# Examining the Feasibility of Using Home Visiting Models to Support Home-Based Child Care Providers

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# Table of Contents

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# Executive Summary

Over seven million children from birth through age 5 receive child care in home-based child care (HBCC) settings, the most common form of nonparental child care in the United States.[1,2] In its simplest form, HBCC is child care that is provided in a caregiver's home by someone other than the child's parent or primary caretaker. States and locales vary in the specific rules they set for regulation and/or licensing of these homes, including how many children a provider can care for without needing to be licensed.

Research shows that professional development can help child care providers improve the quality of care that they offer, potentially improving children's outcomes.[3,4] HBCC providers, however, often work alone and provide care outside of standard work hours, which can make it difficult for them to participate in traditional professional development trainings that happen outside of the home. These traditional trainings are also often developed for child care providers working in center-based settings and do not address the unique needs of HBCC providers. In addition, HBCC provider participation in state systems intended to support the quality of child care settings varies depending on state and local policies, as well as on outreach to support HBCC provider involvement.

To ensure that HBCC providers receive the support they need to successfully foster learning and development for children in their care, early childhood education systems and agencies must explore new professional development methods that align more closely with HBCC providers' needs. Some state agencies and home visiting model developers have begun to explore home visiting as a professional development approach to support HBCC providers. Home visiting is a prevention strategy provided in the home to families by qualified professionals such as social workers, child development specialists, nurses, and others. While home visiting traditionally focuses on parents and their children, the in-home model of delivery and the focus on child development topics make it well suited to adaptation for HBCC providers.

## Key conclusions

- **Implementing a home visiting model as a professional development strategy for HBCC requires coordination among multiple entities.** Stakeholders involved in HBCC—including state officials, HBCC providers, and parents—have different priorities, all of which are important to incorporate into new professional development strategies. Creating an effective professional development intervention will require coordination among all of these stakeholder groups to ensure that the model fits the requirements of states while also meeting the needs and interests of HBCC providers and families.

- **Expanding the evidence base for using home visiting to support HBCC may facilitate efforts to scale up the model.** Research on home visiting for HBCC providers has focused on ways to support implementation, as well as model-specific research on outcomes, but it is still in the early stages. Further research exploring the feasibility and scalability of this professional development strategy will expand the knowledge base and potentially increase buy-in for researchers, policymakers, and practitioners interested in the approach.

- **Improving professional development for HBCC providers may help improve quality of care for children and families who have been historically disadvantaged.** Families from racial and ethnic minority groups, as well as other populations that may have less access to resources—including low-income families, families with single parents, and children whose parents have limited education—tend to use HBCC more often.[5,6] Using home visiting approaches in HBCC settings may have the potential to both expand access to high-quality ECE and increase the number of children who have access to the type of support provided by home visiting models.

- **Home visiting is a feasible strategy for supporting HBCC, but implementing it at scale in states and communities will require additional research, funding, and professional development system infrastructure.** HBCC providers are a heterogeneous group and have varied access to professional development and classroom resources to support their work. Some home visiting models have leveraged state and federal funding to support home visiting as a strategy to provide professional development for HBCC providers, but not at a national scale. Increased support from philanthropy could also expand opportunities to implement the home visiting approach.

# Introduction

Over seven million children from birth through age 5 receive child care in home-based child care (HBCC) settings, the most common form of nonparental child care in the United States.[7,8] In its simplest form, HBCC is child care that is provided in a caregiver's home by someone other than the child's parent or primary caretaker. States and locales vary in the specific rules they set for regulation and/or licensing of these homes, including how many children a provider can care for without needing to be licensed.

Research shows that professional development can help child care providers improve the quality of care that they offer, potentially improving children's outcomes.[9,10] HBCC providers, however, often work alone and provide care outside of standard work hours, which can make it difficult for them to participate in traditional professional development trainings that happen outside of the home. These traditional trainings are also often developed for child care providers working in center-based settings and do not address the unique needs of HBCC providers. In addition, HBCC provider participation in state systems intended to support the quality of child care settings varies depending on state and local policies, as well as outreach to support HBCC provider involvement.

To ensure that HBCC providers receive the support they need to successfully foster learning and development for children in their care, early childhood education systems and agencies must explore new professional development methods that align more closely with HBCC providers' needs. Some state agencies and home visiting model developers have begun to explore home visiting as a professional development approach to support HBCC providers. Home visiting is a prevention strategy provided in the home to families by qualified professionals such as social workers, child development specialists, nurses, and others. While home visiting traditionally focuses on parents and their children, the in-home model of delivery and the focus on child development topics make it well suited to adaptation for HBCC providers.

To explore the potential for scaling up this model of professional development for HBCC providers, Child Trends, with funding from the Foundation for Child Development (FCD), examined home visiting models and curricula, state- and federal-level policies related to early care and education and home visiting, funding streams to support early care and education and home visiting, and the perspectives of HBCC providers and parents. The report concludes with suggestions for ways that organizations that fund research, technical assistance, and other activities to support HBCC providers can support this work.

## Key findings

- **Home visiting addresses common barriers to HBCC provider participation in professional development.** Providers interviewed for this report discussed challenges with traveling to training locations and finding training that did not conflict with their work schedules. Home visiting can address these issues by providing professional development in the home and providing support on a schedule that aligns with providers' needs.

- **Existing federal and state policies and funding streams could support this type of professional development for HBCC providers.** Early care and education funding streams and policies often allocate money for quality improvement efforts, which could be used to support home visiting for HBCC providers.

- **Existing work by home visiting models to adapt their curricula for HBCC providers provides insight into how this could work at a larger scale.** Information gathered from current efforts to adapt and pilot home visiting for HBCC providers can inform future efforts to scale up this model.

## Background on HBCC

Definitions of HBCC vary widely. In the broadest sense, HBCC can be divided into two main categories: providers who are listed and providers who are unlisted[11] (see Table 1). Listed providers are paid directly by families or through subsidies and can be licensed, certified, or registered with a state. This means that they appear on state or national lists, receive health and safety inspections, and typically have access to formal professional development and technical assistance opportunities through state and local agencies. The listed providers category also includes license-exempt or family, friend, and neighbor care providers who are formally known to states and organizations,

but who generally care for fewer children and have less rigorous regulatory requirements. License-exempt providers are also paid directly by families and can receive subsidies, but tend to have less access to professional development and technical assistance opportunities from state and local organizations. Unlisted providers, on the other hand, are not known to state and local systems. They can be paid or unpaid, but range in type from group HBCC settings operating outside of state or local regulations to a relative providing care for a child on a regular or as-needed basis.

Despite differences between listed and unlisted HBCC providers, it is notable that, on average, HBCC providers have lower levels of education and are paid less than providers working in other child care settings, such as centers.[12] Moreover, given providers' geographic proximity to families and the economic homogeneity of most neighborhoods, HBCC providers tend to mirror the demographics and socioeconomic status (SES) of the populations they serve; that is, HBCC providers who care for children residing in economically depressed communities tend to live in those same communities and face similar economic challenges.[13] These contextual and geographical factors can limit the level of access that HBCC providers, especially those working in unlisted settings, have to resources, which can cause challenges for the families they serve.

**Table 1.** Categories of HBCC providers

| Listed | | Unlisted |
|---|---|---|
| **Licensed/certified/registered homes** | **License-exempt/family, friend, and neighbor care** | <ul><li>Not licensed</li><li>Do not appear on state/national lists</li><li>No maximum number of children</li><li>None or very limited professional development or technical assistance opportunities</li></ul> |
| <ul><li>Trainings, inspections to register in state and appear on state/national lists of early care and education (ECE) providers</li><li>Maximum number of children varies by state from 6 to 12 per household</li><li>Formal professional development and technical assistance opportunities (e.g., state departments, Child Care Resource & Referral agencies [CCR&Rs], quality rating and improvement systems [QRIS])</li></ul> | <ul><li>May appear on state/national lists of ECE providers, but regulatory requirements are not as rigorous as for licensed providers</li><li>Maximum number of children varies by state, but often fewer than licensed homes</li><li>Limited professional development and technical assistance opportunities</li></ul> | |

Note: Adapted from the National Survey of Early Care and Education Project Team (2016)

Families choose HBCC for many reasons, including the fact that it is typically more affordable and offers more flexibility than center-based child care. Economically disadvantaged families, families of infants and toddlers, and families living in rural communities use HBCC at higher rates than other families.[14] In addition, parents who work nonstandard hours or have variable work schedules have cited HBCC as a better fit for their situations.[15,16] Parents also report other reasons for using HBCC, including their view that the setting feels more intimate than a child care center, their ability to choose providers who share their cultural backgrounds and/or home languages, and their ability to have all their children cared for in the same setting.[17] Some families of children with special needs also choose HBCC because of the level of individualized care it allows.[18]

In terms of quality, the limited evidence available on HBCC suggests these settings provide safe, nurturing environments for children; evidence also suggests that staff turnover rates are lower than in child care centers, allowing for more continuity of care.[19] On the other hand, observational assessments of HBCC find mixed quality of care in areas such as caregivers' attention to children's cognitive development and learning activities[20]; this could be partially due to HBCC providers' long work hours, which may not afford them the time to intentionally plan lessons or reflect on children's strengths, needs, and limitations. These realities suggest a need for tailored support to increase providers' capacity to offer more enriched learning environments for the children in their care.

Most states include licensed HBCC in their quality rating and improvement system (QRIS),[21] and federal programs like Head Start and Early Head Start also operate in licensed HBCC settings.[a] Despite the existence of these supports, HBCC providers face challenges to participating in professional development. QRIS supports, for example, were primarily developed with center-based child care in mind. Consequently, they may not address challenges unique to HBCC settings, such as providing care to children of multiple ages in one classroom or effectively implementing quality indicators with infants.[22,23] In addition, as mentioned earlier, HBCC providers face challenges with traveling to the locations where training occurs and with finding trainings that happen during a time that works with their schedule.

## Home visiting as a professional development approach

There is a range of different home visiting models, but all generally promote children's healthy development by building high-quality relationships between families and the home visitor via support services. These services include providing education to parents on child development, conducting child screenings and assessments, referring families to community resources, and assisting families in identifying informal and formal support networks. Home visiting models use curricula to guide visitors' work with families, but home visitors also tailor their interventions as needed to meet the immediate needs of the families they serve.[24]

Home visiting models, which aim to increase caregivers' capacity to care for their children, are well positioned to be modified to support the specific needs of HBCC providers. In fact, some states, cities, and organizations have had some success in exploring the use of home visiting models as a support to address professional development challenges for HBCC providers. For example, Colorado is adding home visitors specifically for HBCC providers into its existing work with Parents as Teachers (PAT) and Home Instruction for Parents of Preschool Youngsters (HIPPY) as part of their Preschool Development Grant Birth Through Five (PDG B-5) grant.[25]

# Design of the project

This project focuses on three main goals. The key research questions for each goal are presented below and will be explored throughout this report.

- **Goal 1: Review the content of home visiting curricula and how it aligns with the needs of HBCC providers.** Key research questions include: What home visiting curricula exist that are evidence-based, scalable and relevant to HBCC providers? What components of home visiting models meet the needs of HBCC providers best? Is there variation based on provider characteristics? What components of home visiting models need adaptation to implement them with HBCC providers?

- **Goal 2: Assess the alignment of home visiting models with the characteristics of HBCC providers and their needs.** Key research questions include: Are there HBCC providers that may be more or less open to participation in in-home professional development? What supports are needed to facilitate providers' participation in in-home professional development? Is there variation based on provider characteristics?

- **Goal 3: Assess the feasibility of expanding access to in-home professional development as a model for HBCC within the context of state and/or local systems.** Key research questions include: What systems exist to facilitate in-home professional development reaching HBCC providers? What is the policy and funding climate that may support using in-home professional development to support HBCC providers? What infrastructure is available to sustain the implementation and financing of an in-home professional development model for HBCC?

We explored these questions with a focus on four states and one city: Georgia, Minnesota, New Jersey, New York state, and New York City. These locations were chosen to ensure geographic diversity, both across regions and in terms of our ability to speak with HBCC providers in both urban and rural areas. We chose to look at a city in addition to states with the idea that cities may have more flexibility to pilot new initiatives at the local level.

