Research indicates that curriculum use is an indicator of high-quality practice (Burchinal, 2018; NSECE, 2015a), yet only a quarter of the SFCCNs in our sample reported that they required providers to use a specific evidence-based curriculum (Table 10: Types of Curriculum Help).

Among the 40 SFCCNs that reported requiring a specific curriculum, 30 used the evidence-based Creative Curriculum™ (Ruddick, Colker, & Trister Dodge, 2009), and six used a state-approved curriculum or set of early learning guidelines. One SFCCN reported using a High Scope curriculum and another, Gee Whiz, an on-line curriculum. Two SFCCNs did not identify the specific curriculum used. Head Start requires FCC providers to use an evidence-based curriculum, and we found that Head Start networks in our sample were significantly more likely to require providers to use a specific curriculum than either CCR&R or other types of SFCCNs.

Conversely, more than half of the SFCCNs reported that they helped providers develop their own curriculum. Our survey data, however, do not detail what SFCCNs mean when they indicate "help" nor do the data indicate exactly how SFCCNs define provider-created curriculum (e.g., activities, daily schedules, etc.).

TABLE 10: TYPES OF CURRICULUM HELP[a]

	ALL SFCCN N=152	CCR&R SFCCNS N=63	HEAD START SFCCNS N=21	OTHER SFCCNS N=68
Require providers to use a specific evidence-based curriculum	26% (40)	**14% (9)***	**76% (16)***	22% (15)
Help providers choose a curriculum	28% (42)	37% (23)	19% (4)	22% (15)
Help providers develop their own curriculum	53% (81)	62% (39)	**29% (6)***	53% (36)

[a]Categories of curriculum help are not mutually exclusive.
Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

WHAT TYPES OF BUSINESS AND ADMINISTRATIVE HELP DO SFCCNS OFFER?

Most SFCCNs in our sample reported helping providers with basic administrative and business tasks such as developing contracts and handbooks, completing required paperwork, or recruiting potential families into their FCC programs (Table 11: Business and Administrative Support). Fewer reported offering specific business services such as health or liability insurance, helping providers collect parent fees, or tax preparation. Only a fifth of SFCCNs reported offering substitute caregivers, a service that allows providers to attend training activities or professional conferences or take a sick day. Survey data do not indicate if SFCCNs offered business and administrative support to providers on an as-needed basis or as a regular part of services offered to all providers at the SFCCN.

CCR&Rs were more likely than either Head Start or other SFCCNs to focus services on helping providers with their administrative practices. This included helping providers develop policy handbooks for their programs and helping them complete required forms and applications, both of which could also be related to support that CCR&R networks offered providers around participation in a QRIS.

TABLE 11: BUSINESS AND ADMINISTRATIVE SUPPORT

	ALL SFCCN N=156	CCR&R SFCCNS N=66	HEAD START SFCCNS N=21	OTHER SFCCNS N=69
Develop policy handbooks and parent contracts	76% (119)	**88% (58)****	**57% (12)****	71% (49)
Help complete forms and applications	74% (116)	**88% (58)****	67% (14)	**64% (44)****
Help recruit and enroll new families[a]	72% (112)	69% (45)	95% (20)*	68% (47)
Help with recordkeeping	62% (96)	70% (46)	57% (12)	55% (38)
Process subsidy payments or help providers collect subsidy payments	35% (55)	35% (23)	43% (9)	33% (23)
Offer health or liability insurance	34% (53)	38% (25)	33% (7)	30% (21)
Collect parent fees or help providers collect parent fees	28% (43)	21% (14)	29% (6)	33% (23)
Offer help with tax preparation	27% (42)	33% (22)	24% (5)	22% (15)
Offer help with substitute caregivers	20% (31)	17% (11)	19% (4)	23% (16)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]N=155

BOX 5: EXAMPLES OF BUSINESS AND ADMINISTRATIVE SUPPORT

Although research does not typically include business sustainability as an aspect of quality, a recent conceptual model of quality in HBCC (Blasberg et al., forthcoming) identifies managing a child care business as a foundational quality element, and there is emerging consensus around this notion. Business practices and the use of budgets and projections allow providers to plan and make informed decisions on issues such as enrollment, quality enhancements, and employee benefits. FCC providers who cannot sustain their programs may leave the field due to the stress of balancing program revenues and expenses. Such stress may also shape a provider's capacity to offer responsive and sensitive care to children (Østbye et al., 2015). Business support may free up time for providers to focus on their interactions with children and the learning environment.

SHARED SERVICES BACK-OFFICE SUPPORT

Early Learning Ventures in Colorado uses a shared services approach to improve child care quality to both centers and FCC homes by supporting business and recordkeeping to "give [providers] more time, more dollars so they can focus on what they do best. If you work with us and we get you using our system, the return on investment shows that you get that time back. Then we can get you connected with other things to improve your business—to focus on your families and bringing resources to you. It goes to the more time and more money."

For a monthly $25 fee, Early Learning Ventures provides Alliance Core, a fully-automated, on-line business dashboard that tracks licensing compliance, children's enrollment and attendance, CACFP reporting, parent invoicing, and tuition payments. Once providers sign an agreement with Early Learning Ventures, they receive an on-boarding visit from a specialist who helps them learn how to use the system and shows them how parents can sign in and out. Providers can then opt for continued support through phone calls or email with the specialists or move up to the next level of add-on "family services," a second visit from a specialist to introduce access to other services such as the Healthy Options for Preschoolers and Parents program.

Early Learning Ventures' resource platform includes marketing materials, program templates for policies and procedures, classroom tools, and a 15-hour on-line licensing training. Providers can also receive discounts through access to bulk purchasing of children's materials, food, office supplies, and pay roll processing.

COMPREHENSIVE BUSINESS SUPPORT

All Our Kin offers business supports for providers to help them develop sustainable businesses and improve their financial well-being. The support consists of two primary components: 1) a proprietary business curriculum on entrepreneurship and how to run a FCC business, and; 2) coaching from business coaches who visit providers' homes to help them with business-related issues such as organizing their files and reviewing their parent contracts. In addition to the foundational business training, All Our Kin offers stand-alone workshops on taxes, recordkeeping, and marketing. It also offers a zero-interest loan program to provide access to additional capital.

WHAT TYPES OF MATERIAL INCENTIVES DO SFCCNS OFFER?

