Illinois Study of License-Exempt Child Care: Interim Report

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Executive Summary

Background and Research Questions

This interim report presents the first-year research findings from the Illinois Study of License-Exempt Care, which is investigating subsidized license-exempt care provision through the Illinois Child Care Program (ICCP). The use of license-exempt caregivers, such as relatives and neighbors, is common in Illinois and in other subsidized child care programs across the United States. Its prevalence raises important policy questions in subsidized child care programs.

The Illinois Department of Human Services (IDHS) received funding for the study through the Child Care Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services. IDHS is contracting with researchers at the University of Illinois at Urbana-Champaign to conduct project research activities. The three-year study is using a variety of survey and administrative data methods to examine license-exempt caregiving issues, with an emphasis on learning about the perspectives of both subsidized license-exempt caregivers and parents who use this type of care. Most of the project research is being carried out in three diverse geographic areas: the North Lawndale and South Lawndale neighborhoods in Chicago (urban), Peoria County (mid-sized urban), and the "Southern Seven" Illinois counties (rural).

For study purposes, we have defined license-exempt care as child care provided in home settings that have been legally exempted from state licensing requirements for no more than three children, including the provider's own children (unless all children are from the same household). Four types of care settings are included in this definition:

1) Non-relatives who provide care in their own home);
2) Non-relatives who provide care in the child's home;
3) Relatives who provide care in the relative's home; and,
4) Relatives who provide care in the child's home.

Six principal research questions are guiding project research activities:

1) What are the patterns of care for families and children that utilize subsidized license-exempt child care, and how do these differ from families and children that rely on subsidized licensed child care?
2) Do parents who use license-exempt child care differ in demographic characteristics and other important respects from parents who rely on licensed care?
3) What factors influence families to choose license-exempt child care providers rather than licensed providers, or to choose a mix of these providers?
4) What are the characteristics of license-exempt subsidized child care providers, and what levels of experience and training do they have in providing child care?
5) How do parents and license-exempt child care providers assess the quality of license-exempt care, and what specific strengths and weaknesses do they identify with this type of care?
6) Based on study findings and analysis of related research, what policy implications can be drawn for enhancing the quality of subsidized license-exempt child care?

Data and Methods

Several data collection methods were employed to gather information on these research questions during the first year of the project. Some research activities were conducted statewide, while others focused on the three geographic study areas.

Administrative Data. Administrative data statewide were collected from three sources for data analysis 1) the IDHS Child Care Tracking System (CCTS), which records monthly subsidy payment and service information for families receiving subsidy assistance, as well as their basic demographic characteristics and information on their service providers; 2) the IDHS Client Database, which contains monthly cross-sectional extracts of public assistance cases (including TANF/AFDC, Medicaid, and Food Stamp receipt); and 3) the Illinois Department of Employment Security Unemployment Insurance (UI) wage records of quarterly earnings reported by employers to state UI agencies.

Researchers from the Chapin Hall Center for Children at the University of Chicago linked data records from the CCTS to records from the Client Database and UI wage records to allow description of the service use and earnings patterns of subsidy recipients. Both point-in-time and longitudinal assessments of license-exempt child care usage and characteristics of users then were conducted using this data.

Key Informant Interviews. Key informant interviews were conducted in each of the three study areas to gain perspectives on prominent license-exempt child care issues, as well as to learn about local child care supply issues. Key informants were identified through discussions with state officials and with the local child care resource and referral (CCR&R) agency director in each area. A total of 14 key informant interviews were conducted. Key informants included the local CCR&R director, other CCR&R staff, IDHS local office directors, child care center staff, and other community service providers. Project directors used an interview guide with broad, open-ended questions.

CCR&R Interviews. A structured statewide telephone survey was conducted with a random sample of 115 CCR&R subsidy specialists, who complete initial ICCP eligibility determinations and re-determinations, and who answer any follow-up questions that subsidy recipients might have. Key informants also identified several other categories of CCR&R staff who have unique perspectives on subsidized license-exempt care issues. Therefore, semi-structured in-person interviews also were conducted with 10 total additional CCR&R staff in the three study areas. These staff typically were involved in a variety of child care quality enhancement initiatives.

Focus Groups. Fifteen focus groups with a total of 115 license-exempt providers and parents who use license-exempt care were conducted in each of the three study areas. Separate focus groups were conducted for parents and providers, and the groups were organized with the assistance of the CCR&R's in the three areas. Focus group participants were recruited through mailings to lists of parents active in the subsidy program. Focus groups were held in the local communities.

Focus group participants were asked to complete a background questionnaire which collected basic demographics at the beginning of their group. Project staff facilitated the groups, using

separate parent and provider focus group guides. Two focus groups were conducted in Spanish, as key informants in South Lawndale noted the prevalence of Hispanic families in this community. Each focus group included 6-10 participants and generally lasted two hours. Focus groups sessions were audio-taped, transcribed, and then coded. Analysis centered on identifying both common and divergent themes between parents and providers, and between the different geographic areas.

Strengths of this study include the utilization of multiple methods and a diversity of informants to investigate these research questions. Limitations of the study include a focus only on subsidized license-exempt caregiving in one state program context and three study areas. In addition, our study does not include direct observation of caregiving situations, so interpretations about the quality of care are limited to the perspectives of the persons interviewed.

Summary of Major Findings

Who Uses the Illinois Child Care Program (ICCP) Overall?

(Administrative data, January 2001)

- The number of families using the ICCP grew approximately 61 percent between July 1998 and January 2001, and the number of children receiving care through the ICCP grew approximately 60 percent during this same period.
- In January 2001, nearly 87,000 families received subsidized child care services. Of those, over half (53.5 percent) used a single license-exempt provider, 38.6 percent used a single licensed provider, and the remaining 7.8 percent used a mixture of license-exempt and licensed providers.
- In January 2001, over 172,000 children were in subsidized child care. Of those, 63.9 percent were cared for by a single license-exempt provider.
- Nearly three-fourths of the families using the ICCP have either one (41.5 percent) or two (32 percent) subsidized children in care.
- In January 2001, just over half (53.5 percent) of the household heads receiving subsidies were in their twenties, and 40.3 percent were age 30 and over. The ICCP predominantly serves families with very low incomes (average quarterly income was $3,253, which equates to $13,012 annually). Nearly two-thirds of families also received TANF, Medicaid, or Food Stamps in January 2001.

What Are the Patterns of Care for Families Using Subsidized License-Exempt Home Care?

(Administrative data, January 2001)

- About four-fifths of children aged six and over, and over three-fifths of infants (61.2 percent) were in license-exempt care. Just over half of the toddlers (54.8 percent) and preschoolers (52.7 percent) were in license-exempt settings.
- In January 2001, over three-fifths of the families using license-exempt care had a relative caregiver (37.1 percent used a relative in the relative's home and 24.4 percent used a relative in the child's home). Over one-third (34.7 percent) of families used non-relative caregivers in the child's home, and only 4.9 percent of families used license-exempt family child care home providers.

- Young children are more likely to be cared for by relatives, with about 64 percent of infants and toddlers cared for by relatives, compared to 57.7 percent of school-age children. Nearly 40 percent of school-age children are cared for by non-relatives in their own homes, compared to 29.9 percent of infants and toddlers.

What Are the Characteristics of ICCP License-Exempt Providers?
(Administrative data, January 2001; Focus group data, Spring 2002)

- In January 2001, roughly three-fifths (60.4 percent) of license-exempt providers were caring for either one or two subsidized children, and an additional 22.8 percent were caring for three subsidized children.
- Just over one-fourth (27.1 percent) of license-exempt providers were using TANF, Medicaid or Food Stamps in January 2001, and nearly 40 percent had used one of these services at some point in the last two years.
- Provider focus group data revealed that providers generally provided full-time care, with an average of 34.6 hours per week. Most caregivers provided some care for children in the evenings (55.9 percent) , over two-fifths (42.4 percent) provided care on weekends.

What Factors Influence Families to Choose License-Exempt Care?
(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- The most important choice factor mentioned in focus groups, key informant and CCR&R interviews is the trust parents have in their license-exempt caregivers. Trust in the caregiver provided a sense of confidence that children would be safe in care, and fostered the belief that providers shared parental philosophies about child-rearing.
- Parents, key informants, and CCR&R staff also highlighted the convenient and flexible care provided in license-exempt settings. Care that was convenient and flexible was especially important to parents who were struggling to balance the demands of work and family, particularly if the parent had a non-traditional work schedule. Even parents who had positive opinions of licensed child care preferred care in their own home during evening hours, because it was less disruptive for the children, and re-assured the parent about the child's safety and comfort during evening hours.
- As previously noted, most license-exempt providers cared for a small number of children. This finding is consistent with focus group parents emphasis on the desirability of license-exempt care because of low child to caregiver ratios.
- Licensed child care supply shortages during traditional care hours were infrequently emphasized as child care choice factors. Key informants and CCR&R staff who highlighted supply issues tended to view it as a localized community factor. In addition, information deficiencies about licensed child care availability were mentioned by some key informants and CCR&R staff as affecting child care choices.
- Cost was mentioned as another constraint on parental choice. Although the ICCP payment policy was intended to be cost neutral with respect to type of provider selected, the cost considerations for parents favored license-exempt caregivers for several reasons. These include: 1) fees charged by licensed child care programs were not covered by ICCP (e.g., registration, supply, or transportation fees), 2) subsidy reimbursement rates in

some areas of the state do not cover price of care which results in parents paying additional out-of-pocket fees beyond the co-payment, and 3) waiver or deferral of co-payments by some license-exempt providers allow parents more payment flexibility.

- Cultural issues limited access to licensed care in some communities. In South Lawndale, some Hispanic study participants noted concerns that both lack of knowledge and fears about involvement with formal agencies constrained choice. In these instances, parents were seen as favoring license-exempt caregivers, who provided a sense of cultural comfort.

What Motivates Caregivers to Provide License-Exempt Care?
(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- Providers stressed a desire to care for children, and an enjoyment of providing care as motivators for license-exempt caregiving. Grandparents and other relatives commonly expressed love for child care. The sense of enjoyment included interests in teaching children at various ages through skill development and social interactions. Grandparents were interested in staying active and involved in the children's development.
- Providers, key informants, and CCR&R staff mentioned helping parents as another caregiving motivator. Care provision was a critical factor in allowing parents to work. Caregivers spoke of the importance of intervening with troubled families, and the care they provided was critical to improving the quality of daily life for children and their families. Providers also mentioned their interest in helping to shape the character of the children, or serving as role models.
- Key informants and CCR&R staff emphasized earning an income as the driving motivation for license-exempt caregiving. Yet, providers mentioned this factor infrequently during focus groups; they noted compensation was not a major motivation partly because the pay level was low.
- Providers, especially grandparents, often indicated during focus groups that they had begun caring for children before they began receiving subsidy. Many also indicated that they would continue caring for these children even if they did not receive subsidies, although they noted that the subsidy promoted consistency of care and allowed the purchase of supplies and activities for the children that enhanced the quality of care for children.

How Do License-Exempt Providers, Parents Using License-Exempt Care, and Community Child Care Professionals Describe the Quality of License-Exempt Care?
(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- Few study participants thought that the positive aspects they discussed concerning license-exempt care were substantially offset by losses in quality of care.
- Most key informants and CCR&R staff pointed out that child care quality varied widely in both license-exempt and licensed child care settings, and consequently one could not assume that licensed child care quality was better. They indicated that they believed there was a quality of care continuum within both licensed and license-exempt care settings, meaning that both licensed child care settings and license-exempt child care settings each had a range of high quality and low quality options within them.

- Parents stressed during focus groups the personalized attention that occurred in license-exempt settings. Parents and providers also mentioned the close, ongoing personal relationships that extend beyond the child care arrangement. They stressed that such relationships established positive caregiving interactions that were the framework for accomplishing developmental goals with children.
- Parents in the focus groups mentioned the consistency of care provided in license-exempt settings because of regular interaction with the same provider. In contrast, they discussed high child to staff ratios and staff turnover as compromising the consistency of care and the development of personalized caregiving relationships in child care centers.
- Providers in the focus groups and CCR&R staff emphasized the importance of a positive relationship between the parent and provider as a key quality of care factor. This relationship was viewed as providing parents with confidence about the provider's caregiving ability, and as assuring parents that providers shared their caregiving views.
- Some parents emphasized the importance of having children's basic physical needs met (clean, well-fed, healthy environment). In addition, parents with difficult daily work lives appreciated providers who took extra steps for the parent, such as cleaning the house or getting the children ready for bed.
- CCR&R staff underscored the importance of caregiver interactions with the children as important to the quality of care. They emphasized the value of having caregivers who took an interest in the children, who interacted warmly with and nurtured the children, and who had access to age appropriate activities for children in their care.
- Parents and providers in the focus groups discussed the importance of caregivers playing a variety of teaching roles, ranging from traditional educational concerns, to safety issues, to social skills and character development.
- CCR&R staff mentioned the importance of having caregivers who are trained on caring for children. In contrast, parents and providers often argued that they did not need further training on how to care for children because they had years of experience raising children. Some providers did express an interest, however, in receiving more information and resources on caring for children.

What Are the Concerns about License-Exempt Care?

(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- Key informants and CCR&R staff identified the lack of regulation and monitoring as the main weakness of license-exempt care. Key informants noted that it is difficult to know if license-exempt providers are complying with the legal guidelines for license-exempt care.
- Another key informant and CCR&R staff concern was the provider's skill level and physical abilities to care for the children. Interviewees noted that most license-exempt caregivers that they had worked with had not received any training on caring for children.
- Some key informants were concerned about lack of care consistency in license-exempt arrangements. For example, having different caregivers for different schedules during the week. Yet, many parents and providers in the focus groups did not share this concern, and

suggested that the personalized relationships between the family and caregiver promoted consistency of care.

- Most study participants believed licensed care settings better provided teaching opportunities for children.

Conclusions and Implications

Most study participants believed that license-exempt care is an essential, legitimate child care option that supports the needs of working parents and their children. Consequently, there was widespread support among study participants for continued subsidization of license-exempt care arrangements. The study findings suggest that steps to reinforce license-exempt care, through policies to enhance resource provision and training, would be supported by parents, providers, and child care staff. While licensing was considered a desirable goal by most child care professionals, most parents and providers in our focus groups were skeptical about the potential benefits of licensed care, and many license-exempt providers had little interest in becoming licensed.

Suggestions for Improving License-Exempt Care

(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- **Raise subsidy payment rates**. Study participants noted the low payment rates for license-exempt caregivers when compared to other types of work. Some providers noted that by the time they paid for food and other costs associated with the provision of care, they had little to show for their efforts. Some suggested that low payment levels sent a negative signal concerning the level of care that was acceptable or expected.
- **Provide resources to license-exempt providers.** Study participants identified several different types of resources and information that they thought could enhance license-exempt caregiving. These include:
    - Teaching and recreation-related materials and equipment (e.g., lending libraries, outdoor equipment)
    - Information about available child care and community resources and programs
    - Idea exchanges, support groups, and other networking arrangements with providers or child care staff
    - Training on various child care topics (e.g., health and safety topics, FirstAaid and CPR)
    - Information about how the subsidy program works
    - Information or assistance with licensing

Suggestions for Improving the Illinois Child Care Program

(Focus group data, Spring 2002; Child care professional interviews, Spring 2002)

- **Improve Payment and Co-Payment Process.** Aside from raising payment levels, several other payment related suggestions were offered. Some suggested that the ICCP could reimburse providers for the cost of food they provided to children, or else make them eligible for food programs comparable to those available to licensed providers. Other care-related tasks for which reimbursement was requested included activities for children and costs associated with transporting children to various activities. Many

participants felt co-payments should be eliminated or reduced. If co-payments were necessary, then providers preferred that payments be collected by the state. Providers also complained that the state did not withhold income taxes from their checks, which left many surprised by their tax amounts when filing income taxes.

- **Ensure Minimum Quality of Care Standards and Offer Support for Licensing.** Many study participants thought the state needed to play a stronger role in assuring that providers offered adequate care. In particular, key informants and CCR&R staff often suggested that license-exempt caregivers should have to meet minimum health and safety standards and training requirements. They also thought that more information on licensing benefits and requirements should be provided to the subset of providers interested in becoming licensed. Indicated barriers to licensing included inadequate housing and inaccessibility of classes
- **Improve Information Delivery about ICCP.** Many study participants discussed the importance of disseminating information about the ICCP. CCR&R staff frequently noted that they spent a large amount of time explaining and clarifying the program rules, and focus group parents and providers often displayed a lack of knowledge about important program features. Some CCR&R staff suggested offering ICCP program orientations for parents and providers to introduce them to the program policies and procedures. In addition, new methods of delivering information may be needed for license-exempt users and providers, such as welcome visits to their homes.

Future Project Activities

Two structured survey instruments are being developed using the results from this interim report—one for parents using license-exempt care and one for license-exempt providers. These surveys will be administered to a random sample of 300 linked pairs of license-exempt users and providers in the three project study areas. The intent is to develop a more systematic assessment of parental and provider perspectives on various license-exempt care issues. Administrative data analysis of statewide ICCP subsidy use patterns will continue to allow for longitudinal analysis of license-exempt care patterns.

Chapter 1: Introduction

This interim report presents research findings from the Illinois Study of License-Exempt Care, which is investigating subsidized license-exempt child care provision in the Illinois Child Care Program (ICCP). The use of such license-exempt caregivers, such as relatives and neighbors, is common both in the Illinois program and in other child care subsidy programs across the United States. Its prevalence raises important public policy questions in rapidly growing subsidized child care program environments.

The study is using multiple methods to assess the caregiving perspectives of both subsidized license-exempt care providers and parents who use this care, as well as to develop data on aggregate subsidized license-exempt caregiving patterns. In addition, staff opinions about license-exempt caregiving issues are being obtained through interviews with both program managers and direct staff working in Child Care Resource and Referral (CCR&R) agencies.

The project is guided by six principal research questions, all of which are important for assessing subsidized license-exempt child care provision. These questions are:

1. What are the patterns of care for families and children that utilize subsidized license-exempt child care, and how do these differ from families and children that rely on subsidized licensed child care?
2. Do parents who use license-exempt care differ in demographic characteristics and other important respects from parents who rely on licensed care?
3. What factors influence families to choose license-exempt child care providers rather than licensed child care providers, or to choose a mix of these provider types?
4. What are the characteristics of license-exempt subsidized child care providers, and what levels of experience and training do they have in providing child care?
5. How do parents and license-exempt care providers describe the quality of license-exempt care, and what specific strengths and weaknesses do they identify with this type of care?
6. Based on study findings and analysis of related research, what policy implications can be drawn for enhancing the quality of subsidized license-exempt child care?

Research on these questions and other issues related to child care quality is critical, given that previous studies have demonstrated the benefits of high quality child care for children's development (Cost, Quality, and Child Outcomes Study Team, 1995; National Institute of Child Health and Human Development, 1999). The rapid growth of subsidized programs for low-income persons since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has made these issues even more compelling. The Temporary Assistance for Needy Families (TANF) programs established under PRWORA have led to large increases in welfare recipients entering work or training programs, and to a concomitant increase in demands for child care by low-income working families. The federal government and the states have responded to these demands by significantly expanding child care funding, through the establishment of the Child Care Development Fund (CCDF) and other funding sources. In Illinois, for example, spending for the ICCP in fiscal year 2001 was $620.8 million, which was

more than triple the $199.7 million appropriated for TANF cash assistance. This is a remarkable shift in social program direction and associated funding in a short time period.

License-Exempt Care Definition and Study Setting

Because definitions of license-exempt care vary across program contexts and research studies, it is important to first establish how license-exempt care is defined in the current study. We will define license-exempt care as legal care in home settings that have been exempted from state licensing requirements. This definition includes four types of license-exempt care: non-relative family child care home providers who care for no more than three children including their own (unless all of the children are from the same family); non-relatives providing care in the child's home; and relative providers caring for children in the relative's home; and relatives providing care in the child's home. For comparative purposes, we will at times contrast such license-exempt care with other forms of care provided through the program, which we will refer to as "licensed". This broad licensed care category includes all licensed child care centers and licensed family child care homes, and a small number of license-exempt child care centers in schools or government agencies.

The specific program context in which the research questions will be examined likewise has important study implications. The ICCP is a large, statewide child care program that provides subsidies to families with incomes up to 50 percent of the 1997 state median income. The program features parental choice of either licensed or license-exempt providers, and there are no waiting lists for services. It therefore is an excellent environment in which to study parental and provider perspectives on subsidized license-exempt care.

While selected research activities are being conducted statewide, the project is focusing upon three diverse geographic areas within Illinois: the North and South Lawndale neighborhoods in Chicago, Peoria County, and the southernmost seven counties in the state (hereafter referred to as the "Southern Seven"). These three study sites represent a mix of large central city (Chicago), mid-sized urban (Peoria), and rural (Southern Seven) areas. In addition, North Lawndale is predominantly African American and South Lawndale is largely Hispanic, which brings additional ethnic diversity to the project. Both Peoria County and the Southern Seven areas also have sizable African American populations.

First-Year Research Activities and Report Organization

Activities during the first year focused heavily upon obtaining initial perspectives related to project research questions from as wide a spectrum of actors as possible, with the intent of uncovering and clarifying a variety of issues in subsidized license-exempt care. These activities have included:

- Development of administrative data on statewide subsidized license-exempt caregiving patterns;
- Focus groups in the three study areas with 115 license-exempt providers and parents using license-exempt care;

- A statewide survey of 115 staff involved with parents and license-exempt caregivers through the CCR&Rs;
- Interviews with 25 CCR&R program managers, resource development staff and other key informants in the three study areas.

These activities have provided useful information on license-exempt caregiving strengths and weaknesses and on related subsidized child care program issues. In addition, first-year findings are guiding the development of structured survey instruments to be administered to linked samples of parents using license-exempt care and their caregivers beginning in the second year of the study.

We begin by presenting a brief review of literature related to license-exempt caregiving, including findings from both the parental and license-exempt provider perspectives. Issues pertaining to subsidized license-exempt care that have evolved from previous research are delineated, as is the relevance of the present study in addressing these issues. We then describe both the ICCP and the study communities to provide a fuller context for the study. Methods used for the various study components are detailed next, and findings resulting from each principal study activity are presented. These findings then are integrated in a discussion chapter, including implications for license-exempt care development and further research. A final chapter previews research activities to be conducted in the final two years of the project.

Chapter 2: Literature Review

In this section, we summarize research findings on who uses license-exempt care, what factors may influence parental choice of license-exempt care, who provides license-exempt care, what motivates license-exempt caregivers to provide care, and what quality of care factors may be important in license-exempt settings. We will also identify areas where additional research questions remain.

License-Exempt Care Utilization Patterns

Recent national data reveal that in 1997, three out of four children under age five with employed mothers are regularly in non-parental child care (Capizzano, Adams, & Sonenstein, 2000). Nearly half of these children in non-parental child care arrangements were using license-exempt child care (Brown-Lyons, Robertson, & Layzer, 2001). These arrangements include care by relatives, in-home care by non-relatives (e.g., nannies or sitters), and license-exempt family child care homes.

In national studies of child care usage patterns, the proportion of families that use license-exempt care arrangements has been found to vary according to several demographic characteristics. These include the parents' education level, household income, work schedule, family structure, ethnicity, and community setting. Several studies have found that less educated mothers and lower income families are more likely to rely on relative care and license-exempt family child care homes (Capizzano et al., 2000; Casper, 1997; Ehrle, Adams, & Tout, 2001; Emlen, Koren, & Schultze, 1999; Galinsky, Howes, Kontos, Shinn, 1994; and West, Wright, & Hausken, 1996).

Census data and other large-scale national population surveys (e.g., National Survey of American Families) have found that mothers employed part-time are more likely than mothers employed full-time to rely on relative care for children under age five (Casper, 1997; Ehrle et al., 2001; Hofferth, Brayfield, Deich, & Holcomb, 1991; West et al., 1996). In addition, mothers who work evening or overnight shifts have been found to be more likely than mothers who work day shifts to rely on license-exempt care arrangements (Casper, 1997).

Children in single parent families are more likely than children from two-parent families to be cared for by relatives (Ehrle et al., 2001; Sonenstein, Gates, Schmidt, & Bolshun, 2002). The use of license-exempt care also has been found to vary across ethnic groups. Hispanic families more commonly use relative care with infants and toddlers than African American families or Caucasian families (Ehrle et al., 2001).

While there appear to be differences across geographic areas in the proportions of parents using different types of providers, findings in this respect have been inconsistent. For example, Hofferth et al. (1991) found that families living in rural areas are more likely than families in metropolitan areas to use relative care and less likely to use center care. This trend may be partly attributed to the absence of child care centers and licensed family child care homes in rural areas (Brown-Lyons et al., 2001). In contrast, Casper (1997) did not find differences in the use of relative or center-based care between families living in rural versus inner-city neighborhoods. However, among those using license-exempt care, inner-city families were more likely to use

license-exempt in-home care providers and less likely to use family child care homes than families in rural areas.

Factors that Influence Parental Choice of License-Exempt Care

Several studies have examined the underlying factors that might influence whether or not parents select license-exempt care. These studies suggest that parents make their child care choices based on a variety of considerations, and that their choices reflect trade-offs between the needs of the children, the parent, and/or the family (Brown-Lyons et al., 2001). Parent preferences, the age of the children, and practical constraints on choice all appear to be important in this selection process.

Many families have a preference for license-exempt care because they want their children cared for by someone they know and trust (Brown-Lyons et al., 2001). According to the low-income mothers moving from welfare-to-work interviewed by Mensing, French, Fuller, and Kagan (2000), trust referred to mothers' feeling confident that their children will be physically safe from harm, and their children's basic needs will be attended to (e.g., child will have diapers changed, be fed, and will not be ignored or abused). Studies have found that parents of all income levels are seeking a caregiver that they are comfortable with, who they believe will care for the child in a similar manner as the parent, or who shares similar values and beliefs as the parent (Galinsky et al., 1994; Hertz & Ferguson, 1996).

These preferences have been found to change as the child grows older. The number of children cared for by relatives or in family child care settings has been found to decrease as the age of the child increases from age one (30 percent) to age five (14 percent) (Tout, Zaslow, Papillo, & Vandivere, 2001). Studies have reported that parents prefer to have their younger children cared for in home-like settings; and as children grow older, parents prefer the learning opportunities provided by center-based programs (Hayes, Palmer, & Zaslow, 1990; Porter, 1999).

Some studies have found that aside from parental preferences for license-exempt care settings, at times parents choose license-exempt care because they lack regulated child care options that match their families' needs (Butler, Bringham, & Schultheiss, 1991; Siegel & Loman, 1991). This includes a lack of child care options that meet the family's scheduling needs or that are affordable to the family. Licensed child care options, especially child care centers, frequently do not offer care during non-traditional work hours (e.g., evenings, weekends). Yet, many low-income parents work rotating shifts (e.g., in a restaurant or hospital) or during evening or weekend hours (Henly & Lyons, 2000; Okuyama & Weber, 2001). As a result, license-exempt providers have been found to better accommodate non-traditional work schedules (Butler et al., 1991; Emlen, Koren, & Schultze, 1999; Henly & Lyons, 2000). It is important to note, however, that several state and community efforts aimed at increasing the amount of non-traditional hour care within licensed child care settings have not succeeded due to a lack of enrollment (Brown-Lyons et al., 2001). This suggests that other factors, such as parental preferences, need to be disentangled from the issue of flexible schedules when examining parental choice of child care.

The cost of care is frequently cited as a major factor in the choice of child care. In particular, some studies have found that the high rates charged by licensed centers and family child care

homes have prevented many families from enrolling their children (Siegel & Loman, 1991). Some argue that this lack of affordable licensed child care options forces low-income families to use lower cost license-exempt care (Brown-Lyons et al., 2001). Child care subsidies have been introduced to alleviate such cost constraints, and have been demonstrated to result in increased use of licensed facilities in some instances (e.g., Fuller & Kagan, 2000; Siegel & Loman, 1991). Yet, other studies have found that child care subsidy programs were associated with increased use of license-exempt care (e.g., Emlen et al., 1999; Piecyk, Collins, & Kreader, 1999). These conflicting results suggest that the specific administrative policies of the state subsidy program may affect how subsidies impact parental choice (Brown-Lyons et al., 2001).

In contrast to licensed care, license-exempt care may be more desirable to families because of both lower overall costs and greater flexibility in payment schedules. For example, studies have found that between 46 and 83 percent of relative providers do not charge for their services (Brown-Lyons et al., 2001). In addition, license-exempt providers have been found to allow flexible payment schedules or accept in-kind payments from parents (Henly & Lyons, 2000). In contrast, licensed child care settings cannot afford to continue operating if they do not receive regular payments from the parents they serve. Beach (1997) has found that the affordability and flexibility of license-exempt care appears to be as important to families in rural areas as in families in larger metropolitan areas.

Characteristics of License-Exempt Providers

Research findings on the characteristics of license-exempt providers vary depending on the specific group of providers studied, and limited representative national data are available. The available findings are summarized below.

Provider Relationship to Children in Care

Several studies report that grandmothers were the most commonly reported form of relative caregivers (Brandon, Maher, Joesch, & Doyle, 2002; Emlen, 1998; Galinsky et al., 1994; Henly & Lyons, 2000). Other studies have also found aunts to be common relative providers (Galinsky et al., 1994; Porter, 1999). Galinsky et al. (1994) found that two-thirds of the relative caregivers in their sample were grandmothers and one-fourth were aunts. In the Brandon et al. (2002) study, over one-third (36 percent) of the license-exempt caregivers were grandmothers, and one-fifth were other relatives (22 percent).

Provider Age/Race

A few studies have reported on the age of license-exempt caregivers. These studies have found that relative caregivers tend to be older than other license-exempt providers. Galinsky et al. (1994) found that the average age of their sample of family child care providers from three large cities in the U.S. was 42.4 years, with relative providers being substantially older on average (52.9 years) than other license-exempt providers (35.9 years) or licensed providers (40.5 years).

In their study of child care use by low-income mothers moving from welfare to work in three states (California, Connecticut, and Florida), Fuller and Kagan (2000) found that the average age

of the relative caregivers was 47 years. Center teachers were younger, with an average age of 37 years, and the average age of family child care home providers (both licensed and license-exempt) was 43 years. Brandon et al. (2002), in their survey of 300 license-exempt caregivers in Washington State, found that the average provider age was 41 years. Butler et al. (1991) surveyed in-home[1] and relative caregivers who provided child care for families receiving subsidies in Rhode Island. These authors found that the average age overall was 48 years, with a considerable difference between relatives (54 years) and in-home providers (36 years).

While all of these studies include race/ethnicity demographic data, the findings varied depending on the sample of license-exempt providers studied, and were not representative of the population as a whole.

Provider Education/Training

License-exempt caregivers on average are less educated than licensed providers, and relative providers have been found to have less education than other license-exempt providers (Brown-Lyons et al., 2001). Galinsky et al. (1994) found that almost half (46 percent) of the relative caregivers in their study and one-third (33 percent) of license-exempt non-relative caregivers had not completed high school, compared with 6 percent of licensed providers. Porter (1999) reported that most of the 99 caregivers who participated in her focus groups in New York and California had no education beyond high school. Fuller and Kagan (2000) found that just over one-fourth (26 percent) of the relative caregivers had some formal education beyond high school, compared to half (51 percent) of the family child care providers and almost two-thirds (65 percent) of the center-based providers. Brandon et al. (2002) found that only 15 percent of the license-exempt caregivers in their study had a college degree or beyond.

As might be expected, licensed providers generally report receiving more training in child care or early education than license-exempt non-relative providers (Brandon et al., 2002; Butler et al., 1991; Galinsky et al., 1994; NICHD, 1996). In turn, license-exempt non-relative caregivers in those studies generally report having received more training than relative caregivers. Brandon et al. (2002) found that the majority of the license-exempt providers (61 percent) had no specific training. Those who had attended training mentioned a variety of topics and formats, including parenting training, courses in early childhood education, courses in child development, workshops, and video training.

Some studies have investigated whether this lack of training by many license-exempt caregivers is tied to a lack of interest in receiving training and educational resources. Brandon et al. (2002) found that almost two-thirds (65 percent) of the license-exempt caregivers reported wanting at least one form of support, with an average of four supports and resources chosen. Of those, over half wanted a newsletter containing ideas, tips and resources on caring for children. Close to one-third were interested in toys or activity kits, home safety items (e.g., fire extinguisher), someone to call to help resolve problems, back-up care when the provider was unavailable, and meetings

[1] An in-home provider was an individual who provided child care services in the child's own home. These providers were generally unregulated (license-exempt) and care was purchased by the Rhode Island Department of Human Services from providers with DHS approval. (Butler et al., 1991).

with other caregivers. Less popular options were help with transportation, training on becoming licensed, and home visits (only mentioned by 10-15 percent of the providers).

In a survey of subsidized license-exempt caregivers in Oregon, Emlen (1998) found that about one-third were interested in health and safety training. In addition, about one-fourth of those who were interested in training had already completed at least some health and safety training.

Porter (1999) also found that the license-exempt caregivers in her focus groups in New York and California wanted information on a variety of topics. These topics include child development, health and nutrition, discipline, activities for children, and dealing with parents. These providers indicated that they wanted to get the information from "meetings like this one" (p. 33), where they could exchange information, problem solve, and learn from each other, rather than in a workshop or lecture format. They generally thought that written materials would be less useful and that they would not have time to watch video tapes. Over 87 percent of the subsidized in-home and relative caregivers surveyed by Butler et al. (1991) also expressed interest in get-togethers or support groups to learn more about child care from each other.

License-Exempt Caregiver Motivations for Providing Care

License-exempt caregivers offer a variety of reasons for beginning to provide care and for continuing to remain a child care provider. Galinsky et al. (1994) found that both licensed and license-exempt family child care home providers most often reported wanting to be employed (i.e., earn an income) while staying at home with their own children as the primary motivator for providing care. On the other hand, relative providers most often reported wanting to help the mothers/family of the children as the primary motivator for providing care.

Other studies (Brandon et al., 2002; Porter, 1999; Smith, 1991) have reported that the majority of license-exempt caregivers reported wanting to help out a relative or friend as the primary reason for beginning to provide care. Then, these caregivers reported that their motivations for continuing to remain a child care provider include the satisfaction of watching the children grow and learn, an interest in working with children, and the gratification of being able to help out and support their community. It is interesting to note that in Smith's (1991) study of families participating in the New Jersey welfare-to-work program, only 9 percent of the license-exempt providers used by these families reported money as their primary motivation for providing child care.

Quality Components of License-Exempt Care

One concern about license-exempt care is the level of child care quality provided, because these settings are not regulated. While parents, researchers, and child care providers do not always agree on definitions of quality of care, there are several core elements of child care quality that have been recognized as being important to children's development, regardless of the child care setting. According to Cryer (1999), these include:

- "Safe care, with diligent adult supervision that is appropriate for the child's age, safe toys, safe equipment, and safe furnishings;

- Healthy care, where children have opportunities for activity and rest, developing self-help skills in cleanliness (e.g., washing hands), and having their nutritional needs met;
- Developmentally appropriate stimulation, where children have choices of opportunity for play and learning in a variety of areas such language, creativity through art, music and dramatic play, fine and gross motor skills, and nature or science;
- Positive interactions with adults, where children can trust, learn from and enjoy the adults who care for and educate them;
- Promoting individual emotional growth, encouraging children to act independently, cooperatively, securely, and competently; and,
- Promoting positive relationships with other children, allowing children to interact with their peers, with the environmental supports and adult guidance required to help such interactions go smoothly." (p. 42)

Using these core elements identified by researchers, parents, and providers, several researchers have attempted to examine child care quality using a variety of techniques in different settings. However, measuring quality of care in license-exempt settings is more complex than in licensed settings (Brown-Lyons et al., 2001). For example, quality of care scales such as the Early Childhood Environment Rating Scale (ECERS) or the Family Day Care Rating Scale (FDCRS) have been developed for licensed settings to assess several dimensions of the child care environment (Harms & Clifford, 1998; Harms & Clifford, 1989). These include space and furnishings, health and safety, learning activities, basic needs, social development, language and reasoning, and child-provider interactions. These scales provide a composite score of quality for these settings. Yet, it is more difficult to determine an overall quality of care score when care is provided by a loving relative who is a permanent figure in a child's life (Fuller & Kagan, 2000).

In those studies that have attempted to compare the quality of care provided across different child care settings using global assessments of quality, variability has been found both within types of care and across types of care. For example, research on parents' perceptions of child care quality indicates that parents perceive more variations in the quality of care within different types of child care than between the types of care (e.g., center versus family child care versus relative care; Emlen, 1998). Yet, in several studies home-based settings have been rated lower in quality than center-based programs, and license-exempt programs have been rated lower than licensed programs (Brown-Lyons et al., 2001).

Fuller and Kagan (2000) found that 71 percent of license-exempt family child care providers and relative caregivers were rated at the minimal level of quality or worse using the FDCRS, while 42 percent of child care centers were rated similarly using the ECERS. Likewise, Galinsky et al. (1994) found that 13 percent of the licensed family child care providers, half of the license-exempt family child care providers, and over two-thirds (69 percent) of the relative providers had inadequate quality ratings. Reasons for poor quality ratings in these studies include few educational materials, high usage of videos and television, lack of an organized environment, and lack of cleanliness.

Because of the complexity in measuring child care quality across settings with a global assessment scale, other studies have examined specific structural elements of child care that have been linked to children's outcomes. The elements most often studied include health and safety

indicators, child-adult ratios, the number of children in the group, and the child care provider's training and experience (Brown-Lyons et al., 2001). The National Institute of Child Health and Human Development (NICHD) is currently conducting a comprehensive national longitudinal study of early child care and youth development to investigate links between the structural aspects of the child care arrangement and providers' caregiving practices across five different types of care. In initial reports from this study, these researchers found that small group size; low child-adult ratios; safe, clean, and stimulating environments; and caregivers' non-authoritarian child-rearing beliefs were linked with providers who provided sensitive, responsive, warm, and cognitively stimulating infant care in all child care settings studied (Brown-Lyons, 2001; NICHD, 1996). In addition, small group sizes and low child-adult ratios were most often found in license-exempt care in the child's home, and there were no significant differences found in the quality of the physical environment between licensed and license-exempt home-based care settings.

Some studies have found health and safety problems in license-exempt settings that parallel similar problems found in the children's own homes (Collins & Carlson, 1998). Butler et al. (1991) found that in 42 percent of the children's own homes and relative caregivers' homes there were safety problems such as peeling paint, electrical outlets without safety caps, open windows on upper floors, or dangerous objects within a child's reach. This same study found that 92 percent of the children observed were clean and well-cared for physically.

License-exempt settings consistently have been found to have less of an educational focus than center-based care. In one study, license-exempt family child care providers reported that their primary goal was keeping the children safe and healthy, and emphasized physical care over providing opportunities for educational or social development (Zinsser, 1991). Children in license-exempt settings have been found to be less likely to engage in activities aimed at promoting literacy and learning than children in centers and licensed family child care homes (Brown-Lyons, 2001). Others have found license-exempt homes to have fewer books (Butler et al., 1991); to use educational toys and materials less often (Butler et al., 1991; Zinsser, 1991); and to use television and videos more often rather than other teaching activities (Fuller & Kagan, 2000; Porter, 1998; Zinsser, 1991).

Despite all of this research on child care quality, only one study has attempted to assess both parents' and providers' definitions of child care quality (Galinsky et al., 1994). In that study, providers and mothers rated the same aspects of care as most crucial, regardless of the type of care: a safe environment, a warm and attentive relationship with the child, and positive parent-provider communication. In addition, both the parents and providers rated a provider who is licensed by the state and the teaching of cultural or religious values as least important to the quality of care. With all of the variability in findings on quality in license-exempt settings, it is important to develop a better understanding of how parents who use license-exempt care and license-exempt providers define child care quality. It also is critical to link the views of the parents and providers in order to better understand if they define child care quality in the same way or if they have divergent views of quality care. Without understanding how parents and providers define child care quality in license-exempt settings, it will be difficult for researchers or policymakers to assess the quality of care in those settings.

Summary

While this research review summarizes the growing body of information on license-exempt care, there is still much to learn. License-exempt caregivers by their nature are not part of any regulated system, which creates difficulties in identifying representative samples of these caregivers for study. For example, previous research generally has studied those license-exempt caregivers who are part of state subsidy and/or welfare programs, or alternately is based on findings from population surveys of families who use non-parental child care. Only a handful of studies have been able to recruit samples of license-exempt caregivers without contacting parents first to gather information on the providers (e.g., Porter, 1998).

National survey data on child care usage patterns of families indicate that more children are in non-parental care than ever before. Examining these data over time reveals variations in the types of care used both across and within states. Some of these variations can be attributed to differing definitions of child care types. For example, the definition of who is considered to be a license-exempt family child care home provider varies from state to state. In one state, a neighbor caring for her own child and two non-related children in her home for compensation might be defined as providing licensed family child care, yet in another state that same neighbor might be defined as providing license-exempt family child care. Other variations are related to demographic differences in the families surveyed. Finally, some variations in usage patterns are related to changes in state subsidy programs that have occurred over the last twenty years. For example, the Family Support Act of 1988 required states to use federal subsidies to pay for all legal forms of child care, and PRWORA then continued to emphasize parental choice of all legal forms of child care.

Reasons for parental choice of license-exempt care have remained fairly consistent over time and across economic levels. Several studies over the past decade have found that parents choose license-exempt care primarily because they prefer to have their children cared for by someone they know and trust (Brandon et al., 2002; Galinsky et al., 1994; Hofferth et al., 1991; Fuller & Kagan, 2001; Smith, 1991; Zinsser, 1991). These studies have included families receiving subsidies (e.g., Butler et al., 1991) and those who were not (e.g., Galinsky et al., 1994). Yet, despite this consistency in reasons for choosing license-exempt care, questions remain regarding whether this preference is present across families who may have different demographic characteristics (e.g., age of child, family income, and education level). Additional information is needed to disentangle parental preferences for license-exempt care from family constraints (e.g., work schedules and cost issues) that may lead parents to choose license-exempt arrangements.

Less is known about license-exempt providers than about parents who use license-exempt care. Only fragmented data are available on license-exempt caregivers. This results partially from the fact that many studies have used different definitions of the providers surveyed, because state regulations vary on who is considered to be license-exempt. This disparity in regulations not only complicates cross-state comparisons, but also makes drawing a composite picture of the supply of license-exempt care almost impossible. Further complexity arises because some states may subject subsidized license-exempt caregivers to a set of regulations that are more stringent than licensing standards for licensed family child care providers in other states. Such differences in state requirements probably account for some of the variations in types of care used by some

families (Collins & Carlson, 1998). The impact of state regulation on child care choice is another issue for which further study is needed.

Those studies that have explored the motivations for providing license-exempt care have consistently found that the primary reason relative caregivers provide care is to help out a relative or friend. License-exempt and licensed family child care home providers most often report wanting to be employed while staying at home with their own children as the primary motivator for providing care. Some studies have found that license-exempt caregivers report an interest in working with children and helping children learn as reasons for continuing to provide child care.

Most license-exempt providers surveyed have not received much, if any, child care training. Yet, many license-exempt providers have expressed an interest in having training and other supports available to them. There is some variability in how the providers would like to receive the resources, so additional research is needed on this issue.

The quality of care in license-exempt settings is of concern to parents, child care providers, and policymakers. Policymakers often are hesitant to invest public resources in unregulated settings, but many want to respect parental choices and do not want to impose regulations on relative caregivers that may restrict a parent's care options.

Several studies that have compared child care quality between the types of care have used scales that were developed for licensed settings; as a result, license-exempt settings are usually rated lower than licensed settings. Other studies have examined specific structural quality elements of child care, and the results vary. The NICHD study (1996) found no differences in the quality of the physical environment between licensed and license-exempt home-based settings. Others have found that license-exempt settings have more health and safety problems than licensed settings (Butler et al., 1991), and are less educationally focused. Despite this complexity in measuring child care quality, only one study has examined whether parents' and providers' have shared or divergent perceptions of child care quality (Galinsky et al., 1994).

Given the many dimensions of license-exempt care yet to be fully understood, the current study of subsidized license-exempt care in Illinois will focus on learning more about 1) the characteristics of the parents using license-exempt care; 2) the factors that contribute to parental choice of license-exempt care; 3) the characteristics of license-exempt providers and their motivations for providing care; 4) the types of resources license-exempt providers would like to have available to them, and the method for delivering such resources; and, 5) the components of quality in license-exempt care according to parents and providers. Because less is known about child care in rural areas, we will study both urban and rural areas of the state to determine whether any geographic variations appear to exist.

Chapter 3: Study Context

This chapter provides information on the context in which the current study is being conducted. First of all, this involves an understanding of the scope of the Illinois Child Care Program (ICCP), including the program rules that appear to have the greatest impact on license-exempt caregiving. Because the characteristics of the communities in which the study is being conducted also may affect study findings, profiles of these communities are then presented.

Description of ICCP

The Illinois Child Care Subsidy Program (ICCP) was established in 1997 and will serve approximately 195,000 children in 2002. The goal of the program is to ensure that high quality child care services are available, affordable, and meet certain standards that promote the healthy development of children. The program is administered through the Illinois Department of Human Services (IDHS), and uses a combination of federal funds, state funds, and parent co-payments. Families must fall within established income limits, and be either working or in an educational program, to qualify for ICCP services.

Child care spending Illinois has increased dramatically since the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1997. Before PRWORA, Illinois initiated the Direct Pay Child Care Program in 1993. This program guaranteed child care subsidies to welfare recipients who were employed. In 1994, the Direct Pay program disbursed $15 million in funds, and by 1996 it had grown to $144 million. The Transitional Child Care program supplemented the Direct Pay program by providing subsidies for up to one year for families that left welfare. Overall, Illinois spent $262.8 million on child care subsidies in Fiscal Year 1997, the last year before PRWORA was implemented. Since the establishment of the ICCP in 1997, combined federal and state child care spending has grown by 142 percent, reaching $635.0 million in 2002 (Table 3-1).

Table 3–1. State and Federal Child Care Spending in Illinois (in millions)

Year	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Spending	$226.0	$262.8	$307.0	$448.0	$574.0	$620.8	$635.0

Illinois has made a commitment to serve every family that applies for ICCP and meets the eligibility requirements. Of the estimated 372,000 children under age 13 who are potentially subsidy eligible, approximately 59 percent will receive assistance in 2002 (Stohr, Lee, & Nyman, 2002). There is currently no waiting list for assistance, or limits on the length of time that families may receive the subsidies. The ICCP program is designed to assist families whose income is up to 50 percent of the State's median family income level. However, the income levels were established using median income from 1997, and they have not been adjusted since that time. Income eligibility ceilings ($21,819 for a family of three) are approximately 39 percent of the current state median income level, which is $55,739 for a family of three. Table 3-2 shows the income guidelines for selected family sizes.

Table 3–2. Subsidy Income Limits

Family Size	Monthly Income[1]	Annual Income*
2	$1,472	$17,663
3	$1,818	$21,819
4	$2,165	$25,975
5	$2,857	$30,131
6	$2,511	$34,288

[1] Income is defined as the total gross employer salary or wages minus a 10 percent deduction, plus any government benefits, child support, or self- employment income.

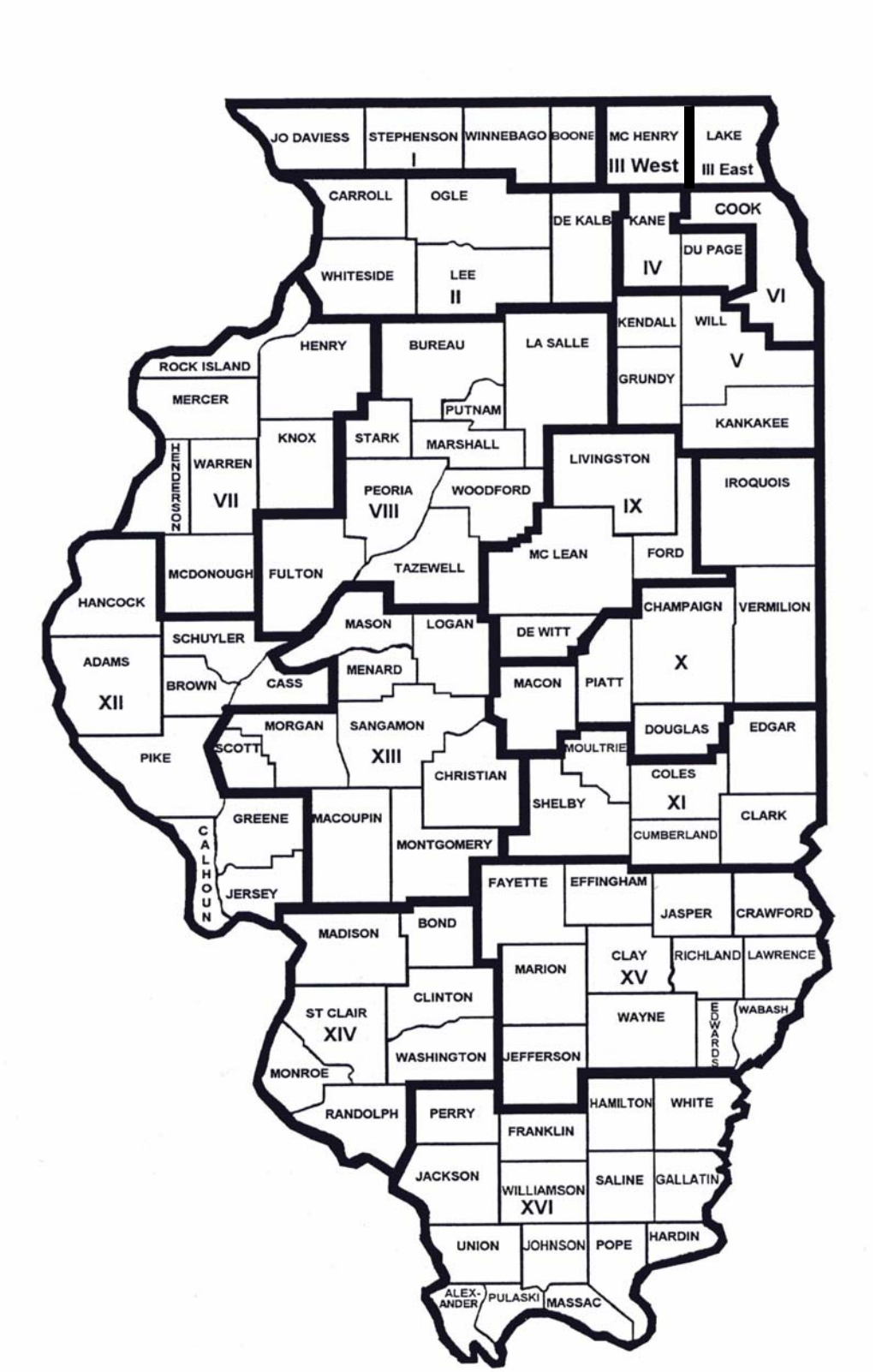
In addition to meeting income eligibility requirements, parents must have a child under age 13[2] and must either be working or engaged in approved education or training activities. If the family is a TANF recipient, they are eligible for child care assistance if they are working or in an education/training or other program approved by their caseworker. Eligible education and training activities for non-TANF families include:

- Working toward completion of a high school degree, Adult Education Program, GED Program, or English as a Second Language Program; **or**
- Attending an occupational or vocational training program (e.g., Cosmetology School); **or**
- Working a minimum of 10 hours/week (can be averaged on a monthly basis) **and** attending classes towards a Bachelor's or Associate's Degree (1st degree only), **or** a combination of employment and unpaid educationally required work activity (e.g., student teaching, internships, practica, or clinicals averaging 20 hours/week)**.**

The most common way for parents to apply for a child care subsidy is through their local Child Care Resource and Referral agency (CCR&R). These agencies operate through contracts with IDHS to provide a variety of child care related services. There are 17 CCR&R agencies throughout the state, covering all 102 counties. Each family has a designated agency based on the county in which they live (Figure 3–1). It should be noted that Cook County (Region VI on the map) includes the City of Chicago and surrounding suburban areas. The CCR&R's are responsible for determining parent eligibility for the child care subsidy, calculating the parent co-payment, issuing provider billing certificates each month, and processing billing and provider payment paperwork for IDHS.