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[a] Head Start and Early Head Start programs have the option of serving license exempt providers, though few do.

To address the goals and answer the research questions, the project team conducted four main activities:

- **Home visiting model and curricula reviews:** Child Trends reviewed 10 different home visiting models and curricula using the Administration for Children & Families' (ACF) Home Visiting Evidence of Effectiveness (HomVEE) website to increase our understanding of which home visiting components and curricula may best inform and support the proposed work. Of the 10 curricula reviewed, Child Trends conducted an in-depth exploration of three to learn more about their experiences with adapting, piloting, and implementing their models with HBCC providers. The in-depth exploration included reviewing the curricula components and materials and interviewing developers to better understand potential alignment with the needs of HBCC providers, as well as the children and families they serve.

- **Interviews, focus groups, and surveys:** Child Trends conducted interviews with key stakeholders, including home visiting curricula developers, Child Care Resource & Referral (CCR&R) state administrators, child care technical assistance providers and coaches, home visiting state administrators, and other early care and education advocates. In addition, Child Trends interviewed and conducted focus groups in both English and Spanish with HBCC providers and parents of children who attend HBCC. Participating HBCC providers and parents also completed surveys to provide background information on their experience with HBCC.

- **Federal and state policy scans:** The project team reviewed federal and state policies that inform the implementation of child care and home visiting services, with the goal of understanding whether using a home visiting model as a professional development support for HBCC providers is feasible and scalable. The scan provided information on systems, regulations, and funding structures that support or have the potential to support child care and home visiting.

- **Dissemination:** Child Trends shared findings from this project through a presentation at the Ounce of Prevention's National Summit on Quality in Home Visiting. In addition, Child Trends conducted three webinars to present findings not only to stakeholders, but also to HBCC providers and parents who participated in interviews and focus groups; the webinars also provided an opportunity to get feedback from project participants to make sure we were presenting project findings in a way that accurately represented their experiences. Two of these webinars were conducted in English and one was conducted in Spanish.

# Exploring Home Visiting Models and Curricula

The project team reviewed key characteristics of existing home visiting models and curricula to understand whether they could support the needs of HBCC providers. We looked at target outcomes of each model, evidence supporting the models and curricula, characteristics of service delivery, the target population served, and other factors that may influence their fit for use in HBCC settings. This section provides an overview of findings from the model and curricula review. We also highlight examples of home visiting models that have adapted their curricula to reach HBCC providers.

## Home visiting model and curricula review

The review of home visiting models and curricula provided the foundation for the team to address the first two goals of the project. As previously mentioned, Goal 1 focuses on understanding the alignment of home visiting models and curricula with the needs of HBCC providers, while Goal 2 seeks to understand whether the alignment changes based on specific characteristics of providers, such as their location or the types of families they serve.

To begin addressing the research questions related to these goals, we reviewed 10 different home visiting models and the curricula they use.[b] We used sources such as the [ACF's HomVEE website](), [c] the National Home Visiting Resource Center's (NHVRC) [2018 Yearbook](), and individual model developers' websites. With the exception of one

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[b] The 10 curricula were: Attachment Biobehavioral Catch-Up (ABC), Early Head Start (EHS), Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), Parents as Teachers (PAT), SafeCare, and ParentChild+ (formerly known as Parent Child Home Program).

[c] The 10 curricula were chosen for review using the ACF HomVEE website and limited to those that served children ages three to four or older and focused on outcomes in child development, school readiness, and positive parenting practices.

international model, all of the models reviewed were used in at least one of the states included in this project (Table 2).

**Table 2.** Evidence-based or -informed home visiting models, by state

| | ABC | EHS | HFA | HIPPY | NFP | PAT | SafeCare | ParentChild+ | Other |
|---|---|---|---|---|---|---|---|---|---|
| **Georgia** | | √ | √ | | √ | √ | √ | √ | |
| **Minnesota** | √ | √ | √ | | √ | √ | | √ | Family Spirit |
| **New Jersey** | | √ | √ | √ | √ | √ | | √ | |
| **New York State/City** | √ | √ | √ | √ | √ | √ | √ | √ | Bank Street |

Sources: National Home Visiting Resource Center Yearbook (2018); state home visiting agency websites (See Appendix C); home visiting model developer websites; NYS Council on Children and Families (n.d.)

Below is a summary of what we learned from our review of home visiting models and their curricula:

- **Targeted outcomes:** All home visiting models included target outcomes for both children and caregivers and/or families. Child outcomes focused on areas such as social-emotional development, behavior, academics, and language/cognitive development. For caregivers, models addressed outcomes like parenting knowledge and attitudes, stress and mental health, positive parenting, and improved home environment. Finally, at the family level, models focused on outcomes like reduced child/family maltreatment, increased access to support services, and assistance with improving family income via employment or educational pursuits.

- **Level of evidence and outcomes:** The models had different levels of research supporting their effectiveness at achieving outcomes. ACF's HomVEE reviewed the research evidence of effectiveness for specific home visiting models using the Department of Health and Human Services' (HHS) criteria for evidence-based models. All models reviewed for this project had evidence of favorable outcomes in the domains of child development and school readiness and/or positive parenting practices. In addition, all but one model met the HHS criteria to be considered evidence-based.

- **Program characteristics:** Models differed in how many sessions they conducted in a month or a year and in how long families received services. In addition, the length of an individual home visiting session ranged from 30 minutes to three hours. In terms of home visitor qualifications, about half of the models required a high school diploma or equivalent, while the other half required a bachelor's or master's degree.

- **Targeted population:** The models supported families at a range of stages, from the prenatal period through families with children up to age 5. Almost all models targeted services toward families from low-income backgrounds, and half of the models targeted services toward parents with limited educational attainment. Other common family characteristics that models prioritized included children with special needs or disabilities, parents experiencing substance abuse and mental health challenges, and parents who are at risk of or have a history of child abuse or maltreatment.

- **Accessibility:** In addition, we gathered information about the cost of implementing each model, which ranged from $1,500 per child or family to $12,000 per child or family, and whether the curricula used had been translated into other languages, like Spanish. In terms of reach, only two models operate in all 50 states and the District of Columbia, while the other models range from operating in three to 37 states (one model was solely international).

## Examples of models that have adapted curricula for HBCC providers

In addition to looking at characteristics of existing, traditional home visiting models, we also looked for examples of models that have adapted curricula for use with HBCC providers. Child Trends conducted in-depth interviews and curricula reviews (e.g., review of curricula handouts, a demo walk-through of a home visiting session for HBCC

providers) with three home visiting models that have adapted or revised their curricula for use in HBCC settings. Model developers discussed the steps their teams have taken to adapt curricula for HBCC providers, specific curricula elements directed towards HBCC providers, funding options, and implementation experiences (e.g., lessons learned, successes, challenges). In addition, the project's principal investigator met in person with the New York City ParentChild+ team and visited a HBCC site to observe how the adaptations to the model were being implemented on the ground. Information on the models below came from conversations with model developers, review of curricula, and the models' websites. Below we describe each model and how it has been adapted to support HBCC providers.

## ParentChild+

ParentChild+ has been implementing their curriculum in HBCC settings since 2009. The curriculum focuses on supporting HBCC providers in the areas of school readiness for children and better engaging families. In addition, it uses a relationship-based approach to professional development that views the HBCC provider as a partner in the process. ParentChild+'s HBCC curriculum focuses on working with children from infancy through age three; it guides providers through the process of gaining the skills and knowledge they need to create their own curriculum and understand which activities help children develop. The HBCC curriculum has been used in six states: Massachusetts, Minnesota, New Jersey, New York, South Carolina, and Washington.

## Parents as Teachers (PAT)

PAT began work to support HBCC providers in the 1990s. Their curricula for HBCC providers, *Supporting Care Providers Through Personal Visits*, supports providers through visits, group meetings with other providers, developmental screenings for children, and a network for finding resources to support professional development. It provides activities aimed at meeting the developmental needs of children of multiple ages, addressing special topics from a multi-age perspective, and supporting group activities. Although much of PAT's work has focused on unlisted providers, their model has been used with listed providers—for example, through a pilot of Early Head Start implementation in listed HBCC settings.

## Home Instruction for Parents of Preschool Youngsters (HIPPY)

HIPPY USA has developed and is beginning to pilot resources for HBCC providers. The goal of their work is to support providers who work with young children but may not currently have the resources or skills to provide those children with the care they need. While the standard HIPPY curriculum focuses on using materials readily available in a family's home, curriculum targeted at HBCC providers includes materials, such as books, that home visitors bring with them. The curriculum focuses on offering suggestions, techniques, and guidance for HBCC providers around how to shape learning experiences for children and how to foster parent/provider communication. HIPPY has partnered with the state of Colorado through their PDG B-5 to pilot their curriculum with providers.

For further information on these three models and their curricula adaptations, see our brief on the topic: *Curricula Considerations for Home Visiting for Home-Based Child Care Providers*.

# Perspectives of Providers and Parents

In addition to exploring the structure of home visiting models and the content of home visiting curricula, the research team conducted interviews and focus groups with HBCC providers and parents who have children in HBCC. In these conversations, our aim was to understand how providers and parents viewed the feasibility of using home visiting to support HBCC providers. Participants also completed a questionnaire via Survey Gizmo (in English or Spanish) prior to participating in the focus groups and interviews to provide background information on their demographics and experiences with HBCC (see Appendix B). Through these activities, we collected information to further address research questions related to Goal 1 and Goal 2 of the project.

## Focus group and interview participants

### HBCC providers

A total of 59 HBCC providers completed a background survey in addition to participating in focus groups/interviews.[d] Providers ranged in age from 27 to 69 years, with a median age of 54 years, and almost all providers were female.[e] A majority of providers identified as either white (37%) or African American (34%), with 17 percent reporting another race, and 9 percent not reporting any race. About a third of providers also indicated that they were of Hispanic, Latino, or Spanish origin (36%).[f] In terms of educational attainment, more than half of providers (58%) held either an associate, bachelor's, or master's degree, while the remainder had either completed high school or attended some college. Of those with college degrees, the most frequently reported majors were early childhood education (24%) and early childhood development (15%). About 20 percent of providers reported other majors in fields related to education or development, such as counseling, elementary education, or nursing; a quarter of providers (25%) reported majors in non-educational or human development fields, such as business and economics.

Providers reported caring for a median of 7 children, with the total number of children in care ranging from 2 to 20.[g] Providers most commonly reported caring for toddlers, followed by preschool children, infants, and school-aged children. Over half of the providers (56%) reported receiving subsidies for at least one child in their care, about a third of providers (37%) reported not receiving any subsidies, and 7 percent did not respond or were not sure. The majority of providers (83%) cared for children all day, and some providers (12%) cared for children after school hours, in addition to all-day care. Three-quarters of providers (75%) reported using a curriculum.

### Parents who use HBCC

All 13 parents who participated in the focus groups and interviews also completed the background survey. These focus groups, interviews, and surveys were all conducted in English. All participants were female and ranged in age from 28 to 59 years, with a median age of 33. Almost all parents identified as either African American (54%) or white (38%), and almost all participants reported English as their primary language. Over half of parents (54%) held an associate degree, while the rest had completed either a high school degree or equivalent, some college, or some graduate coursework. The majority of parents were married and working full-time.

The number of children in the household ranged from one to four, with a median of two children. Parents had from one to three children participating in HBCC at the time of the study, with a median of two children in care. Parents' length of time using HBCC ranged from less than one year to nine years, with a median of three years. Nearly two-thirds of parents (62%) reported having no previous experience using other forms of child care, while the rest had experiences with either center-based care, care through other organizations (e.g., church), a babysitter, or another arrangement. Finally, no parents who participated in this study reported receiving child care subsidies. Given the number of providers who reported caring for children receiving subsidies, this indicates that these parents may not be economically reflective of the larger group of parents served by participating providers.

