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Staffed Family Child Care Networks:
A Research-Informed Strategy for Supporting High-Quality Family Child Care

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Executive Summary

Family child care[1] (FCC)—non-parental child care provided within a caregiver's home—is a critical component of the national child care system. Nationally, about one in four children (24 percent) receiving child care funded by the Child Care and Development Fund (CCDF) program are cared for in FCC settings. Families choose FCC for a variety of reasons (Bromer & Henly, 2004; Chaudry et al., 2011; Gordon, Colaner, Usdansky, & Melgar, 2013; NSECE, 2014; Porter et al., 2010) including the following:

♦ flexible hours, which are especially important given many families' nontraditional work schedules;

♦ location, which is neighborhood-based, thus eliminating transportation barriers;

♦ mixed-age groups, allowing siblings to be cared for together;

♦ generally lower cost; and

♦ an intimate, home-like setting that is often compatible with the cultural and linguistic preferences of children and families.

The quality of family child care, however, is often reported to be low, especially for providers serving children from low-income families as well as dual language learners (Gordon et al., 2013; Helburn, Morris, & Modigliani, 2002; Kontos, Howes, Shinn, & Galinsky, 1995; Raikes, Raikes, & Wilcox, 2005). Because children from low-income families and children who are dual language learners tend to benefit even more from high-quality early care and education experiences than do their more advantaged peers, improving the quality of care in family child care homes is imperative for their healthy development and well-being. Given the growing recognition of FCC as a significant sector of the early care and education field, there is a need for understanding effective quality improvement approaches that engage and sustain provider participation in regulatory systems and quality improvement initiatives.

Research has identified predictors of quality in FCC, which include licensing, professional support, training, financial resources, and provider experience (Forry et al., 2013; Raikes et al., 2013). Staffed FCC networks providing an ongoing menu of supports related to these predictors—offered in local communities, provided in multiple languages where needed, and led by culturally competent trainers and coaches with specialized training in FCC—are a promising strategy for States and local communities seeking to build the supply of high-quality FCC.

Peer support, including opportunities to socialize, build relationships, and solve problems together, is important as FCC can be isolating. FCC providers may have limited access to information, training, and resources on quality child care or quality improvement opportunities. They may also find it difficult to attend offsite training during the day when they are providing care to children with little or no backup staffing support. Some are English language learners who may face barriers accessing content in their primary languages. Therefore, promising strategies include offering group trainings on evenings and weekends, delivering content in multiple languages, and including opportunities for peer-to-peer networking and relationship-building.

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[1] The term "family child care" refers to all care offered in a provider's home. The term can also be used to refer to licensed care specifically. "Family, friend, and neighbor care" is used to refer to unlicensed care arrangements.

FCC providers need support to address their barriers and meet new licensing and higher quality standards. These supports, together with payment rates sufficient to support quality, can ensure that families receiving CCDF program funds continue to have access to the full range of child care settings. CCDF grantees can support quality FCC through multiple strategies, such as funding staffed FCC networks or contracting directly with networks for high-quality child care slots. Grantees can also consider using tiered reimbursement rates for providers who participate in networks as well as for providers who serve special populations of children (infants and toddlers or children with special needs) or offer non-traditional hours of care (Office of Child Care, 2016).

This brief is the first in a series of resources designed to provide research-based evidence and best practices for supporting FCC providers, and improving the availability and sustainability of FCC in States, Territories, and Tribes. CCDF administrators, community child care partners (such as child care resource and referral agencies, colleges, and universities), Early Head Start–Child Care partnerships, child care associations, and policymakers may find this information useful as they make decisions about how to best support FCC providers.

Introduction

In 2014, the Child Care and Development Block Grant (CCDBG), the primary source of federal funding for child care subsidies for low-income families, was reauthorized for the first time since its inception nearly 20 years ago. The reauthorization included new regulations intended to protect children's health and safety in child care settings and to improve child care quality. These regulations include training on 11 health and safety topics, annual monitoring inspections, and comprehensive background checks for any adults older than 18 who may have contact with children in the child care setting (Office of Child Care, 2016). The CCDBG Act requires that even if a child care provider that is otherwise exempt from licensing by the Lead Agency provides services to a child receiving CCDF assistance, that child care provider is subject to health and safety requirements in the CCDF law. The only exception to this requirement is for providers who are caring only for their own relatives.

The federal Office of Child Care (OCC) has endorsed family child care networks as a strategy to help home-based providers meet the new regulations and improve quality (Office of Child Care, 2015). Family child care networks are community-based programs that have paid staff who offer a menu of ongoing services and supports to affiliated providers (Bromer, vanHaitsma, Daley, & Modigliani, 2009). Network services typically include some combination of visits to providers' homes to offer technical assistance, coaching or consultation; training workshops and peer networking opportunities; warm lines through which providers can obtain answers to their questions; business and administrative support; and materials and equipment. Following OCC's lead, at least 12 States indicated that they intend to develop or expand family child care networks in their 2016–2018 Child Care and Development Fund (CCDF) Plans (Ramsburg, 2016).

While family child care networks exist in many communities across the country, policymakers and program administrators may lack information about the components that can contribute to their effectiveness. This brief provides guidance, based on research, about the elements that are essential for family child care networks' potential to make a difference for providers. The brief concludes with a discussion of future policy and program directions.

Background

U.S. Census data indicate that nearly half (44 percent) of all children younger than 5 years in the United States whose mothers are working spend regular time with providers who offer care in their own homes. Most of these children are cared for by their grandparents. Yet 13 percent are in regulated family child care and other non-relative arrangements such as friends and neighbors (Laughlin, 2013). The vast majority of home-based providers care for children younger than 5 years and are more likely to care for infants and toddlers than center-based programs (NSECE, 2016). While the proportions of White, Black, and Hispanic children in home-based child care are approximately the same, Hispanic children are less likely to be in regulated family child care arrangements than White or Black children (Crosby, Mendez, Guzman, & Lopez, 2016).

The 2012 National Survey of Early Care and Education (NSCEC), the first nationally representative survey of early care and education since the 1990s, used a set of four surveys, including a household survey and surveys of home-based providers, center-based providers, and the center-based early care and education workforce. Results also confirm that home-based child care is the most prevalent child care arrangement for young children. The approximately 4 million home-based providers were almost quadruple the number of center-based child care staff (NSECE, 2013). Home-based child care is a term commonly used in research to distinguish center-based care from home-based care; however, for purposes of this brief, home-based care equates with family child care.