Some research suggests that incentives are an important feature of programs that aim to improve quality, because these kinds of supports can encourage initial participation and continued engagement in services (Paulsell et al., 2010; Porter, Nichols, et al., 2010). Incentives may include meals or refreshments, transportation, materials, and gift cards. Moreover, research suggests that providers may have limited resources (Porter, et al., 2010; Susman-Stillman & Banghart, 2011) and may have challenges obtaining materials such as toys, books, and equipment for the children in their programs. This lack of resources may have effects on the quality of child care because providers may not be able to provide an optimal environment for children.

Close to three in four SFCCNs in our sample reported offering free materials and equipment as an incentive to participating in services and half reported providing a resource library where providers could borrow materials for their child care programs (Table 12: Incentives and Materials). Almost six in ten SFCCNs provided refreshments or meals. Far fewer, however, reported offering other types of incentives such as monetary payment, coverage of fees, bulk purchasing, or a resource van for providers. A small fraction of SFCCNs reported offering providers transportation services for children in their care.

TABLE 12: INCENTIVES AND MATERIALS

	ALL SFCCN N=151	CCR&R SFCCNS N=63	HEAD START SFCCNS N=21	OTHER SFCCNS N=67
Materials and/or equipment	72% (109)	70% (44)	81% (17)	72% (48)
Refreshments and food	59% (89)	54% (34)	62% (13)	63% (42)
Toy or book lending library[a]	51% (79)	47% (31)	57% (12)	52% (36)
Monetary payment or gift card for participation	29% (44)	32% (20)	48% (10)*	21% (14)
Accreditation materials and fees	25% (38)	24% (15)	38% (8)	22% (15)
Bulk purchasing[a]	16% (25)	11% (7)	29% (6)	17% (12)
Resource van[a]	14% (22)	9% (6)	**33% (7)***	13% (9)
Transportation for children and providers	6% (9)	3% (2)	10% (2)	7% (5)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.

****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]N= 156 for these variables.

WHAT TYPES OF COMPREHENSIVE RESOURCES FOR CHILDREN AND FAMILIES DO SFCCNS OFFER?

Fewer than half of SFCCNs in our sample reported directly offering mental health, developmental screening, and/or health services to families and children through SFCCN staff (Table 13: Comprehensive Resources for Children and Families). Slightly higher proportions reported helping families link to these services in the community.

Consistent with Head Start Performance Standards, the small number of Head Start networks in our sample were more likely to have staff who offer comprehensive services such as early childhood mental health consultation, developmental screenings, family counseling, and health and nutrition services for families and children enrolled in their FCC programs. By contrast, CCR&Rs were more likely to report referring providers to external community resources.

TABLE 13: COMPREHENSIVE RESOURCES FOR CHILDREN AND FAMILIES

	ALL SFCCN N=151	CCR&R SFCCNS N=63	HEAD START SFCCNS N=20	OTHER SFCCNS N=68
OFFERED BY SFCCN STAFF				
Developmental screening of children	49% (74)	**35% (22) *****	**95% (19) *****	49% (33)
Health & nutrition services for children	46% (69)	44% (28)	**75% (15)***	38% (26)
Early childhood/infant mental health consultation	35% (53)	**22% (14)*****	**85% (17)*****	32% (22)
Family counseling	19% (28)	**11% (7)***	**40% (8)***	19% (13)
SFCCN LINKS TO COMMUNITY RESOURCE				
Developmental screening of children	45% (68)	**56% (35) *****	**5% (1) *****	47% (32)
Health & nutrition services for children	48% (73)	52% (33)	**20% (4)***	53% (36)
Early childhood/infant mental health consultation	56% (85)	**68% (43) *****	**10% (2) *****	59% (40)
Family counseling	69% (104)	**81% (51)***	**50% (10)***	63% (43)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

BOX 6: EXAMPLES OF COMPREHENSIVE RESOURCES FOR CHILDREN AND FAMILIES

SFCCNs may have the capacity to offer comprehensive resources such as mental health support and counseling, developmental screening, and health and nutrition services for families and children enrolled in FCC. SFCCNs may include these supports as an integral component of their programs with specialized staff or they may connect families and providers to these resources in the community. Most likely, the difference in these approaches depends on the type of organization that houses the SFCCN. Large social service agencies, for example, may have access to mental health consultants on site whereas a smaller, free-standing SFCCN might need to refer families to consultants in the community.

The Cole-Harrington Family Child Care System is part of Enable, Inc. in Canton, MA, and works with FCC providers who care for at least one child in the child welfare system. Half of the families are referred from the Massachusetts Department of Children and Families (DCF). As a support to these families, Enable has five clinical social workers on staff who make regular visits to family homes as well as accompany specialists on visits to FCC provider homes when needed. “Our clinical social workers’ goal is to work with the families that are part of DCF and make sure that those families are on track and doing what’s expected of them in order for them to keep their children and in order for them to become more functional and provide for their children long-term.”

SGA Youth & Family Services in Chicago, IL, operates an Early Head Start-Family Child Care partnership with 10 providers. SGA offers comprehensive services to children and families enrolled in the FCC homes. A strong focus is on helping providers engage families in their programs. A family support specialist works with providers: “The providers really enjoy that collaboration with families, because before it almost felt like a drive-thru, parents would just come, drop off the child, and pick up the child. There was minimal communication and limited family engagement.” As well as family engagement, SGA offers wellness, health, and nutritional promotion for families. In cases where families have diverse learners, SGA has services to support their needs as well. According to SGA’s Vice President of Programming, “They have all of these resources at their fingertips; whenever they need something, it’s right there for them. They don’t have to wait a whole year until their representative from the Department of Children and Family Services comes, and they don’t have to go look somewhere else.”

WHICH PROMISING COMBINATIONS OF SERVICES ARE OFFERED?

Prior research suggests that combinations of services may be more effective in promoting child care quality than single supports alone (Bromer et al., 2009; Bromer & Korfmacher, 2017; Koh & Neuman, 2009; Moreno et al., 2015; Neuman & Cunningham, 2009; Porter, et al., 2010). Yet few research studies articulate the combinations of services that are most likely to lead to specific quality outcomes. Based on evidence from other studies, we hypothesized three promising services that could be described as predictive of quality outcomes: 1) high-frequency home visiting (defined as more than monthly) (Bromer et al., 2009; McCabe & Cochran, 2008); 2) use of an evidence-based curriculum (Burchinal, 2018); and 3) offering resources for children and families such as developmental screening, mental health consultation, health and nutrition services, and/or family counseling (NSECE, 2015a). When combined, these services may have the potential to shape quality outcomes for children and families.