[2] Children 13 or older are eligible if they are under court supervision or have written documentation from a medical provider that they are mentally or physically incapable of caring for themselves.

Figure 3–1: Geographic Areas Served by Each Illinois CCR&R



Parents must have selected a legal child care provider arrangement before they can submit their child care subsidy application. Legal child care is defined as:

- Licensed child care centers, which are profit or not-for-profit centers licensed by the Department of Children and Family Services (DCFS);
- Licensed family child day care homes, which are licensed by DCFS and in which care is provided for more than three and up to 12 unrelated children under age 13, including the provider's children;
- License-exempt child care centers, which are for children at least three years of age and include programs operated by public or private school systems, on federal government premises, and other programs recognized or registered with the Illinois State Board of Education;
- Group family child care homes licensed by DCFS where up to 16 unrelated children under age 13 (including provider's children) are cared for;
- License-exempt family day care homes, in which providers are non-relatives who are at least 18 years of age and who care for no more than 3 children, including their own children, unless all of the other children are from the same family; or,
- Relatives, who are not the parents, stepparents, or legal guardians of the children, either in the relative's or the child's home.

If the parent does not have a child care provider or if they lose their child care provider after they have been approved for a child care subsidy, the parent can contact the Parent Referral Department of the CCR&R to obtain assistance in finding a child care provider. All CCR&R's can provide child care referrals to parents from a provider database they maintain of both licensed and license-exempt child care centers and family child care homes. While the CCR&R's do not directly arrange care for a family, they will perform a customized search of the database to identify a list of referrals best matching each family's child care needs and preferences (e.g., age of child, work hours, location, and type of care).

After finding a provider, the parent must submit a child care subsidy application to the CCR&R that includes four pages of parent/family information. The provider completes two pages of this application, including certification of compliance with several health and safety statements. If the parent has more than one provider (either on a regular basis or for back-up care), all providers must complete the provider pages on the application. Both the parent and provider must sign the application. Parents must also send the CCR&R two copies of their most recent pay stubs and/or class schedule before the child care subsidy application can be approved.

Each provider must also submit a W-9 tax form that will be certified by the State of Illinois Comptroller's Office. If the provider is license-exempt, an authorization form for conducting a Child Abuse and Neglect Tracking System (CANTS) check must also be completed by the provider and all members of the provider's household who are 13 years of age and older. This form authorizes DCFS to run a computerized check of the CANTS databases to determine if a person ever committed child abuse or neglect. These forms must all be returned before child care subsidy payments can be approved for the provider.

Eligibility is re-determined every six months if there have been no changes in the family or provider status. If there has been any change of parent or provider status, such as a new job or a change in provider, then re-determination is done at that time. Parents are sent a re-determination form by the CCR&R two months prior to their re-determination date, which contains much of the same information as the application. If the completed re-determination form is not received by the CCR&R by the re-determination date, the child care subsidy for this parent will be cancelled.

A second way that parent eligibility for a child care subsidy is determined is through one of nearly 200 site-administered licensed child care centers or family child care home networks across the state. These centers and networks have been contracted by IDHS for payment for service up to a specified maximum number of children from subsidy-eligible families. The child care subsidy eligibility for the parents is determined initially by the contracted center, and then finalized by IDHS Bureau of Child Care and Development staff. For approved families, the site-contracted center or home network is then directly reimbursed for the children in their care by the state. Illinois increased spending for site-administered contracts in FY 1999 to $100 million. It is estimated that in that year the site-administered programs served 22,200 children.

Child Care Subsidy Approval and Payments

Within 30 days of receipt of completed child care applications, both the parent and provider are notified by IDHS of approval or denial of the child care subsidy. If the application is denied, the reason for denial is included in the notice letter.

The provider receives their first payment 4-8 weeks after the application has been approved and the provider's W-9 form has been certified by the Comptroller's Office. Subsequently, billing certificates are sent to the provider each month to be completed and signed by both the parent and provider, and then returned to the CCR&R. Payments arrive 3-4 weeks after the provider has submitted the monthly billing certificate. All providers are notified in the child care subsidy application form that they are considered self-employed (not employees of the IDHS or the CCR&R) and are responsible for paying taxes on their income to the IRS. Consequently, there is no income tax withholding from the pay checks that providers receive. The Comptroller's Office will send providers earning more than $500 a 1099 form at the end of the year.

Families approved for a child care subsidy are required to help pay for a portion of their child care costs, through a co-payment made directly by the parent to the provider.[3] The co-payment amount is based on adjusted gross income (total gross employer salary or wages minus a 10 percent deduction, plus any government benefits, child support, or self- employment income.), family size, the number of children receiving care, and whether the children are in care full-time or part-time. For example, a single parent earning $20,000 per year with two children (family size of 3) in care full-time would be assessed a monthly co-payment of $233.98, or $54.00 per week.

[3] The only exception to the co-payment rules is a non-parent representative payee (RPY) case. A non-parent RPY might be a grandmother who has custody of a child receiving a TANF grant.

Co-payments are determined by the CCR&R as part of the child care application process. The amount of the co-payment is printed on the approval notice, which is sent to both the parent and approved provider(s) from IDHS. The parent also receives a co-payment information sheet, which describes the co-payment process and contains a series of co-payment charts that provide the co-payment amounts based on family size and income. For example, the co-payment information explains that if the parent is approved for more than one provider, only the provider who receives the highest reimbursement amount will be assigned to collect the co-payment. Also, the information sheet explains that providers can collect the co-payment on a weekly or monthly basis. There is no monitoring by the state or the CCR&Rs to determine whether the parent makes the required co-payment.

The remaining amount of the child care subsidy rate is reimbursed directly to the provider, based on reimbursement rates established by IDHS. Reimbursement rates vary depending on the age of the child, the county in which the care is provided, the type of child care arrangement, licensure status, and whether the child is in full-time or part-time care. IDHS conducts a market rate survey of child care providers every two years, as required by Child Care Development Fund (CCDF) rules, and uses this survey to re-evaluate reimbursement levels regionally.

Table 3–3 presents the daily reimbursement rates that have been in effect since July 1, 2000. For care provided less than five hours per day, either the part-day or school age-day rate is used to calculate the daily subsidy reimbursement rate, depending on the age of the child. For care provided five through 12 hours per day, the full-day rate is used. For care provided more than 12 hours but less than 17 hours in a day, the full day rate is used for the first 12 hours and then the part-day rate is used for the remainder. For care provided from 17 through 24 hours in a day, two full-day rates are used to calculate the subsidy reimbursement. Travel times to and from work or other eligible activities are included in the reimbursable hours of care.

Providers cannot charge a parent approved for a child care subsidy a higher rate than parents who are private paying (not receiving a subsidy). However, if a provider's rate to all families is higher than the subsidy reimbursement rate, the provider may require subsidy parents to pay the differential in addition to their co-payment fee. As a result, in some regions of the state, the price of desired child care arrangements may be too high if families cannot afford to pay the co-payment plus the rate differential to the provider.

Finally, given the study focus on license-exempt care, we should note the license-exempt care rates presented in Table 3-3. These rates, which are uniform throughout the state, are $9.48 per day for full-day care and $4.74 for part-day care. These rates are substantially lower than all forms of licensed care.

Table 3–3. Illinois Daily Child Care Subsidy Rates

Group 1A Counties *Cook, DuPage, Kane, Kendall, Lake, McHenry*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$33.77	$16.89	$24.34	$12.17	$12.17
Licensed Day Care Home or Licensed Group Day Care Home	$21.53	$10.77	$20.50	$10.25	N/A
Group 1B Counties *Boone, Champaign, DeKalb, Kankakee, Madison, McLean, Monroe, Ogle, Peoria, Rock Island, Sangamon, St. Clair, Tazewell, Whiteside, Will, Winnebago, Woodford*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$33.77	$16.89	$20.50	$10.25	$11.85
Licensed Day Care Home or Licensed Group Day Care Home	$19.14	$9.57	$16.40	$8.20	N/A
Group II Counties *All other counties not listed above*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$24.36	$12.18	$17.68	$8.84	$10.74
Licensed Day Care Home or Licensed Group Day Care Home	$16.59	$8.30	$13.84	$6.92	N/A

All Counties/All Children	**Full-Day**	**Part-Day**
License-Exempt Day Care Home, Non-Relative in a Child's Home, or Relative	$9.48	$4.74

Community Profiles

The three study sites of North and South Lawndale (Chicago area), Peoria County, and the Southern Seven counties were chosen to represent the wide array of geographic, ethnic, and economic diversity throughout Illinois. The total population of the state is 12.4 million, with about 5.4 million of these located in Chicago's home county of Cook and 2.9 million in the City of Chicago. The state also has extensive rural areas. About two-thirds of the state's population is Caucasian, while African Americans and Hispanics comprise 15.1 percent and 12.3 percent of the population, respectively (Tables 3-4 and 3-5). A brief description of each area follows, with Tables 3–4 to 3–11 providing basic social and economic characteristics for each study area. All data are from the 2000 Census, unless otherwise indicated.

Table 3–4. Selected Population Characteristics

		State of Illinois	Peoria County	Southern Seven Counties	South Lawndale	North Lawndale	City of Chicago
Total Population		**12,419,293**	**183,433**	**72,483**	**91,071**	**41,768**	**2,896,016**
Ages of Children	Under 5 years	876,549	12,612	4,025	9,032	4,020	218,522
	5 to 9 years	929,858	13,161	4,546	8,440	4,846	224,012
	10 to 14 years	905,097	12,684	4,819	6,850	4,682	200,802
	15 to 19 years	894,002	13,471	5,130	9,018	3,774	200,962
Families with Own Children Under 18 Years		**1,514,561**	**21,711**	**8,462**	**10,903**	**5,187**	**306,456**
Family Type	Married Couple Families	1,113,582	14,302	6,116	8,132	1,266	179,408
	Single Mother Families	315,957	6,081	1,846	1,899	3,571	105,705
	Single Father Families	85,022	1,328	500	872	350	21,343
Race & Ethnicity	Caucasian	8,424,140	143,932	61,386	3,210	383	1,215,315
	African American	1,876,875	29,532	8,729	11,759	39,164	1,065,009
	Hispanic	1,530,262	3,827	1,308	75,613	1,896	753,644

Source: U.S. Census Bureau, 2000.

Table 3–5. Percent Distribution of Selected Population Characteristics

		State of Illinois	Peoria County	Southern 7 Counties	South Lawndale	North Lawndale	City of Chicago
Total Population		**12,419,293**	**183,433**	**72,483**	**91,071**	**41,768**	**2,896,016**
Ages of Children	Under 5 years	7.1%	6.9%	5.6%	9.9%	9.6%	7.5%
	5 to 9 years	7.5%	7.2%	6.3%	9.3%	11.6%	7.7%
	10 to 14 years	7.3%	6.9%	6.6%	7.5%	11.2%	6.9%
	15 to 19 years	7.2%	7.3%	7.1%	9.9%	9.0%	6.9%
Families with Own Children Under 18 Years		**1,514,561**	**21,711**	**8,462**	**10,903**	**5,187**	**306,456**
Family Type	Married Couple Family	73.5%	65.9%	7.3%	74.6%	24.4%	58.5%
	Single Mother Family	20.9%	28.0%	21.8%	17.4%	6.8%	34.5%
	Single Father Family	5.6%	6.1%	5.9%	8.0%	6.7%	7.0%
Race & Ethnicity	Caucasian	67.8%	78.5%	84.7%	3.5%	0.9%	42.0%
	African American	15.1%	16.1%	12.0%	12.9%	93.8%	36.8%
	Hispanic	12.3%	2.1%	1.8%	83.0%	4.5%	26.0%

Source: U.S. Census Bureau, 2000.

Overview of Study Areas

North and South Lawndale

North and South Lawndale are located on the west side of Chicago, in Cook County. The northeastern border of the neighborhoods begins about 20 blocks west and a few blocks south of Chicago's central downtown area. Bus and elevated train routes serve both neighborhoods. Although North and South Lawndale are contiguous, like many urban neighborhoods they are fundamentally different. In particular, ethnic differences are striking. North Lawndale's population of 41,768 is almost 94 percent African American, and 97.7 percent of the residents are U. S. natives. In comparison, 83.0 percent of South Lawndale's population of 91,071 is Hispanic, with the large majority of these individuals of Mexican descent. Only half of South Lawndale residents were born in the United States, and nearly four-fifths percent speak a language other than English in their homes.

North Lawndale has been experiencing a declining population and a loss of jobs, and efforts are being made to revitalize the area. For example, the Pyramid West Development Corporation is attempting to bring commercial enterprise to the area. Most recently, a movie theatre complex has been opened. Homan Square, a development containing townhouses, condominiums, and rental apartments, also was recently completed. A few social service centers and Mount Sinai Hospital serve the area. (Illinois Facilities Fund, 2001).

South Lawndale is known as "Little Village" by most of the people who live there. In the past ten years, the neighborhood's population has grown significantly. Three new schools have been built, and more are planned. The population growth has led to limitations in available housing, and several organizations are working with residents to increase home ownership. There are active initiatives in the neighborhood on crime reduction, educational reform, and child care. In addition, the Chamber of Commerce is attempting to improve the climate for businesses in the area. (Illinois Facilities Fund, 2001).

Because population, ethnic, and other characteristics vary so much between sub-areas within large urban centers, some basic information on Cook County and the City of Chicago also is useful in establishing the current study context. Cook County is an urban, ethnically diverse area that includes the City of Chicago and 30 surrounding townships. The suburban townships constitute the older, inner suburbs of the greater Chicago metropolitan area, and vary substantially in social and economic characteristics. Cook County has seen a decrease in the Caucasian population and an increase in other ethnic populations in the last ten years, especially among African Americans and Hispanic populations.

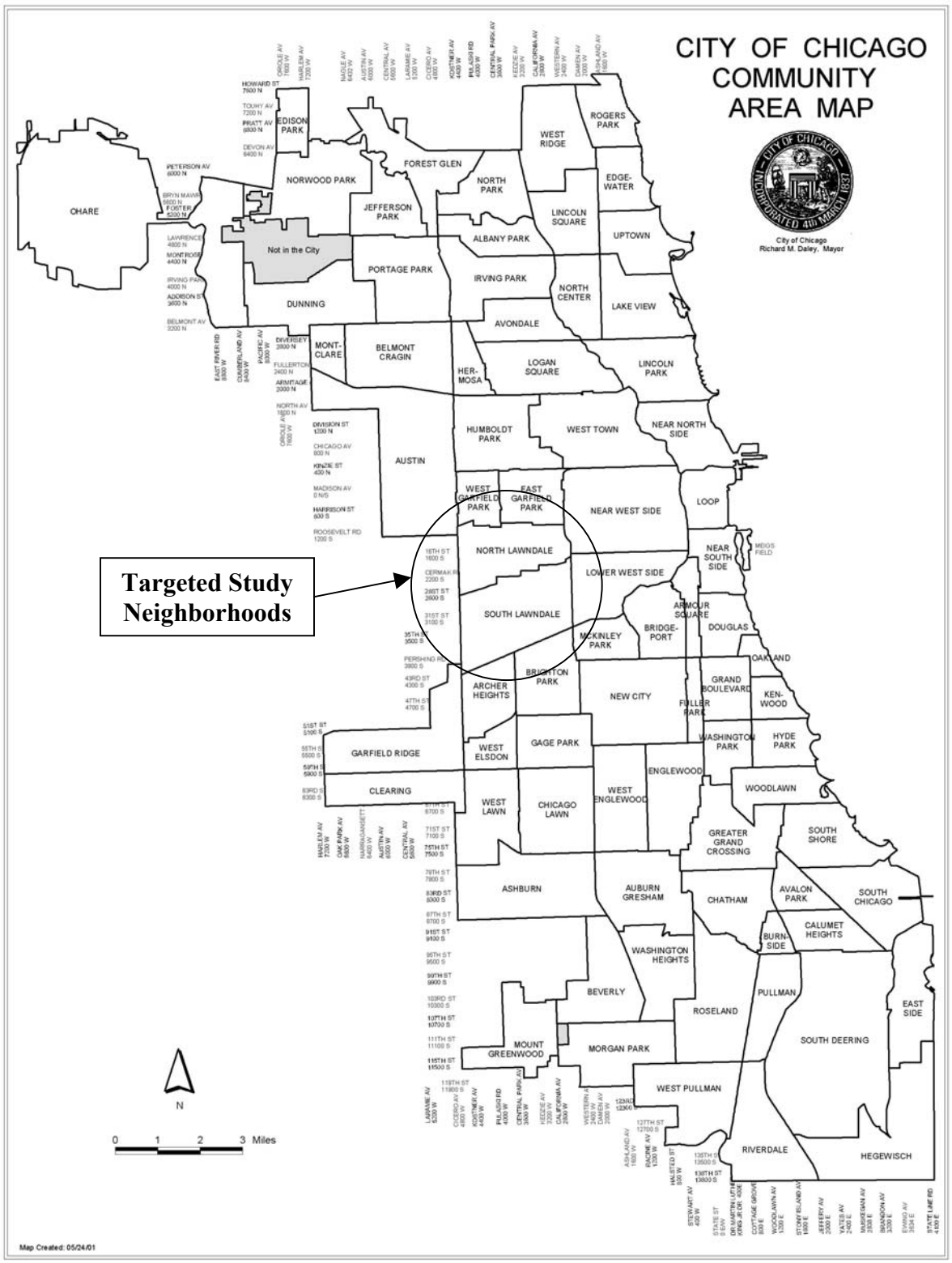
Chicago is the third largest city in the United States. Its population of 2.9 million is ethnically diverse; approximately 42 percent is Caucasian, 37 percent is African American, and 26 percent is Hispanic. The city is divided into 76 community areas for planning purposes (Figure 3-2). These community areas vary substantially in demographic, social, and economic characteristics.

Peoria County

Located between Chicago and St. Louis, Peoria County has a total population of 183,433, with 61.6 percent of these individuals living in the city of Peoria. Over three-fourths of the population (78.5 percent) is Caucasian, while 16.1 percent is African American, and 2.1 percent is Hispanic.

Peoria County includes four cities (Peoria, West Peoria, Chillicothe and Elmwood), 11 villages, and 20 townships, and has both urban and rural areas. The county has 103 public schools, and also is the home to Illinois Central College, Bradley University, Robert Morris College, and the University of Illinois College of Medicine. The world headquarters of Caterpillar Inc. (earthmoving equipment manufacturer) are in Peoria County. Other major employers include Keystone Steel and Wire, OSF St. Francis Medical Center, and the United States Postal Service.

Figure 3-2. City of Chicago Community Area Map with Targeted Neighborhoods



The Southern Seven Counties

The Southern Seven area includes Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union counties. These heavily rural counties, which are located in the southern tip of Illinois, have a total population of 72,483. The largest city in the area, Metropolis, has a population of only 6,482, followed by Anna with a population of 5,136. The Shawnee National Forest covers large portions of the area. Table 3-6 provides some basic demographic and economic information on each of the counties comprising the Southern Seven area.

Over four-fifths of the Southern Seven population is Caucasian, 12.0 percent is African American, and 1.8 percent is Hispanic. However, the ethnic composition of the population varies considerably between the seven counties. For example, 35.4 percent of the Alexander County population is African American, as is 31.7 percent of the Pulaski County population (Table 3-6). In comparison, African Americans comprise less than five percent of the population in Hardin, Pope and Union counties.

Alexander County is located at the southern tip of Illinois, where the Mississippi River and the Ohio River meet. The population center in this heavily rural county is Cairo, an economically depressed city with a population of 3,632. In the last few years the largest employer in the area closed, and many of the remaining jobs in the county involve part time and shift work. The poverty rate in Alexander County is over 26 percent.

In the last ten years, Hardin County has had a decline in both the economic climate and in population. The median family income for the county is only $31,625, which is the lowest among the Southern Seven. Conversely, Johnson County has seen a 13.5 percent increase in population and a decrease in the number of people living in poverty. A majority of the population works in retail, heath and social service jobs. The Vienna Correctional Facility is a major employer in the area, and public discussions about closing it were occurring as this study began.

Massac County is located on the Ohio River, with a riverboat casino in Metropolis as its largest employer. Pope County also borders the Ohio River, but has no single major employer. Both Shawnee Community College and the Tamms Correctional Center are located in Pulaski County. Despite these two employers, the population has been decreasing, and the poverty rate is nearly 25 percent. Many of the people employed in Pulaski County commute from other counties.

The final county in the Southern Seven area is Union County. The county has had a slight increase in population in the last ten years, but has experienced several economic setbacks. There are several small towns that provide retail and social service centers, with Anna and Jonesboro the largest of these.

Table 3–6: Southern Seven Counties -- Selected Demographic Information

		Alexander		Hardin		Johnson		Massac		Pope		Pulaski		Union	
Population	**Total**	**9,590**	**%**	**4,800**	**%**	**12,878**	**%**	**15,161**	**%**	**4,413**	**%**	**7,348**	**%**	**18,293**	**%**
	Under 5 years	600	6.3	263	5.5	604	4.7	940	6.2	211	4.8	450	6.1	957	5.2
	5 to 9 years	673	7.0	251	5.2	654	5.1	989	6.5	236	5.3	548	7.5	1,195	6.5
	10 to 14 years	731	7.6	260	5.4	673	5.2	953	6.3	273	6.2	622	8.5	1,307	7.1
	15 to 19 years	691	7.2	343	7.1	827	6.4	1,013	6.7	412	9.3	591	8.0	1,253	6.8
Race And Ethnicity	Caucasian	5,968	62.2	4,554	94.9	10,553	81.9	13,962	92.1	4,104	94.6	4,841	65.9	17,404	95.2
	African American	3,347	35.4	132	2.9	1,840	14.3	831	6.0	166	4.1	2,278	31.7	150	1.0
	Hispanic	138	1.4	51	1.1	368	2.9	123	0.8	40	0.9	107	1.5	481	2.6
Poverty	Total persons in poverty	2,352	26.1	850	18.6	1,149	11.3	2,000	13.5	793	18.2	1,746	24.7	2,975	16.5
	Families in poverty	536	21.2	200	14.7	245	8.1	448	10.4	122	9.8	397	20.5	542	10.8
	Families with children less than 18 years in poverty	420	32.7	142	24.1	152	11.3	335	16.0	96	16.8	292	29.0	421	18.1
	Families with children less than 5 years in poverty	154	36.0	65	31.4	84	17.0	155	18.1	38	19.4	89	26.3	207	24.1
Family Income	Median	$31,824		$31,625		$40,275		$39,068		$37,860		$33,193		$37,710	

Household Composition

Household composition is of obvious importance in considering child care issues across geographic areas. The relative proportions of children in a geographic area provide crude indications of the likely need for child care. In addition, indicators such as the presence of single parent families often are correlated with limited incomes and the need for subsidized child care.

In Illinois, nearly 22 percent of the population is under fifteen years of age, and 7.1 percent is under the age of five (Table 3-5). The percentage of the population below age fifteen and age five in Peoria County and the Southern Seven counties is similar to the state average. In comparison, both North Lawndale and South Lawndale have higher percentages of children in their populations. In North Lawndale, 9.6 percent of the population is under age five, and 32.4 percent is under age fifteen. In South Lawndale, 9.9 percent of the population is under age five, and 26.7 percent is under age fifteen.

Nearly three-fourths of Illinois families with children under age eighteen include a married couple (Table 3-5). In comparison, a single-parent mother heads 20.9 percent of these families, and a single-parent father heads 5.6 percent. These family composition characteristics are similar to the state percentages in both the Southern Seven counties and in South Lawndale. Families with children under 18 in Peoria County are slightly less likely to consist of married couples and more likely to be headed by a single parent; about two-thirds of these families include two parents, and 28.0 percent are in families headed by a single female parent. North Lawndale easily varies the most from the state percentages and from the other study areas. Only 24.4 percent of families with children under 18 include both parents in North Lawndale, while 68.8 percent live in female headed single parent families and 6.7 percent live in male headed single parent families.

Educational Attainment

Educational levels vary dramatically across the study areas (Table 3-7). Statewide, only 18.6 percent of the population has not completed high school, and almost 54 percent has completed at least some college. Educational attainment levels are very similar to the state levels in Peoria County, while they are somewhat lower in the Southern Seven counties. For example, 28.1 percent of the population has not completed high school in the Southern Seven area, and only 40.3 percent has attended some college.

Educational levels lag even further behind the state averages in North and South Lawndale, and also are considerably lower in these neighborhoods than for the City of Chicago as a whole. In North Lawndale, almost 40 percent of the population has not completed high school, and less than one-third has attended college. Probably reflecting the recent immigrant status of many residents, over 62 percent of the South Lawndale population has not graduated from high school, and nearly 40 percent has not even completed ninth grade. Less than one-fifth of South Lawndale residents have attended college.

Table 3–7: Selected Educational Characteristics

		State of Illinois		Peoria County		Southern Seven Counties		South Lawndale		North Lawndale		City of Chicago	
Population Over 24 Years		**7,973,671**	**%**	**118,498**	**%**	**49,753**	**%**	**46,511**	**%**	**21,461**	**%**	**1,815,896**	**%**
Highest Grade Completed	Less than 9th grade	597,684	7.5	6,585	5.6	5,502	11.1	18,578	39.9	2,361	11.0	225,497	12.4
	9th to 12th grade (no diploma)	882,759	11.1	12,571	10.6	8,452	17.0	10,590	22.8	6,122	28.5	286,277	15.8
	High School Graduate	2,212,291	27.7	34,920	29.5	15,789	31.6	9,058	19.5	6,311	29.4	418,113	23.0
	Some College	1,720,386	21.6	28,375	23.9	10,805	21.7	4,928	10.6	4,451	20.7	338,983	18.7
	Associate Degree	482,502	6.1	8,386	7.1	3,608	7.3	1,169	2.5	705	3.3	84,243	4.6
	Bachelor's Degree	1,317,182	16.5	18,049	15.2	3,564	7.2	1,483	3.2	1,174	5.5	281,549	15.5
	Graduate Degree	760,867	9.5	9,612	8.1	2,033	4.1	705	1.5	337	1.6	181,234	10.0

Source: U.S. Census Bureau, 2000.

Income and Employment

The median family income for the state of Illinois is $55,545 (Table 3-8). Less than 10 percent of households have incomes less than $10,000 (8.3 percent), 16.8 percent have incomes between $10,000-24,999, 11.9 percent have incomes between $25,000-34,999, and 63 percent have incomes over $35,000. The poverty rate for all persons is 10.7 percent, while 11.6 percent of families with children under 18, and 14.5 percent of families with children under the age of five have incomes at or below poverty level.

All study areas have income and poverty characteristics worse than the state figures, although Peoria County most closely parallels the state. The Southern Seven poverty rates are higher, and correspondingly lower percentages of Southern Seven residents have incomes above $35,000 (42.5 percent in the Southern Seven vs. 63.0 percent statewide). The median family income in the Southern Seven area also is considerably lower than the state median ($35,936 vs. $55,545). The South Lawndale income distribution is similar to that of the Southern Seven counties, although poverty rates are somewhat higher and median income is lower. This is especially true for families with children under age five; about one-third of South Lawndale families with children under age five are in poverty, as compared to 23.4 percent in the Southern Seven area. The median income in South Lawndale is $32,317. North Lawndale has the most troubling economic characteristics among the study areas. The median income is only $20,253, which is about half of the state median. The poverty rate for all persons is 45.2 percent, and 55.9 percent of the families with children under age five are in poverty. In addition, only 28.5 percent of North Lawndale residents have incomes over $35,000.

Illinois has a diversified economy. More than one-third (34.2 percent) of employed persons age 16 and over are in management or professional positions (Table 3-9). Sales or office positions are the next most common occupations in the state, with over one quarter (27.6 percent) of the population employed in these positions. Large portions of the population also are employed in production, transportation, and material moving (15.7 percent), and in service occupations (13.9 percent). Education and health (19.4 percent), manufacturing (16.0 percent), retail sales (11.0 percent), and professional services (10.1 percent) are the most common industries.

Peoria County occupational and industrial distributions are very similar to the state as a whole. In the Southern Seven area, lower percentages of people are employed in management and professional and in sales or office positions, while higher percentages are employed in service occupations and construction or maintenance. The Southern Seven area has more employees working in agriculture, fishing, and mining and in educational and health positions than the state distribution, and less in manufacturing, finance, insurance and professional services. North Lawndale likewise has proportionally fewer persons working in professional and management positions and more in service occupations than the state distribution, and also slightly higher percentages working in production, transportation and material moving. The occupational and industrial classifications for South Lawndale differ the most from the state, and from the other study areas. Over 42 percent of its employees work in production, transportation and material moving, which is nearly triple the state percentage. About one-third of South Lawndale employees work in the manufacturing industry; which is double the statewide percentage.

Table 3–8: Selected Income Characteristics

		State of Illinois		Peoria County		Southern Seven Counties		South Lawndale		North Lawndale		City of Chicago	
Total Households		**4,592,740**	**% of total**	**72,739**	**% of total**	**28,169**	**% of total**	**19,265**	**% of total**	**12,391**	**% of total**	**1,061,964**	**% of total**
Income and Benefits	Less than $10,000	383,299	8.3	7,344	10.1	4,330	15.4	2,649	13.8	4,213	34.0	146,192	13.8
	$10,000 to $14,999	252,485	5.5	4,939	6.8	2,973	10.6	1,586	8.2	1,232	9.9	71,103	6.7
	$15,000 to $24,999	517,812	11.3	9,851	13.5	4,628	16.4	3,026	15.7	1,915	15.5	132,339	12.5
	$25,000 to $34,999	545,962	11.9	9,768	13.4	4,255	15.1	3,107	16.1	1,501	12.1	133,670	12.6
	$35,000 or more	2,893,182	63.0	40,837	56.2	11,983	42.5	8,897	46.2	3,530	28.5	578,660	54.5
Median Family Income		$55,545	---	$50,592	---	$35,936	---	$32,317	---	$20,253	---	$42,724	---
Total Persons in Poverty		1,291,958	10.7	24,228	13.7	11,865	17.7	21,057	26.5	18,485	45.2	556,791	19.6
Families with Children Less Than 18 years in Poverty		192,590	11.6	3,962	16.7	1,858	20.2	3,398	27.6	3,422	51.5	84,598	23.1
Families with Children Less Than 5 years in Poverty		98,467	14.5	2,135	22.4	792	23.4	2,210	32.7	1,645	55.9	43,994	26.4

Source: U.S. Census Bureau, 2000.

Table 3–9: Selected Employment and Industry Characteristics

		State of Illinois	Peoria County	Southern Seven Counties	South Lawndale	North Lawndale	City of Chicago
Employed Civilian Population 16 Years and Over		**5,842,406**	**85,258**	**28,441**	**27,394**	**9,492**	**1,220,040**
Occupations by Percentage of Total Employed	Management/Professional	34.2%	35.2%	26.8%	9.7%	21.7%	33.5%
	Service Occupations	13.9%	16.2%	21.5%	17.6%	22.5%	16.6%
	Sales/Office	27.6%	26.6%	20.7%	18.4%	28.8%	27.0%
	Farming/Fishing/Forestry	0.3%	0.1%	1.0%	0.4%	0.0%	0.0%
	Construction/Maintenance	8.2%	7.7%	12.0%	11.8%	5.1%	6.6%
	Production/Transportation/Material moving	15.7%	14.1%	18.0%	42.1%	21.9%	16.2%
Industry By Percentage of Total Employed	Agriculture/Fishing/Mining	1.1%	0.7%	7.4%	0.2%	0.0%	0.0%
	Construction	5.7%	5.2%	6.7%	7.0%	3.2%	4.4%
	Manufacturing	16.0%	17.8%	10.3%	32.6%	12.8%	13.1%
	Retail	11.0%	11.2%	10.7%	9.3%	9.8%	8.9%
	Transportation/Utilities	6.0%	4.1%	7.7%	4.4%	10.8%	6.8%
	Finance/Insurance	7.9%	5.8%	3.2%	3.9%	7.4%	9.1%
	Professional Services	10.1%	9.4%	3.5%	10.3%	9.6%	13.6%
	Educational/Health	19.4%	22.9%	25.4%	8.3%	24.3%	19.0%
	Arts/Recreation/Food	7.2%	8.7%	7.1%	9.9%	7.3%	8.5%
	Other	15.6%	14.2%	18.0%	14.1%	14.8%	16.6%

Source: U.S. Census Bureau, 2000.

Child Care Capacity and Costs

The 17 CCR&Rs in Illinois maintain data on the number of child care facilities, as well as the number of slots within each facility, in their geographic coverage area. While the resulting database provides the best available Illinois data on the publicly available child care market capacity (potential slots available), two limitations should be noted. First, although all licensed facilities are included in the database, license-exempt family child care home providers are included only on a voluntary basis. Relative caregivers and non-relatives who provide care in the child's home are not included in the CCR&R database, as they are not considered to be part of the publicly available child care market. Thus, the data in Tables 3-10 and 3-11 indicate a higher concentration of licensed care capacity than may be the case in all areas. For example, it is known from the administrative data analysis presented in Chapter 5 of this report that nearly two-thirds of all children who receive ICCP subsidies are cared for in license-exempt settings, while the slot information in Table 3-11 indicates that only 29.8 percent of the child care capacity statewide is in license-exempt settings. However, subsidy data reflects utilization of child care slots by low-income families only. The pattern of use of licensed versus license-exempt care may be different for those families than for all Illinois families. That is, some licensed centers and slots are not reflected in the subsidy data.

A second limitation is that the database does not provide community-level geographic data, so no data are available for North and South Lawndale. As a result, we include data in Tables 3-10 and 3-11 for the smallest geographic level available that encompasses North and South Lawndale, which is the City of Chicago, except for the slots by schedule data, which reflect all of Cook County.

The state of Illinois has a total of 14,353 child care facilities listed with the CCR&R's across the state, with a total capacity of 377,009 slots. Of these, 2,910 licensed centers account for 51.4 percent of the total slot capacity. There are also 8,601 licensed family child care homes that comprise 17.9 percent of the total slot capacity. In addition, there are 2,587 license-exempt child care facilities (both centers and family child care homes) that have voluntarily listed with the CCR&R's; these facilities account for 29.8 percent of the total slot capacity.

Table 3–10. Number of Child Care Facilities and Slots

			Illinois	Peoria County	Southern Seven Counties	City of Chicago
Type of Care	Total	Facilities:	14,353	268	97	2,271
		Slots:	377,009	8,135	2,229	57,252
	Licensed Centers	Facilities:	2,910	73	14	522
		Slots:	193,699	5,139	1,006	34,102
	Licensed FCC[1]	Facilities:	8,601	142	46	1,356
		Slots:	67,554	1,073	395	10,895
	Licensed Group FCC	Facilities:	255	5	4	39
		Slots:	3,417	69	55	572
	License-Exempt	Facilities:	2,587	48	33	354
		Slots:	112,339	1,854	773	11,683
Slots by Age[2]	Infants (0-14 months)		19,771	558	105	2,324
	Toddlers (15-23 months)		22,419	638	107	2,682
	Two's (24-35 months)		38,192	940	174	6,315
	Preschool (36-59 months)		121,427	2,694	1,284	19,396
	Five's (60-71 months)		79,710	1,561	370	16,740
	School-Age—Before & After School		66,813	992	144	9,259
Slots by Schedule[3]	Full-Time		267,558	5,473	1674	82,024
	Evening		20,737	285	125	2,696
	Overnight		10,673	227	58	1,682
	Weekend		9643	180	60	1,009
	Rotating		66,955	2,647	442	6,456
	Before School		182,125	3,092	811	50,337
	After School		198,184	3,194	972	59,447
Average Weekly Rates	Infants		$109.84	$111.94	$76.87	$116.52
	Preschool		$98.94	$94.57	$68.77	$105.51

[1] FCC is a family child care home provider.
[2] Child care programs listed with the local CCR&R report maximum possible slot capacity by age group. Because of adult/child ratio licensing regulations, it is possible for the total capacity reported to vary for centers and homes from the capacity by age data.
[3] Multiple responses are possible because slots may fall into more than one schedule category. These data include all of Cook County, not just City of Chicago.

Table 3–11. Percentage Distribution of Child Care Facilities and Slots

			Illinois	Peoria County	Southern 7 Counties	City of Chicago
Type of Care	Licensed Centers	Facilities:	20.3%	23.0%	14.4%	23.0%
		Slots:	51.4%	59.6%	45.1%	59.6%
	Licensed FCC[1]	Facilities:	59.9%	59.7%	47.4%	59.7%
		Slots:	17.9%	19.0%	17.7%	19.0%
	Licensed Group FCC	Facilities:	1.8%	1.7%	4.1%	1.7%
		Slots:	0.9%	1.0%	2.5%	1.0%
	License-Exempt	Facilities:	18.0%	15.6%	34.0%	15.6%
		Slots:	29.8%	20.4%	34.7%	20.4%
Slots by Age[2]	Infants (0-14 months)		5.2%	6.9%	4.1%	4.1%
	Toddlers (15-23 months)		5.9%	7.8%	4.7%	4.7%
	Two's (24-35 months)		10.1%	11.6%	11.0%	11.0%
	Preschool (36-59 months)		32.2%	33.1%	33.9%	33.9%
	Five's (60-71 months)		21.1%	19.2%	29.2%	29.2%
	School-Age—Before & After School		17.7%	12.2%	16.2%	16.2%
Slots by Schedule[3]	Full-Time		71.0%	67.3%	75.1%	76.8%
	Evening		5.5%	3.5%	5.6%	2.5%
	Overnight		2.8%	2.8%	2.6%	1.6%
	Weekend		2.6%	2.2%	2.7%	0.9%
	Rotating		17.8%	32.5%	19.8%	6.0%
	Before School		48.3%	38.0%	36.4%	47.1%
	After School		52.6%	39.3%	43.6%	55.7%

[1] FCC is a family child care home provider.
[2] Child care programs listed with the local CCR&R report maximum possible slot capacity by age group. Because of adult/child ratio licensing regulations, it is possible for the total capacity reported to vary for centers and homes from the capacity by age data.
[3] Multiple responses are possible because slots may fall into more than one schedule category. These data include all of Cook County, not just City of Chicago.

Chapter 4: Study Methodology

This chapter describes the methodologies employed in the various first-year research activities. For each study component, we describe the primary data sources, sampling procedures, geographic coverage issues, data collection instruments, and forms of data analysis. Limitations in the methodologies used also are identified.

Administrative Data Analysis

Three sources of data were used in developing the administrative data analysis for this report. First, for describing the patterns of ICCP subsidy use, we used administrative data from the IDHS Child Care Tracking System. Second, we utilized the IDHS Client Database to analyze the patterns of other services used by child care subsidy users and providers, such as TANF, Medicaid, and Food Stamps. Third, for the patterns of earnings of the child care subsidy families, we utilized Unemployment Insurance (UI) wage records from the Illinois Department of Employment Security. Below, we describe each data source and the methods employed to link the data records from each system for the study.

Patterns of ICCP Subsidy Use

The Chapin Hall Center for Children received monthly extracts of the IDHS Child Care Tracking System (CCTS) for purposes of this research. This database records monthly subsidy payment and service information for subsidy families, as well as their basic characteristics and information on their service providers. The database contains longitudinal information on child care subsidy receipt on a monthly basis at the individual family and child levels. Using the monthly CCTS extracts, Chapin Hall has created a longitudinal database that tracks information such as months of subsidized child care used, types of care used, voucher amounts, addresses of parents, types of providers, addresses of providers, and demographic information about families using care. Upon receipt of each data shipment, Chapin Hall extracts the pertinent variables, reformats the data into relational files, and stores them in a relational database (Sybase). The study to date has utilized selected data from July 1998 to July 2001 from this database.

Illinois makes child care subsidy payments through two methods: vouchers and contracts. Vouchers are issued to eligible families to purchase care from providers, while the contracts are negotiated with the providers to serve blocks of eligible children. Prior to December 2000, the CCTS system only contained information on families using voucher subsidies. The contract service system data were added to CCTS beginning in January 2001. Thus, our study only captures a portion of the total subsidy population for the period from July 1998 to December 2000. However, recent data show that the vast majority of Illinois children receiving subsidies (about 83 percent) were served through vouchers (Piecyk, Collins, and Kreader, 1999).

TANF, Medicaid, and Food Stamp Use

Chapin Hall received monthly extracts of the IDHS Client Database for purposes of conducting this study. Each extract contains mainly cross-sectional data, with some limited historical information. The Illinois Longitudinal Public Assistance Research Database (IL LPARD) is a longitudinal database of public assistance cases (including AFDC/TANF, Medicaid, and Food Stamp receipt) in Illinois that Chapin Hall built from these monthly extracts. This database currently contains data from February 1989 to the present.

Chapin Hall's purpose in creating the IL LPARD was to structure the IDHS Client Database data in a way that would facilitate longitudinal research. On receipt of each data shipment, Chapin Hall extracts the pertinent variables, reformats the data into relational files, and stores them in a relational database (Sybase). This relational database uses less space than the original hierarchical structure, facilitates a longitudinal design, and provides researchers with more flexibility in their analyses. In addition, by allowing users to track the changes that occur in the data, the relational structure improves on that of the original data, which required all changes to overwrite existing information. The IL LPARD is updated monthly with new cases from the IDHS system and also updates records that IDHS changed in the past month.

Earnings of Child Care Subsidy Families

Unemployment Insurance (UI) wage records consist of total quarterly earnings reported by employers to state UI agencies for each employee. The database contains information on quarterly earnings, employee Social Security number (SSN), employer SSN or Federal Employer Identification Number (FEIN), and employer address. Any employer paying $1,500 in wages during a calendar quarter is subject to a state UI tax and must report the quarterly amount paid to each employee.

It is generally known that more than 90 percent of a state's employed population is covered. Major types of employment that are not covered include federal government civilian and military employees, U.S. Postal Service employees, railroad employees, employees of some philanthropic and religious organizations, and independent contractors. A potential limitation of the data is that the coverage extends only to a state's borders, so Illinois residents who work in Wisconsin or in Missouri, for example, appear in the UI wage record databases of those jurisdictions. Another limitation of the data is that some persons, especially in low-income populations, work in the "underground" or cash economy, and such cash transactions generally are not reported to the Illinois Department of Employment Security. Both of these limitations lead to some understatement of earnings, and use of this method also does not capture non-earnings sources of income.

Chapin Hall received Illinois Department of Employment Security (IDES) quarterly wage report data for this study from the IDHS through an interagency data-sharing agreement. The quarterly data are linked over time at the individual level, and the employee records

also are linked to employer records over time to allow examination of the quarterly earnings for a family receiving subsidies in a given month. For example, the mean and median earnings reported for January 2001 represent the earnings reported in the first quarter of 2001.

Record Linking

Linking data records from the CCTS reliably and accurately to TANF, Medicaid, Food Stamp and UI wage records is a key to being able to describe the service use and earnings patterns of subsidy recipients. The linking process is complicated by the fact that no single variable, even Social Security Number in some cases, can be relied on completely to establish the identity of a client from the records of various agencies. A process called probabilistic record matching, first developed by researchers in the fields of demography and epidemiology, is used for these purposes (Newcombe, 1988; Winkler, 1988; Jaro, 1985; 1989). Probabilistic record matching is based on the assumption that no single match between variables common to the source databases will identify a client with complete reliability. Instead, probabilistic record matching calculates the probability that two records belong to the same client, using multiple pieces of identifying information. Such identifying data may include name, Social Security Number, birth date, gender, race/ethnicity, and address of residence. When multiple pieces of identifying information from two databases are comparable, the probability of a correct match is increased.

Once a match has been determined, a unique number is assigned to the matched record so that each record can be uniquely identified. The end result of computer matching is a new link file, which contains the unique number assigned during matching, the client's identifying data (name, birth date, race/ethnicity, gender, and origin of residence), and all the identification numbers assigned by agencies.

Key Informant Interviews

The first stage of data collection for the project involved conducting key informant interviews in the three geographic areas selected for intensive study: the North Lawndale and South Lawndale neighborhoods in Chicago, Peoria County, and the Southern Seven area. Key informants initially were identified through discussions with state officials and with the CCR&R director in each area. Additional key informants then were suggested by this first set of interviewees. A total of 14 key informant interviews were conducted in the three areas. The key informants included the local CCR&R directors, other CCR&R staff, local TANF office administrators, child care center staff, and other community service providers. In order to introduce the project adequately to local child care experts and to obtain some initial observations about each of the research areas, all key informant interviews were conducted in person.

The principal investigators for the project conducted the key informant interviews, using an interview guide with fairly broad open-ended questions (see Appendix A). The interviews were intended to gain perspectives on prominent license-exempt child care issues, as well as to learn about child care supply and other service issues specific to the

community. Interviews generally lasted from 45 minutes to one hour. The interviews were audio recorded and transcribed. Project staff then coded the interviews to identify common themes, as well as themes unique to specific communities. Informant quotes illustrative of major themes also were identified, and will be presented in the findings.

Surveys and Interviews with CCR&R Staff

Two separate sets of activities were conducted with CCR&R staff. First, a structured statewide telephone survey (see Appendix B) was conducted with a random sample of 115 staff who complete initial ICCP eligibility determinations and re-determinations, and who answer any follow-up questions that subsidy recipients may have. These staff, who typically are referred to as "subsidy specialists", were selected for study because they generally have the most contact with license-exempt care providers and with subsidy recipients who use license-exempt care.

Key informant interviews suggested that other CCR&R staff also had unique perspectives on subsidized license-exempt caregiving. Therefore, more limited interviewing was conducted with additional staff recommended by CCR&R directors in the three study areas. The following sections describe the procedures used to conduct both the statewide survey and these additional interviews.

Statewide Survey of Subsidy Specialists

The statewide survey of subsidy specialists involved the collaboration of UIUC project staff, the Survey Research Office (SRO) at the University of Illinois at Springfield, IDHS, and the CCR&Rs. UIUC project staff developed the survey instrument, with input from IDHS and the CCR&Rs. SRO staff drew the sample, programmed the survey for Computer Assisted Telephone Interviewing (CATI), conducted all interviews, and prepared data for analysis. UIUC project staff then conducted the data analysis.

The survey relied heavily on the cooperation of the CCR&R agencies. The project directors solicited such cooperation at a statewide meeting of CCR&R directors. A description of the intent of the survey and the nature of questioning was presented, and CCR&R directors were asked to sign a consent form authorizing project staff to interview the subsidy specialists during normal working hours. After follow-up e-mail and telephone correspondence to address questions, all 17 of the CCR&R directors agreed to participate.

Development of Survey Instrument

The survey was intended to learn about license-exempt caregiving issues that subsidy specialists encounter during the course of their work. Respondents were asked about:

- the types of issues they talk about with license-exempt care providers and parents using license-exempt care;

- why they thought parents they worked with selected license-exempt care providers;
- the frequency with which parents and license-exempt caregivers contacted them with information or resource requests;
- the motivations of license-exempt caregivers in providing care;
- whether they thought license-exempt caregivers were generally interested in becoming licensed;
- the factors most important to the quality of child care that children receive;
- whether they thought the state should provide subsidies to license-exempt providers; and
- what they thought could be done to improve subsidized license-exempt care.

In addition, limited demographic, education, and work experience information was collected on each respondent.

Sampling

Because no statewide list of subsidy specialists existed, a necessary first step was developing such a list to serve as a sampling frame. Each CCR&R was asked to send a list with the names and telephone numbers of subsidy specialist staff, and a resulting list of 320 subsidy specialists was compiled. Just over half (52.5 percent) of these staff worked in the Chicago CCR&R.

