Implementing Benchmarks for High-Quality Home-Based Child Care Networks: Findings from a National Survey

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Introduction and Report Background

Home-based child care (HBCC) networks have drawn attention in the past decade as a way to support licensed family child care and family, friend, and neighbor care. Increased recognition of networks' potential to enhance HBCC quality and expand supply has driven this focus.[1] Yet the early care and education (ECE) field has lacked a framework for understanding what high-quality networks look like. In 2022, Erikson Institute and Home Grown published an evidence-based framework for high-quality HBCC networks, which aimed to fill this gap.[2]

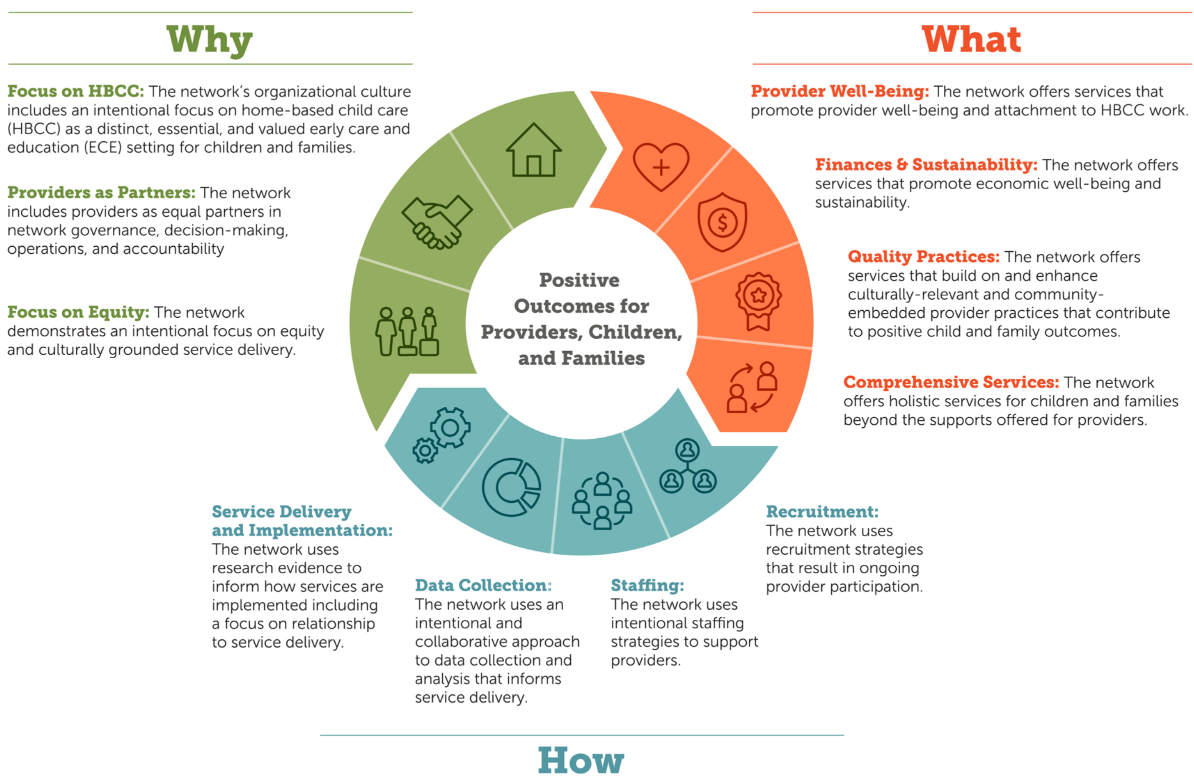
The framework includes 11 benchmarks and indicators for high-quality HBCC networks grounded in evidence about their links to positive outcomes for providers, children, and families (Figure 1). The framework is intended to help networks engage in self-assessment and continuous quality improvement, as well as to inform public and philanthropic investments in establishing new networks and strengthening existing ones.

In winter 2022–2023, Erikson Institute conducted a survey to understand whether the benchmarks are relevant and meaningful for a broad range of networks across the U.S., how networks are implementing the benchmarks, and which benchmarks are more challenging for networks to meet. The survey was distributed to 276 organizations that fit the definition of an HBCC network. They included networks that support licensed family child care (FCC) providers as well as those that support family, friend, and neighbor (FFN) providers. Fifty-one networks submitted responses. Because of the low response rate from networks that serve FFN

HBCC Networks

HBCC networks are defined as groups of providers, families, and other community members who come together to enhance supports for HBCC.[3] HBCC networks may focus on enhancing quality, access to services, and sustainability through formal or informal mechanisms. Networks may be situated within a larger organization or hub that coordinates services and funding, or networks may be stand-alone organizations or groups.

Figure 1. Network benchmarks



providers, the survey was reopened in summer 2023 with a goal of including more responses from networks supporting those providers. The survey was distributed to 25 networks that support FFN providers,[a] and 10 of these networks responded, resulting in a new total sample of 61 networks. The overall response rate for the survey was 21%. In the summer and fall of 2023, Erikson Institute also conducted focus groups with a subsample of network directors and affiliated HBCC providers. Those findings are presented in a series of companion briefs.

Frequencies were calculated for all survey responses. To account for small expected cell counts, two-tailed Fisher's exact tests were used to analyze differences between network subgroups (see Differences Across Network Subgroups section).

Report Organization

This report describes survey results from the 61 networks and is organized by the 11 benchmarks described in Strengthening Home-Based Child Care Networks: An Evidence-Based Framework for High-Quality. The first section describes the survey sample, including type, location, funding, and providers served. Subsequent sections describe findings from the survey as they relate to each benchmark. These sections are followed by an analysis of differences across network subgroups. The report concludes with a discussion of findings and recommendations for developing and enhancing high-quality networks.

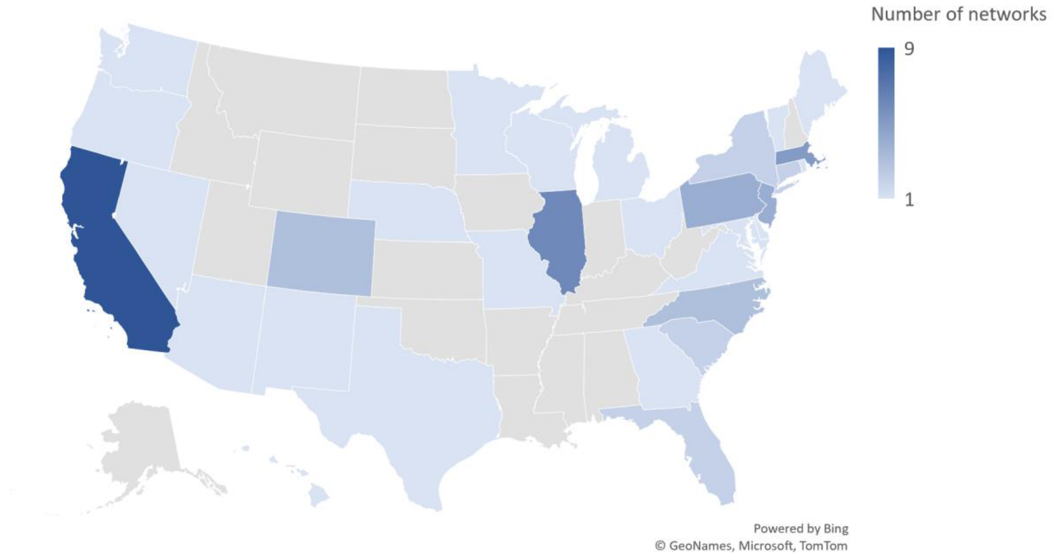
a Twelve of these networks were included in the first round. The second round of distribution included more targeted outreach to the networks.

Sample Description

Location of Networks

Sixty-one networks across 31 states responded to the survey (Figure 2).[b] Five or more networks each responded from California (9), Illinois (6), and Massachusetts (5).

Figure 2. Network distribution by state

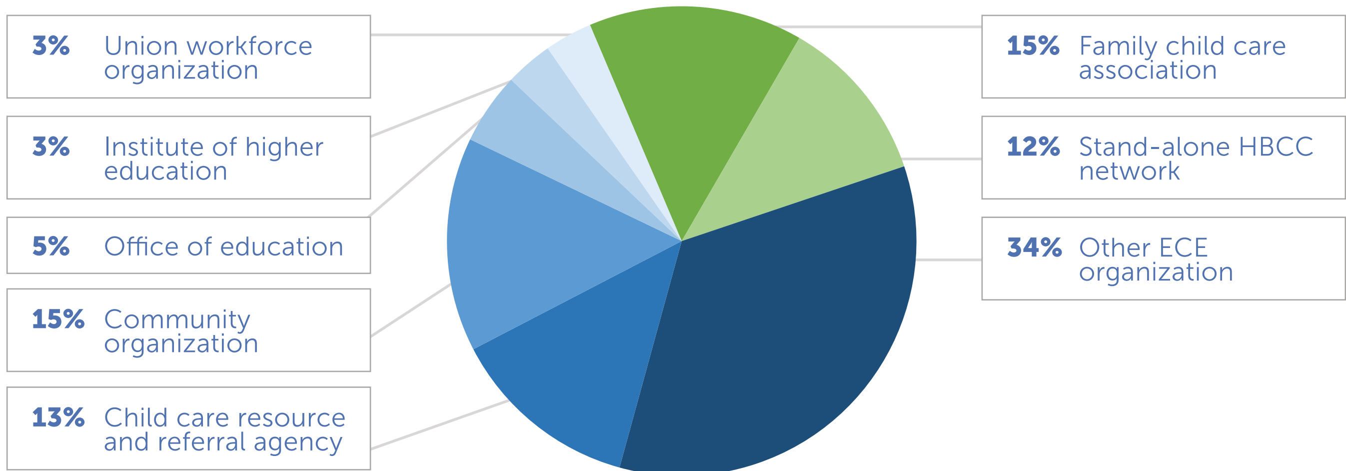


Of the networks that report the communities they serve, a majority serve providers in urban communities (84%), followed by those that serve providers in suburban communities (65%) and rural communities (55%). Over half of the networks serve providers across different types of geographic communities (59%).

Network Platforms

Networks in our sample include different platforms and organizational structures (Figure 3). The majority of networks (74%) are part of a larger organization, including child care resource and referral agencies, other ECE agencies, community-based organizations, offices of education and institutes of higher education, and unions. Just over a quarter of networks are not part of a larger organization and are stand-alone organizations funded to support HBCC or membership-based FCC associations.

Figure 3. Network platform (n=61)



b One network is in two states and is counted twice in Figure 2.

