

# Close to Home



## **State Strategies to Strengthen and Support Family, Friend, and Neighbor Care**

The National Women’s Law Center is a nonprofit organization that has been working since 1972 to advance and protect women’s legal rights. The Center focuses on major policy areas of importance to women and their families, including employment, education, health and reproductive rights, and family economic security.

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## INTRODUCTION

With millions of working parents relying on family, friends, or neighbors (FFN) to care for their children, it is important that public policies regarding early care and education and family support focus on strategies for bolstering this care. While many factors other than state policies may affect a family's decision to use FFN care, there are multiple strategies that states can adopt to help support and strengthen FFN care. This is particularly critical given that many low-income children—who are often most at risk for starting school behind their more advantaged peers and stand to benefit the most from a good early learning environment—are in FFN care. By focusing a portion of state resources and attention on FFN care, states can help improve the quality of care these children receive. Increased investment in FFN care also matters because many FFN providers are low-income women who themselves are in need of support and resources.

Definitions of FFN care vary, but for the purposes of this report, unless otherwise noted, it is defined as nonparental care that is provided in a home setting for a small number of children and that is not required by the state to be regulated—which means that what is considered FFN care will vary across states. This is a diverse group, as an FFN provider may be a relative or non-relative, may be paid or unpaid, may or may not have a close relationship with the family, and may be caring for just one child or several children, depending on the state and the types of providers it exempts from regulation. An FFN provider may be a grandparent helping out her child and grandchildren for a short period of time or may be someone who has made a long-term commitment to providing child care as a primary source of income. The diversity of FFN providers can make it challenging to determine their needs, much less identify policies to address those needs. It is likely that multiple strategies are required to address the varied circumstances of FFN providers. Many of the strategies designed to support FFN care can also apply to regulated home-based care, and in some cases, center care as well.

This report addresses some of the policy decisions states make or could make to support FFN care, including:

- ❑ Determining which providers are exempt from state licensing or regulation.
- ❑ Setting standards for FFN providers receiving public funds.
- ❑ Establishing policies for child care assistance programs that help parents pay for FFN care, including provider reimbursement rates and parent copayments.
- ❑ Supporting initiatives to improve the quality of child care, including FFN care.
- ❑ Allowing FFN providers to participate in the Child and Adult Care Food Program.
- ❑ Facilitating coordination of state prekindergarten initiatives with FFN care.
- ❑ Assisting FFN providers caring for children with disabilities and other special needs.
- ❑ Making home visiting and family support programs available to FFN providers.
- ❑ Permitting unionization of FFN providers.

The report discusses the policy options states have in each of the areas, how these policies can affect families using FFN care as well as FFN providers, and examples of promising approaches states have taken. Many of these policies are related to the child care subsidy system, since it offers one of the few levers available for influencing FFN providers, whose unregulated status typically leaves them otherwise disconnected from state programs and policies. However, there are still a number of policy strategies to reach out to the many FFN providers who are not receiving subsidies yet who could benefit from additional supports.

## Background Data on Family, Friend, and Neighbor Care

Because of the diverse definitions of FFN care, data on the use of this care are limited and not always comparable. Most studies do not designate a separate category for FFN care as defined here, and instead use a category of “home-based care” that includes both regulated family child care and FFN care, or use a different definition of FFN care than that used here. As a result, it is not possible to determine the number or proportion of children in FFN care, but some approximations can be made.

For example, an analysis of data from the 2003 National Survey of Children’s Health distinguishes child care arrangements by setting, but not by whether the child care is regulated. The analysis found that 65 percent of all children under age six—nearly 15.5 million children—regularly received nonparental child care.<sup>1</sup> Of these children, 42 percent—approximately 6.5 million children—spent at least some of their time in a home-based setting, as opposed to center-based care, including 1.5 million children who only used a home-based setting.<sup>2</sup>

Data from the National Survey of America’s Families (NSAF) distinguish family child care from nonparental relative care, but do not distinguish between regulated or unregulated care. According to these data, in 2002, 39 percent of children under age five with employed mothers were in family child care (16 percent) or nonparental relative care (23 percent) as their primary arrangement, while 32 percent were in center-based care, and 6 percent were cared for by a nanny or other non-relative caregiver in the child’s home.<sup>3</sup> The remaining 24 percent had no regular child care arrangement or were cared for only by their parents.<sup>4</sup>

An analysis of 2005 National Household Education Survey (NHES) data defines FFN care as nonparental relative care, non-relative unpaid care outside the child’s home, and non-relative care inside the child’s home care (paid or unpaid), excluding from the definition non-relative paid care outside the child’s home that is not required to be regulated.<sup>5</sup> The analysis found that nearly one-quarter of all children under age six—over 5 million children—regularly used at least one of these types of care.<sup>6</sup> Children using FFN care as defined in this analysis were in this type of care for an average of thirty-one hours a week.<sup>7</sup> Slightly over half (51 percent) of children under age three were in nonparental child care in a typical week, and 41 percent of the hours spent in nonparental care were spent in FFN care as defined in this analysis.<sup>8</sup> Nearly three-quarters (74 percent) of children ages three to five were in nonparental child care in a typical week, and 31 percent of the hours spent in nonparental care were spent in FFN care as defined in this analysis.<sup>9</sup>

Studies on child care arrangements of school-age children similarly do not disaggregate their data in ways that allow identification of how many children are in FFN care. However, the available data indicate that a substantial proportion of school-age children spend time in home-based care. In 2005, 24 percent of children in kindergarten through third grade spent at least part of their time in home-



based care, according to NHES data.<sup>10</sup> Among children in fourth through eighth grade, 18 percent were in such care for at least part of their day.<sup>11</sup> Another study, using 1999 NSAF data, found that 23 percent of children ages six through twelve with employed parents were in nonparental relative care as their primary arrangement, compared to 15 percent who attended before- or after-school programs, 7 percent who were in family child care settings, and 10 percent who cared for themselves as their primary arrangement (the remaining 41 percent were in parent care or enrichment activities not considered to be child care).<sup>12</sup>

### Families Using Family, Friend, and Neighbor Care

FFN care is used by a wide range of families, according to two studies synthesizing the research data on this type of care.<sup>13</sup> Although the research data are not wholly consistent, they identify some background and family characteristics that may be correlated with at least certain types of FFN care, such as nonparental relative care, or with the broader category of home-based care that includes FFN care. Factors such as parents' work schedules, race and ethnicity, family income, family structure, and whether the family lives in an urban or rural area may influence the use of FFN care.

- ▼ A five-state study that, like the analysis of the 2005 NHES data discussed above, defined FFN care as nonparental relative care, non-relative unpaid care outside the child's home, and non-relative care inside the child's home care (paid or unpaid), found that a higher percentage of this care than other types of care was provided during nonstandard hours such as evenings and weekends.<sup>14</sup> Over half (54 percent) of FFN care as defined in this analysis was provided during evenings or weekends, compared to 26 percent for family child care and 9 percent for center-based care.<sup>15</sup> The study suggested that this might be because parents with nontraditional work hours need the flexible arrangements that FFN care may be more likely to offer.<sup>16</sup> However, another study found that the percentage of preschool-age children in nonparental relative care was approximately the same for both children with parents working traditional hours and children with parents working nontraditional hours.<sup>17</sup> This study did not provide an explanation for why this pattern occurred.
- ▼ Use of FFN care may be affected not only by when parents work, but also by how many hours they work. For example, one 2004 study found that mothers who work more than forty hours per week were less likely to use family child care or nonparental relative care and more likely to use center care as their primary arrangement.<sup>18</sup>
- ▼ According to an analysis of NSAF data, Hispanic and black families are both more likely than white families to regularly use nonparental relative care, either as their sole arrangement or in combination with other arrangements.<sup>19</sup> Thirty-two percent of white children under age three with employed parents were in relative care in 1999, compared to 43 percent each for black and Hispanic children under age three.<sup>20</sup> Twenty-eight percent of white three- and four-year-olds were in relative care, compared to 36 percent for black three- and four-year-olds and 40 percent of Hispanic three- and four-year-olds.<sup>21</sup> However, an analysis of 1997 and 1999 NSAF data on primary child care arrangements (defined as the type of child care used for the most hours) found a somewhat different picture.<sup>22</sup> Hispanic children under age five with employed parents were much more likely than black or white children under age five with employed parents to be in relative care as their primary arrangement (40 percent versus 28 percent and 24 percent, respectively).<sup>23</sup> Black children under age five with employed parents were much more likely

than white or Hispanic children to be in center care as their primary child care arrangement (44 percent versus 32 percent and 20 percent, respectively).<sup>24</sup>