SRO staff then drew a random sample of 118 subsidy specialists from this list to form an initial pool of potential respondents. An additional 92 subsidy specialists subsequently were selected to supplement the pool. The need to do so resulted both because a sizeable portion of the initial sample was determined to be "out of population" when screening questions were asked of potential participants, and because some sample members could not be reached for interviewing despite numerous attempts to contact them (see following sections on "Survey Administration" and "Response Rate" for elaboration of this issue). The complete pool consisted of 210 randomly selected subsidy specialists, of which 118 were located in Chicago and 92 in the rest of the state (hereafter referred to as "Downstate"). Each of the 17 CCR&Rs was represented in this pool.

Survey Administration

Letters describing the study and soliciting participation were sent by SRO to the entire list of subsidy specialists. The reason for sending the letter to the entire population rather than only to the sample was to protect the confidentiality of sample members. The letters indicated that the agency director was cooperating with the study and had authorized staff to complete telephone interviews at the agency during normal working hours. However, it also stressed that staff participation was voluntary, and that agency directors would not be informed about which staff completed interviews. The letters indicated that follow-up calls to determine willingness to complete interviews would be forthcoming, and an SRO 800 number also was provided in the event that staff wanted to call and initiate an interview.

Interviews were conducted by trained SRO telephone interviewers, who received an orientation from the project investigators concerning the purpose of the study and of various survey components. When SRO interviewers reached potential respondents, they again described the survey and asked if the person would be willing to complete an interview. A brief set of screening questions designed to determine if the person was eligible for the study then were completed. These questions screened out staff who no longer worked as subsidy specialists, who had worked as a subsidy specialist for less than three months, or who had no contact with either subsidy parents who used license-exempt care or with license-exempt care providers. If the subsidy specialists met screening requirements and had time available when initial telephone contact was made, the interviews were conducted immediately. Otherwise, follow-up interview times were scheduled at the convenience of the subsidy specialists. The average length of an interview was 31 minutes.

Response Rate

Table 4–1 summarizes response rate information for the survey. The overall response rate was 68.5 percent. The response rate was slightly higher for Downstate than for Chicago (73.2 percent versus 64.0 percent), and the reasons for non-response also varied between the two areas. That is, only 12.8 percent of eligible Chicago staff refused to complete interviews, as opposed to 25.6 percent of Downstate staff. However, a much higher portion of Chicago staff (23.3 percent versus 1.2 percent Downstate) could not be reached to determine willingness to complete interviews. The higher level of non-contact cases in Chicago may have partially resulted from the fact that major changes in the CCR&R phone system were being implemented in Chicago as the telephone survey was being conducted. A case generally was not closed due to such non-contact until at least eight telephone contacts were attempted.

About one-fifth of potential respondents were defined as “out of the population”. These included staff that had left the agency, changed jobs within the agency, who had worked for less than three months as a subsidy specialist, or who had not had interactions with either parents using license-exempt care or license-exempt care providers.

Table 4–1. Response Rate Information for Subsidy Specialist Survey

	Chicago		Downstate		Total	
	Number	%	Number	%	Number	%
Completion	55	64.0%	60	73.2%	115	68.5%
Refusal	11	12.8%	21	25.6%	32	19.0%
Not reached for completed interview[1]	20	23.3%	1	1.2%	21	12.5%
Out of population[2]	32	---	10	---	42	---
Total	118	---	92	---	210	---
Total excluding "Out of population"	86	100.0%	82	100.0%	168	100.0%

[1] These are sample members who were not reached for a completed interview despite numerous attempts to reach them. Depending on the history of the calls, these sample members were generally called at least 8 to 12 times.

[2] "Out of population" includes those who have left the agency, who have a different job, and who did not meet the eligibility criteria in the survey (worked less than 3 months in their job and no interactions with relevant parents and providers). These were excluded from response rate percentage calculation.

Data Analysis

Responses to closed-ended questions were entered directly into SPSS files with the use of CATI software, while open-ended question responses were entered into text files. The open-ended responses subsequently were coded by SRO and entered into SPSS files. Frequency distributions were run on all study questions. Cross-tabulations also were run to determine if survey response patterns varied according to the characteristics of the subsidy specialists.

Limitations of Subsidy Specialists Survey

While these findings provide a staff perspective often overlooked in studies of subsidized child care programs, two limitations of this component of our study should be noted. First, because of the nature of their positions, subsidy specialists often are the staff members who receive complaints from both license-exempt care providers and from parents using license-exempt care when difficulties arise. Subsidy specialists therefore may tend to interact with a subset of license-exempt care parents and providers that are biased somewhat in terms of experiencing care problems.

Second, some of the survey questions asked subsidy specialists to interpret parental reasons for selecting license-exempt care providers or license-exempt caregiver motivations for providing care. It may be noted that this approach provides only second-hand opinions about issues that can be ascertained more directly through questioning of parents and license-exempt care providers. We will be completing such direct questioning

of parents and providers during the second phase of the study, and suggest caution in interpreting the subsidy specialist opinions on such matters.

Nonetheless, we think subsidy specialists opinions about parents and providers are useful for two reasons. First, regardless of whether such opinions accurately reflect the attitudes of parents and providers, they may affect staff ideas about license-exempt caregiving, and even may influence staff service delivery. For example, if subsequent surveying indicates parent and provider attitudes differ substantially from how staff perceive them, educational efforts to inform staff about parent and provider issues may be warranted. Second, while direct questioning of parents and providers is in general a preferable single approach, having interpretations from staff based on actual service experience may provide a useful balance to parent and provider perspectives. This is particularly true in instances in which some responses may be more socially desirable than others, as may be the case both in parents' perceptions about reasons for selecting license-exempt caregivers and license-exempt caregivers' motivations for offering care.

Interviews with Additional CCR&R Staff

The staff selected to supplement the perspectives offered by the subsidy specialists were identified based on consultation with the CCR&R directors in each study area. These staff included parent services coordinators, resource development and recruitment specialists, Quality Counts specialists, and Healthy Child Care Illinois nurse consultants. While the roles of these staff differ, each has direct interactions with parents using license-exempt care or with license-exempt providers.

Parent services staff interact with parents who are seeking a child care provider and provide information to parents on factors to consider in making child care choices. Resource development and recruitment specialists identify child care needs in their service area and attempt to recruit child care providers—licensed and license-exempt—who can meet those needs. Quality counts specialists assist in improving the quality of care provided in all child care settings by making a variety of developmentally appropriate materials and resources (e.g., books, activities, equipment) available to both licensed and license-exempt providers in each service area. This includes delivering the materials directly to the provider in their home with the Quality Counts vans, and then modeling developmentally appropriate activities with the provider and children. Healthy Child Care Illinois nurse consultants, in collaboration with a partner health department in each area, deliver a variety of health-related information and resources to licensed and license-exempt providers in their service area. This includes offering training on health, nutrition, and safety topics such as car seat safety, hand washing, and immunizations.

A total of 10 interviews were conducted with such staff in the three study areas. All interviews were conducted in-person, and featured semi-structured discussions using an interview guide similar to that used in key informant interviews. The nature of the results from these interviews thus is less quantitative and more impressionistic than the results from the subsidy specialist surveys. Nonetheless, these interviews provide a useful complement to the subsidy specialist survey.

Focus Groups

Focus groups with license-exempt providers and parents who use license-exempt care were conducted in each of the three study areas. Because the experiences and major issues facing parents and providers were expected to differ in important aspects, separate focus groups were held for parents and providers. The groups were organized with the assistance of the CCR&Rs and child care providers in the three areas.

Focus Group Recruitment

Focus group recruitment began in each area by meeting with the CCR&R directors to discuss recruiting strategies. These meetings led to agreements with the CCR&Rs to cooperate with the mailing of flyers advertising the groups to parents and providers currently involved in the subsidy program. In Chicago, two community service providers in North Lawndale and South Lawndale also agreed to assist with focus group recruitment: the Carole Robertson Child Care Center (North Lawndale) and Project Hope (South Lawndale).

Project staff developed a letter introducing the project and the purpose of the focus groups, as well as an accompanying flyer seeking participation. The flyer offered a $40 payment to parents using license-exempt care and to license-exempt care providers for participating in a two-hour focus group. The flyer included a toll-free number for parents and providers to call if they were interested in participating. The letter and flyers were mailed to lists of parents and providers that CCR&R databases indicated were active in the subsidy program.

Calls from those interested in focus group participation were fielded either by project staff or by staff from the cooperating community child care agencies. Callers again were informed about the intent of the groups, and they also were screened to assure that they currently either were using or providing license-exempt care through the ICCP. Persons who were determined to be active in the ICCP, and who were interested in participating, then were scheduled for groups. The groups were scheduled for weekday evenings and Saturday mornings to accommodate work schedules.

Focus Group Conduct

The focus groups were held in the CCR&Rs, community child care agencies, and a community college, with project staff serving as group moderators. At the beginning of each group, all participants were provided with written and oral assurances that the groups were confidential and that they would not be individually identified in project written reports or in any other way. Focus group participants also completed a brief background survey at this time (see section on "Background Characteristics of Focus Group Participants" in Chapter 8 for results of these surveys). Refreshments and light meals were served at the beginning of the groups.

Project staff used focus group guides to facilitate the discussion. Separate parent and provider focus group guides were developed for this purpose (see Appendix C). Although attempts were made to cover all material included in these focus group guides, group members were given considerable latitude to introduce other issues and topics.

All but two of the groups were conducted in English. Because South Lawndale is predominantly Hispanic and is the home to many recent immigrants, discussions with key informants in this community indicated these groups should be conducted in Spanish. Two bilingual women with a history of involvement in South Lawndale were hired to recruit and conduct these groups. All recruiting materials, the focus group guides, and background surveys were translated into Spanish for these groups. Then, the audiotapes of the sessions and survey responses were translated into English for analysis. Due to concerns that knowledge about and access to the program may be limited in communities with large numbers of immigrants, we included three home-based child care providers not currently receiving subsidies in this focus group.

Each focus group, which generally included 6-10 participants, lasted about two hours. All focus group discussions were audio taped. Respondents were paid $40 in cash at the conclusion of the groups, and also were offered a copy of the report to be developed based on the groups. A total of eight parent groups and seven provider groups were held, with at least two parent and two provider groups held in each geographic area (Table 4–2). A total of 55 parents and 60 providers participated.

Table 4–2. Focus Group Participants in Each Study Area

Study Area	Parents Using License-Exempt Care		License-Exempt Care Providers	
	Number of Groups	Number of Participants	Number of Groups	Number of Participants
Chicago (North Lawndale and South Lawndale)	3	22	3	24
Peoria County	2	15	2	17
Southern Seven Counties	3	18	2	19
Total	**8**	**55**	**7**	**60**

Focus Group Analysis

Each focus group tape was transcribed. Project staff then coded the transcripts, identifying common and divergent themes. Attention was given to assessing how parent and provider perspectives were similar and different, and whether issues varied between the different geographic areas. Quotes that represented various themes also were selected for inclusion in the findings sections of this report; these quotes are presented verbatim to assure the integrity of participant comments.

Chapter 5: Statewide Program Characteristics Based on Administrative Data Analysis

This chapter presents preliminary analyses of statewide administrative data for the ICCP. In general, two types of data are presented. First, data for selected months provide an overview of program characteristics at single time points. Data for six time points have been developed for this interim report: July 1998, January 1999, July 1999, January 2000, July 2000, and January 2001. Both the July and January time points were included in each fiscal year (FY) so that we could assess whether major differences in caregiving patterns occur in months in which children are or are not in school.[4] To simplify presentation, we generally will present data for July 2001 unless examination of other months suggested interesting seasonal or temporal variations.

Second, data are being developed for three yearly cohorts to assess selected care patterns over time. These cohorts correspond to families and children entering the subsidy program in FY 1999, 2000, and 2001. Because insufficient time has passed with the later yearly cohorts to alleviate issues associated with incomplete care spells (i.e., right censoring problems), cohort data in this report will be presented only for those entering the program in FY 1999. This allows for the presentation of cohort data for eight quarters, or two years.

Overview of Illinois Program Growth and Composition

Figure 5-1 illustrates the rapid growth of the ICCP over the period from July 1998 to January 2001. Beginning with a caseload of 53,765 families in July 1998, the number of families using the program increased about 61 percent to 86,758 by January 2001. Children receiving care through the program similarly grew by 60 percent during this period, reaching a total of 172,815 in January 2001.

[4] We should remind the reader that the Illinois fiscal year begins July 1 and ends June 30.

Figure 5-1. Growth of Illinois

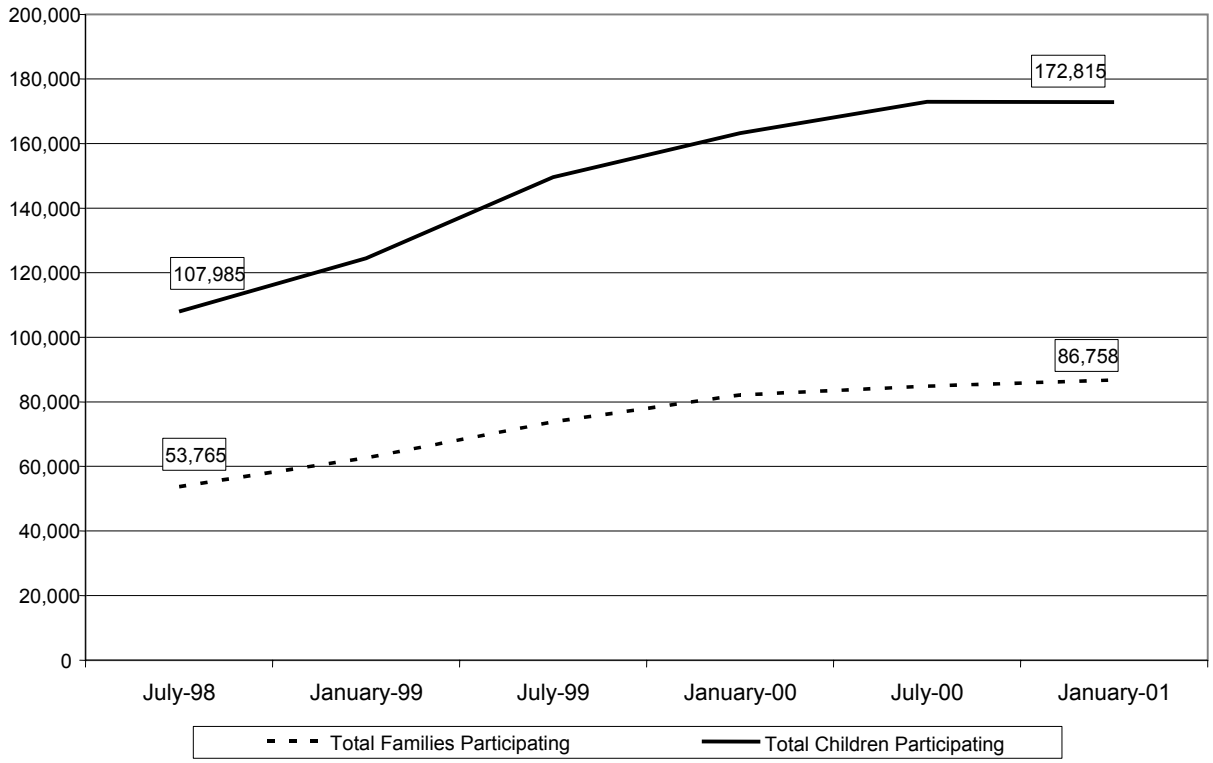


Table 5–1 presents data on the ages of children served by the subsidy program in January 2001. Over 45 percent of children served by the program were age 6 and over[5], while another third were in the 2.5 – <6 age group. A relatively small portion of program services was being provided to infants (6.6 percent). Analysis of the percentage distribution of care by age groups for other time periods revealed only minor variations when compared to the January 2001 percentages.

Table 5–1. Age Composition of Children Receiving Care Through the Illinois Child Care Program: January 2001

	Number	Percent of Total
Children Under 1	11,365	6.6%
Children 1- <2.5	24,887	14.4%
Children 2.5-<6	58,337	33.7%
Children 6 and Over	78,226	45.3%
Total	**172,815**	**100.0%**

[5] Because care for children over age 13 is only allowed under special circumstances, nearly all children receiving care in the age 6 and over category are under age 13. For example, of the 78,226 children age 6 and over receiving care in January 2001, only 352 children were age 13 and over.

Administrative data also have been developed to differentiate between families with only one child in subsidized care versus families with more than one child in subsidized care. About 58.5 percent of the children receiving subsidies lived in families with more than one child in subsidized care.

Types of Care Providers Used at Single Points in Time

Table 5-2 provides data on the types of child care providers used by families and their children in the program in January 2001. The data suggest the prevalence of license-exempt care provision in the Illinois program. For families, slightly over half (53.5 percent) were using a single license-exempt provider, while 38.6 percent were using a single licensed provider. The relatively infrequent use of subsidized multiple providers at a single point in time also is illustrated by the data.[6] Only 7.8 percent of all families who received subsidies in January 2001 were using more than one subsidized provider (derived from table), with most of these (4.3 percent) using a mix of license-exempt and licensed providers.

Table 5-2. Distribution of Subsidized Child Care for Children and Families, by Type of Provider Used: January 2001

	Numbers Using Provider Type		Percentage of Total Using Provider Type	
	Families	Children	Families	Children
One License-Exempt	46,444	110,484	53.5%	63.9%
Multiple LE[1]	819	1,103	0.9%	0.6%
One Licensed	33,492	57,516	38.6%	33.3%
Multiple Licensed	2,242	892	2.6%	0.5%
Both Licensed & LE	3,761	2,820	4.3%	1.6%
Total	**86,758**	**172,815**	**100.0%**	**100.0%**

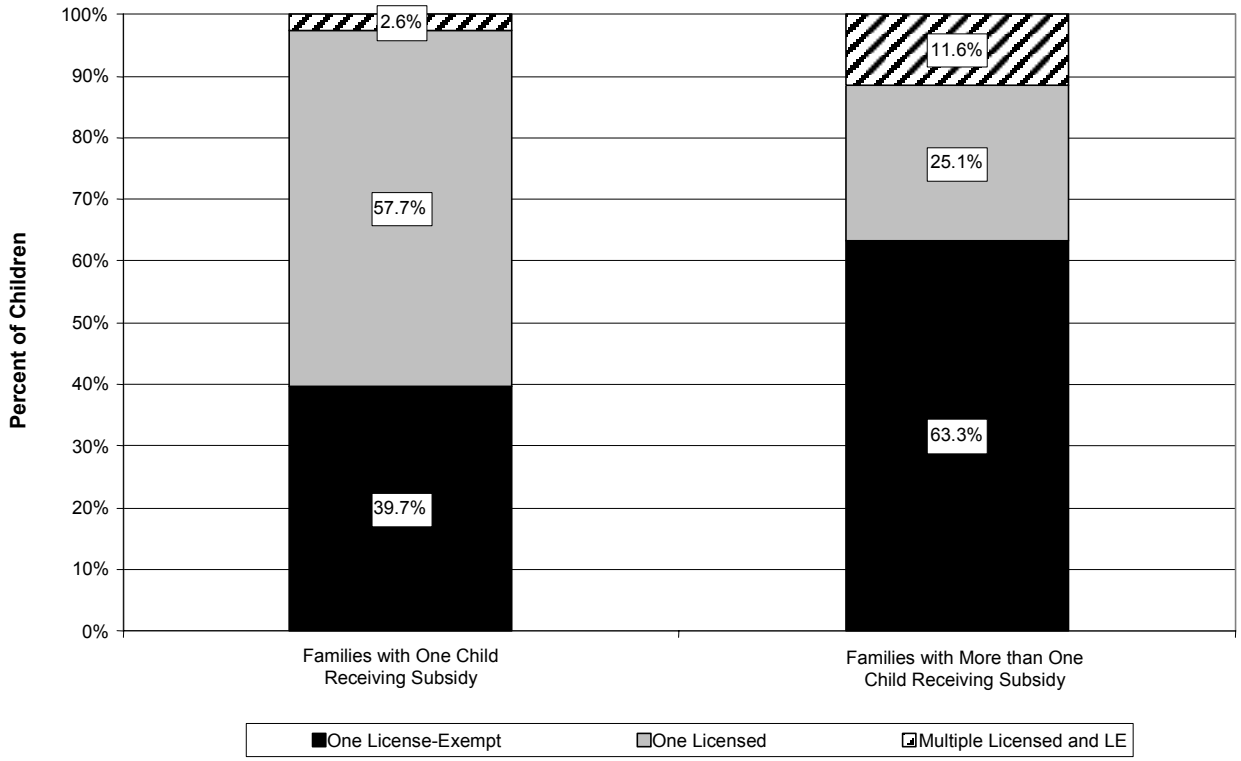
[1] LE = License-Exempt

Children receiving subsidies were even more likely to be served by a license-exempt provider, with 63.9 percent cared for by a single license-exempt provider in January 2001 (Table 5-2). This higher proportional prevalence of license-exempt care use by children as compared to families results from interesting differences in use patterns according to the number of children in a family that receives subsidies (Table 5-3 and Figure 5-2). That is, families with only one child receiving a subsidy are more likely to use a single licensed provider than a single license-exempt provider (57.7 percent versus 39.7 percent). However, families with more than one child receiving subsidies are much more likely to use a single license-exempt provider (63.3 percent versus 25.1 percent using a single licensed provider). These families with more than one child receiving subsidies comprise nearly three-fifths of all subsidy children and include an average of 2.7 children in subsidized care per family. The heavy usage of license exempt providers within

[6] We should remind the reader that when referring to multiple providers, we always mean multiple providers who are receiving subsidies. It is possible, for example, that many other families receive a subsidy for a single provider, but then supplement this care with another provider who does not receive a subsidy. The administrative data do not allow the determination of the extent to which this contingency occurs.

such families thus results in children in the program being more reliant on license-exempt care than would be suggested by the percentages of families that use this form of care.

Figure 5-2. Types of Care Used by Family Composition: January 2001



A final point concerning the use of multiple subsidized care providers at a single point in time also may be observed from Tables 5-2 and 5-3. It is rare for a child to be in care with more than one subsidized provider at a time. For example, only 2.7 percent of children were using multiple subsidized providers in January 2001 (derived from Table 5–2). However, the use of multiple subsidized providers is more common among families with more than one child, with 11.6 percent of these families using multiple providers in January 2001 (derived from Table 5-3). This suggests that multiple subsidized provider usage at a point in time generally results from using multiple providers for different children, as opposed to multiple providers for the same child.

Table 5-3. Distribution of Subsidized Child Care for Families with One Child or More Than One Child Receiving Subsidy, by Type of Provider Used: January 2001

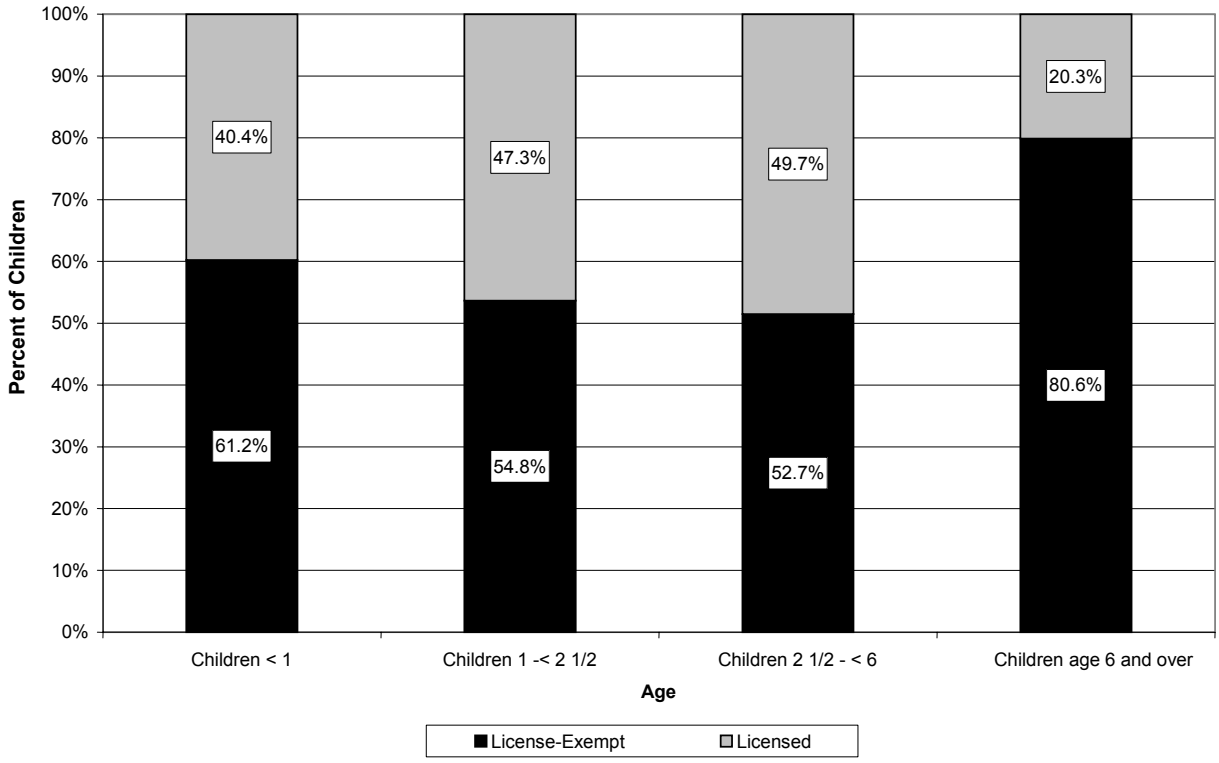
	Number Using Provider Type		Percentage Using Provider Type	
	Families with One Child Receiving Subsidy	Families with More Than One Child Receiving Subsidy	Families with One Child Receiving Subsidy	Families with More Than One Child Receiving Subsidy
One License-Exempt	14,285	32,159	39.7%	63.3%
Multiple LE[1]	100	719	0.3%	1.4%
One Licensed	20,770	12,722	57.7%	25.1%
Multiple Licensed	268	1,974	0.7%	3.9%
Both Licensed & LE	563	3,198	1.6%	6.3%
Total	**35,986**	**50,772**	**100.0%**	**100.0%**

[1] LE = License-Exempt

There are substantial differences in the types of subsidized care arrangements used by children in different age groups (Figure 5-3). The difference between license-exempt and licensed subsidy use is greatest for children aged six and over, with about four-fifths of children in this group using license-exempt providers. Utilization of license-exempt care also is much more common than licensed care for infants. In January 2001, for example, 61.2 percent of the infants in the program received care from license-exempt providers, as compared to 40.4 percent receiving care from licensed providers.[7] While subsidized license-exempt care also is common among children in the 1 – <2.5 and 2.5 – <6 year age groups, the differences in percentages using license-exempt versus licensed care narrow. For example, 52.7 percent of children between the ages of 2.5 and 6 received care from license-exempt care providers in January 2001, while 49.7 percent used licensed providers.

[7] The reader may note that these percentages add up to more than 100 percent, which results from the fact that some children were using both licensed and license-exempt providers.

Figure 5-3. Use of License-Exempt versus Licensed Child Care Providers, by Age of Child: January 2001



The data suggest a slight trend toward increased use of licensed care providers over the six time points (Table 5-4). For example, the proportion of families receiving subsidies that used at least one licensed care provider increased from 38.6 percent in July 1998 to 45.5 percent in January 2001 (derived from table). In comparison, the proportion of families relying on a single license-exempt provider declined from 60.2 percent in July 1998 to 53.5 percent in January 2001. A similar trend may be observed in the types of providers used by children over the same time period (Table 5-4). We should note, however, that beginning is January 2001, site-administered child care data began to be added to the Child Care Tracking System. Because all of these sites are licensed, the latter part of the trend shown in Table 5–4 may be based primarily on the data change, as opposed to real movement in the program toward licensed care usage.

Table 5–4. Change in Percentage Distributions of Provider Types Used by Families and Children: July 1998 – January 2001

Families Receiving Subsidy						
	July 1998	**January 1999**	**July 1999**	**January 2000**	**July 2000**	**January 2001**
One License-Exempt	60.2%	59.4%	59.6%	57.0%	57.0%	53.5%
Multiple LE[1]	1.2%	1.1%	1.1%	1.1%	1.1%	0.9%
One Licensed	33.7%	34.0%	34.2%	35.9%	36.3%	38.6%
Multiple Licensed	1.5%	1.7%	1.7%	2.0%	1.9%	2.6%
Both Licensed & LE	3.4%	3.7%	3.3%	3.9%	3.6%	4.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Children Receiving Subsidy						
	July 1998	**January 1999**	**July 1999**	**January 2000**	**July 2000**	**January 2001**
One License-Exempt	68.3%	68.7%	68.3%	66.8%	66.3%	63.9%
Multiple LE[1]	1.0%	0.9%	0.8%	0.8%	0.8%	0.6%
One Licensed	28.5%	28.4%	28.9%	30.4%	31.0%	33.3%
Multiple Licensed	0.4%	0.4%	0.4%	0.5%	0.4%	0.5%
Both Licensed & LE	1.7%	1.6%	1.5%	1.5%	1.5%	1.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

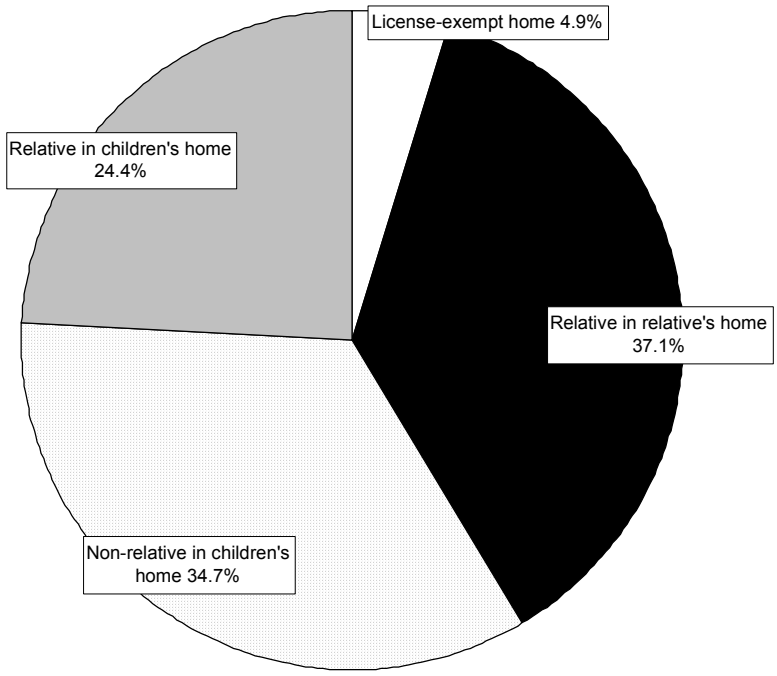
[1] LE = License-Exempt

Types of License-Exempt Providers Used

The administrative data provide information on the number of families and children that receive care through four types of license-exempt arrangements: relative caregivers in the child's home, relative caregivers outside the child's home, non-relative caregivers in the child's home, and license-exempt homes[8] (Figure 5-4).

[8] In license-exempt homes, non-relatives care for children in the provider's home.

Figure 5-4. Type of License-Exempt Care Used by Families, January 2001



Several observations can be made from Table 5-5 and Figure 5-4, which show the distribution of care among these four license-exempt care types for all subsidy families and children in January 2001. First, relatives provided 61.5 percent of subsidized license-exempt care for families in January 2001, with 37.1 percent provided outside the child's home and 24.4 percent in the child's home. Second, 59.1 percent of all subsidized license-exempt care used by families in January 2001 took place in the child's home; in addition to the 24.4 percent of families that received care from relatives in the home, 34.7 percent received care from non-relatives in the home. Third, only about 5 percent of the license-exempt care for families was provided through license-exempt homes. Finally, the distribution of care for children across these four types of license-exempt care is similar to that for families.

Table 5–5. Type of License-Exempt Provider Used by Families and Children: January 2001

	Families Using License-Exempt Care		Children Using License-Exempt Care	
	Number	Percent	Number	Percent
Relative in Child's Home	12,436	24.4%	28,397	25.8%
Relative Outside Child's Home	18,908	37.1%	40,151	35.1%
Non-relative in Child's Home	17,673	34.7%	41,773	36.5%
License-Exempt Home	2,472	4.9%	4,715	4.1%
Total[1]	**50,958**	**101.1%**	**114,407**	**101.5%**

[1] Percentage totals more than 100 percent because some families use more than one type of license-exempt care.

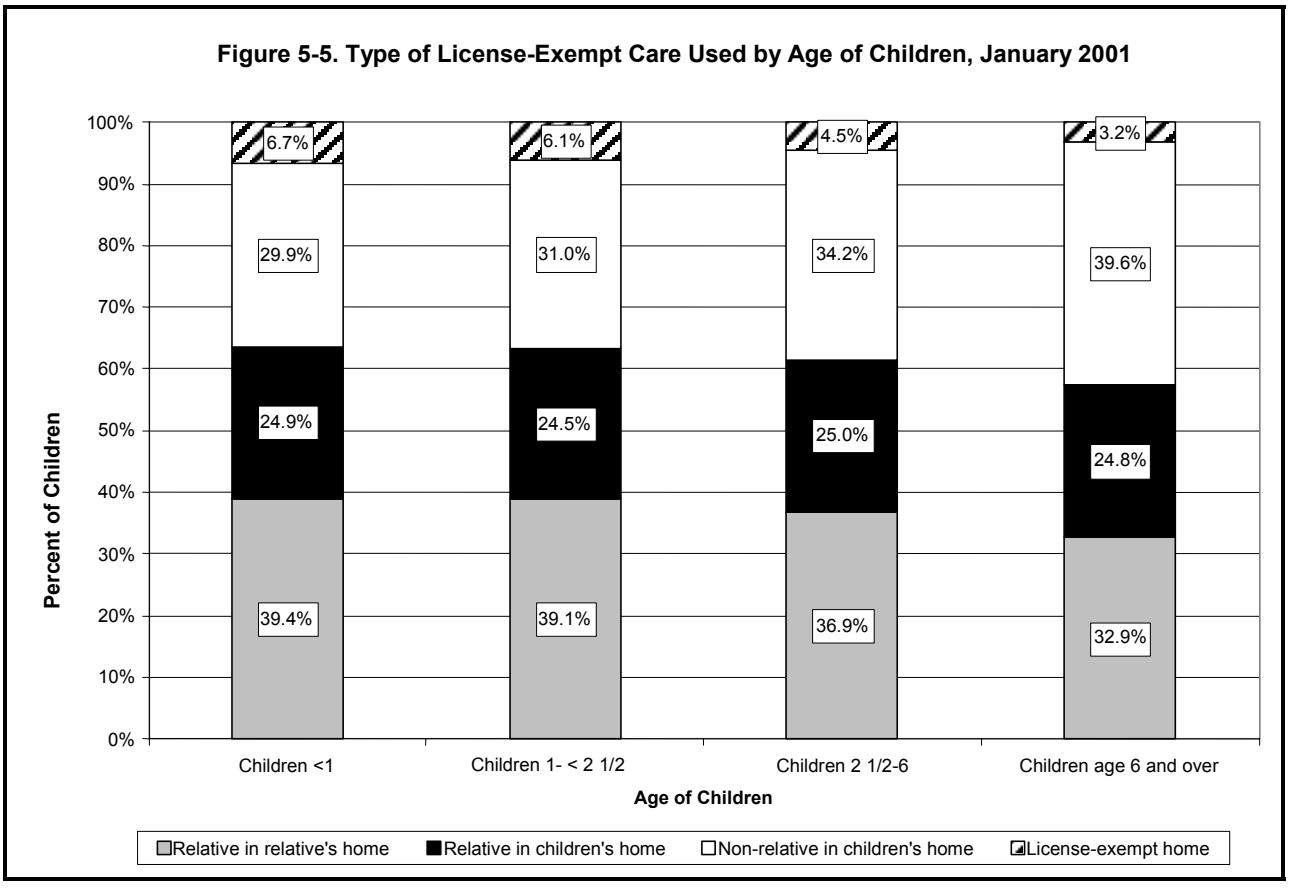
The distribution of license-exempt care across these four types of care varies slightly according to the number of children receiving subsidies in a family. In particular, families with more than one child receiving subsidies are more likely to have their children cared for in their own homes by non-relatives than are families with just one child (37 percent versus 30 percent). In comparison, families with one child are more likely to have their children cared for outside of the home, either in license-exempt homes or by a relative (46 percent versus 40 percent for families with more than one child receiving a subsidy).

Differences in the distribution of license-exempt provider types according to the age of the child are presented in Table 5-6 and Figure 5-5. Young children are slightly more likely than other children to be cared for by a relative. For example, in January 2001, about 64 percent of both infants and children age 1 – <2.5 in license-exempt settings were cared for by a relative, as compared to 57.7 percent of children age 6 and over (derived from Table 5–6). This difference results from a lower percentage of relative care outside the child's home in the age 6 and over sub-group; the percentage of children cared for by relatives in the child's home is approximately 25 percent for each age group. In contrast, the percentage of license-exempt care provided by non-relatives in the child's home increases with age. Among those aged 6 and over in license-exempt care, nearly 40 percent are cared for in their own homes by a non-relative, as compared to 29.9 percent among infants. The percentage of care provided through license-exempt homes declines with age, from 6.7 percent for infants to 3.2 percent for children age 6 and over.

Table 5-6. Percent Distribution of Children in Various Types of License-Exempt Care, by Age of Child: January 2001

	Percent Distribution* for Children Aged			
	< 1	1 – <2.5	2.5 – <6	Age 6 and over
Relative in Child's Home	24.9%	24.5%	25.0%	24.8%
Relative Outside Child's Home	39.4%	39.1%	36.9%	32.9%
Non-relative in Child's Home	29.9%	31.0%	34.2%	39.6%
License-Exempt Home	6.7%	6.1%	4.5%	3.2%

Percentage totals more than 100 percent because some families use more than one type of license-exempt care.



Characteristics of Families Using Care

The administrative data provide limited demographic and economic information on the families receiving subsidies, which are summarized for January 2001 in Table 5-7. The table shows that over half (53.5 percent) of families receiving subsidies are headed by a person aged 20-29, while

40.3 percent are headed by someone age 30 and over. Only 6.2 percent of the household heads are under age 20.

Table 5-7 also provides basic earnings information for families receiving subsidies for January 2001. Earned income data, based on wage reporting data from the Illinois Department of Employment Security, indicate that families receiving subsidies earned an average of $3,253 in the first quarter of 2001. This equates to $13,012 annually, and suggests that the program generally serves a very low-income population despite its eligibility ceiling of 50 percent of the 1997 state median income. This point is reiterated by examining the earned income distribution shown in Table 5-7. Nearly seventy-eight (77.5) percent of subsidy families earned less than $5,000 in the first quarter of 2001, which equates to only $20,000 on an annualized basis.

Table 5-7. Demographic Characteristics of Household Heads Who Use Illinois Child Care Subsidies: January 2001

		Number	Percent of Total
Age of Household Head			
	< 18 years	1,644	2.0%
	18 – 19 years	3,450	4.2%
	20 – 23 years	22,878	28.0%
	24 – 29 years	20,785	25.5%
	30 years and over	32,900	40.3%
Number of Children in Family that Receive Subsidies			
	One	35,986	41.5%
	Two	27,730	32.0%
	Three	14,466	16.7%
	Four of more	8,576	9.9%
Income in First Quarter of 2001			
	< $1,000	24,764	28.5%
	$1,000 – $4,999	42,479	49.0%
	$5,000 – $9,999	16,864	19.4%
	$10,000 – $14,999	1,946	2.2%
	$15,000 and over	705	0.8%
	Mean (in dollars)	3,253	---
	Median (in dollars)	2,884	---

Source: Data on age of household heads and number of children per family are from the IDHS Child Care Tracking System. Income data are derived from wage reporting files from the Illinois Department of Employment Security.

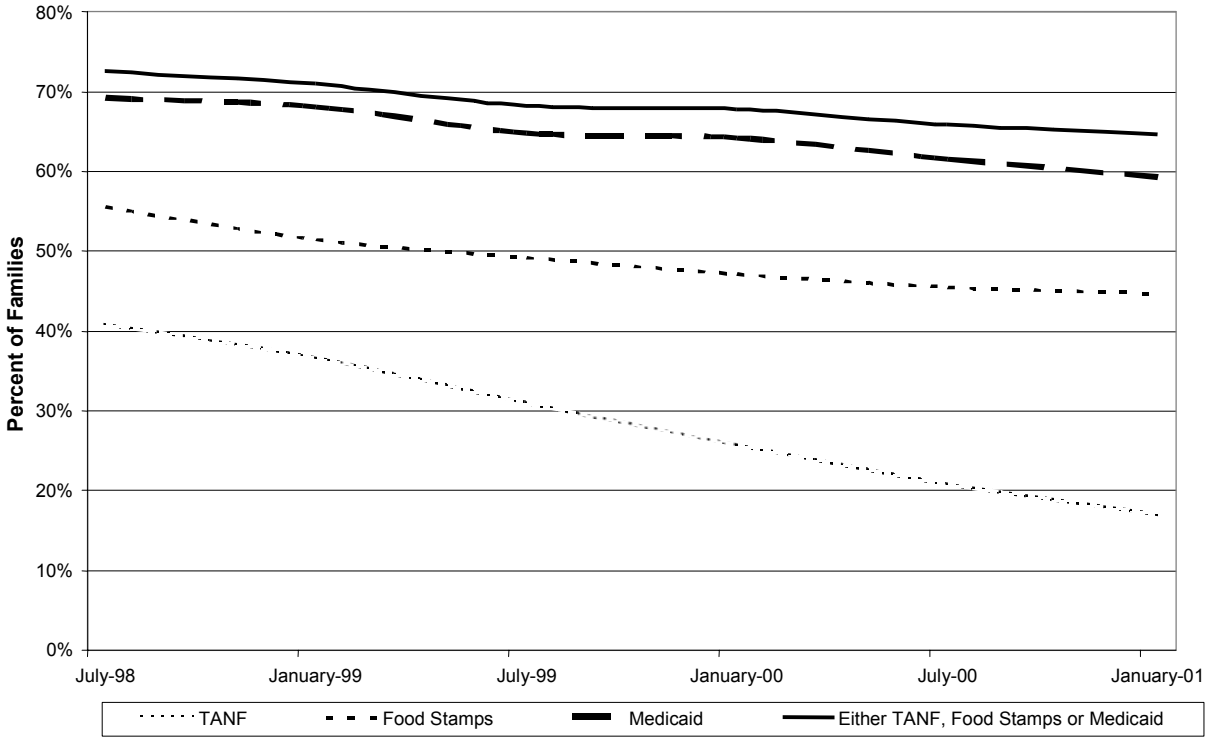
Data on use of other IDHS programs by families receiving subsidies point both to the low-income characteristics of subsidy users and to the manner in which other departmental programs provide income and service support to subsidy users (Table 5-8). In January 2001, nearly two-thirds of subsidy users were using TANF, Food Stamps, or Medicaid. It is important to note that these users of other IDHS services are not primarily TANF recipients, as only 17 percent of families receiving subsidies in January 2001 were also receiving TANF. Medicaid (59.3 percent) and Food Stamps (44.7 percent) were received much more frequently by child care subsidy

users, indicating that substantial numbers of families receiving subsidies not on TANF still were accessing these other support services. The use of these other services is one area in which there is substantial variation in the data over the six time points on which administrative data have been developed. In particular, the usage of these other IDHS services declined over the July 1998 to January 2001 period (Figure 5-6).

Table 5-8. Use of TANF, Food Stamps, and Medicaid by Families That Receive Child Care Subsidies: July 1998 – January 2001

Number of Families Currently Using						
	July 1998	**January 1999**	**July 1999**	**January 2000**	**July 2000**	**January 2001**
TANF	21,967	22,991	22,894	21,176	17,668	14,779
Food Stamps	29,865	32,238	36,307	38,733	38,626	38,762
Medicaid	37,225	42,685	47,842	52,778	52,292	51,454
Either TANF, Food Stamps, or Medicaid	39,026	44,470	50,369	55,736	55,913	56,162
All of the Above	20,903	21,513	21,514	19,964	16,757	14,008
None of the Above	14,739	18,184	23,426	26,417	28,964	30,596
Total	**53,765**	**62,654**	**73,795**	**82,153**	**84,877**	**86,758**
Percent Distribution of Families Currently Using						
	July 1998	**January 1999**	**July 1999**	**January 2000**	**July 2000**	**January 2001**
TANF	40.9%	36.7%	31.0%	25.8%	20.8%	17.0%
Food Stamps	55.5%	51.5%	49.2%	47.2%	45.5%	44.7%
Medicaid	69.2%	68.1%	64.8%	64.2%	61.6%	59.3%
Either TANF, Food Stamps, or Medicaid	72.6%	71.0%	68.3%	67.8%	65.9%	64.7%
All of the Above	38.9%	34.3%	29.2%	24.3%	19.7%	16.1%
None of the Above	27.4%	29.0%	31.7%	32.2%	34.1%	35.3%

Figure 5-6. Use of TANF, Food Stamps, and Medicaid by Families Receiving Subsidies, July 1998-January 2001

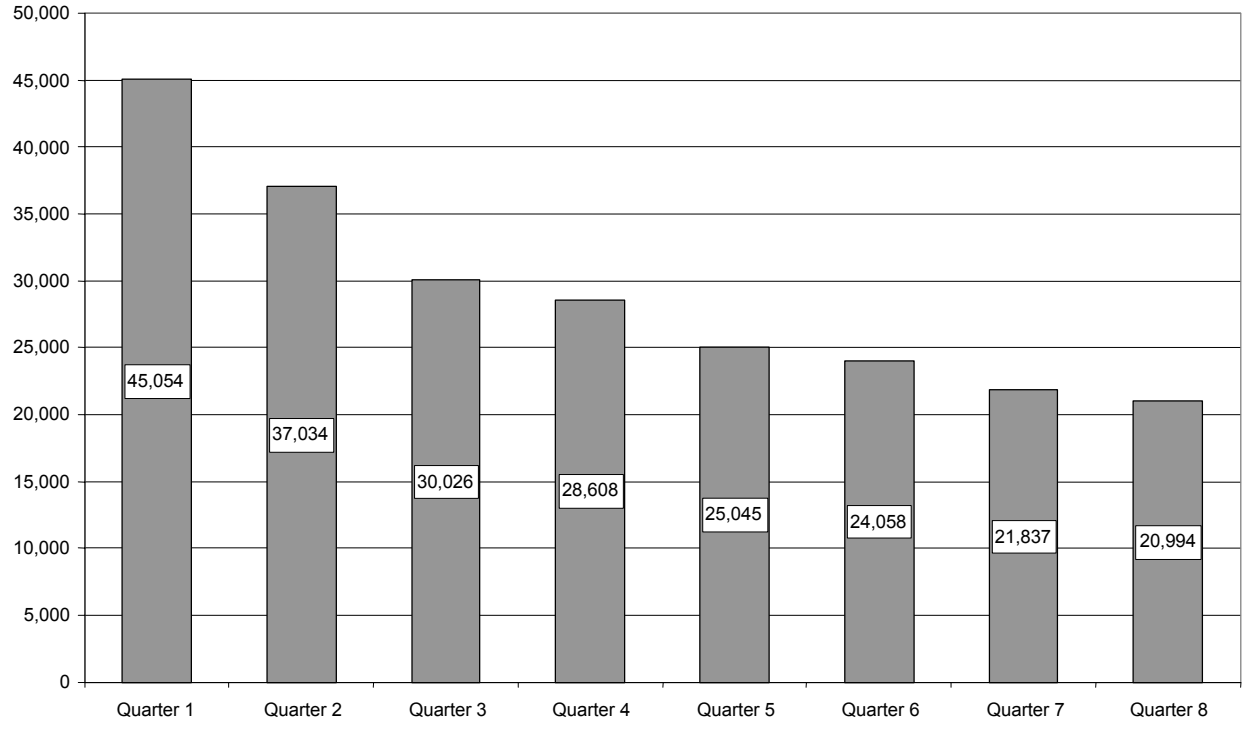


The most notable change in this respect has been the decline in the percentage of subsidy users who receive TANF (Table 5-8). In July 1998, 40.9 percent of subsidy families also were TANF recipients, while by January 2001 this figure had steadily declined to 17 percent. This decrease is consistent with the large declines in TANF caseloads during this period. However, both the earned income data and the substantial number of subsidy participants who still use at least one income based program underscore that the subsidy program has continued to serve a largely low-income population.

Subsidy Use Over Time by 1999 Entry Cohort

Analyzing subsidy use over time allows elaboration of several additional subsidy care patterns. At the most basic level, Figure 5-7 illustrates the number of families that began receiving subsidies in 1999 that remained active in the subsequent eight quarters. The number active in subsequent quarters includes both those who receive subsidies continuously, as well as those who leave the subsidy program but then return. As the figure indicates, the number of families receiving subsidies decreases fairly rapidly from 45,054 in the first quarter to 30,026 in the third quarter, and then declines more gradually to 20,994 in the eighth quarter. As a result, 46.6 percent of those who began care in 1999 still were active eight quarters later.

Figure 5-7. Number of Families Receiving Subsidies Entering Care in FY1999 That Remain Active in Subsequent Quarters



Types of Providers Used and Number of Placements

Tables 5-9 to 5-12 present data on the types of providers used and the number of different providers used for the cohort of 45,054 subsidy families that entered the program in FY 1999. While data for eight subsequent quarters were developed for all such subsidy users, the tables include only quarters 1, 4, and 8 to simplify the presentation. These quarters were selected to approximate care patterns during the entry quarter, at one year, and at two years. The data presented represent cumulative use patterns through the quarter in question, as opposed to use only in that particular quarter. In some instances, cumulative data will be presented for all cases in a subsequent quarter, regardless of whether the case is active in that quarter (Tables 5-9 and 5-11). In other cases, analysis will focus more narrowly on the subset of cases that is active in a subsequent quarter (Tables 5-10 and 5-12).

