Contract No.: 233-02-0086(14)
MPR Reference No.: 6107-703

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Policy Research, Inc.

Strategies for Supporting Quality in Kith and Kin Child Care: Findings from the Early Head Start Enhanced Home Visiting Pilot Evaluation

Final Report

July 28, 2006

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ACKNOWLEDGMENTS

This report would not have been possible without participation of the dedicated directors and staff of the 23 Enhanced Home Visiting Pilot programs who generously shared their time, insights, and experiences with us. We are grateful to all who participated in the site visits and collected information for the record-keeping system. We are also grateful to the parents and caregivers in each community who contributed their time, candidly shared their experiences with the pilot, and allowed us into their homes.

We would also like to thank others who contributed to this report. Judie Jerald at the Head Start Bureau and Rachel Cohen at ACF's Office of Planning, Research, and Evaluation provided guidance, support, and suggestions that helped shape all stages of the research. Toni Porter and her colleagues Rena Rice and Elizabeth Rivera at the Bank Street College of Education trained our team to conduct child care observations using the Child Care Assessment Tool for Relatives (CCAT-R) and provided valuable guidance and advice about collecting and analyzing the observation data. A number of other researchers gave us helpful feedback on our site visit protocols in the evaluation's early stages: Steven Anderson, University of Illinois at Urbana-Champaign ; Judy Carta, University of Kansas; Ellen Kisker, Twin Peaks Consulting; Jon Korfmacher, Erikson Institute; Eva Marie Shivers, University of Pittsburgh; and Susan Spieker, University of Washington.

Kimberly Boller at Mathematica Policy Research, Inc. (MPR) and Gina Adams at the Urban Institute carefully reviewed drafts and contributed thoughtful comments and suggestions. In addition to the authors, Robin Koralek, Carolyn O'Brien, and Nancy Pindus at the Urban Institute and David Eden, Laura Hawkinson, Jamila Henderson, and Barbara Schiff at MPR conducted site visits. Also at MPR, Anne Bloomenthal designed the record-keeping system and Jamila Henderson and Vatsala Karwe providing programming support. Bryan Gustus skillfully produced the report.

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EXECUTIVE SUMMARY

Families with infants and toddlers, especially low-income families, rely heavily on child care that is provided by family, friends, and neighbors ("kith and kin" caregivers) for their young children (Ehrle et al. 2001). In fact, research suggests that kith and kin care may be the predominant form of nonparental infant-toddler care (Brandon 2005). The national evaluation of Early Head Start found that a large proportion of program families used kith and kin care, especially in home-based programs (Administration for Children and Families 2004). Information about the quality of care provided in kith and kin settings is sparse; however, limited evidence from child care quality studies indicates some positive aspects of care, as well as some areas of concern.

The high prevalence of kith and kin child care for infants and toddlers, coupled with research evidence suggesting cause for concern about quality in these settings, points to a critical need for policies and programs to support kith and kin caregivers in providing quality care. A number of state and local agencies are exploring strategies for supporting kith and kin caregivers; however, relatively little is known about how to engage them effectively and provide services in ways that support the quality of care they provide for young children (Anderson et al. 2005; Collins and Carlson 1998; Porter 1998).

In summer 2004, the Office of Head Start funded 24 Early Head Start programs to implement the Enhanced Home Visiting Pilot Project, an initiative designed to support the quality of care that kith and kin caregivers provided to infants and toddlers enrolled in Early Head Start.[1] Programs participating in the pilot were directed to continue providing all services to children and parents required by the Head Start Program Performance Standards for home-based programs. In addition, they provided home visits to caregivers, organized training workshops and support groups for them, and gave or loaned them materials and equipment.

The Office of Head Start contracted with Mathematica Policy Research, Inc. (MPR) and its subcontractor, the Urban Institute (UI) to conduct a two-year evaluation of the pilot project. Because so little is known about the needs of kith and kin caregivers, the quality of

[1] Funded by the Office of Head Start, Early Head Start programs provide comprehensive, two-generation services for families with pregnant women and/or children ages birth to 3. Currently, more than 700 programs are in operation with more than 70,000 families enrolled nationwide.

care they provide, and the effectiveness of service delivery approaches targeted to this population, the evaluation was designed to be descriptive. The evaluation focused on identifying program models, documenting implementation strategies and challenges, learning about promising practices, and assessing the quality of kith and kin child care settings. Data sources for the evaluation include site visits, staff telephone interviews, quality observations, caregiver interviews, and administrative records on the characteristics of children, families, and caregivers and the services that caregivers received during the first two years of the pilot.

RESEARCH QUESTIONS

Six primary research questions guided the evaluation:

1. What are the characteristics of families served by kith and kin caregivers in the pilot program?

2. What are the characteristics and needs of kith and kin caregivers participating in the pilot program?

3. What program models are the pilot sites implementing?

4. How is the pilot program being implemented, and what services are sites providing?

5. What community partnerships have sites developed to support the pilot program?

6. What is the quality of care provided by kith and kin caregivers participating in the pilot program?

KEY FINDINGS

Programs established four main goals for the Enhanced Home Visiting Pilot: (1) improving the quality of care provided by kith and kin caregivers, (2) increasing the consistency of caregiving practices across home and child care settings, (3) improving parent-caregiver relationships, and (4) supporting caregiver needs. They targeted primarily unregulated family, friend, or neighbor caregivers of Early Head Start children for enrollment in the pilot. Three programs, however, included some licensed family child care providers. In addition, one targeted foster parents and relatives assigned as kinship caregivers by the child welfare agency, and one targeted residential and nonresidential fathers. Below, we summarize the evaluation's main findings, organized according to research question.