- ❑ According to a 2004 analysis of data from the Survey of Income and Program Participation, low-income families are less likely to use center care than high-income families.<sup>25</sup> However, an analysis of 1999 NSAF data indicates an intriguing pattern in the use of nonparental relative care for toddlers and preschoolers—it is greatest among both the lowest and highest income groups.<sup>26</sup>
- ❑ According to an analysis of 1999 NSAF data, single mothers with children under age thirteen rely more on nonparental relative care than two-parent families.<sup>27</sup> For example, 47 percent of three- and four-year-olds in single-parent families were regularly in nonparental relative care (either as the only child care arrangement or in combination with other arrangements), compared to 27 percent of three- and four-year-olds in two-parent families.<sup>28</sup> Similarly, 38 percent of six- through nine-year-olds in single-parent families were regularly in nonparental relative care, compared to 23 percent of six- through nine-year-olds in two-parent families.<sup>29</sup>
- ❑ According to an analysis of 2002 data from the Survey of Income and Program Participation, families with children under age five living in rural areas are more likely to use non-relative home-based care for their children than families with children under age five in urban areas, although the use of nonparental relative care is similar across urban and rural areas.<sup>30</sup>
- ❑ According to an analysis of 1995 NHES data, children with special needs are more likely than other children to be in center-based care.<sup>31</sup> However, according to an analysis of 1999 NHES data using the same definition of FFN care as was used in the five-state study discussed above, there are 200,000 children with special needs in FFN care, and one in eight (12.7 percent) children who use FFN care have special needs.<sup>32</sup>

Parents give a number of reasons for using FFN care. Parents most commonly report that it is because they know and trust their FFN providers and feel their children will be safe and receive individualized attention.<sup>33</sup> While few parents specifically cite shared values and culture as their motivation for choosing this type of care, this may be an underlying factor in their feelings of trust toward their FFN provider.<sup>34</sup> Parents using nonparental relative care also believe that this will help enhance family relationships.<sup>35</sup> Other reasons that some parents cite for choosing FFN care are cost, low child-provider ratios, and convenient hours.<sup>36</sup>

### Family, Friend, and Neighbor Providers

FFN providers constitute a significant proportion of the overall child care provider population. Of the estimated 4.7 million child care providers in a given week, about two-thirds (3.0 million) were nonparental relatives, including 2.2 million who were unpaid and 804,000 who were paid, according to a study by the Center for the Child Care Workforce and the Human Services Policy Center.<sup>37</sup> A 2005 study found that the most common nonparental relative provider was a grandmother.<sup>38</sup> The remaining child care provider population included 650,000 paid non-relative providers caring for children in the provider's home, 550,000 paid center providers, 298,000 other paid non-relative providers (typically, those providing care in the child's home), and 121,000 unpaid non-relative providers (in each case, these providers may have been regulated or unregulated—the study does not distinguish between the two).<sup>39</sup>

Data on the characteristics of FFN providers are limited, but two state-level studies—in Washington and Minnesota—offer some information about these providers, including the hours they work and how much they are paid.

The 2002 Washington state study (which defined FFN care as either regulated or unregulated care by nonparental relatives, friends, neighbors, or other types of paid or unpaid caregivers who are not licensed child care centers or family child care providers)<sup>40</sup> found that over half (53 percent) of the FFN caregivers provided care for more than ten hours a week, including one-quarter (25 percent) who provided care for more than thirty hours a week.<sup>41</sup> Among FFN providers caring for children birth through age five, over two-thirds (69 percent) had been providing care for the same child for one to four years; over half (51 percent) had been providing care for the same child for at least two years.<sup>42</sup> Forty percent of the FFN providers reported that they were paid for at least one of the children in their care,<sup>43</sup> and their hourly rates were similar to those paid for center-based care and regulated family child care.<sup>44</sup>

The 2006 Minnesota study found that 41 percent of FFN caregivers (defined as nonparental relatives, friends, and neighbors who provide home-based care that is regulated or unregulated) provided child care for more than ten hours a week, including 23 percent who provided care for more than thirty hours a week.<sup>45</sup> On average, they reported that they had provided FFN care for eleven years.<sup>46</sup> Nearly one-quarter (24 percent) of FFN providers reported that they received payment for providing care, with the amount averaging \$117 to \$126 per week.<sup>47</sup>

FFN providers report several reasons for choosing to provide care, including wanting to assist the child's parents, help the child develop, build a close relationship with family members, and stay home with their own children.<sup>48</sup> For example, in the study of Washington FFN providers, 57 percent said that they were providing care to help the child's parent.<sup>49</sup> In the Minnesota study, 59 percent of FFN providers said that the reason they provided child care was to help a family member or friend.<sup>50</sup>

Although there is little information about FFN providers' incomes, the data that are available indicate that many FFN providers have relatively low or moderate incomes or live in households with low or moderate incomes.<sup>51</sup> For example, the study of Washington FFN providers found that their median household income was \$30,282, compared to the statewide median household income of \$47,000 in 2000.<sup>52</sup> The survey of Minnesota FFN providers found that 40 percent had household incomes below \$40,000 a year in 2004.<sup>53</sup> A 2003 study of FFN providers offering subsidized care in Illinois found that over one-quarter (27 percent) were receiving TANF, Food Stamps, and/or Medicaid, and that 40 percent had used at least one of these benefits at some point in the previous two years.<sup>54</sup> FFN providers generally are similar in their income levels and have the same ethnicity as the children they are caring for, according to a 2005 summary of studies.<sup>55</sup>

Research on the quality of FFN care indicates both areas for improvement as well as strengths upon which to build. Studies that use observational measures to evaluate various child care settings generally find that quality of much FFN care is low, according to two recent reports summarizing such studies.<sup>56</sup> Studies that look specifically at the relationship between FFN caregivers and children have produced varying results, with several finding warm, supportive interactions,<sup>57</sup> but one finding less warmth and sensitivity in the relationships between FFN providers and children than between providers and children in other child care settings.<sup>58</sup>

According to a summary of several studies, FFN providers typically have lower levels of education than regulated providers and limited education or formal training in child care or child development,<sup>59</sup> which may affect the quality of care.<sup>60</sup> The survey of Washington FFN providers found that their overall general education level was lower than that of the adult population, and lower than that for center-based or family child care providers.<sup>61</sup> In addition, 61 percent reported that they had received no specific training in child care, child development, or parenting.<sup>62</sup>

On the other hand, FFN care tends to have low child-provider ratios,<sup>63</sup> a factor that may improve the quality of care.<sup>64</sup> For example, an analysis of 1999 NHES data (that defined FFN care as nonparental relative care, non-relative unpaid care outside the child's home, and non-relative care inside the child's home care) found that for children between birth and age five, ratios in FFN care averaged 1.5 children per adult, compared to 3.5 children per adult in family child care and 6.5 children per adult in center-based care.<sup>65</sup>

Parents using FFN care and their FFN providers report good communication and positive feelings about their relationships with one another, according to a 2005 summary of studies.<sup>66</sup> For example, in a 2001 study of low-income families in three cities, mothers using unregulated care reported that they were more satisfied with their care, had better communication with their child care provider, and found their child care provider to be more accessible, reliable, dependable, and flexible in meeting their needs than mothers using regulated care.<sup>67</sup>

## STATE POLICIES

### Defining Family, Friend, and Neighbor Care

Given that FFN care is defined here as home-based care exempt from state regulation, and the types of home-based child care providers that states exempt from regulation differ across states, what is considered FFN care will vary from state to state.