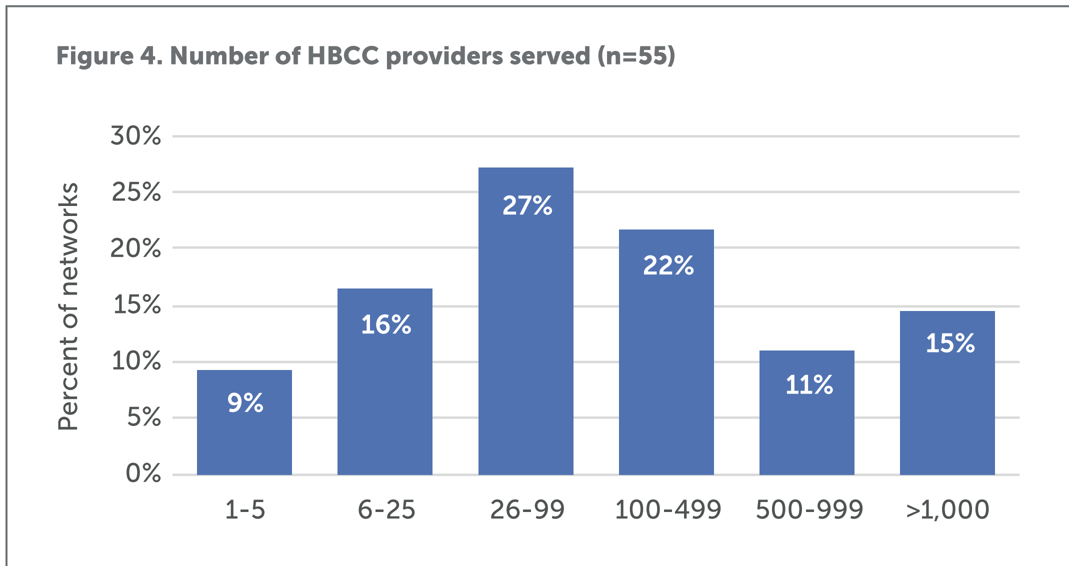
Network Leadership

Networks are categorized as provider-run if they identify as an FCC association or a network that is fully operated by current HBCC providers. In our sample, 18% of networks are provider-run entities.[c] Nine of these provider-run networks are FCC associations, and two are stand-alone HBCC networks.

Providers Served

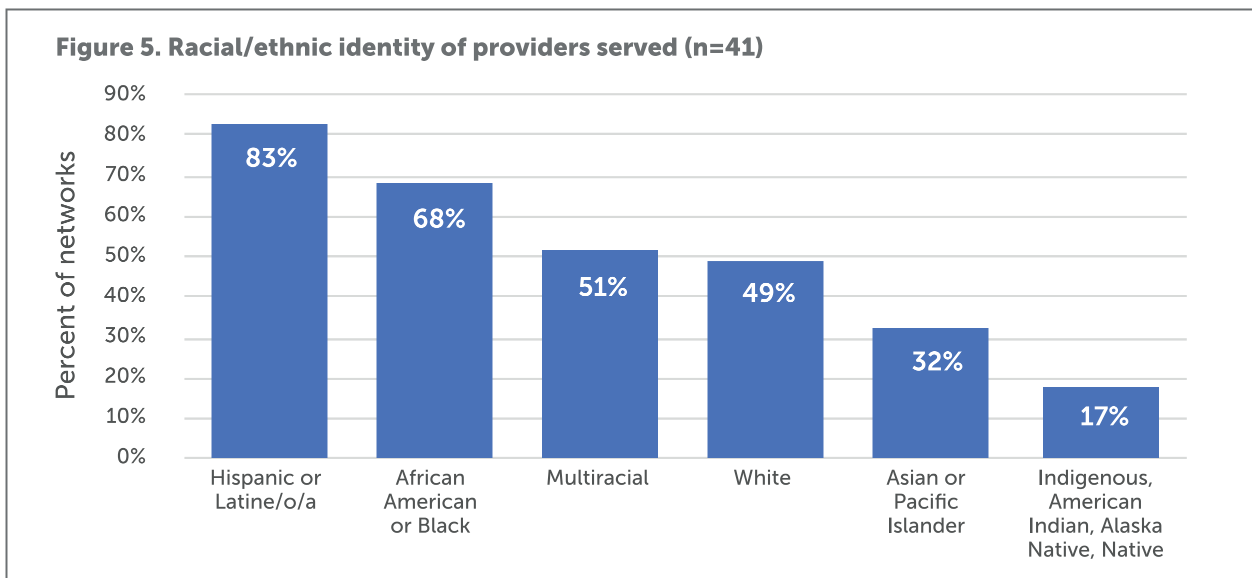
Almost all the networks in our sample serve licensed, certified, or registered FCC providers (95%). Just under half (49%) serve unlicensed or legally-exempt FFN providers. Three networks serve only FFN providers. The number of providers served by networks varies greatly from one to 27,000 (Figure 4).

Figure 4. Number of HBCC providers served (n=55)



Two thirds of networks reported the racial/ethnic identity of the providers they serve. Of these 41 networks, the majority serve Black and Latine providers (Figure 5).

Figure 5. Racial/ethnic identity of providers served (n=41)



c The survey did not ask if networks are provider-run. The survey asked if networks are "family child care associations." Two networks that participated in our focus groups reported that they are provider-run organizations although they did not categorize themselves as family child care associations, probably because they also serve FFN providers. Based on this information, we recoded their survey responses into the provider-run category. It is possible there are other networks in our survey sample that are provider-run. Unions, for example, may be led by providers, but our survey did not ask about this, and so they are not included in the provider-run category.

Networks serve diverse groups of providers, including those who speak many languages other than English (Figure 6). The majority of networks serve English-speakers (92%) and Spanish-speakers (87%).

Funding Sources

More than half (53%) of the networks report multiple funding sources (Table 1). Two thirds (68%) receive public funding, and 58% receive private organization or philanthropic funding. Approximately a quarter (23%) are funded by provider fees.

Figure 6. Languages providers speak

Table 1. Network funding sources (n=57)

	N	%
Any public funding (federal, state, or local)	**39**	**68%**
Federal government	**17**	**30%**
Federal Head Start/Early Head Start	7	12%
Child and Adult Care Food Program	4	7%
Federal Community Services Block Grant	1	2%
Other	7	12%
State government	**25**	**44%**
State contract to administer subsidized child care slots	12	21%
State contract for network services (separate from subsidy)	11	19%
Other state government	12	21%
Local government	**11**	**19%**
Philanthropy (private organization)	**33**	**58%**
Provider fees	**13**	**23%**
Provider network membership dues	10	18%
Provider fees for individual network services	4	7%
Parent fees	**6**	**11%**
Other	**5**	**9%**

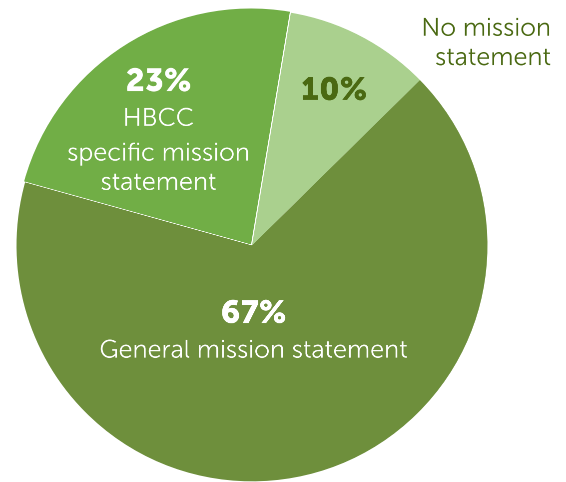
Note: Networks were instructed to select all that apply.

Benchmark A—Focus on HBCC

The network's organizational culture includes an intentional focus on HBCC as a distinct, essential, and valued ECE setting for children and families.

Networks that have a mission statement specifically focused on HBCC may be more responsive to the unique needs of these providers. Just under a quarter of organizations that responded to the survey have a mission statement that specifically mentions HBCC providers (Figure A.1).

Figure A.1. Mission statement (n=60)

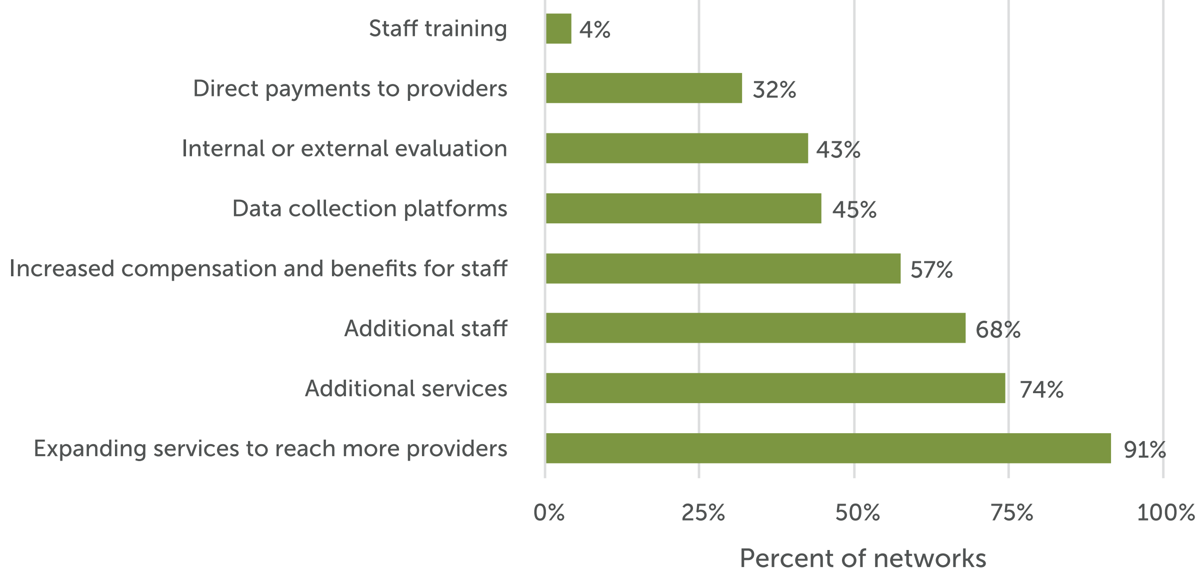


Networks may play a key role in promoting inclusion of HBCC providers in publicly funded ECE systems and initiatives. **Approximately 85% of networks support HBCC provider participation in ECE systems, and 93% collaborate with other organizations to advocate for the inclusion of HBCC in systems.** (See Benchmark E for more detail about how networks help providers navigate ECE systems).

To deliver meaningful support and commitment to HBCC providers, networks must maintain efforts to secure sustainable funding. Only 23% of networks agree that their current funding covers the full cost of supporting and delivering services to providers. Figure A.2 indicates that networks report needing additional funding for reaching more providers, offering direct financial support to providers, increased compensation and training for network staff, and data and evaluation efforts.

77% of networks report current funding does not cover full cost of services.

Figure A.2. Funding needs of networks (n=47)

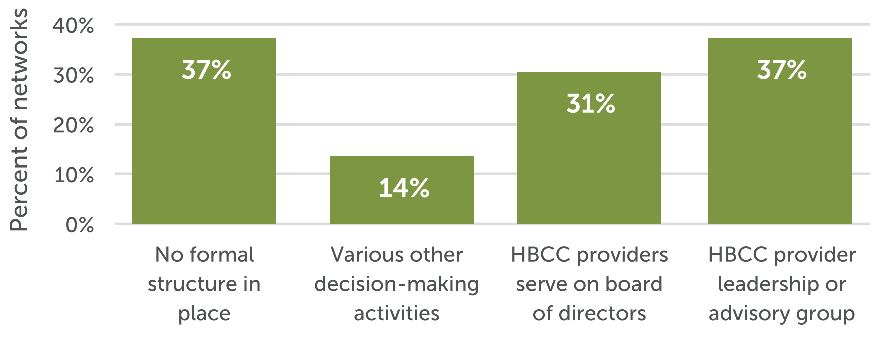


Benchmark B—Providers as Partners

The network includes providers as equal decision-making partners in network governance, operations, and accountability.