What Are the Characteristics of Families Served by Kith and Kin Caregivers in the Pilot Program?

The demographic characteristics of children and families enrolled in the pilot were similar to those of the larger population of children and families served in each site's Early Head Start program. Early Head Start children were 17 months old, on average, when they enrolled in the pilot. Sixteen percent had a disability or developmental delay. Parents were 27 years old, on average, at enrollment; 20 percent were teen parents. Most were white, and nearly half were married or living with a significant other. Eleven percent did not speak English as a first language. Two-third of parents were working or in school when they enrolled.

What Are the Characteristics and Needs of Kith and Kin Caregivers Participating in the Pilot Program?

More than two-thirds of the caregivers enrolled in the pilot were related to the children in their care. Nearly half were the children's grandparents. The average age of caregivers at enrollment in the pilot was 41. Two-thirds were married or living with a "significant other," and half had annual household incomes of $20,000 or less. More than 70 percent of the caregivers were white, and one-third had not completed high school. One-tenth of the caregivers were licensed or registered family child care providers. Most unregulated caregivers did not express interest in pursuing licensure, but most expressed motivation to continue caring for children.

Most kith and kin child care arrangements in our sample were stable ones that lasted for more than a year. The average duration of the arrangements was 17 months. More than half the children were in care for 20 hours or more a week; 40 percent were in care for more than 40 hours a week. Nearly 30 percent of the caregivers reported receiving compensation for these arrangements; 16 percent reported receiving a child care subsidy.

What Program Models Are the Pilot Sites Implementing? How Is the Pilot Program Being Implemented, and What Services Are Sites Providing?

The pilot sites took three main approaches to staffing: (1) a dual home visitor approach, in which a pilot home visitor worked with the caregiver, and an Early Head Start home visitor worked with the parent; (2) a single home visitor approach, in which the Early Head Start home visitor worked with both the caregiver and parent; and (3) a community partner approach, in which community partner staff worked with the caregiver and an Early Head Start home visitor worked with the parent. Pilot staff were highly qualified; most had education and experience in early childhood education and home visiting. However, staff turnover was fairly high; 15 of the 23 pilot sites experienced turnover in home visitors during the first two years of implementation.

Recruiting, enrolling, and retaining caregivers in the pilot was challenging throughout the first two years of implementation. At the end of the data collection period, most of the sites were serving 75 percent or fewer of the caregivers they planned to enroll. Staff in most

sites reported, however, that enrollment was low primarily because of the narrow eligibility criteria for the program, rather than because of a lack of interest among kith and kin caregivers. To be eligible, caregivers had to be caring for a child already enrolled in Early Head Start. Many sites did not have enough enrolled families already using kith and kin care and could not easily enroll more because they were already at full enrollment and had long waiting lists.

The average duration of caregiver enrollment was nine months; nearly half the caregivers left the program after about six months. Staff reported that, to some extent, turnover was more the result of families' tumultuous lives than of caregivers' lack of interest. For example, nearly half the caregivers left the program because the child and family left Early Head Start. In many cases, however, the caregiver continued to care for the child and wanted to continue participating in the pilot. About a third of the caregivers left the program because the child care arrangement ended. According to pilot staff, parents' child care needs often changed because of changes in work or school schedules.

More than 90 percent of caregivers received at least one home visit; across all sites, they received an average of nine visits. Most programs planned to conduct home visits with caregivers weekly, biweekly, or monthly. On average, they completed about half the number of home visits per caregiver they intended to provide each month. Overall, programs that used the dual home visitor or community partner staffing approaches completed more of their planned visits than those using a single home visitor for parents and caregivers. Most caregiver home visits included a discussion with the caregiver on a child development topic and an activity with the child, caregiver, and home visitor. Nearly half the visits also included activities focused on meeting the caregivers' needs, such as providing emotional support, problem solving, and making referrals for social services.

Across all programs, one-third of the caregivers attended at least one training workshop, support group, or group socialization event. According to pilot staff, lack of transportation was the most common obstacle that prevented caregivers from attending. Five programs, however, had high levels of attendance. These programs tailored group activities to the expressed interests of the caregivers, and they provided transportation, child care, and participation incentives.

Nearly all the pilot sites provided caregivers with materials and equipment to improve the quality of the caregiving environment. The most commonly provided items were educational materials, toys, books, and safety equipment. Two-thirds of caregivers received at least one item, and nearly 60 percent received two or more.

Nearly all programs implemented strategies to improve communication and increase consistency in caregiving practices between parents and caregivers. They did this by sharing information about the caregiver visits with parents, conducting periodic joint visits, encouraging both parties to attend group events, sharing consistent educational information about child care and development with both parties, and encouraging direct communication.