Table 5-9 and Figure 5-8 show considerable diversity in provider type use over time. In the first quarter after entry, almost 90 percent of families used a single provider, with 56 percent of families choosing a single license-exempt provider and 33.7 using a single licensed provider. Only 10.3 percent used multiple providers in the first quarter (derived from Table 5–9). By quarter 8, only a little over half of families receiving subsidies have used a single provider, with 33.4 percent relying on one license-exempt provider and 21.5 percent on a single licensed provider. The use of multiple providers correspondingly has increased from only 10.3 percent in quarter 1 to 45 percent by quarter 8 (derived from Table 5–9). This suggests that, while multiple provider use is relatively infrequent at a point in time, many subsidy users are faced with the

need to change providers within two years of entering the program. It also is noteworthy that multiple provider use over time often involves combinations of license exempt and licensed providers. For example, 18.6 percent of all families entering care in 1999 had used a mix of licensed and license-exempt providers by quarter 8. Table 5–9 also shows the prevalence of license-exempt care use in the ICCP among families over time. That is, within eight quarters or two years, 68.9 percent of the families that entered care in FY 1999 had used a license-exempt provider at some time (derived from Table5-9).

Table 5-9. Cumulative Percentage Distribution of Types of Providers Used by Families in First Quarter, Fourth Quarter, and Eighth Quarter After Entering Program: For Families Entering Program in FY 1999

	1st Quarter		4th Quarter		8th Quarter	
	Number	Percent of Total Families	Number	Percent of Total Families	Number	Percent of Total Families
One License-Exempt	25,239	56.0%	18,993	42.2%	15,030	33.4%
Multiple LE[1]	1,450	3.2%	5,481	12.2%	7,635	16.9%
One Licensed	15,191	33.7%	11,841	26.3%	9,706	21.5%
Multiple Licensed	1,336	3.0%	3,261	7.2%	4,287	9.5%
Both Licensed & LE	1,838	4.1%	5,478	12.2%	8,396	18.6%
Total	**45,054**	**100.0%**	**45,054**	**100.0%**	**45,054**	**100.0%**

[1] LE = License-Exempt

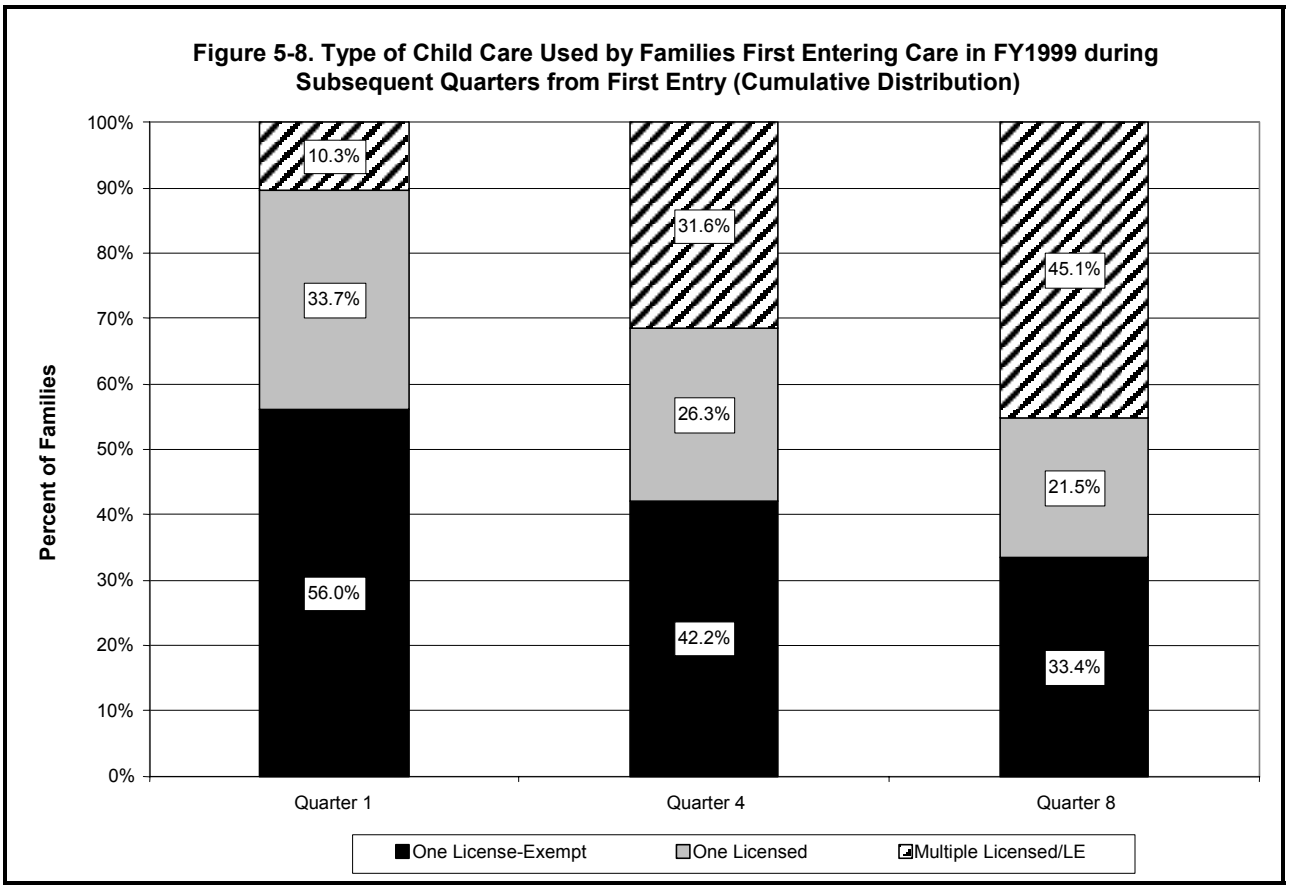


Table 5-10 shows the same cumulative distribution of care by type of provider over time for the 1999 entry cohort as Table 5-9, except that it limits the analysis to cases remaining active in the quarter in question. The data show that cases that remain active in quarter 8 (about 47 percent of the entry cohort), typically have relied on multiple providers over the eight quarters. For example, only 24.3 percent of families active in quarter 8 have relied on a single license-exempt provider, and only 12.4 percent have used a single licensed provider. Among the remaining 63.3 percent who have used multiple providers by quarter 8, the use of both license-exempt and licensed providers has become a common pattern (27.0 percent of active cases).

Table 5-10. Cumulative Distribution of Types of Providers Used by Families in First Quarter, Fourth Quarter, and Eighth Quarter After Entering Program: For Families Entering Program in FY 1999 and Remaining Active in Quarter

	Active in 1st Quarter		Active in 4th Quarter		Active in 8th Quarter	
	Number	Percent of Active Cases	Number	Percent of Active Cases	Number	Percent of Active Cases
One License-Exempt	25,239	56.0%	10,323	36.1%	5,099	24.3%
Multiple LE[1]	1,450	3.2%	4,674	16.3%	5,138	24.5%
One Licensed	15,191	33.7%	6,381	22.3%	2,613	12.4%
Multiple Licensed	1,336	3.0%	2,654	9.3%	2,485	11.8%
Both Licensed & LE	1,838	4.1%	4,576	16.0%	5,659	27.0%
Total Active	**45,054**	**100.0%**	**28,608**	**100.0%**	**20,994**	**100.0%**

[1] LE = License-Exempt

Table 5-11 presents data on the cumulative number of providers used by the FY 1999 entry cohort in the quarter of entry, quarter 4, and quarter 8. The data show that by quarter 8, 55.3 percent of subsidy families had used only one provider and an additional 27.2 percent had used two providers. The mean number of providers used by quarter 8 was 1.7.

Table 5-11. Cumulative Distribution of Number of Subsidized Child Care Providers Used by Families in First Quarter, Fourth Quarter, and Eighth Quarter After Entering Program: For Families Entering Program in FY 1999

	1st Quarter		4th Quarter		8th Quarter	
	Number	Percent of Cases	Number	Percent of Cases	Number	Percent of Cases
One	40,508	89.9%	31,032	68.9%	24,931	55.3%
Two	4,179	9.3%	10,561	23.4%	12,239	27.2%
Three	334	0.7%	2,708	6.0%	5,091	11.3%
Four	30	0.1%	578	1.3%	1,821	4.0%
Five or More	3	0.0%	175	0.4%	972	2.2%
Total	**45,054**	**100.0%**	**45,054**	**100.0%**	**45,054**	**100.0%**
Mean	1.11	---	1.41	---	1.72	---

Table 5-12 provides comparable data on the cumulative number of placements for those cases that remain active in the quarter under consideration. Of cases that remained active in quarter 8, just 37.2 percent had used just one placement. In comparison, about a third of active cases had used two providers by quarter 8, and 28.6 percent had used three or more providers.

Table 5-12. Cumulative Distribution of Number of Subsidized Child Care Providers Used by Families in First Quarter, Fourth Quarter, and Eighth Quarter After Entering Program: For Families Entering Program in FY 1999 and Remaining Active in Quarter

	Active in 1st Quarter		Active in 4th Quarter		Active in 8th Quarter	
	Number	Percent of Cases	Number	Percent of Cases	Number	Percent of Cases
One	40,508	89.9%	16,853	58.9%	7,808	37.2%
Two	4,179	9.3%	8,628	30.2%	7,195	34.3%
Three	334	0.7%	2,426	8.5%	3,688	17.6%
Four	30	0.1%	542	1.9%	1,488	7.1%
Five or More	3	0.0%	159	0.6%	815	3.9%
Total	**45,054**	**100.0%**	**28,608**	**100.0%**	**20,994**	**100.0%**
Mean	1.11	---	1.55	---	2.08	---

Length of Initial Care Spell and Repeat Use of the Subsidy Program

Table 5-13 presents data on the length of time families whose cases opened in FY 1999 received care during their initial care spell; it thus does not take into account any repeat use of the program after the case has closed. The table shows that the average case in this entry cohort remained open approximately one year (11.9 months).[9] The frequency distribution for length of time cases remained open indicates that nearly half of cases (47.3 percent) closed within six months, while about one-third (33.7 percent) remained open for more than one year (derived from Table 5–13). Only a small minority (16.8 percent) remained open for more than two years.

[9] Because some cases in the FY 1999 cohort remained open at the time of analysis in July 2001, the mean is sensitive to right censoring. The mean estimated here therefore is somewhat lower than the true mean that will result when all cases in the cohort have closed.

Table 5-13. Length of Time Cases for Families Entering Care in FY 1999 Remained Open, by Type of Provider Used

	Total	Percent That Remained Open:			
		Total (n=45,054)	LE[1] Only (n=24,866)	Licensed Only (n=15,235)	Mixed LE & Licensed (n=4,953)
< 1 month	2,853	6.3%	7.2%	7.0%	0.3%
2 – 3 months	7,878	17.5%	19.6%	18.5%	3.7%
4 – 6 months	10,577	23.5%	26.6%	22.6%	10.5%
7 – 12 months	8,569	19.0%	18.1%	20.6%	18.9%
13 – 24 months	7,629	16.9%	14.4%	17.5%	27.7%
> 24 months	7,548	16.8%	14.1%	13.8%	38.9%
Total	**45,054**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Mean	11.9	11.9	10.7	11.1	19.9

[1] LE = License-Exempt

Table 5-13 also shows the length of time that cases remained open depending upon whether only license-exempt care, only licensed care, or a combination of licensed and license-exempt care was used during the initial spell. Cases that used either licensed or license-exempt care exclusively remained open for very similar lengths of time. In comparison, cases that used a combination of both license-exempt and licensed options remained open much longer. Such cases remained open an average of 19.9 months, as compared to 11.1 months for licensed only and 10.7 months for license-exempt only care. The percentage of cases that had short initial spells also was similar for families using licensed versus license-exempt care. For example, 53.4 percent of the families that used only license-exempt caregivers and 48.1 percent that used only licensed caregivers had initial spells of less than six months (derived from Table 5-13).

Table 5-14 presents data on repeat use of the subsidy program for a cohort of cases that closed for the first-time in FY 1999. This cohort was defined to allow two years to pass after initial case closings. It was restricted to first-time closures to limit consideration of what happens to families in terms of future subsidy use once they complete an initial subsidy spell. Roughly three-fifths (61.5 percent) of the 24,542 families whose cases closed for the first time in FY 1999 did not use the subsidy program again within two years. Slightly over one-fourth (26.8 percent) had only one subsequent spell within two years, while only 11.6 percent had two or more subsequent spells. This suggests that, although subsequent use of the subsidy program is fairly common among those whose cases close, families do not tend to frequently move in and out of program utilization. The median and mean times that elapse after initial case closures until subsequent spells are three months and five months, respectively.

Table 5-14. Frequency of Subsequent Spells in Next Two Years for Cases that Closed for First Time in FY 1999

		Type of Care Used During Initial Spell			
		Total	LE[1] Only	Mixed LE & Licensed	Licensed Only
No subsequent spells in following 24 months		15,091	7,789	1,218	6,084
Number	1 subsequent spell	6,583	3,139	1,639	1,805
	2 subsequent spells	2,267	1,067	706	494
	3 or more subsequent spells	601	295	201	105
Total		**24,542**	**12,290**	**3,764**	**8,488**
Percentage with no subsequent spells in following 24 months		61.5%	63.4%	32.4%	71.7%
Percent	1 subsequent spell	26.8%	25.5%	43.5%	21.3%
	2 subsequent spells	9.2%	8.7%	18.8%	5.8%
	3 or more subsequent spells	2.4%	2.4%	5.3%	1.2%
Mean time from initial closing to first subsequent spell		4.98	4.85	5.52	4.65
Median time from initial closing to first subsequent spell		3	3	3	3

[1] LE = License-Exempt

Table 5-14 also provides data on subsequent use of the subsidy program according to the type of provider that the families used during their initial spell (license-exempt only, licensed only, or combination of license-exempt and licensed). Those families who used only licensed providers during their initial spell were less likely to have their cases re-opened within two years (29.3 percent—derived from Table 5-14), followed closely by families who had used only license-exempt providers (36.6 percent). In contrast, about two-thirds of families that had used a combination of license-exempt and licensed providers had subsequent spells of subsidy use during the following two years.

Selected Caregiving Patterns and Characteristics of License-Exempt Providers

The administrative data analysis completed to date provides limited information on license-exempt caregivers. Table 5-15 presents data on the number of license-exempt providers caring for children receiving subsidies in January 2001. Roughly three-fifths (60.4 percent) of license-exempt providers were caring for either one or two children at this point in time, while an additional 22.8 percent were caring for three children.

Table 5-15. Number of Subsidized Children Cared for by License-Exempt Providers: January 2001

	Number of License-Exempt Providers Caring For:				
	All LE[1] Providers	LE Home	Relative Outside Children's Home	Non-Relative in Children's Home	Relative in Children's Home
1 child	13,812	730	5,516	4,131	3,443
2 children	15,466	712	5,823	5,363	3,571
3 children	11,039	440	3,888	4,017	2,691
4 children	5,052	182	1,548	2,034	1,290
5-9 children	3,098	91	935	1,250	820
10+ children	32		10	12	10
Total	**48,499**	**2,155**	**17,720**	**16,807**	**11,825**
Mean	2.3	2.2	2.2	2.5	2.4
	Percentage Distribution of License-Exempt Providers Caring For:				
	All LE Providers	LE Home	Relative Outside Children's Home	Non-Relative in Children's Home	Relative in Children's Home
1 child	28.5	33.9	31.1	24.6	29.1
2 children	31.9	33.0	32.9	31.9	30.2
3 children	22.8	20.4	21.9	23.9	22.8
4 children	10.4	8.4	8.7	12.1	10.9
5-9 children	6.4	4.2	5.3	7.4	6.9
10+ children	0.1	0.0	0.1	0.1	0.1

[1] LE = License-Exempt

The number of children cared for was quite similar across the four types of license-exempt providers, with the mean number of children cared for ranging from 2.2 for license-exempt homes and relatives outside the children's home, to 2.4 for relatives in the children's homes and 2.5 for non-relatives in the children's homes. The higher mean number of children cared for by both non-relatives and relatives in children's home resulted largely from lower percentages caring for only one child and higher percentages caring for 3 to 9 children.

License-Exempt Provider Use of IDHS Services

Table 5-16 and Figure 5-9 present data on the use of TANF, Food Stamps, and Medicaid by license-exempt care providers. Slightly over one-fourth (27.2 percent) of license-exempt providers were using at least one of these three services in January 2001, and nearly 40 percent

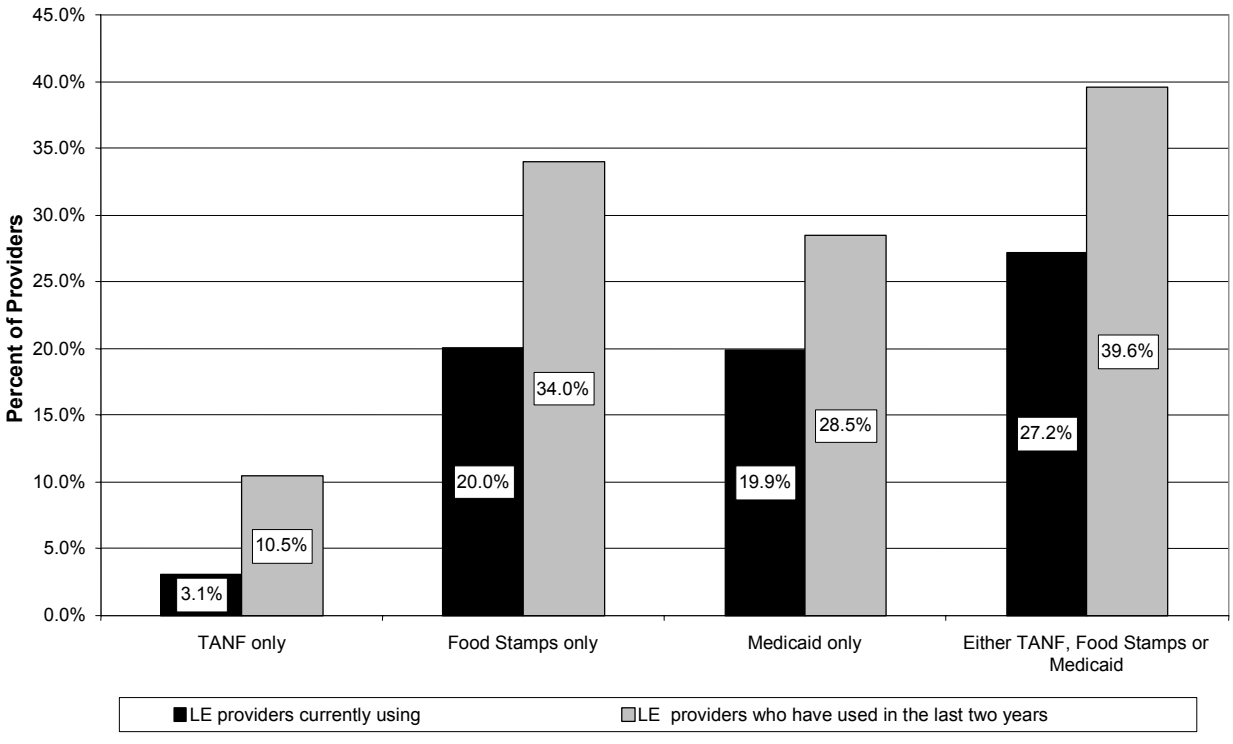
had used one of these services at some time in the last two years. Food Stamps and Medicaid were used the most often, with about 20 percent using these programs in January 2001 and over a third using Food Stamps at some time in the previous two years. Only 3 percent of license-exempt providers were using TANF, but 10 percent had used TANF in the previous two years.

Table 5-16. Current and Previous Use of TANF, Food Stamps, and Medicaid by License-Exempt Providers: January 2001

	Currently Using Services		Used in Last Two Years	
	Number	Percent of all LE[1] Providers	Number	Percent of all LE Providers
TANF	1,719	3.1%	5,800	10.5%
Food Stamps	11,105	20.0%	18,858	34.0%
Medicaid	11,031	19.9%	15,781	28.5%
Either TANF, Food Stamps, or Medicaid	15,088	27.2%	21,928	39.6%
All of the Above	1,627	2.9%	5,681	10.2%
None of the Above	40,343	72.8%	33,503	60.4%

[1] LE = License-Exempt

Figure 5-9. Use of Services by License-Exempt Providers, for Providers Active in January 2001



Chapter 6: Key Informant Interview Findings

This section presents themes from the fourteen key informant interviews conducted in the three study areas. These interviews represented the initial introduction of the study into the child care program environment in each area, and consequently were viewed as exploratory in nature. A structured interview guide was used for all interviews (see Appendix A), but questions were open-ended, and key informants were encouraged to offer their views on a wide range of child care issues affecting their communities. The findings are organized according to major issues for parents using license-exempt care and for license-exempt care providers; the role of the community service agency in responding to those issues; and the policy issues surrounding license-exempt care in general.

Reasons Parents Choose License-Exempt Care

Key informants identified ten different reasons why parents choose license-exempt care providers. These include:

- Flexibility of license-exempt care;
- Parents' comfort with and trust in the license-exempt provider;
- Cultural preferences for license-exempt care;
- Lack of licensed child care options;
- Lack of knowledge about other child care options;
- Convenient location;
- Smaller caregiver to child ratio in license-exempt settings;
- Less government intrusion in license-exempt settings;
- Child's age; and,
- Greater possibilities of establishing mentoring relationships.

Flexibility of License-Exempt Care

Key informants reported that parents use license-exempt care because it offers more flexibility than licensed child care options. There was some variation in how key informants defined flexibility—some referred to the flexible schedule or to flexible regulations, while others mentioned payment flexibility. From a scheduling perspective, interviewees reported that license-exempt care providers are more flexible than licensed caregivers in providing care during nontraditional work hours, including evenings and during rotating shift schedules.

*"Many parents are working sort of that marginal job where your shifts can change. If you're lucky, you'll know a week ahead of time ... a [*license-exempt*] home provider often is more able and willing to be more flexible about [the varying schedule] and can make do with that."*

Two interviewees reported that many parents may prefer license-exempt options for non-traditional hours, even if licensed options are available. Both had attempted to address the

unavailability of licensed care during non-traditional and rotating schedules by offering evening and overnight care at their local licensed child care programs. Each dealt with a population of parents employed at hospitals who worked both nontraditional and rotating shift schedules. Both eventually closed the extended hour programs, because of lack of parental interest in using the programs, and because the programs were difficult to operate.

> "*I tried operating an extended hours program at the hospital where I have a population of parents who I know work these nontraditional hours and rotating schedules. I tried to be responsive and flexible to their needs. But I ended up shutting the option down as parents did not want to bring their children into this setting. They wanted a mix for their children. A formal, licensed child care setting that provided structure and activities was alright during the day. But at night, they wanted their children at home. So even if the slots exist, parents want other options during these hours."*

> "*It was not a workable solution for us for two reasons. It was hard to get through the licensing process because it was a new concept, and so licensing had a lot of road blocks. But it was also hard for us to work with too, as it was hard to staff when a child might come one week during the day, the next week during 2nd shift, and the next week during the 3rd shift. Finally, a lot of people just weren't really comfortable with their child being/sleeping in a center overnight. The [need for] trust with the center is hugely maximized at night, just because if there is any worry about safety with the center, it suddenly becomes much bigger when you're talking about you're going to put my child to bed and that child is going to sleep there—suddenly that feels really scary."*

Flexibility was also discussed from a regulation perspective. Key informants reported that license-exempt providers have more flexibility since they are not required to meet the same regulations as licensed providers. For example, in a licensed child care setting, licensing regulations prohibit the attendance of children who have a fever or a contagious illness. This can limit parents' flexibility, as they must either find someone to temporarily care for the child on short notice, or else stay home from work. In contrast, in a license-exempt setting, parents still can take a sick child to grandma's house, for example, and not have to miss work.

Finally, flexibility was discussed from a payment or cost perspective. According to interviewees, license-exempt care may be less costly for families for two reasons. First, even though parents are assessed the same co-payment amount regardless of the type of provider used, license-exempt providers may be more likely than licensed providers to waive the co-payment, either on an as-needed basis or altogether. Second, license-exempt care providers may allow the parent to trade the co-payment for another service. For example, a license-exempt care provider may ask the parent to buy groceries rather than accept the co-payment from the parent. In comparison, licensed child care providers as a general business practice cannot afford to waive co-payments nor barter the care for other services from the parents.

Comfort with and Trust in License-Exempt Providers

Several key informants noted that parents feel more secure and comfortable having their child cared for by someone they know and trust—whether that is a relative or a friend. They have a sense that their relatives and friends will raise the children like they would. Moreover, the children have already developed a relationship with this person.

> *"..there's a sense of trust there - the peace of mind that they may not have in a setting that they don't really know the person and it's more of a business arrangement. You know, 'This is my friend, she's taking care of my child.' Even if they didn't start out as friends, they usually become friends or think of each other as friends. So then it's not so much of an employer or business relationship."*

> *"I think when parents look at Grandma or Aunt or somebody like that who is watching the child it's a sense of security. They know this person and they know how this person is going to care for the child in a comfortable place. The child knows the individual and so it is an easier transition especially when it's a younger child."*

Cultural Preferences for License-Exempt Care

Embedded in the issue of trust and familiarity are the separate issues of race, culture and language. Some key informants suggested that not only do parents prefer a provider who they trust, but they want someone who shares their cultural identity.

> *"The Latino home day care providers tend to take care of Latino children, African American providers take care of African American children, etc. The parents seem to prefer it this way."*

One interviewee pointed out that, specifically in the case of Hispanic families, this could be related to two factors. First, there is a tendency for recent Hispanic immigrant families to prefer license-exempt care because they feel uncomfortable becoming involved in anything formal, organized, or governmental. Second, there are language issues. Parents want to be able to communicate clearly with their provider, so finding a provider who speaks their native language may be especially important. In addition, those with limited English-speaking skills may be reticent about approaching agencies if they are unsure about the extent to which English-speaking skills will be needed.

> *"There is extreme reluctance in the Hispanic community to become involved in any kind of government program due to cultural and Immigration and Naturalization Services (INS) issues."*

Lack of Licensed Child Care Options

Some key informants suggested that a lack of available licensed child care options contributes to parental selection of license-exempt providers. In these instances, supply constraints may either push parents toward license-exempt alternatives or else reinforce

more positive reasons for selecting license-exempt providers. There was little consistency in key informant opinions regarding the extent to which licensed supply issues existed in their areas. In Chicago, supply issues were seen as varying considerably by neighborhood. In the Southern Seven area, key informants mentioned the difficulty that centers other than Head Start have in surviving because of the economics in the region. Whereas Head Start is a federally subsidized program that qualified low-income families attend for free, other centers are dependent on parent fees to generate their revenue. There is often not a concentrated enough parent base in any one location within the region to sustain such licensed child care programs.

It also should be noted that issues of licensed care supply were viewed qualitatively as well as quantitatively. That is, some key informants were skeptical of the quality of much of the licensed supply that existed, and suggested that parents often were aware of such shortcomings.

Lack of Knowledge about Child Care Options

According to some key informants, parents may not understand the range of child care options that may be available. This was seen as resulting both from general knowledge deficits about child care alternatives, as well as from lack of information about the functioning of the CCR&Rs and the ICCP. For example, some parents receiving subsidies may not be aware that the subsidy allows them access to a range of options.

> *"For some parents, it's a lack of knowledge about what good daycare can do for the kids. [This one parent] was really thrilled [to learn] that she could take her kid down there and drop him off at seven in the morning and come back at three-thirty, when she got off, and the kid was, you know, happy as a lark. I mean they did nap times, they had their meals, they had books, enrichment classes, they went on little field trips sometimes, it was like…you mean I'm not gonna have to pay a lot extra for something like that."*

Convenient Location

Key informants suggested that parents may prefer to select a neighbor or relative who lives nearby to care for the child, or to have the license-exempt provider care for the child in the child's home because of the sense of familiar surroundings for the child. Either of these options may be viewed as home-like settings that would be similar to the care the child would receive if the parent could stay home with their child. In addition, one interviewee mentioned that transportation problems may force some parents to choose nearby license-exempt child care options.

Smaller Child to Provider Ratio in License-Exempt Settings

Because license-exempt providers can legally care for no more than three children including their own children (unless the children are all from the same family), key informants thought that some parents feel their children will do better in this smaller

setting. One interviewee noted this was especially true for younger children and children with special needs, as they may receive more individual attention in a license-exempt care setting.

> "*When I ran a child care center, my second child was at my center in the mornings and went to an informal provider in the afternoon because she couldn't stand the structure. She couldn't be in a group all day, she needed the quiet. She couldn't move in a group all day. It was too much for her. And my third child stayed with the informal provider most of the time. And then when he was 4, the provider took him to a pre-school in the morning for 3 days a week. Because he was born into a group, with her he got one-on-one [attention]. He didn't need the socialization 'cause he was born into that. He was always sharing so he wasn't going to get enough individual attention on a regular basis with me at home but he could get it with her. It is a real issue and I tell that story to parents who are concerned about leaving their child with an informal care provider because they are worried that because it is not licensed so it's not good. I tell them that you need to think about these things. The group size can be a real positive."*

Less Government Intrusion

Some key informants suggested that parents choose license-exempt care providers because there is less government intrusion, because the license-exempt providers are not regulated by the licensing agency. This may allow them to avoid contact with government or social service agency staff, who often are mistrusted in low-income communities.

> *"Parents may choose informal care because there is less paperwork, policies, and rules involved, and it is therefore easier to access than licensed care. In addition, there is a general mistrust of the Department of Children and Family Services (DCFS) and of governmental agencies in the community, and parents may prefer informal care providers who have less involvement with the government."*

Child's Age

Key informants noted that parents may be more likely to choose license-exempt care for young babies and school-age children, because children at these ages have different needs than preschool-aged children. For example, while licensed settings may provide many educational benefits to preschool children, young children need a great deal of individual attention that can be difficult to provide in larger licensed group settings. Similarly, school-age children who are in school the majority of their time may need to have a break from a large group setting, and a license-exempt provider can serve this purpose. In contrast, some key informants mentioned that many parents wanted center care for preschool-aged children, largely to help prepare them for school.

Mentor Relationship

One key informant noted that teenage parents may see the license-exempt care provider as someone who can teach them more about parenting.

> *"I think also for younger parents and teen parents it's also a feeling that I'm not quite sure how to raise my child, but I think you might have a good idea about how to help me with that as well. They're looking for some expertise from that provider."*

Reasons People Provide License-Exempt Care

All key informants were asked for their perspectives regarding why people choose to become license-exempt caregivers. Six principal reasons were reported:

- Money;
- Less government hassle than becoming licensed;
- Want to stay at home with own children/grandchildren;
- Help out the parents and children;
- Lack of knowledge of how to become licensed; and,
- Temporarily meet TANF work requirements.

Money

Key informants frequently cited earning money as a reason that people become license-exempt care providers. Even though many license-exempt providers are relatives, they are still interested in being paid for providing care. Key informants also mentioned that license-exempt caregiving provides a job for those not qualified to get any other employment, or those persons living in communities in which job opportunities are scarce. It also provides supplemental income for those with other earnings sources. For example, some single parents may be able to arrange their work schedule to coordinate with another single parent's work schedule so that each can earn additional money by watching one another's children when the other is working.

> *"It's just a way to increase their income. They're getting social security and it's not high enough or they're not employable in other ways or you know, you've got people on a disability. And they can take care of their grandchildren over night and they make $24 a night while their grandchildren sleep."*

Less Government Intrusion

Key informants suggested that some license-exempt providers care for children without becoming licensed because they want to avoid government intrusion by licensing agencies. Providers may not want to deal with the paperwork involved with becoming licensed, or have a general mistrust of the government and the Department of Children and Family Services (DCFS). They also may worry that if they open their doors to

licensing representatives, they could be at risk of having the children taken away or having to make expensive changes to their houses to continue caring for children.

> "*Some people are concerned about any child welfare system involvement in homes. In some communities the child welfare agency has a bad name. They're kind of seen as a big brother or somebody who might come and take your kid - so I'm not necessarily doing anything wrong but just because there's a distrust of government."*

Want to Stay at Home with Own Children/Grandchildren

Key informants reported that some parents and grandparents viewed subsidized license-exempt care provision as a way to stay at home with their own children or grandchildren. For parents who wanted to stay at home with their own children, they could care for a small number of additional children to earn money without incurring child care costs of their own. For grandparents, they can provide care for their grandchildren and earn a small income for something they might have done anyway without being paid.

> "*[Another reason] is the people who really need a second income in our home, but I could stay home with my kids [and earn more money that way]. Those people are keeping their own kids and adding on someone else's as additional income."*

> *"They give them a little pocket change; it doesn't give them much money. But it does give them a little money where perhaps they might have already been staying home and not earning that money this way they're earning a little bit of money…With many individuals who stay home and provide care, I think there's that sense of nurturing or caring for that child that is a good positive feel for that individual."*

Help Out the Parent/Family

License-exempt care providers also were viewed by key informants as wanting to provide care to help out their relatives, friends or children. Particularly for relatives or close friends, a "family love" may lead the provider to care for the children for as long as they know the family needs assistance.

> "*They just feel like they're relatives and they're doing [this] because of a favor. Therefore, this is how I raised your Mom so it's good enough for you. There are lots of grandparents who are filling the gap and especially for school-age kids. I am even doing that with my own grandchildren. We're not on subsidy and we're not paid. We just do it because we love them."*

> *"Well, they're able to stay home and maybe help out someone they know, especially the informal care. They're typically helping out a friend, family member, an individual they know…Probably the majority I would guess are not*

doing it for the sole purpose of income, certainly they're not making that much money doing it. So there's other things driving it. Such as knowing the individual and trying to help out the family."

Lack of Knowledge of How to Become Licensed

Several key informants thought that license-exempt care providers may lack knowledge about the licensing process. They may believe it is more difficult than it is, or else not know the benefits of being licensed. If they have parents coming to them for care as it is, they also may not see the point of becoming licensed.

"*If we can show them the difference [by being licensed], if we can articulate the difference to them, like I talked about a thing when we do our informational meetings. You know, you can earn more. And some people say, 'well, I'm only taking care of my neighbor's kids.' And we say to them, 'but you know you're going to be paid more.' You don't, just because you get licensed, [have to care for more children]. It gives you some flexibility and options. If they take the time to understand that, our success rate is usually pretty good in getting them licensed. Because they start to see, they can, it may just change their rate. And they don't have to change the number of children they provide care for. They don't have to change anything of what they do. But we have to articulate to them about how you can offset the cost of getting your physicals and all of that. If they don't know that, then that is a struggle. Because then it's why should I want DCFS in my home."*

Temporary Employment to Meet TANF Work Requirements

Key informants stated that some people were caring for children on a temporary basis to meet their TANF work requirements until they could find another job. This appeared to be more of an issue in the immediate period after TANF was implemented, as many persons at that time were first being exposed to work requirements.

"There's been an encouragement of people to take care of children in daycare situations and unlicensed situations because it provided employment for the TANF program. At the start of the [TANF reform] process, we did look at encouraging people to pick-up a child or two in an unlicensed situation—it counts as employment to stop the clock and now that has been pretty well worked out of the cases we have. …We'd have them submit a work plan of how they were planning to develop this where they would have enough money to show that they could become self-sufficient over time. We had one gal even get close to what I'd consider a plan that she put on paper and we allowed her to have it and gave her about three months and she never earned more than fifty dollars in a month and she just decided she was…she just can't make it doing this [daycare] and she went on to some other type of work."

Benefits of License-Exempt Care

In addition to asking key informants why they think parents use license-exempt care, we asked them to discuss benefits or advantages of license-exempt care from their own perspectives. Key informants offered three main advantages of license-exempt care for parents and children, some of which overlap with the reasons why they think parents use license-exempt care. First, interviewees mentioned that license-exempt care enhances parental choice by increasing the number and type of child care options available for families. For example, license-exempt care was seen as providing parents with more flexible child care options than licensed care. Because it is difficult for most licensed child care facilities to provide care during non-traditional hours, key informants believed that license-exempt care can fulfill this need. They also mentioned that license-exempt care can meet the needs of parents when they need sick care, and that license-exempt care providers can serve as back-up care when licensed child care settings are unavailable.
Second, key informants stated that license-exempt care may provide the opportunity for a closer and better relationship between the parent, provider, and children, because they frequently have an ongoing relationship beyond the child care arrangement.

> "*I think for some situations the child and provider stay connected longer. There are other situations where the provider has other connections to the family. So either the child stays in care with that provider for a longer time or even if a child moves on to another provider, there is still a connection between them and so the child can have the provider come to a birthday party and sees them on the block. So I think there's a real benefit to that long term connection with the child."*

Third, key informants mentioned that license-exempt care might be more responsive to meeting the individual needs of the children and family, because of its flexibility and the smaller child to provider ratio. Because it is less structured than licensed care, license-exempt care providers also were seen as having the capability to frequently adapt their schedule to meet the child's needs. Children in license-exempt care also may engage in a variety of experiential learning opportunities, such as going along with providers to the grocery store or the post office. Such experiences are not always available for children in licensed child care programs, because of the larger group size.

> "*When my daughter went to a license-exempt care provider in the afternoon, when she needed a nap and she needed to sleep for four hours, she could sleep for four hours. If she didn't need a nap and wasn't tired, she could lay down for an hour. She could read a book. That is a huge difference. You know, everything isn't structured. And the reality is, that it really can be good license-exempt care, can be the most developmentally appropriate care because the child can learn to grow. Everybody is not potty trained at the same time. And everybody is not taking their nap at the same time…if you're taking care of three children, it's a whole lot easier to know what one child needs."*

Problems with License-Exempt Care

Similarly, we asked all key informants to identify the problems or disadvantages of license-exempt care. Key informants identified the lack of regulation and monitoring as the main disadvantage. Whereas licensed child care settings have received a "stamp of approval" indicating they have met minimum standards, license-exempt care settings are not monitored. There is no guarantee that the providers have met or will maintain any safety or quality of care standards. Key informants elaborated that this did not necessarily mean that license-exempt care is of lower quality than licensed care. It is just that the license-exempt care providers have not had to demonstrate that they meet any minimum health and safety standards.

> "*With regulation, it is minimal compliance with standards, but it does mean that someone checks to be sure occasionally - once or twice a year - that the provider has complied with basic health and safety for kids."*

Related to the problem of limited monitoring, interviewees indicated that it is difficult to know if license-exempt providers are complying with the legal guidelines for remaining an exempt provider, such as not exceeding the maximum number of children allowed in care. Even though participation in the subsidy program assures that no more than the legal limit of children will be approved for a subsidy, there is no way to know if the provider is caring for more children who are not receiving a subsidy.

The license-exempt provider's skill level and physical abilities also were questioned, especially in caring for children with special needs. Key informants indicated that many license-exempt care providers have not had any specific training in caring for such children, and that parents may not always offer the provider information about the special care needs of their children. For example, a neighbor may be called on short notice to care for a child who has asthma and needs daily breathing treatments. The provider may not have any training on how to administer these treatments, and the parent may not remember every detail when talking to the provider. Similarly, some license-exempt care providers may not be in the best physical health to care for children if they have disabilities; this concern also was expressed about some elderly caregivers. For example, interviewees argued that persons with physical limitations may have trouble lifting the children or following the children around the house, which could lead to safety problems.

Finally, key informants mentioned concern for the consistency of license-exempt care. For example, because there is less likely to be a formalized caregiving relationship between the parent and provider, the children may go to grandma's house one day, to the neighbor the next day, and to the aunt's house the next day. In such cases, there is no consistent caregiver, which may impact the quality of care.

Disadvantages of Providing License-Exempt Care

We were also interested to learn from key informants about what problems they thought license-exempt caregivers may face as they provide care. First, key informants suggested that the lack of structure in the parent-provider relationship could lead to conflicts.

> "*The informal nature of the arrangement makes it more likely that miscommunications will occur between providers and parents. There is no formal structure in place to handle problems such as the parent failing to pay their co-payment or bringing their child late. These problems may strain family relationships in cases of relative care. For some relative providers it may be difficult to act as a collection agency against one's own family, so often the co-payment is not collected."*

Another suggested problem for license-exempt caregivers was the lack of clarity of the subsidy program. The program guidelines and materials are directed towards parents, and sometimes are confusing for providers. In particular, interviewees indicated that license-exempt care providers may not understand that they are supposed to collect a co-payment, and they may not know that the co-payment amount will be deducted from the gross amount they are told they will receive for providing care. This may result in providers not collecting intended co-payments, as well as disillusionment when state payments fall below anticipated levels. In addition, parental failures to complete needed paperwork can result in substantial payment delays for providers.

> "*[Informal care] providers are also at a disadvantage because it can take awhile to get the first check issued to them, because sometimes the parent is negligent in getting all of the paperwork in so that the case can be approved. It may take 4 weeks to receive everything from the parent and meanwhile the provider has been providing child care for 6 to 8 weeks. The provider is dependent on the parent communicating much of the program information to them and it's not always accurate. Sometimes parents tell the providers that they will receive $9.48 per hour rather than $9.48 per day."*

This type of program confusion probably is less common in licensed programs, because of the more formal business-like relationship between the parent and provider.

A third disadvantage mentioned was the lack of resources available to license-exempt care providers, and an associated sense of isolation from supports. These providers may not have access to training classes or resources, such as a variety of food, toys and books, especially because many have low incomes. They may need more support and guidance for issues such as working with special needs children, and they may not know where to go for assistance. In contrast, licensed providers often have the option of participating in networks or other assistance programs, such as the Child and Adult Food Program that helps provide food for children in licensed child care settings.

Role of CCR&R's and Community Agencies

Interviewees differed in their perspectives regarding the extent to which licensed caregiving should be encouraged. While one key informant thought that the goal should be to achieve licensed status for all subsidized caregivers, most others suggested that quality varied within both licensed and license-exempt options and considered license-exempt care a valuable resource.

> *"If I had my druthers, all children would be in regulated care. And that comes from a long history of working in the field. Because although it is minimal compliance with standards it does mean that someone checks to be sure occasionally once a year/twice a year. It also means that the provider has complied with basic health and safety for kids. And so in a perfect world, all kids would be in some kind of regulated care. ... [for those providers currently exempt] we would work with them and try to push them in some kind of steps toward a license.*
>
> *"Maybe they [informal care providers] don't need anything. And maybe that's our first problem is thinking they do. And you know, and clearly there's some horrible exempt providers. But there's horrible licensed providers. And maybe our first problem is we think they should be part of our [CCR&R] system [and licensing]. Maybe you having access to information is a good thing. But maybe getting a newsletter or a little something at home would be just as useful and cost-effective. Bringing something to their home that's less intrusive...rather than asking them to come in and we tell them what they need to do."*

The predominant perception was that the CCR&R's and community agencies should play several inter-related roles in supporting license-exempt care users and providers. One such role involves providing support and engaging in more outreach to license-exempt care providers, especially those of different ethnic groups. Another is educating parents about how to select caregivers and how to monitor the quality of care their children receive in license-exempt care settings. Key informants also discussed the need for the CCR&R's to mentor license-exempt care providers either to become licensed, or to meet minimum quality indicators that provide children a safe and healthy caregiving environment.

> "*Quality of care varies both within formal and informal care, so one cannot claim that licensed care will always be better than informal care. Type of child care used is the parents' choice and the CCR&R should not encourage one type over the other. Parents want the best for their children and different types of care will better suit individual needs at different ages and in different situations."*
>
> *"The CCR&R role is to provide support and encourage informal care providers and provide basic resources, equipment and training in a non-threatening way."*

In attempting to provide supports for license-exempt caregivers, interviewees believed it was important for the CCR&R's to utilize strategies that may be different from those

used with licensed providers. License-exempt providers may not attend child care fairs like licensed child care providers, so it may be necessary to go to other places such as schools or community agencies to promote the child care services available. It also was suggested that the CCR&R could develop a newsletter for license-exempt care providers and parents that focused on issues specific to their situations. In addition, key informants mentioned the importance of reaching out to parents and providers of different ethnic groups by having materials available in several languages. For some ethnic groups, it may also be important to build a relationship with different community agencies to gain the trust of the parents and providers before trying to deliver information or materials.

Key informants also discussed the importance of the CCR&R's in continuing to develop strategies for educating parents about how to select quality child care. CCR&R's use a variety of outreach methods to encourage quality care, such as public service announcements, newspapers ads and articles, and distributing flyers on the importance of child care quality at local events. Nonetheless, there are still parents who may not know about the different quality of care factors—whether provided by license-exempt care providers or in licensed child care settings—so they may not be making well- informed choices. Parents who contact the CCR&R's seeking child care referrals receive a wide array of information on indicators of quality care, as well as checklists on how to assess child care quality as they visit providers. However, parents who already have selected a child care provider do not receive these consumer education materials. Consequently, expanding such information dissemination was considered to be an important tool in continuing to educate parents about desirable child care attributes.

Policy Issues Related to License-Exempt Care

Key informants emphasized three major policy issues related to license-exempt care: 1) the need for more information about license-exempt care users and providers, 2) the need for greater financial support and resources for the CCR&R's and for the license-exempt care providers, and 3) the interactions between welfare reform, the economy and the use of license-exempt care. Because little is known about license-exempt care, key informants mentioned the need for more information to guide policy development. Until more is learned about the issues specific to license-exempt care, they feared that many uninformed policy decisions could be made.

This relates to the second policy issue of the need for greater financial support of license-exempt care. Much of the CCR&R agency funding is based on supporting licensed child care providers, because some funding formulas are based on the number of providers in the agency's referral database. That is, the CCR&R's receive certain programmatic allocations based on the number of providers listed in their referral databases, and have certain contractual obligations to serve providers listed in their database (e.g., send them a newsletter). Because all licensed providers are included in the database, and license-exempt providers are only included on a voluntary basis, the CCR&R funding allocation disproportionately biases the service delivery to licensed child care providers.

"*The R&R funding was always based on the number of licensed providers you had in your [referral] database. And early, early on, we worked hard to recruit exempt providers to the database -- so they would be getting information as part of the system [but they didn't want to be part of the database]. So you weren't funded for them. And so at a certain point, you say, now how much time does it take, I mean when you really have to make those decisions. It is not about the money, it's about making sure you're serving the people you're paid to serve. What was the incentive, you know, they didn't qualify for these services [sent to providers on the referral database], and they couldn't get professional help and grants that they wanted…Or they were thinking 'I'm a grandparent, I don't want a grant [to get more training.]'*"

Even those funds that have some flexibility in serving both licensed and license-exempt care providers may not be fully utilized by license-exempt care providers, if the CCR&R is not aware of the outreach techniques that may be needed to publicize the resource or if the agency can devote limited attention to serving license-exempt providers.

It may be that the traditional activities funded for the support of licensed child care providers need to be modified to meet the needs of license-exempt care providers. In particular, one key informant discussed how CCR&R's and other agencies might need to learn how to connect license-exempt care providers with other community resources. For example, perhaps local licensed child care programs could set aside one day per week where license-exempt care providers can bring the children they care for to the center, so that the children can play on the outdoor equipment that may not be available in the neighborhood where the license-exempt care is provided. It also was stated that the CCR&Rs and other community agencies needed to be more creative in providing cultural and other opportunities for children in license-exempt care. For example, networks could be established that allowed children in license-exempt care to engage in field trips to museums and to engage in recreational activities. Such activities could be coordinated with licensed centers.

Key informants also expressed the need to learn more about how welfare reform and the economy might have impacted the use of license-exempt care. Because TANF placed pressure on many parents to work, there was an increased need for care. This was seen as leading many parents to seek license-exempt care options, especially if no other options were available. At the same time, the improved economy may have decreased the number of license-exempt care providers, because some providers could earn more working outside of the home.

Other policy issues mentioned were:

- The need for greater accountability by license-exempt care providers.

  "Since license-exempt care providers are receiving public funding, the policies should be changed so that they are more accountable to DCFS for the quality of care they provide."

- The need to identify ways to provide short-term support for those license-exempt care providers who view themselves as only providing care on a temporary basis rather than as a career.

  "People who do not plan to provide child care for the long term do not need and would not be likely to become licensed, but they can still benefit from the training materials and resources offered."

- The need for license-exempt care providers to have access to special needs training.

  "Support networks and provider training need to be in place for any provider to identify and provide assistance to children with special needs before they enter school."

- The need to address parent and provider confusion about the relationship between IDHS and the CCR&R's in administering the subsidy program.

  "Parents and providers often confuse their local child care program [CCR&R] with IDHS and do not realize the subsidy program is actually a state program [part of IDHS]. Part of the confusion comes from mailings and checks that use varying names [the local program's name versus notices from the state]. They may disregard notices from the state because they do not realize that they are using a governmental program."

Chapter 7: CCR&R Staff Interview Findings

This section presents the results from statewide survey interviews with 115 subsidy specialists, and themes from interviews with 10 additional CCR&R resource specialists conducted in the three study areas. The purpose of the subsidy specialist survey was to gather staff perspectives on key issues facing license-exempt caregivers and parents using license-exempt care. The survey contained open- and closed-ended questions on a wide range of issues (see Appendix B). After providing basic demographic information on the subsidy specialists, the survey findings are organized according to major reasons parents choose license-exempt care, motivations for license-exempt caregiving, perceived license-exempt care issues for parents and providers, resources requested by parents and providers, factors considered important for license-exempt care quality, and suggestions for improving the ICCP.