NSECE groups home-based providers into three broad categories:

♦ *Listed providers*: Regulated providers and license-exempt providers (those who are legally exempt from regulation) who are included in state or local licensing lists or other databases.

♦ *Unlisted paid providers*: Those who are not included in any formal kind of listing, receive payment for at least one child, and were identified through the household survey.

♦ *Unlisted unpaid providers*: Those identified through the household survey and who may be family and friends who provide care in their own homes or the children's homes free of charge (NSECE, 2016).

Approximately 27 percent of all home-based providers are paid to provide care. Listed providers, most likely family child care providers, account for approximately 11 percent of the total number of paid providers (NSECE, 2016).

A recent analysis of the NSECE household survey finds that there is some variation in families' perceptions about these arrangements. For example, a smaller proportion of Hispanic families rated the flexibility of nonrelative home-based child care favorably compared to Black families. A significantly lower proportion of Hispanic families perceived these arrangements as safe, compared to White and Black families (Guzman, Hickman, Turner, & Gennetian, 2016).

Family Child Care Networks: A Brief Overview

Family child care networks exist in many States and localities (Hamm, Gault, & Jones-DeWeever, 2005; Hershfield, Moeller, Cohen, & The Mills Consulting Group, 2005; Larner, 1994; Larner & Chaudry, 1993; Musick, 1996). The terms hubs, satellites, or systems are often used interchangeably with the term networks; but, they all have one thing in common, they deliver a menu of services to both regulated family child care providers as well as home-based providers seeking to become licensed or registered, depending on specific state requirements.

Network Auspices

- Community-based organizations (All Our Kin, New Haven, CT; Infant-Toddler Family Day Care, Virginia)
- State- or city-wide initiatives (Massachusetts Family Child Care Systems; New York City EarlyLearn Networks)
- Child care resource and referral agencies (Focused Family Child Care Networks in Oregon)
- Social service and family support agencies
- Universities (Family Child Care Partnerships, Auburn University, Alabama)
- Early Head Start/Head Start initiatives that partner with family child care
- Shared services initiatives

Networks offer providers opportunities to develop a continuing long-term professional relationship with a network coordinator or family child care specialist and a place to connect with other providers. These opportunities improve child care quality by reducing the isolation that many family child care providers experience (Hamm et al., 2005; Hershfield et al., 2005; Musick, 1996). Networks support providers at different stages of their career trajectory. For example, networks help new providers with licensing assistance or start-up equipment. Networks help more experienced providers with specific support for improving their practice, obtaining professional development, or attaining national accreditation.

Networks also serve as vehicles for development and infrastructure building in low-income communities (Gilman, 2001; Marshall et al., 2003; Meyer, Smith, Porter, & Cardenas, 2003). Providers who affiliate with networks or systems tend to serve predominantly low-income families. Networks are often housed in community-based organizations where they can readily connect providers and the families they serve to resources; and, they can increase community awareness and recognition of family child care as an important neighborhood service for families with young children.

There is limited quantitative research on family child care networks, but a handful of descriptive studies exists pointing to the benefits of network participation for family child care providers. The Family Child Care Network Impact Study (Bromer et al., 2009) examined the relationship of network affiliation and quality caregiving among a sample of mostly Black and Hispanic licensed family child care providers participating in 35 different networks in the city of Chicago. The study found that providers who were affiliated with staffed networks that delivered a combination of ongoing support services were more likely to offer higher quality care than unaffiliated providers. More recently, an evaluation of the All Our Kin (AOK) Family Child Care Network in Connecticut also found that affiliated network providers, more than 82 percent of whom were women of color, offered higher quality care than a comparison group of unaffiliated providers, of whom two-thirds were women of color. The AOK network offers a combination of intensive visits to provider programs as well as group supports, training, and materials (Porter & Reiman, 2015).

Essential Elements of Effective Family Child Care Networks

Studies of initiatives to improve family child care quality, and research in the related fields of home visiting and program implementation, point to elements to consider when developing or strengthening networks that support family child care providers. A recent literature review on the components of high-quality support to home-based child care suggests several program elements that may lead to positive outcomes, including an articulated theory of change model to guide network services, network service delivery strategies, staff-provider relationships, and staff training and support (Bromer & Korfmacher, 2016). These are crucial to consider for networks because they can affect provider participation, continued engagement, and satisfaction (Paulsell et al., 2010). Each element is described in subsequent sections of this brief (also see Table 1).

Table 1. Essential Elements of Staffed Family Child Care Networks

Theory of change model

♦ Articulated and realistic vision of how network services impact provider, child, family, and community outcomes.

Service delivery strategies

♦ Individual supports (visits to child care homes, coaching, consultation, warm lines) and group supports (training workshops, facilitated peer support groups)

♦ Content of support services is relevant to and customized for family child care homes and providers

Staff-provider relationships

♦ Staff-provider relationships are collaborative and foster mutual problem solving