The pilot sites relied on a combination of their pilot grant from the Office of Head Start, in-kind resources from the Early Head Start program, and in-kind contribution from

community partners to cover the cost of implementing the Enhanced Home Visiting Pilot. Salaries and benefits for home visitors were by far the largest cost. Other resources—such as staff training, supervision, and materials—were contributed to varying degrees by Early Head Start agencies and community partners. Because the pilot was designed to be an enhancement to home visiting services already provided to Early Head Start families, there were few start-up costs involved in adding a caregiver component to the existing program.

What Community Partnerships Have Sites Developed to Support the Pilot Program?

All of the pilot sites recruited at least one community partner to provide training, materials, or referrals for the pilot. The most common type of partner was the local Child Care Resource & Referral Agency (CCR&R), followed by family support and home visiting programs such as Parents As Teachers. In six sites, these partnerships were essential to the pilot because they provided key staff, space, or access to the target population that the pilot site would not have had on its own. In 10 sites, the partnerships enriched pilot services by contributing materials, training expertise and other resources. However, in seven sites the partnerships were never implemented as planned.

What Is the Quality of Care Provided by Kith and Kin Caregivers Participating in the Pilot Program?

To assess the quality of the caregiving environment, we checked for the presence of health and safety features and developmentally appropriate materials and books. Overall, the caregivers' homes we observed met health and safety criteria, but some critical safety features were not observed, which, if not present, could pose an immediate danger to the child. For example, only 40 percent had electrical cords secured, only 30 percent had safety caps on electrical sockets, and only 23 percent had dangerous substances in locked cabinets or out of reach. Caregivers' homes contained a wide variety of developmentally appropriate materials; nearly all homes had at least one children's book.

To assess the quality of child-caregiver interaction, we conducted in-home observations using the Child Care Assessment Tool for Relatives (CCAT-R) and the Arnett Caregiver Interaction Scale. We observed incidents of caregiver and child language and engagement in a large proportion of the observation periods. Children interacted with the caregiver and with safe materials or objects during more than three-quarters of the observation periods. We observed incidents of nurturing behavior, such as kissing or patting the child, during half the observation periods, and we observed very few incidents of harsh or ignoring caregiver behavior. Findings from the Arnett Scale were consistent with those of the CCAT-R, showing a high level of caregiver engagement with the child and few instances of harsh or ignoring behavior.

POTENTIAL NEXT STEPS

Early Head Start children enrolled in the Enhanced Home Visiting Pilot spent large amounts of time with their kith and kin caregivers, in child care arrangements that lasted for

17 months, on average. Because children spend so much time in kith and kin child care during their critical first three years of life, developing an intervention within Early Head Start to improve the quality of care provided in these settings seems warranted.

The Enhanced Home Visiting Pilot represents the first step in developing such an intervention. Through their experiences implementing the pilot, sites have demonstrated the feasibility of recruiting kith and kin caregivers, the levels of need for and interest in these services among Early Head Start families (particularly those enrolled in the home-based option), the levels of service delivery that can be achieved, and the staffing patterns that seem most promising. They have also identified a number of lessons related to implementation and service delivery that could be applied to future attempts at replication.

Experiences of the pilot sites also suggest that initiatives for improving the quality of kith and kin child care settings can be implemented in Early Head Start programs with fairly modest amounts of additional resources. Additional funding is needed primarily to cover the cost of hiring home visitors to work with caregivers, and for purchasing safety and educational materials. Early Head Start programs already have expertise in early childhood development and home visiting, along with well-developed systems for staff training and supervision, that can be drawn on to support a kith and kin initiative.

As a next step in developing an effective initiative to improve the quality of kith and kin child care used by Early Head Start families, the Office of Head Start could consider launching another intervention in selected programs that builds on lessons learned from the Enhanced Home Visiting Pilot, and potentially testing the effectiveness of the intervention with a more rigorously designed evaluation. For example, the Office of Head Start might consider developing a set of standards for the intervention based on the findings from this study—such as requiring programs to hire at least one full-time home visitor to work with 10 to 12 caregivers and provide biweekly home visits and monthly group training or socialization events. The effectiveness of such an intervention could be tested by assessing its impact on the quality of care provided by kith and kin caregivers and children's outcomes to determine if the intervention produces the desired results. If the intervention is found to be beneficial for Early Head Start children, the Office of Head Start could consider options for supporting broader implementation.

CHAPTER I

INTRODUCTION

Families with infants and toddlers, especially low-income families, rely heavily on child care provided by family, friends, and neighbors ("kith and kin" caregivers) for their young children (Ehrle et al. 2001). In fact, research suggests that kith and kin care may be the predominant form of nonparental infant-toddler care (Brandon 2005). The national evaluation of Early Head Start found that a large proportion of program families used kith and kin care, especially in home-based programs (Administration for Children and Families 2004). Forty-two percent of families enrolled in home-based options reported using kith and kin care, compared to 17 percent in center-based options and 37 percent in mixed-approach options. Families who use kith and kin child care do so for reasons related to accessibility—low cost, availability during nonstandard hours, flexibility, convenience—and personal preferences—trust in the caregiver, low caregiver-child ratio, and shared language and culture (Brandon 2005; Emlen 1999; Larner and Phillips 1994; Porter 1991).