Additional interviews with resource specialists were conducted in-person, and featured semi-structured discussions using an interview guide similar to that employed in the key informant interviews. Interview findings are organized according to reasons parents choose license-exempt care, provider motivations for caregiving, perceived benefits of and concerns about license-exempt care, perceptions about access to the ICCP, and suggestions for improving the ICCP.

CCR&R Subsidy Specialist Survey Findings

Even when limiting the survey sample to subsidy specialists, staff in different agencies have a variety of titles for their position. We asked respondents to provide us with their current title. Of the 115 respondents, 83 percent had titles that indicated they were in a subsidy specialist role only (e.g., subsidy specialist, family resource specialist, certificate program specialist), and 17 percent reported that they were in a subsidy supervisory role (e.g., subsidy services coordinator, team leader, family resource coordinator).

Table 7-1 summarizes the demographic characteristics of respondents. Almost ninety percent of the respondents were women. There was some ethnic diversity among respondents, with Caucasians (42.4 percent) and African Americans (36.8 percent) comprising the highest percentages of respondents. The average age of respondents was 32 years, with almost half of the participants falling into the 20-29 year age range.

Nearly two-thirds of the respondents had completed a college degree (associate's degree or higher), and another one-fourth had taken some college courses but not completed a degree. Of those who had attended college, the fields of study reported most often included child development, early childhood education, education, social work, psychology, and criminal justice. In a separate question, 57 percent of the respondents reported that they had taken a college course in child development, early childhood education, child psychology, or child welfare (not shown in table). In addition, 62 percent of the respondents reported that they had attended a training session that discussed license-exempt care issues during the course of their current work position.

Respondents had worked in their current position for an average of 2.3 years, with a range from 3 months to 8.5 years. In addition, respondents had worked in their agency for an average of 2.7

years, with a range from 3 months to 11 years. One-third of the respondents had held at least one previous position in the child care field outside of their current agency, working in such positions for an average of 5.7 years. Almost one half (46.1 percent) had held previous positions in which they worked with children, with an average of 4.6 years worked in such positions.

Table 7-1. Demographic Characteristics of Subsidy Specialist Respondents (n = 115)

		Number	Percent
Gender	Female	103	89.6
	Male	12	10.4
Race/Ethnicity	Caucasian	54	47.4
	African-American	42	36.8
	Hispanic	9	7.9
	Asian	2	1.8
	Multi-racial	7	6.1
Age	Average age	32 years	---
	20-29 years	53	46.9
	30-39 years	43	38.1
	40-49 years	11	9.7
	50 and older	6	5.3
Highest Education Level Completed	High school	11	9.6
	Some college, no degree	30	26.1
	Associate's degree	16	13.9
	Bachelor's degree	50	43.5
	Master's degree or higher	8	6.9
Field of College Courses	Psychology	15	13.0
	Social Work	10	8.7
	Child Development	9	7.8
	Criminal Justice	6	5.2
	Early Childhood Education	5	4.3
	Education	3	2.6
	Other	56	48.7
Work Experience	Held past position in child care outside of agency	38	33.3
	Held past positions working with children	53	46.1
	Average # years in current position	2.3	---
	Average # years in agency	2.7	---
	Average # years in child care outside of agency	5.7	---
	Average # years worked with children in other position	4.6	---

Interactions with Parents and Providers during a Typical Week

Respondents were asked to estimate how many in-person or phone interactions they had in a typical week both with license-exempt providers and parents using license-exempt care. They reported an average of 97 interactions with parents using license-exempt care, with a range from 0 to 300 interactions. Respondents reported an average of 89 interactions during a typical week with license-exempt care providers, ranging from 0 to 350 interactions.

In addition, respondents estimated that of all the parents using the subsidy program that they interact with during a typical week, just over half (52.7 percent) are using or are submitting an application to use a license-exempt care provider[10]. Similarly, participants estimated that over half (56.2 percent) of all the providers that they interact with during a typical week are license-exempt. These findings confirm the starting assumption that subsidy specialists would have frequent contact with both license-exempt providers and parents who use license-exempt care.

The topics that respondents have discussed with parents using license-exempt care during these interactions in the last 30 days vary, as illustrated in Table 7-2. Easily the most frequently reported topic was payments or co-payments, with 86.4 percent of respondents mentioning these topics. This includes questions about provider rates, the payment process, co-payment amounts, and why co-payments are required. Other topics were helping with applications and other paperwork (21.8 percent); general questions about the ICCP (17.3 percent); changes in case information, including a new provider or address changes (15.5 percent); questions on the status of a case (14.5 percent), and eligibility questions (13.6 percent). Interestingly, complaints about the program in general or about the provider were not commonly reported (5.5 percent).

Table 7-2. Topics Subsidy Specialists Discussed During Last 30 Days with Parents Using License-Exempt Care (n=110)

Topic	Percent
Payments / co-payments issues	86.4
Helping with paperwork / applications	21.8
General program questions	17.3
Change in case (including provider)	15.5
Status of case / time frame	14.5
Eligibility rules	13.6
Discuss approval periods / issues	9.1
Background checks (CANTS) / W9 forms / Provider certification issues	9.1
Issues/complaints – program / provider	5.5
Employment issues (work hours)	1.8
Other	4.5

Note. Multiple responses are possible so total percentage exceed 100 percent.

[10] We should note that these subsidy specialist estimates correspond closely with actual license-exempt use patterns found in the administrative data analysis (see Chapter 5). For example, in January 2001, 58.7 percent of families receiving subsidies were using a license-exempt provider for at least part of their care.

The topics that respondents have discussed with license-exempt care providers during these interactions in the last 30 days also varied, as illustrated in Table 7-3. As with interactions with parents, easily the most frequently reported topic concerned payment or co-payment issues (94.6 percent). This includes questions about the payment process, payment dates, payment status, billing information, the co-payment process, and how to collect co-payments. Other commonly mentioned topics were questions about the parental approval or redetermination process, including how many days the provider was approved to provide care (27 percent); helping the provider with paperwork (11.7 percent); changes in the parent or provider's case information (9.9 percent); provider certification issues, including W-9 tax forms and CANTS status (8.1 percent); and general program questions (8.1 percent).

Table 7-3. Topics Subsidy Specialists Discussed During Last 30 Days with License-Exempt Care Providers (n=111)

Topic	Percent
Payments / co-payments	94.6
Approval / redetermination issues (e.g., has parent approval been completed?)	27.0
Helping providers with paperwork	11.7
Change / ask about specific case	9.9
Provider certification issues (e.g., CANTS check)	8.1
General / multiple program questions	8.1
Status of cases / time frame	7.2
Licensing issues	5.4
Parent schedule	1.8
Other	4.5

Note. Multiple responses are possible so total percentage exceed 100 percent.

Parental Selection of License-Exempt Care Providers

In this section we discuss the subsidy specialist responses to a series of questions related to why they think parents choose license-exempt care providers. First, we asked an open-ended question "Based on your experiences at work, what do you think are the most important reasons why parents use license-exempt child care?" Respondents reported a variety of reasons, with five reasons most prominently mentioned (Table 7-4). Trust or familiarity with the provider was easily the most frequently mentioned reason, with half (50.0 percent) of all respondents indicating its importance. The convenience of the child care location was mentioned the next most often (29.8 percent), followed by cost reasons (23.7 percent). Greater flexibility with work and school schedules, as well as flexibility in co-payment arrangements, were mentioned as important factors to parents by about one-fifth of respondents.

Table 7-4. Subsidy Specialists Perceptions about Reasons Parents Choose License-Exempt Care (n = 114)

Reason	Percent
Trust / familiarity with provider	50.0
Convenience (location)	29.8
Cost	23.7
More flexibility with work / school schedule	19.3
Co-payment arrangements / flexibility	18.4
Better care	5.3
Lack other options	3.5
Can keep children in own home	3.5
Young children	1.8
Other	.9

Note. Multiple responses are possible so total percentage exceed 100 percent.

Next, we asked respondents to rate a list of reasons why parents might choose license-exempt care as very important, somewhat important or not important. As shown in Table 7-5, over 80 percent of the respondents rated parent trust and familiarity with the license-exempt care provider as a very important reason for parents choosing license-exempt care; this is consistent with the responses to the previous open-ended question. Other reasons that were rated as very important by at least 60 percent of survey respondents were:

- License-exempt care is more flexible (78.3 percent)
- License-exempt care better fits the parent's work and/or school schedule (76.5 percent)
- License-exempt care is easier for the parent from a location or transportation perspective (67.0 percent)
- License-exempt care providers may not require the parent to pay the co-payment (65.8 percent)
- License-exempt care is less costly (61.7 percent)

Overall, the vast majority of respondents rated each of the reasons as at least somewhat important, suggesting that subsidy specialists typically believed that multiple factors play a role in parent's child care choices.

Table 7-5. Rating of Reasons for Parents Selecting License-Exempt Child Care (n = 115)

	Very important	Somewhat important	Not important
Parent trusts license-exempt care provider	81.7%	14.8%	3.5%
License-exempt care more flexible	78.3%	19.1%	2.6%
License-exempt care fits better with parent' work/school schedule	76.5%	21.7%	1.7%
License-exempt care is easier from a location or transportation perspective	67.0%	27.8%	5.2%
License-exempt care provider may not require the parent to pay their co-payment	65.8%	25.2%	9.0%
License-exempt care less costly	61.7%	26.1%	12.2%
Parent prefers license-exempt care when their children are younger	53.6%	37.3%	9.1%
Parent wants children cared for in their own home	53.1%	38.1%	8.8%
Easier to have single provider for all children	51.3%	38.9%	9.7%
License-exempt care provides a warm and nurturing environment	47.3%	42.7%	10.0%
License-exempt care gives children more individual attention	41.2%	47.4%	11.4%
There are fewer cultural differences between parents and license-exempt care providers	31.2%	41.3%	27.5%
No other child care options available	29.1%	40.9%	30.0%
License-exempt care is seen by the parent as more consistent or reliable	28.8%	49.5%	21.6%
Parent does not have information about other child care options	25.7%	54.0%	20.4%

The lack of other available child care options was the reason most often cited as not important in parental choice of care. Nonetheless, only 30 percent of subsidy specialists thought that lack of options was not important. Another reason frequently rated as not important was the existence of fewer cultural differences with license-exempt care providers (27.5 percent). Other reasons rated most often as unimportant were the parental view that license-exempt care is more consistent or reliable (21.6 percent), and the lack of parental information about other child care choices (20.4 percent).

Finally, we asked respondents their opinions about what type of care they thought parents would choose if cost and availability were not an issue. Since we expected responses to vary depending on the age of the child needing care, we asked this question for four different age ranges, and then included four child care options.

As shown in Table 7-6, there was substantial variability in responses depending on the age of the child. For children under one year, most respondents (72.2 percent) reported that they thought parents would be most likely to select license-exempt care by a relative, even if the cost and availability for other types of care were not factors. For toddlers and young preschool aged

children (1-3 years of age), survey respondents were almost equally split between three types of care—centers (36.5 percent), licensed family child care homes (30.4 percent), and license-exempt care by a relative (31.3 percent). For older preschool-aged children (4-5 years of age), a majority of respondents (86.0 percent) reported that they thought parents would choose a child care center setting, including nursery schools and preschools. Finally, for school-aged children (6-12 years), most respondents (57.9 percent) reported that they believed parents would select a center setting, including before- and after-school programs. Thus, at least from the subsidy specialist perspective, parental preferences for type of care are strongly influenced by the age of the children needing care.

Table 7-6. Subsidy Specialists Perceptions about Parental Choice of Child Care Type by Age of Child, Controlling for Cost and Availability

	Child Under 1 Year	Child 1-3 Years	Child 4-5 Years	Child 6-12 Years
License-exempt care by a relative	72.2%	31.3%	1.8%	21.1%
Licensed family child home	17.4%	30.4%	10.5%	5.3%
Child care center[1]	7.0%	36.5%	86.0%	57.9%
License-exempt care by a friend or neighbor	3.5%	1.7%	1.8%	15.8%
n	**115**	**115**	**114**	**114**

[1] Includes nursery school, preschool, before-and after-school program, depending on age of child

Motivations for License-Exempt Care Provision

In this section we discuss the respondents' answers to a series of questions regarding why they think license-exempt caregivers begin providing care. First, we asked an open-ended question: "Based on your experiences at work, what do you think are the major reasons license-exempt caregivers provide care?" Almost two-thirds (62.2 percent) of respondents reported that earning an income was a major reason for providing care (Table 7-7). About half (48.6 percent) reported that they believed license-exempt caregivers provided care to help out family members or as a favor to the parents. Interestingly, reasons specifically related to caring for children were mentioned much less frequently by the subsidy specialists than in the focus group discussions (see Chapter 8 for focus group perspectives on this issue). For example, only 13.5 percent of respondents thought that enjoying working with and helping children was an important care motivation for license-exempt providers.

Table 7-7. Subsidy Specialists Perceptions about Reasons for Providing License-Exempt Care (n = 111)

Reason	Percent
To earn an income	62.2
To help out family / provide a favor to parents	48.6
Want to have the convenience and flexibility of working at home	18.9
Enjoy working with and helping children	13.5
Do not want a full-time job (e.g., retired)	7.2
Want family to care for young children	6.3
It is easy because do not have to follow licensing standards	1.8
Safe environment	.9
Other	.9

Note. Multiple responses are possible so total percentage exceed 100 percent.

Next, we asked survey respondents to indicate whether selected reasons for providing care were very important, somewhat important, or not important to license-exempt providers. As presented in Table 7-8, a majority of subsidy specialists rated four reasons as being "very important":

- Want to earn money (77.0 percent);
- Help out parents (65.2 percent);
- Want child care provided by a family member (64.9 percent); and,
- Want to stay at home with own children or grandchildren (54.9 percent).

Overall, most respondents rated each of the reasons listed as at least somewhat important. This suggests that subsidy specialists view caregiver motivations as being influenced by multiple factors.

Only four reasons for providing license-exempt care were rated by more than one-fifth of the respondents as not important:

- It is the only job the license-exempt care provider can find (27.8 percent);
- To avoid government intrusions (26.5 percent);
- Pressure from relatives to care for children (25.7 percent); and,
- License-exempt care providers enjoy teaching children (20.2 percent).

Table 7-8. Subsidy Specialists Ratings of Reasons for Providing License-Exempt Care

	Very important	Somewhat important	Not important
License-exempt care providers want to earn money	77.0%	20.4%	2.7%
License-exempt care providers want to help out parent or family member	65.2%	33.0%	1.7%
License-exempt care providers want child care provided by family member	64.9%	33.3%	1.8%
License-exempt care providers want to stay at home with own children / grandchildren	54.9%	37.2%	8.0%
License-exempt care providers enjoy caring for children	38.5%	55.0%	6.4%
Need job to meet welfare reform work requirements	37.0%	50.0%	13.0%
License-exempt care providers enjoy teaching children	27.5%	52.3%	20.2%
Avoid government intrusion (e.g., from licensing)	25.5%	48.0%	26.5%
License-exempt care providers feel pressure from relatives to help out	22.9%	51.4%	25.7%
It is the only job the license-exempt care provider can find	11.3%	46.1%	27.8%

We asked respondents a set of questions designed to determine why they thought license-exempt caregivers were not licensed. First, we asked if they thought the license-exempt caregivers they had interacted with were interested in becoming licensed. Respondents were roughly evenly split on this question, with 56 percent responding that the license-exempt care providers were interested in becoming licensed and 44 percent responding they were not interested.

Next, we asked those respondents who believed providers were interested in becoming licensed what difficulties, if any, the license-exempt caregivers they have interacted with might face in becoming licensed. As illustrated in Table 7-9, the two greatest difficulties reported were the provider not having enough space or an adequate caregiving environment to meet licensing standards (26.0 percent), and the cost and inconvenience of training courses needed to become licensed and maintain a license (26.0 percent). In addition, nearly a fifth (18.0 percent) indicated that the licensing process was confusing for license-exempt caregivers, or that the caregivers lacked sufficient knowledge about becoming licensed.

Table 7-9. Subsidy Specialists Perceptions about Difficulties License-Exempt Caregivers Face in Becoming Licensed (Open-Ended Question Responses)

Reasons	Percent
Having adequate space / living conditions	26.0
Training is inconvenient / costly	26.0
Licensing process is confusing / not know enough about how to become licensed	18.0
Having to undergo a background check	14.0
Length of licensing process	12.0
Lack of education / skills to meet licensing standards	12.0
Fear of DCFS / licensing system	10.0
Red tape / licensing paperwork	6.0
Not having resources for licensing process	4.0
Other	6.0

Note. Multiple responses are possible so total percentage exceed 100 percent.

Finally, we asked those respondents who reported that license-exempt caregivers were not interested in being licensed, why they thought the caregivers did not become licensed. As shown in Table 7-10, the most commonly cited reason was that the providers believe the licensing process is too much of a hassle (25.7 percent)—either because of the paperwork, training classes or DCFS orientations. In addition, over one-fifth (21.6 percent) of respondents indicated that they thought license-exempt caregivers wanted to avoid DCFS or other state intrusions that accompany licensing (e.g., home visits, background checks).

Table 7-10. Subsidy Specialists Perspectives about Why License-Exempt Caregivers Are Not Licensed

Reasons	Percent
Too much hassle—paperwork, training	25.7
Avoid state / DCFS intrusion	21.6
Only providing care to help family	12.2
Afraid will not be approved	12.2
View caregiving as a temporary /short-term arrangement	10.8
Does not know how to become licensed	9.5
Not interested	4.1
Have another job	1.4
Only provide care for the money-Not interested in taking care of children	2.7

Note. Multiple responses are possible so total percentage exceed 100 percent.

Perceived Problems Faced by Parents Using License-Exempt Care and License-Exempt Providers

We asked respondents to offer their thoughts on what they perceived to be the greatest problems or issues faced by license-exempt providers and by parents using license-exempt care, based on interactions the respondents had with each of these groups. Table 7-11 shows that subsidy

specialists most frequently mentioned problems that parents faced were finding affordable child care (43.7 percent); finding stable and consistent care for their children (26.2 percent); quality of care issues, such as finding developmentally appropriate care, (15.5 percent); and finding child care they can trust (13.6 percent). Supply and transportation-related reasons were mentioned by 11.7 percent of respondents.

Table 7-11. Subsidy Specialists Perspectives about the Greatest Problems Faced by Parents Using License-Exempt Care (n = 103)

Problem	Percent
Payment / cost issues	43.7
Reliability / keeping the same provider	26.2
Quality of care	15.5
Background / trust issues	13.6
Availability/Transportation/Location	11.7
Relationship with provider	9.7
Back-up provider plans	6.8
Provider education / experience	6.8
Parent schedule (e.g., non-traditional or odd hour care needs)	6.8
Children not learning	5.8
System / program information / complaints	2.9
Rules / regulations / paperwork	2.9
Not many problems	1.0
Other	9.7

Note. Multiple responses are possible so total percentage exceed 100 percent.

As shown in Table 7-12, payment-related issues dominated responses regarding the greatest problems facing license-exempt providers. Over half (51.4 percent) cited difficulties related to the receipt of or timeliness in receiving child care co-payments. In addition, low pay (21 percent) and timeliness of payments from the state (19 percent) were mentioned by a substantial number of respondents. Among issues that were not specifically payment-related, subsidy specialists most often suggested that lack of parental responsibility was a problem facing license-exempt providers (25.7 percent). This problem, rarely mentioned in the literature, also was alluded to by some focus group participants (see Chapter 8). Provider lack of education or training in child care, as well as the need for information about their cases or the ICCP more generally, each was seen as a problem by about one-tenth of the subsidy specialists.

Table 7-12. Subsidy Specialists Perspectives about Greatest Problems Faced by License-Exempt Care Providers (n = 105)

Problem	Percent
Lack / timeliness of co-payments	51.4
Parental lack responsibility	25.7
Pay too low	21.0
Timeliness of check	19.0
Lack education / training in child care	10.5
Information about their case / the program	8.6
Certificate length of time	4.8
Not have enough resources / equipment	4.8
Paperwork	4.8
Relationship with parents	3.8
Discipline issues	2.9
Other	7.6

Note. Multiple responses are possible so total percentage exceed 100 percent.

Information and Resources Requested by Parents and Providers

In this section, we describe the responses to a set of questions asking the subsidy specialists how often license-exempt providers and parents using license-exempt care request information or resources on a variety of topics. For each topic, subsidy specialists were asked how often they had received information and resource requests from license-exempt providers and parents using license-exempt care—frequently, sometimes, rarely, or never.

For most topics, at least half of the respondents had never had a parent using license-exempt care request information or resources (Table 7-13). Although it is not possible to determine from our data, this finding may result partially from parents seeking such information or resources from other CCR&R departments (e.g., the training department or Healthy Child Care nurse consultant) directly or by calling other agencies rather than the CCR&R.

The information and resource topic on which survey respondents had received the most requests from parents concerned communicating with child care providers. One fourth said that they received such requests frequently, and 65.2 percent had received these requests at least sometimes. Information on health, nutrition, and immunizations was reported as either frequently requested (3.5 percent) or sometimes requested (26.3 percent) by nearly one-third of the respondents. About one-fourth of subsidy specialists reported that they either frequently or sometimes received information requests about available community resources and about resources to help children learn.

Table 7-13. Subsidy Specialists Reports of Information or Resources Requested by Parents Using License-Exempt Care (n = 115)

Type of Information or Resource	Frequently	Sometimes	Rarely	Never
Information about communicating with child care providers	25.0%	40.2%	24.1%	10.7%
Information about available community resources (e.g., discounted bus passes, pool passes)	10.5%	16.7%	26.3%	46.5%
Information on activities to do with children	5.3%	10.5%	28.1%	56.1%
Information about resources to help children learn (e.g., toys, books, activities)	5.3%	18.4%	26.3%	50.0%
Information on health, nutrition, or immunizations	3.5%	26.3%	24.6%	45.6%
Information about safety equipment (e.g., first aid kits, smoke detectors)	2.6%	14.0%	17.5%	65.8%
Information about equipment for parent homes (e.g., cribs, strollers, car seats)	2.6%	12.3%	25.4%	59.6%
Information on caring for children (e.g., discipline, sleeping, toilet training)	1.8%	11.4%	26.3%	60.5%
Information about obtaining outdoor recreation equipment	1.8%	9.6%	21.9%	66.7%

In addition to the list provided in Table 7-13, survey respondents were asked to report any other types of information or resources requested by parents using license-exempt care. Information about finding other providers (35.4 percent) and information related to payment issues (26.2 percent) were the most commonly reported requests in response to this question.

Considering information and resources requested by license-exempt child care providers, at least half of the respondents reported that they had never had any license-exempt providers request information or resources for most topics listed in Table 7-14. The greatest exception concerned requests for information on licensing. Almost half of the survey respondents (46.1 percent) reported that they had frequently received requests from license-exempt providers for licensing information or resources, and an additional 36.5 percent indicated they sometimes had received such requests. Other topics most often reported as either frequently requested or sometimes requested by license-exempt providers include information on communicating with parents (61.4 percent); information on courses, workshops or other training activities (59.1 percent); and information about resources to help children learn, such as toys and books (31.9 percent).

Respondents also were asked to report any other types of information or resources requested by license-exempt providers. The most commonly reported information in this respect was related to payment issues (37.5 percent), collection of payments from parents (18.8 percent), and procedures for getting listed for provider jobs (18.8 percent).

Table 7-14. Subsidy Specialists Reports of Information and Resources Requested by License-Exempt Providers (n = 115)

Type of Information or Resource	Frequently	Sometimes	Rarely	Never
Information on licensing	46.1%	36.5%	10.4%	7.0%
Information on communicating with parents	20.2%	41.2%	18.4%	20.2%
Information about courses, workshops, or training activities	16.5%	42.6%	19.1%	21.7%
Information about resources to help children learn (e.g., toys, books)	11.5%	20.4%	23.0%	45.1%
Information about community resources (e.g., discounted bus passes, pool passes)	7.1%	21.2%	20.4%	51.3%
Information on business management	6.1%	15.8%	19.3%	58.8%
Information on activities to do with children	6.1%	19.3%	25.4%	49.1%
Information about equipment for providers' homes (e.g., cribs, strollers, car seats)	5.3%	17.7%	23.0%	54.0%
Information about outdoor recreation equipment	3.5%	9.7%	21.2%	65.5%
Information about safety equipment (e.g., first aid kits, smoke detectors)	2.7%	18.6%	23.0%	55.8%
Information on caring for children (e.g., discipline, sleeping, toilet training)	2.6%	19.3%	17.5%	60.5%
Information on health, nutrition, immunizations	1.8%	25.7%	14.2%	58.4%

Perceptions of Factors Important to Care that Children Receive

In this section we present findings from ratings of factors that subsidy specialists believed to be important to the care that children receive. Most factors in Table 7-15 were considered to be "very important" by a majority of respondents. The most frequently mentioned of these very important factors included having a safe and healthy environment (93.0 percent), having a clean environment (87.0 percent), and the caregiver showing a lot of interest in the children they are caring for (80.9 percent). Other factors commonly rated as very important were having a caregiver who interacts warmly with the children (73.9 percent), having developmentally appropriate activities for the children (70.4 percent), having a good relationship between the caregiver and parent (68.7 percent), having access to developmentally appropriate activities (67.8 percent), having a caregiver who has received training on how to care for children (64.3 percent), and having an environment with lots of activities for the children (61.7 percent).

Table 7-15. Subsidy Specialists Ratings of Factors Important to Care Children Receive (n = 115)

How important is…	Very Important	Important	Somewhat Important	Not Very Important	Not Important
A safe and healthy environment	93.0%	2.6%	4.3%	---	---
A clean environment	87.0%	7.0%	6.1%	---	---
A caregiver who shows a lot of interest in the children	80.9%	14.8%	4.3%	---	---
A warm caregiver	73.9%	16.5%	8.7%	0.9%	---
An environment with activities specific to child's developmental needs	70.4%	16.5%	8.7%	4.3%	---
A good relationship between the caregiver and parent	68.7%	23.5%	7.8%	---	---
Access to toys and activities that meet the child's developmental needs	67.8%	20.0%	9.6%	2.6%	---
A caregiver who has received training in how to care for children	64.3%	16.5%	15.7%	2.6%	0.9%
An environment with lots of activities	61.7%	21.7%	15.7%	0.9%	---
An environment where the child can interact with other children	53.9%	22.6%	21.7%	1.7%	---
A low staff-child ratio	52.6%	25.4%	16.7%	3.5%	1.8%
Low staff/caregiver turnover	50.4%	21.7%	19.1%	7.0%	1.7%
Care that is tailored to the age of the child (e.g., developmentally appropriate care)	43.5%	26.1%	22.6%	7.0%	0.9%
An environment that is racially/ culturally diverse	33.3%	23.7%	26.3%	12.3%	4.4%
A caregiver who has a degree in early childhood education or child development	13.9%	14.8%	45.2%	20.9%	5.2%

The factor rated most often as either "not very important" or "not important" was having a provider who has a degree in child development or early childhood education (26.1 percent). In addition, only about one-fourth of respondents thought that having such degrees was very important or important. Having a child care environment that is racially and culturally diverse was the second most commonly mentioned "not important" or "not very important" factor, but only 16.7 percent of survey participants offered these responses.

Perceptions about the ICCP Policies Related to License-Exempt Care

A series of questions asked respondents their opinions about the ICCP policies related to license-exempt care. First, we asked respondents whether they believed the state should provide subsidies to license-exempt providers. Eighty-seven percent of subsidy specialists responded affirmatively. However, eighty percent of those surveyed also believed that the state should require license-exempt providers to complete some kind of training activities in order to receive subsidies.

We asked survey respondents an open-ended question about what they thought was the most important thing that could be done to improve the care provided by license-exempt caregivers (Table 7-16). The most frequently cited suggestion for improving license-exempt care was to require license-exempt providers to meet minimum training or educational standards before they could receive a subsidy (77.9 percent). Most respondents made this recommendation from a general perspective, but some suggested specific training areas. These included training in child development (12.6 percent) or in first aid or safety issues (8.4 percent). Almost one-fifth of the respondents suggested that the state needed more monitoring of license-exempt child care providers—either through home visits, background checks, or fraud investigations (17.9 percent).

Table 7-16. Subsidy Specialists Suggestions for Improving License-Exempt Child Care Provision (n = 95)

Suggestion for Improving Care	Percent
Require provider to have education or training before receiving subsidy	77.9
Education/training topic- general	60.0
Education/training topic– first aid, safety	8.4
Education/training topic– child development	12.6
Education/training topic – other	4.2
Home visits/background checks/fraud checks of child care providers	17.9
Information / communication to providers about subsidy process	4.2
More resources available (e.g., equipment, food)	4.2
More standards for license-exempt care	4.2
Improve safety in provider's homes	3.2
Provider pay – increase amount and improve payment process	3.2
Licensing information	2.1
More literature / information for parents on choosing a child care provider	2.1
Other	1.1

Note. Multiple responses are possible so total percentage exceed 100 percent.

In comparison, respondents only infrequently mentioned some suggestions as being needed areas of improvement. For example, only 3.2 percent of respondents thought that improving either the pay level or payment process was the most important step needed to improve the care provided by license-exempt providers. Making more resources available, such as equipment or food, also was rarely mentioned (4.2 percent). Several information dissemination activities were presented

as "most important" ways to improve the care provided by license-exempt providers. These included licensing information, information to assist parents in selecting providers, and information for providers about the subsidy process. However, only small numbers of respondents mentioned each of these suggestions.

Finally, whereas the previous question focused specifically on suggestions for improving license-exempt care provision, we also asked respondents if they had any general suggestions for improving the subsidy program (Table 7-17). The most commonly suggested program improvements were requiring home visits/fraud investigations (23.5 percent), increasing provider pay and improving the payment process (20.6 percent), and requiring license-exempt providers to have some level of education or training before receiving subsidies (17.6 percent).

Table 7-17. Subsidy Specialists Suggestions for Improving the ICCP Overall (n = 68)

Suggestions for Improving the ICCP	Percent
Home visits/background checks/fraud checks of child care providers	23.5
Provider pay – increase amount and improve payment process	20.6
Require provider to have education or training before receiving subsidy	17.6
Education/training topic– general	11.8
Education/training topic– first aid, safety	1.5
Education/training topic– child development	1.5
Education/training topic– other	4.4
Lower / broaden income eligibility levels for parents	14.7
Information / communication to providers about subsidy process	11.8
More standards for license-exempt care	11.8
More convenient / user-friendly process (e.g., less paperwork)	8.8
More funding / program resources to the CCR&R	7.4
Licensing information	5.9
More resources available to providers (e.g., equipment, food)	2.9
More literature / information for parents on choosing a child care provider	1.5
Other	7.4

Note. Multiple responses are possible so total percentage exceed 100 percent.

Interviews with Additional CCR&R Staff

As previously mentioned, interviews with the ten additional CCR&R staff followed a structured, open-ended format similar to that used in the key informant interviews. Several of these staff were directly involved in initiatives, such as Healthy Child Care Illinois and Quality Counts, designed to improve training and the quality of services provided by license-exempt caregivers. Some were engaged in initiatives to help license-exempt providers become licensed, and others helped parents by providing information about available providers, including both licensed and license-exempt providers. These staff thus had a range of service provision roles that differed from those of the subsidy specialists. Nonetheless, many of the points discussed by these additional staff closely paralleled those raised by the subsidy specialists and by the key informants. When this was the case, we will simply note this consistency, and instead focus on

variations of these themes as well as on additional themes. To simplify presentation, and because all of these staff shared the goal of improving either the child care selection process or the quality of child care provided, we will refer to this diverse group of staff in the following sections as "resource specialists".

Parental Choice of License-Exempt Providers

Consistent with the other staff interviewed, the resource specialists prominently mentioned familiarity with and trust in the provider as important reasons that parents often favor relatives and other license-exempt providers. Likewise, many of these staff emphasized the scheduling flexibility that the use of license-exempt providers afforded parents, especially those working weekends, rotating schedules, and irregular hours. This not only was seen as making life easier for parents as they juggled work and child rearing responsibilities, but also as being less disruptive for children, particularly when care was provided in the child's home. Transportation issues also were viewed as important choice factors in all three study areas, with the proximity of license-exempt providers both to the parent's home and to schools frequently stressed. The manner in which these factors may interact to favor the choice of a relative or friend for care provision was neatly summarized by one interviewee, and the generally positive nature of this decision-making process was stressed by another.

> *"I think the ability to schedule is the flexibility for someone to work with your schedule, and if you're working nights or weekends they might come and stay over at the house so the kids don't have to get out of bed and go home. I think when parents look at grandma or aunt or somebody like that who is watching the child, it's a sense of security. They know this person and they know how this person is going to care for the child as a comfortable place. The child knows that individual and so it is an easier transition, especially when it's a younger child. And again, for after school kids, sometimes they live in the neighborhood where the school is at so they can get back and forth to school quite easily - transportation is not so much an issue in getting them back and forth to school."*

> *"I think it's generally a good choice for the parent. I have not noticed a lot of parents saying, 'I'm going to put my child in this home, but it's really not my choice.' I think mostly what I've seen is these are the middle of the road folks that are not necessarily afraid of any kind of licenser, you know. But some parents just don't want that larger group setting – the center setting. They want a smaller, homey setting. So my experiences have been that parents who choose home providers are consciously making that choice and are satisfied with that choice."*

Consistent with both key informant and subsidy specialist interview findings, several resource specialists further suggested that selection factors varied in importance with the age of children. In general, the perspective was that a relative or other in-home provider tended to be favored for infants and very young children, while licensed centers were preferred for preschoolers. This latter preference was seen as being driven by a desire for preschoolers to receive some educational activities to prepare them for school.

Some resource specialists also emphasized that barriers to obtaining licensed care influenced the selection of license-exempt providers. Cost comparisons generally were not seen as the primary factor affecting choice, but nonetheless were viewed as important. In fact, one interviewee argued that cost considerations often ultimately were the overriding factor.

> *"You talk to them [parents] about it and ask what the main thing is [in choosing a provider]. 'I want someone who's going to love my child, you know. Treat my baby well, who's going to provide an educational experience, going to provide a safe, caring environment' – all those things. But the things that can get in the way immediately, the barrier that crosses out [many choices] from their main priority of finding quality child care, is often cost. It's like the number one thing."*

As was mentioned in the key informant interviews and focus groups (see Chapter 8), considerations of cost issues can be quite nuanced. Resource specialists recognized that the subsidy program was allowing many parents to purchase licensed care that otherwise would have been unaffordable. However, even though the ICCP had developed a co-payment policy that was intended to make the selection of licensed or license-exempt care providers cost neutral, in practice cost factors often favored license-exempt providers for several reasons. First, resource specialists mentioned that the state-assigned co-pay either was waived or lowered by many license-exempt providers, and even those license-exempt providers that required full co-payments often were flexible regarding the timing for collecting co-payments. These practices lowered the actual cost of license-exempt care in relationship to intended state policy.

At the same time, the practices of licensed providers sometimes raised the cost of care above the rate suggested by the ICCP subsidy rate and associated co-payments. In particular, some licensed providers were said to charge initial registration fees not covered by the subsidy program, and others charged rates above the maximum level that could be reimbursed through the ICCP. As one interviewee summarized, this could bias a provider selection process in favor of license-exempt care provision.

> *"Sometimes we have facilities that do charge the parents the rate difference between what the state pays and what a private parent would pay, which might be as much as ten or more dollars a day. This is on top of the co-payment, and that may be factor in whether or not they use the facility because they may or may not be able to afford that. They're likely not to be able to afford it, because the co-payment is really determined to be the maximum that they can afford."*

Opinions concerning whether general shortages of licensed care options pushed parents toward the choice of license-exempt providers differed, suggesting that this issue varied in importance at the community and neighborhood levels. If supply was not viewed as sufficient at the neighborhood level, then transportation issues became more important and could lessen the desirability of more distant licensed provision. That is, the absence of sufficient licensed care supply in a proximate geographic area required transportation to more distant areas if licensed care was desired, and this was seen as posing a problem for many families. The supply of licensed providers also was seen as varying according to the age of children needing care. For example, one Chicago interviewee indicated that there was substantial shortfalls in licensed

centers in the city for children under age two, largely because licensing requirements for younger children are more stringent.

A few resource specialists suggested that the supply issue was less one about the number of slots than about the quality of slots that were available. These staff argued that quality of care varied substantially across licensed settings, and that some centers in their areas had vacancies. As one interviewee stated:

> *"I think the biggest factor is we don't have enough quality supply [of licensed options]… I think centers struggle to meet what we consider minimal care. And that is pretty well known [in the community]… So it's not just supply."*

A final factor mentioned by some Chicago resource specialists concerned the impact of welfare reform on provider selection. In particular, TANF work and training requirements were seen as introducing a sense of crisis into child care provider selection. That is, pressure for immediate work or training placements sometimes truncated the time available to find a provider, which led to choices based on immediate convenience or availability. As one staff member said:

> *"The crisis drives it a lot of times. Who I choose to take care of this child may have very little to do with what they really want in a quality sense. They look for 'What can I do because I've got all this pressure on me right now to find something in the next week? What can I do right at this moment?'"*

Positive Aspects of License-Exempt Care Provision

In each interview, resource specialists were asked about what they considered to be the primary strengths of license-exempt care provision, as well as about concerns they had with license-exempt care. Two attributes of license-exempt care were most frequently mentioned when discussing positive aspects of care. First, consistent with their belief that parents often choose license-exempt providers due to scheduling demands, interviewees indicated that license-exempt care was especially valuable in meeting care needs during hours when licensed providers were unavailable for care. As one interviewee succinctly put it, "They're doing all the work that nobody else wants to do. They're doing all the evening work, all the weekend work, and all the 24-hour work". Along these lines, the greater willingness of license-exempt providers to care for children when they became ill also was mentioned.

Second, many resource specialists believed that license-exempt care typically resulted in more individualized attention for children, due to lower children to staff ratios. This was seen as creating the potential for greater nurturing of the child. Interviewees spoke in terms both of greater attention at a single point in time, as well as the establishment of quality long-term relationships. The following quotes illustrate these two perspectives:

> *"It can be a more personal setting, as opposed to a huge classroom with 12-15 children and different people coming in and out of that classroom."*

"I would want for the children to feel as though they can create a long-lasting relationship with someone who cares enough about kids to care for them when I couldn't be there."

One resource specialist also mentioned that license-exempt caregiving situations may be preferable for selected children with special needs:

"There may be a child with special needs – it may be a child that cannot function in a group setting… Some children just can't deal with sharing that adult and it depends on the age of the child. So it's probably easier for the informal arrangement to customize their day or set up their day around that child's needs."

One concern for child care policy development is the extent to which subsidized care supplants care that relatives would have provided voluntarily without subsidies. While some may consider providing subsidies in these cases a questionable allocation of resources, one resource specialist indicated that a longer-term care perspective might cast doubt on such an assumption. In responding to a question regarding whether subsidies often were paid to relatives who would have provided care anyway, she responded:

"Yes, I do think that grandma would normally do that for free anyway, and an aunt often would do it for free or in exchange for something else. What I think factors into this, however, in the long term is consistency. I think that there is burnout in that you can only be the kind person for so long without feeling taken advantage of. I think that by getting some money, some payment, that it provides some incentive or motive to continue to help the family out."

Concerns about License-Exempt Care

Resource specialists expressed several concerns about license-exempt care. Prominent among these was that license-exempt providers usually are not adequately trained, and consequently often do not provide developmentally appropriate activities for the children in their care.

"With license-exempt caregivers, they're not receiving a lot of training. A lot of the license-exempt providers are not aware of the developmental stages and age appropriate activities. So if they would become more educated on keeping children more on a professional level, instead of a baby-sitting level, I think it would really make it more helpful within a community."

In some cases, resource specialists indicated that license-exempt providers had limited interest in receiving more training. This was viewed as resulting partially from a sense that some license-exempt providers thought their previous child rearing and other life experiences made such training unnecessary. In addition, the belief among license-exempt providers that they were only "helping out", or perhaps providing care only on a limited basis, may limit consideration of child care as a professional role requiring adequate training. The following quotes elaborate upon these issues.

"If they are not of a mind that they want to participate in this [training] and if they don't view themselves in a certain way, they may not see that information as important to them. 'I'm this child's grandparent, I raised her mother – I've raised a dozen kids. I know what's good and I don't need any of that CPR stuff – I can call 911 or whatever.'"

"They're looking at it as 'I'm helping you out'. So, how you change that from you're helping that person out to more of a professional level, that's going to take some work."

One resource specialist also mentioned that, especially when relative providers were used, the expectations for care might not be as high. In particular, this person thought parents were less likely to have a relative caregiver emphasize education with their child than they would if they used either a licensed provider or license-exempt non-relative. To the extent that this was true, lack of parental expectations could interact with a lack of training and result in lower quality care.

Some resource specialists also suggested that a portion of license-exempt providers had limitations that may diminish the quality of care they provide. For example, two interviewees stated that elderly relatives sometimes had physical disabilities or other health problems that presented safety issues when caring for children. Concerns about a lack of telephones in the homes where care was provided also was mentioned.

Given these concerns both about the inadequate training and sometimes limited capabilities among license-exempt providers, it is not surprising that the lack of monitoring of license-exempt providers was viewed as an important shortcoming. While most resource specialists believed that a range of quality existed in both licensed and license-exempt care settings, the licensing process was seen as providing at least some safeguards concerning minimal quality standards. In comparison, there was little if any monitoring of most license-exempt settings, which led to basic concerns about health and safety. As one interviewee said:

"The negative piece is that there is no check in terms of the health and safety of that environment. I think the environment first and foremost has to be a safe environment, and then you can talk about the developmental kinds of things that probably should be happening."

One interviewee noted that, without better monitoring, it was not possible to determine whether program limitations regarding the number of children being cared for by each license-exempt provider actually were being met: "We can count the number of subsidy heads that we're paying for, but how many other children are in that home that we don't know about?" Others were worried that the lack of monitoring raised the possibility of fraudulent ICCP payments being made.

Provider Motivations

Resource specialist interpretations of license-exempt provider motivations for offering care paralleled those of the subsidy specialists and key informants quite closely. The importance of income derived from care provision was mentioned most often. However, recognizing that the

pay for license-exempt care provision was very low, interviewees indicated that income-related motivations typically interacted with other caregiving motivations. For example, relatives and friends often were viewed as having a desire to help out the parent, and the pay simply reinforced such altruistic motives. Two quotes are illustrative:

> *"Probably the majority I would guess are not doing it for the sole purpose of income – certainly they're not making that much money doing it. So there are other things driving it – such as knowing the individual, trying to help out the family. Those kinds of things."*

> *"I would imagine that they have a sense of being able to help out. Sometimes it's extra income. They don't have the hassle of licensing or the monitoring or those kinds of things. But it's something that they maybe would have done anyway – on a very informal basis. But now they can get paid to do that."*

In some instances, license-exempt care provision may represent an economic opportunity for persons with few viable employment alternatives. This view seemed to be most prevalent in Chicago, and appeared to be closely related both to the state of the economy and to the implementation of welfare reform. In discussing how license-exempt providers she had interacted with became involved in care provision, one Chicago resource specialist said, "A lot of people have lost their jobs, and they've been approached by someone they know who says, 'Do you want to take care of my kids', and that sort of starts them." Another interviewee indicated that many of the calls she received from providers about becoming licensed suggested a sense of desperation:

> *"If most of the calls I get seem to revolve around financial questions, it's about surviving… 'How am I going to keep my own family going?' Sometimes it is one of the last straws for these people."*

Given a sense of need for work and limited skills, this resource specialist indicated that becoming licensed was one of the easiest ways to start a business for those already engaged in license-exempt caregiving. The same interviewee stated that such basic family income considerations also depended upon family size. In referring to one woman she had worked with who had a large number of children, she said, "It was cost effective for her to stay home with her kids and be a child care provider … she had too many kids of her own, so it [working outside the home] wasn't going to work."

It appeared that welfare reform pressures on low-income persons to find work led some TANF recipients or former TANF recipients to turn to license-exempt child care provision. As TANF was initially implemented, turning to license-exempt care provision may have been a temporary response to meet new work demands. However, one respondent suggested that this approach to meeting work requirements seemed to abate as the economy improved, which indicates the important interactions between welfare reform policies and the state of the economy.

> *[Interviewer]: "Do you think that TANF led to more parents becoming license-exempt care providers to meet work and training requirements?"*

"You know, maybe about three or four years ago I might have said yes, because they were really desperate to get jobs and they were just doing whatever it is that they could do. And that was one of the options - to provide child care to stop this time clock from ticking [the lifetime time limit on receipt of TANF]. Our economy has improved of course, but I don't know about now. A few years ago it had improved to the point where there were jobs and people were going out and working. It was actually better for them to work outside the home then than to stay home and provide child care."

Program Access

Several resource specialists spoke of difficulties that some parents had in accessing the program, with a lack of knowledge about the program's existence seen as the primary barrier to access. Some interviewees also indicated that, even if parents were aware of the program, some did not fully understand the possibility of receiving subsidies for the use of license-exempt care.

There were no common themes across the three study areas regarding common problems in access. However, a few ideas raised by interviewees deserve mention. First, some resource specialists mentioned access problems in Hispanic neighborhoods. Limited access in these areas was thought to result both from lack of knowledge about the CCR&Rs and reluctance to approach centers in pursuit of care. As one staff member said, "It is intimidating to go out to centers looking for care if you are Hispanic. And there really hasn't been much outreach to this community." In addition, the lack of social security numbers and issues related to citizenship status were seen as problems for both parents and license-exempt care providers.

Two interviewees saw the implementation of TANF as affecting access to the ICCP in two different ways. First, one resource specialist indicated that the welfare system had been an important source of information about the subsidized child care program for low-income persons, because caseworkers provided information to persons receiving welfare. However, as welfare reform led to the decline of caseloads, this referral and information source reached fewer people and so became less useful. In contrast, another resource specialist said that, among some segments of the population, the child care program had become stigmatized in the past because of its close linkage with welfare. Even though this linkage no longer was prevalent, the welfare stigma was seen as remaining, and consequently as discouraging some persons from applying.

Ideas about Improving License-Exempt Care Provision

There were several interesting commonalities across the three study areas regarding the role of license-exempt care provision in the ICCP. Most generally, although one interviewee felt it was inappropriate to pay grandparents to care for their grandchildren, all resource specialists in each area thought that license-exempt care provision should continue to play an important role in the subsidy program. License-exempt care was seen as filling important service needs that otherwise would be difficult if not impossible to meet, so not including it in the mix of care options was not viewed as viable. Interviewees feared that without license-exempt care, or even with substantial increases in regulation of these providers, child care supply problems would result. Particularly in the TANF environment of work and training requirements, one interviewee expressed concern that more children would be left alone if there was not a supply of license-exempt caregivers.

Support for continued license-exempt care provision also was bolstered by a fairly consistent view that the role of the CCR&R is to provide guidance, mentoring, and quality improvement in child care choice and provision, but within the context of the parent being ultimately responsible for provider selection. The following quote illustrates this orientation.

> *"So we educate parents on how to find quality care. And it is up to them to decide. Because what might be quality for me, quality for a parent might just be that there are [providers] available. Everyone has a different definition of what quality is to them. But our job is to educate them on what to look for when looking for quality."*

Need for Additional Training and Monitoring

Despite this general support for license-exempt care provision, all of the resource specialists interviewed indicated that additional training and/or standards for license-exempt providers are needed. Interviewees commonly indicated that, much like licensed care provision, there was a wide range of quality across license-exempt caregivers. However, the lack of training for and monitoring of license-exempt providers raised concerns about some of the unregulated care settings that were being subsidized with public funds. There also was a more general worry that failure to engage license-exempt providers was a missed opportunity to improve care with many providers who would be interested in such opportunities. As one interviewee said:

> *"There has to be some point of access for these folks. I mean, because they are providing good care. It's just that they don't have resources. And nobody is out here shaking the bushes saying, 'I want to help you out. This is how you do it, or you can refer to here for help or I'm here to help you.'"*

In thinking about the best ways to improve license-exempt care settings, interviewees commonly mentioned the desirability of encouraging licensed-exempt providers to become licensed. However, they also felt that only a portion of the large numbers of license-exempt providers would ever become licensed. This was seen as especially true for relatives, who in many cases only wanted to provide care as a result of interest in relative children or as a way of helping out the family, and who consequently had little interest in professionalizing their caregiving. Licensing requests were seen as more frequently coming from non-relatives, and the licensing process often was overwhelming for these providers. As one interviewee said:

> *"Their standards are intimidating. It's a document this big. When that person begins to look through those standards and they see them, they say 'Oh my God, how am I going to make sure that all these things are in place?' Facility wise, as far as their home is concerned, how are they going to meet these standards? It's an overwhelming process. Many people are very intimidated by it."*

Given the perception that large numbers of license-exempt providers were unlikely to become licensed, resource specialists typically were experimenting with strategies for improving quality within license-exempt care settings. While these strategies varied, they shared some common features. For example, several interviewees felt the need to overcome fears that many persons had concerning any involvement with staff from a public agency. This reluctance was said to

result from a distrust of governmental agencies, as well as from caregiver insecurities about their abilities. Most often mentioned in this respect was the considerable distrust of child welfare agencies that existed in many low-income communities. Fear among immigrants about becoming involved with agencies was a more specialized problem in some communities.

Based on field experiences with these issues, resource specialists had thoughtfully considered how best to engage license-exempt caregivers in quality improvement efforts. A common strategy was to approach license-exempt providers in a non-threatening manner in an attempt to build rapport so that on-going quality improvement efforts might be possible. For example, in one study area, those caregivers who preferred to remain license-exempt but who wanted to be included on provider referral lists used by the CCR&R were asked to engage in a follow-up visit with a resource specialist. This person explained her approach to the visit:

> *"And then I go and do a welcome visit, and I take with me a fire extinguisher, a smoke detector, and a first-aid kit … when I ask to come to their home and do the welcome visit, I don't just say 'I'm coming to inspect your home', I say, 'I'm coming to do a welcome visit that will take about 45 minutes to an hour, depending on how 'talky' we are, and in this process I'm going to tell you what we've got to offer you.' So when I go in with a free gift, I've got a little of honey instead of vinegar, and that just makes good sense."*

This visit then was viewed as an entrée into a relationship in which the provider might be more receptive to future overtures regarding training and perhaps licensing.