Fewer than a quarter of the SFCCNs in our sample reported offering combinations of two of these services to providers, and only 11% reported offering all three services (Table 14: Combinations of Services). Use of an evidence-based curriculum and offering comprehensive resources for children and families was the most common service combination. Fewer SFCCNs reported high-

frequency visits combined with other services. Consistent with Head Start's evidence-based program, the 12 Head Start networks in our sample that reported using a combination of the three research-based strategies for improving quality (high-frequency visiting and an evidence-based curriculum and comprehensive resources for children and families) accounted for all but one of the 13 SFCCNs that reported offering this combination.

TABLE 14. COMBINATIONS OF SERVICES

	ALL SFCCN	CCR&R SFCCNS	HEAD START SFCCNS	OTHER SFCCNS
Evidence-based curriculum and comprehensive resources for children and families[a]	23% (34)	**11% (7)***	**75% (15)***	18% (12)
High-frequency visits and comprehensive resources for children and families[b]	15% (22)	**3% (2)***	**80% (16) ***	**6% (4)***
Evidence-based curriculum and high-frequency visits[c]	9% (13)	**2% (1)***	**57% (12) ***	**0% (0)***
High-frequency visits and evidence-based curriculum and comprehensive resources for children and families[d]	9% (13)	**2% (1)***	**60% (12)***	**0% (0)***

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*
[a]N=148; [b] N=146; [c]N=147; [d] N=143

SUMMARY OF SERVICES OFFERED

- A small proportion of SFCCNs in our sample reported offering high-frequency visits (more than monthly) to providers.
- More than three quarters of SFCCNs offered some type of peer support opportunities for providers.
- Only a quarter of SFCCNs reported using an evidence-based curriculum, yet more than half reported helping providers develop their own curriculum.
- Broad business support was common among SFCCNs, but fewer reported specific help with insurance, taxes, or substitute caregivers.
- Fewer than half of SFCCNs reported offering comprehensive services for children and families.
- CCR&R networks were most likely to help providers participate in a QRIS but were less likely to offer research-based services such as curriculum, high-frequency visits, or comprehensive services for children and families.
- Head Start networks were most likely to offer research-based services and supports (high frequency visits, evidence-based curriculum, and comprehensive resources for children and families), reflecting the Head Start Performance Standards.
- SFCCNs that were not housed in CCR&Rs and that did not offer Head Start were most likely to offer opportunities for peer support, perhaps suggesting a greater focus on provider needs.

STAFFING AND SUPERVISION

SFCCN staff are essential to the delivery of supports to HBCC providers. SFCCNs that have dedicated staff for working with HBCC providers may be more focused on provider needs and interests than SFCCNs that do not have specialized staff. Moreover, staff who work with HBCC may need a combination of skills and knowledge around child development as well as how to work with adults, given that they need to interact and communicate with providers around quality improvement (Ackerman, 2008; Bromer et al., 2009; Bromer & Korfmacher 2017).

WHAT TYPES OF STAFF POSITIONS DO SFCCNS HAVE?

The most common staff position to work with HBCC across SFCCNs in our sample was a family child care specialist, consultant, or coach. Many SFCCNs were housed in larger organizations with staffing across specialties and departments. Although a majority of SFCCNs reported having dedicated staff who work with HBCC providers, only 60% reported that all of their staff worked with HBCC providers (Table 15: Staff Positions). This may indicate a lack of prioritization or focus on HBCC in organizations that house SFCCNs, especially those that serve both center-based programs and HBCC providers. Lower proportions (45%) reported that all of their staff conducted visits to provider homes. Some SFCCNs may have staff who provide direct support such as training, although these staff may not make visits.

Staffing patterns of CCR&R networks paralleled the focus of service delivery on systems participation. CCR&R networks were more likely than Head Start or other networks to have a QRIS specialist or a CACFP specialist on staff to work with FCC providers. CCR&Rs were also more likely to report that all of their staff positions worked with HBCC providers and conducted visits to provider homes.

Staffing at Head Start networks also matched the types of services offered and aligned with the Head Start focus on comprehensive services for children and families. A majority of Head Start networks had an early childhood mental health consultant, nurse consultant, family support specialist, and/or a curriculum specialist on staff; half had a disabilities consultant.

TABLE 15: STAFF POSITIONS

	ALL SFCCN N=150	CCR&R SFCCNS N=62	HEAD START SFCCNS N=20	OTHER SFCCNS N=68
All staff positions at organization that houses a SFCCN work with HBCC providers	60% (90)	**74% (46)****	60% (12)	**47% (32)****
All staff positions at organization that houses a SFCCN conduct visits to HBCC homes	45% (68)	**61% (38)****	30% (6)	**35% (24)****
SPECIFIC STAFF POSITIONS AT ORGANIZATION THAT HOUSES A SFCCN				
Family child care specialist (coach, consultant)	68% (102)	65%(40)	80% (16)	68% (46)
Quality rating and improvement specialist	44% (66)	**66% (41) *****	30% (6)	**28% (19) *****
Infant/toddler specialist	33% (50)	39% (24)	45% (9)	25% (17)
Curriculum expert	32% (48)	**23% (14) *****	**65% (13) *****	31% (21)
Family support specialist or family services worker	30% (45)	24% (15)	**85% (17) *****	19% (13)
CACFP specialist	27% (41)	**39% (24)***	10% (2)	22% (15)
Child assessment expert	25% (38)	23% (14)	40% (8)	24% (16)
Early childhood or infant mental health consultant	24% (36)	18% (11)	**60% (12)*****	19% (13)
Nurse consultant	20% (30)	13% (8)	**60% (12) *****	15% (10)
Disabilities expert	19% (29)	16% (10)	**50% (10)*****	13% (9)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

WHAT QUALIFICATIONS DO SFCCNS REQUIRE FOR STAFF?

Half of the SFCCNs in our sample reported that they require staff who work with HBCC providers to have a minimum of a bachelor's degree, and only six required staff who work with providers to hold a master's degree (Table 16: Staff Qualifications). Nearly all of the SFCCNs indicated they require staff to have a background in early childhood education and child development. Yet, the lower education levels required for staff across the SFCCNs suggest that many in our sample may not have staff with the clinical training and/or deep knowledge of child development that is needed to work effectively with providers and children.