Information about the quality of care provided in kith and kin settings is sparse; however, limited evidence from child care quality studies indicates some positive aspects of care, as well as some cause for concern. On the positive side, evidence suggests that child-adult ratios in kith and kin settings are typically much lower than in child care centers and family child care homes, providing the opportunity for more interaction between children and caregivers (Brandon 2005; Maher et al. 2003). On the other hand, several studies of child care quality have found low levels of quality based on standard observational rating scales (Raikes 2003; Fuller and Kagan 2000; Kontos et al. 1995).[1] Moreover, evidence on the low education levels of kith and kin caregivers and lack of training in child care or child development raises concerns about the capacity of some kith and kin caregivers to support children's healthy development during their critical early years (Brandon 2005; Brandon and Martinez-Beck 2005).

[1] Some child care quality researchers believe these standard observation measures, such as the Family Day Care Rating Scale (FDCRS; Harms and Clifford 1989) are not appropriate for measuring quality in kith and kin settings because they were developed for use in regulated family child care homes (Porter et al. 2006a). Nevertheless, consistently low ratings across studies indicate cause for concern.

The high prevalence of kith and kin child care for infants and toddlers (especially those from low-income families who are at greater developmental risk), coupled with research evidence suggesting cause for concern about the quality of care in these settings, points to a critical need for policies and programs to support kith and kin caregivers in providing quality care. A number of state and local agencies are exploring strategies for supporting kith and kin caregivers; however, relatively little is known about how to engage them effectively and provide services in ways that support the quality of care they provide for young children (Anderson et al. 2005; Collins and Carlson 1998; Porter 1998).

Early Head Start, with more than 700 programs and 70,000 families enrolled nationwide, serves as a national laboratory for developing and testing strategies to support the development of infants and toddlers. Moreover, the Head Start Bureau (now known as the Office of Head Start) has given programs a mandate to support the quality of all settings where children receive care by providing high-quality services and supporting parents and child care providers in caring for their young children. Thus, Early Head Start provides fertile ground for designing and testing strategies to support quality in kith and kin child care settings.

In summer 2004, the Office of Head Start funded 24 Early Head Start programs to implement the Enhanced Home Visiting Pilot Project, an initiative designed to support the quality of care that kith and kin caregivers provide to infants and toddlers enrolled in Early Head Start. The pilot program provides an important opportunity to learn more about the needs of these caregivers and how to support them. Lessons learned from the pilot can benefit other Early Head Start programs and the broader early childhood education community.

The Office of Head Start contracted with Mathematica Policy Research, Inc. (MPR) and its subcontractor, the Urban Institute (UI) to conduct a two-year evaluation of the pilot project. The evaluation focused on identifying program models, documenting implementation strategies and challenges, learning about promising practices, and assessing the quality of kith and kin child care settings. An interim evaluation report, documenting implementation in the pilot's first year, was released in January 2006 (Paulsell et al. 2006; see box next page).

This final report describes the experiences of the pilot projects during their first two years of implementation. It is based on site visits to all of the pilot sites after approximately one year of operation, follow-up telephone interviews with key program staff six months later, and a second round of site visits to 12 sites after two years of implementation. During this second round of site visits, the research team also conducted quality observations and caregiver interviews in a subsample of caregivers' homes. In addition, we analyzed administrative records on the characteristics of children, families, and caregivers and the services that caregivers received during the first two years of the pilot. In the rest of this introductory chapter, we provide an overview of the pilot program and the evaluation.

OVERVIEW OF INTERIM FINDINGS FROM THE ENHANCED HOME VISITING PILOT EVALUATION

Participating Early Head Start programs established four main goals for the pilot: (1) improving the quality of care provided by kith and kin caregivers, (2) increasing consistency in caregiving between parents and caregivers, (3) improving communication between parents and caregivers, and (4) addressing caregivers' needs. Sites deployed highly experienced home visitors to work with caregivers. Most had at least three years of experience in early childhood education; more than half had three or more years of experience as home visitors. Key findings on recruitment and service delivery strategies during the pilot's first year include the following:

Connections to Early Head Start make recruitment easier. Programs were successful in recruiting caregivers largely because they had already established a positive, trusting relationship with the child's family. Parents told caregivers about their experiences with Early Head Start and encouraged them to enroll in the pilot.

Sites built on the Early Head Start service delivery approach to working with caregivers. Most programs based their pilot services on what they were already doing and knew how to do well. During home visits, they tried to maintain a primary focus on the child and strategies for supporting his or her development, and they individualized services for the caregiver and child. They worked on building strong relationships and promoting bonds between caregivers, children, and parents.

Most sites reported visiting caregivers at least monthly. Overall, home visitors reported completing visits as scheduled. Typical visits lasted 60 to 90 minutes and often included a child-caregiver activity and discussion of a child development topic. Almost all home visitors completed a home safety check during an early visit.

Sites gave or loaned materials and equipment to caregivers. Some sites provided materials directly; others had community partners that supplied materials. Health and safety devices—such as first aid kits, baby gates, cabinet latches, smoke alarms, and outlet covers—were reported to be the most frequently supplied items. Others items included children's books, toys, and equipment such as car seats.