At the time of our visit, Chicago staff were initiating a similar but more general outreach-oriented effort to improve license-exempt care quality. The CCR&R was using interns geographically dispersed across the city to approach license-exempt providers in their homes. Child care-related materials and information are provided during this initial visit, and periodic follow-ups then will be attempted to determine if the providers are interested in training sessions or licensing.

Some resource specialists thought that the system needed to improve incentives for completing training or other desired ICCP activities. As one interviewee stated, "There's no other avenue [other than licensing] for license-exempt providers at this point – to say that they have some kind of level of experience or training or something like that." Given the difficulty in becoming licensed, some advocated for a tiered system in which a provider could become certified if they completed selected training and/or other requirements. The possibility of providing levels of pay higher than the basic license-exempt rate but lower than the licensed rate for those who met such certification requirements also was discussed.

Need for Better Program Information for License-Exempt Providers

Another common concern expressed by resource specialists was that license-exempt providers do not understand the ICCP well enough. As one interviewee said, "They just don't know anything about the program itself. They don't know all the different steps that really need to happen and the overall protocol – how it [the program] really works". Resource specialists stated that the program primarily communicated with parents, with little interaction with license-

exempt providers unless these caregivers called with problems. This often was seen as resulting in provider disillusionment, as program experiences departed from expectations that were based on incorrect information. These misunderstandings also created additional work for the CCR&R staff, due to the need to field calls on basic informational issues or to resolve conflicts between parents and providers that derived from an incomplete understanding of the program.

Payment issues were most often mentioned as problems that resulted from a lack of program information among license-exempt providers. In particular, providers often did not understand that they had to collect the co-payment amount from the parent in order to receive the total amount of payment offered through the program. Consequently, when they received a check from the state that was less than what they anticipated (because the parent co-pay amount had been deducted), they were confused and disillusioned.

Because of these concerns, resource specialists commonly thought that some type of orientation for license-exempt providers should be developed. Interviewee comments on areas in which license-exempt providers lacked information suggested the core content for such an orientation session. This included:

- a basic introduction about the purpose of the program and how it works;
- a clear description of how the payment process functions, including co-pays, tax issues, and the timing of initial and subsequent payments;
- the need for and purposes of the limited background check;
- the re-determination process;
- an introduction to procedures for becoming licensed; and
- the resources available through the CCR&Rs, such as lending libraries and training sessions.

The orientation session thus was seen as a means to establish an initial link with license-exempt providers that does not exist at present, and to make caregivers aware both of basic program rules and of quality enhancement possibilities.

Bureaucratic Issues

There were few complaints in the interviews about the paperwork and other operational requirements associated with the program. A few resource specialists thought that the initial certification and payment process took too long, although we received no specific recommendations for improving this process.

One issue of frustration expressed in one study area concerned the difficulty in coordinating child care services between the ICCP, Head Start, and child care programs operated through the schools. One interviewee indicated that the state often encouraged and even pushed localities operating these different programs to coordinate their services, and that local providers were interested in doing so. However, different funding streams and regulations emanating from the state often undercut this very coordination. She suggested that for coordination of these programs to be effectively implemented, issues of funding and common regulations needed to be negotiated at higher levels of government.

Chapter 8: Focus Group Findings

This section presents findings from the 15 focus groups. We begin by providing selected background information on focus group participants that was collected in the brief background surveys completed by all participants. Then findings are organized according to major issues facing license-exempt care providers and parents who use license-exempt care.

Background Characteristics of Focus Group Participants

As participants entered each focus group, they were asked to fill out a brief survey that provided information about their demographic characteristics and their current caregiving situation. Each individual was told that the information would be anonymous, and was asked not to include his or her name. Project staff were available to answer any questions that the participants had about filling out the form.

Table 8-1 summarizes the demographic characteristics of focus group parents and providers. The groups primarily consisted of female participants. Nearly ninety-one percent of the parents who participated were women, and 80 percent of the providers were women.

The demographic factor that varied the most by location was ethnicity. All of the participants in the North Lawndale groups were African American, while the groups conducted in South Lawndale were comprised completely of Hispanic participants. In the Peoria groups, there was a mix of 67.7 percent African American attendees and 32.2 percent Caucasian attendees. In the Southern Seven counties, 81.1 percent of the participants were African American and 18.9 percent were Caucasian. In general, these racial and ethnic characteristics reflect the low-income populations in the communities in which the groups were held. North Lawndale, for example, is heavily African American, while South Lawndale is largely Hispanic. However, participants in the Southern Seven focus groups were more likely to be African American than would be suggested by the area's population. This probably was partially due to the focus groups being held either in or close to Cairo, which has a predominantly African American population.

Table 8-1. Demographic Characteristics of Focus Group Participants

		Parents		Providers	
		Number	Percent	Number	Percent
Geographic location	Chicago	22	40.0	24	40.0
	Peoria	15	27.3	17	28.3
	Southern 7	18	32.7	19	31.7
Gender	Female	50	90.9	48	80.0
	Male	5	9.1	12	20.0
Race/ethnicity	African American	44	80.0	40	69.0
	Caucasian	4	7.3	13	22.4
	Hispanic	7	12.7	5	8.6
Number of Children	Average number	2.5	---	1.4	---
	Children < 1	14	10.4	1	1.2
	Children 1 – 2	17	12.7	4	4.9
	Children 3 – 4	21	15.7	4	4.9
	Children 5 – 12	69	51.5	16	19.8
	Children 13 – 17	11	8.2	7	8.6
	Children 18+ [1]	2	1.5	49	60.5
Age of Participant	Average age	31.3	---	42.7	---
	Participants < 21	4	7.4	3	5.1
	21-30	28	51.9	12	20.3
	31-40	12	22.2	10	16.9
	41-50	6	11.1	11	18.6
	51-60	4	7.4	18	30.5
	60 and over	0	0.0	5	8.5

[1] Not all providers listed children over age 18.

Parents in the focus groups reported having an average of 2.5 children. About 90 percent of these children were under age 13, and 23.1 percent were under age 3. Providers also typically had children, but these children were much more likely to be grown. For example, 39.4 percent of providers had a child under age 18, and only 30.8 percent had a child under age 13.

The average age of participating parents was 31.3 years old, as compared to 42.7 years old for providers. There was a wide range of ages in both groups. About half of the participating parents fell within the 21-30 age range, and nearly three-fourths were between 21-40. Providers tended to be somewhat older. About 31 percent were between ages 51-60, and nearly half were between 41-60.

There was also a wide range of educational levels in both groups, ranging from 2nd grade to Bachelors degrees in the parent groups, and from 8th grade to a Masters degree in the provider groups. The average highest grade completed was similar for both groups: 12.0 years for parents, and 12.1 for providers (Table 8-2). About 24 percent of parents were currently attending school, as compared to 10.0 percent of providers.

Nearly 44 percent of parents had received TANF cash assistance within the last two years, and 25.5 percent currently were receiving TANF. Providers were much less likely to have received TANF, with 11.7 percent having received it in the last two years and only 3.4 percent currently receiving it.[11]

Over three-quarters (78.2 percent) of the parents in the focus groups were employed, and these parents worked an average of 36.1 hours per week (Table 8-2). Providers cared for children average of about 34.6 hours a week, and one-fourth also had other jobs (Tables 8-2 and 8-3).

Table 8-2. Employment, Education, and TANF Receipt by Focus Group Participants

	Parents		Providers	
	Number	Percent	Number	Percent
Employed	43	78.2	60	100.0
Provider employed in addition to child care	---	---	15	25.0
Received TANF in last two years	24	43.6	7	11.7
Currently receiving TANF	14	25.5	2	3.4
Currently attending school	13	23.6	6	10.0
Highest Grade Completed (Average)	12.0	---	12.1	---
Weekly hours worked by employed parents (Average)	36.1	---	---	---

Table 8-3 displays some basic characteristics of the child care situations of focus group parents and providers. Most parents were involved in child care situations that at least approached full-time, with an average of 31.4 hours per week in care. Parents had an average of 2.2 children in care, and the average age of children in care was 5.7. The parents had used their current license-exempt provider for an average of 2.4 years.

The focus group providers reported caring for children an average of 34.6 hours per week, and about half provided care for at least 40 hours per week. They provided care to an average of 2.8 children, and the average age of these children was 5.6. The providers indicated that they had been providing child care for children other than their own for an average of 4.5 years, and that they had received pay for a little over half of this time (2.7 years).

[11] We should note that these provider characteristics closely parallel those found in the administrative data analysis for all license-exempt providers (see Chapter 5).

Table 8-3. Basic Characteristics of Child Care for Focus Group Participants

Parents	Average hours per week children in care	31.4
	% with children in care less than 10 hours per week	5.5
	% with children in care 10-19 hours	11.8
	% with children in care 20-29 hours	18.2
	% with children in care 30-39 hours	23.6
	% with children in care 40-49 hours	33.6
	% with children in care over 50 hours	7.3
	Average years with current provider	2.4
	Average number of children in care	2.2
	Average age of children in care	5.7
Providers	Average hours per week providing care	34.6
	% with children in care less than 10 hours per week	7.7
	% with children in care 10-19 hours	7.6
	% with children in care 20-29 hours	19.2
	% with children in care 30-39 hours	15.3
	% with children in care 40-49 hours	38.4
	% with children in care over 50 hours	11.4
	% also caring for their own children	18.3
	Average number of years providing child care	4.5
	Average number of years providing paid child care	2.7
	Average number of children providing care for	2.8
	Average age of children providing care for	5.6

Table 8-4 shows that child care during weekdays was a staple of both parents and providers, with about four-fifths of both groups involved in care during these hours. However, the important role of license-exempt providers in caring for children during evening and weekend hours also is illustrated. About two-fifths of the parents in the groups used child care during the evenings, and 55.9 percent of the providers were engaged in evening care. Over 42 percent of the providers cared for children during weekends, while only 14.9 percent of the parents reported using such weekend care.

Table 8-4. Types of Care Schedule Used and Provided by Focus Group Participants

Type of Care Schedule Used by Parent				
	Yes		No	
	Number	Percent	Number	Percent
Weekdays	37	78.7	10	21.3
Evenings	19	40.4	28	59.6
Weekends	7	14.9	40	85.1
Use more than one provider	7	13.4	45	86.6
Type of Care Schedule Provided by Caregiver				
	Yes		No	
	Number	Percent	Number	Percent
Weekdays	48	81.4	11	18.6
Evenings	33	55.9	26	44.1
Weekends	25	42.4	34	57.6

As Table 8-5 shows, 64.4 percent of focus group providers were related to a child they cared for, and 58.2 percent of focus group parents reported using a caregiver related to their child.[12] Grandparents were easily the most common relative caregivers, representing 74.3 percent of relative caregivers in the provider groups and 60.0 percent of relative caregivers in the parent groups. Aunts were the next most common relative provider used in both groups.

Table 8-5. Relationships between Caregivers and Children

Provider's Relationship with the Child in Care						
	Parent Survey Responses			Providers Survey Responses		
	Number	Percent of Total	Percent that Use Relative Providers	Number	Percent of Total	Percent of Relative Providers
Related to at least one child	**32**	**58.2**	**100.0**	**38**	**64.4**	**100.0**
Grandparent	18	32.7	60.0	26	43.3	74.3
Aunt	3	5.5	10.0	4	6.7	11.4
Cousin	2	3.6	6.7	2	3.3	5.7
Sister	2	3.6	6.7	1	1.7	2.9
Great Aunt	2	3.6	6.7	0	0.0	0.0
Great Uncle	1	1.8	3.3	0	0.0	0.0
Multiple Relationships	2	3.6	6.7	2	3.3	5.7
Not Related	**23**	**41.8**	**---**	**21**	**35.6**	**---**

[12] We should note that these relationship characteristics closely parallel those found in the administrative data analysis for all families using license-exempt care (see Chapter 5).

Over four-fifths of both the parents and providers indicated that they were highly satisfied with the license-exempt child care arrangements in which they were involved (Table 8-6). Focus group participants had learned about the subsidy program from a variety of sources (Table 8-7). Public assistance or TANF was the referral source for about two-fifths of parents, again demonstrating the close linkage between TANF and the ICCP. Friends and family members had told about one-third of the parents about the program. In comparison, friends and family members easily were the most common ICCP information source for license-exempt providers, with nearly half of focus group providers learning about the program from these sources.[13]

Table 8-6. Focus Group Participant's Satisfaction with Caregiving Situation

	Number	Percent
Parent satisfaction with current child care		
Very satisfied	43	81.1
Somewhat satisfied	6	11.3
Somewhat dissatisfied	2	3.8
Very dissatisfied	2	3.8
Provider satisfaction with providing care		
Very satisfied	49	83.1
Somewhat satisfied	7	11.9
Somewhat dissatisfied	0	0.0
Very dissatisfied	3	5.1

Table 8-7. How Participants Learned about the ICCP

	Parents		Providers	
	Number	Percent of Parents	Number	Percent of Providers
Public Assistance/TANF	19	41.3	7	12.7
Friend	11	23.9	15	27.3
Counselor/Caseworker	5	10.9	0	0.0
Family	4	8.7	12	21.8
Mailing	1	2.2	6	10.9
Provider/Parent	1	2.2	5	9.1
DCFS	1	2.2	1	1.8
Phonebook	1	2.2	0	0.0
Other	3	6.5	9	16.4
Total	**46**	**100.0**	**55**	**100.0**

[13] These differences in how parents and providers had learned about the program may be explained by the fact that parents must apply for the program and find their own providers. Consequently, providers often learn about the program from the parents that they will provide care for.

Major Themes Arising from the Focus Groups

The following sections present and discuss major themes that arose in the focus groups, as well as variations that occurred in some study areas or among sub-groups of participants. Because some content between the parent and provider focus groups overlaps, selected group topics are based on both the parent and provider groups. Other topics are specific either to parents or to providers.

The findings hopefully will convey the rich variety of caregiving perspectives we encountered in our group conversations with parents and license-exempt care providers. To place these themes in proper perspective, we will begin by providing several overview points that will present the context in which we think the findings are most usefully interpreted.

First, we should stress that while the findings explicate many important caregiving themes, they are less helpful in quantifying the prevalence of such themes. Focus groups do not lend themselves well to quantification, both because of the non-random selection techniques employed, and because of nuances in how questions typically are explored across groups. For example, while we attempted to explore all of the material in the focus group guides in each group, different groups emphasized some content because of the responsiveness of the groups to that content. This is a methodological strength in the sense that its flexibility allows better responsiveness to the perspectives of participants, as well as the emergence of themes that may have been overlooked by the researchers. Nonetheless, this flexibility, along with possible "group effects" that sometimes occur when group members respond to an issue raised by one member, suggest that caution must be used in interpreting the frequency with which various themes are raised. We therefore tend not to emphasize the frequencies of themes, except when they were extremely common or rare. The intent rather is to delineate a variety of themes as fully as possible, and then to test the prevalence of such themes through randomly sampled individual interviews in the next phase of the project.

Second, we must emphasize the diversity of license-exempt care situations in which our focus group parents and providers were involved. This diversity included a broad range of relative and non-relative caregivers, variations in care settings and the ages of children cared for, and differences in the amount of care and hours in which care was provided. Most significantly, while public policy discussions often focus on differences in quality of care between licensed and license-exempt care situations, our groups also suggested far-ranging quality of care differences within license-exempt settings. Participant experiences with licensed child care settings similarly suggested substantial quality differences in those settings, which indicates that quality of care is an issue that must be examined within as well as across types of care settings.

Third, the limited financial means of most focus group members must be stressed. While the Illinois program allows eligibility for up to one-half of the 1997 state median income, financial means are modest even at the highest eligible income levels. Many participants also live in neighborhoods in which public recreational and other activities are lacking and in which concerns about crime and safety are high. These factors often mean that resources that middle and upper-income families take for granted in caring for their children simply are not available. At the same time, we were taken by the extended sense of family and community frequently

referred to in the groups. For example, bartering over or waiving of parent co-payments reflected recognition of common economic difficulties that should be shared. This perspective, which is consistent with considerable previous ethnographic research in poor communities (see, for example Dodson, 1998; Edin and Lein, 1997; Jarrett, 1994), often represents a family and community strength upon which public policy can build.

Parental Selection of License-Exempt Caregivers: What Factors Appear to Be Most Important?

Parents in each focus group were asked to discuss the principal reasons they selected the license-exempt caregiver they currently were using. Participants most often expressed positive aspects of license-exempt caregiving when discussing their child care choices, but undesirable features of center-based care and lack of availability of other care options also were mentioned. Issues of safety and trust, convenience, and cost all were viewed as important by many parents, and in some cases these factors interacted. As one parent summarized when speaking about her license-exempt care provider, "Everything is easier – at least if you know the person. And you know your child is in good hands. And it's just more convenient. And in day care, they charge like a dollar a minute if you're late." We present the factors that appeared most influential in parental decision-making in the following sections.

Safety and Trust as Decision-Making Factors

Parents in all three locations mentioned concerns about safety in discussing their choice of providers. Selection of a caregiver with whom the parent had a trusting relationship typically was viewed as the best way to ensure safety, so the choice of relatives and friends is not surprising in this respect. The often straightforward nature of this calculus is illustrated by the following comments.

> *"Because with everything going on in the world today, you have to be careful about who takes care of your children. To me that is one person, and that person is my mom. She wouldn't do anything to harm them."*
>
> *"Because we know them people. And we ain't feeling that they're going to hurt our children, we know these people…"*
>
> *"So I would rather they be at home, amongst friends and family, because they're taken care of properly… When my kids are at home, I don't have to worry about are they being fed or being abused or this or that."*
> *"I have three young ladies. And I don't trust no male. I'm not trying to be, you know, prejudiced against men or anything. But I have young women. And you know, I don't trust nobody with my girls except another female, which would be my sister or my mother… I just don't trust no one else outside of my home to care for my girls."*

In contrast, one parent without access to a trusted provider illustrated the concerns that parents in such situations may have: "We just moved here. I don't know anybody. And I'm not really comfortable with any strangers watching my kids."

The issue of trust in providers extended well beyond the issue of safety. It also was seen as contributing to quality of care more broadly, because of confidence that the provider was genuinely interested in the well-being and development of the child. The fact that most of the parents had pre-existing relationships with their license-exempt caregiver often served to re-assure parents that the provider shared a common care philosophy, or that the provider would care for the child much like the parent would.

> *"[I chose] my mom because I don't really trust very much people with my daughter. She's very picky already. And she needs somebody familiar. I know I can trust her, and I know she's going to go with my wishes."*

> *"Because that's my momma – that's my blood. I know my mom is going to take care of my kids – she raised me."*

> *"She takes care of them the way that I take care of them. She mothers them. She's their second mother."*

> *"And you also feel like since you know how you were raised, you know what you're mom's doing."*

Although positive feelings of trust in relatives and friends appeared to be powerful motivations favoring selection of license-exempt providers, such sentiments often were reinforced by negative perceptions about safety and other quality of care issues in licensed child care settings. Although some participants indicated that licensing regulations assured reasonable levels of safety in child care centers, others doubted this. This skepticism often resulted from negative personal experiences with child care centers, or from stories they had heard from friends.

> *"I've had a couple of friends that took their kids to day cares. And they come to pick them up and their diapers are beyond full."*

> *"I don't really trust day cares. Just because I've been to a couple of them, and the ones that I was in, there were people taking kids out of the room into different rooms."*

> *"Well I hear some people say when they drop their child off to day care, they come back and there's a bruise, there's a knot, there's something there. And then you ask the person who was in custody of that child what happened. 'Oh, one of the kids may have done something, or that may have been [done by] anybody. Could have been one of the adults, could have been one of the kids.' And if you were a provider, where were you when this was going on? So you have plenty of questions and everything."*

> *"And I have a girl friend, she has a one year old. The baby is in licensed care. And he'd be biting my baby all the time. So that makes me think that at his licensed home, that somebody is biting on him."*

Media coverage of abusive treatment in child care centers also sometimes fueled concerns about safety. The potential power of such media coverage was especially evident in one Southern

Seven group. One participant stated that he did not consider choosing a child care center for care because of his concerns about safety in centers. In explaining these reservations, he said, "You know, you rely on people in day care. And then there are times when the children are left on the buses. And you've heard it all on the news – molestation and that stuff. You know, its kind of scary." Other members quickly joined in agreement with statements such as "That's right, I've seen those stories."

While parental concerns about child safety obviously are not unique to low-income persons, the impact that the dangerous neighborhoods in which many low-income persons reside cannot be overemphasized in interpreting safety issues. Fears about the possible negative impacts of neighborhoods existed regardless of the ages of the children in care, and included concerns about both potential physical harm and negative neighborhood influences. In talking about older children, parents worried about children being "out on the streets" or being susceptible to gang influences. Interestingly, while proponents of child care centers often speak of the positive benefits of young children interacting with other children, some parents feared exposing their children to "bad children".

> *"I'm particular about what my kids be around and what they learn. And I might adore the provider, but the other kids she keeps may not be what I really want my kids to be around."*

Convenience and Flexibility

Aside from trust and safety considerations, convenience and flexibility were the most commonly mentioned factors influencing care-giving decisions. Some parents viewed convenience in fairly general terms, such as the lack of travel that was needed when children were cared for in their own homes or in the homes of nearby friends or relatives. Care in the home also was seen by some as convenient in the sense that time was saved by not having to pack toys, books, and other items for children to take to care.

> *"Because it was convenient… I only had to walk out my door and cross the road."*
>
> *"And then with my dad right downstairs, it's convenient."*
>
> *"[Provider's name] didn't have any children of her own… we were close. I'm a truck driver [and am on the road a lot]. It was very convenient for me."*

For others, the flexibility of license-exempt caregivers in responding to the specific needs of parents was viewed as a determining factor when selecting caregivers. This flexibility extended to several different practical needs, but seemed especially important in terms of minimizing hassles when the parent had to work overtime or to work shifts outside of normal hours. Some parents also spoke of the willingness of license-exempt providers to care for sick children, which saved the parent the trouble of altering work schedules or searching for back-up caregivers when children became sick.

"My sister babysits. I have three daughters. And usually by the time they're off school, I have to be at work at 3:30. And I don't get off until midnight. So they're basically over to my sister's house until I get off work. And sometimes she'll bring them across – I don't live too far, I live right across the alley. So she takes them home and has them in bed by the time I get home from work."

"If you get a schedule change or something, then you know you can always count on that person to be there."

"Flexibility … she's the only one I could find. She's the only one that would take the kids, considering my shift, because I don't have a 9 to 5 shift. And I didn't have a regular schedule. And she said she's home all the time. She's the only one that would meet my shift needs. Nobody wanted to watch the kids unless I had a 9 to 5 shift."

Personalized and Consistent Care

Parents frequently mentioned that concerns about personalized care also contributed to their selection of a license-exempt care provider. Several different dimensions appeared to contribute to considerations about personalized care. First, some persons stressed that the close relationship between the provider and the child assured that a high level of individualized care would be provided. In many cases, this seemed related to the previously discussed trust factor, and was most prominent with parents who were using relative caregivers.

Parents also referred to higher child to staff ratios in child care centers when discussing why they had selected a license-exempt caregiver.

"And, I don't know, they have so many more kids [in day care]. You know, they can't be watching the kids all the time. Not that that isn't an issue for a single person doing it too. But there's a little bit more one on one. It just feels more secure that way. Especially with a baby."

"And if they're at the licensed place, they might have too many kids, you know. They can't keep – I can't even keep an eye on my own child. So you know and just imagine – that she has five other little children to keep an eye on."

In addition, turnover in child care centers was seen as compromising the consistency of care and the development of relationships between caregivers and children. As one parent said, "When they're kids, they get attached to people they spend a lot of time with. And if they're in a daycare center, people come and go, they leave, they get new jobs or the kids outgrow the day care centers and stuff. And they have to say goodbye. I think it's nice for them to have somebody that's going to be there – to continue for the rest of their lives."

Availability and Cost Issues

The perceived unavailability of child care centers also contributed to parents' selection of license-exempt care providers. In some cases, feelings about center unavailability were fairly

vague and reflected beliefs that center care was not available in the community or else would be too expensive. As one provider said, "Well, I haven't chosen a licensed place because he's going to be – he's just three. He's three years old now, and most day cares probably don't have room for him." Others more specifically indicated that costs of child care centers, licensed homes or license-exempt providers other than the ones they were using simply were too high.

> *"It's kind of hard to find somebody to watch your kids, especially when they're not licensed and they want to pay $9.74 for however many hours. I work eight hours, plus my lunch is an hour in between, so I'm gone about nine and one-half hours a day. That's a dollar an hour. Who are you going to find to pay – that's going to accept a dollar an hour to watch your kids. They're going to resent your child more than likely."*
>
> *"I don't think I could get anybody else to watch my kids, for that amount of money that the program pays."*
>
> *"I think the biggest thing is, honestly though, besides the trust issue is that the cost issue is just so different… I mean, there was a difference between like $50 a week to $185 a week or something for two kids."*
>
> *"If it wasn't about the money, and I found a good day care, I wouldn't say I wouldn't put my baby in a licensed day care. As long as they're good and it's convenient for me. If it's like convenient at the time, more than likely I would put them in, if money wasn't the issue."*

Because parent co-pays in the subsidy program are the same regardless of whether a license-exempt or licensed provider was used, it was not clear that parents fully understood the cost implications associated with choosing a provider. However, many parents also indicated that there was greater flexibility in whether and when the co-pay was collected. (For additional discussion of this issue, see "Co-payment Issues" on page 135.)

In addition, several parents stated that charges assessed by centers when parents were late in picking up their children could be burdensome. As one parent complained, "Whatever you put on your application, that's when they expect you to pick up your son… if you're 10 minutes late, that's an extra five dollars or an extra eight dollars."

Concerns about Children's Specific Care Needs

A final set of caregiver choice factors mentioned by a small group of participants pertained to particular care needs they saw for their children. For example, one parent indicated that her child had special needs that best could be met in a home-based setting, while another believed that a child care center might not be willing to take her child because of the child's behavior problems. A few parents also worried about what their children might be expected to do or what they might learn in a center. Such concerns were obviated by the choice of a relative caregiver in a home setting, which corresponds to the previously discussed issue of choosing a trusted provider.

"And something I really don't feel comfortable with is her being around other people. Because my mother knows a lot about what's wrong with her. She has asthma. And she has a machine at home."

Interacting with License-Exempt Caregivers: The Parental Perspective

Most parents expressed a high degree of satisfaction with their care arrangements, and relatively few indicated that they would like to change caregivers. Even though the parents typically had indicated that their pre-existing relationships had been an important factor in selecting their provider, we thought that exploring whether the addition of caregiving interactions affected these relationships would be useful. In addition, each parent group included discussions of how parents tried to resolve any caregiving disagreements that they might encounter with their providers.

Perceived Effects of License-Exempt Caregiving on Relationships with Providers

Those focus group participants who had pre-existing relationships with their provider were asked if that relationship had changed in any way as the result of the caregiving experience. While most parents did not note any differences in relationships, a substantial number suggested that changes had occurred. Changes most often were seen in a positive light, and generally reflected a closer relationship based on a mutual interest in caring for the child. In particular, several parents stated that collaborating with and observing the provider in the caregiving situation had enhanced their appreciation of the person. This reaction appeared especially common in care arrangements in which the grandparent was the caregiver.

"As for me and my mom, I mean, before the kids, we saw less of each other. And now its like – she has them all the time. And they're a major part of her life. And we always have time for that conversation. Just like picking them up or dropping them off, you have that time for conversation. So it's brought us closer."

"Because it opens up communications in the areas that you may not have ever had it before… They just want to know how the kids are doing. Basically my mom is involved. And so she's telling me a lot more than I'm telling her in most cases. So we have to spend more time communicating with one another. And I think that's just made it easier for us to talk to one another – be more open about things. So it's a nice side effect."

Parents who indicated that pre-existing relationships had been strained by the caregiving experience generally focused upon disagreements regarding the care of the child. For example, two parents spoke of their difficulties in establishing the limits of their caregivers' responsibility for the children.

"If I'm there and she's disciplining one of the kids, sometimes I'll get upset with her for that. 'I'm right here – you don't have to do that while I'm here.' And if I'm there and she's just visiting, she tends to take over sometimes. And we have to discuss it. But it never causes any serous problems."

"Its good, but I mean, it's kind of divided a little bit because of the fact that she's grandma and I'm mom now. And you know, its like whenever I make a decision, it's always something different or turned around. So I mean, it's kind of like we're still close, but there's that little fine line – that neither of us crosses."

<u>*Disagreements and Dispute Resolutions*</u>

Parents were asked if they ever had disagreements or problems with their caregivers regarding how care was being provided, and if so, how these disputes were resolved. Most participants indicated that they had no such care difficulties, and they typically suggested this was because they shared a common care philosophy with the provider. Disagreements regarding how strictly to discipline children were perhaps the most common problem mentioned. Several parents believed that the caregiver was not strict enough with their children, or else spoiled them. The caregivers in these situations frequently were grandparents.

Some parents indicated that providers were unreceptive to their attempts to change selected caregiving practices, while others complained that providers did not always follow through on their care instructions. For example, one parent said "She grandma. So when you come to her and try to discuss it [differences of opinion regarding care] with her, then it's 'I raised you and you made it through 33 years.' So you just kind of let it go." Another parent discussed with irritation how her provider tried to tell her how to care for her child.

"She tried to tell me what to put on my child. Like clothes… then when I get home from work, my baby's kind of messy and food is everywhere. Then she tells me to put on some old clothes and clean her back up."

There were few complaints like the one above concerning dissatisfaction with the level of basic care children received, and dissatisfaction with other specific aspects of caregiving also was uncommon. One parent was displeased because the provider maintained a different care schedule than had been agreed to, which created scheduling difficulties for the family. Another was dissatisfied with her provider's follow-through in working with her children on homework.

"Because a lot of times he let's them slack off with everything. I give them work every day - four or five pages of work to do. When I get off work, that work better be done. And sometimes he tells me, 'They need to rest'. No, they don't need to rest. If they need to rest, then your pocket needs to rest. Because I'm not going to pay you, if you're not letting them do what they're supposed to do. Because they're still growing, and I don't want them growing up not knowing."

Most of these disagreements did not appear to be of sufficient magnitude to jeopardize the caregiving situation. When asked how they sought to resolve disputes with caregivers, one response was simply to "let it slide". In addition, some parents indicated that they could approach providers fairly directly about any care disagreements: "I feel like if I have a problem, I can go directly to her."

The Motivations for License-Exempt Caregiving: How and Why Do License-Exempt Care Providers Become Involved in the ICCP?

Understanding how and why license-exempt providers become involved in caregiving can provide useful information about both the strengths and limitations of subsidized license-exempt child care. Provider motivations are especially helpful in assessing the extent to which subsidies may lead to an extension and improvement of care, as opposed to merely offering public funding for care that would be provided voluntarily if subsidies were unavailable. Provider perspectives in this respect also may assist in identifying ways in which public policy can best reinforce license-exempt caregiving efforts. Given these possibilities, the license-exempt care provider focus groups included discussions about how providers entered their current caregiving situation, what motivated them to provide care, and what they viewed as the most positive and negative aspects of caregiving.

The Initiation of Caregiving

The focus group participants had followed a variety of pathways in becoming subsidized license-exempt care providers. Particularly among grandparents, it was common for a relative to have already been providing care before receiving the ICCP subsidy. Many of these providers had cared for the children for a long time; one common occurrence was for the provider to have begun caring for the child soon after birth so that the mother could return to work. In these cases, the parent generally later learned about the ICCP and then took the steps needed to apply for the program and have subsidy payments initiated.

The extent to which the provision of subsidies affected the license-exempt caregiving situation among those who already had been providing care was not always clear. In some such cases, again particularly among relatives, it appeared that caregivers would have continued to offer care indefinitely regardless of the subsidy provisions. The following comments illustrate provider perspectives for this subset of caregivers:

> *"I've been babysitting my oldest niece for eight years now – ever since she was an infant"*
>
> *"I started helping out when she [the mother] went to work, and of course that was freebies, because I was grandma and when child care kicked in about two and a half years ago and we found out about it, we applied for it and it does help."*
>
> *"I believe I'd been doing it for about a year and my daughter said 'well mama, there's other grandparents that are getting paid for it, so you might as well.' I didn't feel like I should be getting paid for this because these are my grandchildren. But she said 'well, they've got this program for providers – go ahead and sign up and maybe you might get on.'"*

Many of those providers who said they would provide care regardless of the availability of subsidies nonetheless felt that subsidies enhanced the quality of care they could provide. In fact, given the low level of the subsidy payments, some participants viewed the subsidies solely in

quality enhancement terms. Although the subsidy levels were considered unsatisfactory by most providers (see "Provider and Parent Recommendations for ICCP Changes", page 145), the ability to use the subsidies to purchase items such as food, books, or toys was considered especially important given the limited incomes of many parents and providers.

Another sub-group of focus group participants, who were more often non-relatives, had been involved in child care provision for some time, both through private payments or through other child care programs. For these providers, the development of ICCP was seen as another vehicle to allow them to continue or expand their child care provision.

Still others appeared to have entered child care largely because of the program. Many of these participants viewed the program as a viable opportunity to earn money. Some of these caregivers heard about the program through word of mouth in their neighborhoods or from friends. TANF stimulated at least a portion of this group, because TANF work requirements led both to pressures for sustainable employment situations and to greater demands for child care. In fact, some providers had learned of the program through their TANF caseworkers. In other cases, the parents recruited the caregiver after being told about the program by their TANF caseworkers. As one grandmother who provided license-exempt care said:

> *"My daughter graduated out of high school and TANF got her a job… they got her a job working for pay, and then the people ended up hiring her…. And seeing as my grandchild was living with me already, it didn't make any sense for them to send her out of the home. That's how I got into this."*

Caregiving Motivations and Most-Liked Aspects of Caregiving

Focus group participants were asked to discuss the primary reason they had become involved in providing child care, as well as to identify the aspect of caregiving they found most rewarding. Participants most often spoke of their enjoyment of caring for children as their greatest gratification in being a child care provider. The reasons offered for this enjoyment varied. Some participants simply obtained satisfaction from being around and interacting with children. Not surprisingly, these motivations seemed particularly strong among the many grandparents who attended the groups. The following comments were typical in this respect.

> *"I love being with them, and I love to influence them in any way that I can."*

> *"I would miss her if I didn't have her. It's just a joy to, you know… she's all excited when she comes in and then whenever her mommy comes to get her, she's excited to see her… and I just get to see all of this."*

> *"I really enjoy working with them – just as if they was my own."*

Others stressed that they liked watching children grow and develop. These participants emphasized the teaching role they played in assisting children's development. Such developmental interests ranged from helping children learn basic tasks, to educational learning such as the alphabet or reading, to character development. (For further discussion of provider

teaching roles, see "The Role of Teaching and Nurturance" on page 138 and "Character Development and Role Modeling" on page 139.)

In discussing the reasons that teaching children served as a motivation for providing care, some providers indicated that they wanted to impart their own values or knowledge on the children they cared for. In some cases, providers thought they were in a better position to teach children in their care than the child's parents were, either because of the greater amount of time they spent with the children or because of perceived deficiencies in the care provided by parents.

Another set of care motivations revolved around a desire to help the parents. Given that most focus group providers had some pre-existing relationship with the parents, many had become involved in caregiving out of a sense of obligation or a desire to assist a relative or friend in need. Many of these caregivers also enjoyed caring for children, so helping the parent corresponded well with their own interests.

> *"I'm very happy with the program, and my enjoyment is just knowing that I'm helping her out… she's a single mom… I have them a couple of days a week, and then she has her mom do it one day and her dad do it one day a week, so just knowing I can fill in when she needs me…"*

> *"The way I got started was that this lady and her family kind of broke up, and she was abandoned at the time that she had to go back to work. So by me being there – and I'm a stay at home mom – I just went ahead and took responsibility. She works overnight, so it's kind of difficult to leave your child overnight with someone you don't know."*

> *"I was babysitting one girl that basically was living in a house that didn't have any heat or anything, and she needed a job and didn't have any money. And nobody knew about CCR&R at that time, and I just kind of gradually started taking care of the kid, so that she could go to work. And then she found CCR&R, so that's how I got involved."*

> *"I've been taking care of my grandson since December. My daughter got a divorce and she had to go back to work, so I'm trying to take care of him."*

In some cases, a sense of obligation to the parent seemed predominant, and it was questionable if caregiving otherwise would have occurred. As one grandparent said:

> *"My daughter is kind of trapped and my mother don't feel good. And so I do it, because you know it's the family and stuff. No, it's not something I would seek personally."*

Both relative and non-relative caregivers mentioned both the child-related and parent-related caregiving motives discussed above. Nonetheless, these factors often seemed particularly strong among grandparents. Caring for their grandchildren was seen as very fulfilling by most grandparents in our groups, and many also felt a sense of responsibility to do so in order to support their children as they juggled work and child-rearing responsibilities.

One interesting result from the focus groups concerned participants' emphasis on providing care that helped children and parents in troubled families and communities. This motivation, which has received little attention in the literature, typically infused a sense of importance for the caregiver in the work. In some cases, providers emphasized that parents had personal difficulties and were not well equipped to raise their children. These providers often prided themselves on offering structure and stability to the lives of children they cared for, which they contended would be absent otherwise. Male providers also spoke of the value of providing a role model or "father figure" in homes where fathers were absent and not involved in the lives of their children.

> *"This has become very satisfying… it appears that we are getting closer and closer together… you can talk to me about anything and everything …. The problems that you're having at school, girls, whatever – I've been there, done that. And now he's beginning to understand. Certainly there's been disappointments, but they are the minimum when I see what he is doing now."*

> *"They're a blessing. I mean, you're not only sometimes helping kids that come from homes that are in the middle of divorces, or single parents or whatever… and you're stable because you've got the same set of rules. You know that no matter what their outside life is like, you're there with hugs and kisses and something to drink, and you know they'll give you love back."*

> *"I think the thing I like most is the influence – I do get to take kids to church and just get them exposed to a lot of things. Right now, they're playing basketball as we speak. They're playing with my kids, too, on a team… it's taken them out of a negative situation."*

> *"Grandpa and I had to bring them up better than what the mother's doing. We take them to church and Sunday school, and we provide them with places to go and things to do during the summer."*

Many providers also recognized the economic difficulties that the parents they served were experiencing, and they viewed themselves as a vital source of support as parents struggled to sustain their families. For example, working mothers sometimes were portrayed as being so consumed with earning enough money to make ends meet that they had limited time and energy to spend with their children. Providers felt that they provided substitute parenting in many of these cases, and that their caregiving provided more focused and consistent attention for the children than was possible by the parent.

> *"I can be the teacher and things that I know his mother don't have the time for, or that people her age don't do."*

> *"We teach them more than the parents will, because we have them more… they didn't have parents [around] really that much. So the values that they have are really not their parents – they're yours, because you have them."*

The sense of providing care for children in troubled families was elevated by concerns about the neighborhoods in which many parents and providers lived. Providers frequently stressed the importance of protecting children from bad neighborhood influences, as well as for the need to provide positive alternatives, direction, and role modeling. The daily presence of violence, substance abuse, and other indicators of personal and community dysfunction in some neighborhoods provided continual reminders to caregivers of the importance of their work.

Caregiving also seemed to correspond well with the personal needs or desires of the provider. For example, several providers emphasized that they enjoyed the companionship that children in their care offered, and one provider viewed caregiving as a substitute for not having any children of her own. In addition, providers sometimes mentioned that the children they cared for kept them active and busy. Caregiving also was consistent with the desire of some providers to remain at home, either for health-related or other reasons.

> *"I enjoy caring for my grandbabies – I just love them to death. I enjoy it, because if I wasn't babysitting, I would be home alone by myself – I'd be bored to death."*
>
> *"I really enjoy it – being at home. Because my husband, well I have to stay home really. Because my husband has congestive heart failure and that gives me time with him. And when kids are there, it keeps him going, and he's happy. He's like in another world."*
>
> *"I don't have no time for myself, but that's o.k., because I love children. I don't have none of my own, and I told my sister – I said 'thank you very much', because I don't have children of my own, so they're like my little ones that belong to me. So I really enjoy being there."*
>
> *"He's not really a bad child, and I enjoy it… it keeps you young. It keeps you going, you know, it keeps you moving… you have to be ready and it's a beautiful thing."*

Problems Facing License-Exempt Caregivers

All provider groups included discussions about the aspects of caregiving that participants considered to be the most difficult. We asked members to focus on difficulties in providing care per se, as opposed to shortcomings that they may have observed in the subsidy program. (These latter issues are discussed in the section on "Provider and Parent Recommendations for ICCP Changes" on page 145.) In general, difficulties in providing care were less often mentioned than positive aspects of caregiving. In fact, many group members did not identify anything that they found to be difficult or undesirable about providing care.

Nonetheless, several issues emerged that are useful in understanding strains on license-exempt caregivers. Group members mentioned three principal types of problems. First, they sometimes spoke of issues specifically related to providing care for children, without reference to issues with their parents. Second, participants discussed how child care difficulties could be affected by the actions of the parents or by differing parental and provider philosophies regarding how children should be cared for. Finally, they raised issues that pertained solely to interactions with the parents.

Although a few participants only half-jokingly indicated that what they most liked about being a child care provider was when "the kids went home," providers generally did not emphasize specific child-related difficulties they experienced in providing care. The most common problems mentioned concerned getting children to listen to them or to get along with one another, as well as issues of when and how to discipline children. In some instances, frustrations with problem behaviors were seen simply as inevitable problems that arose when children interacted. In other cases, the provider at least partially blamed problems they had with children on the parents.

> *"[the mother] is very soft. She lets him get away with everything. They stomp, they holler, they do everything to her."*

> *"I have a hard time ... they talk different at home than they talk at grandma's. That's hard, because I always have to correct them with their English. They know how to speak – it's just when they're home they can speak slang, whatever they want."*

Disciplinary issues centered on the providers' comfort level with exercising discipline with children, their compatibility with parents in disciplinary practices, and their concern that such practices comported with societal expectations. Some providers did not seem to have problems regarding when and how they disciplined children, but others expressed reservations about their ability or inclination to do so. The need for disciplinary practices to conform to parental expectations was more often mentioned. The following quotes are illustrative of the concerns raised by those participants who expressed reservations about disciplining children in care.

> *"I think one [problem] is the boundary of when you discipline them – whether the parents are going to respond to them in that way or in a different fashion."*

> *"I guess I should feel very qualified to do what I do now, but there are some built-in problems when you're dealing with someone else's kids. Because I find myself wondering how far to go or if I've gone overboard in my discipline…"*

> *"I run into some problems, but you've got to remember that they're the parents. So whatever they say, sometimes you've got to let it go."*

Nonetheless, many providers made it clear that when the child was in their care, decisions about proper disciplinary procedures resided with them. This was a point that apparently often was made clear to the parents, and sometimes may have reflected extended authority structures in families when grandparents were the caregivers.

> *"I just do it my way – I'm mom. Hey, they can fire me if they want to, but they're o.k... We may not agree on some things, but basically they know what I'm doing is right."*

> *"I don't have a problem with my daughter, because I keep the kids all the time and I've had them since birth and I've never had a problem [with them] acting up. I tell them [the parents] how, if I can't chastise your child, then you find another sitter."*

In addition to disciplinary matters, providers also complained more generally that selected parental child-rearing practices were inconsistent with how the child was treated when in the provider's care. Not surprisingly, providers felt that the inconsistency resulted from parental practices that had adverse effects on children. Such complaints pertained to basic care practices such as feeding, and to behavioral issues as well. From the provider perspective, these inconsistent and undesirable parental practices were unhealthy for the child, and also made it more difficult to provide care as children struggled with changing expectations.

> *"I'm real big on, you know, what I give my kids to eat and what they eat and how it affects their behaviors… she happens to bring them over and they've had junk food or candy, and that really affects their moods. And it's just hard for me to tell her – 'feed them good food, it changes the way they act.'"*

> *"Quality time to me is just what it is – spending time with them, giving them me so they know they have me and I'm paying full attention to them and they don't have to worry about what they're gonna be doing or anything like that. They know grandma's there. I try to explain that to my daughter – she thinks time for the kids is playing and things and that's what everything's about. And I said, 'no, give them you and they'll be tickled to death. It's not what you buy them, because you can get anybody to buy kids things…'"*

Providers also had difficulties in dealing with parents on issues that did not pertain to the actual care provided. Probably the most common complaint in this respect concerned the tendency of parents to be late in picking up their children or to not keep the provider well informed of the needed care schedule. Some providers also indicated that parents did not bother to call to inform them when they would be late. Providers recognized that late pick-ups generally were not tolerated in child care centers, and that substantial late charges often were levied. Thus, the failure to communicate with providers concerning schedule changes not only was viewed as a practical problem for providers, but also sometimes created the sense that they were being taken advantage of. The fact that providers typically were relatives or friends probably accentuated this feeling, and in some cases led to a broader questioning of the parenting performance or general behavior of the parent.

> *"It's a lack of calling and letting me know that you're going to be here for the kids, you know, at a certain time, because I got something to do.*

> *"That's the only bad part about it. Everything else is lovable. But they don't want to come and get them on time."*

> *"There ain't nothing bad with me and my grandkids. The only bad spot I've got with that is my daughter. She will not come home and it's tiring. It's tiring us out, babysitting."*

Some providers also felt taken advantage of because they thought parental expectations for care had risen once the provider started receiving subsidy payments. While this would be considered a desirable aspect of a subsidy program within well-defined boundaries, the rising expectations sometimes appeared to extend beyond reasonable program expectations. In particular, two

providers spoke of increasing demands from parents to provide care beyond what the subsidy was paying for.

> *"Well, they think because you get this stipend that you're obligated to keep them until they are ready to come get them. They don't look at the time clock, you know, like child care pays you for four hours a day or even for a full day, or whatever. They don't realize you worked your eight hours and I was here taking care of your child, and now that your eight hours is up your obligated to come get him – not to go like shop."*

> *"My daughter [says] 'Momma, why should you want to charge me [when she works late], when these are your grandchildren?' I said, 'but they're not my birthly children. I had to pay for you. You've got to pay for them… even though I'm grandma, you still have to pay. Nothing comes free…'"*

Finally, it was clear that providers sometimes experienced periods when caregiving was especially tiring or stressful. Consistent with the previously mentioned relief that occurred "when the children went home", some providers indicated that it would be very helpful to receive at least occasional breaks in caring for children. This is an area in which they thought the subsidy program might be helpful, either by providing resources for back-up caregivers or access to more programming for children in their communities. This is an issue to which we will return in discussing possible program revisions suggested by parents and providers. (For further discussion, see section on "Provider and Parent Recommendations for ICCP Changes" on page 145.)

Relationship Strains Resulting from Caregiving Interactions

Providers also were asked more directly about strains in relationships with parents that resulted from the caregiving situation. Most providers did not report any specific difficulties in this respect. However, a few relative caregivers indicated that they did not feel appreciated by the parents. This may be a sentiment more common to relative than to non-relative caregivers, because of the mix of voluntary and paid care in which relatives commonly engage.

Some providers also spoke of tensions with the parent that arose because of parental perceptions of their children's' relationship with the provider. In particular, there was a feeling that parents sometimes became jealous of providers, because the child came to identify more with the provider than with the parent. Similarly, parents were at times perceived as resenting what the caregiver did with or for the child, due to the parents' inability to do as much. As one grandmother caregiver stated:

> *"My daughter, she's twenty-five… her daughter went and told her that she respects me more than she respects her own mother."*

Another non-relative provider added:

> *"Sometimes he [the child] looks more to me than to his own mother. And when that kid slipped the other day, he said '[provider's name] can I call you mommy?' And the*

mother told me that the child says that 'you do more for me than my own mother and my own father.' You see, they're in the middle of a divorce and my husband has been there more for him than his own dad …"

Co-payment Issues

Perspectives on parent co-payments varied considerably in our groups. At the most basic level, a minority of providers was not even aware that they were supposed to receive parent co-payments. Another subset of participants was aware of the co-payments but never received them.

Participants offered several reasons in explaining why they did not receive co-payments. In some cases, non-receipt of co-payments was a source of frustration, and did not represent a voluntary choice by the provider. Some of these providers indicated that they simply had difficulty in collecting the co-payment from parents, or that they were afraid to ask for payment. As one said, "I didn't make the decision [not to collect the co-payment]. I just didn't have the guts to ask." These difficulties sometimes were complicated by the fact that the parents for whom they provided care were relatives or friends. Frustration at times was exacerbated by perceptions that the inability of parents to make co-payments resulted at least partially from money management shortcomings. For example, one provider noted, "If I look at how they spend it, it ticks me off."

Some group members indicated that they voluntarily chose not to collect co-payments. This sometimes resulted from co-habitation or other arrangements in which the providers shared expenses with parents. Others did not pursue co-payments as a result of sympathy for the parent. These providers viewed the parents as needing the money more than they did, and some providers expressed the hope that parents who did not make co-payments would spend at least part of this money on their children.

"I told her, 'you don't have to pay me. Just spend it on the boy, that's all I ask, for you to take the money and spend it on the boy.'"

Many other providers did collect co-payments. However, even in these cases, payments often were irregular. Particularly among those who provided care for relatives, the collection of co-payments was viewed as an informal family matter. The payments in such cases often were collected only when the parent was seen as being able to afford it, and the payment rates were negotiated below the level stipulated by the program.