♦ Staff recognize and respect provider cultures, values, and home environment

♦ Open communication and dialogue is used to engage providers

♦ Staff focus on enhancing the provider-child and provider-family relationship
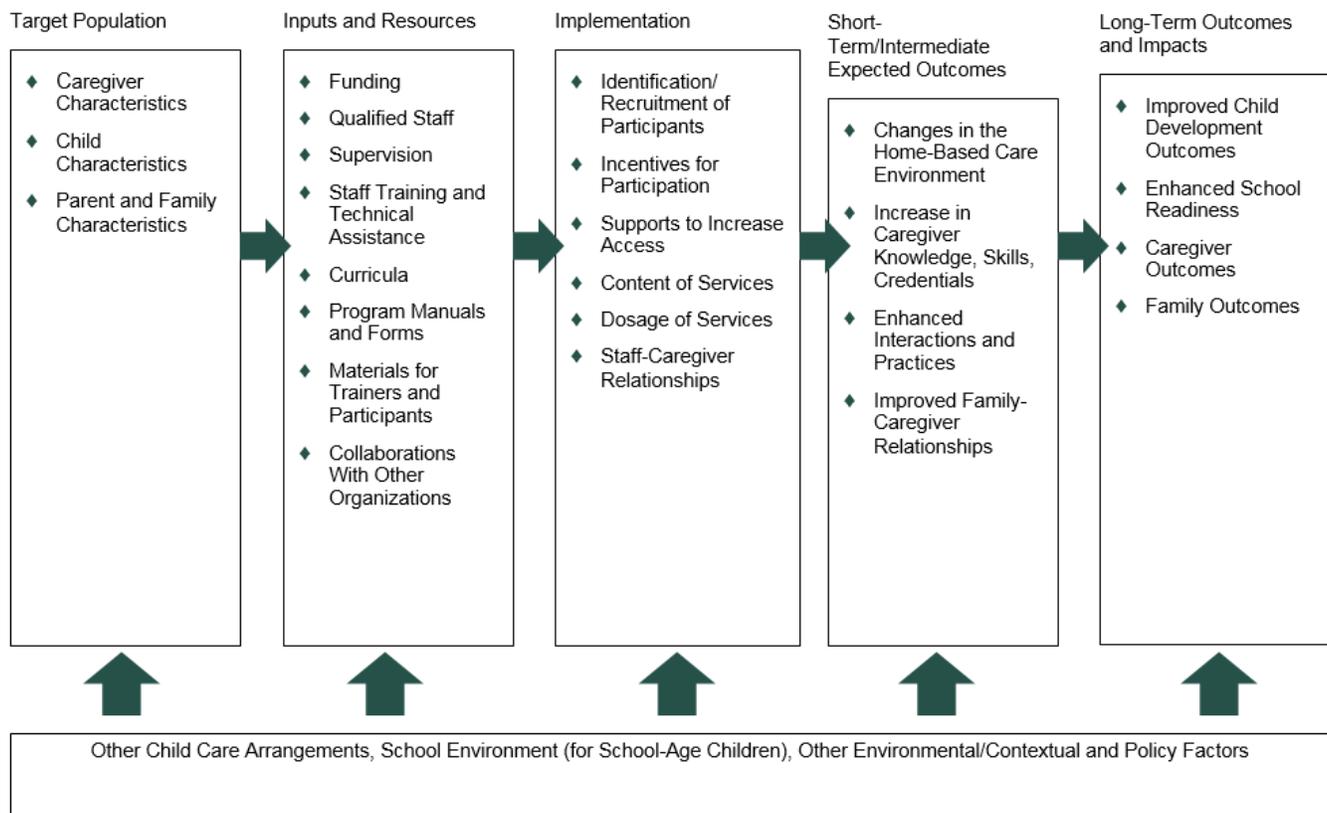
Staff training and support

♦ Staff receive specialized training in working with family child care providers and child development across the age range

♦ Staff have opportunities to engage in reflective supervision with supervisors as well as peer support with other network staff

Adapted from: Bromer, J. & Korfmacher, J. (2016). Providing high-quality support services to home-based child care: A conceptual model and literature review. Early Education and Development. Retrieved from: http://dx.doi.org/10.1080/10409289.2016.1256720

Theory of Change Models

Research suggests that a theory of change logic model is an essential element for designing, implementing, and evaluating initiatives to improve quality in home-based child care (see Figure 1). Unlike conceptual models that depict relationships among provider characteristics and potential outcomes and the pathways that influence these outcomes, theory of change logic models *specify* the long-term and intermediate outcomes the initiative aims to achieve, the target population that it intends to serve, and the strategies that will be used to reach these goals (Paulsell et al., 2010). Logic models are particularly important for family child care networks that wish to achieve different kinds of goals, depending on the population served.

Figure 1. Illustrative Logic Model for a Home-Based Care Initiative

Target Population	Inputs and Resources	Implementation	Short-Term/Intermediate Expected Outcomes	Long-Term Outcomes and Impacts
◆ Caregiver Characteristics ◆ Child Characteristics ◆ Parent and Family Characteristics	◆ Funding ◆ Qualified Staff ◆ Supervision ◆ Staff Training and Technical Assistance ◆ Curricula ◆ Program Manuals and Forms ◆ Materials for Trainers and Participants ◆ Collaborations With Other Organizations	◆ Identification/ Recruitment of Participants ◆ Incentives for Participation ◆ Supports to Increase Access ◆ Content of Services ◆ Dosage of Services ◆ Staff-Caregiver Relationships	◆ Changes in the Home-Based Care Environment ◆ Increase in Caregiver Knowledge, Skills, Credentials ◆ Enhanced Interactions and Practices ◆ Improved Family-Caregiver Relationships	◆ Improved Child Development Outcomes ◆ Enhanced School Readiness ◆ Caregiver Outcomes ◆ Family Outcomes

Other Child Care Arrangements, School Environment (for School-Age Children), Other Environmental/Contextual and Policy Factors

Adapted from: Paulsell, D., Porter, T., Kirby, G., Boller, K., Martin, E. S., Burwick, A., Ross, C., & Begnoche, C. (2010). *Supporting quality in home-based child care: Initiative design and evaluation options*. Princeton, NJ: Mathematica Policy Research, Inc. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/supporting_options.pdf

Outcomes

Family child care network theory of change logic models articulate long-term outcomes for providers, children and/or families, and organizations. Improving child outcomes, however, is often difficult, because it requires high thresholds of quality (Zaslow, Anderson, Redd, Wessel, Tarullo, & Burchinal, 2010). Family child care networks, like other quality improvement efforts, may choose to identify some aspect of improving provider quality that is associated with improved child outcomes as the long-term outcome instead.

Family child care networks can articulate different kinds of long-term and intermediate outcomes for their intended target populations (see Table 2). For example:

◆ Networks that serve **family, friend, and neighbor caregivers** can specify regulation that has been associated with quality for this type of care (Raikes, Raikes, & Wilcox, 2005) as a long-term provider outcome. In this case, the intermediate outcomes might be that homes are equipped to comply with regulatory requirements or have completed the regulatory process, including criminal background checks, health and safety inspections, and required paperwork.

◆ Networks that serve **newly regulated providers** as a target population can articulate a variety of long-term outcomes that research has associated with quality. These outcomes can include improved practice, an improved sense of professionalism, or increased social support (Burchinal, Howes, & Kontos, 2002; Forry et

al., 2013; Weaver, 2002). Intermediate outcomes that might precede these long-term outcomes are improved knowledge about how to create supportive environments and engage in positive interactions with a mixed-age group of children, enhanced provider confidence in their capacity to make a difference for children, and increased contact with other family child care providers and family child care network specialists.