Targeting activities and offering incentives improved attendance at group events. Sites offered group events such as training, support groups, and play groups. Overall attendance was low, but those with the best attendance provided incentives such as small stipends, door prizes, and meals, as well as transportation and child care. Caregivers were more likely to attend events tailored just for them, rather than general caregiver training offered by a child care resource and referral agency.

Improving parent-caregiver relationships was an important focus. Home visitors worked on improving parent-caregiver communication to promote continuity in caregiving practices and resolve disagreements about how to care for the child. Strategies included conducting periodic joint visits with parents and caregivers, sharing information about the visits between parents and caregivers, and providing coaching on communication strategies.

Early Successes and Challenges. Early implementation successes included raising awareness of the caregiver's important role in the child's life, reducing caregivers' social isolation, increasing consistency in caregiving between parents and caregivers, and implementing services as planned. Sites also faced ongoing challenges, including caregiver recruitment, caregiver turnover, and low attendance at group events.

THE ENHANCED HOME VISITING PILOT PROJECT

Most families enrolled in Early Head Start need child care for their infants and toddlers while parents work or attend school or training programs (Administration for Children and Families 2004). Because the quality of care that young children receive plays an important role in their development, Early Head Start has made helping families obtain good-quality child care for their infants and toddlers a high priority—whether that care is provided by an Early Head Start center, a child care center in the community, a family child care home, or a relative or friend. In keeping with this priority, the purpose of the Enhanced Home Visiting Pilot Project was to develop program models for supporting kith and kin caregivers in acquiring the knowledge, training, and skills they need to support children's healthy development. The Office of Head Start set five main goals for the pilot program:

1. Identify the needs of kith and kin caregivers and the support they need to provide quality care.

2. Increase the availability of quality infant-toddler child care in the pilot communities by providing training and support to caregivers.

3. Provide an enhanced quality of care to Early Head Start children as a result of the support, training, resources, and home visits caregivers receive.

4. Provide children with positive experiences in the enhanced care settings to lay a strong foundation for early learning, improved child outcomes, and school readiness.

5. Enhance relationships, communication, and understanding between programs, parents, and caregivers in support of children's development.

In spring 2003, the Office of Head Start invited Early Head Start programs providing services to families through the home-based option to apply to participate in the pilot.[2] Twenty-four programs were selected to participate during a three-year grant period; they began operations in summer 2004.[3] Programs participating in the pilot were directed to continue providing all services to children and parents that the Head Start Program Performance Standards for home-based programs require. In addition, they provided training, resources, and support to kith and kin caregivers of enrolled Early Head Start children, tailored to the specific strengths and needs of their communities. Pilot programs delivered these services to kith and kin caregivers primarily through home visits and group

[2] Early Head Start programs that provide services through the home-based option must provide families with weekly home visits lasting at least 90 minutes and with at least two group socialization activities per month. Under the home-based option, programs do not provide center-based child care to families (either directly or through partnerships with community child care providers).

[3] One of the 24 sites selected for the pilot subsequently relinquished its Early Head Start grant and withdrew from the pilot.

events. The Office of Head Start also required all pilot sites to collaborate with community partners—such as community-based home visiting programs or community agencies that offer training to child care providers—in their work with caregivers. Most of the pilot sites planned to provide regular home visits to caregivers, organize group training and socialization activities, and offer materials and supplies.

Table I.1 lists the pilot sites, organized by Administration for Children and Families (ACF) region.[4] The table also displays the number of Early Head Start children each program was funded to serve, the number of those enrollment slots designated for the home-based option, and the number designated for the Enhanced Home Visiting Pilot Project.

THE ENHANCED HOME VISITING PILOT EVALUATION

Through the pilot evaluation, the Office of Head Start aimed to collect and disseminate information about the program models and service delivery strategies developed by the pilot sites so that all Early Head Start programs and families could benefit from their experiences. Because so little is known about the needs of kith and kin caregivers, the quality of care they provide, and the effectiveness of service delivery approaches targeted to this population, the evaluation was designed to be descriptive. Data collection activities focused on learning about program operations and service delivery strategies, rather than on assessing the pilot's effects on child care quality and children's outcomes. The main goals of the evaluation were the following:

- Learn about the characteristics and needs of kith and kin caregivers and the families that rely on them for child care.
- Identify promising program models for reaching out to caregivers and supporting them in providing good-quality infant-toddler care.
- Identify implementation strategies and challenges.
- Document the quality of care that caregivers participating in the pilot program provide.
- Identify and disseminate lessons learned from the pilot.

In the rest of this section, we describe the pilot evaluation in more detail, including the primary research questions, data sources, and analytic methods used.

[4] The table lists 23 sites, instead of 24, because (as mentioned above) one program relinquished its Early Head Start grant and withdrew from the pilot.