"No [I don't collect it regularly], because if I run short and I need something and she does got it, I've got no problem getting it – it's a family deal… as far as getting it on time, every time, no, it's no big deal to me."

In addition, providers who collected the co-payment sometimes indicated that the money went back to the children or parents, in the form of food, clothing, or other goods that they purchased. As one provider said, "My daughter gives me mine, but it goes right back to her… to me, its considered as a loan, because we do for each other."

Providers recognized that this irregular co-payment pattern differentiated their caregiving from licensed arrangements such as child care centers. That is, they knew that parents would not be allowed to continue receiving care at the child care center if they did not make required co-payments in a timely manner. Yet, only a few group members suggested that they had established rigorous procedures for assuring the routine collection of co-payments. For example, one participant had initiated the practice of collecting the entire cost (subsidy plus co-payment) of the care provision from the parent before the subsidy amount was received from the state, and then reimbursing the parent after the state subsidy check arrived.

Factors Considered Important in Contributing to Quality of Care

Both parents and providers were asked about the factors they considered to be most important in contributing to the quality of care that children received. Group members defined a wide-ranging set of factors, including health and safety concerns, teaching, nurturance, interaction with other children, and personalized attention. The quality of care factors suggested by parents often corresponded closely with the reasons they offered for choosing a license-exempt caregiver. Likewise, provider discussions of quality of care issues sometimes dovetailed with their perceptions of the most positive aspects of caregiving. These and other factors will be explored in this section.

Personalized Attention and Care

In discussing child care quality, both parents and providers emphasized the close personal relationships between children and their license-exempt caregivers. They stressed that such loving and nurturing relationships set the framework or foundation for interactions with the child, and hence were a necessary prerequisite to accomplishing other developmental goals with children. They felt that license-exempt caregiver involvement with children often contrasted with what they viewed as less consistent and less personalized interactions in child care centers. (For further discussion of perceptions of license-exempt care versus care in licensed settings, see section on "Quality of Care Comparisons of License-Exempt Care with Licensed Care" on page 140.) The following quotes illustrate several of these points.

> *"It takes patience, it takes love, and you have to have time for attention."*

> *"It's the individual attention… it's only three kids, versus in a child care center there probably would be a whole lot more, so it's cool because I can give them the personal attention that they need."*

> *"Well, I want to know that they're getting played with. And they're being like, read to. And that they have attention – that they're getting attention from whoever is watching them. They're not just being shoved in a corner. So they have some interactions. And if they have questions, they have someone they can go to with them. They have people that genuinely care about kids"*

> *"I know my mom spends a lot of time with her – like reading to her and playing with her. She don't just toss her aside."*

"I know she loves them. She doesn't just care for them – she loves them."

Parents sometimes indicated that the provider they had selected was best qualified to provide personalized attention. This belief typically stemmed from the fact that the child and the provider had a relationship that extended beyond the caregiving situation, such as in the case of relatives.

"Well, I think because she's got a personal investment in the situation – they're her grandchildren. So of course she cares about how they turn out. So that helps."

"I mean they're related to the child or it's your friend's child, you know, so they care. They actually care."

Some parents also highlighted their own pre-existing relationship with the provider. This both provided them with confidence about the caregiver's ability to provide personalized care for their children, and also re-assured them that the provider would share their views about how best to raise children.

"If you already know how that person is, that's a big part of the problem right there – is knowing people. You can be around a person all your life and not know them. But if you don't know your mother, there's something wrong."

"My sister – she has no children, and she raises my children as if they were hers. When I'm not there, her motherly instinct takes over there. So I grew up with my sister, all our lives. So I know her, she knows me, and my kids look to her as a second mom."

The personalized attention provided by license-exempt care providers also was seen as fostering greater consistency in the manner in which children were cared for. That is, parents mentioned that children tended to be treated consistently in license-exempt care settings, because they regularly interacted with the same provider.

"I think it's more personal – that it's somebody they know who actually cares about them, not just somebody who's been told 'O.K., if this happens you're going to do this to the kid because that's how it's supposed to work.' Somebody who actually is in there, like all the time – cares about them. Loves them because they are a relative. Who's going to be more personal about it, rather than just 'O.K. you have to do this because this is what I've been trained to tell you to do.'"

<u>*Caring for Children in Their Own Homes*</u>

A few participants also suggested that the developmental needs of children were best met through care in their own homes. This preference at times was based on the belief that children learn best in their own surroundings or environment, or else that starting to teach children in the home would better prepare them for the time when they moved to school and other settings outside of the home.

"You got to teach them at home. I don't expect the daycare to teach my kids stuff like that. You got to teach them at home, so that when they go, they can already know. And they can continue teaching it. Because my kids haven't been in day care. And they share and they're polite and they wash their hands and stuff like that."

In other cases, thoughts that home-based care resulted in quality of care seemed based more on parental concerns that their children would be intimidated in care settings outside the home, or else would learn undesirable behaviors from other children.

"My daughter cries when I leave her with someone who's not part of the family."

"If she really don't want to stay around no one that she really don't know that well, she will run from them."

The Role of Teaching and Nurturance

Group members discussed a variety of teaching roles for caregivers, ranging from traditional educational concerns, to safety issues, to social skills and character development. While parental emphases on teaching varied considerably, many parents recognized the importance of their children learning while in child care. As one parent summarized, "I don't want them to be behind. Somebody is always going to be above them, but I want them to be at least average." Not surprisingly, teaching issues were seen as varying somewhat depending upon the age of the children. For example, in discussing the care of very young children, the importance of teaching children how to perform basic tasks such as toilet training and learning how to feed themselves was stressed.

For children reaching pre-school age, as well as for older children, attention shifted more to educational issues. Several providers indicated that it was important to read to or with children in care, as well as to assist them with their homework. Many parents likewise emphasized the importance of the child care setting in providing their children with learning opportunities.

"That's one thing about my mother that I know is a big thing. She used to always read to me when I was little. So I know she's working with [my children] every day, as far as helping with the language development and that sort of thing. That's very, very important to me."

"She [the license-exempt care provider] works with them a lot. She loves to count with them. She loves singing her ABCs."

"Because he's learning something every day, and he's showing me… And he knows stuff like his numbers and colors. Then I know he's not just sitting around everyday, not doing something."

The importance of teaching social skills was another aspect of care mentioned by some parents and providers. The caregiving situation was seen as providing an important opportunity to teach children about proper modes of interaction both with other children and with adults.

"Teaching kids how to play with other little kids without everything being a fight. Because it's a big deal, especially since she's got a little brother and he's a baby. That's one thing about my mother [as provider] – I don't have to question any of that. I don't have to wonder if any of that sort of thing is being overlooked because there's another emergency going on or there's just too many people around."

"I think good quality child care involves teaching, and it involves discipline and structure to help them with their social skills. I think more importantly than education, [that they need to] have social skills. Because if they don't, when they get to school, no matter how much they know they won't be able to get it across."

Character Development and Role Modeling

Many focus group participants, especially providers, placed importance upon character development in the child care environment. These participants stressed creating a structured and disciplined environment in which children were taught a sense of responsibility and of right and wrong. Some providers mentioned the importance of adult modeling of responsible behavior and the provision of adult friendship with children.

"You have to have control over the children or they're going to control you. And that's why they're having problems in school now – because these kids want control and you have to take that away from them or otherwise they are going to grow up and they are going to be in jail."

It appeared that these attributes were stressed primarily for two reasons. First, providers sometimes juxtaposed the care environment they tried to create with the unstructured and sometimes troubled home environments in which the children they provided care for lived. Second, providers recognized that children in their care often lived in neighborhoods fraught with dangers, and they saw character development and discipline as critical to adaptation and survival.

Assurance that Basic Care is Adequately Provided

Most parents in our focus groups did not seem to be content with defining child care quality simply in terms of basic adequacy of physical care, such as making sure that the child was clean, safe, well-fed, and in a healthy environment. However, several parents did stress these factors. In some cases, the emphasis on these aspects of care appeared related to the difficult circumstances of the parents' work lives. That is, parents indicated that they were extremely tired after working, and wanted to be assured that their children already had their basic needs met when the parent picked them up. They felt that their license-exempt caregivers understood this, and often took extra steps that parents appreciated, such as cleaning up the house or having the kids ready for bed.

Quality of Care Comparisons of License-Exempt Care with Licensed Care

Both public policy discussions and academic research have focused upon the relative merits of license-exempt versus licensed care, and our focus group participants similarly often held strong views on this subject. In most cases, these perspectives appeared to be based on personal experience with one or more of these forms of care, or the experiences of relatives or friends. Most parents in the groups favored license-exempt arrangements over child care settings, so their choices of license-exempt care providers usually represented a satisfactory option rather than being driven by the unavailability of licensed care settings or by economic factors. Parental comparisons of license-exempt versus licensed care situations also overlapped considerably with their discussions about why they had chosen their current license-exempt provider. Nonetheless, discussions of the relative merits of license-exempt versus licensed care were more general in nature, and a subset of participants did see selected advantages of licensed care settings.

Several distinct factors were thought to favor license-exempt care situations when compared to care in centers. Participants most often mentioned that they believed that children received more personalized attention in license-exempt care settings. Several different reasons were offered as to why this was the case. Most prominent among these was that children enjoyed special relationships with their license-exempt caregiver. This appeared especially important in care situations in which the caregiver was a relative or close friend. However, the perceived higher child to staff ratios in centers, as well as staff turnover in centers, also were said to favor more personalized relationships in license-exempt settings.

For some participants, perceptions about more personalized care in license-exempt settings also resulted in feelings of greater consistency of care and related clearer expectations for children. For example, one participant suggested that parents who used centers could not be sure who was caring for their children on a given day, because of variations in staff scheduling and on-going staff turnover. This was not seen as an issue in license-exempt care settings.

In addition, some parents indicated that they had greater input regarding how their children were cared for in license-exempt settings. This resulted from the often close personal relationships they enjoyed with their care providers, as well as from the belief that child care centers were relatively "fixed" in their program orientations and hence were not particularly interested in parental views about care. Similarly, one provider indicated that it was easier to pinpoint responsibility and to address problems when things went wrong.

We should point out that concerns about lack of parental involvement in care decisions did not extend to focus group parents who had been involved in Head Start programs. These parents emphasized Head Start's requirements for and interest in parental involvement, and they viewed this aspect of Head Start very positively. Nonetheless, respondents generally did not think that comparable interest in parental involvement existed in most licensed care situations.

Parents often referred to the inconvenience and inflexibility of child care centers. Given that many parents worked nights or else had unpredictable work shifts, the fact that centers generally offered care only during regular daytime work hours was of particular concern. The need to pull children from centers when they had even minor illnesses also was viewed as problematic.

Several participants pointed to the cost advantages of license-exempt care. Some cost concerns were voiced in terms of overall costs, while others pertained to more specific differences in license-exempt and licensed care costs. For example, several parents indicated that license-exempt care providers were more willing to accept payment delays when unexpected financial difficulties were encountered. In addition, parents sometimes complained that child care centers rigidly applied late charges even if they were only late by small amounts of time. Such potential tardiness was seen as inevitable by some due to unanticipated overtime work or other circumstances. Similarly, some parents did not like the idea of having to pay the center when the child was sick or when the family went on vacation. The sickness issue was exacerbated by beliefs that children were exposed to more illnesses when in a child care center, and that license-exempt providers could continue caring for children with minor illnesses while centers could not.

These various cost concerns generally did not appear to be the sole or even predominant issue favoring license-exempt care among those participants who mentioned costs. This suggested that, even if the relative cost advantages of license-exempt care were neutralized, most participants would continue to choose license-exempt settings.

While most comparisons of license-exempt versus licensed care did not appear to be based on negative perceptions of child care centers, it was clear that such views existed among a subset of focus group participants. Some thought that centers generally were not clean or else provided poor care, and many seemed to have incorporated media accounts of abuse of children or other scandals in centers into their more general perceptions of center care.

Although both parents and providers in these groups generally favored license-exempt caregiving, they also saw advantages to care in centers. Probably most often mentioned in this respect was that child care centers could provide better educational opportunities, as well as the chance to develop social skills by interacting with other children. Some parents suggested that licensed staff were better trained to work with and teach children. Others felt more generally that licensing served to assure that children would be well cared for. These positive attributes of centers occasionally were coupled with concerns that license-exempt caregivers may not be up to date in terms of educating or teaching children, or that in some cases they might not be as interested in receiving training to improve their skills.

While several parents and providers mentioned these potential advantages of child care centers, others did not accept them. With respect to teaching, some participants thought that the perceived higher levels of individualized attention in license-exempt settings also translated into better learning opportunities. For example, parents argued that it was easier to teach children in smaller groups, and that license-exempt settings provided this opportunity.

Some parents likewise stressed that while child care centers may offer greater potential in terms of the quantity of interaction with other children, the quality of such interactions may be greater in license-exempt settings. This belief at times corresponded with parental interest in developing relationships with siblings or other relatives and friends. It also was driven by more negative concerns about potential undesirable interactions with children or staff in centers.

Finally, while providers in the focus groups typically had minimal formal child care training, several parents and providers spoke of the experience providers had in raising their own children as an important form of training. In fact, such experiences at times were contrasted with the more formal training received by child care center staff.

> *"[you need] experience, because that's where you learn about life."*
> *"The older people don't need training, because they grew up with it, you know. It was instilled in us by our parents."*

> *"I had four children of my own – my youngest child will be 30 years old this year. And, you know, when you have children of your own you will have patience… it takes patience and it takes a good person to care for children. And if you're not a good person or a good parent, don't bother with nobody else's children because you will mistreat them."*

Improving the Quality of Subsidized License-Exempt Care: What Resources Are Needed?

Both parents and providers were asked to discuss what additional resources would result in improved quality in their caregiving situations. Opinions about resource needs fell into several different categories. These included:

- teaching and recreation-related materials and equipment;
- information about available resources and programs;
- idea exchanges, support groups, and arrangements with other providers or with child care staff;
- training on various child care issues;
- information or assistance with licensing; and
- information about how the subsidy program works.

Participants often talked about how educational and recreational materials and activities would improve the quality of care that children receive. Most common in this respect were requests for books and toys. The intent sometimes was to make the homes where care was provided resemble licensed child care settings, with reading and play areas. Lending libraries were seen as a viable mechanism for making such materials available. Some providers had taken advantage of the lending libraries available from the CCR&Rs, but many others did not seem to know that such assistance was available. Others indicated that it was difficult to get to the CCR&Rs to take advantage of available resources.

Some participants also expressed concern about the lack of outdoor or community activities available to children in their neighborhoods. This led to requests for outdoor equipment for the caregivers' homes, as well as for information about activities that might be available in the community. As one provider said, "Just give us a list of things that the kids can do, like if we can take them some place." The need for local governments or service agencies to provide more recreational and other activities for children in the neighborhoods also was mentioned.

Many providers stated that they were interested in receiving training to improve their caregiving expertise. As one provider said:

"I think these day care providers ought to have a trainer – they need some kind of training. I don't think they deserve to be paying people to provide this care and you don't know whether these people got the training or whatever."

While training interests tended to be general in nature, specific recommendations also were offered. For example, several providers stated that safety related training was needed, such as CPR and first aid. Some also indicated a need for safety-related equipment such as gates for hallways, first aid kits, and fire extinguishers.

Other providers emphasized the need for training on various child care issues, such as how to teach and interact with children. As one provider stated simply, "Teach us so that we can teach." Some providers wanted training that would help them in working with children with special needs. In addition, a few providers expressed a desire to learn about computers. This interest was fueled partially by a need to "keep up" with the children they cared for, in that the providers recognized that children were becoming proficient with computers at a very early age.

"I'm an illiterate on the computer… I could probably go to a computer class on my own and therefore be able to assist the children. But they'd probably assist me. They are very knowledgeable."

Another set of concerns was related more to practical issues associated with being a child care provider. At the most basic level, some providers indicated that they would like more information on how the subsidy program operates. The lack of information that many providers had about the program was evidenced by frequent confusion regarding co-payment requirements and other program features. (For a more general discussion of information problems, see section on "Lack of Information about Program Rules" on page 146.) Providers also desired more information about the services and resources that might be available to both parents and providers.

"If people actually knew of the access you all give, and the parents knew it… because even the parents don't know they have access to all this, and I don't know how you go about doing it [informing them]."

Providers indicated that they would like to have more contact with other providers, in order to share information and to exchange ideas. They commonly indicated that they enjoyed the focus group meetings in which they were participating, and thought that similar formats could be used to provide training and to meet with other providers.

"If they had meetings for the providers, they could get together and say, 'well this is what I do with the kids', and another could say what she did. And we could learn about different activities and resources."

"They're [other providers] a big help, you know. You listen to them about how they've raised their children, and maybe you lacked something of that when you raised yours and you can do something differently with these children."

"It does feel good to be able to talk to people, because it does help. Because you do get lonely and think, you know, why did this happen to me? I didn't want this, you know, but it does help to talk to people."

"We had a class at [training site] about grandparents raising grandchildren, and it was very interesting. Sometimes, you feel like you're the only one out there, but you're not… there's a lot of them out there raising their grandchildren…"

"We might have a problem and somebody already dealt with it – been through that. They can give me some pointers on something that I don't know what the deal was."

The development of a more organized system to assist providers with various child care needs also was suggested, as was the establishment of on-line information exchanges to keep providers better informed of opportunities and activities for children. The intent was to network with other providers on areas of mutual concern to create a "provider exchange system of sorts". Such a system also was seen as providing the possibility for developing contacts with back-up providers, which was important to many study participants.

"If you run into a problem, you can count on each other. It might be somebody, you know, that if you had a death in your family and you can't watch the kids, you can call to take over for you that day… Or if one of the kids needs to go to the doctor one day and somebody else has a car available [another provider could help]."

"*We need a way to get a babysitter for the babysitter. That's my big problem. I'm serious… I had to get a babysitter for tonight, you know [to attend the focus group]."*

"I'd like to have day care, because I have an eighteen hour a day day care, and it's hard for me. My mother babysits, but she's 77 and I'm not real comfortable with that… to have day care available would be wonderful."

Provider Aspirations Regarding Licensing

Although most providers did not indicate an interest in becoming licensed, a subset did express aspirations in this respect. However, reservations about or perceived problems in becoming licensed were noted. Several factors contributed to concerns about becoming licensed. For example, one provider suggested that better information about the benefits and responsibilities associated with becoming licensed should be offered, so that providers could make informed choices about whether to pursue the licensing option. Inadequate housing arrangements also were seen as precluding the possibility of licensure, as was the inaccessibility of classes viewed as needed to become licensed.

Given the existence of some of these barriers, one provider suggested that an alternative should be established that paid more than the license-exempt care subsidy rate but less than the licensed rate. Such an alternative was envisioned to require less stringent standards than licensed providers are subject to; however, providers still could be required to complete some basic training in order to receive the higher payment.

Provider and Parent Recommendations for ICCP Changes

Both parents and providers generally appeared to be fairly satisfied with the ICCP. They appreciated that the state was providing subsidies so that children could be adequately cared for while parents worked. Several providers also indicated that the program allowed them to be compensated for work that they enjoyed doing, or more generally that it created work opportunities for persons who needed jobs.

Despite this basic level of satisfaction with the program, focus group participants identified many ways in which they thought the program could be strengthened. Pay-related issues dominated the discussions when participants were asked about the most important things that could be done to improve the subsidy program, and raising the pay levels was easily the most common recommendation among both parents and providers. Comments regarding higher pay levels often simply reflected the belief that the pay level was inadequate for any type of work or to provide a reasonable income.

The low pay levels often seemed to create an undesirable choice in which providers either felt they received inadequate compensation or else had to compromise on the quality of care they wished to provide. For example, some caregivers argued that, by the time they paid for food and other costs associated with child care, they were left with little to show for their efforts. Others argued that they were severely constrained by the pay levels in the activities in which they could engage children, and that pay level increases therefore would translate into quality of care improvements.

Many comments focused on other pay-related issues. Several of these recommendations pertained to specific reimbursements the program might offer providers. For example, it was suggested that the program could reimburse caregivers for the cost of food they provided, or else make them eligible for food programs comparable to those available to licensed providers. Other care-related tasks for which reimbursement was requested included activities for children and costs associated with transporting children to various activities.

Group members also suggested changes in how subsidy payments were calculated for those who were determined eligible. In particular, because the hours of care provided by caregivers varied substantially, some participants advocated calculating pay rates by the hour rather than by the day. Some also viewed varying pay levels by the age of the child as worthy of consideration.

Several changes related to the co-payments were recommended. Many, but not all, participants felt that the co-payments should be reduced or eliminated, because of the poor financial circumstances prevailing for most parents. If co-payments were considered necessary, providers preferred that payments be collected by the state from the parent as a condition of program participation. This was seen as freeing providers from the often awkward and difficult process of obtaining co-payments from the parents, which for relative caregivers can be especially difficult because of on-going relationships beyond child care. This also would allow the providers to receive a single state pay check including the state subsidy and parental co-payments.

Some providers also thought that the co-payment calculation was overly sensitive to temporary shifts in parental incomes. That is, the state pay level was seen as being reduced quickly as parental income increased, even if such increases were temporary. This left the provider in the position of having to ask the parent for higher co-payments in order to maintain their same pay level. If the income increase was temporary, the parent's income may already have decreased back to previous levels by the time that the higher co-payment was established.

A final area of suggested pay-related changes involved the processing of payments. Several providers complained that the payment process was too slow, although the length of payment delays in general did not appear to be extreme. Probably the most common complaint by providers regarding payment processing was that the state did not withhold income taxes from their checks. This left some providers surprised by the amount they owed when it came time to file income taxes. Several providers indicated that it would be preferable for taxes to be withheld. Some providers also advocated a system that would allow the direct deposit of their paychecks.

Issues related to paperwork or interactions with program staff were raised much less often. Providers in one group suggested that meetings with program representatives be held occasionally to address issues such as the proper processing of paperwork. Complaints about interactions with CCR&R staff were not very common, although some providers expressed difficulties in contacting them. Only a few providers indicated that CCR&R staff did not understand the program well, and concerns about poor interpersonal treatment by these staff also were infrequent.

A few group members thought that the state needed to play a stronger role in assuring that providers offered adequate care. For example, one provider recommended that more field workers were needed to make home visits to monitor provider performance.

Lack of Information about Program Rules

The focus groups were not designed to determine how well participants understood various aspects of the ICCP. Nonetheless, participant lack of information and confusion about program rules and benefits were observed in most groups, particularly when discussing needed resources and recommended program changes. Such deficiencies at times made it difficult to discern the extent to which perceptions about the program were biased by inaccurate information.

Several examples of information shortcomings are illustrative. Perhaps most noticeable was lack of knowledge by providers about required parental co-pays. Although the intended co-payment amount appeared on the billing statement they received, many providers did not understand that they were supposed to collect this amount from the parent. Similarly, some parents complained that child care was not available if a parent wanted to pursue education rather than work, but the program allows care for those in educational activities.

Participants raised two issues related to the eligibility of parents to receive subsidy payments that also illustrate a lack of understanding about the ICCP. First, one provider recommended that parents should be eligible to continue receiving subsidies for an extended period if they become

sick or disabled. Yet, parents are eligible to continue receiving subsidies for up to six weeks of medical or maternity leave. Second, Hispanic providers in the South Lawndale neighborhood raised the concern that many parents were denied access to subsidies because they were recent immigrants who had not yet become citizens. Yet, children of immigrants who are citizens, and children who are immigrants and who supply an alien registration number are eligible for a child care subsidy.

There also was confusion about the number of days in a week for which subsidy payments were allowable. Some participants recommended extending the maximum number of days for which subsidies could be provided beyond five days a week, as some parents worked additional days. Yet, there currently are no such day limitations on reimbursement, as long as the parent is working or in school.

As previously mentioned, many providers spoke of the need for lending libraries that offered books and toys for children. Given that the CCR&Rs in each of the study areas had lending libraries, it appeared likely that most of these providers simply did not know that the resources were available. Similarly, in discussing needed program changes, one provider spoke of the need for background checks on license-exempt caregivers, and others spoke of the need for reimbursement for back-up providers. Both of these provisions already existed in ICCP policy.

Chapter 9: Discussion of Interim Findings

This chapter integrates and discusses major findings from the project activities described in this report. For this purpose, we return to the six questions guiding the research project. Because this is an interim report, findings to date are more developed on some questions than on others; we note those instances in which data related to a particular research question have received limited research attention. In addition, it is likely that findings related to each of these questions will be refined as new data are developed through second and third year project activities. The final chapter clarifies how these additional project activities will be structured in the next two years.

Research Question 1: What are the patterns of care for families and children that utilize subsidized license-exempt child care, and how do these differ from families and children that rely on subsidized licensed child care?

Administrative data show that the ICCP is a large and rapidly growing program, with caseload growth of 61 percent between July 1998 and January 2001. The nearly 87,000 families receiving subsidies through the program utilize a variety of licensed and license-exempt care options. For example, for the most recent single time point for which administrative data have been developed (January 2001), 53.5 percent of families receiving subsidies used a single license-exempt provider, 38.6 percent used a single licensed provider, and the remaining 7.8 percent used multiple providers. License-exempt providers cared for an even higher percentage of children receiving subsidies, with 63.9 percent of all children cared for by a single license-exempt provider in January 2001. This higher proportion of children cared for in license exempt settings, when compared to families using such care, results from families with more than one child in care receiving subsidy being more likely than families with one child to use license-exempt providers (See section on Research Question 2 for further elaboration of this difference).

The administrative data for the six time points examined thus far suggest a slight trend toward increasing use of licensed care by families receiving subsidies. That is, the percentage of families receiving subsidies using a licensed provider increased from 38.6 percent in July 1998 to 45.5 percent in January 2001. A portion of this proportional increase resulted from the addition of site-administered, licensed centers to the database beginning in January 2001. The trend will continue to be monitored during the remainder of the project.

Examining subsidy use patterns longitudinally reveals an even greater prevalence of license-exempt care use in the ICCP. Among the 45,054 families that began receiving subsidies in FY 1999, 68.9 percent used at least one subsidized license-exempt provider within two years. Thus, efforts to better understand this form of care, as well as to consider it in ICCP quality improvement initiatives, are vital to the further development of the program.

Longitudinal data also demonstrate that families frequently need to change providers, so that the use of multiple providers over time becomes a modal pattern for families that remain active in the program. For example, for those entering the program in FY 1999, only 10.3 percent had used multiple providers within one quarter. However, among those still active in the eighth quarter after entry, nearly two-thirds (63.3 percent) had used multiple providers. This points to

the need to better understand the reasons for provider changes, and to learn about issues associated with the process of transitioning from one provider to another.

Comparisons between lengths of initial and subsequent spells for families receiving subsidies indicate similar patterns for those using license-exempt and licensed care. The average length of the initial spell for the cohort beginning care in FY 1999 was 10.7 months for families using only license-exempt care and 11.1 months for families using only licensed care. Fairly short initial spell lengths were common among families using each form of care, with 53.4 percent of the families that used only license-exempt caregivers and 48.1 percent of those that used only licensed caregivers having initial spells of six months or less. Families that used both license-exempt and licensed caregivers had longer initial spells, with a spell average of 19.9 months and with two-thirds having initial spells of over a year in length.

Subsequent subsidy use for those cases that close are common, and follow similar patterns for families using license-exempt and licensed care. Analysis of a cohort of 24,542 ICCP cases that closed for the first time in FY 1999 found that 36.6 percent of families that used only license-exempt care and 29.3 percent of families that used only licensed care re-opened within two years. The average time between closing and re-opening was just under five months for each group, and the median time was only three months.

This relatively high frequency of case re-openings raises questions about the reasons that cases close and subsequently re-open, often within short time periods. Both the focus group and staff interview findings suggest that the re-determination process sometimes confuses parents and providers. However, these initial survey and interview efforts provide no basis for quantifying the extent to which such difficulties contribute to case closings and subsequent re-openings, or for understanding other factors that may explain this phenomenon. We will include questions in our survey of parents during the next stage of the study that will explore these issues further, and also will explore this issue through additional administrative data analysis.

Administrative data show that families usually use one of three types of license-exempt care options. Slightly over three-fifths of the nearly 51,000 families using license-exempt care in January 2001 used a relative caregiver, with 37.1 percent using a relative caregiver outside the child's home and 24.4 percent using a relative inside the child's home. The other prevalent form of license-exempt care was by a non-relative in the child's home (34.7 percent of all license-exempt care provision in January 2001). Only 4.9 percent of those families using license exempt care used the fourth allowable type of license-exempt care – license-exempt homes. By adding the percentages of families receiving care from relatives or from non-relatives inside the child's home, it can be seen that nearly three-fifths of the families using license-exempt care in January 2001 received this care in their homes.

Use patterns for these types of license-exempt care vary only slightly by age of the child in care. The greatest differences are between patterns for children under age 1 and those aged 6 and over. While 39.4 percent of children under age 1 using license-exempt providers in January 2001 were cared for in the relative's home, only 32.9 percent of children aged 6 and over were cared for in this setting. In contrast, children under age 1 were less likely than those aged 6 and over to receive care from a non-relative in the child's home (29.9 percent versus 39.6 percent).

Research Question 2: Do parents who use license-exempt care differ in demographic characteristics and other important respects from parents who rely on licensed care?

Administrative data analysis to date provides only limited information differentiating characteristics between families using subsidized license-exempt care and licensed care. We tested for differences based on number of children receiving subsidy in the family and the age of children in subsidized care. One difference found was greater use of licensed providers by families with only one child in subsidized care. About 58 percent of the families with one child receiving subsidy used a single licensed caregiver in January 2001, as compared to 25.1 percent of families with more than one child receiving subsidy in care. This may point to difficulties in finding and scheduling licensed care as the number of children needing care grows. Factors such as differences in the ages of children within families may be important in this respect, and will be explored further in the next stages of the project.

The use of license-exempt versus licensed care in the ICCP also varies according to the age of children in care. In January 2001, for example, license-exempt care was more commonly used than licensed care for each age group. The differences in percentages using license-exempt versus licensed care were slight for children aged 1-<2.5 and aged 2.5-<6. However, license-exempt care was much more likely to be used for children aged 6 and over, with four-fifths of children in these age groups using license-exempt care. License-exempt care also was used by over three-fifths of the infants receiving care through the program.

While comparisons between families using license-exempt care and licensed care are not yet available, additional data have been developed for all families using the ICCP. These data indicate that nearly three-fourths of families using the program have either one (41.5 percent) or two (32.0 percent) children in subsidized care. In January 2001, just over half (53.5 percent) of household heads were in their twenties, and 40.3 percent were aged 30 and over. Administrative data also demonstrate that the program predominantly serves families with very low incomes. Average quarterly income for families using the program in January 2001 was $3,253, which equates to $13,012 annually. Over three-fourths had quarterly incomes less than $5,000.

The low-income characteristics of families using the ICCP are further illustrated by analyses of use of other income-based programs by families that receive subsidies. For example, nearly two-thirds of families receiving subsidies also received either TANF, Medicaid, or Food Stamps in January 2001. Use of these other programs did decline somewhat between July 1998 and January 2001, with the decline most notable in use of TANF by subsidy recipients. While 40.9 percent of families receiving subsidies also were TANF recipients in July 1998, only 17 percent were TANF recipients in January 2001.

Analyses currently are being conducted to determine the proportion of families receiving subsidies that have used TANF and other income-based services in prior years, which will be useful in assessing the extent to which the program continues to serve former TANF recipients versus other low-income families. Later reports also will provide additional information comparing both demographic and economic characteristics of families that use licensed versus license-exempt subsidized care.

Research Question 3: What factors influence families to choose license-exempt child care providers rather than licensed child care providers, or to choose a mix of these provider types?

Parents in the focus groups, key informants, and CCR&R staff were asked about the principal reasons that families select license-exempt caregivers. There was considerable agreement across these groups regarding the most important reasons for license-exempt care choices, and the reasons offered also closely mirrored findings from previous research.

Parents may be influenced by both positive factors and by constraints in selecting caregivers, but positive factors were emphasized in the focus groups and in key informant and CCR&R staff interviews. The trust that parents have in their license-exempt caregivers appeared to be the most important positive factor. Most fundamentally, trust in the caregiver was said to provide a sense of confidence that the child would be safe while in care. It also fostered the belief that providers shared parental philosophies about child-rearing, would closely follow parental wishes about how to care for the child, and were genuinely concerned about the well-being of the children in care. This often led parents to believe that their child would receive higher quality care than would be possible in alternative settings.

The positive relationships that parents often enjoyed with their license-exempt providers also led many parents to believe they would have more input into how their child was cared for. In contrast, some parents spoke of care philosophies as being relatively fixed in child care centers, which provided the belief that parental caregiving perspectives were not needed or encouraged.

Parents, key informants, and CCR&R staff also highlighted the convenient and flexible care provided by license-exempt providers. These care attributes provide tangible benefits for parents often struggling with difficult and non-traditional work schedules. For example, parents talked of transportation time they saved by having their child cared for in their own home or in the home of a nearby relative. Some also spoke of less trouble in terms of getting together toys, books, and other materials that children may need while in care. Even more critical was care that was provided during non-regular or shifting work hours and in emergency situations. Many parents work shifts during hours when other forms of child care simply are not available, and they rely on the willingness of license-exempt caregivers to provide care when unexpected needs arise.

While lack of licensed care contributed to the need for off-hour license-exempt care, it appeared that preferences for license-exempt care may be strong during evening hours even if the supply of licensed care was more plentiful. Even those parents who had positive opinions about child care centers sometimes preferred care in the home by a relative or friend during evening hours. This reassured parents of the safety and comfort of their children during these hours. In addition, care provided in the parent's home or another familiar home was seen as being less disruptive for the children, and parents especially appreciated the convenience of having their children already at home and asleep in their own beds when they returned from work at night. The prevalence of crime and other perceived negative influences in the neighborhoods in which many families receiving subsidies lived also contributed to concerns about where children are cared for during night hours.

Licensed child care supply shortages during traditional care hours were infrequently emphasized by child care professionals as problems that may affect parental choice. There were no consistent geographic differences between the study areas in this respect. However, key informants and CCR&R staff who highlighted supply issues tended to view these as localized to certain communities or neighborhoods. Some key informants and CCR&R staff also viewed information deficiencies about available licensed options as limiting consideration by parents of care alternatives other than license-exempt care.

Cost was another constraint that was seen as contributing to the selection of license-exempt caregivers by the child care professionals and parents interviewed. Although the ICCP provider payment policy was intended to be cost neutral with respect to the selection of a licensed or license-exempt provider, actual cost considerations facing parents often favored license-exempt caregivers for several reasons. First, some licensed child care programs assess registration fees, transportation fees, or supply fees, none of which are covered by the ICCP. Second, child care programs sometimes do not accept the state subsidy payment and parent co-pay as full payment; so parents may be required to pay the child care provider an additional out-of-pocket amount beyond the co-pay amount. Finally, co-payments may be waived by license-exempt caregivers, or at least deferred when parents encounter short-term financial problems. Because licensed child care programs are run as a business and must meet budgeted staffing and other program costs, they rarely have such flexibility.

Some parents and child care professionals also saw cultural issues also as limiting access to licensed care alternatives. Particularly in Hispanic communities and other ethnic neighborhoods with high concentrations of recent immigrants, there were concerns that both lack of knowledge and fears about involvement with formal agencies constrained choice. In these circumstances, parents were seen as favoring license-exempt caregivers, who typically provided a greater sense of cultural comfort.

While positive reasons for choosing a license-exempt caregiver thus were offered most often, the constraints discussed above illustrate some of the important interactions between positive choice factors and the limitations that exist with alternative forms of care. For example, the convenience and flexibility of license-exempt care provision often was contrasted with the lack of these benefits in child care centers, and the costliness of centers sometimes enhanced the relative cost attractiveness of license-exempt care. Our inclination is that most parents in the focus groups would have chosen license-exempt care providers even if some of the constraints of licensed care alternatives were substantially mitigated. However, untangling the interactions between positive and negative choice factors is difficult, and is an important area for further study.

Research Question 4: What are the characteristics and motivations of license-exempt subsidized child care providers, and what levels of experience and training do they have in providing child care?

Limited information on the characteristics of license-exempt caregivers is available from the administrative data. As mentioned earlier, relatives cared for over three-fifths of the children receiving care from license-exempt providers. Over 60 percent of license-exempt providers were caring for only one or two subsidized children, and an additional 22.8 percent were caring for

three subsidized children. This finding of small numbers of subsidized children being cared for by most providers is consistent with the focus group, key informant, and child care professional findings, all of which pointed to the desirability of license-exempt care in terms of low child to caregivers ratios. Previous research similarly has identified such low child to caregiver ratios as an important reason that some parents prefer license-exempt care.

While income data are not available on license-exempt providers receiving subsidies, use of income-based programs by providers is considerably lower than for parents that receive subsidies. For example, 27.2 percent of subsidized license-exempt providers received TANF, Medicaid, or Food Stamps in January 2001, and only 3.1 percent were current TANF recipients. Nonetheless, it is clear that many subsidized license-exempt caregivers have histories of low-income, as evidenced by the nearly 40 percent of providers who received at least one of these three income-based services in the past two years. This underscores the importance of the provision of adequate tangible resources and supports to enrich license-exempt caregiving environments.

The focus groups contained fairly small numbers of participants (n=115), and so cannot be considered representative of all subsidized license-exempt caregivers or parents receiving subsidies that use license-exempt care. Nonetheless, background surveys completed by these participants complement the administrative data, and provide some interesting information that has received only limited attention in previous research. Most notably, the subsidized license-exempt providers in our focus groups generally provided full-time child care, with an average of 34.6 hours per week. Most license-exempt caregivers in our focus groups provided care in the evenings (55.9 percent), and over two-fifths provided care on weekends (42.4 percent). Over half of the parents in our focus groups likewise received evening (40.4 percent) and/or weekend care (14.9 percent) from their license-exempt providers. These data are consistent with focus group discussions and child care professionals findings, as well as previous research, with regard to the importance of license-exempt care for families in need of non-weekday care.

Provider focus groups, as well as the key informant and staff interviews, offer many insights for license-exempt caregiver motivations to provide care. While several consistent motivations were reported by these different study participants, there also were differences. In particular, while child care professionals often emphasized the need to make money as a driving motivation for caregiving, this was mentioned only infrequently by license-exempt providers in the focus groups. Ironically, providers in our focus groups indicated that part of the reason that money was not a major motivator was that the pay level for license-exempt caregiving was so low.

Consistent with the lack of a monetary focus among many license-exempt providers, focus group providers often indicated that they had begun caring for children before receiving the subsidy. This was especially true for grandparents. They also typically indicated that they would continue caring for these children even if they did not receive subsidies. However, parents and providers in our focus groups often suggested that, even in this subset of cases, the subsidy promoted consistency of care and also allowed the purchase of tangible supplies and activities that enhanced the quality of care for children.

In explaining why they were caregivers, focus group providers most often stressed a desire to care for children, and an enjoyment of providing such care. They generally were extremely positive about their roles as license-exempt caregivers. As might be expected, expressions of love for child care were especially common among grandparents and other relatives. The sense of enjoyment in caring for children often included interests in teaching children at various ages, with teaching interests including both basic skill development and acceptable interpersonal behaviors. It also corresponded, especially in grandparents, with perceived caregiver needs to stay active and involved, and to be a part of the child's growing up.

Another provider motivation was helping parents; this motivation likewise was mentioned by many child care professionals interviewed, and is consistent with previous research. Care provision was seen as critical in allowing parents to work while simultaneously assuring that their children received proper care. The interest that caregivers took in intervening with troubled families also was striking. Many providers in our focus groups felt that the parents they were involved with had a difficult time adequately caring for their children, and that the provider's help was vital to improving the quality of daily life for children and their families. The economically disadvantaged neighborhoods in which many families lived, and the accompanying lack of recreational and other constructive activities for children, often accentuated this desire to provide stability and guidance for children. Many providers spoke of their interest in helping shape the character of children, or of serving as role models. Collectively, these factors served as important motivators for a substantial subset of providers, and heightened the sense of accomplishment resulting from their work.

Undesirable aspects of care generally did not counterbalance these positive motivators for care. Although some license-exempt providers in our focus groups spoke of stresses associated with care provision, including both disagreements with parents and difficulties with children, these complaints were relatively few in number and of limited intensity. Thus, we were left with an overriding sense of provider satisfaction with care provision, and of the possibilities of child care policies building upon the many non-monetary positive motivations that appeared to stimulate care provision.

Data on providers' levels of experience and training will be collected during the second and third year project activities.

Research Question 5: How do license-exempt providers, parents using license-exempt care, and community child care professionals describe the quality of license-exempt care? What specific strengths and weaknesses does each group identify with this type of care?

One of the principal concerns of key informants, and of previous research, regarding license-exempt care is the quality of care that children receive in license-exempt settings. Because license-exempt care is not regulated, there often is a perception that it is of lower quality than the care offered in licensed settings. In fact, a growing body of literature highlights the positive developmental outcomes for children attending licensed child care programs rated high on child care quality scales when compared to children attending child care settings rated low on child care quality scales, which typically included license-exempt care (e.g., Fuller & Kagan, 2000; NICHD Early Child Care Research Network, 1996; Cost, Quality, and Child Outcomes Study

Team, 1995). However, the quality assessments in these studies frequently use measures designed for licensed settings, which may not be appropriate for use in license-exempt settings. As a result, it has not been clearly established whether the quality of care in license-exempt settings is actually lower than in licensed settings.

In discussing their perspectives about quality of care in license-exempt settings, few key informants, CCR&R staff, or focus group participants thought that the benefits they believed were offered in license-exempt care settings were substantially offset by losses in quality. Many key informants and a few parents thought the state should do more to stimulate caregivers to become licensed, with the aim of assuring at least minimal training standards, and thus, assumed associated levels of quality. Yet, most key informants and CCR&R resource specialists suggested that child care quality varied widely in both license-exempt and licensed care, and consequently that one could not assume that licensed care quality was consistently better. Several key informants also negatively characterized the quality of care in some licensed child care centers in their area, which contributed to their perspectives. They indicated that they believed there was a quality of care continuum within both licensed and license-exempt care settings, meaning that both licensed child care settings and license-exempt child care settings each had a range of high quality and low quality options within them.

Perceptions about Quality of Care Factors and Related License-Exempt Care Strengths

Because all of the parents in our focus groups were using license-exempt care providers, it should not be surprising that they typically thought that their license-exempt care arrangements were of higher quality than licensed alternatives were. Nonetheless, both the frequency and intensity with which parents spoke of license-exempt quality of care advantages were striking. It seemed that the foundation of such perceptions was the trust that parents had in their providers, which generally had been an important factor in the selection of providers. In general, trust fostered confidence that the provider would care for the child much as the parent would (for additional discussion of the importance of trust, see the discussion under "Research Question 3" in this chapter).

In discussing child care quality, many parents in our focus groups spoke of the more personalized attention they believed occurred in license-exempt caregiving settings. Both parents and providers in our focus groups often emphasized the close personal relationships between children and their license-exempt caregivers. They stressed that such loving and nurturing relationships established a positive framework for interactions with the child, and hence were a necessary prerequisite to accomplishing other developmental goals with children. The personalized attention provided by license-exempt care providers also was seen by parents as fostering greater consistency of care. That is, parents mentioned that children tended to be treated consistently in license-exempt care settings, because they regularly interacted with the same provider. In contrast, both high child to staff ratios and staff turnover were viewed by parents in our focus groups as compromising the consistency of care and the development of personalized caregiving relationships in child care centers.

Providers and CCR&R staff also emphasized the importance of a positive relationship between the parent and provider as a key factor when discussing child care quality. This provided parents

with confidence about the caregiver's ability to provide personalized care for their children, and also assured them that the provider would share their views about how best to raise their children. Both parents and providers often contrasted these personalized care attributes with examples of impersonal and unprofessional care in licensed child care programs, based either on personal experience, word of mouth, or media accounts focusing on child care scandals.

Most parents in our focus groups did not seem content with defining child care quality simply in terms of basic adequacy of physical care, such as making sure that the child was clean, safe, well-fed, and in a healthy environment. However, several parents did stress these factors. In some cases, the emphasis on these aspects of care appeared related to the difficult circumstances of the parents' work lives. That is, parents indicated that they were extremely tired after working, and wanted to be assured that their children had their basic needs met when the parent picked them up. They felt that their license-exempt caregivers understood this, and often took extra steps that parents appreciated, such as cleaning up the house or having the children ready for bed. The importance of having a safe, healthy and clean environment was also mentioned by CCR&R staff as an important quality of care factor in license-exempt settings.

In describing the importance of caregiver interactions to child care quality, CCR&R staff underscored the value of having caregivers who had an interest in caring for children, who interacted warmly with and nurtured the children, and who had access to age appropriate activities for the children in their care. Parents and providers discussed the importance of having a variety of teaching roles for caregivers, ranging from traditional educational concerns, to safety issues, to social skills and character development. While parental emphases on teaching varied considerably, many parents recognized the importance of their children learning while in child care. As one parent summarized, "I don't want them to be behind. Somebody is always going to be above them, but I want them to be at least average."

Not surprisingly, teaching issues were seen as varying somewhat depending upon the age of the children. For example, in discussing the care of very young children, the importance of teaching children how to perform basic tasks such as toilet training and learning how to feed themselves was stressed by parents and providers in our focus groups. For children reaching preschool age, as well as for older children, attention shifted more to educational issues. Several providers indicated that it was important to read to or with children in care, as well as to assist them with their homework. Many parents likewise emphasized the importance of the child care setting in providing their children with learning opportunities.

Another aspect of care mentioned by some parents and providers concerned the teaching of social skills. The caregiving situation was seen as providing an important opportunity to teach children about proper modes of interaction both with other children and with adults. In addition, many focus group participants, especially providers, placed importance upon character development in the child care environment. Focus group participants stressed creating a structured and disciplined environment in which children were taught a sense of responsibility and of right and wrong. Some providers mentioned the importance of adult modeling of responsible behavior and the provision of adult friendship with children.

It appeared that these attributes were stressed primarily for two reasons. First, providers sometimes juxtaposed the care environment they tried to create with the unstructured and sometimes troubled home environments in which the children they provided care for lived. Second, providers recognized negative factors in the neighborhoods in which children they cared for lived, and saw character development and discipline as critical to development and survival.

One quality of care factor considered important to CCR&R staff, but not mentioned by parents and providers in our focus groups, was having a caregiver who has training on caring for children. CCR&R staff believed it was important to child care quality for children to be cared for by someone who had received some minimum training on how to care for children, child development topics, and health and safety topics. In contrast, several parents and providers in the focus groups argued training on how to care for children was unnecessary because the providers had years of experience raising children. Nonetheless, some providers did indicate that they would be interested in receiving more information and resources on caring for children.

It is interesting to note that, for the most part, the quality of care factors mentioned as important by study participants are consistent with the research findings on child care quality indicators. In only a few instances, parents and providers discussed similar factors in slightly different terms from the child care professionals. For example, parents and providers often discussed the importance of safety in terms of protecting children from harm outside of the child care setting (e.g., dangerous neighborhood influences). In contrast, child care professionals typically discuss safety in terms of protecting children from harm inside the child care setting (e.g., electrical hazards).

Weaknesses of License-Exempt Care

The main weakness of license-exempt care identified by key informants and CCR&R staff is the lack of regulation and monitoring. Child care professionals noted that whereas licensed child care settings receive a stamp of approval that the child care setting and the caregiver have met a set of minimum child care quality standards, there is no guarantee that license-exempt caregivers will maintain safety or quality of care standards. For example, key informants reported that it is difficult to know if license-exempt providers are complying with the legal guidelines for remaining an exempt provider (e.g., such as not exceeding the maximum number of children allowed in care). We should note that most key informants and CCR&R staff did not suggest that license-exempt care was generally of lower quality than licensed care; they simply felt that monitoring quality in these settings was difficult and currently received little attention.

Another key informant and CCR&R staff concern about license-exempt care was the provider's skill level and physical abilities to care for children, especially if the child had a special need. Interviewees indicated that many license-exempt caregivers have not had any specific training in caring for children. If the child has a special need, the provider is dependent on the parent to provide the necessary information about how to care for the child; both lack of training and miscommunication with parents can result in inadequate care in such situations. In addition, child care professionals believed some license-exempt care providers might not be in the best physical health to care for children. This may create difficulty in lifting the children or closely following the child around the house, which could jeopardize the child's safety.

Some key informants were concerned about a lack of care consistency in license-exempt arrangements. For example, they had experienced some families where grandma might care for the children three days a week, a neighbor provided care on the weekends, and an aunt provided care in the evenings. These key informants were concerned that such variations in care were an issue because many research studies have identified consistency as an important indicator of care quality. It is interesting to note that parents and providers did not generally share this concern, and instead suggested that the personalized relationships that developed between the license-exempt providers and the children promoted consistency of care.

One area in which many study participants, including some parents, saw advantages within licensed settings was teaching opportunities. As mentioned in the previous section, learning opportunities while in child care was viewed as an important quality of care indicator. It was recognized that many child care centers were designed to emphasize such learning, while license-exempt care setting were not always equipped to do so. This led to discussions of resources that would be necessary to encourage learning in license-exempt settings (see discussion of resource-related issues under "Research Question 6").

Research Question 6: Based on study findings and analysis of related research, what policy implications can be drawn for enhancing the quality of subsidized license-exempt care?

Most study participants believed that license-exempt care is an essential, legitimate child care option that supports the needs of working parents and their children, and should continue to be subsidized. Both these generally positive attitudes about license-exempt care, and more selective negative perceptions of licensed child care arrangements, have interesting policy implications. They suggest that steps to reinforce license-exempt caregiving efforts, through policies to enhance resource provision or training, would be enthusiastically supported by many parents, providers and CCR&R staff. For example, while 87 percent of subsidy specialists supported the provision of subsidies for license-exempt providers, nearly as many believed that such support should be contingent upon improved training for and monitoring of these providers.