♦ Networks that serve **experienced providers** can specify long-term outcomes that are appropriate for providers who have been doing this work for several years and have already demonstrated improved knowledge and some improved practices. These outcomes could include attainment of a professional credential or college degree in early childhood, high levels in a quality rating and improvement system (QRIS), or high-quality practices in a specific domain of child development. In these cases, intermediate outcomes might include enrollment or completion of credit-bearing courses toward a degree, improved practices related to QRIS standards or implementation of a professional development plan, or improved understanding of children's social-emotional development.

♦ Networks can also articulate long-term outcomes and intermediate outcomes for **families**, which research suggests are associated with strong and positive relationships with providers. Possible long-term outcomes might be improved family well-being or improved family-child relationships, both of which are related to positive child outcomes (Forry, Bromer, Chrisler, Rothenberg, Simkin, & Daneri, 2012). To achieve intermediate outcomes that lead to these goals, networks might focus on improved provider-family relationships in family child care programs, parental satisfaction with child care arrangements, or improved continuity of care.

Logic models for networks that identify all three provider populations (unregulated, newly regulated, and experienced providers) will require complex logic models that specify long-term outcomes and intermediate outcomes for each type of provider. Creating such logic models, like developing any logic model, will likely be an iterative process. The network will likely need to refine outcomes as it accumulates evidence from early implementation.

Table 2: Potential Outcomes for a Theory of Change Model for Family Child Care Networks

Caregiver outcomes	Family outcomes	Child outcomes
♦ Improved health and safety of the home ♦ Improved environment for supporting children's cognitive, language, social-emotional, and physical development ♦ Increased knowledge of child development ♦ Improved caregiving skills/practices ♦ Enhanced regulatory/quality rating status ♦ Improved access to community resources/government supports ♦ Increased income/Business sustainability ♦ Increased professionalism ♦ Increased formal educational status ♦ Improved relationships with families ♦ Improved satisfaction in caregiver/provider role ♦ Enhanced self-efficacy ♦ Improved access to social supports ♦ Reduced isolation ♦ Improved psychological well-being	♦ Increased satisfaction with child care arrangements ♦ Improved continuity of care ♦ Greater ability to balance work and family ♦ Reduced work absenteeism ♦ Improved relationship with caregiver ♦ Improved knowledge of child development ♦ Improved caregiving skills ♦ Improved family-child relationship ♦ Improved psychological well-being	♦ Reduced injuries and accidents in child care ♦ Improved health status ♦ Improved social-emotional development (social skills, self-regulation) ♦ Reduced behavior problems ♦ Improved language and literacy development ♦ Improved cognitive development ♦ Positive racial/ethnic socialization and identity

Adapted from: Paulsell, D., Porter, T., Kirby, G., Boller, K., Martin, E. S., Burwick, A., & Ross, C. (2010). *Supporting quality in home-based child care: Initiative design and evaluation options.* Princeton, NJ: Mathematica Policy Research, Inc. Retrieved from: http://www.acf.hhs.gov/sites/default/files/opre/supporting_options.pdf

Network Service Delivery Strategies

One of the central foci of a theory of change model is the service delivery strategies that will be used to achieve the anticipated intermediate and long-term outcomes. Like the choice of outcomes, the decision about service delivery strategies should be grounded in some evidence that suggests that the strategies can produce positive results as well as provider interest in this kind of support (Paulsell et al., 2010). In addition, networks should take into account the feasibility of implementing specific strategies; that is, the available resources such as staff and funding, the time it takes to achieve the intermediate outcomes, and the capacity to offer multiple services simultaneously.

Unlike quality improvement initiatives that may be time-limited or focused on only one mode of service delivery (e.g., a training series), networks have the capacity to offer combinations of linked services, such as workshops accompanied by coaching. Research suggests that this combined approach to service delivery is more effective than offering workshops alone (Moreno, Green, & Koehn, 2015; Ota & Austin, 2013). Networks can also build a continuum of services based on levels of intensity and formality of services, adding peer networking opportunities, connections to formal educational opportunities and community resources, and providing infrastructure supports such as materials and equipment and business development. The service delivery strategies are described in the next sections.

One-on-One Supports

Research suggests that one-on-one interactions between network staff and providers have the potential for improving quality and reducing isolation in family child care (Bromer & Korfmacher, 2016; Porter et al., 2010). These interactions can include visits to child care homes to offer technical assistance, coaching, consultation, or mentoring, or warm lines that providers can call to obtain answers to questions.

Preliminary research about the types of visits program staff conduct finds that most program visits do not conform to a research-based model. A descriptive study of 12 agencies serving diverse groups of providers found that a majority of visits to provider homes were used for compliance and administrative paperwork (Bromer & Korfmacher, 2016). Similarly, two recent reports on networks in New York City, which included interviews and focus groups with predominately Hispanic and Black providers, found that visits to child care homes that focused on monitoring and compliance took providers away from their interactions with children, reducing the potential for improvement in quality (Banghart & Porter, 2016; Hurley & Shen, 2016).

The frequency, intensity, and dosage of visits to child care homes will vary depending on network goals, funding and staff capacity, and provider needs and experiences. Frequent visits from network staff focused on caregiver-child interactions and promoting positive child development are more likely to result in higher provider quality than less frequent visits and visits that are focused on compliance or administrative tasks (Bromer et al., 2009). However, more research on the necessary thresholds for improving quality is needed.

One study of an initiative that used discussions about video-taped provider-child interactions in a series of six weekly visits with providers with low educational levels resulted in improved environmental quality and improved attitudes toward sensitive caregiving (Groenveld, Vermeer, vanIJzendoorn, & Linting, 2011). Other studies suggest that visits over a longer period and with different levels of intensity can also achieve positive provider outcomes. For example, a random assignment evaluation of a coaching initiative with a sample of mostly White, monolingual English speaking providers and consultants, found that an average of 16 visits over 6 to 12 months had a greater effect on provider quality than an average of 7 visits (Bryant et al., 2009). Another random assignment evaluation of an initiative that used the family child care version of the Parents as Teachers home visiting curriculum with a sample of mostly Black providers found higher quality among providers who had received 2-hour bi-weekly visits for 6 to 9 months compared to the control group (McCabe & Cochran, 2008). No studies have examined similar in-home coaching or home visiting interventions with populations of providers who are non-English speakers. In fact, some English is often a prerequisite to participating in program interventions.