TABLE 16: STAFF QUALIFICATIONS

	ALL SFCCN	CCR&R SFCCNS	HEAD START SFCCNS	OTHER SFCCNS
STAFF QUALIFICATIONS: DEGREE	**N=152**	**N=63**	**N=21**	**N=68**
Requires HS diploma/ GED or less	16% (24)	14% (9)	14% (3)	18% (12)
Requires AA degree	22% (33)	19% (12)	29% (6)	22% (15)
Requires BA degree	52% (79)	57% (36)	48% (10)	49% (33)
Requires MA degree	4% (6)	2% (1)	0% (0)	7% (5)
Not sure	6% (10)	8% (5)	10% (2)	4% (3)
STAFF QUALIFICATIONS: FIELD OF STUDY	**N=151**	**N=63**	**N=21**	**N=67**
Requires a specific field of study	81% (123)	79% (50)	95% (20)	79% (53)
SPECIFIC FIELD OF STUDY REQUIRED	**N=123**	**N=50**	**N=20**	**N=53**
Early childhood education	98% (121)	100% (50)	100% (20)	96% (51)
Child development	94% (116)	98% (49)	90% (18)	92% (49)
Social work/social services	61% (75)	66% (33)	65% (13)	55% (29)
Psychology	40% (49)	46% (23)	30% (6)	38% (20)
Administration/business	15% (19)	16% (8)	15% (3)	15% (8)
Nursing	11% (13)	10% (5)	10% (2)	11% (6)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.

WHICH LANGUAGES DO SFCCNS USE IN SERVICE DELIVERY?

SFCCNs in our sample reported that providers spoke more than 30 different languages, and 61% of the SFCCNs reported offering services to providers in a language other than English (Table 17: Language of Service Delivery). The remaining SFCCNs reported delivering services in English only. A fifth of the sample did not provide a linguistic match for non-English speaking providers. Limited staff capacity and resources may have shaped the extent to which SFCCNs could be culturally and linguistically responsive to all affiliated providers.

TABLE 17: LANGUAGE OF SERVICE DELIVERY

	ALL SFCCN N=153	CCR&R SFCCNS N=64	HEAD START SFCCNS N=21	OTHER SFCCNS N=68
Services delivered in languages other than English	61% (94)	66% (42)	67% (14)	56% (38)
Services delivered in English only	39% (59)	34% (22)	33% (7)	44% (30)
Services delivered in English but providers speak other languages[a]	20% (31)	15% (10)	14% (3)	26% (18)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
[a]N=156

WHICH IN-SERVICE STAFF TRAINING TOPICS DO SFCCNS OFFER?

Fewer than half of the SFCCNs in our sample reported offering or planning to offer[7] a promising combination of staff training (Bromer et al., 2009; Bromer, Weaver, & Korfmacher, 2013) on child development, working with adult learners (e.g. home visiting, organization and case management, communication and listening, and adult learning styles), and the family child care context (e.g. working with mixed ages and managing a child care business) (Table 18: In-Service Training Topics). The two most commonly reported topics for in-service staff training were child development and social-emotional development. Smaller proportions, but still a majority, reported offering in-service staff training in child care program-related topics (e.g. observation, curriculum, family partnerships, literacy, nutrition) and systems-related topics such as CCDF and licensing.

CCR&R networks were more likely than other SFCCNs to offer in-service staff training on licensing, CCDF-health and safety topics, and running a child care business, mirroring the training topics offered to providers by these networks. CCR&R networks were also more likely than either Head Start or other SFCCNs to offer a combination of staff training focused on child development, working with adults, and the unique context of home-based child care. Head Start networks were more likely to offer staff training on curriculum, nutrition, and working with dual language learners.

7 The survey did not distinguish between staff training offered in the last 12 months and training that a SFCCN plans to offer in the coming year.

TABLE 18: IN-SERVICE STAFF TRAINING TOPICS

	ALL SFCCN N=151	CCR&R SFCCNS N=62	HEAD START SFCCNS N=21	OTHER SFCCNS N=68
Any in-service staff training offered/plan to offer	86% (130)	85% (53)	100% (21)	82% (56)
SPECIFIC TOPICS OFFERED/ PLAN TO OFFER	**N=130**	**N=53**	**N=21**	**N=56**
Promising staff training (child development AND working with adults AND working with HBCC)	48% (62)	**60% (32)***	33% (7)	41% (23)
Principles of child development	76% (99)	75% (40)	95% (20)	70% (39)
Children's social and emotional development	74% (96)	75% (40)	90% (19)	66% (37)
Licensing regulations	67% (87)	**79% (42)***	67% (14)	**55% (31)***
Cultural responsiveness	67% (87)	74% (39)	76% (16)	57% (32)
Early literacy	64% (83)	64% (34)	71% (15)	61% (34)
Observation and assessment	62% (81)	57% (30)	81% (17)	61% (34)
Nutrition and physical activity	61% (79)	64% (34)	**86% (18)****	**48% (27)****
Child care home environments	60% (78)	64% (34)	62% (13)	55% (31)
CCDF health and safety topics	59% (77)	**70% (37)***	67% (14)	**59% (77)***
Curriculum	58% (75)	53% (28)	**86% (18)***	52% (29)
Partnerships with families	57% (74)	60% (32)	71% (15)	48% (27)
Inclusion and working with special needs learners	56% (73)	57% (30)	71% (15)	50% (28)
Coaching and consultation models	51% (66)	55% (29)	48% (10)	48% (27)
Communication and listening	48% (63)	55% (29)	29% (6)	50% (28)
Managing a child care business	46% (60)	**60% (32)***	38% (8)	**36% (20)***
Stress management	46% (60)	40% (21)	43% (9)	54% (30)
Adult learning styles	45% (59)	55% (29)	33% (7)	41% (23)
Caring for mixed-age groups	43% (56)	49% (26)	57% (12)	32% (18)
Working with dual language learners	40% (52)	45% (24)	**62% (13)****	**27% (15)****
Home visiting	35% (45)	38% (20)	38% (8)	30% (17)
Organization and case management	25% (32)	28% (15)	29% (6)	20% (11)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other SFCCNs. Bold indicates a medium or large effect size for which type of SFCCN is more or less likely to offer the service.*

BOX 7: EXAMPLES OF IN-SERVICE STAFF TRAINING

Some research has identified staff training as a key to effective service delivery across early childhood fields (Daro, Boller, & Hart, 2014) as well as with HBCC providers (Abell, Arsiwalla, Putnam, & Miller, 2014; Bromer et al., 2009) and, specifically, staff training that prepares staff to work in the unique context of provider homes. Prior research on family child care support (Bromer et al., 2009; Bromer, Weaver, & Korfmacher, 2013) has identified promising staff training as a combination of: 1) learning how to work with adult learners; 2) understanding child development; and 3) understanding the unique environmental context of family child care such as how to work with mixed-ages, child care environments, and managing a child care business.

