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SESSION 5

Issues in Measuring Quality in Home-Based Settings

This session will consider measurement issues when assessing child care quality in a range of home-based settings. What do we know about quality in home-based settings? How has quality been measured? What types of measures exist? How do these measures vary depending on the type of home-based setting—from family, friend, and neighbor caregivers to licensed family child care providers?

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Discussants: Wendy Wagner Robeson, Center for Research on Women, Wellesley College

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Challenges of Studying Home-Based Providers

- Family child care looks different across regions, states, localities—in part because regulations vary
- It is difficult to operationalize what quality in home-based care is because:
 - Children in home-based settings are often from mixed age groups
 - Caregiver characteristics differ from centers
 - There is high caregiver turnover
 - For example, in Massachusetts and Maine, had to talk to 800 people to get 200 participants; in North Carolina, had to talk to 1,600 to get 190 participants: 59 percent response rate
 - Main reason for those contacted not participating was that they were no longer providing care

- No State regulations exist for caregivers who are relatives of the children in their care
- How do we know what quality is for these groups?
- What aspects of relative caregiving may be different from other home-based settings?
- How do we measure quality of care in mixed age groups?
- How do you ensure your instruments capture information on infants and school-age children, as well as other age groups in these settings?
- How do you define quality of care for school-age children? Most observations are not conducted during the hours when school-age children are home; it may help to try afternoon or summer observations.

Issues in Recruiting Study Participants from FFN (family, friend, neighbor) Settings

In Massachusetts:

- Providers were recruited from diverse home settings (rural, urban, suburban throughout state)
- Recruitment was proportional to market share in region, to get a true distribution

What kinds of outreach efforts can maximize participation? Approaches that have been tried include:

- Sending out newsletters;
- Using more “inviting” (less institutional-looking) letters;
- Developing logo/letterhead separate from that of institution/university;
- Sending letters packaged with children’s book to encourage opening letter;
- Using consistent, bright colors and logo for all materials to make them easier for providers to identify;
- Including with the letter a kit of practical health and safety materials as an incentive to participate (e.g., fire extinguisher, easy-to-read health reference materials, crayons, children’s books);
- Sending birthday cards to children cared for by providers;
- Developing relationship between the researcher and provider, especially for longitudinal studies;
- Using the same researcher or staff to make all contacts with a particular provider;
- Responding to the needs of some home-based providers (especially in rural areas, where they are more isolated) to talk and have some social/professional interaction.

Challenges of recruitment in home-based settings:

- The sole/single provider makes challenges of recruitment different from centers. Research takes place in the provider home, through observation and interviews
- Unregulated providers are particularly difficult to recruit, partly because they are difficult to identify
- Recruiting never stops. To encourage participants to stay throughout the study, researchers are trained to continue to “sell” the study and make participants comfortable with what is essentially an invasive process

- In matching researchers to providers in rural/urban areas, it helps to have researchers/observers from the local (rural) area to make the first contact
- Outreach is often hindered by providers being hard to reach (phones often disconnected) and provider resistance to the idea of a long interview or on-site visit

Approaches to Measuring Quality

Adaptation of Home Observation for Measurement of the Environment (HOME) assessment to phone interview (Kelly Maxwell):

- Phone surveys were used instead of in-person interviews in North Carolina. They found that providers were more willing to participate over the phone.
- Adaptation of HOME measurement to phone interview:
 - Focus is on infant/toddlers items that are adaptable to a phone interview: materials, involvement of caregiver, variety of stimulation, organization of materials
 - Phone survey, and HOME, FDCRS—was done in this case to allow for comparison of home observations and phone surveys. It also may be a way of assessing quality if there is no access to the home

Child Care Assessment Tool for Relatives (CCATR, Toni Porter)

- Health and safety, materials checklist used for needs assessment and analysis rather than a quality assessment
- Time sampling of relationships
- Look at focal child rather than group—relative care usually involves only one or two children
- Emphasis on interaction rather than environment
- Detailed rather than global
- Look for “red flag” items in quality measurement
- 80% inter-rater reliability
- Content validity
- Factor analysis
- Easy to learn
- Different way of thinking about child care quality
- Use quality assessment for program use as well as assessment

Massachusetts and Maine Studies of Family Child Care: Studies of licensed family child care (different population than FFN care) (Wendy Robeson and Joanne Roberts)

Measures used:

- Family Day Care Rating Scale (FDCRS)
- Arnett Caregiver Interaction Scale
- Abt Environmental Snapshot was done every 20 minutes; counted who was currently in the house, including children and all adults in the house; “who was doing what” (list of children’s activities: how many in dramatic play, gross motor, nothing, etc.); television scale (how long the television is on, whether children are watching or it is only on in the background; what the content of programming is and whether it is appropriate)
 - In Maine: looked at activities by age of child; dynamics of mixed-age group
 - Using interviews to assess quality:
 - Cost and fees: Shared expenses between providers and parents—exchanges used to negotiate rates (exchange of services by parents for child care by provider) made it difficult to determine cost of child care
 - Also looked at provider goals, job stresses (workforce issues)