Neither the network literature nor literature from other fields provides much guidance on caseload size for network staff. While a caseload of 10 to 12 providers is often used as a standard (because Early Head Start uses this number for home visits to families), the ratio of providers to network staff may vary depending on the objective of the visits, the intended intensity, and the conditions under which the visits will be made. Network staff who offer visits as technical assistance to help providers become regulated, for example, may be able to manage high caseloads because they may be able to serve more providers with fewer visits. By contrast, network staff who offer coaching, consultation, or mentoring may only be able to manage a small caseload given the length of visits and their frequency. Similarly, staff who serve providers in a densely-populated area may be able to make more visits during a weekly period than those in rural areas who may have to travel long distances to reach providers. Safety in the community may be another factor: staff may need to travel in pairs to visit providers in neighborhoods where their safety is in jeopardy, thus reducing their caseload capacity.

Training and Peer Support

Training and peer support offer providers an opportunity to come together with other providers and network staff. It may include one-time workshops or workshop series, professional development activities, and facilitation of peer networking. Some research indicates that training and professional development are promising strategies for improving quality (Porter et al., 2010). A review of research on adult learning methods among college and English as a Second Language students suggests that training that includes hands-on, interactive approaches based on adult learning principles are more likely to lead to positive learning outcomes versus lecture-based approaches (Trivette, Dunst, Hamby, & O'Herin, 2009).

Teaching strategies should also be designed to meet the needs of the target population.

Strategies for engaging family child care providers in group training, workshops, professional development, and peer support groups:

- Offer training in providers' preferred languages;
- Consider the literacy levels when developing training materials;
- Offer trainings in the community;
- Ensure training schedules meet needs of family child care providers (e.g., offer trainings during weekends, evenings);
- Offer materials, equipment or cash incentives;
- Provide opportunities for socializing and networking;
- Offer refreshments and meals; and
- Provide child care and transportation.

(Paulsell et al., 2010; Banghart & Porter, 2016)

Like one-on-one supports, the intensity, duration, and dosage of training workshops can vary. Workshop series that are offered over time are more likely to increase knowledge than stand-alone workshops, especially for understanding complex content such as interacting with children. One meta-analysis found that workshops that offered at least 10 hours of training over multiple sessions produced greater gains than workshops that offered fewer than 10 hours of training (Trivette et al., 2009).

Facilitated training workshops—those that are closer to support groups than traditional workshops—are another promising approach. For example, a study of a 14-week facilitated support group series for mostly Mexican immigrant family, friend, and neighbor caregivers that focused on injury prevention in child care homes found positive improvements in provider knowledge, health and safety practices, and observed quality (Shivers, Farago, & Goubeaux, 2016).

Service Content Tailored to Family Child Care

Through individualized approaches, networks can offer providers information that is relevant and specific to their individual needs, interests, and strengths. Information about child development and working with families are areas that all early childhood professionals require, yet family child care providers may need tailored information. For example, they might need information about working with mixed-age groups of children from infants through school-age as well as negotiating professional and responsive relationships with families, including how to set boundaries within intimate home-based child care settings. Family child care providers may also need additional resources and information about administrative practices such as contracts with families and budgeting and fiscal management, which can help providers strengthen the sustainability of their businesses and improve their retention in the field.

Staff-Provider Relationships

In addition to the types and content of services a network offers, a focus on *how* services are delivered is a component of high-quality, effective networks. Building professional and responsive relationships with providers involves one-on-one, strengths-based engagement between network staff and providers. Network staff who engage in a relationship-based approach to supporting providers may be more likely to understand the needs and circumstances of providers and children in their care (Bromer & Korfmacher, 2016).

Components of responsive staff-provider relationships may include personal and professional encouragement, nurturing, and confidential sharing as described in a case study of four family child care providers including three Black providers and one White provider who participated in an Early Head Start program (Buell, Pfister, & Gamel-McCormick, 2002). Cultural sensitivity is another component of building strong staff-provider relationships. It requires that network staff understand and respect the cultural and community contexts in which providers work and tailor their approaches to align with the daily realities and circumstances of providers' lives (Shivers & Sanders, 2011).

The quality of communication between network staff and providers is another key component of high-quality network support. Strategies that are most likely to lead to positive changes in provider practices with children and families include communication that focuses on seeking clarification rather than making assumptions and that uses open-ended and reflective questioning to gather information about and understand providers' perspectives on difficult or challenging situations (Bromer & Korfmacher, 2016).

Staff-provider relationships:

- Are strength-based—support builds on providers' knowledge, strengths, and interests;
- Are responsive to providers' perspectives, circumstances, and needs;
- Offer emotional support and encouragement;
- Ensure provider confidentiality;
- Are culturally sensitive;
- Encourage two-way communication and feedback among network staff and providers; and
- Emphasize problem solving and information sharing.

(Bromer & Korfmacher, 2016)

Network Staff Training and Support

Family child care settings are unique and different from center-based programs. In order to deliver responsive and relevant support to providers, network staff may require additional specialized training in how to work with family child care providers, including topics relevant to them: infant/toddler care within mixed age groups, family child care quality, business practices, and home child care environments (Bromer et al., 2009; Bromer & Weaver, 2016). Bromer et al. (2009) found that networks with specially trained staff who had received professional development in infant-toddler caregiving in family child care contexts were more effective than networks without specially trained staff. Network staff also need to have the knowledge and skills to work with adult learners and training in cultural competence because they may be serving providers with backgrounds that differ from their own (Bromer & Bibbs, 2011).

Supervision and support for network staff may also enhance their capacity and effectiveness in working with family child care. Some research suggests the importance of an organizational commitment to family child care as central to the agency's mission, and integration of services for family child care providers into all aspects of the agency's work (Bromer, Weaver, & Korfmacher, 2013; Douglass, 2011; Porter & Rice, 2000). Network staff who have regular opportunities to reflect with a supervisor about their work with providers may feel more confident and effective in their roles. Reflective supervision is widely cited in the early childhood field as a key component of relationship-based professional development (Heffron, 2005; National Center on Parent, Family, & Community Engagement, 2012). Peer support, including opportunities to share strategies and problem solve with other staff, is also important for network staff, as working with home-based child care can sometimes be isolating and challenging.

Future Policy and Program Directions

Given the growing recognition of home-based child care as a significant sector of the early care and education field, there is a great need for understanding effective quality improvement approaches that engage and sustain provider participation. Recent federal policy initiatives require States and local communities to strengthen their efforts to improve health, safety, and quality through engaging diverse groups of providers in regulatory systems and quality improvement initiatives including increasing the supply of high quality care for infants and toddlers, children with special needs, children experiencing homelessness, and other vulnerable populations including children in need of nontraditional hour care and children in poor communities. Family child care staffed networks that offer a menu of supports are a promising strategy for States and local communities seeking to implement new approaches and interventions.