While licensing is considered a desirable goal by most child care professionals and by a subset of license-exempt providers, most parents and providers in our focus groups were skeptical about the potential benefits of licensed care, and many license-exempt providers in our focus groups had little interest in becoming licensed. This suggests that simply improving the supply of licensed child care programs often will be insufficient to change parental child care choices, and also that quality enhancement initiatives that concentrate exclusively on licensing will omit large numbers of caregivers. Therefore, study findings point to the need for initiatives that focus on the improvement of license-exempt care provision.

Suggestions for Supporting License-Exempt Care Provision

Study participants offered many recommendations for enhancing license-exempt care provision, which ranged from fairly broad program enhancements to very specific program implementation issues. In this section, we summarize broad ideas for improving license-exempt care that engendered substantial support among study participants.

License-Exempt Subsidy Rates. Easily the most commonly suggested program change by focus group participants was to raise the payment rate for license-exempt caregivers; this issue also was raised by substantial numbers of child care professionals. The recommendation responded to the very low pay rates for license-exempt caregivers when compared to other types of work. License-exempt caregivers currently earn $9.48 per day for full-time care, compared to licensed family child care home providers who earn between $13.84 and $21.53 per day, depending on the age of the children in their care and the area of the state where the care is provided.

The low pay levels often seemed to create an undesirable choice in which providers either felt they received inadequate compensation or else had to compromise on the quality of care they wished to provide. For example, some caregivers argued that, by the time they paid for food and other costs associated with the provision of care, they were left with little to show for their efforts. Others argued that they were severely constrained by the pay levels in terms of the activities in which they could engage children, and that pay level increases therefore would translate into quality of care improvements. A few providers also suggested that the low subsidy levels sent a negative signal concerning the level of care that was acceptable or expected.

Resources for License-Exempt Providers. Study participants identified several types of resources and information that could enhance caregiving by license-exempt providers. These included:

- teaching and recreation-related materials and equipment (e.g., lending libraries, outdoor play equipment);
- information about available child care and community resources and programs for the parents and providers;
- idea exchanges, support groups, and other networking arrangements with other providers or with child care staff;
- training on various child care topics (e.g., health and safety, first aid, and CPR);
- information or assistance with licensing;
- information about how the subsidy program works; and,
- information or assistance with licensing.

Many of these requests for additional resources offered during focus groups were supported by findings from the CCR&R survey of subsidy specialists, who had also received similar requests from license-exempt providers.

Providers in our focus groups often talked about how educational and recreational materials and activities would improve the quality of care that they offered. Most common in this respect were requests for books and toys. Their intent sometimes was to make the homes where care was provided resemble licensed child care settings, with reading and play areas. Lending libraries were seen as a viable mechanism for making such materials available. Some providers had taken advantage of the lending libraries available from the CCR&Rs, but many others did not seem to know that such assistance was available. Others indicated that it was difficult to get to the CCR&R to take advantage of available resources. Again, most providers were not aware that the CCR&R's had the ability to deliver such resources to the provider through the Quality Counts initiatives, which include a resource van.

Some participants also expressed concern about the lack of outdoor or community activities available to children in their neighborhoods. This led to requests for outdoor play equipment for the caregivers' homes, as well as for information about activities that might be available in the community. As one provider said, "Just give us a list of things that the kids can do, like if we can take them some place." The need for local governments or service agencies to provide more recreational and other activities for children in the neighborhoods also was mentioned, and some key informants and CCR&R staff emphasized the coordinative role that the CCR&R could play in such efforts.

Many providers also stated interests in receiving training that would improve their caregiving expertise. While training interests tended to be general in nature, several more specific topics also were offered. For example, several providers stated that safety related training was needed, such as CPR and first aid. Some also indicated a need for safety-related equipment, such as gates for hallways, first aid kits, and fire extinguishers.

Other providers emphasized the need for training on various child care issues, such as how to teach and interact with children. As one provider stated simply, "Teach us so that we can teach." Some providers were interested in training that would help them in working with children with special needs. In addition, a few providers were interested in learning more about computers so that they could better "keep up" with the children they cared for.

Providers indicated that they would like to have more contact with other providers, in order to share information and to exchange ideas. They commonly indicated that they enjoyed the focus group meetings in which they were participating, and thought that similar formats could be used to provide training and to meet with other providers.

The development of a more organized system to assist providers with various child care needs also was suggested, as was the establishment of on-line information exchanges to keep providers better informed of opportunities and activities for children. The intent was to network with other providers on areas of mutual concern to create a "provider exchange system of sorts". Several providers expressed concern about the availability of back-up child care providers, and thought a support network could help in such instances when providers became ill or needed time off.

Interestingly, licensed family child care providers frequently develop similar support networks through the creation of a local family child care association, sometimes with the support of local CCR&R training staff. Existing associations may only need to better promote their existence and actively recruit license-exempt caregivers to join, so that the license-exempt caregivers can benefit from the support of other caregivers in their communities.

Specific ICCP Program Issues

Overall, most focus group parents and providers appeared to be satisfied with the ICCP. They appreciated receiving subsidies so children could be adequately cared for while parents worked. Several providers also indicated that the program allowed them to be compensated for work that they enjoyed doing, or more generally that it created work opportunities for persons who needed

jobs. Despite this basic level of satisfaction with the program, study participants offered several specific recommendations for improving the delivery of the ICCP.

Payment and Co-Payment Process. As previously mentioned, raising the pay levels was easily the most common recommendation among focus group participants. Several other recommendations were made concerning specific reimbursements the program might offer to providers. For example, it was suggested that the program could reimburse caregivers for the cost of food they provided to children, or else make them eligible for food programs comparable to those available to licensed providers. Other care-related tasks for which reimbursement was requested included activities for children and costs associated with transporting children to various activities.

Several changes related to the co-payments also were recommended. Many participants felt that the co-payments should be reduced or eliminated, because of the poor financial circumstances prevailing for most parents. If co-payments were considered necessary, providers preferred that payments be collected by the state from the parent as a condition of program participation. This was seen as freeing providers from the often awkward and difficult process of obtaining co-payments from the parents, which for relative caregivers can be especially difficult because of on-going relationships beyond child care. This also would allow the providers to receive a single state pay check including the state subsidy and parental co-payments.

Some providers thought that the co-payment calculation was overly sensitive to temporary shifts in parental incomes. That is, the state pay level was seen as being reduced quickly as parental income increased, even if such increases were temporary. This left the provider in the position of having to ask the parent for higher co-payments in order to maintain their same pay level. If the income increase was temporary, the parent's income may already have decreased back to previous income levels by the time that the higher co-payment was established.

Focus group participants also suggested changes in how subsidy payments were calculated for those who were determined eligible. In particular, because the hours of care provided by caregivers varied substantially, some participants advocated calculating pay rates by the hour rather than by the day. Some also viewed varying pay levels by the age of the child as worthy of consideration.

A final area of suggested pay-related changes involved the processing of payments. Probably the most common complaint by providers in this respect was that the state did not withhold income taxes from their checks. This left some providers surprised by the amount of taxes they owed when it came time to file income taxes. Several providers indicated that it would be preferable for taxes to be withheld.

Minimum Quality of Care Standards and Licensing Issues. Most key informants and CCR&R staff, and a few focus group participants, thought that the state needed to play a stronger role in assuring that providers offered adequate care. In particular, these study participants believed that license-exempt providers needed to be required to meet minimum health and safety standards and basic training requirements. The need for on-going monitoring of license-exempt care provision also was mentioned by a subset of study participants.

Most focus group providers did not indicate an interest in becoming licensed. However, a subset of providers did express aspirations in this respect, and CCR&R staff reported frequent requests for information on licensing. Interested providers expressed several potential problems in becoming licensed. For example, one provider suggested that better information about the benefits and responsibilities associated with becoming licensed needed to be offered, so that providers could make informed choices about whether to pursue the licensing option. Inadequate housing arrangements also were seen as precluding the possibility of licensure, as was the inaccessibility of classes considered necessary in order to become licensed.

Given the existence of some of these barriers, one provider suggested that an alternative should be established that paid more than the license-exempt care subsidy rate but less than the licensed rate. To receive the higher rate, the provider would be required to complete some basic training, but also would be subject to less stringent standards than licensed providers.

Information about the ICCP. Several providers and CCR&R staff discussed the importance of improving the dissemination of information about the ICCP. CCR&R staff reported that many of their interactions with license-exempt providers and parents using license-exempt care involved explaining how the subsidy program worked and clarifying the program rules. Some CCR&R staff suggested holding program orientation meetings for parents and providers, so that both parties were introduced to the program policies and procedures.

It may also be necessary for the CCR&R's and ICCP to identify different methods of information delivery to parents and providers. For example, one CCR&R nurse consultant had found some success in conducting "welcome visits" to license-exempt providers. She used the opportunity of the visit to bring along some safety-related items (e.g., smoke detector) and share information on the types of resources she could offer the provider. These visits helped the provider begin to build trust in and familiarity with the CCR&R services in a way that may not be possible through written communications.

Because the focus groups were not designed to determine how well participants understood various aspects of the ICCP, it was not possible to gauge the extent of lacking or incorrect information. However, information deficiencies appeared to be substantial in several substantive areas, and again suggested the need for better orientation to basic program rules and policies. Perhaps most noticeable was lack of knowledge by providers about required parental co-pays. Many providers who were not receiving the co-payments did not know about them. Although the intended co-payment amount appeared on the billing statement they received, these providers did not understand that they were supposed to collect this amount from the parent.

Similarly, some parents complained that child care was not available if a parent wanted to pursue education rather than work, but the program allows care for those in educational activities. Some providers were concerned about parents who were temporarily ill or disabled not being eligible for child care assistance, or parents who were not U.S. citizens being denied access to the program, even if their children were citizens. In both of these instances, the parents would be eligible for child care subsidies.

These information problems may affect parental choices in undesirable ways. For example, some key informants suggested that parents chose license-exempt arrangements because they lacked information about alternatives. This lack of information could involve simply not knowing about the availability of licensed child care programs in the area, or else failing to understand that the child care subsidy co-payment was the same whether one used a licensed setting or a license-exempt provider. Parents also were sometimes thought to lack knowledge about the important developmental stages that children experience, and about how high quality child care can contribute to successful development in each of these stages. Such knowledge deficiencies were thought to lead some parents to underestimate the value of the developmentally appropriate care and training provided in many licensed settings.

Parent and provider lack of understanding of resources currently available to them also seemed to limit access to child care related services. For example, several focus group participants spoke of how it would be helpful if they could receive or borrow books and toys; yet these were available through CCR&R lending libraries in the areas where the focus groups were held. Others indicated that back-up providers were needed in case of sickness or emergencies; this policy already was in place in the subsidy program. Given the desire of most child care professionals to encourage licensing, the general lack of knowledge about both the requirements of and benefits associated with being licensed also was disappointing.

We should note that lack of knowledge about program benefits and rules is common across a wide set of social services, so our findings are consistent with prior research and not an anomaly of this program. Nonetheless, the importance of sound knowledge about child care rules and resources must be stressed, particularly because the benefits may be quite important in improving care by parents and providers operating at very thin financial margins. The emphasis that focus group participants placed upon developing activities for children in the communities similarly suggests the need for parents and providers to be well educated on whatever community activities are available.

Issues related to paperwork or interactions with program staff were raised much less often. Providers in one group suggested that meetings with program representatives be held occasionally to address issues such as the proper processing of paperwork. Complaints about interactions with CCR&R staff were not very common in the groups, although some providers expressed difficulties in contacting them. Only a few providers indicated that CCR&R staff did not understand the program well, and concerns about poor interpersonal treatment by these staff also were infrequent.

Chapter 10: Study Limitations and Preview of Future Project Activities

This study is one of the few to date that is utilizing multiple data sources to investigate subsidized license-exempt care provision, and which is examining the perspectives of a wide variety of actors involved in child care service delivery. This multiple-method approach allows a fullness and balance of interpretations that generally are not possible with studies that employ a single method or data source. Nonetheless, several limitations of the present study should be noted, in addition to those that we have included in discussing specific study components within the report. Some of these are inherent in the study, while others arise primarily because this is an interim report that provides information only the subset of project activities already completed. We therefore conclude by briefly describing future project activities.

Study Limitations

We should first of all reemphasize that the study only examines subsidized caregiving, which is only one important subset of all child care provision. In addition, even when limiting analysis to subsidized program contexts, Meyers (2002) and her colleagues have noted that service devolution has exacerbated already large differences in state and local child care programs. Because such program contexts may have powerful effects on parents and provider attitudes and actions, generalizing findings from this study beyond the Illinois program context requires caution and knowledge of the possible effects of variations in policies and programs.

Second, we purposively selected a mix of large city, mid-sized urban, and rural areas to attempt to capture potential geographic variations in issues. Nonetheless, our geographic scope is limited. For example, our key informant and CCR&R staff interviews suggested the diversity of caregiving environments that may exist in different neighborhoods in a large city like Chicago. Other geographic variations not controlled in this study, such as the relative economic prosperity of an area, may powerfully affect child care delivery systems. These and other factors that may differentiate the child care environment in various geographic areas require careful research scrutiny.

Third, while our study provides aggregate administrative data on selected aspects of license-exempt child care provision and rich information on license-exempt caregiving from the perspectives of parents, providers, and community child care professionals involved with such care, the study does not involve actual observations by the researchers of caregiving situations. Therefore, interpretations of the quality of care that occurs in such caregiving arrangements is limited to the perceptions of those persons interviewed.

Fourth, while our focus upon license-exempt caregivers and parents using license-exempt care offers the potential for further understanding of this particular form of care, the perspectives of parents using licensed care may be fundamentally different. Therefore, it is important to emphasize that the perspectives presented in our study are most likely to reflect parents who are most positive about such care forms. Nonetheless, given that such persons often are portrayed as

being driven by a lack of care alternatives, these perspectives are invaluable in understanding subsidized license-exempt care issues.

Finally, because this is an interim report, our findings on parent and provider perceptions are based on focus groups that did not involve the random selection of subjects. While these groups were diverse and offered a wide range of perspectives on license-exempt caregiving issues, the findings from them should be interpreted in an exploratory vein. Interviews with larger, randomly selected samples of license-exempt caregivers and parents using license-exempt care during the second phase of the study should result in substantial refinement of many of the findings presented here.

Despite these limitations, the findings from the study to date both reinforce and extend findings from previous research. In addition, these interim findings will guide project activity during the remainder of the project, as described in the following section.

Future Project Activities

The findings presented in this interim report have formed the basis for the development of two structured survey instruments – one for parents using license-exempt care and one for license-exempt providers. These survey instruments are designed to be administered to linked pairs of license-exempt care users and providers. Drafts of these surveys already have been completed, and currently are being refined based on consultation with child care and survey experts. The principal research activity for the next year then will be the administration of these surveys with 300 linked pairs of license-exempt care users and providers.

Because the parent and provider surveys will be linked, some comparable questioning will be included in these two surveys. For example, it will be important to learn whether parents and their providers share the same major goals and objectives regarding the care of the child, and whether they agree about the types of activities in which the child should be engaged while in care. Issues such as expected educational activities, disciplinary expectations, and basic child-rearing approaches also will be illuminated by comparing parent and provider perspectives. Both groups also will be asked to identify strengths and weaknesses with the ICCP program, and to suggest recommended program improvements.

Other questioning will vary between the parent and provider surveys. For example, parents will be asked about the decision-making processes they have experienced in making choices about care providers, as well as the most important factors that influenced these decision-making processes. They also will be questioned about their perspectives on both the most important strengths and weaknesses of license-exempt care, and about how satisfied they are with their current care arrangements. In comparison, providers will be asked about their motivations for providing care, their experience and credentials, their perceptions about additional resources and training needs, and about their satisfaction with various aspects of care provision.

Unlike the current year focus groups, we will be able to administer the survey to random samples of license-exempt care users and providers in each of the three study areas. Administrative records from IDHS will be used to create sampling frames for each of the three targeted

geographic areas. The sampling frame will include all cases that utilized license-exempt care as their primary source of subsidized child care in a selected month. From these sampling frames, random samples of prospective subjects will be drawn. Sufficient samples will be drawn to assure that 100 parents and 100 of their license-exempt care providers will be interviewed in each area. Completion of these interviews and related analysis is expected in early 2004.

In addition to surveying license-exempt users and providers, administrative data analysis of statewide ICCP subsidy use patterns will continue. Subsequent analyses will allow us to assess longitudinal usage patterns of families and children receiving child care subsidies and using licensed and license-exempt care over long time periods. Comparative data on selected characteristics of families using licensed versus license-exempt care also are being developed, as is additional information on full-time versus part-time caregiving patterns, reasons for case openings, and use of other services by both parents and license-exempt caregivers.

References

Beach, B. (1997). Rural and urban families' use of child care. Family Relations, 43, 16-22.

Brandon, R., Maher, E., Joesch, J., & Doyle, S. (2002, February). Understanding family, friend, and neighbor care in Washington State: Developing appropriate training and support. Human Services Policy Center, Evans School of Public Affairs, University of Washington. Available: http://hspc.org/publications/early_ed/FFN_report_2002.pdf (May, 2002)

Brown-Lyons, M., Robertson, A., & Layzer, J. (2001). Kith and kin-informal child care: Highlights from recent research. New York: National Center for Children in Poverty. Available: http://cpmcnet.columbia.edu/dept/nccp/index.html (May, 2002)

Butler, J., Bringham, N. & Schultheiss, S. (1991). No place like home: A study of subsidized in-home and relative child day care. Philadelphia, PA: Rosenblum and Associates.

Capizzano, J., Adams, G., & Sonenstein, F. (2000). Child care arrangements for children under five: Variation across states. Series B, No. B-7. Washington, DC: The Urban Institute. Available: http://www.urban.org/UploadedPDF/anf_b7.pdf (May 2002)

Casper, L. (1997). Who's minding our preschoolers? Fall 1994 Update (Current Population Reports, Household Economic Studies, P70-62). Washington, DC: U.S. Department of Commerce.

Collins, A. & Carlson, B. (1998). Child care by kith and kin: Supporting family, friends, and neighbors caring for children. Children and Welfare Reform, Issue Brief 5. New York: National Center for Children in Poverty. Available: http://www.cpmcnet.columbia.edu/dept/nccp/main6.html (May 2002)

Cost, Quality, and Child Outcomes Study Team. (1995). Cost, quality, and child outcomes in child care centers, executive summary. Denver, CO: Economics Department, University of Colorado at Denver.

Cryer, D. (1999). Defining and assessing early childhood program quality. The Annals of the American Academy of Political and Social Science, 563, 39-55.

Dodson, L. (1998). Don't call us out of name: The untold lives of women and girls in poor America. Boston: Beacon Press.

Edin, K., and Lein, L. (1997). Making ends meet: How mothers survive welfare and low-wage work. New York: Russell Sage Foundation.

Ehrle, J., Adams, G., & Tout, K. (2001). Who's caring for our youngest children? Child care patterns of infants and toddlers. Occasional Paper #42. Washington, DC: The Urban Institute. Available: http://www.urban.org/UploadedPDF/310029_occa42.pdf (April 2002)

Emlen, A. (1998). AFS provider survey: From child-care providers serving parents who receive child-care assistance. Portland, OR: Oregon Child Care Research Partnership. Available: http://www.lbcc.cc.or.us/familyresources/researchpartner/ (May 2002).

Emlen, A., Koren, P., & Schultze, K. (1999). From a parent's point of view: Measuring the quality of child care: Final report. Portland, OR: Regional Research Institute for Human Services, Portland State University.

Fuller, B., & Kagan, S.L., (2000). Remember the children: Mothers balance work and child care under welfare reform (Growing Up in Poverty Project: Wave I Findings). Berkeley, CA: University of California, Berkeley and New Haven, CT: Yale University.

Galinsky, E., Howes, C., Kontos, S., & Shinn, M. (1994). The study of children in family child care and relative care: Highlights of findings. New York: Families and Work Institute.

Harms, T., and Clifford, R. (1989). Family day care rating scale. New York: Teachers College Press.

Harms, T. and Clifford, R. (1998). Early childhood environment rating scale: Revised edition. New York: Teachers College Press.

Hayes, C., Palmer, J., & Zaslow, M. (Eds.). (1990). Who cares for America's children? Child care policy for the 1990s. Washington, DC: National Academy of Sciences, National Research Council.

Henly, J.R., & Lyons, S. (2000). The negotiation of child care and employment demands among low-income parents. Journal of Social Issues, 56(4), 683-705.

Hertz, R., & Ferguson, F.I.T. (1996). Childcare choice and constraints in the United States: Social class, race and the influence of family views. Journal of Comparative Family Studies, 27(2), 249-80.

Hofferth, S.L., Brayfield, A., Deich, S. & Holcomb, P. (1991). National child care survey, 1990. Washington, DC: Urban Institute Press.

Illinois Facilities Fund (2001). Early childhood care and education fact book. Chicago: Author

Jaro, M. A. (1985). Current record linkage research. Proceedings of the Statistical Computing. Washington, DC: American Statistical Association.

Jaro, M. A. (1989). Advances in record-linkage methodology as applied to matching the 1985 census of Tampa, Florida. Journal of the American Statistical Association 84(406), 414-420.

Jarrett, R. L. (1994). Living poor: Family life among single parent, African-American women. Social Problems, 41, 30-49.

Mensing, J., French, D., Fuller, B., and Kagan, S. (2000). Child care selection under welfare reform: How mothers balance work requirements and parenting. Early Education and Development, 11, 573-595.

Myers, M. K., Peck. L. R., Davis, E.E., Collins, A, Kreader, J. L., Georges, A., Weber, R., Schexnayder, D. T., Schroeder, D. G., and Olson, J. A. (2002). The dynamics of child care subsidy use: A collaborative study of five states. New York: National Center for Children in Poverty.

National Institute of Child Health and Human Development. (1999). NICD Study of early child care. Washington, D. C.: National Institute of Child Health and Human Development.

Newcombe, H.B. (1988). Handbook of record linkage: Methods for health and statistical studies, administration, and business. Oxford: Oxford University Press.

NICHD Early Child Care Research Network. (1996). Characteristics of infant child care: Factors contributing to positive caregiving. Early Childhood Research Quarterly, 11, 269-306.

Okuyama, K. & Weber, R. (2001). Parents receiving child care subsidies: Where do they work? Albany, Oregon: Oregon Child Care Research Partnership. Available: www.lbcc.or.us/familyresources/researchpartner (April 2002).

Piecyk, J., Collins, A., & Kreader, J. (1999). Patterns and growth of child care voucher use by families connected to cash assistance in Illinois and Maryland. Child Care Research Partnership Report No. 2. New York: National Center for Children in Poverty. Available: http://www.cpmcnet.columbia.edu/dept/nccp/main6.html (May 2002).

Porter, T. (1998). Neighborhood child care: Family, friends, and neighbors talk about caring for other people's children. New York: Bank Street College of Education.

Porter, T. (1999). Infants and toddlers in kith and kin care: Findings from the informal child care project. Zero to Three, 19 (6), 27-35.

Siegel, G. & Loman, L. (1991). Child care and AFDC recipients in Illinois: Patterns, problems, and needs. St. Louis, MO: Institute of Applied Research.

Smith, J. (1991). REACH/JOBS participants "approved home" child care survey. Trenton, NJ: State of New Jersey, Department of Human Services, Division of Economic Assistance.

Sonenstein, F., Gates, G., Schmidt, S., & Bolshun, N. (2002). Primary child care arrangements of employed parents: Findings from the 1999 National Survey of America's

Families (New Federalism: National Survey of America's Families, Occasional Paper #59). Washington, DC: The Urban Institute.

Stohr, K., Lee, S., & Nyman, S. (2002). The Illinois child care experience since 1996: Implications for federal and state policy. Day Care Action Council of Illinois. Available: http://daycareaction.org/illinoisfinal.pdf

Tout, K., Zaslow, M., Papillo, A.R., & Vandivere, S. (2001). Early childcare and education: Work support for families and developmental opportunities for young children. (New Federalism, National Survey of America's Families, Occasional Paper #51). Available: http://www.urban.org/UploadedPDF/occa51.pdf (April 2002).

U.S. Census Bureau (2001). Census 2000 Summary File 1. Washington, D.C.: Author. Available: http://factfinder.census.gov/servlet/BasicFactsServlet.

U.S. Census Bureau (2002). Census 2000 Summary File 3. Washington, D.C.: Author. Available: http://factfinder.census.gov/servlet/BasicFactsServlet.

West, J., Wright, D., & Hausken, E. (1996). Statistics in brief: Child care and early education program participation of infants, toddlers, and preschoolers. Washington, DC: National Center for Educational Statistics.

Winkler, W.E. (1988). Using the EM algorithm for weight computation in the Fellegi-Sunter model of record linkage. In Proceedings of the Section Survey Research Methods, 1-5. American Statistical Association.

Zinsser, C. (1991). Raised in East Urban: Child care changes in a working class community. New York: NY: Teachers College Press.

Appendix A:

Key Informant Interview Guide

Key Informant Interview Guide: Illinois Study of License-Exempt Child Care

Purpose of Interviews

The purpose of these interviews is to learn as much as possible about how community child care leaders view license-exempt care issues. By license-exempt care, we mean license-exempt care provided in home-based settings. We will use the information you provide to help us develop survey instruments that we will administer to both parents and license-exempt care providers later in the study. We also will be conducting focus groups with parents and providers and interviewing CCR&R staff, and your ideas will help us define issues to be considered in these research activities.

In particular, we hope to learn more from you today about:

- issues concerning subsidized license-exempt child care from the perspectives of community service experts

- the child care service environment in your community, and how this environment may influence license-exempt care giving.

Questions about the Community Service Environment

1. In this community, how adequate is the supply of licensed child care for low-income persons?

2. Are there any service issues in this community that serve to either increase or decrease the frequency with which license-exempt care is used?

3. Aside from the CCR&R, what child care or other service officials would be most useful to talk to regarding child care issues in this community?

Questions on Perceptions about License-Exempt Care Quality Issues and Decision-Making about License-Exempt Care

1. What do you think are some of the key issues related to license-exempt child care from the parent point of view?

    a. What do you think are some of the positive aspects for parents of license-exempt care use?

    b. What do you think are some of the negative aspects for parents?

c. What do you think are the reasons that parents choose license-exempt child care? (Note: After allowing an open-ended response, follow-up with issues not mentioned. Issues to cover include cost, supply, co-pays, safety, cultural compatibility, and shift hours)

2. What do you think are some of the key issues related to license-exempt child care from the provider's point of view?

    a. What do you think are some of the positive aspects for providers of license-exempt care-giving?

    b. What do you think are some of the negative aspects for providers?

    c. What do you think are the reasons why license-exempt care providers provide care?

3. What do you think are some of the key issues related to license-exempt child care from a community service provider (CCR&R, agency) point of view?

    a. What are some of the positive aspects that community service providers may see with the use of license-exempt care?

    b. What are some of the negative aspects for community service providers?

    c. What do you think that community agencies can do to best serve parents and providers who use or provide license-exempt care?

    d. Do you think that community service providers should encourage parents to use licensed child care rather than license-exempt child care? Why or why not?

4. What do you think are some of the key issues related to license-exempt child care from the child's point of view?

    a. Do you think that children are more likely to view license-exempt care positively than they would view care in a licensed facility?

    b. Are there specific benefits that you think commonly accrue to children that use license-exempt care providers?

5. Research has found that parents using license-exempt child care frequently report high satisfaction with this type of care.

    a. What do you think are some of the reasons for this?

6. Some researchers feel that children's developmental needs are not met as well in license-exempt care as in more formal child care centers. What are your perspectives on this?

Questions about Public Policies and Supports Affecting License-Exempt Care

1. Research has found that license-exempt care providers frequently report a need for more resources and support.

    a. What types of support do you think should be available for license-exempt care providers?

    b. Who should fund such supports?

2. The Illinois Child Care Program includes payment policies and other policies that affect how both license-exempt and formal subsidized child care are provided in Illinois. Are there any specific policy changes you would like to see made in the Illinois Child Care Program related to license-exempt care, or related policy issues you would like to see addressed?

3. Has welfare reform made a difference in terms of license-exempt child care provision in your area? If so, what have the major impacts been?

4. What other concerns or issues do you think is important for us to know about license-exempt child care in Illinois?

5. How would you rate the access to the Illinois Child Care Program in this area? That is, do issues such as lack of knowledge about services, lack of transportation, fear of public programs, or other factors limit program participation?

Appendix B

CCR&R Subsidy Specialist Survey

Illinois Study of License-Exempt Child Care
Child Care Resource and Referral Subsidy Staff Survey

Telephone Protocol for Recruiting CCR&R Staff Subjects

Hello, my name is [name], and I'm calling from the University of Illinois. I am part of a research project that is studying child care issues in several Illinois communities. We are especially interested in issues related to license-exempt child care – care in home settings by relatives, friends, and others who are not licensed by the Illinois Department of Children and Family Services (DCFS).

As part of our study, we are interviewing child care resource and referral (CCR&R) staff around the state to learn about their perspectives on this type of care. We are conducting telephone interviews that take about 20-30 minutes to complete, and are hopeful that you might be willing to participate. The director of your agency [name], has agreed to participate in the project, and has told us that it is all right to interview workers during their work shifts. This in no way suggests that you need to complete an interview. The choice of whether or not to be interviewed is totally voluntary, and we will not inform [name of agency director] which workers completed interviews.

Your responses also are confidential. That is, your name never will be associated with any comments you may make. We will be writing a report on our findings that is intended to improve the child care services provided through the Illinois Child Care Program, which includes the subsidy program. However, our report will not report on responses at the CCR&R agency level, so that it will not be possible for anyone to learn what the responses by staff in a particular agency were.

If you have any questions about the research, you can call Professor Steve Anderson toll-free at the University of Illinois (1-877-892-5188), or contact him in writing at 1207 W. Oregon, Urbana, IL 61801. If you want to know more about your rights as participants in research, you can contact the Institutional Review Board at the University of Illinois, 417 Swanlund Administration Building, Urbana, IL 61801 (Telephone: 217-333-2670).

We schedule interviews at any time that is convenient to CCR&R staff. Would you be willing to complete an interview with us now, or at a later time?

[If no, terminate the telephone call]

[If yes, arrange interview time or begin interview]

Introduction to Subsidy Specialist Survey

THE PURPOSE OF THIS SURVEY IS TO LEARN AS MUCH AS WE CAN ABOUT YOUR VIEWS ON LICENSE-EXEMPT CARE, WHICH WE DEFINE AS CARE PROVIDED IN HOME SETTINGS BY RELATIVES, FRIENDS, NEIGHBORS OR OTHERS WHO ARE NOT LICENSED BY DCFS. I WANT TO EMPHASIZE THAT THERE ARE NO RIGHT OR WRONG ANSWERS TO THE QUESTIONS WE WILL ASK. WE SIMPLY WANT TO LEARN YOUR OPINIONS BASED ON YOUR WORK EXPERIENCES AT THIS AGENCY. YOUR RESPONSES ARE CONFIDENTIAL, AND YOUR NAME WILL NEVER BE USED IN THE PRESENTATION OF ANY INFORMATION FROM OUR SURVEY.

WE WOULD LIKE FOR YOU TO BASE YOUR ANSWERS TO OUR QUESTIONS SOLELY ON YOUR EXPERIENCES YOU HAVE HAD IN YOUR WORK AT THIS AGENCY. BECAUSE WE ARE TALKING TO STAFF FROM MANY DIFFERENT AGENCIES, SOME QUESTIONS WE ASK MAY NOT APPLY TO YOUR OWN JOB EXPERIENCES. AS A RESULT, IF YOU HAVE NOT HAD JOB EXPERIENCES DIRECTLY RELATED TO ANY QUESTION WE MAY ASK, PLEASE JUST ANSWER "DON'T KNOW" TO THAT QUESTION.

TO BEGIN WITH, WE'D LIKE TO ASK YOU A FEW QUESTIONS ABOUT YOUR WORK EXPERIENCES AT THIS AGENCY.

1. What is your current title? _____

2. How long have your worked in your current position? _____ years _____ months

[IF LESS THAN 3 MONTHS, END THIS INTERVIEW.]

3. How long have you worked in this agency? _____years _____ months

4. In the course of your work in this position, have you ever had any interactions by phone or in-person with parents who are either applying for or who are already receiving a subsidy and who are using an license-exempt care provider?

   ☐ Yes ☐ No ☐ Don't Know

5. In the course of your work in this position, have you ever had any interactions by phone or in-person with license-exempt care providers receiving a subsidy?

   ☐ Yes ☐ No ☐ Don't Know

[IF PERSON RESPONDS "NO" TO Q.4 AND Q.5., END THE INTERVIEW.]

6. On average, about how many interactions by phone or in-person do you have with either parents using any type of child care or with any child care providers in a week? (**Note for interviewer:** You may need to probe if respondent is uncertain - "WE ONLY ARE LOOKING FOR AN ESTIMATE HERE")

   _____

7. About how many of these interactions are with parents? _____

8. About how many of these interactions are with child care providers? _____

9. About what portion of your time during a typical week do you spend ….
   (**Note for interviewer:** Responses should total equal to or less than 100%)

Talking on the phone or in person with parents using license-exempt care	%	Don't Know
Talking on the phone or in person with license-exempt care providers	%	Don't Know
Processing paperwork for parents using license-exempt care	%	Don't Know
Processing paperwork for license-exempt care providers	%	Don't Know
Other interactions related to parents using license-exempt care (specify)	%	Don't Know
Other interactions related to license-exempt care providers (specify)	%	Don't Know

NOW I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT ANY INTERACTIONS YOU HAVE HAD WITH PARENTS USING CHILD CARE SUBSIDIES WHILE WORKING IN YOUR CURRENT POSITION.

10. Of the parents using the subsidy program that you interact with in an average week, about what percentage would you estimate are using or submitting an application to use license-exempt care providers? (**Note for interviewer:** You may need to probe if respondent is uncertain - "WE ONLY ARE LOOKING FOR AN ESTIMATE HERE")

    _____

11. Thinking of any interactions you have had in the past 30 days with parents using license-exempt care, what types of issues did you talk about with these parents?

    _____

    _____

    _____

12. Based on your experiences at work, what are the most important reasons you think parents use license-exempt child care?

    _____

    _____

    _____

13. Following are some reasons that have been offered for why parents choose license-exempt care. I would like you to think about how important you think each of the following reasons for choosing license-exempt care are for parents you have worked with. Using a 5-point scale, with 1 being very important and 5 being not at all important, how important are these reasons for choosing license-exempt care?

	Very Important				Not Important	Don't Know
a. License-exempt care is less costly	1	2	3	4	5	8
b. License-exempt care is more flexible	1	2	3	4	5	8
c. There are no other child care options available	1	2	3	4	5	8
d. The parent does not have information about other available child care options	1	2	3	4	5	8
e. License-exempt care fits better with the parent's work schedule	1	2	3	4	5	8
f. The parent trusts the license-exempt care provider	1	2	3	4	5	8
g. License-exempt care is easier from a location or transportation perspective	1	2	3	4	5	8
h. There are fewer cultural differences with license-exempt care providers	1	2	3	4	5	8
i. The parent prefers license-exempt care for their children when they are young	1	2	3	4	5	8
j. It is easier to have a single license-exempt care provider care for all children in the family	1	2	3	4	5	8
k. License-exempt care is seen by the parent as more consistent or reliable	1	2	3	4	5	8
l. The license-exempt care provider may not require that the co-payment be paid	1	2	3	4	5	8
m. License-exempt care provides a warm and nurturing environment.	1	2	3	4	5	8
n. Children get more individual attention in license-exempt care.	1	2	3	4	5	8
o. The parent wants their children cared for in their own home.	1	2	3	4	5	8

14. Based on your work experiences working with parents using license-exempt care providers, what would you say are the greatest child care related problems or issues that these parents face?

_____

15. If the costs of care were about the same and all types of care were available, which of the following types of care do you think parents you work with would prefer?

a. For a child under age 1:

☐ Center or nursery school
☐ Licensed family child care home
☐ License-exempt care by a relative
☐ License-exempt care by a friend or neighbor
☐ Don't Know

b. For a child aged 1-3:

☐ Center or nursery school
☐ Licensed family child care home
☐ License-exempt care by a relative
☐ License-exempt care by a friend or neighbor
☐ Don't Know

c. For a child aged 4-5:

☐ Center or nursery school
☐ Licensed family child care home
☐ License-exempt care by a relative
☐ License-exempt care by a friend or neighbor
☐ Don't Know

d. For a child aged 6-12:

☐ Center or school-age program
☐ Licensed family child care home
☐ License-exempt care by a relative
☐ License-exempt care by a friend or neighbor
☐ Don't Know

16. For each of the following topics, I would like for you to estimate how often have parents using license-exempt care asked you for information or advice, even if you transferred the parent to another staff person in your agency to respond to the request.

	Frequently	Sometimes	Never	Don't know
a. Information on activities to do with children				
b. Information on caring for children – discipline, sleeping, toilet training				
c. Information about communicating with child care providers				
d. Information about resources such as toys, books or other activities to help children learn				
e. Information about outdoor recreational equipment				
f. Information about community resources such as discounted bus passes, pool passes				
g. Information about safety equipment, such as first aid kits, fire extinguishers, smoke detectors				
h. Information about equipment for their homes such as cribs, strollers, tables				
i. Information on health, nutrition, immunizations, or health screenings.				

i. Are there other types of information that parents using license-exempt care have requested?

☐ Yes ☐ No ☐ Don't Know

(If Yes) What other types of information do parents request? _____

_____

NOW I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT ANY INTERACTIONS YOU HAVE HAD WITH PROVIDERS RECEIVING SUBSIDIES WHILE WORKING IN YOUR CURRENT POSITION.

17. Of the child care providers you talk with that receive subsidies in an average week, about what percentage would you estimate are from license-exempt care providers? (**Note for interviewer:** You may need to probe if respondent is uncertain - "We only are looking for an estimate here")

_____

18. Thinking of any interactions you have had in the past 30 days with license-exempt care providers, what types of issues did you talk about with these providers?

_____

_____

19. Based on your work experiences, what are the major reasons that you think license-exempt caregivers provide care?

_____

_____

_____

20. Following are some reasons that have been offered for explaining why license-exempt caregivers provide care. I would like you to think about how important you think each of the following reasons are for license-exempt caregivers you have worked with for providing license-exempt care. Using a 5-point scale, with 1 being very important and 5 being not at all important, how important are these reasons for providing license-exempt care?

	Most Important				Not Important	Don't Know
a. License-exempt care providers want to help out the parent or family member	1	2	3	4	5	8
b. License-exempt care providers want the child cared for by a family member	1	2	3	4	5	8
c. License-exempt care providers want to earn money	1	2	3	4	5	8
d. License-exempt care providers want to stay at home with their own children or grandchildren	1	2	3	4	5	8
e. License-exempt care providers enjoy caring for children	1	2	3	4	5	8
f. License-exempt care providers enjoy teaching children	1	2	3	4	5	8
h. License-exempt care providers feel pressure from relatives to help out	1	2	3	4	5	8
i. License-exempt care providers want to avoid intrusion from the government or licensing	1	2	3	4	5	8
j. License-exempt care providers need a job because of welfare reform	1	2	3	4	5	8
k. It is the only job the license-exempt care providers can find.	1	2	3	4	5	8

21. Based on your work experiences with license-exempt care providers, what would you say are the greatest child care related problems or issues that these providers face?

_____

_____

_____

22. For each of the following topics, I would like for you to estimate how often license-exempt care providers have requested information or advice, even if you transferred the provider to another staff person in your agency to respond to the request.

	Frequently	Sometimes	Never	Don't know
a. Information on activities to do with the children				
b. Information on caring for children – discipline, sleeping, toilet training				
c. Information about communicating with parents				
d. Information on business management				
e. Information about resources such as toys, books or other activities to help children learn				
f. Information about outdoor recreational equipment				
g. Information about community resources such as discounted bus passes, pool passes				
h. Information about safety equipment, such as first aid kits, fire extinguishers, smoke detectors				
i. Information on health, nutrition, immunizations, or health screenings.				
j. Information about equipment for their homes such as cribs, strollers, tables				
k. Information on becoming licensed.				
l. Information on courses, workshops, or other training programs.				

m. Are there other types of information that license-exempt care providers request?

☐ Yes ☐ No ☐ Don't Know

(IF YES), What other types of information do license-exempt care providers request?

_____

_____

23. Do you think most license-exempt care providers you have worked with are interested in being licensed?

☐ Yes ☐ No ☐ Don't Know

(IF YES), What are the greatest difficulties, if anything, that these providers face in becoming licensed?

_____

_____

(IF NO), What are the reasons you think the license-exempt care providers you have worked with do not want to become licensed?

_____

_____

NOW I WOULD LIKE TO GIVE YOUR OPINION ON FACTORS IMPORTANT TO THE CARE CHILDREN RECEIVE.

24. Following are some factors that have been offered as important to the care that children receive. I would like you to think about how important you think each of the following factors are to the care that children receive. Using a 5-point scale, with 1 being very important and 5 being not at all important, how important is:

	Very Important				Not Important	Don't Know
a. An environment that is safe and healthy for children	1	2	3	4	5	8
b. An environment that is clean	1	2	3	4	5	8
c. An environment with a lot of activities for children	1	2	3	4	5	8
d. A caregiver who is warm	1	2	3	4	5	8
e. A caregiver who shows a lot of interest in the children	1	2	3	4	5	8
f. A caregiver who has received training in how to care for children	1	2	3	4	5	8
g. A caregiver with a degree in early childhood education or child development	1	2	3	4	5	8
h. The child has a chance to interact with other children	1	2	3	4	5	8
i. The environment is racially and culturally diverse	1	2	3	4	5	8
j. An environment with activities available that are specific to the developmental needs of the child	1	2	3	4	5	8
k. There is access to toys and activities that meet the development needs of the child	1	2	3	4	5	8
l. The care provided is tailored to the age of the child	1	2	3	4	5	8
m. An environment with low staff-child ratios	1	2	3	4	5	8
n. An environment with low staff turnover	1	2	3	4	5	8
o. The caregiver and the parent have a good relationship	1	2	3	4	5	8

25. Based on your work experiences, do you think that the state should provide subsidies to license-exempt care providers?

☐ Yes ☐ No ☐ Don't Know

26. Based on your work experiences, do you think that the state should require license-exempt care providers to complete training in order to receive subsidies?

☐ Yes ☐ No ☐ Don't Know

27. In general, based on your work experiences, what do you think is the most important thing that could be done to improve the care provided by license-exempt caregivers?

_____

28. Do you have any other suggestions for improving the subsidy program?

_____

_____

Background Information

I'D LIKE TO CLOSE BY ASKING YOU A FEW BACKGROUND QUESTIONS ABOUT YOURSELF AND YOUR EXPERIENCES IN THE CHILD CARE FIELD.

29. Have you had any previous positions outside of this agency in the child care field?

☐ Yes ☐ No

IF YES, How long did you work in these previous positions? ____ years _____ months

30. Have you had any other previous positions in which you worked with children?

☐ Yes ☐ No

IF YES, How long did you work in these previous positions? ____ years _____ months

31. What is the highest grade of school you ever completed? _____

a. IF 12 YEARS OR LESS, Did you receive a high school diploma or GED?

☐ Yes ☐ No

b. IF COLLEGE, what is the highest degree you earned? _____

(1) What was your major field of study? _____

c. IF SOME COLLEGE, how many semesters did you complete? _____ semesters

32. Have you ever taken a college course on child development, early childhood education, child psychology, or child welfare?

☐ Yes ☐ No

33. In the course of your work, have you ever attended any training sessions that discussed license-exempt care issues?

☐ Yes ☐ No ☐ Don't Know

34. What is your gender?

☐ Female ☐ Male

35. How old are you? _____ years

36. What is your race/ethnicity?

☐ African-American
☐ White/Non-Hispanic
☐ Hispanic/Latino
☐ Native American
☐ Asian
☐ Other _____

37. Finally, is there anything else you think is important for us to know about license-exempt care?

_____

_____

THANK YOU FOR YOUR TIME!

Appendix C:

Focus Group Guides

Parent Focus Group Interview Guide

1. **Introductions**. Thank you again for coming. I'd like to begin by learning a little more about you. So could we begin by having you introduce yourself by your first name, and then telling us how your children are cared for while you are working or in school. Who takes care of your children? Is it a relative, a friend, or someone else? Do you use only one provider, or do you have more than one provider? If you use more than one provider, do they all receive subsidy payments?

2. **What were some of your reasons for choosing the person you selected for your child care, as opposed to a licensed center or another provider?** (After initial responses, probe for factors not mentioned, such as cost; work schedule; availability of center care or other options; convenience; age of child; ICCP program rules concerning subsidy use; provider flexibility, reliability; safety; cultural differences; compatibility of child rearing values).

3. **People have different opinions about whether it is better to care for kids in unlicensed home-based settings with relatives or friends, or whether it is better to use licensed child care programs. If you could choose one type of care setting for your children, what would you choose? What is the most important reason you say this?**

   - If you are not currently using the setting that you prefer, what are the main reasons you are not using the care you prefer?

   - What additional resources do you think you would need in order to get the kind of child care you desire?

4. **Now I'd like to discuss child care quality issues with you. What factors do you think are most important to the quality of care your children receive or make the most difference to you and your children?** (After initial responses, probe for factors not mentioned, such as learning opportunities, chances to interact with other children, individual attention or flexibility in responding to the child's needs, chances to interact with people who have been trained in child care, good toys and play opportunities, affection from someone who cares about them)

5. **I would like to discuss some ways of assuring that relatives and friends provide high quality child care in home-based settings?**

   - Do you have any suggestions for making sure this care is of the highest quality?

   - Do you have any ideas about resources that would help persons who provide this care?

   - Do you have any ideas about resources that need to be made available to parents so that they get the most out of this type of care?

- Has having a relative or friend caring for your child made a difference in your relationship with that person – either for the better or for the worse?

6. **Now I'd like to talk to you about how satisfied you are with your current child care arrangements.**

    - First of all, what do you like best about your current arrangements?

    - What, if anything, would you most like to change about your current arrangements?

    - Sometimes parents have disagreements or problems with their providers? Has this ever happened to you? If so, what kinds of problems do you have in general? How did you handle the problem or disagreement? (After initial responses, probe for problems agreeing on payment, differing expectations regarding care of the child, problems with discipline methods, unequal treatment of the child)

    - Have you ever changed child care providers? If so, why did you change?

7. **Finally, I would like to ask you about your experiences with the subsidy program that gives you help in paying for child care (mention the CCR&R name).**

    - How did you find out about the subsidy help you could get through the (mention CCR&R name)?

    - Did you have any trouble in getting the help that you needed when you applied?

    - Overall, how satisfied are you with how this program works?

    - Have you had any problems with the program?

    - Do you have any suggestions for improving the program?

Conclusion

I would really like to thank you for taking the time to get together with us and share your ideas. The information you have provided will be valuable to us as we study the child care system and make recommendations for improving the services you receive.

Provider Focus Group Interview Guide

1. **Introductions.** Thank you again for coming. I'd like to begin by learning a little more about you. So could we go around the room and have everyone introduce themselves by their first name? I would also like for you to fill out the brief background sheet we passed out, so that we know a little more about the people who come to our groups. We do not need your names on these sheets.

2. **I want to talk first about the care you provide for other people's children**. Could each of you briefly talk about how many children you provide care for, what their ages are, and whether or not they are related to you? Also, where do you provide this care?

3. **I'd like to hear about how you began caring for the children you are caring for now.** In addition, could you tell us about how long you have been caring for these children?

4. **What is it that you like best about caring for other people's children?** (After initial responses, probe for factors not mentioned, such as taking care of children, helping out a relative or friend, earning money from child care, teaching children, being home with own children, having the company of children, and teaching children).

5. **What is the hardest thing about taking care of other people's children**? (After initial responses, probe for factors not mentioned, such as problems in dealing with the children's parents, problems in getting paid for the care that is provided, strains on relationships with the parents, differing child care expectations between what you think is best versus what the parent thinks is best, problems in disciplining the children, and conflicts it creates in caring for own children or taking care of other family needs).

6. **In thinking about the quality of child care that children receive, what things do you think are most important or make the most difference to children?** (After initial responses, probe for factors not mentioned, such as learning opportunities, chances to interact with other children, individual attention or flexibility in responding to the child's needs, chances to interact with people who have been trained in child care, good toys and play opportunities, and affection from someone who cares about them).

7. **I would like to talk now about any help that you think would make providing child care easier for you.** Thinking about your own experiences, what resources or other support would be most helpful to you in caring for children. (After initial responses, probe for factors not mentioned, such as books, games, or other activities that help children learn; toys or other activities to entertain children; equipment, such as cribs, strollers, tables, toy boxes; safety equipment, such as first aid kits, fire extinguishers, or smoke detectors; outdoor recreational equipment; information or training about caring for children)

8. **I would like to talk about any training or other information that may be helpful to you as a child care provider. What if anything would be most important for you?** (After initial responses, probe for factors not mentioned, such as information about how

to become a licensed provider, training on how to teach or work with children, safety information, information on the Illinois subsidy program and how it works).

What do you think would be the best way to get any training or other resources you need (for example, through training sessions, home visits, etc.)

Have you ever received any training or other resources to help you with the child care that you provide (probe to determine if they have received any child development training, or safety training)

9. **I would like to ask you about your experiences with the Illinois Child Care Program that you receive payment from.** Overall, how satisfied are you with how this program works? What do you like best about this program, and what do you think could be done to improve it?

10. **Finally, given all that you have said, what is the one thing that could be done to most help you as a child care provider?**

Conclusion

I would really like to thank you for taking the time to get together with us and share your ideas. The information you have provided will be valuable to us as we study the child care system and make recommendations for improving it.

(At this point, staff should pay each of the participants, and the group can brought to a close)