## Key perspectives from HBCC providers and parents

Information from surveys, focus groups, and interviews provided insight into providers' professional development experience, reasons for entering the field, and job roles, as well as parents' preferences for care. Findings from surveys are reported using the number and percentage of providers who selected a certain response. Responses from providers who participated in focus groups/interviews in English and providers who participated in focus groups/interviews in Spanish are reported separately in certain instances to highlight differences between the two groups. To protect confidentiality, tables indicate when a category has fewer than five responses but do not indicate

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[d] One provider did not have the chance to take the survey and the project team was not successful at reaching the participant via follow-up.
[e] Percentage not reported because fewer than five men participated in focus groups and respondents did not select gender options other than male or female.
[f] We use "Hispanic" and "Latino" interchangeably throughout this report. Consistent with the U.S. Census definition, this includes individuals having origins in Mexico, Puerto Rico, and Cuba, as well as other "Hispanic, Latino, or Spanish" origins.
[g] Some providers worked with assistants, allowing for a larger number of children to enroll while staying within ratio requirements.

the actual number of responses or percentage of total respondents for those responses. Findings from focus groups/interviews do not include information about the number or percentage of providers who shared responses, but rather highlight key quotes that illustrate themes.

## Many HBCC providers entered the field to care for their own children but remained in the field after their children got older.

Providers most commonly reported entering the HBCC field to care for their own children. They gave a range of reasons for doing so, including interest in spending time with their own children; an inability to pay for child care; an inability to find care that aligned with their preferences; and a lack of flexibility in their job to take time off, for instance, if their child was sick.

> " *My first child that I had was actually my [relative]…my [relative] was my starting point. So, as he developed into a young man, I can see the effects that I've had on his life. Not just as his [relative] but I'm his child care provider.*

Many providers also reported entering the field after being an educator in a different setting, such as a K-12 environment. In addition, a large proportion of providers who participated in focus groups in Spanish immigrated to the United States from another country, where they had pursued higher education and worked as an educator.

> " *I started taking care of children in my house when I came to this country. I was a teacher in my country… and when I got here, I found the language made it difficult to get a job to continue what I really like, which is teaching children. Then a friend told me, "Well, you have your baby. Put your business in the house." She more or less explained to me the process and it interested me, so that's what led me to work with children in my house.[h]*

The number of years providers had cared for children in their homes ranged from 2 to 43, with a median of 14 years. Most providers, particularly those who participated in focus groups/interviews in Spanish, reported having at least one related work experience before becoming a HBCC provider (see Table 3). Compared with providers who participated in focus groups/interviews in English, a greater proportion of providers in the Spanish group reported prior experiences caring directly for children, either as a caretaker for someone else's children or as a center-based teacher.

**Table 3.** Provider experience before becoming a HBCC provider, by language

| Experience before becoming HBCC provider | English (n = 39) | | Spanish (n = 20) | |
|---|---|---|---|---|
| | No. of providers | % of providers | No. of providers | % of providers |
| **Caretaker of someone else's children** | 11 | 28.2% | 13 | 65.0% |
| **Center-based director** | <5 | - | <5 | - |
| **Center-based teacher** | 10 | 25.6% | 9 | 45.0% |
| **Counselor** | 0 | - | <5 | - |
| **Infant/toddler specialist** | 0 | - | <5 | - |
| **Mental health professional** | 0 | - | <5 | - |
| **None** | 12 | 30.8% | <5 | - |
| **Other** | 16 | 41.0% | 6 | 30.0% |
| **Not reported** | <5 | - | 0 | - |

Note: Percentages do not add up to 100% because some providers selected multiple options. "Other" includes roles such as working in K-12 education, food services, business, retail management, and personal care.

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[h] Original quote: "Yo empecé a cuidar niños en mi casa cuando llegué a este país. Era maestra en mi país, y llegue aquí, se me dificultó el idioma para conseguir un empleo para continuar en lo que a mí realmente me gusta, que es la educación de los niños. Entonces una amiga me dijo, 'Bueno, tú tienes tu nena. Pon tu negocio en la casa.' Me explico más o menos cómo era el proceso y me interesó y eso hace que estoy trabajando con niños en mi casa."

## HBCC providers have a range of responsibilities outside of direct child care, including business obligations.

HBCC providers viewed themselves as educators and caregivers, but many also reported that their job included roles like business ownership, meal prep, and a host of other activities related to the day-to-day care of children. Nearly all providers who participated in focus groups and interviews mentioned their role as business owners.

> *I'm a businesswoman, I am the director, I am the janitor, I'm the cook, I'm the administrator. So, it's kind of like I wear different hats. I don't necessarily think I have a role because everything, all parts, make up the one.*

In addition, some providers noted their unique role in serving their communities.

> *My role is a community connector. Not only does this serve as a foundation of helping out parents who need nontraditional childcare services, but also providing them with resources, providing them with ways to get assistance, any assistance with their rent or light bill as well as maybe they may need for their child to participate in some like sports activities. And I can direct them to those services. So, serving as the community connector is the key.*

Providers often found that professional development opportunities available to them did not encompass this range of roles. In particular, providers said trainings often focused on the early childhood development and education aspects of their work but did not address the unique challenges of small business ownership or the reality of HBCC.

> *[O]n the business side of it, how do you market? How do you increase your enrollment? A lot of that stuff I just had to learn on my own... So, what about the people out there who really don't have a clue?*

## Providers had a range of professional development experience outside of the home.

Providers had participated in a range of educational opportunities in preparation for becoming a HBCC provider (see Table 4). According to surveys, the most common type of preparation undertaken by providers who participated in focus groups/interviews in both English and Spanish was participation in mandatory regulatory training, including state licensing and health/safety requirements. Providers who participated in focus groups/interviews in English and Spanish participated in professional development opportunities prior to becoming HBCC providers at similar rates, with the exception of formal training opportunities, like credentialing. Over half of providers who participated in focus groups/interviews in Spanish (60%) had participated in formal training, compared to about a third of providers who participated in focus group/interviews in English (33%).

**Table 4.** Education providers received to prepare to be a HBCC provider, by language

| Professional development opportunity | English (n = 39) | | Spanish (n = 20) | |
|---|---|---|---|---|
| | No. of providers | % of providers | No. of providers | % of providers |
| Formal education (e.g., college courses or degree) | 12 | 30.8% | 7 | 35.0% |
| Formal training (e.g., credentialing) | 13 | 33.3% | 12 | 60.0% |
| Regulatory training (e.g., licensing, health/safety) | 26 | 66.7% | 15 | 75.0% |
| Participation in a formal peer learning community | 10 | 25.6% | <5 | - |
| Other training (e.g., webinars, technical assistance, organized meetings with colleagues/peers on ECE-related topics) | 23 | 59.0% | 11 | 55.0% |
| Other | <5 | - | <5 | - |
| Not reported | <5 | - | 0 | - |

Note: Percentages do not add up to 100% because some providers selected multiple options.

In addition to pre-service activities, providers had also participated in a range of professional development opportunities the year prior to the survey. As seen in Table 5, the three most common activities for both English- and Spanish-speaking providers were workshops or group trainings, conferences or seminars, and online trainings.

**Table 5.** Participation in professional development opportunities over the past 12 months, by language

| Professional development opportunity | English (n = 39) | | Spanish (n = 20) | |
|---|---|---|---|---|
| | No. of providers | % of providers | No. of providers | % of providers |
| Coaching/mentoring | 19 | 48.7% | 8 | 40.0% |
| College courses | <5 | - | <5 | - |
| Formal meetings with other HBCC providers to discuss issues related to your work | 18 | 30.5% | 7 | 35.0% |
| Conferences or seminars | 27 | 69.2% | 10 | 50.0% |
| Credentialing | 5 | 12.8% | 5 | 25.0% |
| Degree programs | <5 | - | <5 | - |
| In-service training | 8 | 20.5% | 5 | 25.0% |
| Online trainings | 30 | 76.9% | 9 | 45.0% |
| Onsite technical assistance | 14 | 35.9% | <5 | - |
| QRIS professional development activities | 11 | 28.2% | 5 | 25.0% |
| Workshops or group trainings | 29 | 74.4% | 16 | 80.0% |
| Other | <5 | - | <5 | - |
| Not reported | <5 | - | 0 | - |

Note: Percentages do not add up to 100% because some providers selected multiple options.

While providers participated in some types of professional development activities at similar rates (e.g., QRIS, in-service training), there were some differences, by language, in providers' activities. In particular, providers who participated in focus groups/interviews in Spanish had less experience with onsite technical assistance than providers who participated in focus groups in English (5% compared to 36%). Providers had participated in a range of credentialing activities in the prior year, including pursing a Child Development Associate (CDA; 46%), a Technical College Diploma (12%), and other state or local credentials (36%).

In sum, the vast majority of providers had participated in professional development activities outside of the home, but HBCC providers participating in the Spanish-speaking focus groups/interviews reported participating in fewer online trainings and less on-site technical assistance, suggesting they may be less open to these type of supports. One Spanish-speaking provider, for example, noted that her reluctance about having professional development in the home was related to the distractions that affected both the children and her.

> " *[W]hen the children are with a stranger, they behave completely different. They want to express more, play more. So, you can't be mindful of the children when the coach is training you. One of the two things doesn't work out.*[i]

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[i] Original quote: "...Cuando los niños están con una persona extraña, se comportan completamente diferente, quieren como manifestarse más, juegan más. Entonces, tú no puedes estar pendiente a que estás cuidando el niño y al adiestramiento que te están dando, una de las dos cosas no sale bien."

## Many HBCC providers have had prior experiences with in-home technical assistance, coaching, or assessments.

According to data from the provider surveys, almost all providers who participated in the focus groups/interviews were licensed and almost half (49%) participated in their state's QRIS. Many of the providers who participated in focus groups/interviews in English also reported experiencing some form of in-home professional development or technical assistance through their state's QRIS, licensing, state regulatory systems (e.g., health and safety), and other local initiatives.

During the focus groups/interviews, providers reported mixed experiences with these supports. Some felt that the individuals who came into their homes to provide support were helpful; however, others talked about experiences with individuals who were unhelpful or lacked the appropriate knowledge of HBCC settings to provide assistance. Providers also shared that many of the individuals who came into their homes were compliance-driven, meaning they offered feedback that was judgmental and focused on making sure that providers were adhering to regulatory mandates, rather than supportive, with a focus on strengthening quality.

> The coaches that come in from the city or from whatever other institution, what they're going to do is look for whatever mistakes you make while the children are doing [activities], and making a mess, and asking you questions—and you are attending to them, and [coaches are] looking for this and looking for that.[j]

In addition, individuals coming into the home were often from different agencies with different quality improvement priorities. Some providers discussed feeling frustrated because they received conflicting feedback about whether the care provided in their setting was meeting regulations. For example, licensing representatives, who primarily focus on health and safety issues, might conduct visits and find that things were going well, while a QRIS representative, who could be focused on issues like safety, interactions and exchanges between providers and children, and family engagement, might identify issues that needed attention.

Some parents also shared concerns about the number of individuals coming into providers' homes. They worried about disruption of children's routines due to reoccurring visitors and also wondered whether frequent visits might make children uncomfortable. Parents in Minnesota specifically worried that regulations and mandates from multiple sources could prove to be overwhelming to providers.

When asked about their experiences with in-home support, providers who participated in focus groups/interviews in Spanish referred more often to state-regulated health and safety inspections and licensing evaluations, and less often to their experiences with in-home technical assistance or coaching. As mentioned previously, health and safety inspections and licensing evaluations are typically compliance-driven, which may partly explain why this group was less open to and had more negative perceptions of in-home professional development than the providers who participated in English focus groups/interviews.

## Providers experienced barriers to professional development that a home visiting model could address.

Despite their participation in professional development activities, providers reported that they faced challenges to attending trainings and receiving support. The most commonly reported challenges centered on logistics, such as inconvenient timing and having to commute to professional development activities. Many providers, particularly those who participated in focus groups and interviews in Spanish, noted that some professional development opportunities were inaccessible because of their location. Moreover, some providers indicated that trainings often conflicted with the hours that they were providing care to children, which posed challenges with finding and paying for substitute care so they could attend these trainings.