All states exempt FFN providers from regulation if they are relatives of the child—regardless of the number of related children in their care. Although all states exempt parents, they otherwise differ in which relatives they exempt. For example, Minnesota’s definition of exempt relatives includes parents, adoptive parents, stepparents, stepbrothers, stepsisters, nieces, nephews, grandparents, siblings, aunts, uncles, and legal guardians.<sup>68</sup> In contrast, Pennsylvania’s definition includes only parents, stepparents, grandparents, and foster parents.<sup>69</sup>

States also vary in the number of children that a home-based provider can care for before being required to be regulated. Some states require all non-relative home-based providers to be regulated, even if they are only caring for one child in the provider’s home, while several states exempt providers caring for up to five children, and a few states exempt providers caring for an even larger number of children:

- ❑ Ten states require all non-relative home-based providers to meet licensing or regulation requirements even if they are caring for only one child (Alabama, Connecticut, Delaware, District of Columbia, Kansas, Maryland, Massachusetts, Michigan, Oklahoma, and Washington).<sup>70</sup>
- ❑ Five states exempt home-based providers caring for only one child or the children of only one family (California, Colorado, Florida, Minnesota, and South Carolina).
- ❑ Eight states exempt home-based providers caring for up to two children (Georgia, Hawaii, Maine, Montana, New York, North Carolina, Vermont,<sup>71</sup> and Wyoming<sup>72</sup>).
- ❑ Eleven states exempt home-based providers caring for up to three children (Illinois,<sup>73</sup> Kentucky, Nebraska, New Hampshire, North Dakota, Oregon,<sup>74</sup> Pennsylvania, Rhode Island, Texas, West Virginia, and Wisconsin).
- ❑ Seven states exempt home-based providers caring for up to four children (Alaska, Arizona, Missouri, Nevada, New Mexico, Tennessee, and Utah).
- ❑ Six states exempt home-based providers caring for up to five children (Arkansas, Indiana, Iowa, Mississippi, New Jersey, and Virginia).
- ❑ Three states exempt home-based providers caring for up to six children (Idaho, Louisiana, and Ohio).
- ❑ South Dakota exempts home-based providers caring for up to twelve children.

Another basis on which states exempt home-based providers from regulation is if care is not provided on a regular basis or is not otherwise provided as part of an ongoing business. For example, Washington exempts home-based providers if they are not providing care on an ongoing, regular basis for the purpose of engaging in business and not earning more than \$1,000 a year from that care.<sup>75</sup>

## Determining State Child Care Assistance Policies

Families receiving assistance through the federal Child Care and Development Block Grant (CCDBG), the major federal program that provides funds to states to help low-income families pay for child care, may choose to use FFN care, and many do. In 2004, nearly one-quarter (23 percent) of children served through the CCDBG were in FFN care.<sup>76</sup> There was tremendous variation among states in the proportion of children in this care. Three states (Arkansas, Ohio, and Wisconsin) reported no children receiving CCDBG assistance who were in FFN care, and ten additional states (Alabama, Delaware, District of Columbia, Florida, Georgia, Massachusetts, Nevada, North Carolina, Rhode Island, and West Virginia) had less than 10 percent of children receiving CCDBG assistance in FFN care. In contrast, Oregon had 59 percent and Michigan and Wyoming each had two-thirds of their children receiving CCDBG assistance in FFN care.

Depending on the state, FFN providers receiving CCDBG assistance may be primarily nonparental relatives or primarily non-relatives. For example, in Vermont, 20 percent of children receiving CCDBG assistance were cared for by non-relative FFN providers, while just 2 percent of children were cared for by nonparental relative FFN providers. In contrast, 40 percent of children receiving CCDBG assistance in Utah were cared for by nonparental relative FFN providers, while only 3 percent were cared by non-relative FFN providers.

In some states, the percentage of families receiving CCDBG assistance who use FFN care is partially explained by how the state defines legally exempt care, since few providers may qualify as FFN providers if a state only allows limited exemptions from regulation. For example, among the thirteen states where less than 10 percent of children receiving CCDBG assistance used FFN care, four—Alabama, Delaware, District of Columbia, and Massachusetts—require all non-relative providers to be regulated if they are caring for one child, and Florida requires non-relative providers to be regulated if they are caring for children from more than one family. Yet, in other states, there is no apparent relationship between the state definition of exempt care and the extent to which families receiving assistance use FFN care. For example, in Nevada, less than 10 percent of children receiving CCDBG assistance used FFN care, even though non-relative providers can care for up to four children without being regulated.

The use of FFN care among families receiving CCDBG assistance is not only affected by state policies on which providers must be regulated but also by other state child care assistance policies. States make a number of decisions that can affect families' access to FFN care as well as the quality of care offered by FFN providers participating in child care assistance programs.

### Establishing Requirements for Receiving Child Care Assistance

Under the CCDBG program, FFN providers that are not required to be regulated by the state nonetheless must meet a set of health and safety requirements in order to serve children receiving child care assistance.<sup>77</sup> The goal is to ensure that public funds are going to providers that are at a

minimum protecting children and not placing them at risk of harm. States determine the specific requirements, which must address prevention and control of infectious diseases (including an assurance that children receiving CCDBG funds are age-appropriately immunized), building and physical premises safety, and health and safety training. States are permitted to exempt certain relatives (grandparents, great-grandparents, aunts, uncles, and siblings who live in a separate residence from the child in care) from these requirements. Most states still choose to have health and safety requirements for these relatives, although the requirements are not always identical to those that apply to other FFN providers.<sup>78</sup>

States address a variety of health and safety practices in their requirements for FFN providers.<sup>79</sup> These may include requirements for providers to: have appropriate hand-washing practices; keep firearms locked and inaccessible; keep poisonous substances out of the reach of children; cover electric sockets; have operable smoke detectors and fire extinguishers; have documented fire drills and emergency plans; have a working telephone with emergency numbers posted; have first-aid supplies; and have cushioned materials under playground equipment.

States take different approaches to ensuring compliance with health and safety requirements. In some states, FFN providers only have to sign a checklist indicating that they are meeting standards on immunizations, building and premises safety, and basic health and safety.<sup>80</sup> Parents may also be asked to sign the checklist. A few states take stronger measures to verify and enforce compliance, such as requiring home visits or inspections by local fire, building, and health departments or other agencies.