All Our Kin offers extensive in-service training to all staff around topics particularly relevant to working with FCC providers. Training topics include principles of adult learning, reflective supervision, anti-racism/anti-bias practices, and infant mental health. Along with these organization-wide professional development opportunities, each coach is paired with a mentor coach who conducts observations of coaching in action and offers reflective feedback. In addition, coaches participate in monthly group supervision meetings with a licensed clinician who is certified in reflective supervision and guides coaches to “plan, share, problem-solve, and learn.”

WHAT TYPES OF SUPERVISION AND SUPPORT DO SFCCNS OFFER STAFF?

Although most SFCCNs in our sample reported conducting some type of individual supervision or staff meetings for those working with HBCC providers, fewer than a quarter reported conducting weekly team meetings or weekly individual supervision with staff (Table 19: Staff Supervision). Our survey data do not indicate the type of supervision that was offered but research suggests that reflective supervision—opportunities to examine and reflect on experiences and stresses of work —is a key professional development component for SFCCN staff (Heffron, Ivins, & Westin, 2005; National Center on Parent, Family, & Community Engagement, 2012). Group or team meetings may also provide opportunities for staff to solve problems by sharing strategies with one another.

TABLE 19: STAFF SUPERVISION

	ALL SFCCN N=151	CCR&R SFCCNS N=62	HEAD START SFCCNS N=21	OTHER SFCCNS N=68
Offers one-to-one supervision	85% (128)	84% (52)	95% (20)	82% (56)
FREQUENCY OF ONE-TO-ONE SUPERVISION	**N=128**	**N=52**	**N=20**	**N=56**
Weekly	17% (22)	13% (7)	15% (3)	21% (12)
Every other week or every third week	21% (27)	17% (9)	20% (4)	25% (14)
Monthly	44% (57)	50% (26)	55% (11)	36% (20)
1-6 times a year	16% (20)	17% (9)	10% (2)	16% (9)
Not sure	2% (2)	2% (1)	0% (0)	2% (1)
Holds staff team meetings	87% (131)	85% (53)	100% (21)	84% (57)
FREQUENCY OF TEAM MEETINGS	**N=131**	**N=53**	**N=21**	**N=57**
Weekly	21% (27)	11% (6)	19% (4)	30% (17)
Every other week or every third week	17% (23)	19% (10)	24% (5)	14% (8)
Monthly	53% (69)	60% (32)	57% (12)	44% (25)
1-6 times a year	9% (12)	9% (5)	0% (0)	12% (7)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.

SUMMARY OF STAFFING AND SUPERVISION

- A third of SFCCNs in our sample did not have a dedicated specialist to work with HBCC providers suggesting that in these organizations, HBCC providers may receive the same services as center-based programs.
- CCR&R networks were most likely to have a QRIS specialist on staff, and Head Start networks were most likely to have staff who deliver comprehensive services to children and families enrolled in FCC homes.
- Only half of the SFCCNs required staff to hold a BA degree or higher.
- Fewer than half of the SFCCNs offered combined staff training in areas (child development, working with adult learners, and the family child care context) that may be particularly relevant to working with HBCC providers.
- Two-thirds of SFCCNs served providers in languages other than English.
- Fewer than a quarter of SFCCNs reported conducting weekly staff meetings or individual supervision with staff who work with HBCC providers.

EVALUATION AND QUALITY ASSESSMENT

WHAT KINDS OF EVALUATION AND QUALITY ASSESSMENT DO SFCCNS USE?

Most SFCCNs in our sample reported collecting process data on service delivery (e.g. numbers of providers and children served, types of services offered, frequency of services, etc.), and provider satisfaction with services received (Table 20: Evaluation and Assessment). Fewer (but still a majority) reported collecting data on provider quality outcomes. Still fewer reported child or family outcome data, although this varied by type of SFCCN. The focus on process data rather than outcome data may point to the limited capacity of SFCCN staff to collect and analyze data.

The majority of SFCCNs reported using a validated and reliable quality assessment tool with providers; the Family Child Care Environmental Rating Scale (FCCERS; Harms, Cryer, & Clifford, 2006) was, by far, the most commonly reported. Slightly more than a quarter reported they used NAFCC Accreditation standards that are widely recognized by state QRISs, although these standards are not a reliable or validated observation tool. This may suggest a lack of widely available or known tools that capture the distinct features of HBCC such as mixed-age groups, family relationships, and business practices that the NAFCC Accreditation standards address.

Head Start networks were more likely to collect data on family satisfaction and child and family outcomes than other networks, consistent with their focus on families and children. CCR&R networks were more likely to use the Classroom Assessment Scoring System (CLASS: Pianta, La Paro, & Hamre, 2008) as an assessment tool, perhaps in part because it is commonly used in QRISs. Although more than half of the SFCCNs that were not housed in CCR&Rs or did not offer Head Start used the FCCERS as an assessment tool, they were less likely to use the FCCERS than CCR&Rs or Head Start networks.

TABLE 20: EVALUATION AND QUALITY ASSESSMENT

	ALL SFCCN	CCR&R SFCCNS	HEAD START SFCCNS	OTHER SFCCNS
EVALUATION STRATEGIES USED	**N=149**	**N=64**	**N=19**	**N=66**
Any evaluation	95% (141)	97% (62)	100% (19)	100% (66)
Service delivery implementation	95% (141)	97% (62)	100% (19)	91% (60)
Provider satisfaction	85% (127)	92% (59)	74% (14)	82% (54)
Provider quality outcomes	71% (106)	77% (49)	68% (13)	67% (44)
Family satisfaction	64% (96)	64% (41)	**95% (18)****	56% (37)
Child/family outcomes	50% (75)	**31% (20)*****	**95% (18)*****	56% (37)
Cultural/linguistic responsiveness	30% (45)	28% (18)	37% (7)	30% (45)
QUALITY ASSESSMENT TOOLS USED	**N=147**	**N=63**	**N=21**	**N=63**
Any validated and reliable assessment instrument (FCCERS[a], CLASS[b] or PICCOLO[c])	80% (117)	84% (53)	90% (19)	71% (45)
FCCERS[a]	72% (106)	79% (50)	86% (18)	**60% (38)***
CLASS[b]	32% (47)	**43% (27)***	19% (4)	25% (16)
PICCOLO[c]	4% (6)	2% (1)	**14% (3)***	3% (2)
NAFCC Accreditation Observation[d]	27% (39)	32% (20)	29% (6)	21% (13)
Q-CCIIT[e]	4% (6)	6% (1)	10% (2)	5% (3)
CCAT-R[f]	1% (2)	6% (1)	0%	6% (1)
No quality assessment used	15% (22)	13% (8)	10% (2)	19% (12)