Including HBCC providers as equal decision-making partners is essential for ensuring that networks are operating in a way that is meaningful for providers and achieving their intended goals or outcomes.

Figure B.1. Network engagement of providers in decision-making and governance (n=59)



Just under two-thirds (63%) of networks engage providers in network decision making and governance as part of a leadership or advisory group or as members of the board of directors (Figure B.1).

Of these 38 networks, 24 prepare providers for this decision-making role by offering an orientation, training, mentorship, and/or one-on-one coaching.

Table B.1. Information shared with providers in the network

	N	%
Information shared when providers join (n=57)*		
The network's mission statement (n=51)	32	63%
Information about network staff roles as mandated abuse and neglect reporters	33	58%
Information about the network's role in subsidy and licensing monitoring (n=21)	15	71%
The costs associated with network participation (e.g., membership fees) (n=12)	9	75%
The network's theory of change or logic model (n=22)	8	36%
Full financial disclosure (e.g., audits)	5	9%
Other information shared (n=58)		
Staff positions (e.g., staff job titles, roles, responsibilities)	33	57%
Revenues by source	10	17%
Other expenses	6	10%
Administrative costs	5	9%
Staff salaries	0	0%

*Percent is calculated based on the number of applicable networks; a subsample is noted when appropriate.

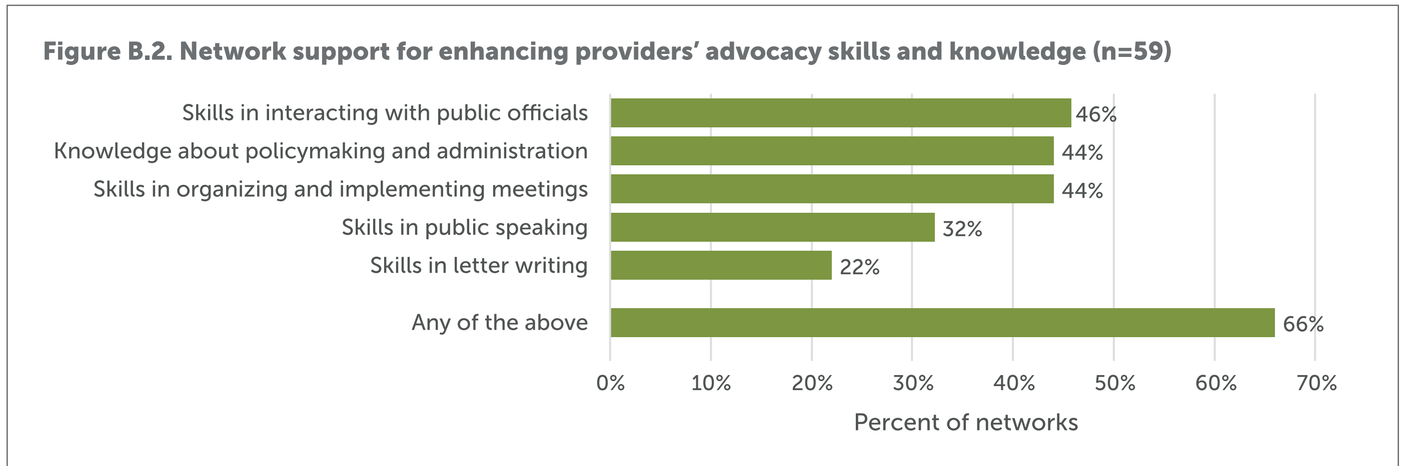
Including providers as equal partners requires that networks are transparent about network management and operations. Table B.1 shows the type of information that networks share with providers in their network. Overall, more networks report transparency around costs associated with network participation, the networks' role in licensing and subsidy monitoring, the mission statement, and staff positions and roles. Fewer networks share information with providers about the financial details of the network's operations or the network's theory of change or logic model.

60% of networks use experienced providers to mentor newer providers.

Networks that center the voices of providers may offer opportunities for newer providers to learn from more experienced providers.[d] Many networks report mentoring strategies for leveraging provider expertise and voice.

Helping providers advocate for HBCC is another way networks facilitate providers as leaders and decision makers.[e]

- **66% of networks report supporting providers as advocates for public policy change related to HBCC.** Networks use a variety of strategies for helping providers acquire advocacy skills and knowledge (Figure B.2).



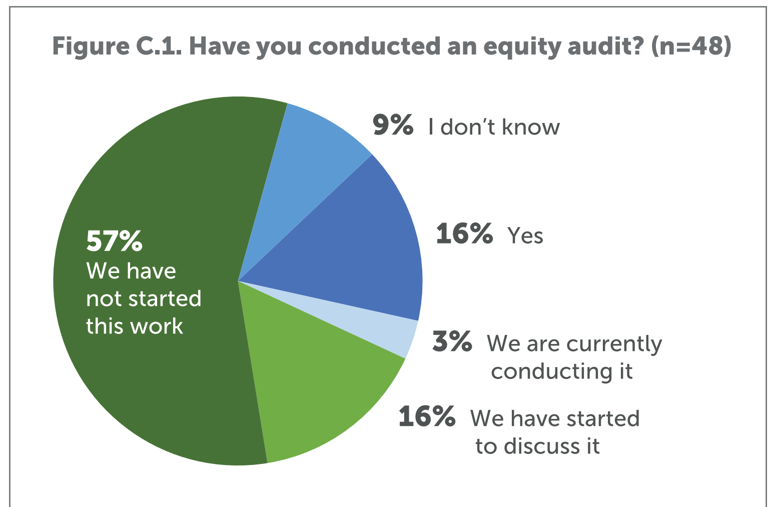
d Offering opportunities for providers to learn from more experienced providers is described in the benchmarks framework document as part of Benchmark K, recruitment.

e Supporting providers as advocates is described in the benchmarks framework document as part of Benchmark E, finances & sustainability

Benchmark C—Focus on Equity

The network demonstrates an intentional focus on equity and culturally grounded service delivery.

Understanding and addressing racial, ethnic, and linguistic bias in service delivery are key to building an equity-focused network. An equity audit is an approach to examining these biases: 19% of networks report implementing one (Figure C.1).

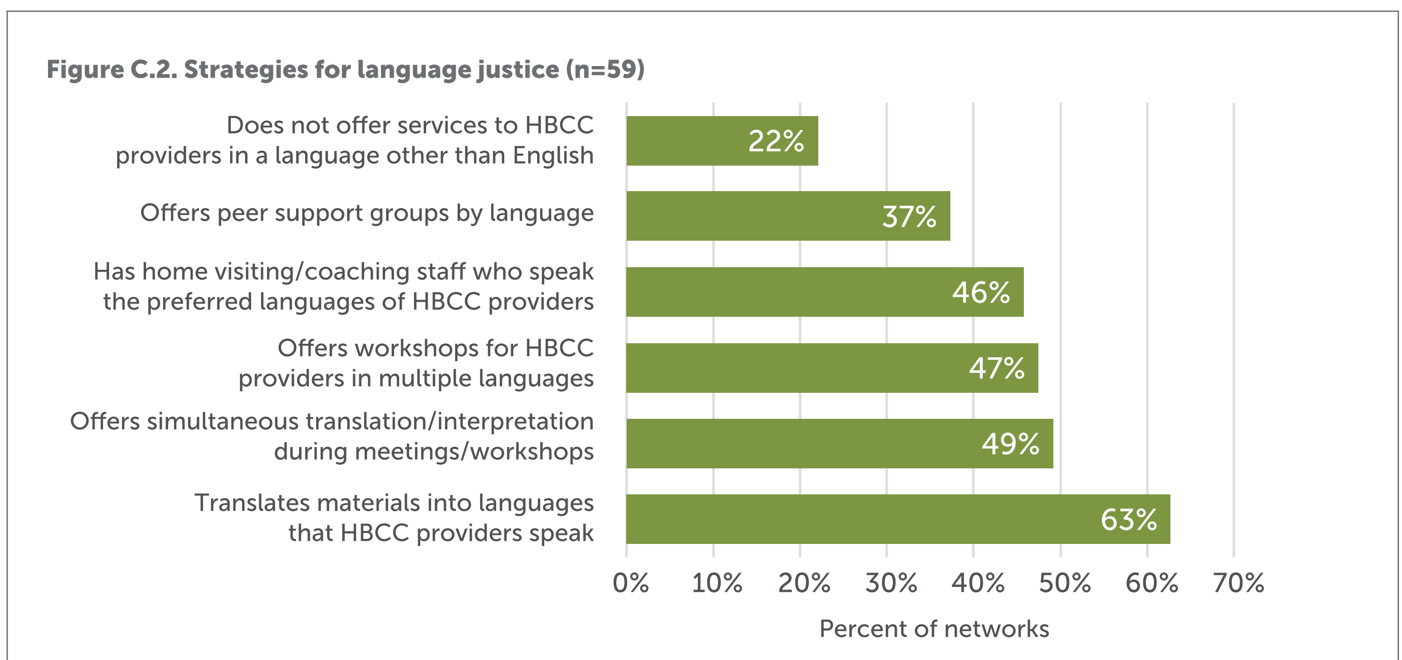


In addition, equity-focused networks may prioritize groups of HBCC providers, children, and families from disinvested communities that have been marginalized. Collecting data about key populations served is foundational to equity-focused service delivery.

- **78% of networks report systematically collecting data about providers served.**
- **80% of networks can describe the types of communities (rural, suburban, urban) where providers live.**
- **67% of networks can describe the race/ethnicity of providers served.**
- **53% of networks report systematically collecting data about children and families who use affiliated HBCC providers.**

Offering supports in preferred languages of providers is one way that networks can redress historical inequities in providers' access to services. Networks use a variety of strategies to support language justice, including translation of materials, interpretation services, and hiring staff members who speak the preferred languages of providers in the network (Figure C.2).

- **81% of networks that serve Spanish-speaking providers report offering services in Spanish.**
- **17% offer services in languages other than English and Spanish.**



Benchmark D—Provider Well-Being

The network offers services that promote provider well-being and attachment to HBCC work.

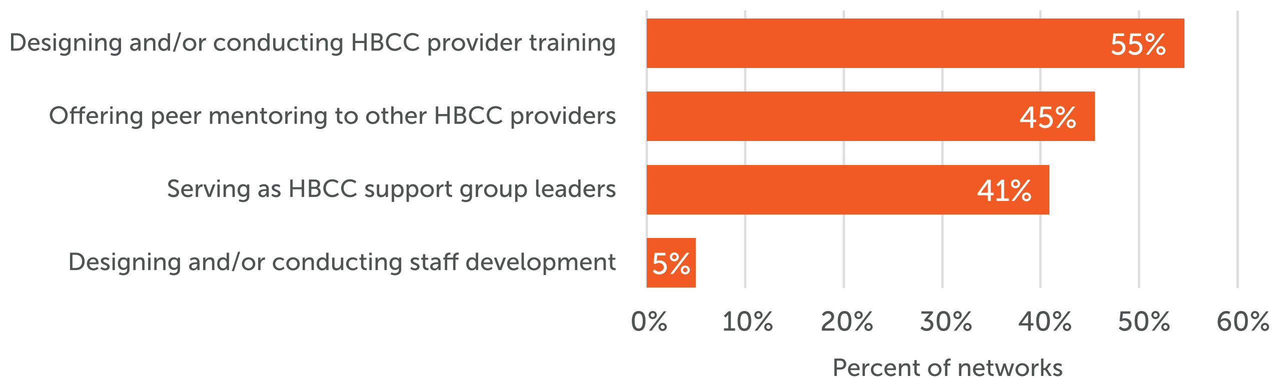
HBCC providers face many stressors, including difficult working conditions such as long hours caring for children, working alone, and balancing the needs of their own families with their caregiving work. These experiences may have negative effects on providers' emotional and psychological well-being and may take a toll on their physical health.[4]

90% of networks support provider well-being and stress management through technical assistance (TA, i.e., training workshops, home visits, coaching, and/or peer support).