- ▼ In Nevada, for example, FFN providers must have a complete home inspection from contractor quality assurance staff within forty-five days of enrolling in the CCDBG program.<sup>81</sup> Providers receive training materials and access to a video training series from the contractors.<sup>82</sup> Providers also receive assistance from consultants in improving their health practices and training from mental health consultants on working with children who have behavioral or emotional challenges.<sup>83</sup>
- ▼ In Georgia, child care licensing monitors visit all FFN providers first enrolling in the CCDBG program as well as a 20 percent sample of FFN providers already participating in the CCDBG program annually.<sup>84</sup> Information related to fire drills, proper storage of poisons, covered outlets, safe outdoor play areas, covered fireplaces, and overall clean and safe areas is evaluated and discussed during monitoring visits.<sup>85</sup> Monitors also share information regarding Georgia's immunization law, which requires parents to have their child immunizations current.<sup>86</sup>

In addition to general health and safety requirements, states may require criminal background checks for FFN providers serving children receiving CCDBG assistance. A 2004 survey of policies in forty-eight states found that thirty-nine require some kind of background checks for these providers.<sup>87</sup> States that require background checks must make several additional decisions. For example, they must determine the types of background checks they will require. Of the thirty-nine states that reported having background check requirements, thirty-two require state criminal records checks, thirty-two check child abuse and neglect histories, and sixteen check FBI fingerprint records.<sup>88</sup>

States must also determine who will be subject to the background checks—just the providers, or others in the household. In addition, they must specify what actions disqualify a person from caring for a child. For example, some states only disqualify a person from providing care if that person has been convicted of a serious or violent crime against other individuals, while other states disqualify

a person for a broader range of crimes, including misdemeanors.<sup>89</sup> States also determine whether to charge providers for the background checks or cover the costs themselves. Some states, such as Delaware,<sup>90</sup> Iowa,<sup>91</sup> New York,<sup>92</sup> and Washington,<sup>93</sup> cover the cost of the background checks for FFN providers.

Two states have some data indicating the proportion of legally exempt providers (a group that in some respects is broader than FFN providers) receiving, or applying to receive, child care subsidies that have criminal backgrounds. In California, 14 percent of these applicants in 2005 had their cases closed due to a criminal or child abuse history, including 102 applicants (0.5 percent of all applicants) that had been convicted of a serious felony.<sup>94</sup> A 2004 study by the Office of the Comptroller of New York State examined the criminal and child abuse histories of a group of 162 randomly selected such providers and identified fifteen providers who may have been convicted of a crime and fourteen providers who may have been the subject of an indicated report of child abuse.<sup>95</sup> In response, the state established requirements for criminal and child welfare background checks of all providers serving children receiving child care assistance.<sup>96</sup> The state also adopted new regulations requiring 20 percent of FFN providers (excluding those participating in the Child and Adult Care Food Program, since—as discussed below—this program involves its own monitoring process) to receive on-site inspections each year.<sup>97</sup>

States also differ in how they address basic child development training requirements for FFN providers serving children receiving child care assistance. Some states simply inform providers about training opportunities or only require training in first aid and CPR or basic health and safety orientations.<sup>98</sup> Other states have more extensive training requirements. For example:

- ▼ FFN providers in Delaware must receive forty-five hours of training, including three hours of training on safety, three hours on health, three hours on nutrition, three hours on early language and literacy, fifteen hours on child development, twelve hours on understanding children's behavior, and six hours on CPR and first aid.<sup>99</sup> Providers must complete the training within ninety days of starting their participation in the CCDBG program.<sup>100</sup>
- ▼ FFN providers in Georgia must participate in eight hours of child-related health and safety training within six months after enrolling in the CCDBG program.<sup>101</sup> Providers may attend health and safety training offered by child care resource and referral agencies, community-based agencies, technical schools, hospitals, county extension agencies, Head Start, or other entities.<sup>102</sup>

### Determining Reimbursement Rate Policies

States determine how much they will reimburse providers who serve families receiving child care assistance as well as other reimbursement policies, such as the payment process. The CCDBG program requires states to set rates that are designed to give children receiving CCDBG assistance access to care that is equal to that available to children whose parents pay for care on their own. CCDBG regulations recommend that states set their rates for care at the 75th percentile of current market rates, which is the rate that allows families access to 75 percent of providers in their communities. Yet this is not a rate requirement, and many states set their rates for all types of care—from center-based to FFN care—far below the 75th percentile, or base the rates on outdated market information. This can limit parents' access to the type of care they want for their children and affect the income of providers.



States can find it particularly difficult to set reimbursement rates for FFN care. For other types of care, states can conduct a survey of market prices. However, for FFN care, the market is skewed by the fact that many providers are not paid, and those that are paid typically do not have published fees and may not charge a standard amount. A provider caring for a grandchild, niece or nephew, or friend's child may not request any payment, or if the provider does, may ask the child's parent just to pay what the parent can afford, and that might differ from week to week. As a result, most states are unable to collect accurate information on fees for FFN care. Instead, many states set their FFN rates based on rates for regulated family child care. Some states set their FFN rates at amounts equal to their rates for regulated family child care, while others set them as a percentage of their regulated family child care rates. A 2006 survey by the National Women's Law Center found that, in half of the states providing data for both FFN care and regulated family child care, the state reimbursement rate for FFN care was equal to 75 percent or less of the family child care rate, and in most of the remaining states, the reimbursement rate for FFN care was between 76 and 95 percent of the family child care rate.<sup>103</sup>

States may set lower rates for FFN care to encourage use of regulated family child care instead, or because they assume FFN care involves lower expenses since these providers avoid costs associated with meeting regulatory requirements.<sup>104</sup> States may also assume that FFN providers do not need a higher reimbursement as an incentive to provide care, since many FFN providers care for children in order to help a friend or relative, rather than for financial reasons. For example, a survey of FFN caregivers registered with the child care assistance program in five Minnesota counties found that only 23 percent of non-relative caregivers and just 13 percent of relative caregivers provided care to earn money.<sup>105</sup> However, there are FFN providers who rely on the reimbursement they receive for their livelihood.

State policies on reimbursement rates for regulated types of care can also have an indirect effect on the use of FFN care. If reimbursement rates for regulated family child care homes and child care centers are far below market prices—as is the case in many states<sup>106</sup>—few providers may be willing to accept the low rates and care for children receiving assistance. Providers that do take these low rates may have difficulty staying in business.<sup>107</sup> As a result, families may be left with few options other than FFN care. Low rates may also cause families to choose FFN care if regulated providers ask parents to make up the difference between the state's rate and the provider's private rate, which is permitted in over two-thirds of the states.<sup>108</sup>

FFN providers' level of reimbursement may not only be affected by the basic rate but by other policies as well. For example, FFN providers' reimbursement often depends on how a state reimburses providers for part-time care, since many FFN providers offer care on a part-time basis. Some states pay a provider a full-day rate if a child is in care for at least five or six hours, while other states pay on an hourly basis. Another reimbursement policy determining FFN providers' compensation concerns whether they are paid for days when a child is absent. Some states do not reimburse any providers for absent days. Some states do reimburse regulated providers for absent days, but not FFN providers.