Ns reflect total numbers of respondents to each question omitting missing responses; valid % are reported.
****p≤.001; **p≤.01; *p≤.05; Denotes significant differences between CCR&R, Head Start, and Other Networks. Bold indicates a medium or large effect size for which type of network is more or less likely to offer the service.*
[a]The Family Child Care Environmental Rating Scale (FCCERS: Harms, Cryer, & Clifford, 2006): A global measure of the child care environment commonly used in QRISs.
[b]The Classroom Assessment Scoring System (CLASS: Pianta, La Paro, & Hamre, 2008): Assesses provider emotional support, program organization, and instructional support and is also used in QRISs.
[c]The Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO: Roggman, Cook, Innocenti, Norman, Christensen, & Anderson, 2013): An assessment of adult-child interactions which has been used in FCC (Norman & Christensen, 2013; Porter & Reiman, 2016).
[d]The National Association for Family Child Care Accreditation Standards: Developed for NAFCC's national accreditation system and used in QRISs but not field tested for reliability or validity. (NAFCC, 2018).
[e]The Quality of Child Care Interactions for Infants and Toddlers (QCCIIT: Atkins-Burnett et al., 2015): A new instrument for assessing provider interactions with infants and toddlers across a range of settings including FCC.
[f]The Child Care Assessment Tool for Relatives (CCAT-R: Porter, Rice & Rivera, 2006): Initially design for use in relative child care but also used in home-based child care settings (Forry, Anderson, Banghart, Zaslow, Kreader & Chrisler, 2011; Paulsell, Mekos, Del Grosso, Rowand, & Banghart, 2006; Shivers, Farago, & Goubeaux, 2015).

BOX 8: EXAMPLES OF EVALUATION AND QUALITY ASSESSMENT

Understanding the effects of different services on provider, child, and family outcomes is essential for implementation and improvement of services (Paulsell et al., 2010). Prior research on family child care networks suggests that using a standardized assessment tool is a promising practice (Bromer et al., 2009).

USE DATA TO INFORM PROGRAM PLANNING

All Our Kin uses the Salesforce™ data system to store data on provider participation and outcomes. Provider information includes demographic characteristics, participation in services, and changes in such areas as licensing status, income, education, accreditation, and FCCERS as well as Business Administration Scale (BAS) scores. All Our Kin systematically reviews the dashboard every four months to understand its reach and effects on the provider community and make programmatic changes to improve its impact. “[We look at] what we’re offering and what we would change. [For example], we realized that in New Haven our social events were no longer as valuable as our content events because providers had already built strong peer connections. The data led us to understand that shift and adjust our program offerings.”

All Our Kin also has a performance management system that connects staff goals to organization-wide goals. “That information actually goes in two directions. It’s not like, ’Oh, you didn’t meet your goal. You’re in trouble.’ If you didn’t meet that goal, there’s something wrong with the way we’re articulating our framing that goal or how we’re supporting you in successfully carrying out programming. Is it the right goal? Are there different things we should be working towards, or different barriers we need to be addressing?”

Since its inception, the *Association for Supportive Child Care* – Kith and Kin Project has used formal external evaluation to inform its planning and service delivery in addition to data collection on provider demographic characteristics and motivation, children served, and pre/post changes in knowledge. “Evaluation has made the program what it is because we’ve had this constant influx of information and data to tell us what the targeted population wants and needs versus us trying to figure out what it is that they want and need.” The three-year evaluation cycles vary in focus. “Currently the program is at the last year phase of our evaluation on fidelity to the model for the work that we’re doing across the State. The three years prior to that, our evaluation model focused on child outcomes, [looking] at the children that were in our on-site care and looking at their language and literacy-related gains in comparison to children that are not in our care. The one before [that] . . . we were going into the home and doing a two-and-a-half to three-hour observation to assess provider quality.”

The Kansas City Local Investment Commission (KCLINC) Educare Network is contracted by the State of Missouri to provide support to license-exempt and regulated FCC providers in Missouri’s subsidy system through technical assistance visits to provider homes and required training. It uses Social Solution’s ™ Apricot internet-accessible data system to collect data. “We’re being constantly asked for information. A lot of the data that we are collecting is to be able to show that we are meeting our contractual requirements that the State of Missouri laid out. They’re wanting to know: When did you visit? Did you formally enroll somebody in a program? There’s not been a lot of focus on outcomes. There’s been more of a focus on levels of activities.”

KCLINC also uses the data system to examine how better to allocate resources. With Tableau, a visualization tool, it can identify the frequency of visits in specific communities, which allows it to identify where communities are over- or under-served: “If we can only visit so many people, are we making the best use of the opportunities to visit the right people who could benefit the most because they don’t have any other resources or they’re serving a large number of subsidized children, and/or they have potential or desire to develop this into a business and serve more children?”