More research is needed to understand how networks improve quality of care and outcomes for children across diverse family child care settings, which combinations of network services are most effective, and the role of network staff, staff training, and staff-provider relationships in the delivery of high-quality supports. As States begin to implement their CCDF Plans, research on network implementation and impact of network services on providers, children, and families will be critical. This will help inform future policy and program directions aimed at improving the quality of caregiving in the millions of diverse child care homes across the United States.

References

Banghart, P., & Porter, T. (2016). *Where our children are: Enhancing supports for New York City's home-based child care providers.* New York, NY: Children's Defense Fund.

Bromer, J. & Bibbs, T. (2011). Improving support services for family child care through relationship-based training. *Zero to Three special issue on family child care, 31* (5), p. 30.

Bromer, J. & Korfmacher, J. (2016). Providing high-quality support services to home-based child care: A conceptual model and literature review. *Early Education and Development.* DOI: 10.1080/10409289.2016.1256720; retrieved from: http://dx.doi.org/10.1080/10409289.2016.1256720

Bromer, J. & Weaver, C. (2016). Supporting family child care and quality improvement: Findings from an exploratory survey of Illinois child care resource and referral agency staff. *International Journal of Child Care and Education Policy, 10*(4). Retrieved from https://ijccep.springeropen.com/articles/10.1186/s40723-016-0020-8

Bromer, J., & Henly, J. R. (2004). Child care as family support: Caregiving practices across child care providers. *Children and Youth Services Review, 26,* 941–964.

Bromer, J., Van Haitsma, M., Daley, K., & Modigliani, K. (2008). *Staffed support networks and quality in family child care: Findings from the Family Child Care Network Impact Study, Executive summary.* Chicago, IL: Herr Research Center for Children and Social Policy, Erikson Institute. Retrieved from http://www.erikson.edu/wp-content/uploads/fccnetwork_execsummary1.pdf

Bromer, J., Weaver, C., & Korfmacher, J. (2013). *Evaluation of Erikson Institute Family Child Care Specialist Training Program phase II.* Chicago, IL: Herr Research Center for Children and Social Policy, Erikson Institute. Retrieved from http://www.erikson.edu/wp-content/uploads/Erikson-FCCSTP-Phase-II-Final-Report-1-8-14.pdf

Bryant, D. M., Wesley, P. W., Burchinal, M., Sideris, J., Taylor, K., Fenson, C., & Iruka, I. U. (2009). *The QUINCE-PFI study: An evaluation of a promising model for child care provider training: Final report.* Chapel Hill, NC: Frank Porter Graham Child Development Institute. Retrieved from http://www.researchconnections.org/childcare/resources/18531/pdf

Buell, M. J., Pfister, I., & Gamel-McCormick, M. (2002). Caring for the caregiver: Early Head Start/family child care partnerships. *Infant Mental Health Journal, 23*(1–2), 213–220.

Burchinal, M., Howes, C., & Kontos, S. (2002). Structural predictors of child care quality in child care homes. *Early Childhood Research Quarterly, 17*(1) 87–105.

Chaudry, A., Pedroza, J.M., Sandstrom, H., Danziger, A., Grosz, M., Scott, M., & Ting, S. (2011). *Child care choices of low-income working families.* Washington, DC: Urban Institute. Retrieved from http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412343-Child-Care-Choices-of-Low-Income-Working-Families.PDF

Crosby, D. A., Mendez, J. L., Guzman, L., & Lopez, M. (2016). *Hispanic children's participation in early care and education: Type of care by household nativity status, race/ethnicity, and child age.* Bethesda, MD: The National Center for Research on Hispanic Families & Children.

Douglass, A. (2011). Improving family engagement: The organizational context and its influence on partnering with parents in formal child care settings. *Early Childhood Research & Practice, 13(*2). Retrieved from http://ecrp.uiuc.edu/v13n2/douglass.html

Forry, N. D., Iruka, I., Tout, K., Torquati, J., Susman-Stillman, A., Bryant, D., & Daneri, M. P. (2013). Predictors of quality and child outcomes in family child care settings. *Early Childhood Research Quarterly, 28*(4), 893–904.

Forry, N., Bromer, J., Chrisler, A., Rothenberg, L., Simkin, S., & Daneri, P. (2012). *Family-provider relationship quality: Review of conceptual and empirical literature of family-provider relationships*, OPRE Report #2012-

46. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/fprq_literature_review.pdf

Gilman, A. R. (2001). *Strengthening family child care in low-income communities*. New York: Surdna Foundation.

Gordon, R.A., Colaner, A. C., Usdansky, M. L., & Melgar, C. (2013). Beyond an "either–or" approach to home- and center-based child care: Comparing children and families who combine care types with those who use just one. *Early Childhood Research Quarterly, 28*(4), 918–935.

Groenveld, M. G., Vermeer, H. J., vanIJzendoorn, M. H., & Linting, M. (2011). Enhancing home-based child care quality through video-feedback intervention: A randomized controlled trial. *Journal of Family Psychology, 25*(1), 86–96.

Guzman, L., Hickman, S., Turner, K., & Gennetian, L. (2016). *Hispanic children's participation in early care and education: Parents' perceptions of child care arrangements and relatives ability to provide care*. MD: The National Center for Research on Hispanic Families & Children.

Hamm, K., Gault, B., & Jones-DeWeever, A. (2005). *In our own backyards: Local and state strategies to improve the quality of family child care*. Washington, DC: Institute for Women's Policy Research.

Heffron, M. C. (2005). Reflective supervision in infant, toddler, and preschool work. In K. Finello (Ed.), *The handbook of training and practice in infant and preschool mental health* (pp. 114–136). San Francisco: Jossey-Bass.

Helburn, S. W., Morris, J. R., & Modigliani, K. (2002). Family child care finances and their effect on quality and incentives. *Early Childhood Research Quarterly, 17*(4), 512–538.

Hershfield, B., Moeller, A., Cohen, A. J., & the Mills Consulting Group. (2005). *Family child care networks/systems: A model for expanding community resources.* New York: Child Welfare League of America.

Hurley, K., & Shen, J. Z. (2016). *Bringing it all home: Problems and possibilities facing NYC's family child care*. New York: Center for New York City Affairs at the New School.

Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1995). *Quality in family child care and relative care*. New York, NY: Teachers College Press.