Table I.1. Funded Enrollment Slots for Early Head Start Enhanced Home Visiting Pilot Sites

Program	Location	Total EHS Enrollment Slots	Home-Based Enrollment Slots	Pilot Enrollment Slots
ACF Region I				
Children's Friend and Service	Providence, RI	98	98	10
Kennebec Valley Community Action	Waterville, ME	64	24	16
Northeast Kingdom Community Action	Newport, VT	72	72	16
ACF Region II				
The Astor Home for Children	Rhinebeck, NY	125	85	20
ACF Region III				
Cen-Clear Services, Inc.	Phillipsburg, PA	176	176	35
Luzerne County Head Start	Wilkes-Barre, PA	96	96	14
Monongalia County Board of Education	Morgantown, WV	121	75	20
Northern Panhandle Head Start, Inc.	Wheeling, WV	48	48	20
ACF Region IV				
Alabama Council on Human Relations, Inc.	Auburn, AL	152	80	20
Mountain Area Child and Family Center	Asheville, NC	100	46	20
ACF Region V				
Mahube Community Council, Inc.	Detroit Lakes, MN	128	58	50
Hamilton Center, Inc.	Terre Haute, IN	80	44	11
Community Action Wayne/Medina	Wooster, OH	96	66	25
Baraga-Houghton-Keweenaw Development Board	Houghton, MI	95	45	25
Eight CAP, Inc.	Greenville, MI	198	178	40
ACF Region VI				
Region 10 Education Service Center	Richardson, TX	120	120	24
Hutchinson Center for Early Learning	Hutchinson, KS	60	54	20
ACF Region VII				
Northwest Nebraska Community Action Head Start	Chadron, NE	36	36	20
Community Action of Siouxland, Inc.	Sioux City, IA	85	85	20
ACF Region VIII				
Developmental Opportunities, Inc. (Starpoint)	Cañon City, CO	65	55	12

Table I.1 *(continued)*

Program	Location	Total EHS Enrollment Slots	Home-Based Enrollment Slots	Pilot Enrollment Slots
ACF Region IX				
Shasta Head Start Child Development, Inc.	Redding, CA	192	100	20
Maricopa County Head Start Zero to Five	Phoenix, AZ	191	191	14
ACF Region X				
Mt. Hood Community College Child Development	Portland, OR	92	84	20
Total		**2,490**	**1,916**	**492**

Source: 2005 site visit interviews.

Research Questions

The Enhanced Home Visiting Pilot evaluation can make an important contribution to the early childhood community by exploring the characteristics, needs, and experiences of kith and kin caregivers and the families who rely on them for child care. Similarly, what we learn about Early Head Start programs' experiences in implementing the pilot program can yield important guidance for program development and implementation to support future initiatives. Building on the Office of Head Start's goals for the pilot program and the evaluation, we identified six primary research questions to guide our evaluation:

1. What are the characteristics of families served by kith and kin caregivers in the pilot program? What are their child care needs and usage patterns?

2. What are the characteristics and needs of kith and kin caregivers participating in the pilot program?

3. What program models are the pilot sites implementing?

4. How is the pilot program being implemented, and what services are sites providing?

5. What community partnerships have sites developed to support the pilot program?

6. What is the quality of care provided by kith and kin caregivers participating in the pilot program?

Data Sources

The evaluation team collected and analyzed information from three main sources: (1) interviews and focus groups conducted during two rounds of site visits to the pilot programs, and one round of telephone interviews with key pilot staff; (2) a program record-keeping system that MPR designed and pilot staff maintained; and (3) observational assessments of the quality of the caregiving environments and interactions between participating children and caregivers.

Site Visits and Telephone Interviews. Much of the data needed for the evaluation was collected during two rounds of site visits to the pilot programs. We visited all 23 sites in summer 2005.[5] In winter 2006, we conducted telephone interviews with key staff at all 23 pilot sites to update information obtained during the first round of site visits. In spring 2006,

[5] One visit was not conducted until October 2005 because the site was delayed in implementing its pilot project.

we visited 12 of these pilot programs a second time.[6] Although the number and titles of pilot staff we interviewed varied somewhat across the sites, we interviewed the following types of staff: (1) the Early Head Start director, (2) the pilot program coordinator, (3) the home visitors who delivered services to enrolled kith and kin caregivers, and (4) staff from community partners involved in the pilot program. Table I.2 displays the number of each type of informant we talked to during site visits and telephone interviews.

In addition to individual and group interviews with pilot staff, we also planned to conduct two focus groups during the first round of visits—one with parents enrolled in the pilot and another with caregivers receiving pilot services. We were able to conduct the parent focus group in 20 of the 23 sites and the caregiver focus group in 21 sites. An average of 4 parents per site participated in each group (ranging from 1 to 9 participants), and an average of 5 caregivers per site participated (ranging from 2 to 11 participants). While some of these groups were relatively small, in part because of lower-than-expected enrollment in the pilot, the focus groups included more than a third of the caregivers and more than a quarter of all parents enrolled in the pilot at the time of the site visits. During the second round of visits, we conducted parent focus groups in 11 of the 12 sites visits and individual caregiver interviews in all sites. During both rounds of visits, we conducted case reviews on a sample of six families and caregivers in each site to discuss with program staff the primary goals of the family and caregiver and the services they received through the pilot.

Table I.2. Type and Number of Site Visit and Telephone Interview Informants

Informants	2005 Site Visits	Telephone Interviews	2006 Site Visits
Grantee Executive Director/Other Agency Director	3	2	4
Early Head Start Director	23	12	12
Pilot Coordinator	33	15	2
Home Visitor	56	8	28
Community Partner Staff	30	0	16
Parent	88	0	51
Caregiver	107	0	78
Total Informants	**340**	**37**	**191**

[6] Because of resource limitations, we visited only 12 of the 23 pilot sites during the second round of site visits. Selection of sites to participate in these visits was purposive. We selected sites that had the highest levels of enrollment at the time of follow-up telephone interviews conducted in winter 2006 and the most intensive levels of service delivery to caregivers according to record-keeping system data. We also tried to select sites in as many ACF regions as possible.