Interview findings:

- Providers were asked what they considered the most important goals of what they were doing as providers.
- Interview responses were rated on Likert scale (not open-ended).
- Provider goals matched observational FDCRS findings: providers recognize as their most important goals providing a safe environment, providing a stimulating environment, learning, language, diversity of materials, activities, etc.
- Thus, FDCRS is in line with what providers recognize as their own goals for program:
 - Validates quality measurement
 - Has implications for technical training
 - Part of quality is being able to identify goals, so even if the providers are not actually meeting their own goals, this is an important step

Challenges to Collecting Data

Wendy Robeson (Massachusetts and Maine)

- One person does the observation, another does the interview (to ensure they are “blind” to the observational data).
- Interview and observation typically done on different days because the interview was in-depth and somewhat invasive and had to be done when children were not present
- In rural areas of Maine, the observation and interview were done by the same person on the same day, due to the constraints of time and money

- Researchers stressed the personal nature of the research (in contrast to center interviews), especially the need to ask about personal finances
- Researchers noted there were often discrepancies between what providers said their goals were (often suggesting high quality), and what was actually happening in programs (often low quality)

Kelly Maxwell (North Carolina)

- Researchers worked hard to develop phone interview questions that were carefully worded to avoid leading providers to give the “right” answer.
- Because the same researcher conducted both the home and phone interviews, this may have made the correlations higher.
- Validity may have been a problem for those participants who took the phone survey before the observation.
 - In phone interviews, which items are more influenced by socially desirable responses versus structural items?

Toni Porter

- Discussants talked about the ethical challenge of how to deal with distressing observations: when should the researcher take off the “researcher hat”?

Other challenges to data collection:

- Researchers must consider how/whether it is possible to be an objective observer when observing caregivers in relative care settings
- Observing quality in home-based and relative care settings broaches issues of what is good parenting (more than just what is good caregiving)
- What is the differential impact of the observer on quality? Individual caregivers might be more likely to adjust their behavior than those in a center in response to being observed, because they can more easily adapt what they are doing
- Cultural, racial, and socioeconomic differences between researchers and providers can also affect levels of trust
- Difficult to calculate costs of care in these settings because there are so many informal relationships that affect the business end (including trade and bartering relationships). But costs can be calculated to take this into consideration. Most providers were found to earn at least 50 percent of the family’s income. Hours per week were higher than expected—average was 60 hours per week (including child care and non-child care duties).

“A-ha Moments” for Researchers Studying FFN Care

- Relationships between caregivers and children, often grandmother and grandchild, play an important—but hard-to-quantify—role
- Relative caregivers often emphasize their desire to foster the child’s moral and character development. This is not typically mentioned as a goal of care in centers
- Parent/family and community relationships across studies were found to be a major factor influencing the caregivers’ motivation for caregiving and the business of caregiving

Challenges to Bringing Providers into Professional Development

New models of professional development are needed for home-based providers because:

- Caregivers in this setting often do not see their work as child care and do not identify what they do as a profession
- Their nonstandard and fluctuating hours of child care preclude participation in traditional trainings, workshops, etc
- Time is also a challenge for licensed providers
- We need to think of professional development in terms of family support and the parent-education perspective rather than from the traditional child care models
- Some States have no regulations for group care, and providers have no incentive to join professional groups
- Also, some home-based providers get into the business so that they can stay home and run their business without getting involved in such activities (the “leave me alone” mentality.)

Effect of Caregiving Context on Quality

Provider characteristics matter:

- Income
- Race/ethnicity
- Age
- Co-residence with child
- Extended family/intergenerational household
- Geographic location
- Education
- Time spent caring for children

Other factors to look at

- Non-standard work hours
- Economic and class differences of families

Are special needs children cared for in home-based settings?

- Researchers found that there was low usage of family child care by families with special needs children
- Findings consistently showed that:
 - Provider education was the most significant predictor of quality
 - Low-income children are consistently in the poorest-quality care

What are caregivers' motivations to be in this business?

- Wanted to stay home with their own children in a family child care setting
- Wanted to help family or relative financially
- Out of love for grandchild/relative

“Burning” Questions

- How can we capture difference in quality of unregulated care and licensed care? (FDCRS allows comparison across homes on structural characteristics, yet misses quality of caregiver interactions)
- How can we look at good caregiving and nurturing across settings? Maybe we should focus on interactions rather than structural items, using different kinds of measures.
- What do parents want for their children? Typically what is most important to them is to have a good provider-child relationship that is nurturing. Therefore, perhaps we should consider having measures of quality that are the same across settings, to capture this element.
- What is quality, regardless of the setting?
- How can we look at FFN care as a bridge between parenting and child care?
- What would motivate providers to get more involved and improve quality?
- How many children in FFN care could have been in other kinds of child care arrangements?