Networks may also support providers' career advancement.

- **87% help providers access education and training opportunities in the community.**
- **37% pay providers to work as staff, consultants, or contractors on behalf of the network.** These 22 networks pay providers for designing and conducting training, one-on-one peer mentoring, and group facilitation (Figure D.1).

Figure D.1. Types of paid work by providers in networks (n=22)



Benchmark E—Finances & Sustainability

The network offers services that promote economic well-being and sustainability.

Most networks support providers' economic well-being through technical assistance (i.e., training workshops, home visits, coaching, and/or peer support) focused on business and financial management. Fewer networks offer direct financial assistance or material supports (Table E.1).

Most networks (85%) help providers navigate publicly funded systems, which may help increase provider income and financial wealth (Table E.2).

Table E.1. Network supports for economic sustainability (n=60)

	N	%
Offers technical assistance around managing a child care business*	46	78%
Offers technical assistance around financial management and wealth building*	38	64%
Helps with advertising/recruitment of potential families/screening of families	30	50%
Offers HBCC providers and families access to a toy- or book-lending library	21	35%
Offers financial assistance such as microloans or mini-grants for providers	20	33%
Offers HBCC providers access to a child care management system	13	22%
Helps HBCC providers access substitute care (e.g., provider directory)	13	22%
Offers bulk purchasing/discounts on educational or other business supplies	11	18%
Intervenes with landlords and/or lobbies state, county, or city agencies	11	18%
Collects parent fees for HBCC providers or helps providers collect parent fees	10	17%
Operates a resource van with materials for HBCC providers to borrow	1	2%
Pays for HBCC providers' liability insurance	1	2%
**n*=59		

35% of networks distribute public relief dollars (e.g., ARPA, CARES[f]) for HBCC providers.

15% of networks help providers access job-related benefits (e.g., health insurance, retirement, PTO[f]).

f ARPA stands for the American Rescue Plan Act; CARES stands for The Coronavirus Aid, Relief, and Economic Security Act; PTO stands for Paid Time Off

Table E.2. Network supports for ECE systems navigation

	N	%
Helps providers participate in Quality Rating and Improvement Systems (QRIS) (n=59)	**38**	**64%**
Helps providers obtain an FCC license (n=60)	**36**	**60%**
Helps providers prepare their homes to comply with licensing requirements*	32	89%
Delivers required training for licensing*	22	61%
Conducts pre-licensing visits*	18	50%
Offers start-up stipends and/or materials to prepare for licensing*	18	50%
Pays for background checks/other fees*	9	25%
Conducts licensing visits*	5	14%
Monitors providers for compliance with licensing/certification/registration regulations (n=60)	**19**	**32%**
Helps providers with the child care subsidy system (n=60)	**34**	**57%**
Helps providers obtain subsidized slots by making referrals^	20	65%
Offers the required health and safety training for participation in the child care subsidy program^	17	55%
Collects and processes child care subsidy payments for providers^	13	42%
Helps providers collect and process subsidy payments from families^	9	29%
Monitors providers for compliance with child care subsidy regulations (n=60)	**15**	**25%**
Administers the Child and Adult Care Food Program for providers (n=59)	**8**	**14%**
Administers Head Start slots in FCC homes (n=59)	**8**	**14%**
Administers publicly funded PreK slots in FCC homes (n=59)	**4**	**7%**

*Out of all networks that report helping providers obtain a license (n=36).
^ Out of all networks that report helping providers with the subsidy system; three missing responses (n=31).

Benchmark F—Quality Practices

The network offers services that build on and enhance culturally relevant and community-embedded provider practices that contribute to positive child and family outcomes.

Networks have the potential to shape provider practices in ways that may promote positive child and family outcomes. Networks offer supports for working with children through home visiting, coaching, mentoring, and training. Most networks offer a range of early childhood topics, such as child development, culturally and linguistically responsive practices, health and safety, and trauma-informed care.

- **Many networks offer content that may be more specific to the HBCC context, such as designing child care home environments or working with mixed-age groups of children (Table F.1).**

Most networks offer technical assistance for developing provider-family partnerships as well as materials that providers can give families to use at home with their children. Fewer networks help providers facilitate family discussions, develop progress reports to share with families, or organize events for families.

Table F.1. Working with children: Professional development content offered through technical assistance (n=59)

	N	%
Putting child development knowledge into practice	54	92%
Designing child care home environments	51	86%
Supporting providers' culturally and linguistically responsive practices	49	83%
Implementing health, safety, and nutrition practices	48	81%
Working with mixed-age groups of children	47	80%
Inclusion and support of children with disabilities	45	76%
Using trauma-informed practices	43	73%
Implementing anti-bias and anti-racists practices	43	73%
Using observation and assessment to inform practice	43	73%
Choosing and implementing curriculum	42	71%
Working with multi- and dual-language learners	40	68%
Administering child screening and assessment	37	63%

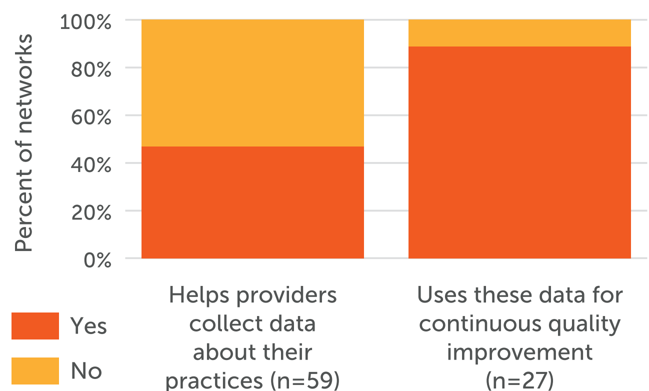
92% of networks help providers engage families in their children's learning (Table F.2)

Table F.2. Helping providers engage families (n=60)

	N	%
Offers technical assistance (training, home visits, peer support) on developing partnerships with families	52	87%
Gives providers materials and activities about learning at home that they can share with families	38	63%
Helps facilitate meetings between HBCC providers and families	21	35%
Helps HBCC providers develop progress reports for children that they can share with families	14	23%
Helps HBCC providers with events and activities for families	4	7%
Does not help HBCC providers engage families	5	8%

47% of networks help providers collect data about their own practices, and most of these networks (89%) help providers use data for continuous quality improvement. (Figure F.1).

Figure F.1. Helping providers use data for quality improvement



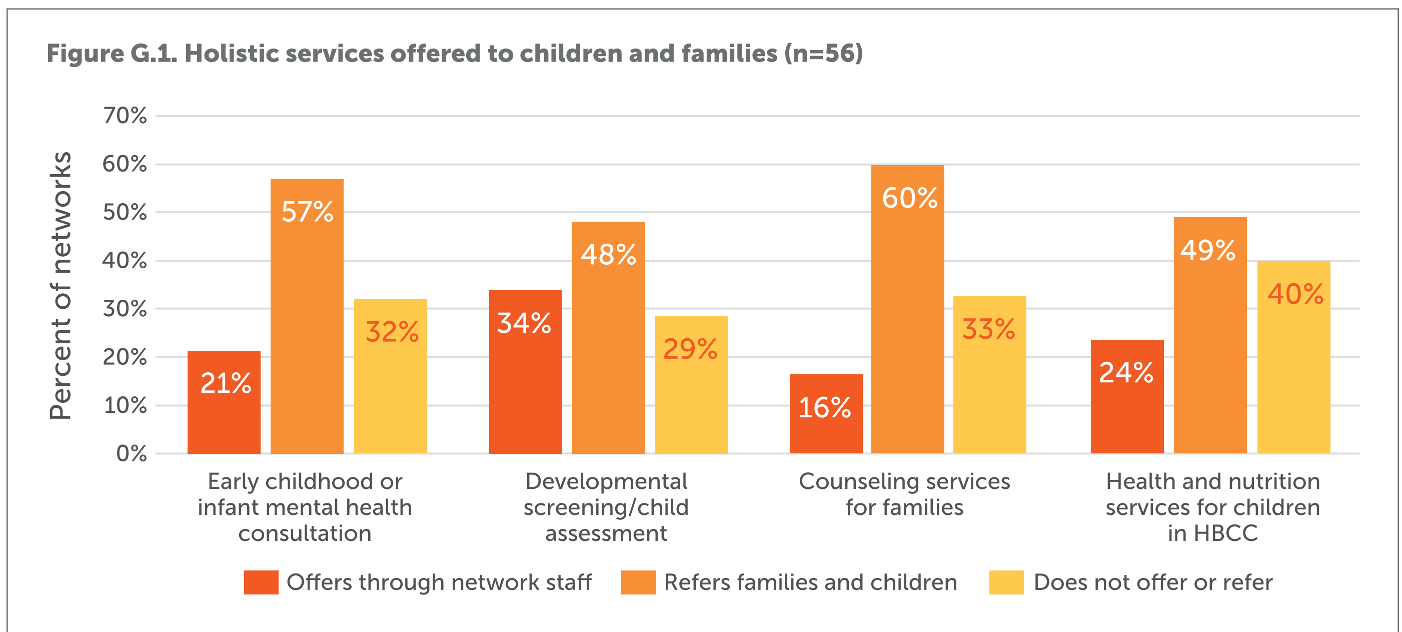
Benchmark G—Comprehensive Services

The network offers holistic services for children and families beyond the supports offered for providers.

Comprehensive and holistic services in early care and education support whole-child and whole family outcomes and may include resources that support the health, mental health, economic stability, and social-emotional wellbeing of families.[5] The most commonly reported holistic service, offered through referrals or direct provision, is developmental screening/child assessment (Figure G.1).

- **38% of networks offer at least one type of holistic service for children and families.**
- **63% refer families to at least one service.**
- **33% do not offer or refer families to holistic services.**
- **80% of networks offer providers and families lists of current services and resources available in the community.**
- **52% of networks who refer families to community services and resources follow up with families about those referrals.**

Figure G.1. Holistic services offered to children and families (n=56)



HBCC providers often offer social–emotional, material, and informational support to families beyond the child care they offer.[6] Networks have the opportunity to support this work that is often informal and overlooked.