The reimbursement that FFN providers receive also depends on whether the state offers bonuses or higher rates for certain types of care that FFN providers may be more likely to provide, such as infant care. Most states set higher rates for infant care, and some states offer additional bonuses for this care as well, although these bonuses are not always available to FFN providers and may instead be limited to regulated family child care home and centers. For example, Illinois reimburses regulated centers and family child care homes at higher rates for children under two-and-a-half years old than for older

children, but uses a single reimbursement rate for FFN providers, regardless of the age of the children in care, which is lower than the rate used either for regulated centers or family child care homes.<sup>109</sup>

Nontraditional-hour care is another type of care that is offered by a large number of FFN providers and that receives higher reimbursement in several states. Nine states (Colorado, District of Columbia, Illinois, Kentucky, Maine, Maryland, Missouri, Montana, and New York) generally offer higher rates for care during nontraditional hours,<sup>110</sup> but as with infant care, these higher rates for nontraditional-hour care are not always available to FFN providers.<sup>111</sup> For example, in Missouri, all providers, including FFN providers, caring for children in the evening or on weekends receive a 15 percent enhancement to their base rate.<sup>112</sup> In contrast, Kentucky only makes its bonus for nontraditional-hour care—\$1 per day above the maximum reimbursement rate—available to regulated child care homes and centers, not FFN providers.<sup>113</sup>

A third type of care that is often reimbursed at higher rates is care for children with special needs. Seventeen states (Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, South Carolina, South Dakota, Virginia, and Washington) have higher rates for this type of care,<sup>114</sup> recognizing that there often are additional costs involved in providing it. FFN providers caring for children with special needs are often eligible for these higher rates.<sup>115</sup> For example:

- ✔ Kentucky pays \$1 per day above the maximum reimbursement rate for any provider—whether a licensed center, regulated family child care home, or FFN caregiver—offering special needs care.<sup>116</sup>
- ✔ Missouri pays 25 percent above the base rate to providers, including FFN providers, caring for children with special needs.<sup>117</sup>
- ✔ Iowa has special needs rates for each category of provider—licensed centers, regulated family child care, regulated group homes, and FFN providers—that exceed the basic rate for each type of provider.<sup>118</sup>

States may offer higher rates to FFN providers that receive some amount of training, or additional training beyond the minimum required. For example:

- ✔ In Michigan, FFN providers caring for children under two-and-a-half years old receive an additional 25 cents per hour if they complete at least sixteen hours of child care training.<sup>119</sup>
- ✔ In Wisconsin, FFN providers that receive fifteen hours of training—referred to as regularly certified providers—receive a reimbursement rate that is equal to 75 percent of the rate for regulated family child care, compared to 50 percent of the regulated family child care rate for FFN providers that do not receive the training.<sup>120</sup>
- ✔ FFN providers in Oregon receive a higher reimbursement rate and are allowed more flexibility in the billing process if they participate in training on health and safety practices and on recognizing child abuse and neglect.<sup>121</sup>

In addition to the amount of the reimbursement, other rate policies may affect FFN providers' willingness to serve children receiving child care assistance. In some states, child care providers must wade through a difficult process to qualify for assistance payments and receive the reimbursement

due to them. This creates a challenge for all providers, and may be particularly burdensome for FFN providers who may be less likely to have administrative staff or help navigating the system than, for example, a child care center.

### Setting Copayment Policies

States determine how much parents receiving child care assistance pay toward the cost of care. Parent copayment amounts are generally set on a sliding scale basis, with families that have higher incomes paying more toward the cost of care. Some states also determine parent copayments based on the cost of care the family uses—typically, having parents pay a percentage of the cost of care, with the percentage increasing as family income increases. States generally do not base copayments on the type of care a family uses—for example, FFN care versus regulated family child care or center care. However, state copayment policies can have an indirect effect on whether a family chooses FFN care.

Several states set high copayments for some families.<sup>122</sup> This can steer some families toward FFN care if family and friends, because of their relationship to the child’s family, are more understanding and flexible when parents fail to pay their full copayment than a child care center or family child care provider (although many centers and family child care providers forgo collection of copayments as well). Yet this means a financial loss or hardship to the FFN provider, who may be dependent on the income.

Some parents may also be more likely to use FFN care when states set copayments according to the cost of care and when FFN providers charge lower fees than regulated child care centers and family child care homes.

### Informing Parents

States vary in the approaches they take in informing parents about the availability of child care assistance through the CCDBG as well as federal and state child care tax credits. States typically distribute information through child care resource and referral agencies, and often rely on other agencies and organizations, including Head Start programs, employment and training centers, and other community agencies.<sup>123</sup> Many states use brochures and printed materials, and in some cases, radio or print ads. Some have extensive outreach efforts, using a variety of methods to let parents know they can receive help paying for child care. In other states—particularly those with waiting lists, demonstrating that the state already is unable to serve all eligible families who apply for help—outreach efforts are much more limited.

States also differ in how much information they provide to parents eligible for assistance about their child care options, including FFN care, and the requirements that must be met by each type of provider. For example, states vary in how much guidance they provide to parents to help them choose child care, including both basic health and safety practices parents can expect of their child care providers as well as broader information about assessing quality of care. In contrast, some states take important steps to ensure parents receive sufficient information, such as by translating information materials into the language that parents speak if they do not speak English and by having staff available who can communicate with parents who do not speak English. For example, Washington’s posters and brochures about child care assistance are available in six languages.

States also differ in what they do to inform providers about the availability of child care assistance, including tax credits, so that the providers can in turn let parents know about it. Little information is available about state efforts in this area, but some state and local agencies attempt to provide outreach through multiple avenues, including family support and other programs that serve child care providers, neighborhood groups, libraries, and other community agencies and organizations. Some states make extra efforts to ensure that they reach FFN providers. They recognize that these providers may be less likely than family child care homes and child care centers to be linked to networks of providers, child care resource and referral programs, or other service agencies that provide information about child care assistance, and less likely to have had some contact with the child care assistance program or with the state through the process of becoming regulated.

## Investing in Quality Improvement Efforts

A portion of CCDBG funding is reserved for quality improvement initiatives. States must spend at least 4 percent of their funding on projects related to enhancing the quality of child care.<sup>124</sup> Currently, an additional \$170 million of CCDBG funding is earmarked for quality activities, and \$98 million is earmarked for supporting infant and toddler care.<sup>125</sup> States may choose to use a portion of these funds to provide training and support for FFN providers or for basic materials and supplies for FFN care such as fire alarms, cribs, high chairs, and books. States may use the quality dollars to assist providers who are caring for children receiving CCDBG assistance as well as those who are not. In low-income communities, FFN providers who are not receiving assistance may be the most isolated, lacking in resources, and in need of support.

State quality initiatives are less likely to involve FFN providers than regulated providers. While 85 percent of state quality initiatives that have child care providers as the primary target serve center teachers or assistant teachers, and an equal percentage of these initiatives serve regulated family child care providers, just 37 percent serve FFN caregivers.<sup>126</sup>

States with quality initiatives that target FFN providers or at least allow FFN providers to participate along with other types of providers have various objectives for their initiatives. Some states design their training efforts and other quality initiatives with the goal of encouraging unregulated FFN providers to become regulated. Other states simply aim to improve the quality of care offered regardless of whether the providers become regulated.

California is using a portion of its CCDBG quality funds to make training available to FFN providers (both those who are receiving subsidies and those who are not) through the California Child Care Resource and Referral Network.<sup>127</sup> With \$9.8 million in CCDBG funds, the network will adapt its Child Care Initiative Project, which was developed to recruit and train regulated family child care providers, to FFN providers. Training modules will be developed specifically for these providers, and resource and referral agencies will provide outreach, support, and training to providers in their communities.

Missouri offers quality improvement activities, including on-site technical assistance, workshops, and group trainings, for subsidized FFN providers through its Educare initiative.<sup>128</sup> Educare is supported with \$3 million per year in state funding that is counted toward the CCDBG maintenance of effort requirement (funding that the state must provide to receive its allocation of federal funds). Some local communities supplement this state funding with local, private foundation, and other

resources. There are seventeen local Educare sites, all of which must follow certain state requirements, but are allowed a great deal of flexibility. As a result, sites vary in the types of activities they offer and approaches they use depending on the providers they serve and other circumstances. For example, in urban areas such as St. Louis, which is more densely populated, it is easier to get groups large enough to hold workshops, while in rural areas where providers are more dispersed, home visits are often more practical. Educare staff try to encourage FFN providers to become regulated, but if the providers are not interested, the staff still work with them to improve their skills. Individual Educare sites use a variety of approaches to engage providers, such as by having events with food at locations where providers submit their invoices for subsidy reimbursement.