Larner, M. & Chaudry, N. (1993). *Promoting professionalism through family day care networks: A study of Child Care Inc.'s Neighborhood Child Care Initiatives Project.* New York: National Center for Children in Poverty, Columbia University. Retrieved from http://www.researchconnections.org/childcare/resources/10336/pdf

Larner, M. (1994). *In the neighborhood: Programs that strengthen family day care for low-income families.* New York: National Center for Children in Poverty, Columbia University. Retrieved from http://www.researchconnections.org/childcare/resources/1420/pdf

Laughlin, L. (2013). Who's minding the kids? Child care arrangements: Spring 2011. *Current Population Reports*, P70-135. Washington, DC: U.S. Census Bureau. Retrieved from https://www.census.gov/prod/2013pubs/p70-135.pdf

Marshall, N. L, Creps, C. L., Burstein, N. R., Cahill, K. E., Robeson, W. W., Wang, S. Y., et al. (2003). Family *child care today: A report of the findings of the Massachusetts Cost/Quality Study: Family child care homes*. Wellesley, MA: Wellesley College Center for Research on Women and Abt Associates, Inc.

McCabe, L., & Cochran, M. (2008). *Can home visiting increase the quality of home-based child care? Findings from the Caring for Quality Project*. (Research and Policy Brief Series, Issue 3). Ithaca, NY: Cornell University. Retrieved from http://www.human.cornell.edu/fldc/cecp/resources/loader.cfm?csModule=security/getfile&PageID=48184

Meyer, D.A., Smith, E.C., Porter, T.B., & Cardenas, S. (2003). *When housing and child care meet: Lessons learned from seven child care and community development partnerships.* Columbia, MD: The Enterprise Foundation.

Moreno, A.J., Green, S., & Koehn, J. (2015). The effectiveness of coursework and onsite coaching at improving the quality of care in infant-toddler settings. *Early Education and Development, 26*, 66–88.

Musick, J. S. (1996). *Uncovering the many sides of family child care: A study of the family child care connection.* Retrieved from ERIC database. (ED400940)

National Center on Parent, Family, & Community Engagement. (2012). *Head Start and Early Head Start relationship-based competencies for staff and supervisors who work with families*. Washington, DC: Office of Head Start, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/foundations/ohs-rbc.pdf

National Survey of Early Care and Education Project Team. (2013). *Number and characteristics of early care and education (ECE) teachers and caregivers: Initial findings from the National Survey of Early Care and Education (NSECE). OPRE Report #2013-38.* Washington DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/nsece_wf_brief_102913_0.pdf

National Survey of Early Care and Education Project Team. (2014). *Household search for and perceptions of early care and education: Initial findings from the National Survey of Early Care and Education (NSECE) (OPRE Report No. 2014-55a).* Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/brief_hh_search_and_perceptions_to_opre_10022014.pdf

National Survey of Early Care and Education Project Team. (2016). *Characteristics of home-based early care and education providers: Initial findings from the National Survey of Early Care and Education. OPRE Report #2016-13.* Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/characteristics_of_home_based_early_care_and_education_to_opre_032416.pdf

Office of Child Care, Administration for Children and Families, U.S. Department of Health and Human Services. (2016). *Overview of the 2016 Child Care and Development Fund final rule.* Retrieved from https://www.acf.hhs.gov/sites/default/files/occ/ccdf_final_rule_fact_sheet.pdf

Ota, C. L., & Austin, A. M. B. (2013). Training and mentoring: Family child care providers' use of linguistic inputs in conversations with children. *Early Childhood Research Quarterly, 28*(4), 972–983.

Paulsell, D., Porter, T., Kirby, G., Boller, K., Martin, E. S., Burwick, A., Ross, C., & Begnoche, C. (2010). *Supporting quality in home-based child care: Initiative design and evaluation options*. Princeton, NJ: Mathematica Policy Research, Inc. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/supporting_options.pdf

Porter, T. & Reiman, K. (2015). *Examining quality in a family child care: An evaluation of All Our Kin*. New Haven, CT: All Our Kin. Retrieved from http://www.allourkin.org/sites/default/files/ExaminingQualityinFCC2016.pdf

Porter, T., & Rice, R. (2000). *Lessons learned: Strategies for working with kith and kin caregivers.* New York: Bank Street College of Education. Retrieved from http://www.researchconnections.org/childcare/resources/6034/pdf

Porter, T., Paulsell, D., Del Grosso, P., Avellar, S., Hass, R., & Vuong, L. (2010). *A review of the literature on home-based child care: Implications for future directions*. Princeton, NJ: Mathematica Policy Research. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/lit_review.pdf

Raikes, H. A., Raikes, H. H., & Wilcox, B. (2005). Regulation, subsidy receipt and provider characteristics: What predicts quality in child care homes? *Early Childhood Research Quarterly, 20*(2), 164–184.

Raikes, H., Torquati, J., Jung, E., Peterson, C., Atwater, J., Scott, J., & Messner, L. (2013). Family child care in four Midwestern states: Multiple measures of quality and relations to outcomes by licensed status and subsidy program participation. *Early Childhood Research Quarterly*, *28*(4), 879–892;

Ramsburg, D. (Office of Child Care correspondence: Food for thought, July 19, 2016)

Office of Child Care. (2015). *Family child care brief*. Washington, DC: Office of Child Care, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/sites/default/files/occ/occ_fcc_brief.pdf

Shivers, E. M., Farago, F., & Goubeaux, P. (2016). *The Arizona Kith and Kin Project evaluation, Brief 1: Improving quality in family, friend and neighbor child care settings*. Phoenix, AZ: Institute for Child Development and Social Change, Indigo Cultural Center. Retrieved from http://www.asccaz.org/pdf/AZ_Kith_and_Kin_Evaluation_FNL_2016.pdf

Shivers, E., & Sanders, K. (2011). Measuring culturally responsive early care and education. In Zaslow, M., Martinez-Beck, I., Tout, K., & Halle, T. (Eds.). *Quality measurement in early childhood settings*. Baltimore, MD: Paul H. Brookes Publishing Company, Inc.

Trivette, C. M., Dunst, C. J., Hamby, D. W., & O'Herin, C. E. (2009). Characteristics and consequences of adult learning methods and strategies. *Research Brief*, *3*(1). Tots n Tech Research Institute. Retrieved from http://www.buildinitiative.org/portals/0/uploads/documents/resource-center/diversity-and-equity-toolkit/adultlearning_rev7-04-09.pdf

Weaver, R. H. (2002). Predictors of quality and commitment in family child care: Provider education, personal resources, and support. *Early Education & Development, 13*(3) 265–282.