These findings were reiterated in surveys, where providers noted top considerations that an individual providing professional development to HBCC providers should think about. As seen in Table 6, almost half of providers

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[j] Original quote: "Los instructores que van de la ciudad de aquí [o] de cualquier otra institución, lo que van es a fijarse en cualquier errorcito que tú cometas mientras los niños están haciendo y deshaciendo y ellos te preguntan y tú atendiéndolos a ellos y tú buscándoles esto y buscándoles lo otro."

participating in both English and Spanish focus groups/interviews (46% and 45%, respectively) reported availability during particular hours (i.e., providing training during hours when HBCC providers are available to attend) as an important consideration. While more than half of providers who participated in focus groups/interviews in English were concerned about cost (51%) and appropriateness or relevance of the topic to the children and families they served (51%), providers who participated in focus groups/interviews in Spanish were more often concerned about the location and space where trainings occur (40%).

**Table 6.** Considerations for HBCC professional development, by language

| Considerations | English (n = 39) | | Spanish (n = 20) | |
|---|---|---|---|---|
| | No. of providers | % of providers | No. of providers | % of providers |
| Length of time it takes to complete | 8 | 20.5% | 3 | 15.0% |
| Cost | 20 | 51.3% | 3 | 15.0% |
| Availability during particular hours | 18 | 46.2% | 9 | 45.0% |
| Location and space where it occurs | 10 | 25.6% | 8 | 40.0% |
| Ability to get credit or continuing education for attendance | 15 | 38.5% | 5 | 25.0% |
| Content and support strengthen professional practice | 16 | 41.0% | 6 | 30.0% |
| Appropriate and relevant to the children and families served | 20 | 51.3% | 5 | 25.0% |
| Other | <5 | - | 5 | 25.0% |
| Not reported | <5 | - | <5 | 5.0% |

Note: Percentages do not add up to 100% because some providers selected multiple options.

Some providers were also uncomfortable with the idea of using substitutes to attend trainings during care hours for a variety of reasons, including not feeling comfortable having a stranger in their home while they were absent, having to pay more for substitutes than they made themselves, and being concerned about the level and quality of care a substitute would provide to children while they were away.

> *I have business liability insurance, so I'm always trying to not get a sub because I don't want something to happen here and have my business liability insurance go up, and let alone something just happen to a child… I would be devastated if something happened to a child here because I have a substitute."*

While one solution might be to provide training during weekday evenings when providers are less likely to be caring for children, providers indicated that this alternative might also be less than ideal. Many said that they started their day very early in the morning and that evening trainings often happened after they had worked 10- to 12-hour days.

> *I try really hard to keep my day to my 10-hour day, but it slides outside of that, especially if I'm working on accreditation or quality rating.*

Key stakeholders also acknowledged this challenge during interviews. Individuals working with HBCC providers through state and local agencies noted that HBCC providers often experience professional isolation, as well as low pay, long hours, and limited time to attend professional development outside of the home.

## Providers would like more support on strategies for engaging with parents.

When asked about topics related to child development, both parents and providers indicated some challenges to addressing this in a HBCC setting. Some parents said they struggled to receive concrete feedback about their child's development from their provider. At the same time, providers who participated in English focus groups/interviews indicated that they felt parents could be resistant to feedback about children's developmental challenges, and they worried about being able to communicate effectively with parents about these challenges. They expressed concern about damaging relationships with parents if they shared feedback that might be perceived as negative.

> " *[We] have to be careful to approach the parents when you see something is very difficult to approach. Because you don't know how the person will react.*

In addition, providers expressed that because they lacked formal assessment or observational tools to legitimize what they were seeing, there were some situations in which pediatricians or other professionals might be better suited to share information about children's development with parents.

## Key takeaways: Model alignment with provider/parent perspectives

Reviews of home visiting curricula and models, as well as information from HBCC providers and parents provide insight into several key research topics related to Goal 1 and Goal 2 of the project.

### Home visiting models address topics that align with the needs and interests of HBCC providers and parents.

Home visiting models target caregiver and child outcomes ranging in focus from cognitive development to social-emotional learning to physical safety. These outcomes align with many of the areas that HBCC providers expressed needing support with during focus groups and interviews. For example, many providers shared that they struggle with how to discuss developmental topics with parents; at the same time, parents expressed an interest in hearing more about this topic from their child's HBCC provider. All home visiting curricula reviewed as part of this study covered topics related to children's social-emotional development, executive functioning, language and cognitive development, and physical health. By coaching HBCC providers in how to address and improve these outcomes for children, these home visiting curricula could help providers become more skillful in identifying these issues and discussing them with parents.

Three home visiting models, in particular, have already begun work to tailor their curricula for HBCC providers. ParentChild+, PAT, and HIPPY have developed and/or piloted curricula that can support providers and the children they care for in their homes. Because these models have connected with HBCC providers and explored their professional development needs, they may be more prepared to scale work to a larger range of providers. In addition, they can offer valuable lessons learned through their experience with curricula adaptation.

There are also some areas in which home visiting models may not address HBCC provider needs. In focus groups and interviews, providers talked about their need for training on how to run a small business, a topic that is currently not covered through existing home visiting models or curricula. However, home visiting models structure support to include connecting parents with outside resources; with adaptations, the models could help providers meet their training needs. For example, in-home visitors could connect HBCC providers with outside resources on business ownership, including local courses or workshops that might fit their needs.

### HBCC providers who participated in focus groups in different languages had some variation in their needs.

This study looked at differences between providers based on the key characteristic of providers' primary language. In addition, many of the providers who participated in focus groups in Spanish indicated that they had immigrated to the United States from a different country. We found that while these providers shared many of the same needs and experienced many of the same struggles as those who participated in focus groups in English, they differed in some of their professional development needs and how home visiting models may address them. In focus

groups/interviews conducted in Spanish, some of the providers indicated that they entered the field because they were unable to find other jobs due to limited English language abilities; many of those who had immigrated to the United States had some sort of experience in early childhood education in their home country.

To meet the needs of these providers, home visitors would, at a minimum, need to be fluent in Spanish and use a curriculum that had been translated into Spanish. Of the models we reviewed, eight used curricula translated into Spanish.[k] Further modifications to ensure that curricula fit within the cultural contexts of HBCC providers would also improve in-home visitors' ability to meet providers' needs. In addition, providers who have immigrated to the United States may need to be connected with specific resources that can help providers navigate early childhood systems in the United States and support their continued professional development (e.g., making sure they are fully registered with the state, finding trainings). Strategic partnerships with peer groups, organizations, and stakeholders who have rapport with Hispanic and Spanish-speaking populations may expand the reach of home visiting and professional development to these communities, particularly since perceptions of an anti-immigrant political climate may deter these providers from seeking to engage with state systems.[26]

## Providers who participated in focus groups in English were more open to participating in in-home professional development than those who participated in Spanish.

Overall, HBCC providers who participated in focus groups and interviews in English indicated an interest in participating in in-home professional development. Nearly half of providers who participated in focus groups/interviews in Spanish also expressed interest, although a larger proportion of these providers were hesitant about the idea. This could be related to the fact that these providers also indicated that their primary experiences with in-home visits were with regulatory staff rather than coaches or technical assistance providers.

**Table 7.** Provider interest in having a coach or mentor come to their home, by language

| Interest in in-home support | English (n = 39) | | Spanish (n = 20) | |
|---|---|---|---|---|
| | No. of providers | % of providers | No. of providers | % of providers |
| **Yes** | 25 | 64.1% | 6 | 30.0% |
| **No** | 6 | 15.4% | 7 | 35.0% |

Note: An original version of this survey given to participants in focus groups in New Jersey (eight providers who participated in a focus group in English and seven providers who participated in a focus group in Spanish) did not ask about providers' interest in in-home support. The survey was revised after these groups met but may impact findings for providers who participated in Spanish in particular, given that a third of those providers did not have the opportunity to answer this question.

## In-home support that aligns with provider preferences may facilitate their participation in in-home professional development.

Providers indicated specific preferences for the type of support they were interested in receiving in the home. For example, providers emphasized that they appreciate having professional development coaches and technical assistance providers model activities and show them concrete strategies that they can implement in their own instruction and routines.

> " *My kids are up and about and dancing and playing, and that's what we know, so I want someone to come [in] and do the same. Their attention spans are so short that I want the coach to come in and give us examples of how we can transition from…this one's age group to this one because we have the different ages and stages.*

In addition, both providers and parents cautioned that in-home visitors should structure their time in a way that would not disrupt the flow of the day for HBCC providers or for children. Suggestions for doing this included limiting the amount of time in-home coaches spent in the home; coordinating in-home visits with other visitors to the home (e.g., from health and safety, QRIS, or accreditation), ensuring the same in-home visitor came to the HBCC setting

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[k] Child First, Early Head Start, Health Families America, HIPPY, ParentChild+, Parents as Teachers, Play and Learning Strategies, and SafeCare.

each time so that children were familiar with them; and having the visit occur during the morning, when children are awake and participating in activities.

In terms of professional development, support that focuses on providers' strengths rather than approaching providers from a compliance-based perspective will help facilitate providers' participation. Parents and stakeholders who participated in this study advised that the goals and approaches of home-visiting must align with the strengths and needs of HBCC providers. Parents recognized providers' unique strengths, including their ability to provide an intimate, family-like setting and to individualize care for different children, and noted that visitors to the provider's home should have appropriate training and qualifications. In addition, many providers in this study entered the field with previous experience through education programs, credentialing programs, caring for their own children, or work experience in a related field, giving them a base on which to grow their skills. Successful in-home support should build upon those strengths and approach the HBCC provider as a partner, rather than as someone who does not know enough about child development or who needs additional regulatory oversight.

# Exploring State and Local HBCC Systems

The policy and funding scan activity focused on addressing Goal 3 of the project: assessing the feasibility of expanding access to in-home professional development as a model for HBCC within the context of state and/or local systems. Both across the nation and within states, early care and education systems are complex and fragmented. For this reason, we drew on a variety of agencies and organizations to inform the scan. A full list of sources reviewed can be found in Appendix C. We also focus heavily on policy and funding related to listed providers because professional development supports for license-exempt and unlisted providers are not always clearly identified by states and agencies, and most of providers participating in this study were licensed. Because information on city-specific systems and funding is limited and often influenced by states, we also highlight and refer to New York state policies and funding when data on New York City is unavailable.

We start by reviewing child care and home visiting more broadly; this includes gathering information about the regulations and agencies that oversee each system, understanding the prevalence of programs in states, and understanding who participates in services. We then turn to an examination of the different primary funding streams and resources available to support the professional development of child care providers and the implementation of home visiting, with the goal of identifying opportunities to adapt home visiting specifically for HBCC providers. Finally, we conclude with key themes and an exploration of ways existing resources can be applied to support home visiting for HBCC providers.

## Understanding child care and home visiting landscapes

In most states, different agencies oversee child care systems and home visiting systems. The agency that coordinates professional development support for HBCC providers, for example, often is not the same agency that coordinates home visiting services. Understanding who is in charge of regulating and supporting both of these systems can help inform strategies for implementing home visiting for HBCC providers at a larger scale with city or state support. In addition, individual state contexts provide information on ways in which implementation might differ by location. States vary in their requirements for HBCC providers as well as in the degree to which they have integrated HBCC providers into their child care quality improvement systems. The following section highlights HBCC regulations across states, HBCC involvement in state systems, and the agencies that coordinate child care and home visiting.

### Child care landscapes

While child care programs operate individually, child care systems are regulated primarily at the state level by agencies such as state departments of education or departments of children and families that monitor child care programs' adherence to state licensing standards. In addition to licensing standards, child care programs that receive funds from federal sources, such as the Child Care and Development Block Grant (CCDBG) or the Child and Adult Care Food Program, may need to meet additional requirements and receive additional monitoring.