OBSERVATIONAL MEASURES OF IN-HOME CHILD CARE ENVIRONMENTS USED FOR THE ENHANCED HOME VISITING PILOT EVALUATION

Arnett Caregiver Interaction Scale (Arnett 1989). This scale measures the quality of the caregiver's interaction with the children in care. Items are scored based on a two-hour observation of the caregiver in the child care setting and measure the extent to which the caregiver spoke warmly, seemed distant or detached, exercised rigid control, or spoke with irritation or hostility. Items are coded on a four-point scale from "not at all" characteristic of the caregiver (1) to "very much" characteristic of the caregiver (4).

Child Care Assessment Tool for Relatives (CCAT-R; Porter et al. 2006b). This observational tool assesses the quality of kith and kin child care environments using two data collection methods: (1) time sampling, and (2) observation checklists. Time sampling in six-minute, 40-second increments was used to obtain snapshots of child-caregiver interactions. The snapshots capture the types of communication the caregiver engages in with the focus child, the caregiver's activities with the child, the focus child's communication with the caregiver and others, and who or what the focus child interacts with or attends to. In addition, a summary behavior checklist is completed at the end of each time sample to capture behaviors that need to be recorded as having happened or not happened during the observation period, rather than recorded incrementally over the six minutes. This checklist evaluates the predominant tone of the child-caregiver interaction, the activities the child and the caregiver are engaged in, and the types of interactions with the focus child, as well as discipline, safety, and toileting/diapering events. The CCAT-R also contains two other checklists that are filled out during the observation period: (1) a health and safety checklist, and (2) a checklist on materials available in the caregiving environment. There are two versions of each checklist—one for children under 3 years of age, and one for children over 3 years of age. The criterion for interrater reliability is .80 exact agreement on individual items.

Program Record-Keeping System. We designed a program record-keeping system to collect consistent information about families and caregivers enrolled in the pilot and about services provided to caregivers across the 23 pilot sites. Pilot staff entered information into the system to create records on (1) pilot participants, (2) child care arrangements, and (3) pilot services that caregivers received. Pilot participants included the caregivers, children, and families enrolled in the pilot and the home visitors who provided services to the caregivers. Child care arrangements tracked in the system were those in which caregivers enrolled in the pilot were caring for Early Head Start children. Pilot services included home visits, group training and support groups, and material support provided to enrolled caregivers. Programs began entering information into the system in July 2005, after Office of Management and Budget (OMB) clearance was obtained, and continued through May 2006.

Observations of In-Home Child Care Settings. During the second round of site visits, we conducted in-home observations of kith and kin care settings and child-caregiver interactions using the Child Care Assessment Tool for Relatives (CCAT-R; Porter et al. 2006b) and the Arnett Caregiver Interaction Scale (Arnett 1989) (see box for more detailed descriptions of these measures). Following each observation, we conducted a 30-minute interview with the caregiver to elicit information about the caregiver's (1) attitudes toward child care, (2) relationship with the child's parents, and (3) experiences with the Enhanced

Home Visiting Pilot. We also asked the caregiver whether the observer was observing a typical day in the setting and whether the child was behaving as if it were a normal day.

Sample Selection and Response Rate. Across the 12 sites participating in the second round of site visits, we planned to complete 96 observations, or 8 observations per site, during an eight-week data collection period. We completed 74 observations and 78 caregiver interviews (Table I.3). We used the set of caregivers entered in the program record-keeping system as our sampling frame. We selected a random sample of eight caregivers in each site (except for two sites that only had seven caregivers enrolled, where we took all available enrollees), and then selected alternates as needed to replace caregivers on the original list who refused to participate. We asked program staff to follow a two-stage process for obtaining consent for the observation. First, staff obtained consent from the parents of the child to be observed, and then they obtained consent from the caregiver.

Table I.3. In-Home Observation Sample Response Rate for the Enhanced Home Visiting Pilot Evaluation

Site	First Selection	Alternate Selection	First Selection Consents	Alternate Selection Consents	Number Completed	Percentage Refused	Percentage of Consenters Completed
A	8	2	7	1	8	20	100
B	7	4	5	2	7	36	100
C	7	1	6	0	5	25	83
D	8	3	6	3	9	18	100
E	8	16	3	5	7	67	88
F	8	2	4	1	5	50	100
G	8	12	2	5	6	65	86
H	8	2	5	2	7	30	100
I	8	1	3	0	3	67	100
J	8	5	4	4	5	38	63
K	8	5	6	2	7	38	88
L	8	0	7	0	5	13	71
Total	**94**	**53**	**58**	**25**	**74**	**44**	**89**

Source: 2006 site visits.