- **65% of networks ask providers about the supports they offer to children and families beyond provision of child care.**

Findings by Benchmark: “How” Benchmarks

Benchmark H—Service Delivery and Implementation

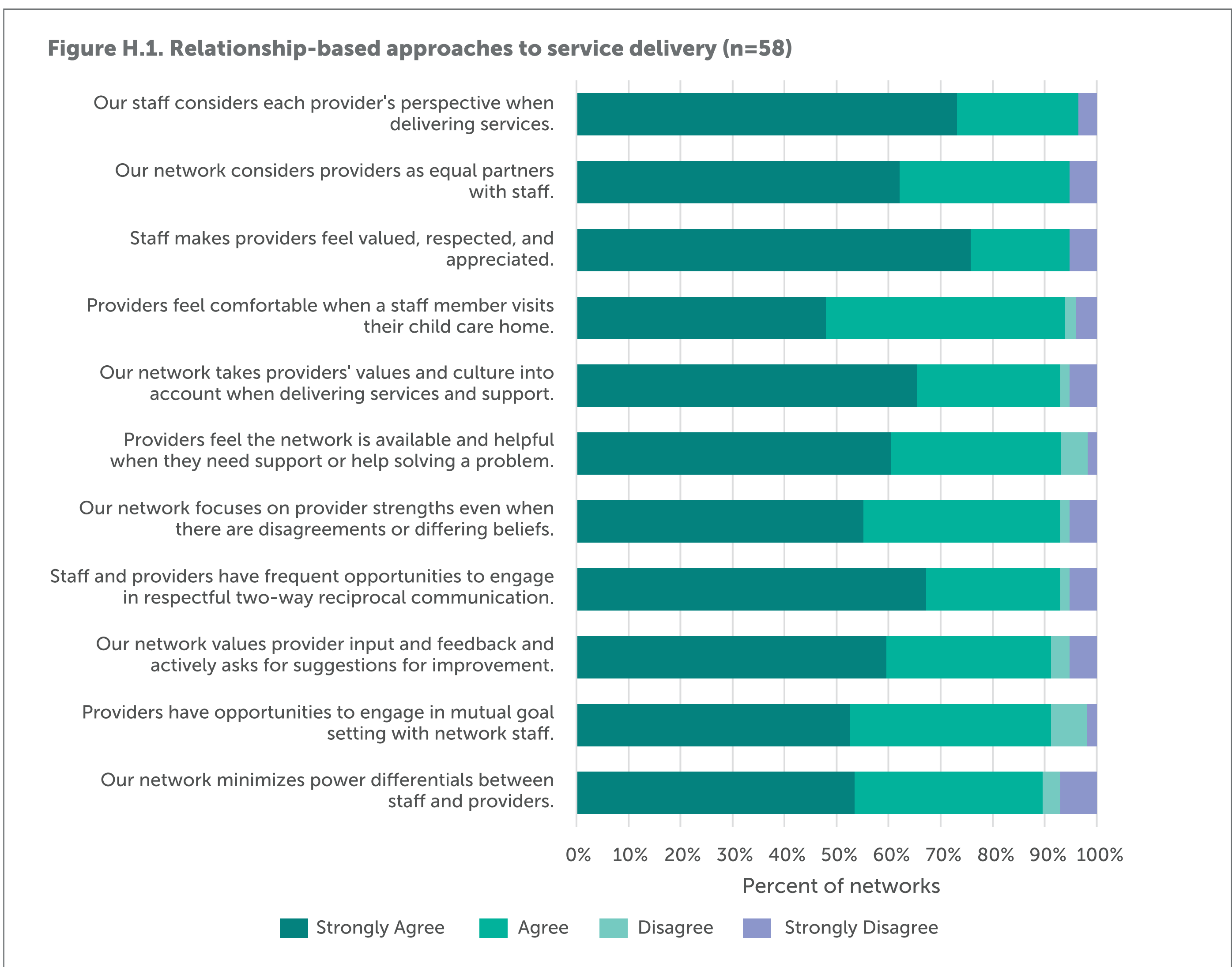
The network uses research evidence to inform how services are implemented, including a focus on relationship-based approaches to service delivery.

Relationship-based approaches

Implementation of services and supports, including relationship-based approaches, is critical for network effectiveness and impact.[7] Networks report that staff and providers have strong professional relationships that are grounded in respect, perspective-taking, mutual goal setting, reciprocal communication, and comfort (Figure H.1).

- **63% of networks offer staff training on relationship-based practices.**
- **45% of networks have protocols or manuals that articulate relationship-based practices for staff.**

Figure H.1. Relationship-based approaches to service delivery (n=58)



A core aspect of relationship-based support is knowledge about providers’ experiences, circumstances, and strengths. Most networks collect data about providers’ language preferences and racial or ethnic identity, but fewer than half collect data on other aspects of providers’ experiences, such as household composition, financial situation, homeownership, other jobs, or the role of culture and faith in child care (Table H.1).

When networks understand the circumstances and experiences of providers, they may be able to differentiate services.

- **67% of networks differentiate services for new, mid-career, and experienced HBCC providers.**

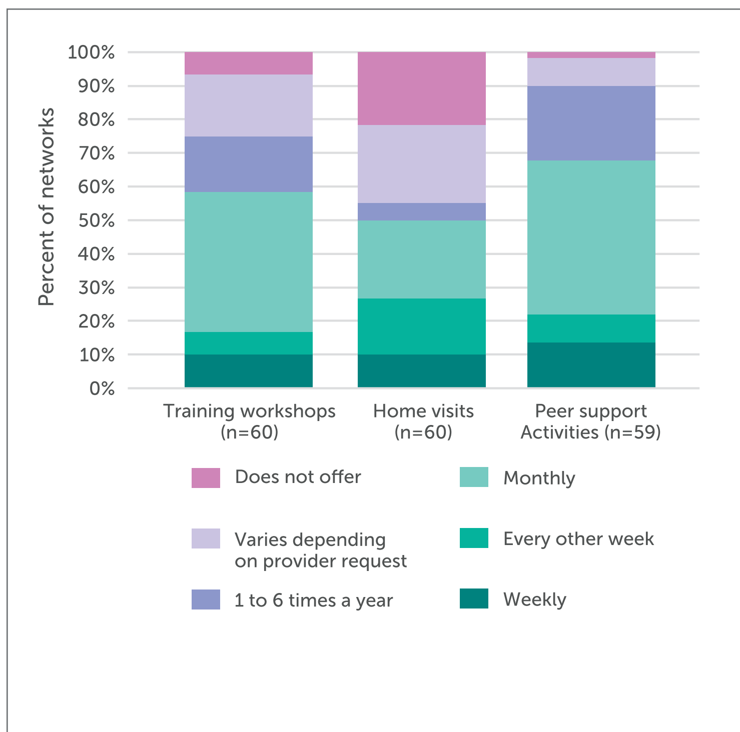
Service delivery strategies

Networks use a variety of technical assistance strategies to support providers, including training workshops, coaching, visits to provider homes, facilitation of peer support groups, and peer mentoring.

Logistical considerations about how and when services are delivered are important to effective implementation (Table H.2). Such considerations include offering services at times that providers can attend, offering supports to reduce barriers, and ensuring that frequency and duration of supports meet the needs and interests of providers.

Frequency of support also may have an impact on network effectiveness. Training workshops and peer support activities are most often offered monthly, while home visits with providers may be offered more frequently and vary depending on individual provider requests (Figure H.2).

Figure H.2. Type and frequency of network services



More networks deliver child development content to providers (e.g., putting child development knowledge into practice, using trauma-informed practices, supporting cultural responsiveness) through training workshops than through home visits or peer-to-peer sharing.

Table H.1. Information collected about HBCC providers in the network (n=60)

	N	%
Preferred languages	39	65%
Racial/ethnic identity	30	50%
Child care schedule	27	45%
Gender identity	19	32%
Household composition	16	27%
Country of origin	14	23%
Other individuals living in the same household	14	23%
Change in provider's home	14	23%
Marital status	12	20%
Financial situation	11	18%
Culture and values	11	18%
Homeownership	9	15%
Health, disability, or mental health status	7	12%
Other jobs the provider holds	3	5%
The role that faith and religion plays in the provider's child care	1	2%
We do not collect demographic data on providers	13	22%

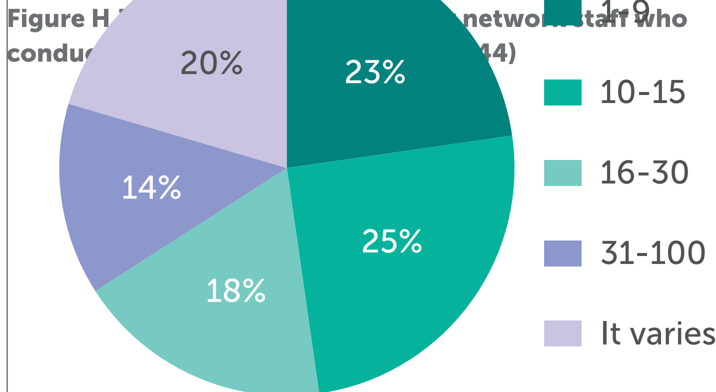
Table H.2. Logistical considerations in network service delivery (n=60)

	N	%
Offer services in the evening	54	90%
Offer services at night (after 8 p.m.)	12	20%
Offer services on the weekends	47	78%
Offer virtual or online services	47	78%
Offer incentives for attending trainings or supports	35	58%
Offer on-site child care	10	17%
Offer transportation or transportation vouchers	5	8%

Caseload

Caseloads for staff members who conduct visits to HBCC providers' homes may also contribute to the types of supports and approaches to support. Caseloads vary widely across networks from fewer than 10 providers per staff member to more than 30. The majority of networks report … providers or fewer (Figure H.3)

Figure H… network staff who conduc… 44)



More networks deliver child development content to providers (e.g., putting child development knowledge into practice, using trauma-informed practices, supporting cultural responsiveness) through training workshops than through home visits or peer-to-peer sharing.

Benchmark I—Data Collection

The network uses an intentional and collaborative approach to data collection and analysis that informs service delivery.

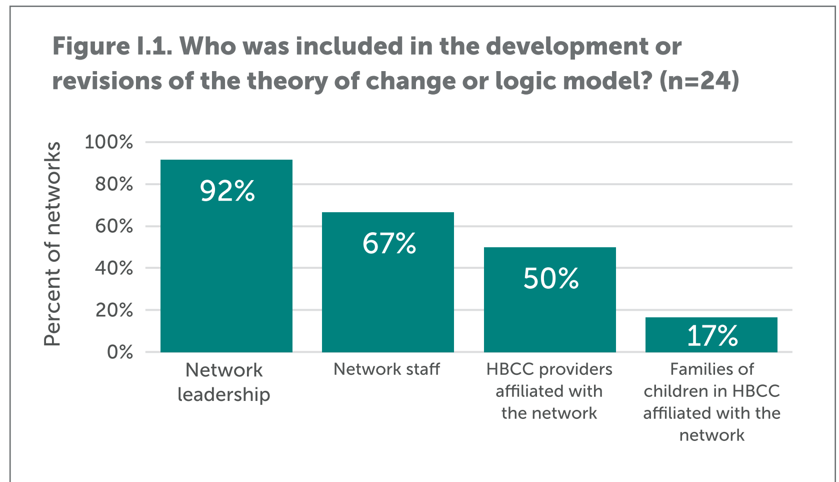


Figure I.1. Who was included in the development or revisions of the theory of change or logic model? (n=24)

Having a logic model or theory of change that guides service delivery is considered a best practice in achieving program success.[8] The 24 networks that have a logic model or theory of change report that their most recent version was developed within the last 5 years or that they are currently revising their model. More networks report including network leadership and staff than providers or families in developing their theory of change or logic model (Figure I.1).

- **40% of networks have developed a theory of change or a logic model to guide implementation of service delivery.[g]**

Collecting meaningful data that can be used to examine the implementation of network services is key to ensuring that the network is achieving its intended goals (Table I.1).

- **66% of networks report engaging staff in how to use data to inform concrete changes and improvements in their work with HBCC providers.**

76% of networks report collecting data on service delivery and provider participation and/or satisfaction compared with just 39% that report collecting data on provider, child, or family outcomes.