Understanding the per capita rate of HBCC settings in a state provides information about the size of an HBCC provider's presence in a state's child care landscape. Of the four states included in this study, New York had the largest number of licensed homes in 2017 and 2018. Proportionally, however, Minnesota had the highest number of licensed homes per child under age 5, with approximately one licensed home per 42 children. In contrast, New York had one licensed home per 97 children; New Jersey had one licensed home per 278 children; and Georgia had one licensed home per 409 children.[l] It is important to remember that these estimates only reflect listed child care settings, and there is likely a larger number of unlisted providers that available data do not capture.

## Licensing regulations and HBCC provider qualifications

State regulations vary in terms of the number of children allowed per provider household, ranging from two to six children across the four locations.[m] As seen in Table 8, Minnesota is the most lenient state, allowing up to 10 children (but no more than six children under school age) in licensed households. License-exempt providers in Minnesota are limited to caring for their own children and children from no more than one unrelated family, but they are not limited in the total number of children they can have in their care. Other states in this study mandate a smaller number of children allowed in licensed households, and they have more stringent regulations for license-exempt providers around their relational status with children and/or the number of hours per day they provide care.

**Table 8.** Number of children allowed per HBCC household, by state and provider type

| State | Licensed | License-exempt |
|---|---|---|
| Georgia | 3 to 6 children under age 13 (plus 2 children age 3 or older if approved) | 2 unrelated children, maximum of 6 (including related children) |
| Minnesota | 2 to 10 children (no more than 6 under school age) | No limit, but provider can only care for related children and children from no more than one unrelated family |
| New Jersey | 3 to 5 children (plus 3 additional if they are the provider's own children) | Up to 2 unrelated children for fewer than 24 hours of care per day; up to 8 children total (if 3 are the provider's own children and the other 5 are siblings) |
| New York State | 3 to 6 children (plus 2 additional school-aged children cared for outside of school time) | Up to 2 unrelated children, or care for children fewer than 3 hours per day, or related to all children in care |

Source: State agency websites and manuals (See Appendix C)

Regulations on the number and ages of children HBCC providers can care for provide insight into the age range of children in HBCC settings as well as the size of groups. Because home visiting curricula generally focus on one child under kindergarten age, adaptations for HBCC providers will need to consider the challenges of supporting multiple children from a wide age range in one setting.

States' licensing regulations and required qualifications for HBCC providers also vary across states. For example, while Minnesota currently requires the smallest number of pre-service training hours to become a licensed provider, it requires the greatest number of ongoing training hours annually (Table 9). Minnesota also has the least stringent qualifications for licensed HBCC providers, requiring only documentation of their physical ability to care for children. New Jersey, on the other hand, requires either a bachelor's degree or three years of supervisory experience in human services, child care, child development, education, nursing, social work, or business. In addition, New Jersey requires 18 pre-service training hours, and eight hours of annual training.

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[l] Total number of children under age 5 per state in 2017 data were pulled from KIDS COUNT (2018)
[m] These regulations apply to households with just one provider. Group home-based child care settings often have more than one adult caring for children and therefore have different child to adult ratios.

**Table 9.** Licensed HBCC provider qualifications, training, and other regulations, by state

| State | Provider qualifications | Pre-service training | Ongoing training | Inspections | Licensure renewal |
|---|---|---|---|---|---|
| **Georgia** | CDA credential, technical certificate or diploma, paraprofessional certificate, or associate degree or above | 20 hours | 10 hours annually | Pre-licensure and two unannounced visits annually | Annually |
| **Minnesota** | Physically able to care for children, as documented by physical exam (group HBCC provider must meet additional qualifications) | 10 hours | 16 hours annually | Pre-licensure and annually, unannounced | Every 4 years |
| **New Jersey** | Bachelor's degree OR three years of managerial or supervisory experience in related field | 18 hours | 8 hours annually | Pre-licensure and annually, unannounced | Annually |
| **New York State/City** | Minimum of two years' experience caring for children under age 6 OR one year of experience caring for children under age 6 and six hours of training or education in early childhood development | 15 hours | 30 hours every 2 years | Pre-licensure and quarterly, unannounced | Every 4 years |

Source: State agency websites and manuals (See Appendix C)

For the most part, states' required training topics for licensed HBCC providers fall into the categories of health and safety; general child development; abuse, neglect, or maltreatment; and business-related topics. All four states in this study require health and safety trainings, such as CPR and first aid, for both pre-service and ongoing requirements for licensed homes. Trainings regarding child abuse and neglect are required for pre-service in two states (Minnesota and New Jersey) and are available in all states as part of ongoing requirements. Business-related topics, such as records maintenance and management, are sparse: they are only offered as part of ongoing training in Georgia and New York. Finally, child development topics are required for pre-service trainings of HBCC providers only in New Jersey; in other states, these topics are offered as part of ongoing trainings. While Minnesota specifies that providers must receive training on "learning and behavior guidance," the other states focus more on general principles and foundations of child development. Many of these required training topics for providers align with topics addressed in home visiting curricula, as identified in the model and curricula scan section of this report.

Because the training and qualifications vary by state, home visiting adaptations will need to consider each state's local context. If HBCC providers receive training on certain required topics from other entities, home visiting for HBCC providers may need to focus on areas not covered by the requirements. Alternatively, home visiting could be a method to provide required professional development to HBCC providers, such as health and safety training, in a way that works better for their schedule. In this case, home visiting curricula developers would need to work closely with state agencies regulating training to ensure it meets licensing requirements.

## Professional development supports for HBCC providers

In addition to licensing requirements, licensed HBCC providers have access to a variety of supports and resources to advance their professional development and support the provision of high-quality care (see Appendix D for details across the four states). CCR&Rs and state QRIS (for providers who participate) play large roles in supporting the professional development of licensed HBCC providers in all four states reviewed for this project. Both agencies offer resources such as low-cost or free trainings on topics that align with state licensing requirements. They also provide onsite technical assistance around quality improvement issues.

The level of HBCC provider involvement in available professional development, however, varies by location. For example, CCR&Rs in Minnesota are the primary deliverers of pre-service and ongoing trainings to meet licensing requirements, and CCR&R staff spend significant time providing in-person professional development, including to HBCC providers. On the other hand, stakeholders interviewed for this study noted that HBCC providers in New

York (both the state and the city), receive a mixture of professional development services from CCR&Rs and child care unions. The stakeholders also shared that the two groups rarely work together, compete for provider attendance at events, and provide professional development that does not always align with what the other group presents in their professional development.

QRIS participation is one indicator of providers' access to state-level supports (Table 10). In Georgia, over half of listed homes participated in the state's QRIS program in 2018. By contrast, Minnesota reported that only 13 percent of listed HBCC providers participated in the state's QRIS program, despite the fact that HBCC makes up a majority of listed child care settings in the state. Finally, in New Jersey, New York State, and New York City, only around one percent of listed HBCC programs participated in QRIS. The reasons for this variability are unknown, but lower rates of participation in certain states may reflect providers' lack of buy-in on QRIS or their perception that QRIS is not relevant to their work. [27,28] It could also indicate a need for states to more actively reach out to and/or target support for HBCC providers. On the other hand, higher rates of participation in QRIS may indicate strong existing infrastructure for supporting HBCC providers, as well as greater willingness of these providers to use professional development opportunities such as home visits.

**Table 10.** Estimated number of licensed centers and homes, and providers' participation in QRIS, by state

| State | Licensed centers | Licensed homes | Licensed HBCC programs participating in QRIS |
|---|---|---|---|
| Georgia | 3,186 | 1,613 | 871 (54%) |
| Minnesota | 1,742 | 8,410 | 1100 (13%) |
| New Jersey | 3,248 | 1,876 | 24 (1%) |
| New York State/City | 4,796 (NYS) | 11,976 (NYS) 5,231 (NYC) | 151 (NYS; 1%) 67 (NYC; 1%) |

Sources: Child Care Aware of America state fact sheets (2017) and (2018); state QRIS databases (See Appendix C); Hurley & Shen (2016)

Local initiatives and partnerships also provide professional development resources for HBCC workers. Family child care networks (funded programs that provide supports and services to meet the needs of HBCC providers), are one example of community-based initiatives that have the potential to provide in-home support to HBCC providers.[29] New York and Minnesota also fund local centers and institutes that provide training for HBCC providers, sometimes on very specific aspects of professional development, like business and finance strategies.

## Home visiting landscapes

Home visiting services are primarily operationalized at the program level, but they can be influenced by federal- and state-level actions. According to the NHVRC 2018 yearbook, there is at least one evidence-based home visiting program in all 50 states, the District of Columbia, and the five United States territories.[30] Several federal, state, and local systems support home visiting. At the federal level, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) is a key funder of home visiting services across the nation. Three-fourths of the federal funding must be used toward supporting HHS evidence-based models, while the other 25 percent of funds may be used to implement and evaluate promising models.[31] In almost all states, the MIECHV grantee is a state government agency, such as the state's department of health or child and family services.[32] While MIECHV is a central federal voice in home visiting, it does not provide the majority of home visiting funding nationwide.[33] Other funding comes from a range of federal, state, and philanthropic entities, all of which have their own requirements for how to use available dollars.[34]

Table 11 highlights select demographics of children served by evidence-based home visiting programs in the states under review for this study. Many home visiting programs target their services toward low-income children and families in under-resourced areas, conditions that disproportionately affect children and families of color.[35] While a diverse range of families use HBCC, economically disadvantaged families, including some families where parents work nontraditional hours, tend to use HBCC at higher rates.[36] This suggests overlap between the children and families served by home visiting and those in HBCC who may benefit from similar services.

**Table 11.** Demographics of children served by evidence-based home visiting models in 2017, by state

| State | Children served | | | |
|---|---|---|---|---|
| | Total | Race | Ethnicity | Primary Language |
| **Georgia** | 3,075 | 0% AI/AN<br>4% Asian<br>47% Black<br>0% NH/PI<br>41% White<br>5% Multiple<br>3% Other | 23% Hispanic or Latino | 77% English<br>22% Spanish<br><1% Other |
| **Minnesota** | 4,628 | 6% AI/AN<br>5% Asian<br>18% Black<br><1% NH/PI<br>60% White<br>9% Multiple<br>1% Other | 19% Hispanic or Latino | 82% English<br>9% Spanish<br>9% Other |
| **New Jersey** | 5,688 | <1% AI/AN<br>2% Asian<br>29% Black<br><1% NH/PI<br>47% White<br>8% Multiple<br>12% Other | 54% Hispanic or Latino | 61% English<br>36% Spanish<br>3% Other |
| **New York State** | 12,000 | <1% AI/AN<br>3% Asian<br>39% Black<br><1% NH/PI<br>44% White<br>7% Multiple<br>5% Other | 35% Hispanic or Latino | 73% English<br>23% Spanish<br>4% Other |

Source: NHVRC Yearbook (2018)
Notes: AI/AN = American Indian/Alaska Native; NH/PI = Native Hawaiian/Pacific Islander; Children who could benefit from HV = pregnant women and families with children under 6 years old not yet in kindergarten, classified as "high-priority" if they meet any 1 of 5 targeting criteria.

States use multiple home visiting models to deliver services to the children and families they serve. The states included in this study primarily used nine different models.[n] Models used across all states included in this study are Early Head Start (EHS), Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents as Teachers (PAT), and ParentChild+.[o] Attachment and Biobehavioral Catch-up (ABC) is used in all states except Georgia. In addition to national models, New York City also uses several locally created home visiting models to support families, such as the Bank Street Guttman Center Curriculum.

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[n] State-level data was available on the National Home Visiting Resource Center (NHVRC) Yearbook 2018 and state-specific home visiting agency websites (e.g., Department of Public Health). Additionally, some model websites list states where their programs are located. ParentChild+, in particular, listed three states (Georgia, Minnesota, and New Jersey) that were not captured in the NHVRC Yearbook or state agency websites. The models used specifically in New York City were searched using the New York State Council on Children and Families (2018) mapping tool.
[o] ParentChild+ was formerly known as Parent Child Home Program.

## Home visitor qualifications and professional development supports

Home visiting efforts are coordinated based on state-level regulations that guide program execution and quality improvement. In addition, home visiting model developers play a key role in setting standards around the professional development of home visitors: Developers provide states with expectations for home visitor qualifications, skills, and needed supports, and states play a critical role by implementing the developers' visions of that workforce support. In one exception to the typical state governance over home visiting, Early Head Start (EHS) bypasses state-level involvement, providing federal funding directly to local agencies.