TABLE 21: SUMMARY TABLE OF SIGNIFICANT DIFFERENCES ACROSS TYPES OF STAFFED FAMILY CHILD CARE NETWORKS	CCR&R SFCCNS	HEAD START SFCCNS	OTHER SFCCNS
ORGANIZATIONAL FEATURES			
Serves statewide area	–		+
Serves a multi-county region	+		
Serves local community		+	
Where providers live: rural			–
Where providers live: suburban		–	
Where providers live: urban	–		
Serves fewer than 50 providers	–	+	
Serves more than 1000 providers	+		
Serves both HBCC and centers	+		–
Serves regulated FCC only and/or centers (no FFN)		+	
FUNDING SOURCES			
Any public funding (federal, state, or other)		+	–
Receives funding through a state contract	+		
Receives federal funding		+	–
Provider-based fees	+		
SERVICES			
Helps providers participate in a QRIS	+		–
Conducts visits with 75-100% of affiliated providers	–	+	
Conducts high-frequency visits (more than monthly)	–	+	
Conducts visits 1-6 times a year	+	–	
Conducts visits on an as-needed basis	+	–	
Offers training on nutrition			+
Offers training on CCDF-required health/safety topics & licensing regulations	+		–
Charges a training fee to providers	+	–	–
Offers child care during training	–		+
Offers any peer support (peer groups and/or provider-to-provider peer mentoring)			+
Requires providers to use an evidence-based curriculum	–	+	
Helps providers develop their own curriculum		–	
Helps providers develop policy handbooks	+	–	
Helps providers complete forms & applications	+		–
Offers a resource van		+	
Offers comprehensive services for families & children	–	+	
Offers community linkages to comprehensive services for families & children	+	–	
Offers a combination of research-based services (visits, curriculum, & resources)	–	+	–

Table Continued >>>

TABLE 21: SUMMARY TABLE OF SIGNIFICANT DIFFERENCES ACROSS TYPES OF STAFFED FAMILY CHILD CARE NETWORKS

	CCR&R SFCCNS	HEAD START SFCCNS	OTHER SFCCNS
STAFFING			
All positions work with HBCC and/or conduct visits	+		–
Child & family-focused staff: early childhood mental health consultant; nurse; disabilities consultant; family support specialist; curriculum specialist		+	
Systems-focused staff: QRIS specialist	+		–
Systems-focused staff: CACFP specialist	+		
Promising staff training: combination of child development, working with adults, & HBCC context	+		
Staff training: licensing regulations, CCDF topics, managing a child care business	+		–
Staff training: nutrition; curriculum; qorking with dual language learners		+	–
EVALUATION & QUALITY ASSESSMENT			
Family satisfaction; child & family outcomes	–	+	
FCCERS			–
CLASS	+		

Differences shown are both statistically significant at the p≤.05 level and have a medium or large effect size based on calculation of Cramer's V as a proxy for effect size.

KEY

+ indicates a higher proportion of SFCCNs in this category

– indicates a lower proportion of SFCCNs in this category

DISCUSSION & RECOMMENDATIONS

DISCUSSION

This study represents the first systematic effort to map the national landscape of staffed family child care networks. Our findings indicate that SFCCNs are a diverse group of programs that differ by organizational type, funding sources, service delivery strategies, and staffing structures. New information on the roles and functions of SFCCNs in state and local early childhood systems, such as licensing and subsidy, suggests that SFCCNs have the potential to increase the supply of regulated family child care in local communities by helping providers navigate and participate in these systems. SFCCNs may also contribute to supply by helping providers recruit and enroll families which can contribute to sustainable businesses. We found that CCR&R networks were more closely connected to a QRIS compared to Head Start and other SFCCNs, and the systems and business supports they offered – training on topics mandated by the licensing and subsidy programs and helping providers with forms and applications—often reflected this connection.

Our findings also suggest that SFCCNs may be a promising approach for helping HBCC providers improve the quality of care and education that they offer to children and families. A large number of SFCCNs in our study reported providing multiple services such as visits to providers' homes, training, peer mentoring, and business support, but our survey findings raise considerable questions about the intensity or depth of services that SFCCNs offer providers.

The majority of SFCCNs in our study reported what could be considered "light touch" services to providers, lacking the dosage and intensity that research suggests has a positive effect on child care quality (Bromer et al., 2009; Bromer & Korfmacher, 2017; McCabe & Cochran, 2008). More than a third offered visits only one to six times a year, and only 17% offered high-intensity weekly or semi-monthly visits to providers' homes. A third reported only offering visits to fewer than half of their enrolled providers, and only 28% reported visiting providers for more than a year.

Most SFCCNs also reported referring providers, families, and children to services such as developmental screenings, early childhood mental health consultation, and health and nutrition services rather than offering these services directly through network staff, although research shows that these resources are important predictors of quality (NSECEa, 2015). Only Head Start, which is required to offer comprehensive services for children and families, evidence-based curricula, and high-frequency home visits, and one other network reported offering this combination of services, which is a predictor of quality (Burchinal, 2018)

Our findings also underscore the important, and perhaps unique, role that SFCCNs may play in responding to the particular needs and interests of providers, many of whom may experience stress from long hours, low pay, and working alone with children, and who may have limited capacity to access external resources and information (NSECE, 2015b; Porter, et al., 2010). Most of the SFCCNs in our sample reported providing some type of peer support, which research suggests may improve quality by reducing isolation and contributing to self-efficacy and a sense of professionalism (Forry et al., 2013; Gray, 2015; Lanigan, 2011; Porter & Reiman, 2016). SFCCNs that were not housed in CCR&R agencies or programs delivering Head Start services were most likely to report offering any peer support, including peer support groups or peer-to-peer mentoring, and, as a result, may have had more latitude to address these types of provider needs. Slightly more than half reported helping providers develop their own curriculum and close to three-quarters helped providers with developing administrative protocols and policy handbooks for their child care businesses, suggesting a network focus on meeting the unique needs of HBCC providers.

Our findings suggest that SFCCNs do not have standards for staff qualifications or staff training, which research indicates may be important aspects of high-quality HBCC programs (Bromer & Korfmacher, 2017). Across the SFCCNs in our sample, staff hiring requirements were minimal, with only half of the SFCCNs requiring staff to have a BA degree or higher. While most SFCCNs reported requiring a degree in early childhood or child development, fewer reported requiring a social work degree which may be one pathway towards learning how to work with adults and families.

In addition, while the majority of SFCCNs in our sample reported offering in-service training for staff, most of it focused on child development. Fewer than half reported offering in-service staff training on topics related to working with adults such as

communication and listening, stress management, adult learning styles, and organization and case management, although research on adult learning suggests that training and education must incorporate principles of adult learning to engage adults and change their behavior (Trivette, Dunst, Hamby, & O'Herin, 2009). The findings around staff supervision also point to minimal attention to staff development and support, with few SFCCNs offering weekly supervision or team meetings.

LIMITATIONS

Given the rapidly changing landscape of programs and policies that include HBCC providers, our sample of SFCCNs is not representative. Sub-samples of SFCCN types are small and only capture a fraction of these types of agencies across the country. Moreover, there are likely other types of organizations that we were not able to recruit for this study. The military system, for example, has a long history of supporting family child care quality for enlisted families, yet the scope of this study did not allow for inclusion of these programs.