Michigan's Child Care Futures Project, which trains an average of 3,000 providers each year through the state's fifteen regional child care resource and referral agencies, previously only worked with regulated providers but now has started reaching out to FFN providers.<sup>129</sup> The state offers a \$150 one-time incentive payment to encourage the participation of these providers.

Maryland and Massachusetts offer outreach and technical assistance to improve the quality of FFN care.<sup>130</sup> Several other states, including Connecticut, Florida, Hawaii, Iowa, and New York, also offer training for FFN providers.<sup>131</sup>

Some states have quality improvement initiatives aimed at infant/toddler caregivers, which often include FFN caregivers. West Virginia makes training available to all providers, including FFN providers, caring for infants and toddlers. The training is implemented by infant/toddler specialists through six regional child care resource and referral agencies. The state makes a one-time payment of \$400 to providers that complete a forty-five-hour infant and toddler class, which includes training on promoting children's language, pre-reading, and numeracy skills development.<sup>132</sup> The state also offers stipends to providers for other training and conferences.<sup>133</sup> However, the stipends and other material resources are only available to regulated providers or FFN providers that register to participate in the child care subsidy program.<sup>134</sup> Sixteen states—Alabama, California, Florida, Indiana, Iowa, Kansas, Kentucky, Maine, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, and Washington—also have networks of infant/toddler specialists that give support and training to child care providers,<sup>135</sup> and these resources are often made available to both FFN providers and regulated providers.

## Encouraging Participation in the Child and Adult Care Food Program

The Child and Adult Care Food Program (CACFP), administered by the U.S. Department of Agriculture, subsidizes nutritious meals and snacks for children enrolled in child care and after-school programs.<sup>136</sup> Family child care homes and child care centers are eligible to participate if they are regulated or if they qualify for alternative approval status by meeting a set of federal requirements. States may also allow FFN providers who are exempt from regulation to participate if they are providing care for children receiving CCDBG funds, and if the state has a minimum set of standards for exempt providers receiving CCDBG funds. Since the CACFP is an entitlement program, there is no set limit on funding and all eligible children can receive the benefits that the CACFP offers.

Allowing FFN providers to participate in the CACFP enables the children in their care to benefit from the nutritious meals and snacks that are funded by the program. The CACFP reimburses providers for the costs of up to two meals and a snack a day for each child. Once an FFN or regulated

family child care provider qualifies for the CACFP based on having at least one child receiving child care assistance, all children cared for by the provider are eligible for the meals and snacks provided by the program. If the provider earns less than 185 percent of poverty, the provider's own children are eligible as well.

FFN providers and the children in their care also benefit from participation in the CACFP because it gives providers access to support and training. They learn about the importance of healthy eating and how to prepare nutritious meals and can be connected to other training opportunities in their communities.

The CACFP visits to participating FFN providers may be the only monitoring visits and training opportunities these providers receive. FFN providers participating in the CACFP program receive three home visits each year. The CACFP monitors that visit FFN providers may need training on working with these providers, who may have different needs and circumstances than regulated providers.

States that make the CACFP available to FFN providers receiving CCDBG funds include Alaska, California, District of Columbia, Georgia, Illinois, Kentucky, and New York.<sup>137</sup> Washington also plans to start permitting these providers to participate in the CACFP. In addition, Connecticut has begun a pilot program allowing FFN providers to participate in the CACFP that covers several areas of the state.

A few states that permit FFN providers to qualify for the CACFP have adopted other policies to facilitate their participation. New York has taken an especially innovative step by allowing an FFN provider to participate in the CACFP for a full year once she or he has been deemed eligible. This means that an FFN provider who serves a child receiving child care assistance and qualifies to participate in the CACFP remains eligible for a year even if that child's family loses eligibility for child care assistance or is no longer cared for by that provider. The CACFP continues to subsidize meals for children being cared for by the provider as well as the provider's own child or children.

## Linking to State Prekindergarten Programs

A growing number of children are enrolled in state prekindergarten programs. Thirty-nine states currently provide funding for prekindergarten initiatives, which primarily serve four-year-olds, and some three-year-olds, and are typically targeted at children from low-income families or with other risk factors.<sup>138</sup> A number of states have significantly increased their investments in state prekindergarten programs in recent years as policymakers have recognized the importance of early education to children's success in school.<sup>139</sup> Yet even with the growth of prekindergarten, there is still a need for FFN care for three- and four-year-olds because it can help fill in gaps not addressed by prekindergarten programs. State policies can affect the extent to which FFN care can effectively complement prekindergarten in order to meet families' needs.

The majority of state prekindergarten programs only operate for a part day, sometimes just two or three hours a day, and only during the school year.<sup>140</sup> As a result, parents working full time need child care before and after the prekindergarten day and during the summer months. In some cases, programs only operate two or three days a week, so parents need full-day care for the remaining days of the week as well. Many parents turn to FFN providers to provide this "wrap-around" care. Families

with children in state-funded prekindergarten programs may also use FFN care if the parents work evenings, nights, or weekends—hours that do not coincide with the prekindergarten day.

In some states, one way that FFN care is coordinated with prekindergarten is by providing transportation for children between the FFN provider's home and the prekindergarten program. FFN providers who are caring for several children may have difficulty picking up or dropping off their prekindergarten-age children. In Chicago, a pilot project sponsored by Illinois Action for Children—a nonprofit organization that provides child care resource and referral services and advocates for high-quality early care and education—and funded through private and public sources is trying to address this issue.<sup>141</sup> It uses vans to transport children between FFN or regulated family child care providers and prekindergarten as part of a broader initiative to support and offer training to both types of providers. Most states allow prekindergarten funds to be used for transportation,<sup>142</sup> but do not require local programs to provide it.<sup>143</sup>

Some states also make it easier for FFN providers to offer care before and/or after prekindergarten by providing a full-day, rather than part-day, reimbursement for this wrap-around care. Since many prekindergarten days last only three or fewer hours, and some parents work eight or more hours a day, in addition to having long commutes, or work nontraditional hours, some children need full-time care before or after the prekindergarten day. In addition, an FFN provider may have to reserve a full-time space for a child who spends part of the day in a prekindergarten class. It is unlikely that the provider can find another child who needs care only during the hours of the prekindergarten class. The provider also may not be able to have children's schedules overlap because of state limits on the number of children she or he can care for at any one time.

Another way states encourage coordination of FFN care and prekindergarten is to share information with FFN providers about prekindergarten programs so that the providers can in turn tell parents about the availability of prekindergarten options and how to apply. Informing providers about prekindergarten also enables providers to help children make the transition to prekindergarten when they start at the beginning of the school year, as well as make the daily adjustment at the end of each prekindergarten day. In Chicago, Illinois Action for Children works to inform FFN providers about prekindergarten programs along with other programs for children and families.

Illinois has taken an innovative step by structuring its prekindergarten program so that a portion of funding is set aside for infant/toddler initiatives.<sup>144</sup> A few communities use some of this funding to assist FFN providers who care for infant and toddlers as well as preschoolers. The vast majority of funding for Illinois' Early Childhood Block Grant—a total of \$318 million in FY 2007—is spent on prekindergarten, but 11 percent of the funding is set aside for grantees serving infants and toddlers. Illinois Action for Children has used funding available through this set-aside to help support its activities involving FFN providers. The agency works with FFN providers caring for infants and toddlers while the preschool-age children cared for by the providers attend prekindergarten.