Despite the prevalence of home visiting across the country, no overarching licensing or regulatory agency sets standards for home visiting models or monitors the skills and qualifications of individuals who implement them. In part this is because standards for home visitors are set by model developers. Since there is no standard set of credentials for home visitors, programs that use home visitors often make hiring decisions based on personal attributes and characteristics that are thought to be effective for developing relationships with families.[37] As a result, individuals from a wide range of professions (nurses, midwives, psychologists, social workers, paraprofessionals, etc.) deliver home visiting services. These diverse professionals also differ with respect to their educational degrees, licenses, and credentials, making it challenging to implement a cohesive approach to professional development. If home visitors deliver adapted curricula to HBCC providers, it would be important to consider how well home visitors' qualifications match the knowledge needed to work specifically with child care providers.

# Funding streams that support child care and home visiting systems

States leverage multiple funding mechanisms across federal, state, and local levels to support early care and education and home visiting services. The source of these dollars, as well as the proportion of funding that comes from each source, varies across states. Understanding where these funds come from is important because the source determines how funds can be used. Below we provide a brief overview of child care and home visiting funding streams, noting where they can be leveraged to support the utilization of home visiting models as a professional development support for HBCC providers.
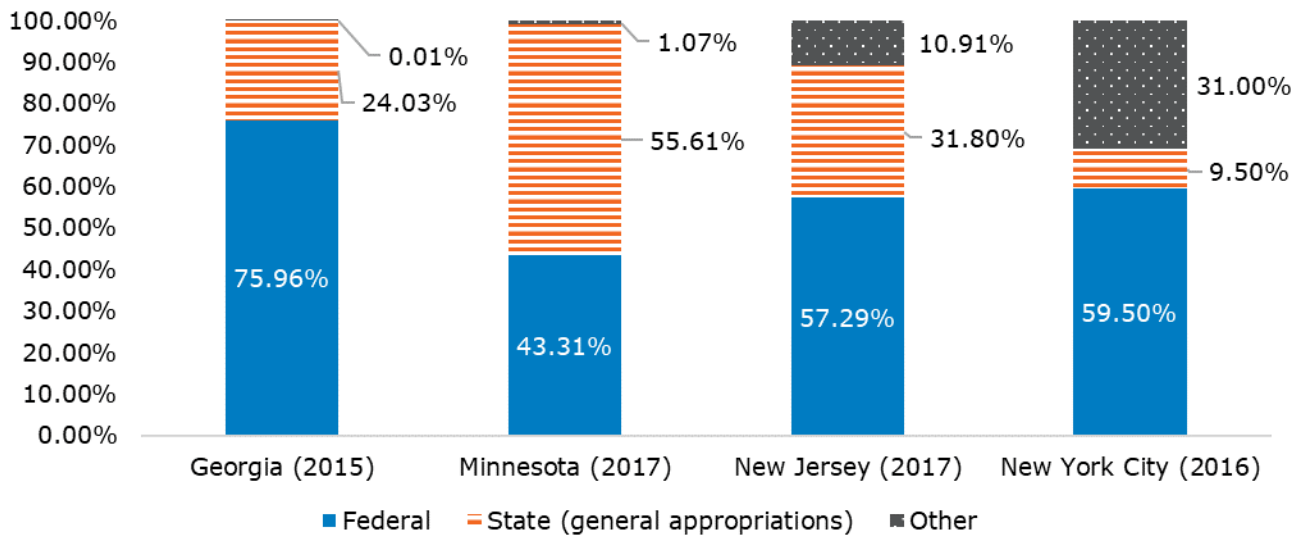
## Child care funding streams

Figure 1 presents the distribution of federal, state, and other funding streams for child care services for the states represented in this study.[p] The Child Care and Development Fund (CCDF), authorized by CCDBG, was the most common source of federal funding reported by all four states in the most recently available data. While some CCDBG policies are determined at the federal level, states have flexibility with setting policies and using funds. For example, CCDBG funds can be used to support professional development activities like training and education for participating child care providers, both home- and center-based. Other sources of federal funding include programs such as Temporary Assistance for Needy Families (TANF) and Head Start. States also use their own funding to support child care. All states included in this study used general fund dollars to support child care, but the proportions differed. [38] Other funding streams included resources from Title IV-E of the Social Security Act, which are federal payments for Foster Care and Adoption Assistance.

In New York City, funding came from the state in the form of universal pre-K dollars, and from city funds, which made up about 31 percent of New York City's total child care funding in 2016. Most of these dollars are spent toward expanding the state's EarlyLearn system, which supports high-quality child care for children eligible for subsidies.[39]

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[p] Because this information was pulled from various data sources, the reported years are not standard across regions. Information from Georgia was not available from NCSL in 2017, so it was pulled from the 2014 state budget actions.

**Figure 1.** Child care funding streams, by state



Sources: NCSL Early Care and Education Budgets (2014) and (2017); NYC Independent Budget Office (2017)

## Home visiting funding streams

At the federal level, home visiting funding comes from the MIECHV program (although these dollars make up only a small percentage of total home visiting funds).[q] MIECHV dollars are prioritized for the provision of home visiting services, and a smaller portion is dedicated to research, evaluation, and program improvement. TANF resources are also used to support home visiting; like MIECHV, the amount dedicated to home visiting is very small. New York received federal TANF dollars to support Nurse Family Partnership specifically,[40] and Minnesota and New Jersey reported using TANF funds to support a variety of home visiting programs.[41]

Some states, like New Jersey, also support home visiting through state education dollars and funds dedicated to preventative measures in child welfare, such as Title IV-B of the Social Security Act (Child and Family Services). In addition, Medicaid dollars have been used to finance the cost of individual visits, although they are unable to be support implementation of entire home visiting programs.[42]

States fund home visiting in a variety of ways, both by distributing funding across home visiting models that operate in a state, and by dedicating certain funds to specific models. Similar to child care, general fund dollars support home visiting implementation and are the most common funding stream for home visiting services in states.[43] In states like New York, private and local government funding from sources including school districts, departments of social services, and foundation grants further support home visiting, highlighting the importance of local initiatives in shaping and implementing home visiting.[44]

Overall, home visiting dollars in each state tend to be directed toward provision of services, such as funding individual family visits. While some funds are dedicated to research, evaluation, and quality improvement activities, the intent is that these activities will support home visiting in areas such as improving program administration and developing the evidence base for the field. Since individual home visiting models often receive local and private funding, those dollars may be directed toward the expansion of models to include the HBCC provider population.

## Opportunities within existing policies and funding structures

As our review uncovered, financing and policy systems in child care and home visiting are siloed. Differences in funding and funding distribution processes result in programs that have varying goals, constituencies, quality standards, and eligibility criteria. However, the policy and funding structure scans did identify two federal funding

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[q] The project team could not locate funding information for New York City specifically, so we referenced the Center for Law and Social Policy (2015) MIECHV state profile for New York State.

sources (CCDF and TANF) that have the potential to support the implementation of home visiting models as a professional development support for HBCC providers. While the underlying premises of the funding sources differ—CCDF was designed to support children's healthy development and school success, while TANF was conceptualized as a parental workforce support—both present opportunities to support workforce development for HBCC providers. Below we briefly review the two funding streams, providing concrete examples of ways they can be used individually and/or in combination to support the implementation of home visiting models as a professional development support for HBCC providers.

## Child Care and Development Fund (CCDF)

CCDF is a block grant administered to state, territory, and tribal governments by the ACF's Office of Child Care under the CCDBG. It is the primary federal funding source for child care subsidies, and the majority of the CCDF is used to fund direct services. In addition to providing financial assistance to states and increasing families' access to child care services, CCDF aims to improve the quality of care providers offer through various means. For example, at least 9 percent of total funds in fiscal year 2020 must be devoted to quality improvement activities[45] within each state, which can include the training and professional development of the workforce, tiered quality rating systems, developmental guidelines, and more.[46] A smaller percentage (3%) of funds must also be set aside to improve the quality of infant/toddler care in particular, which can include expansion of existing quality improvement activities. For example, according to 2016-18 CCDF state plans, New Jersey and New York utilized their dollars to embed infant/toddler standards within their QRIS systems. [47] Other examples of states' efforts included the establishment of regional centers and infant/toddler specialists for the workforce and support of national accreditation for child care programs.

Although these set-aside dollars make up a very small percentage of the total CCDF expenditures within each state, quality improvement activities that qualify for this funding can include home visits to support providers' professional development in various ways, including specific dollars under the infant/toddler set-aside for HBCC providers who serve the zero-to-three population. The Cherokee Nation and four other tribes in Oklahoma, for example, used tribal and CCDBG quality set-aside funds to run a home visiting program focused on supporting quality of care for family, friend, and neighbor care providers.[48] In addition, CCDF's authorizing statute now requires annual visits for participating family, friend, and neighbor care providers. This is another opportunity to use quality funding to support HBCC providers, specifically those providers who may otherwise have less access to professional development support systems.

## Temporary Assistance for Needy Families (TANF)

TANF is funded by federal grants and run by states to assist families with children in becoming self-sufficient through work, education, and/or training. TANF allows funding to be used for the provision of child care services as one way to assist families with meeting this goal. States can use TANF funds to either provide child care services directly within their state TANF programs—meaning supported services only reach TANF recipients—or transfer up to 30 percent of their funds to CCDF.[r] Any funds transferred to CCDF are regulated under CCDF's rules and can be used to contribute to quality improvement activities in a variety of child care programs,[49] providing the most feasible opportunity for supporting home visiting for HBCC providers. As Figure 2 illustrates, Minnesota, New Jersey, and New York transferred between 6 and 8 percent of their TANF funds toward CCDF activities in fiscal year 2016; Georgia did not transfer any of its TANF funds towards CCDF activities.

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[r] Thirty percent of TANF funds may be transferred to CCDF and the Social Service Block Grant (SSBG) collectively.

**Figure 2.** Distribution of federal and state TANF funding, by state
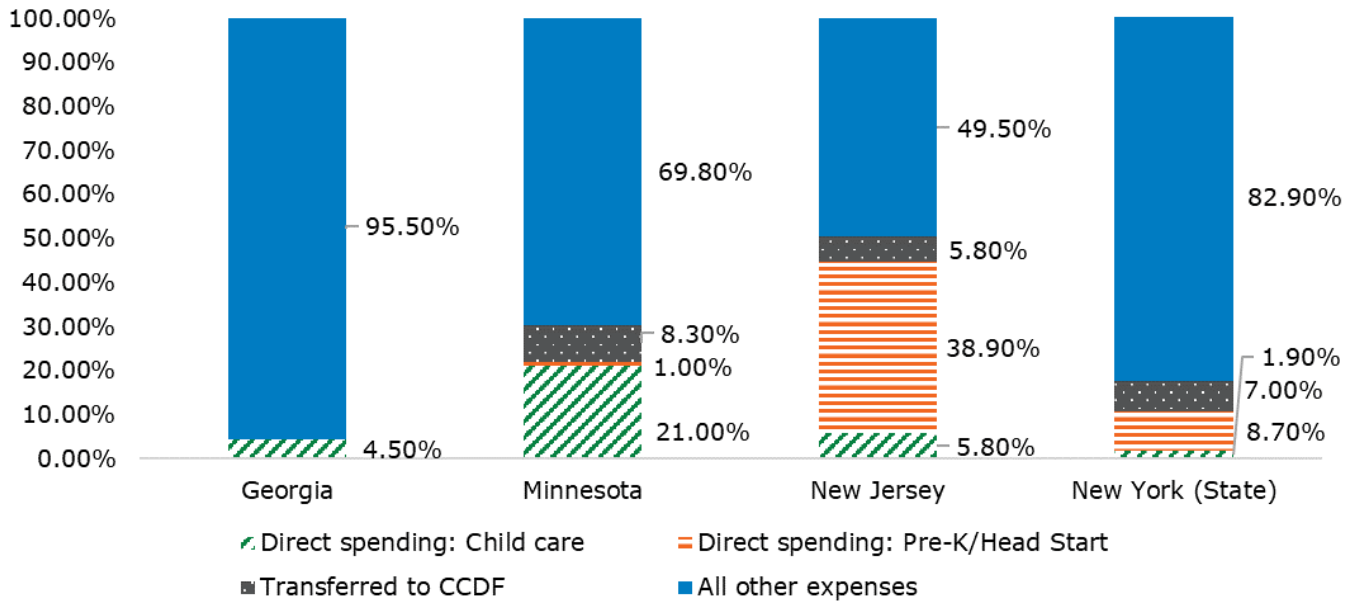


Source: Bipartisan Policy Center state fact sheets (2018)

While both CCDF and TANF are limited and can generally be applied only to licensed or license-exempt HBCC providers, which limits the number and type of children and families benefitting from their use, they do provide opportunities to creatively coordinate and use public funds to support high-quality HBCC programming for vulnerable children and families.