Table I.1. Data collection strategies

		N	%
Types of data collected (n=59)	Tracking service delivery, such as numbers of HBCC providers, families, and children served and/or types of services delivered	42	71%
	HBCC provider satisfaction with services	28	47%
	Family satisfaction with services	16	27%
	Cultural or linguistic responsiveness of services	11	19%
	HBCC provider outcomes (e.g., changes in provider knowledge, quality caregiving practices, education levels, income from the business)	18	31%
	Child assessments	17	29%
	Child and/or family outcomes other than child assessments that result from receiving services from the network	13	22%
Strategies (n=48)*	Surveys	38	79%
	Focus groups	20	42%
	Interviews	18	38%
	Observational tools (e.g., quality assessment tool (FCCERS))	25	52%
	Administrative data (e.g., enrollment, attendance, completion)	30	63%

*Out of all networks that report collecting data on an ongoing or regular basis.

g Because this question resulted in many missing responses (11), it is possible that some networks did not know what a theory of change or logic model meant and did not know how to answer. Forty percent is based on the 60 networks that saw this question.

Networks that use culturally and linguistically responsive data instruments may be more likely to obtain meaningful and representative information from affiliated providers and families.

- **60% of networks report using data collection instruments that are culturally responsive.** Most of these networks (70%) have data instruments in languages that providers and families speak, including English (68%), Spanish (94%), and Chinese (9%; Mandarin and/or Cantonese).

Engagement of providers in network data collection and analysis may help a network improve service delivery effectiveness (Figure I.2).

Beyond internal data collection efforts, networks may partner with external entities to conduct formal evaluation.

- **30% of networks have engaged in an external evaluation in the past 5 years (Table I.2).**

61% of networks engage providers in data collection, but only 39% share findings back with providers, and even fewer include providers in review of data collection and analysis protocols and procedures.

Figure I.2. Provider engagement in data collection and analysis activities (n=57)

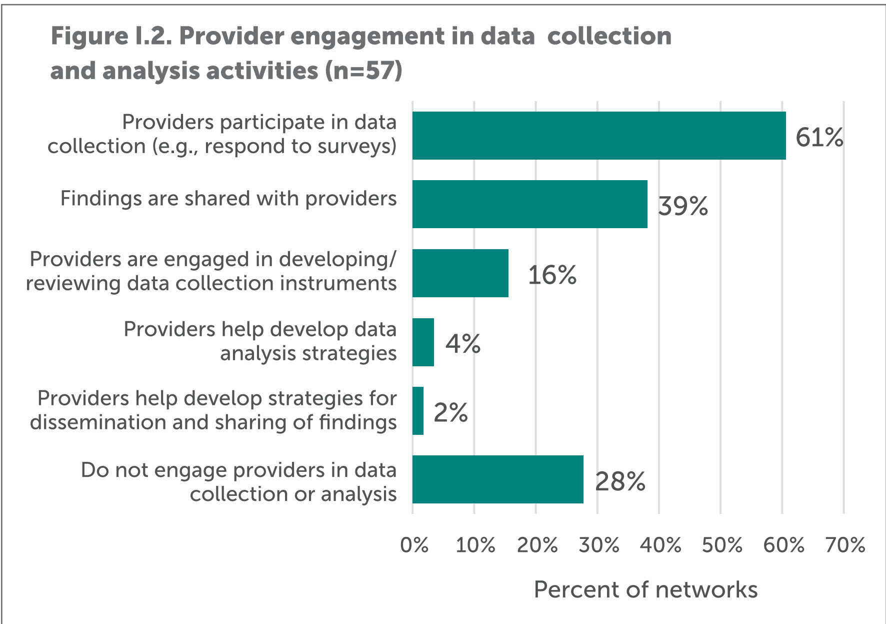


Table I.2. Evaluation strategies (n=18)*

		N	%
Purpose of evaluation	To identify if the network model is connected to positive HBCC provider outcomes	13	72%
	To refine/modify service delivery implementation that was articulated in the theory of change model	9	50%
	To identify if the network model is connected to positive outcomes for children and families who use HBCC	9	50%
	Funder-required review/evaluation	2	11%
Feedback from	HBCC providers affiliated with the network	11	61%
	Families who use HBCC providers affiliated with the network	6	33%
	Network staff	15	83%
	External stakeholders (e.g., community partners, funders)	11	61%
Dissemination Strategies	Press conferences/releases	1	6%
	Presentations to families and HBCC providers at the network	3	17%
	Presentation to policymakers	3	17%
	Presentations to other community groups	4	22%
	Findings published on network website	3	17%
	Only shared with funders	2	11%
	Evaluation is still in process	3	17%
	Did not disseminate evaluation results to stakeholders in the community	5	28%

*Out of all networks that report engaging in an external evaluation.

Benchmark J—Staffing

The network uses intentional staffing strategies to support providers.

Staffing considerations are key to how networks deliver services and supports to providers. Three networks report that they do not have paid staff and rely on volunteers to carry out the goals of the network.[h]

For networks that hire paid staff to work with providers, familiarity with HBCC as well as knowledge and skills related to working with children and adults are relevant qualifications to consider. Table J.1 indicates that most networks in our sample have staff members who are knowledgeable about early childhood and child development and who have prior experience working with adults and with HBCC settings.

- **79% of network staff have prior HBCC experience.**

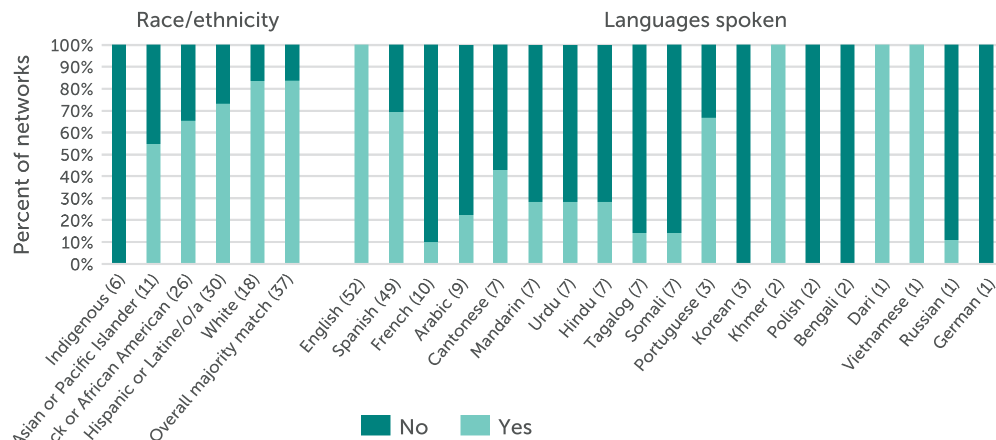
Hiring staff members who match the cultural, ethnic, and linguistic backgrounds of providers they serve may also increase the effectiveness of support.[9]

- **Of the 37 networks that report race/ethnicity data for both staff and providers, 84% have a match between the majority of providers and most of the staff.**
- **Of the networks that work with Spanish-speaking providers, 69% have staff members who speak Spanish.** For many other language groups, there is less consistency in network staff who share a common language with providers (Figure J.1).[i]

Table J.1. Staff qualifications and experience

		N	%
College-level coursework (n=55)	Early childhood education	51	93%
	Child development	45	84%
	Social work/social services	26	47%
	Psychology	21	38%
	Administration/business	20	36%
	Nursing	2	4%
	Current network staff members do not have college-level coursework	1	2%
Prior experience (n=56)	Training in child development and/or early care and education	50	89%
	Skills and/or experience working with adults	43	77%
	Direct knowledge of HBCC (e.g., previous experience)	44	79%
	Center-based child care experience	3	5%
	No specific qualifications required for staff	1	2%

Figure J.1. Networks that have staff members withthe same racial, ethnic, or linguistic background as providers

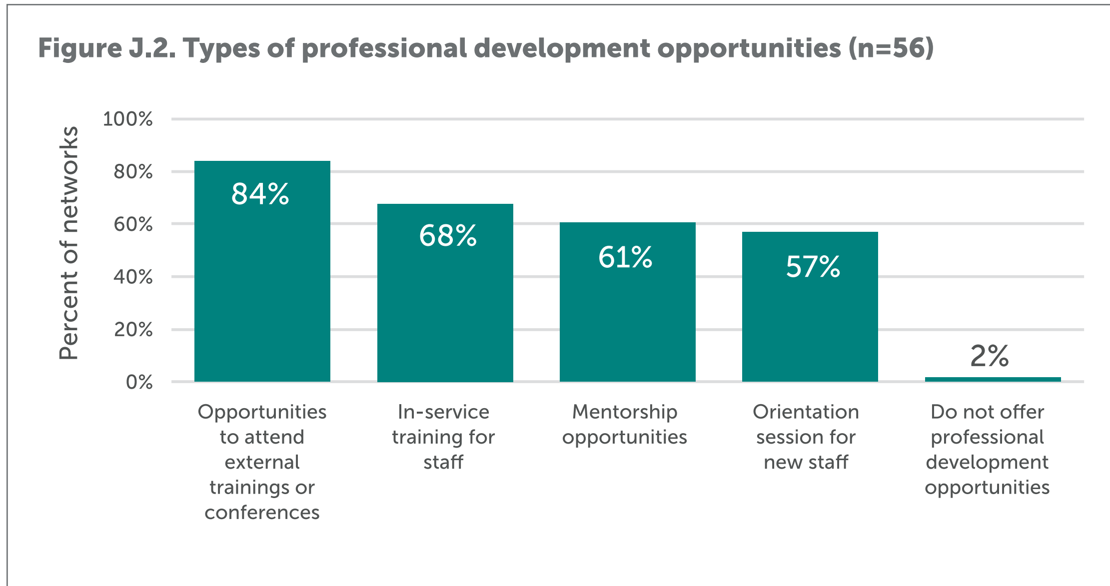


h The survey did not ask this question; this is an estimate based on write-in responses.

i The (n)s in Figure J.1. indicate the total number of networks who serve providers with that racial, ethnic, or linguistic background (out of the networks who reported both staff and provider data). For example, there are 6 networks that serve indigenous providers, 0% of those networks have indigenous staff. For overall majority, we compared the background of the majority of providers with the majority of staff at the network. For example, if a majority of both providers and staff at a network are Black or African American we counted that as a match. Networks do not have a match if a majority of staff are white and a majority of providers do not identify as white.

Nearly all networks (98%) offer staff opportunities for professional development (Figure J.2). Most networks report sending staff to external conferences or trainings. Many also offer in-service training or mentoring opportunities.

Figure J.2. Types of professional development opportunities (n=56)



The most commonly reported topic for in-service staff training is cultural competency and responsiveness. More than half of networks also report offering staff training on topics specific to HBCC settings, such as child care home environments, child development across age groups, and managing a child care business (Table J.2).

Networks with paid staff offer many opportunities for reflection on their work with providers, including group and

Table J.2. Staff in-service training topics covered in the past 12 months (n=36)*

	N	%
Cultural competency and responsiveness	28	78%
Child care home environments	25	69%
ECE system regulations/requirements	25	69%
Child development across domains/age span	24	67%
Curriculum	23	64%
Stress management	22	61%
Partnerships with families	22	61%
Observation and assessment	22	61%
Team building	22	61%
Managing a child care business	20	56%
Inclusion and working with children with disabilities	19	53%
Anti-bias and anti-racist service delivery approaches	17	47%
Relationship-based support	13	36%
Adult learning styles	13	36%
Working with dual-language learners	14	39%
Unique features of HBCC	11	31%
Conflict resolution	10	28%

*Out of all networks that have offered in-service training in the past 12 months; two missing responses.

individual supervision. Most networks also help staff establish clear professional boundaries in their work with providers.