## **Serving Children with Disabilities and Other Special Needs**

The Preschool Grants Program, authorized under Section 619 of Part B of the Individuals with Disabilities Education Act (IDEA), provides grants to states to serve children ages three through five with disabilities.<sup>145</sup> The Early Intervention Program, authorized under Part C of the IDEA, provides funding to states to support services for infants and toddlers with disabilities birth through age two.<sup>146</sup>

These programs aim to identify young children with developmental disabilities or delays, determine what services these children need, and provide these services, either in the child's home or outside the home in a child care or other setting.

States differ in the extent to which they reach out to child care providers, including FFN providers, and involve them in identifying children with special needs and developing and implementing plans to address children's needs. California has provided a total of \$17.6 million since 2002 for an initiative that supports local planning on child care for children with special needs, and local plans may include FFN care.<sup>147</sup> Funds are allocated to counties through local child care planning councils and/or child care resource and referral agencies. Counties develop strategies for expanding the capacity of child care providers to serve children with special needs through outreach, training, technical assistance, and other efforts. Individual counties determine whether their plans will include FFN providers serving children with special needs.

In San Francisco, the Child Care Inclusion Challenge Project assists child care providers, including FFN providers, in working with children who have special needs.<sup>148</sup> The project makes child development specialists available to work with providers in assessing children's needs, identifying ways to adapt the child care environment and curriculum to those needs, and communicating with parents. The project also offers ongoing technical assistance, training opportunities, and referrals to other community resources to help providers and families.

## Reaching Out with Home Visiting Programs

Home visiting programs, although primarily focused on educating and providing resources for parents, can offer resources for FFN providers as well. This is a natural extension of the role of home visiting programs. While parents are their children's first teachers, many children spend long hours in the care of FFN providers, and home visiting programs can offer a valuable opportunity to promote children's learning. While a state may not have a dedicated funding stream for home visiting for FFN providers, it may have related programs—such as parent home visiting programs, infant/toddler initiatives, or comprehensive early childhood initiatives—where a portion of the funding could potentially be used to provide resources and support for FFN providers who wish to participate.

Home visiting programs can give FFN providers the opportunity to receive training in areas such as health and safety, child development, and early literacy. Providers can then use their new skills and knowledge to help offer a more enriching experience to the children in their care, and to reinforce the lessons taught during home visits made to parents. As trusted friends or family members, FFN providers can also pass on the information they learn to the children's parents. In addition, home visitors can connect providers to resources to help them meet their own needs and challenges.

One home visiting model is Parents as Teachers (PAT), which provides parents of young children with information about child development and parenting support.<sup>149</sup> While only Missouri funds PAT statewide, Kansas and Oklahoma provide some state funding for PAT, and the model is used in local communities across the country. PAT primarily focuses on parents, but it now has a curriculum for FFN providers as well.<sup>150</sup> The curriculum was developed with the recognition that many FFN providers could benefit from home visits in many of the same ways as parents, yet that it was necessary to have materials designed specifically for providers. There is a curriculum for providers serving mixed



age groups and, in response to feedback from providers, the PAT National Center is developing a curriculum specifically for infants and toddlers.

While most states do not have targeted funding for implementing the PAT curriculum for FFN providers, some states use other resources. For example, Missouri uses its state-funded PAT initiative to support home visits to parents, but some Educare sites—which, as discussed above, sponsor quality improvement activities for subsidized FFN providers—use the PAT curriculum for home visits with FFN providers. In North Carolina, funding available through Smart Start, a community-based, comprehensive early childhood initiative, has supported trainings that use the PAT materials. In Kansas, infant/toddler specialists are trained in the curriculum.

### ***Early Head Start Enhanced Home Visiting Pilot Project***

Early Head Start's enhanced home visiting project offers an additional model for states that have an interest in extending home visits to FFN providers. Early Head Start, a component of the federal Head Start program, provides high-quality, comprehensive child development and parent education services to low-income infants and toddlers and their families.<sup>152</sup> The enhanced home visiting pilot project was designed to address the fact that many children enrolled in Early Head Start spend time in FFN care.<sup>153</sup> The project aims to enhance the quality of that care by making resources and supports available to FFN providers. Other goals of the project include increasing continuity and consistency in caregiving between parents and providers, improving the relationship between parents and providers, and responding to providers' needs.

The pilot project includes twenty-three Early Head Start programs in twenty different states with ten to fifty enrollment slots per site. A diverse group of caregivers with varied needs and backgrounds are involved. Over half of the caregivers in the initiative are grandparents, but a few sites also serve fathers, foster parents, or regulated family child care providers. Twelve percent of the caregivers speak a primary language other than English. Many of the caregivers have social service or health care needs. About one-third have not completed high school, while one-third have some training in child development. The majority provide care at least twenty hours a week, with one-third providing full-time care. About one-third receive some payment, and 13 percent receive child care assistance payments for providing care.

The Early Head Start project involves a number of community partners, including child care resource and referral agencies, family support programs, health care providers, Part C (services for infants and toddlers with special needs) providers, child welfare agencies, and Even Start programs. These partners help provide a variety of resources, including group training, health and safety equipment, lending libraries, early intervention services, and health services.

In most cases, home visits are made to providers at least once a month and typically involve an activity with the child and caregiver, discussion of a child development topic, completion of a home visit record, and a home safety check. Some Early Head Start pilot sites use the Parents as Teachers curriculum. The home visitor for a child's provider may, but need not, be the same person who visits the child's parents. The project loans or gives providers health and safety equipment such as car seats, first-aid kits, and outlet covers, as well as other materials and equipment such as children's books, toys, high chairs, cribs, and stipends to purchase additional supplies. The project also offers providers the opportunity to attend group events, including trainings, caregiver support groups, and other Early Head Start and community events. Incentives help encourage attendance at these events. In addition, providers are given referrals to various resources, including food banks, tax preparation assistance, and health services.

An initial assessment of the project found that it helped deliver information and resources to providers, reduced their isolation, increased collaboration between parents and providers, and enhanced caregiving practices. Providers appreciated learning new information on child development and getting ideas for new activities. The project is still working to improve its effectiveness in several areas, including overcoming reluctance of some providers to participate, addressing provider turnover, and encouraging greater attendance at group events.

The PAT curriculum for FFN providers is designed to meet providers' individualized interests and needs. Providers define their own goals and identify what they want to get out of the home visits. This approach recognizes that FFN providers differ greatly in their skills and backgrounds. Many providers who have received home visits following the curriculum report that they are excited to learn about activities they can do with children that they never realized they could do before.

Another home visiting model that can be adapted for FFN providers is the Parent-Child Home Program.<sup>151</sup> This program typically involves two visits each week to parents in a child's second and third years of life. The model is replicated in local communities across the country, but only Pennsylvania and Massachusetts fund the program statewide. In Massachusetts, the program can now be used to reach not only parents but family child care and FFN providers as well, if grantees—school districts and some social service agencies—choose to make the program available to providers. The model used for visits with providers is largely the same as that used for visits with parents. Home visitors bring a book or toy and show the provider how she or he can use the materials with the children in their care to promote their language and literacy development. In Pittsfield, the parent-child home program/family child care project has been piloted in collaboration with the state-funded Community Partnerships for Children program, with six home-based providers participating. While so far the pilot has primarily involved licensed family child care providers, the model could be used with FFN providers as well.

## Connecting to Family Support Initiatives

States offer a variety of resources and supports to help parents and their children. These family support initiatives provide another model that states can expand to serve FFN providers. While states have not yet undertaken extensive efforts to reach FFN providers through family support programs, a few states do fund family support efforts that could incorporate strategies to address FFN care.