## Key takeaways: State and local contexts

### Existing funding provides opportunities to support professional development for HBCC providers, but additional infrastructure is needed to support the work.

At least three federal funding streams administered by states have the potential to support providing in-home professional development for HBCC providers. CCDF and TANF currently provide support for the implementation of early childhood education services in all states. In addition, MIECHV, a federally funded program also implemented at the local level, supports the implementation of home visiting. While these programs have differing goals and regulatory mandates regarding implementation, all have either explicit or implicit goals embedded in them for supporting children's growth and development. States vary in where they house CCDF, TANF, and MIECHV funding and how they implement funded programs. For example, TANF might determine that a family is eligible for child care services, but a CCDF agency might make the child care payments to providers on behalf of the TANF recipient. In addition, depending on the age of the children in a family, families might also receive home visiting services funded by MIECHV.

The two main ways of using funding from multiple programs to support a single family are blending and braiding. Blending funds involves combining funding from multiple sources to support one program or initiative, while braiding involves coordinating multiple funding sources toward one service for families.[50] Federal regulations make it difficult to blend funding across programs to meet family's needs because this method does not involve tracking costs by funding source. Braiding, however, does involve tracking costs by funding source and can make it possible to maximize funding and ensure that there is not overlap or waste. It can also facilitate allocation and tracking of expenditures by funding source, ensuring that all programs meet reporting requirements for use of funds. The challenge with this method is that the philosophies and regulatory expectations of programs that may be braided together may not always align with each other. While blended funding is not impossible to manage, it requires expertise and involves cross-walking of regulations in a number of areas—including but not limited to funding cycle beginning and endings, service capacity/caseloads, and data systems—to determine and manage where a lack of

alignment might result in a loss or ineffective implementation of services for families and children. Moreover, because both regulations and program practices change frequently, it would be necessary to have a core group of staff dedicated to this work and an appropriate level of resources to support it.

### Different systems and organizations support the professional development needs of HBCC providers across states and cities.

As previously indicated, the number of licensed HBCC providers who participate in QRIS varies across the states and city reviewed for this study. At the high end, over half of licensed homes in Georgia participate in the state's QRIS program, while Minnesota reports only 13 percent participation and New Jersey and New York City (and state) report approximately one percent. While this study did not explore reasons for low participation levels in QRIS, the findings suggest that states should identify where the majority of their HBCC providers receive quality improvement and professional development supports before making decisions about where to house and fund in-home professional development. Partnering with local organizations that provide professional development outside of state ECE systems may help increase capacity to support HBCC providers, particularly those not participating in state-level quality improvement efforts. For example, HBCC providers in one Minnesota city worked with a state program implemented through local school districts to get in-home professional development support that meets their needs.

### Existing home visiting and early care and education staff have the skills needed to implement in-home professional development with some additional training.

Home visitors, who are trained in specific models that they implement with families, as well as individuals who currently provide support to HBCC providers as part of quality improvement efforts (e.g., coaches, technical assistance providers, quality improvement specialists), have skills that position them well to conduct in-home professional development for providers. Home visitors focus their work on supporting behavior change of adults in the home environment. Similarly, individuals who help facilitate quality improvement efforts work with child care providers to establish relationships, set goals for their work, and model ways to achieve those goals through early care and education practices, [51] which have been linked to positive changes in teachers' behaviors and children's growth and development.[52]

Home visiting professionals are well suited to do this work, given the skills and content they focus on during home visits with families. In addition, the attributes that home visiting model developers consider important for home visitors to have, and the type of training home visitors receive position them well to work with HBCC providers to improve children's development. Home visitors are trained in implementing curricula; they also understand state and local contexts through their connections to the outside resources they work with to support families.

Quality improvement professionals working in systems like QRIS and CCR&Rs also have skillsets that are conducive to supporting HBCC providers in their homes. These individuals are well versed in state and local child care systems and have experience working with providers to improve child care practices. While their experience with using curricula to guide practice may be more limited, ECE quality improvement professionals likely have existing relationships with providers that provide a base for expanding their work.

# Concluding Thoughts and Considerations

Analysis of data collected for this feasibility study suggests that using a home visiting model to strengthen the quality of care offered by HBCC providers is a promising professional development strategy. Providers, parents, and key stakeholders expressed interest in this approach and provided constructive suggestions for implementation. Our review of state and local policies and funding streams, our conversations with home visiting curricula developers, and our examinations of their curricula provide a starting point for thinking concretely about how to launch and sustain larger-scale efforts for supporting HBCC providers through home visiting. We conclude this report by highlighting opportunities and next steps for advancing this work.

## Implementing a home visiting model as a professional development strategy for HBCC requires coordination among multiple entities.

Stakeholders involved in HBCC have different priorities, all of which are important to incorporate into new professional development strategies. States and funders have priorities for HBCC providers based on their goals for their early childhood system and regulations they are required to enforce. HBCC providers and parents of children in HBCC have their own priorities for provider skills and the outcomes they support for children. Finally, home visiting models have knowledge and goals that carry over from their work with families to their work with HBCC providers. Creating an effective professional development intervention will require coordination among all of these stakeholder groups to ensure that the model fits the requirements of states while also meeting the needs and interests of HBCC providers and families.

## Expanding the evidence base for using home visiting to support HBCC may facilitate efforts to scale up the model.

Research on home visiting for HBCC providers has focused on ways to support implementation, as well as model-specific research on outcomes, but it is still in the early stages. In addition, the lack of a centralized database for early childhood systems at both federal and state levels poses challenges to gathering information about professional development needs and the potential for home visiting to meet those needs across states. Existing data on required and available training often lack the detail needed to understand whether the training is useful and accessible to HBCC providers. To broaden efforts to implement home visiting for HBCC providers and gain stakeholders' support, it is necessary to expand the evidence base for conducting this type of professional development at a larger scale and across multiple home visiting models. Current pilots of home visiting for HBCC providers present opportunities to assess this model's effectiveness and identify the aspects of traditional home visiting models that need to be modified for a child care setting. It would also be helpful to gather more information on the potential for home visiting to involve unlicensed providers in state and local early care and education systems, either through licensing or through connections with other resources. With this information, states could to determine whether home visiting can be an effective strategy for better coordinating and regulating the landscape of child care providers in their communities.

## Improving professional development for HBCC providers may help improve quality of care for children and families that have been historically disadvantaged.

Families from racial and ethnic minority groups, as well as other populations that may have less access to resources—including low-income families, families with single parents, and children whose parents have limited education—tend to use HBCC more often.[53, 54] Moreover, research shows that these children and families benefit disproportionately from high quality ECE and home visiting programs. Research on the overlap between children in HBCC and children receiving home visiting services is limited; however, using home visiting approaches in HBCC settings may have the potential to both expand access to high-quality ECE and increase the number of children who have access to the type of support provided by home visiting models. Increasing HBCC providers' skills in providing developmentally appropriate care, fostering children's social emotional development, and connecting families to economic or other supports can improve the early care and education experience for these children and families.

## Home visiting is a feasible strategy for supporting HBCC, but implementing it at scale in states and communities will require additional research, funding, and professional development system infrastructure.

HBCC providers are a heterogeneous group and have varied access to resources to support their work. While federal and state funding can be used to advance quality improvement initiatives for listed HBCC providers who are licensed, certified, registered, and/or license-exempt, unlisted providers tend to have less access to professional

development supports and other resources. At least two home visiting models, ParentChild+ and HIPPY, have been able to provide professional development support to unlisted providers in select states across the country, but they have not been able to provide this support at scale. There are, however, worthwhile lessons from these models' endeavors that can inform potential next steps to extend the reach of this professional development strategy to unlisted providers. Moreover, philanthropic dollars, which tend to be more flexible than federal and state funding, could be used to seed innovation and a larger public investment in professional development for unlisted providers.

HBCC providers often have access to the fewest resources in the child care system and often face the greatest obstacles to accessing professional development, but they have the most to gain from participation. With attention to early care and education at an all-time high, and with growing recognition that large numbers of young children, particularly infants and toddlers, are served in HBCC settings, the climate is favorable for making investments in efforts to support HBCC providers.

# Appendices

## Appendix A: Curricula scan

**Table A1.** Targeted outcomes, by curricula

| | Curriculum | Child First | EHS-HV | Early Start | Family Check-Up | HFA | HIPPY | Parent Child+ | PATs | PALS | Safe Care |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Child** | Social-emotional | | √ | √ | √ | | | √ | | √ | |
| | Behavioral | √ | √ | √ | √ | √ | √ | √ | | √ | √ |
| | Academic outcomes | | | | | √ | √ | | | | |
| | Executive function | | | | | | | | √ | | |
| | Language/cognitive outcomes | √ | √ | | | √ | √ | | √ | √ | |
| | Physical health | | | √ | | √ | | | | | |
| **Caregiver** | Parenting knowledge/attitudes | √ | √ | √ | | √ | | | | | |
| | Stress/mental health | √ | | | √ | | | | | | √ |
| | Positive practices/interactions | | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| | Improved home environment | | √ | | √ | √ | √ | | √ | | √ |
| | Physical health | | √ | | | √ | | | | | |
| **Family** | Reduced child/family maltreatment | √ | √ | √ | | √ | | | √ | | √ |
| | Increased services | √ | √ | | | √ | | | | | √ |
| | Income/education | | √ | | | | | | | | |

Targeted Outcomes

**Table A2.** Implementation factors, by curricula

| Curriculum | Child First | EHS-HV | Early Start | Family Check-Up | HFA | HIPPY | Parent Child+ | PATs | PALS | Safe Care |
|---|---|---|---|---|---|---|---|---|---|---|
| HHS ACF evidence-based | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | ✓ |
| Home visitor requirements | Bachelor's/ Master's | Determined by local agencies | Bachelor's | Master's | HS diploma or Bachelor's | HS diploma, CDA recommended | | HS diploma/ GED + 2 years experience | HS diploma | Master's |
| Number/frequency of Sessions | Twice per week | Weekly, min. of 48/year | Varies from once/week to once/3 months | 3 initial, 3 to 15 optional follow ups | Once per week for 6 months, then varies | 30 weekly + 6 group meetings/year | 23-46 per year, twice per week | 12-24 per year + 12 group meetings | 10-11 sessions, weekly | Weekly or biweekly for 18-22 weeks |
| Length of sessions | 60-90 mins | 90 mins | 1-3 hours | 1 hour | 1 hour | 1-2 hours | 30 mins | 1 hour | 90 mins | 60-90 mins |
| Cost | $7,800 per family | $9000-$12,000 per child | $6,750 NZ dollars per family | NA | $3,577 - $4,473 per family | $1,500 - $2,500 per child | $2,800 per family | $2,575-$6,000 per family | $2,500 per family | $2,275 per family |
| Used with HBCC/FCC providers | X | X | X | X | X | ✓ | ✓ | ✓ | X | X |
| Translated into Spanish | ✓ | ✓ | X | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Translated into other languages | X | Unspecified | X | X | Unspecified | X | Chinese | German | X | X |
| # of states implemented | 3 | All 50 + DC, PR | International | 8 | 37 + Territories | 21 + DC | 15 | 50 + DC | 2 | 16 |