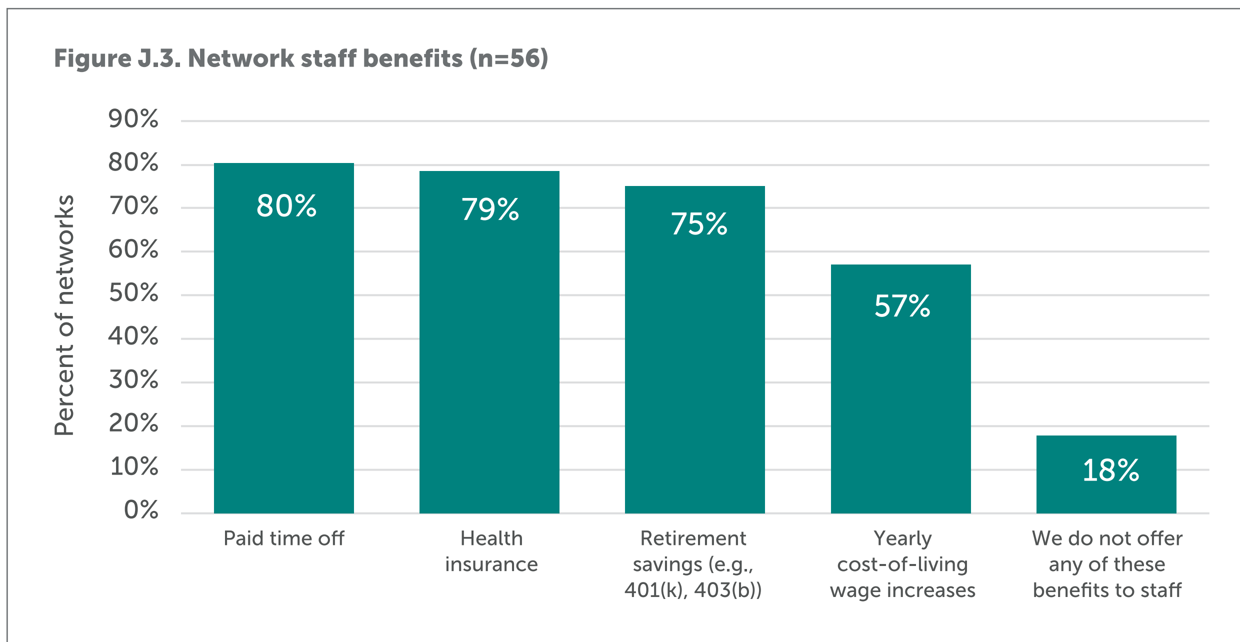
- **40% of networks report having an articulated career ladder for network staff with aligned increases in compensation**

Table J.3. Staff supervision and setting professional boundaries

		N	%
Staff supervision (n=54)	Opportunities to engage in reflection with their supervisor and/or other staff about their own beliefs, values, experiences, and biases related to HBCC	39	72%
	Opportunities for group supervision (e.g., team meeting where staff members get feedback) at least once a month	38	70%
	Monthly one-on-one supervision around their work with HBCC providers	35	65%
	Weekly one-on-one supervision around their work with HBCC providers	27	50%
Professional boundaries (n=56)	Help staff establish clear expectations about work hours and availability	42	75%
	Do not expect staff to use personal accounts (e.g., email, WhatsApp) for communication with providers	37	66%
	Provide staff with mobile work phones so they do not have to use their personal devices	26	46%
	Do not help staff set professional boundaries	4	7%

The majority of networks provide benefits to their staff, with most offering paid time off, health insurance, and retirement savings. Close to one fifth of networks do not offer any job benefits to staff (Figure J.3).

Figure J.3. Network staff benefits (n=56)



Benchmark K—Recruitment

The network uses recruitment strategies that result in ongoing provider participation.

Recruitment and engagement strategies may influence provider participation in the network as well as in network services. The majority of networks (85%) report actively trying to recruit more HBCC providers.[j] Figure K.1 shows the most commonly reported recruitment strategies, which include word-of-mouth, peer-to-peer, and personal outreach.

Figure K.1. Recruitment strategies (n=52)

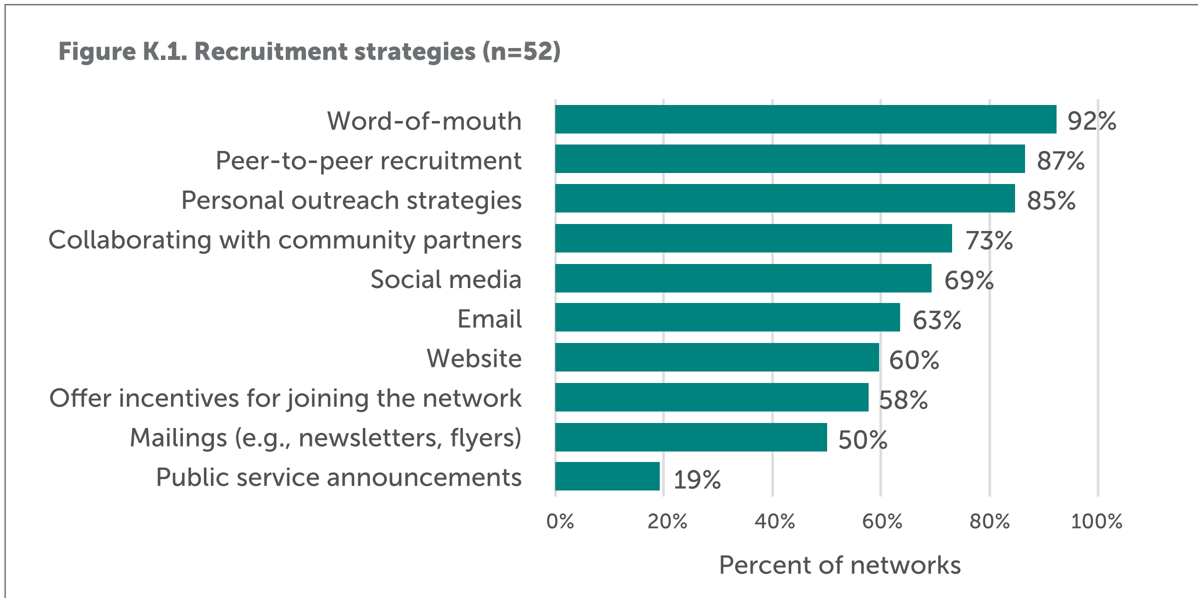


Table K.1. Community partners (n=38)*

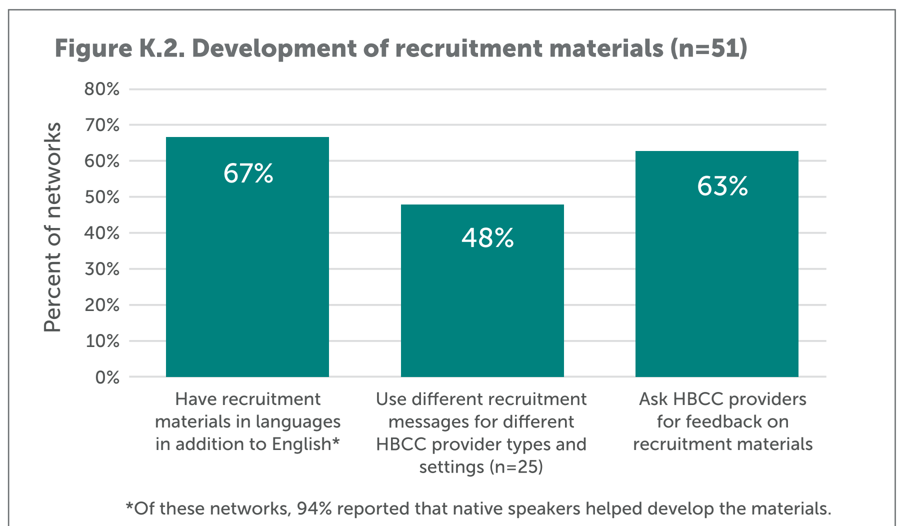
	N	%
Child care resource and referral agencies	24	63%
FCC associations	19	50%
Parent groups	15	39%
Schools	13	34%
Head Start programs	13	34%
Center-based preschools	12	32%
Unions	3	8%

*Out of all networks that report collaborating with community partners.

Seventy-three percent of networks report collaborating with community partners (often other types of networks) to recruit providers. The most common community partners that networks report collaborating with included child care resource and referral agencies and FCC associations (Table K.1).

Networks differentiate strategies for developing recruitment materials, such as translation of materials by native speakers and recruitment messages for different types of providers (Figure K.2). Networks report engaging current providers in recruitment efforts.

Figure K.2. Development of recruitment materials (n=51)



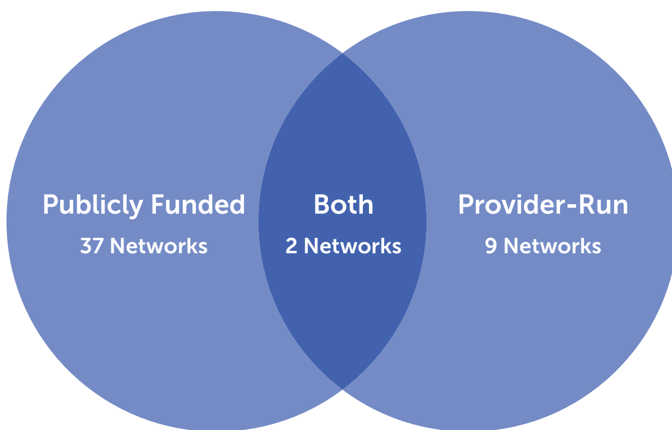
*Of these networks, 94% reported that native speakers helped develop the materials.

j Questions about recruitment strategies were only asked of the 52 networks that reported actively recruiting HBCC providers.

Differences Across Network Subgroups

Bivariate analyses suggest differences in network practices across subgroups of networks.[k] In particular, we found statistically significant differences between publicly funded networks and those that do not receive public funding, as well as differences between provider-run networks and networks that are not provider-run. Two-tailed Fisher's exact tests were used to analyze differences between these network subgroups. These were separate analyses: provider-run and publicly funded networks are not mutually exclusive categories (see Figure 7).

Figure 7. Subgroup analysis overlap



Publicly Funded Networks

Most publicly funded networks in our sample receive funding from state contracts, with fewer receiving local funding such as public PreK, or federal funding for Head Start or the Child and Adult Care Food Program (See Table 1 in the Sample Description section). Public funding accounts for between 8% and 100% of total funding, with an average of 69%.

Public funding may require or allow networks to offer more services to providers, children, and families and to use intentional implementation strategies.

Publicly funded networks are more likely than networks that are not publicly funded to offer services to promote provider economic well-being and sustainability, positive child and family outcomes, and holistic services for children and families, including developmental screenings for children. These networks are also more likely than other networks to use home visits as a strategy.