In California, child care resource and referral agencies have worked with family support programs to recruit, train, and support FFN and family child care providers.<sup>154</sup> The Child Care Resource and Referral Network adapted the model used in its Child Care Initiative Project, which aims to improve the supply of high-quality FFN and family child care, to include family resource centers—community agencies that provide a variety of services for families—as partners. This was a valuable collaboration because family resource centers were able to reach out to and engage FFN and family child care providers and those interested in becoming providers; make training available on site; and offer supportive services and resources to providers. In addition, providers learned about what family resource centers offered, so the providers were able to refer the families they served to various supports and resources the families needed.

## Unionizing

Unionization offers a promising opportunity for FFN providers to increase their influence in the policy process and gain access to additional resources and supports.<sup>155</sup> In the past two years, a number of states, including Illinois, Iowa,<sup>156</sup> Michigan, New Jersey, Oregon, Washington, and Wisconsin have taken steps to allow FFN providers receiving subsidies and regulated family child care providers to organize and negotiate with the state. In a few other states, including California, New York, and Rhode Island, bills allowing family child care and FFN providers to organize passed the legislature








but were vetoed by the governor.<sup>157</sup> Efforts to support unionization are underway in a few additional states as well. Unions can help organize FFN providers who receive child care subsidies and give them a voice in policy decisions that affect their work and livelihoods, which can lead to concrete economic benefits for them.

The issues addressed by unions representing FFN providers can include higher reimbursement rates in the child care assistance program, prompt payment and grievance procedures, health care insurance, support for training and education initiatives, and other benefits. For example, in Illinois, unionization led to an increase in provider reimbursement rates and funding to help providers obtain health care insurance. The union negotiated a contract that includes a 35 percent increase in reimbursement rates for FFN and family child care providers through four rate increases over three years, incentives for receiving training, \$27 million in funding for health insurance beginning in 2008, and a process for resolving problems with the state through a full grievance procedure with arbitration.<sup>158</sup>

## RECOMMENDATIONS

As described above, state policies can affect parents' access to FFN providers and FFN providers' capacity to offer high-quality care that promotes children's successful development. Strategies for supporting and strengthening FFN care are important because this type of care is and will likely continue to be used by many families. States can take a number of steps within the context of the existing child care system to support FFN care along with other types of child care so that parents are able to choose from a range of good options. Specifically, states should:

-  Provide parents with information about the full range of child care options, including FFN care, about the state regulatory and/or child care assistance program requirements that different types of child care providers must meet, and about ways to get help paying for care. This should include information about ways to identify high-quality care that ensures children's health and safety and promotes their development. It should also include information on state and federal child care assistance programs and tax credits that can help families pay for care. Information should be available in multiple languages to meet the needs of parents and providers who do not speak English.
-  Ensure that all providers that serve children receiving child care assistance, including FFN providers, comply with certain basic requirements. At a minimum, providers should be expected to: have basic health, safety, and child development training; verify that they are in good health and do not have any communicable diseases such as tuberculosis; obtain proof that children are up to date with their immunizations; ensure firearms are locked and inaccessible; keep poisonous substances out of the reach of children; cover electric sockets; have operable smoke detectors and fire extinguishers; have operable telephones with emergency numbers posted, including parents' telephone numbers; and obtain authorization for medical care in case children have a medical emergency.
-  Make monitoring visits to all providers that serve children receiving child care assistance, including FFN providers, prior to enrollment of such children and periodically thereafter.
-  Require criminal and child abuse background checks for all providers that serve children receiving child care assistance, including FFN providers, and other adult members of the household to check for serious crimes and violations, particularly crimes against children. States should take steps to ensure that the process for undergoing background checks is straightforward for providers. States should provide clear information to providers about what the requirements are for background checks and how to comply with these requirements. In addition, states should ensure that the background checks are processed in a timely manner and cover the costs of background checks.
-  Set reimbursement rates for all providers that serve children receiving child care assistance, including FFN providers, that adequately reflect the costs of providing care and their need to earn a decent income. Bonuses or higher rates should be available to all providers, including FFN providers, as an incentive to offer care that is more costly to provide or in short supply, including care for infants or children with special needs or care during nontraditional hours such as evenings, nights, or weekends. All providers, including FFN providers, should be reimbursed for days when children are absent due to sickness or other circumstances. Finally, all providers, including FFN providers, should receive higher reimbursement rates if they receive sufficient training and education beyond the minimum required.

-  Use CCDBG quality and infant/toddler set-aside funds to support quality improvements and training opportunities for all providers, including FFN providers. These opportunities should be open to providers who serve children receiving child care assistance as well as those who do not.
-  Allow FFN providers receiving CCDBG funds to be eligible to participate in the Child and Adult Care Food Program and put in place policies that make it easier for all providers to have continuous access to the program.
-  Take steps to coordinate state-funded prekindergarten programs with child care providers, including FFN providers. This includes funding transportation between prekindergarten and child care settings and offering full-day reimbursement rates to FFN and other providers caring for children before and after the prekindergarten day. In addition, a portion of state prekindergarten funding should be set aside to support infant/toddler care, including FFN providers caring for infants and toddlers.
-  Use early intervention programs to identify any child care providers, including FFN providers, caring for children with special needs and extend training opportunities and other supports to these providers.
-  Provide state funding for home visiting and family support programs and community-based agencies serving families to enable them to work with regulated family child care and FFN providers—including both those that serve children receiving child care assistance and those that do not—and tailor these supports to meet providers' particular needs and goals.
-  Connect all providers, including FFN providers, to resources and supports in their communities to help them enhance the care they offer and to enable them to meet their own social service, health care, and other needs.
-  Permit unionization as a strategy for giving all providers, including FFN providers serving children receiving child care assistance, an opportunity to organize, have their voices heard, and bargain for improved compensation, access to health care, professional development, and other supports.

Many of these policies require additional investments in FFN care. To ensure that these investments do not come at the expense of support for other types of child care, it is essential to increase overall child care funding. Initiatives to strengthen FFN care should not compete with other critical priorities, but should be part of a set of strategies to support high-quality child care in all settings as well as other initiatives for low-income children and their families.

## Endnotes

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- 153 Diane Paulsell, Debra Mekos, Patricia Del Grosso, Patti Banghart, and Renée Nogales, *The Enhanced Home Visiting Pilot Project: How Early Head Start Programs Are Reaching Out to Kith and Kin Caregivers: Final Interim Report* (Princeton, NJ: Mathematica Policy Research, Inc., 2006), *available at* <http://www.mathematica-mpr.com/publications/PDFs/homevisitrpt.pdf> (last visited Jan. 16, 2007). This report is also the source for the other information in this text box on Early Head Start's enhanced home visiting project.
- 154 California Child Care Resource and Referral Network, *Linking Child Care and Family Support: Three Successful Collaborations* (San Francisco, CA: California Child Care Resource and Referral Network, 2005). This report is also the source for the other information in this paragraph on California's family support initiative.
- 155 Deborah Chalfie, Helen Blank, and Joan Entmacher, *Getting Organized: Unionizing Home-Based Child Care Providers* (Washington, DC: National Women's Law Center, 2007) (forthcoming). This report is also the source for the other information in this section on unionizing child care providers.
- 156 In Iowa, only regulated family child care providers currently have a union to represent them; FFN providers are not yet represented by a union.
- 157 In Massachusetts, a bill that would have allowed regulated family child care providers—but not FFN providers—to organize was also vetoed by the governor. In addition, a union-sponsored ballot initiative that would have recognized both FFN providers and family child care providers who receive subsidies was on the November 2006 ballot in Massachusetts, but it was defeated.
- 158 SEIU fact sheet, *In First Contract Ever Nationwide, 49,000 Illinois Family Child Care Providers Show That Uniting with SEIU Gets Results* (undated).





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