Zaslow, M., Anderson, R., Redd, Z., Wessel, J., Tarullo, L., & Burchinal, M. (2010). *Quality dosage, thresholds, and features in early childhood settings: A review of the literature*, OPRE 2011-5. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/quality_review_0.pdf

Appendix: Examples of Networks That Work With Special Populations

The All Our Kin Family Child Care Network

Connecticut

Created in 1999, All Our Kin (AOK) trains and supports a network of family child care providers to increase the availability of quality, affordable child care for all children and families. Through AOK's programs, family child care providers succeed as early childhood professionals and as business owners; parents participate in the workforce knowing that their children are safe and learning; and children access the early learning opportunities that lay the foundation for success in school and beyond. Its work is informed by a theory of change logic model that specifies long-term and intermediate outcomes for providers, children, and families.

AOK's FCC network serves approximately 400 licensed family child care providers in four Connecticut cities and the surrounding communities—New Haven, Bridgeport, Stamford, and Norwalk. The network offers a variety of supports and programs that include assistance with the state licensing process, educational and business consulting, monthly professional development opportunities, an Early Head Start partnership, an incentive-based pathway to NAFCC accreditation, and an annual conference. In addition, AOK offers grants and zero-interests loans for projects and purchases that improve the quality of family child care programs. Through All Our Kin, family child care providers join a professional community of early childhood educators and engage in continuous learning and peer networking. AOK offers services in both English and Spanish. Approximately 70 percent of the children in care are eligible for CCDBG subsidies. AOK also runs an EHS-FCC partnership program, which provides Early Head Start services to 30 children and their families.

AOK's staff uses a strength-based approach that views providers as partners and is grounded in values of trust, mutual respect, and collaboration. Like providers, staff engage in continuous learning to produce transformative outcomes for children and families, and meet regularly to reflect on their work.

AOK's Toolkit Licensing Program for Family, Friend, and Neighbor Caregivers

Launched in 2003, the Toolkit Licensing Program consists of four home visits to FFN providers, and the delivery of boxes of materials that help them through the licensing process. The three family child care licensing coordinators recruit caregivers by posting fliers throughout the community and door-to-door, and presenting the program at local schools, job fairs, churches, and community events. They also reach out to local partners, including workforce development organizations, refugee agencies, and faith-based organizations, to recruit candidates to the program. Throughout the licensing process, which takes an average of 3 months, the coordinators provide support and mentorship to FFN caregivers. Because AOK is well-known, FFN caregivers often contact the office for assistance. In 2015, the Toolkit Licensing Program served 92 caregivers, of whom 72 successfully completed the licensing process.

AOK's Toolkit Licensing Program	
Box 1 Information about financial, professional, and community resources.	**1st Visit to Caregiver's Home** Licensing coordinator helps caregiver complete the licensing application and submit the licensing fee to the state Office of Early Childhood (OEC).
Box 2 Guides about business aspects of FCC, such as marketing, record-keeping, insurance and taxes, and a voucher for first aid training.	**2nd Visit to Caregiver's Home** Licensing coordinator helps caregiver complete the fingerprint application and submits application to OEC.
Box 3 Health and safety materials, such as a first aid kit, electrical outlet covers, and a fire extinguisher.	**3rd Visit to Caregiver's Home** After caregiver completes first aid training, licensing coordinator conducts inspection of the environment in preparation for the state OEC inspection visit.
Visit to Caregiver's Home Licensing coordinator visits caregiver's home during the state inspection visit.	
Box 4 Books and toys to help the provider in her work with children.	**4th Visit to Caregiver's Home** Licensing coordinator helps caregiver comply with any changes the State requires. The newly-licensed FCC provider then joins her fellow professionals for a celebration and workshop session that builds her relationship with AOK and the provider community.

ACRE Family Day Care Network – Dual Language Learner Populations

Lowell, Massachusetts

Acre Family Child Care (AFCC) was founded in 1988 to provide a pathway for women to achieve economic independence by operating high-quality child care businesses in their homes. This goal is accomplished by providing training, supervision, and income for women to become licensed child care providers, which creates local, high-quality child care within the community. AFCC helps parents by providing a number of different supports. It also increases parents' ability to foster their children's development by helping them learn about positive parenting practices and child development. AFCC also strengthens parents' social connections within the community through a variety of events.

AFCC offers three core services for participating child care providers: (1) Benchmarks, a 50+ hour training course offered to Providers new to AFCC; (2) profession supports via home visits to provide technical assistance, compliance monitoring, and support for obtaining a Child Development Associate credential or progress through QRIS levels; and (3) back office supports such as referrals, placements, billing, and transportation, as well as regular meetings to provide opportunities for social interaction and information about state policies. AFCC serves a diverse population of child care providers and families. The network currently serves 61 licensed family child care providers who serve many children through the state's child care subsidy system.

All network services are delivered with a culturally and linguistically responsive and sensitive approach. Staff speak the languages of providers and families including Khmer, Spanish, Vietnamese, and Portuguese. The Child Care Department, through which many of the services for family child care providers are offered, consists of six full-time staff: the training coordinator, three child care specialists, a parent engagement coordinator, and chief program officer, all of whom work closely with intake staff, social worker, and Operations Department. The ability

to work well and communicate with culturally and linguistically diverse groups of providers and families is one of the requirements for hiring staff. Staff translate materials into providers' and families' home languages as well as offer interpretation for providers during networking and training meetings.

All members of the staff, including training coordinators, child care specialists, social workers, and bus drivers, participate in cultural sensitivity training and are considered integral members of the network. Network staff who speak Khmer, Spanish, and Vietnamese are matched with providers who speak these languages, and home visits are conducted in the languages preferred by providers and families.

Child Care Specialists conduct home visits no less than twice a month and have a caseload of approximately 20 licensed family child care providers. Visits range from 10 minutes to several hours. On average, one Child Care Specialist can make four or five visits in a day because the routes are planned for a single neighborhood at a time.

All group training sessions are conducted with simultaneous translation in which the training is conducted in English, and translators present the same information in other languages simultaneously via audio headsets that are available for providers who prefer to listen to the training in their home language. Training materials are translated by staff for providers, many of whom do not speak English and some of whom do not have high literacy levels in their home languages.