Publicly funded networks are also more likely to use evidence-based implementation strategies around service delivery than networks without public funding. For example, publicly funded networks report using an intentional approach to data collection that informs service delivery and intentional staffing strategies to support providers.

Publicly funded networks are also more likely to have staff with college-level education and to offer staff benefits compared with networks that do not receive public funding.

Provider-Run Networks

Eighteen percent of networks in the sample are provider-run. Provider-run networks were more likely to report receiving funding from provider dues or fees than networks that are not provider-run This type of funding source accounted for between 0% and 100% of total funding with an average of 45% for this type of network.

Provider-run networks are more likely to include providers as equal decision-making partners in governance, operations, and service delivery.

Provider-run networks are more likely than networks that are not provider-run to have a mission statement focused on supporting HBCC. They are also more likely to support provider advocacy by enhancing provider skills in organizing and implementing meetings and more likely to offer experienced providers opportunities to be mentors to newer providers at the network.

Provider-run networks are more likely to be funded by provider dues and fees and less likely to receive public funding. Funding from provider dues and fees may limit network capacity to hire staff as well as to offer a wide range of services and supports for providers. In addition, provider-run networks may be grassroot organizations that have developed organically and lack traditional funding and staffing infrastructure.

k We did not analyze differences between networks by the type of provider served—whether they served FCC or FFN providers.Nearly all the networks in this sample serve licensed, certified, or registered FCC providers, and approximately half serve legally exempt FFN providers, but the data do not enable us to distinguish between fundamental values, services, and implementation strategies for FFN providers versus FCC providers. Only three networks serve FFN providers exclusively, a sample size that is not sufficient for cross-tabulation.

Summary

Why Benchmarks

The why benchmarks represent the "fundamental values and goals of a network:" organizational culture, providers as equal partners, and equity. Our findings suggest that most networks demonstrate strengths in engaging providers in decision making and governance, promoting inclusion of HBCC in public ECE systems, and consideration of equity issues. Many networks also offer experienced providers opportunities to mentor newer providers as well as offer all providers opportunities to engage in advocacy work.

Networks may have challenges with several aspects of the why benchmarks. Most networks have not developed mission statements with a specific focus on HBCC, nor are many fully transparent about network operations, specifically network revenues, administrative costs, and staff salaries. In addition, most networks report that they lack full funding to deliver desired services, and many struggle with meeting the language needs beyond English and Spanish of all the providers they serve. Furthermore, few networks have invested resources in examining how bias may influence service delivery.

What Benchmarks

The what benchmarks describe network services that focus on goals for providers, children, and families in HBCC settings, including provider well-being, HBCC quality, economic sustainability, and access to holistic services and resources for families and children. Networks in our sample offer many of the services identified in these benchmarks, but the comprehensiveness of the services varies. For example, we found that most networks support provider well-being and attachment to the workforce, but fewer offer opportunities for providers to advance their professional careers by serving as paid staff or trainers at the network. Similarly, many networks provide technical assistance with provider economic well-being and sustainability by offering training on business management or offering support with licensing, subsidy, and QRIS. Fewer help providers access benefits or direct financial supports or provide access to the Child Care and Adult Food Program, publicly funded PreK, or Head Start, which may provide opportunities for increased income.

In addition, while most networks provide technical assistance to enhance provider practices with children, fewer help providers engage in data-informed quality improvement processes. Networks also recognize the important roles that providers play in family support. Many refer children and families to comprehensive services, and many offer developmental screenings for children enrolled in HBCC settings. Yet fewer networks deliver direct services and resources for families and children, and few help families follow up on referrals.

How Benchmarks

The how benchmarks describe evidence-based implementation strategies, including a focus on relationship-based approaches, data collection for improvement and evaluation, intentional staffing, and provider recruitment strategies. Our findings suggest network strengths in several of these benchmarks. Many networks report strong staff–provider relationships and relationship-based support, as well as tailoring services for HBCC providers by offering evening, weekend, and online options. Yet we found that intensity and duration of service delivery may not be deep enough to influence provider, child, or family outcomes.

Our findings indicate that intentional and collaborative data collection and use may be a particular challenge for networks. Less than half report having a theory of change or logic model, an essential foundation for specifying provider, child, and family outcomes and the pathways that will lead to them.[10] Few networks collect data on these outcomes, limiting their capacity to understand their effects on providers, children, and families beyond participation in and satisfaction with services. In addition, few networks have engaged providers in their data collection plans, and few engage in formal evaluations that would contribute to the knowledge base about networks as a promising strategy for supporting HBCC providers.

Regarding the benchmarks on staffing and provider recruitment, our findings indicate that networks hire staff with prior HBCC experience, relevant qualifications, and a racial and/or linguistic match with affiliated providers, and they offer a range of staff training opportunities with a strong focus on cultural competency. Networks also report using various recruitment strategies for new providers that could reach a wide variety of providers, including providers who speak languages other than English and providers who may be exempt from licensing. Yet fewer networks offer career pathways for network staff as opportunities to increase compensation. Many networks do not gather information on the circumstances and experiences of affiliated providers that could enhance staff–provider relationships and service delivery effectiveness. Moreover, few networks offer incentives such as child care or transportation to help providers participate fully in network activities.

Discussion

This study represents the first effort to understand how HBCC networks address the benchmarks and indicators for high-quality networks.[11] Findings reveal insights into networks' organizational culture and values, the kinds of services that networks offer, and the ways networks implement these services. New information suggests that networks may offer a promising strategy for supporting HBCC providers across settings, communities, and backgrounds. Networks, especially those that are provider-run, recognize the importance of incorporating providers' voices into network operations by offering opportunities for providers to be equal partners in network decision making and governance. In addition, findings suggest that many networks are attuned to equity issues. This is evidenced by the numbers of networks that prioritize serving providers from historically marginalized communities by offering services in the preferred languages of providers, hiring staff who reflect the cultural and linguistic backgrounds of providers, and focusing training for staff and providers on cultural responsiveness.

In addition, study findings indicate that receipt of federal, state, or local public funding builds capacity of networks to offer and implement a wide array of services and supports. Compared with networks without public funding sources, networks with public funding are more likely to offer services focused on provider economic well-being, comprehensive services for children and families, and services related to supporting positive child and family outcomes. Public funding also contributes to staffing capacity through implementation of required staff qualifications and training, as well as support for staff compensation and benefits. In addition, funding from public sources may enhance networks' data collection efforts because state, federal, and local funding entities may require accountability for service delivery.

Recommendations for Developing and Enhancing High-Quality Networks

Our findings point to recommendations for how to support network implementation of high-quality practices described in the benchmarks and indicators. These recommendations focus on the areas of the benchmarks where survey findings suggest there is room for improvement.

Recommendations Focused on the Why Benchmarks

HBCC networks have an opportunity to contribute to and drive public messaging about HBCC as a public good that contributes to children's and families' long-term well-being as well as a connective tissue that contributes to community economic stability. Networks can play a key role in redressing the marginalization of HBCC in policy and program discussions by heightening awareness of the critical role of HBCC in creating a comprehensive and equitable vision of high-quality, accessible, and affordable child care. Networks that are intentional about highlighting the strengths of HBCC and the equitable inclusion of HBCC across ECE systems and policies may be more likely to meet the needs of providers, families, and children in these settings.

Increase intentionality of commitment to HBCC within networks.

- Create mission statements focused on the importance of the HBCC sector for children, families, and communities.
- Create network procedures and policies that are fully transparent to affiliated providers.
- Engage providers as decision makers and equal partners in network operations.

Advocate to increase the availability of sustained public funding for HBCC and for supportive infrastructure.

- Advocate for inclusion of HBCC in systems such as public PreK, Head Start and Early Head Start, and the federal Child and Adult Care Food Program, all of which offer opportunities for higher compensation and professional development.[12]
- Collaborate with other organizations to increase recognition and investment in the HBCC sector.

Enhance efforts focused on equitable approaches to network service delivery.

- Conduct an equity audit that examines bias across network service delivery areas.
- Seek funding to serve all providers in their preferred languages, including those who speak languages other than English and Spanish.

Recommendations Focused on the What Benchmarks

HBCC networks have an opportunity to offer supports and services that are aligned with specific provider outcomes. A focus on improving provider psychological and economic outcomes as well as quality caregiving practices has the potential to contribute to positive child, family, and community outcomes.

Deepen the focus on network services that may increase provider professional and economic well-being and sustainability.

- Increase opportunities for HBCC provider career and professional advancement by hiring providers as staff, trainers, peer group facilitators, consultants, and mentors.
- Provide access to direct financial assistance and support.
  - Increase access to public relief funds and other public sources of cash assistance.
  - Offer mini-grants, microloans, materials, and equipment that help providers offset system requirement costs, program enhancements, and emergency costs that may interrupt their businesses.
- Offer providers access to benefits and increased compensation.
  - Connect providers to Affordable Care Act health benefits through the Health Insurance Marketplace.
  - Seek state and local funding to offer stipends to offset the costs of health insurance.
  - Offer grants for providers to contribute to retirement plans.
  - Fund substitutes to enable providers to take time off.
- Offer access to direct financial resources beyond business training and coaching.
  - Facilitate access to economic resources, grants, and public funding.
  - Offer financial planning assistance to help providers reduce debt, set aside savings to obtain benefits, and plan for future goals such as homeownership and college education.
  - Offer technical assistance to help choose accountants, tax experts, and financial planners who can meet providers' needs.
  - Increase providers' direct access to experts who have experience with child care businesses.

Strengthen network services that contribute to positive child and family outcomes.

- Deepen network services that give providers tools to engage in their own continuous quality improvement.
- Expand training and support for providers conducting developmental screening and assessment of children or conduct developmental screenings for children in HBCC settings.
- Expand supports for providers sharing child data and communicating with families.
- Expand holistic services for families and children beyond those offered by providers, including direct services and referrals for infant and early childhood mental health, family counseling, and health and nutrition consultation.
- Institute systematic follow-up processes and procedures to ensure that families gain access to the services they want and need.

Recommendations Focused on the How Benchmarks

Networks use training workshops, visits to providers' homes, and peer support to deliver services to providers. Yet, we found that many networks use a light-touch approach that lacks the intensity and duration that may be necessary for long-term change. Networks can improve the responsiveness and effectiveness of support by using data, theory of change models that align inputs to intended outcomes, and engagement of providers and staff in quality improvement efforts.

Enhance the use of evidence-based service delivery strategies.

- Connect training to individualized supports such as home visiting and coaching that help providers translate learning into practice.
- Increase the dosage and intensity of service delivery.
- Increase opportunities for peer support learning and sharing.

Sharpen network focus on identifying and measuring outcomes for providers, children, and families.

- Collect data on experiences and circumstances of providers that can inform service delivery and recruitment of new providers to the network.
- Develop theory of change or logic models to align service delivery with relevant outcomes.
- Engage providers in data collection, analysis, and dissemination of findings to guide services.
- Collaborate with external partners to conduct evaluations that document network effectiveness.

Conclusion

This report presents the results of the first national survey of HBCC networks based on a new framework for defining high-quality networks. Findings suggest that the framework's standards, which are articulated in 11 benchmarks and indicators, have promise for capturing network strengths. Findings point to how networks support providers, families, and children as well as areas for growth. The report also points to the need for a deeper examination of differences across subgroups of networks, such as those serving FFN providers, in future research with larger, more representative samples. Future research may also build on these findings to consider associations between how networks implement specific benchmarks and aligned provider, child, and family outcomes.

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