**Table A3.** Targeted population, by curricula

| Curriculum | Child First | EHS-HV | Early Start | Family Check-Up | HFA | HIPPY | Parent Child+ | PATs | PALS | Safe Care |
|---|---|---|---|---|---|---|---|---|---|---|
| Child age range | Birth – 5 years | Birth – 3 years | Birth – 5 years | 2 – 5 years | Prenatal – 5 years | 3 -5 years | 2 -3 years | Prenatal - Kindergarten | 5 – 15 months, 18 mo – 4 years | Birth – 5 years |
| Children with behavioral/developmental problems | ✓ | ✓ | | | | | | | ✓ | ✓ |
| Children with special needs or disabilities | | ✓ | | ✓ | | | | ✓ | | ✓ |
| Low-income | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Risk/history of domestic violence | ✓ | | | | ✓ | | | | | ✓ |
| Risk/history of child abuse or maltreatment | ✓ | ✓ | ✓ | | ✓ | | | ✓ | ✓ | ✓ |
| Parents with limited education or skills | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | |
| Parent mental health issues | ✓ | | | ✓ | ✓ | | | ✓ | | ✓ |
| Substance abuse | ✓ | ✓ | ✓ | | ✓ | | | ✓ | | ✓ |
| Single or teen parenthood | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | |
| Limited English | | | | | | ✓ | ✓ | | | |
| Limited literacy | | | | | | | ✓ | ✓ | | |
| Other | Homeless | Children in foster care | First-time parents | Risk of academic failure | | Immigrant families | Homeless, immigrants, isolation | | | Released, reunified, foster parents |

# Appendix B: Study methodology

## Interview and focus group recruitment

To be eligible for the study, providers had to work in a HBCC setting and serve at least three children under age 6. To recruit providers, Child Trends reached out to organizations within each state and city that had connections with HBCC providers.[r] In some cases, individuals from those organizations directly reached out to providers; in others, the Child Trends research team reached out to providers using contact information shared by the organizations. We stratified groups by site and language preference (English focus groups n = 39, Spanish focus groups n = 20). Child Trends also facilitated focus groups with parents of children who were in HBCC at the time of the study (n = 13). Parents were primarily recruited by participating providers, which may have limited parent participation.

We explored additional recruitment strategies during data collection to accommodate study needs. We pursued paid advertisements on Facebook and Instagram, which we expected would be effective for recruiting parents using child care. The advertisement linked to a Spanish-language survey that would screen out individuals who did not meet study the inclusion criteria. However, this strategy was unsuccessful. The advertisement may not have been approved by Facebook because it was written in Spanish and referenced the population of Spanish-speaking parents using child care; Facebook has made policy changes aimed at reducing the level of population-specific targeting allowed by advertisements. We also posted advertisements on Craigslist and asked organizations serving parents who use child care to advertise the study on their websites. Neither of these strategies yielded Spanish-speaking participants. Due to these challenges, we did not have substantial sample sizes to conduct parent focus groups in Spanish. Thus, study results are not generalizable to Spanish-speaking parents overall.

## Data collection procedures

The Child Trends research team developed focus group protocols for providers and parents, which were informed by findings from the curricula review and policy scan, that included questions to assess the alignment of in-home professional development with the characteristics of HBCC providers and their needs. We asked HBCC providers to answer questions about the benefits and challenges of HBCC, the barriers and facilitators that affected their access to professional development, their interest in in-home professional development,[s] and the strategies and supports necessary to improve the capacity of HBCC providers to provide quality care. The parent protocol asked parents who use HBCC about their experiences with HBCC, search and decision-making process, and perceptions of the skills and supports child care providers should have. Our stratification allowed us to better understand whether there were HBCC providers who were more or less open to in-home professional development and whether there was variation based on provider characteristics.

Each focus group lasted approximately one hour. In-person focus groups were conducted at community centers or partner organizations that were relatively accessible for participants. Participants received food during the in-person sessions and $50 in cash at the end. Participants in the virtual groups received a $50 Target or Walmart gift card after the sessions. We also gave participants a flyer with information about the study and a thank you note. Participants agreed to have the discussions audio-recorded. Child Trends' Institutional Review Board (FWA 00005835) exempted the study from review since the intent of the study was to inform improvements to professional development in HBCC and not to contribute to generalizable knowledge.

## Data analysis

After each focus group, the Child Trends study team held debriefing sessions and drafted a summary of participant characteristics and emerging themes to modify the protocol as needed and identify key themes. A contractor transcribed the audio recordings in either English or Spanish prior to data analysis. Two qualitative researchers reviewed all the English transcripts independently and coded participants' responses in Dedoose. Spanish transcripts were coded in Dedoose in Spanish by two native Spanish-speakers to preserve any nuance in the

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[r] The organizations we partnered with include the Georgia Department of Early Care and Learning (DECAL), the Women's Housing and Economic Development Corporation (WHEDco), and the Northland Foundation.

[s] This question was added in after the first English- and Spanish-language focus groups.

language. Quotes and themes were then translated into English. We then discussed commonalities and differences across the English and Spanish groups, identifying themes to create a narrative.

All survey results were analyzed in Stata.

# Appendix C: Policy scan data sources

## Data systems

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The Build Initiative & Child Trends. (2019). A Catalog and Comparison of Quality Initiatives. Retrieved from http://qualitycompendium.org/

## Interviews with key stakeholders

- CCR&R state network administrators
- Child care technical assistance (TA) providers
- Child care state leads
- Home visiting state leads
- Home visiting curriculum developers

## National/state fact sheets

Bipartisan Policy Center. (2018). TANF and Early Childhood. Retrieved from https://bipartisanpolicy.org/library/tanf-and-early-childhood/

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## State agency websites

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Georgia Department of Early Care and Learning. (2019). Child Care Services. Retrieved from http://decal.ga.gov/CCS/Default.aspx

Minnesota Department of Human Services. (2019). Licensed family child care. Retrieved from https://mn.gov/dhs/partners-and-providers/licensing/child-care-and-early-education/family/

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New Jersey Department of Children and Families. (2019). Home Visitation Programs. Retrieved from https://www.state.nj.us/dcf/families/early/visitation/

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New York State Department of Health. (2017). New York State's Home Visiting Programs: Support for Pregnant and Parenting Families. Retrieved from https://www.health.ny.gov/community/pregnancy/home_visiting_programs/

New York State Office of Children and Family Services. (n.d.). Division of Child Care Services. Retrieved from https://ocfs.ny.gov/main/childcare/default.asp

## State applications for PDG B-5 grants

Colorado Department of Human Services, Office of Early Childhood. (2018). Colorado's Preschool Development Grant Birth through Five Application. Retrieved from http://coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=Colorado-Shines-Brighter&lang=en

Georgia Department of Early Care and Learning. (2018). State of Georgia Preschool Development Grant Birth through Five (PDG B-5). Retrieved from http://decal.ga.gov/documents/attachments/GAPDGB5_Application.pdf

Minnesota Department of Education. (2019). Preschool Development Grant Birth-Five (PDG B-5) Project Description. Retrieved from https://education.mn.gov/MDE/dse/early/preschgr/

New York State Council on Children and Families. (2018). New York State: Preschool Development Grant Birth through Five Application. Retrieved from https://www.ccf.ny.gov/files/9815/4775/1818/NYS_PDGB5_Application.pdf

## State CCDF draft plans for FFY 2019-21

Georgia Department of Early Care and Learning. (2018). Child Care and Development Fund (CCDF) Plan for State/Territory – Georgia FFY 2019-2021. Retrieved from http://decal.ga.gov/documents/attachments/CCDFProposedStatePlan.pdf

Minnesota Department of Human Services. (2018). Child Care and Development Fund (CCDF) Plan for State/Territory – Minnesota FFY 2019-2021. Retrieved from https://mn.gov/dhs/assets/Minnesota%27s-proposed-CCDF-2019-2021-federal-plan_tcm1053-336151.pdf

New Jersey Department of Human Services, Division of Family Development. (2018). Child Care and Development Fund (CCDF) Plan for State/Territory – New Jersey FFY 2019-2021. Retrieved from https://www.state.nj.us/humanservices/providers/grants/public/publicnoticefiles/DHS-DFD-DRAFT-NJ%20CCDF%202019-2021(5-31-18).pdf

New York State Office of Children and Family Services (2018). Child Care and Development Fund (CCDF) Plan for State/Territory – New York FFY 2019-2021. https://ocfs.ny.gov/main/childcare/stateplan/documents/ffy2019-21/NYS-FY-2019-2021-DRAFT-CCDF-Plan.pdf

## State child care agency manuals/regulations

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Minnesota Department of Human Services. (2018). Child Care Assistance Program (CCAP) Policy Manual. Chapter 11: Providers. Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=CCAP_11

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New York State Office of Children and Family Services. (n.d.). Child Care Regulations & Policies. Parts 413 - 417. Retrieved from https://ocfs.ny.gov/main/childcare/daycare_regulations.asp

## State QRIS websites

- Grow New Jersey Kids: http://www.grownjkids.gov/Welcome

- Minnesota Parent Aware: https://parentaware.org/

- QualityStars New York: http://qualitystarsny.org/

- Georgia Department of Early Care and Learning Quality Rated: http://decal.ga.gov/QualityInitiatives/QualityRated.aspx

# Appendix D: Supports for HBCC providers, by state

**Table D1.** Professional development supports for HBCC providers, by state

| State | CCR&R | QRIS | FCC networks | Online trainings | Mentors, coaches, consultants, specialists to provide TA | Credentials or Certificates | Partners with Higher Ed Institutions | Other |
|---|---|---|---|---|---|---|---|---|
| Georgia | Yes | Yes | Yes | Yes - DECAL | Yes – CCR&Rs, QRIS, statewide network of I/T specialists | Technical College Certificate, TDA | Yes | Early Head Start Child-Care Partnerships |
| Minnesota | Yes | Yes | Yes | Yes - Center for Inclusive Child care, CCR&R | Yes – CCR&Rs, QRIS, relationship-based PD, I/T specialists | MN Child Care Credential | Yes | Achieve (MN center for Professional Development), First Children's Finance (Business strategies), MNAEYC |
| New Jersey | Yes | Yes | Yes | Yes – DHS/DFD QRIS | Yes – DHS/DFD CCR&Rs, QRIS, I/T specialists, quality improvement specialists, First Steps | None | Yes | Various partner agencies with DHS/DFD |
| New York State/City | Yes | Yes | Yes | Yes - Office of Children and Family Services | Yes – OCFS, CCR&Rs, I/T Specialists, QRIS, quality improvement specialists | Infant Toddler Care & Education Credential (ITCEC), Family Child Care Credential (FCCC) | Yes | New York City Administration for Children's Services (ACS), EarlyLearn NYC program, New York Early Childhood Professional Development Institute, NYAEYC |

Examining the Feasibility of Using Home Visiting Models to Support Home-Based Child Care Providers

**Table D2.** Financial supports for professional development of HBCC providers, by state

| State | Scholarships | Free training & education | Reimbursement for training & education | Incentives | Grants | Loans | Release time for PD |
|---|---|---|---|---|---|---|---|
| **Georgia** | Yes – DECAL Scholars | Yes - through CCR&Rs | No | Yes | No | No | No |
| **Minnesota** | Yes - T.E.A.C.H. Early Childhood Scholarship Program, Early Learning Scholarships through MN Dept of Education | Free or low cost – through Minnesota DHS, CCR&Rs | Yes | Yes - Retaining Early Educators Through Attaining Incentives Now (R.E.E.T.A.I.N.) | Yes – CCR&Rs | No | Yes |
| **New Jersey** | Yes - through DHS/DFD, CCR&Rs | Yes – through DHS/DFD and other partner agencies | No | Yes - QRIS, First Steps Initiative | No | No | No |
| **New York State/City** | Yes - Education Incentive Program (EIP), QRIS | Yes - OCFS, CCR&Rs, Suny Albany Professional Development Program (PDP) | No | Yes - Education Incentive Program (EIP) | Yes – CCR&Rs, Unions | No | No |

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