In addition, self-reported survey and interview responses may not have captured full and/or accurate data about the SFCCNs. Qualitative interviews with a sub-sample of SFCCN directors filled in some gaps where survey data were lacking, but some areas were not probed in the interviews such as curriculum support or staff supervision.

RECOMMENDATIONS FOR PROGRAMS, POLICY, AND RESEARCH

Our findings suggest several future directions for programs, policy, and research. We include recommendations for each of these areas below.

DIRECTIONS FOR STAFFED FAMILY CHILD CARE NETWORKS

The finding that a majority of SFCCNs offer low-touch services to providers suggests the need for innovative solutions to increasing support and contact with providers without increasing costs of service delivery. Approaches such as warm lines and coaching through technology—texting, social media, video conferencing— may offer ways to enhance support for providers and supplement more resource-intensive services such as visits. In addition, SFCCNs might consider building on peer-to-peer connections that naturally occur in networks. Intentional peer-to-peer mentoring, learning communities, and cohorts to connect providers to each other and to provide opportunities for shared learning as well as leadership development may also enhance the intensity and capacity of SFCCNs to support and reach providers.

Our study findings point to limited attention to staff training on topics related to working with adult learners and minimal opportunities for supervision. Yet research indicates that working with HBCC providers may pose unique challenges including provider hesitancy around opening their home to observers, logistical challenges around visiting provider homes, and resistant attitudes towards change (Bromer & Weaver, 2016). The work may require specialized training in working with adults and understanding child development (Bromer et al., 2009). SFCCNs may improve the effectiveness of staff practices by offering training on adult learning principles including communication, active listening, and conflict resolution, as well as training on case management strategies. A focus on adult learning may lead to strategies such as combining workshop sessions with follow-up virtual or in-person coaching sessions or other blended service delivery strategies that help providers put training into practice.

SFCCNs may be more successful in engaging and sustaining the work of quality improvement with FCC providers if the work is recognized as an agency-wide priority that involves all early childhood staff. Prior qualitative research on family child care networks in Chicago found that network coordinators were often isolated in their roles because other staff at the organization were not willing to, or did not have the capacity to, work with HBCC providers (Bromer, Weaver, & Korfmacher, 2013). The current study found that only 60% of SFCCNs reported that all of their staff work with HBCC providers. We do not know if this is related to multiple programs within an organization or if staff were less likely to work with HBCC providers because of the challenges involved in reaching providers in their homes across a community.

SFCCNs may also consider increasing the intensity of supervision and integrating reflective supervision approaches. Prior research suggests the importance of relationship-based practices across family- and child-focused services broadly (Li & Julian, 2012), and in family child care work specifically (Bromer & Korfmacher, 2017). Opportunities for reflective supervision may be particularly important for staff who work directly with providers through visits and training. While our survey did not probe specifically for reflective supervision, most SFCCNs did not report frequent opportunities for individual or group supervision. For SFCCN staff to engage in meaningful, respectful, and goal-oriented relationships with providers, they may need these kinds of more intensive and frequent opportunities to share and reflect on their work.

DIRECTIONS FOR POLICY

Our study suggests that a strength of SFCCNs may be their support for HBCC participation in early childhood systems, particularly licensing, subsidy, and QRISs. Through these supports, SFCCNs may play an important role in the child care supply, encouraging individuals to become licensed as well as to offer subsidized care, and enhancing their attachment to the field through QRIS engagement. SFCCNs could also serve as a hub in communities to link together other organizations such as family child care associations, unions, libraries, and play and learn groups that touch providers. Such an approach has the potential for strengthening local coordination of services to expand supply and increase access to quality improvement supports.

Our study further suggests that states and localities might consider establishing some standards for SFCCNs that receive public support. We lack evidence of "best practices" and the effectiveness of individual services or combinations of services. Yet, our data point to a set of promising services that includes visits to providers' homes, training on specific topics, opportunities for peer support, and business services that may be essential for improving quality and supporting HBCC providers. For these standards, policy makers could look to the strengths of the different types of SFCCNs in our sample. Head Start networks, for example, offer the most intensive services that research suggests are most likely to shape quality outcomes including frequent visits to homes, use of a curriculum, and developmental, mental health, and health resources for children and families.

DIRECTIONS FOR FUTURE RESEARCH

While the findings provide insights into the different kinds of services that SFCCNs offer, we lack information on specific network models, including the theories of change that guide their work and clearly defined approaches for increasing supply, improving quality, and enhancing child outcomes. Our survey findings suggest that, aside from Head Start networks, most SFCCNs do not offer a research-based set of strategies to support providers and most offer low-touch services that may not be sufficient to produce impacts on quality outcomes. Model specification would allow researchers to examine fidelity and ultimately the effectiveness of different network approaches.

There is also a need to understand the effectiveness of different types of SFCCNs. We lack research on the relationship between network supports and child and family outcomes, yet producing positive changes in children's development and family well-being are the ultimate goals of improving child care quality. We also do not know which services are successful in meeting the personal and professional needs of diverse providers who are providing care under different circumstances.

Future research on SFCCNs and quality improvement needs to move beyond descriptive studies to include evaluation methods such as rapid cycle testing and randomized control trials that better capture the effects of services on provider, child, and family outcomes.

CONCLUSION

The federal government has endorsed staffed family child care networks as a strategy for improving the quality of HBCC for infants and toddlers, and, as a result, the interest in this approach has increased. Across the country policy makers and program administrators are seeking information about models of SFCCNs that they can implement in their states and localities. Yet, the research about SFCCNs is limited, and there is little systematic evidence to inform these policy decisions.

This study of the national landscape of staffed family child care networks begins to fill that gap. The findings provide insights into the kinds of organizations that operate SFCCNs, the services they offer to HBCC providers, and their staffing components. SFCCNs have the potential to increase HBCC supply and improve its quality, and different types of networks may have promise for achieving these goals. Additional findings from qualitative interviews with SFCCN directors and case studies of two SFCCNs will enhance our understanding of services implementation, the challenges SFCCNs face in serving providers, and their perceived successes.

Further research on SFCCNs is clearly needed. We do not yet fully understand the fit between services and provider needs nor do we have evidence about the services or combinations of services that are effective in increasing supply or improving quality. In addition, we lack data on the impact of SFCCNs on the outcomes of children or families. This study begins to lay the groundwork for examining these issues.

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