Although caregivers received a $40 incentive for participating in the in-home observation, program staff had difficulty obtaining consent from caregivers. The refusal rate for the observations across all sites was 45 percent; however, we completed 95 percent of the observations for caregivers who consented.[7] Most caregivers who refused simply stated that they were too busy or felt that an observation would be too intrusive. For those who consented, but were not observed, a variety of circumstances prevented site visitors from completing the observations. For example, one child was hospitalized the day before the scheduled observation. In another case, an infant was sleeping at the scheduled observation time, and the visit could not be rescheduled. In a third situation, a program requested that a scheduled observation be cancelled because a child protective services investigation had been initiated on the family.

Our sample was not selected to represent the entire group of kith and kin caregivers enrolled in the pilot. Based on tests for statistical significance, the observation sample differs from the total sample along several dimensions. For example, the proportion of caregivers who were related to the children was higher in the observation sample—77 percent, compared to 69 percent of the total sample. Caregivers in the total sample were also older at enrollment—44 years old, on average, compared to 41 years old for the total sample. In addition, 10 percent of caregivers in the observation sample were African American, compared to 6 percent of the total sample. Moreover, due to the high refusal rate, it is possible that our assessments of quality overestimate the quality of care provided by caregivers enrolled in the pilot, because those who provide lower-quality care may have been more likely to refuse participation in the observation.

Training and Reliability. In March 2006, we conducted a three-day training on the two observation measures. Training on the CCAT-R was conducted by the developers of the measure—Toni Porter, Rena Rice, and Elizabeth Rivera of the Bank Street College of Education—and by one MPR team member who had already been reliably trained by the developers. On the first training day, trainees were introduced to the Action/Communication Snapshot and the Behavior Checklist. The trainers defined each type of caregiver talk to be observed and showed videotaped examples. Trainees were also introduced to the materials and health and safety checklists. Trainers presented the Caregiver Interview item by item, and trainees practiced administering it in pairs.

To practice conducting the observation, trainees coded the Action/Communication Snapshot based on three videotaped examples. Five of the nine trainees achieved 80 percent or better agreement with the "gold standard" coded answers developed by Bank Street for these examples. We conducted in-field practice observations on the second and third days of training and assessed reliability after each one. To conduct the observations, we paired teams of two trainees each with a trainer. After each observation, we calculated percent agreement of the two trainees with the group leader for each group and discussed discrepancies in coding. By the end of training, eight of the nine trainees had achieved

[7] Other studies of in-home child care have yielded similarly high rates of refusal (for example, Administration for Children and Families 2004 and Kontos et al. 1995).

80 percent exact agreement with the trainer on individual items. One trainee conducted additional practice observations after training and then coded a videotaped observation, achieving 80 percent agreement with the gold standard coded answers developed by Bank Street.

On the third day of training, we reviewed the Arnett Caregiver Interaction Scale items and coded a 15-minute practice videotape. We calculated percent agreement of trainees' codes with a gold standard developed by the lead trainer, and we considered each score to be in agreement if it was within one likert-scale point of the gold standard score. All trainees were within 85 percent agreement or better on the scale after viewing the videotape.

Analytic Methods

In this section, we describe our methods for analyzing the data from each source: (1) qualitative data from site visits and telephone interviews, (2) administrative data from the program record-keeping system, and (3) quality observation and caregiver interview data. We report findings from these analyses in subsequent chapters.

Qualitative Interview Data. Because of the large number of pilot sites in the evaluation, we used a qualitative analysis software package, Atlas.ti (Scientific Software Development 1997), to make it easier to organize and synthesize the large amount of data collected during the site visits and telephone interviews. This software enabled research team members to use a structured coding scheme for organizing and categorizing data that are linked to the primary research questions. After the site reports were coded, we used Atlas.ti to conduct searches and retrieve data on our research questions and subtopics. We analyzed these data both within and across sites to identify common themes that emerged across respondents and sites, as well as patterns of service delivery, staffing, and other program dimensions.

Program Record-Keeping System Data. To examine the characteristics of families, children, and caregivers enrolled in the pilot, we used data from the record-keeping system to compute descriptive statistics—such as frequencies, means, percentages, and ranges—on variable characteristics of participants for each site. We also examined information on the child care arrangements of children enrolled in the pilot, including the full range of arrangements they were in at time of enrollment in the pilot, as well as the duration of their kith and kin arrangements. To examine the types, intensity, and duration of services caregivers received, we computed the mean amount of various services received per caregiver, such as mean number of home visits per month, and then computed site means. To examine service receipt across all sites or subgroups of sites, we averaged across these site means. This approach ensures that the experience of each caregiver receives equal weight within sites and that all sites receive equal weight in cross-site analyses.

Quality Observation and Caregiver Interview Data. In preparation for the analysis, we assessed the quality of the data and examined key psychometric properties for full scales, subscales, and individual items as follows:

- ***Threshold for Missing Data.*** If an individual observation was missing more than 20 percent of the items that formed part of a scale or subscale, we did not construct the scale for that observation. The scale or subscale for that observation was coded as missing. If less than 20 percent of the items were missing, we imputed them by averaging across the items that were not missing.

- ***Adequate Distribution of Scores.*** We checked the means, ranges, and standard deviations of constructed variables to determine whether the variables had a distribution similar to those found in other studies using the same or similar measures.

- ***Adequate Internal Consistency Reliability.*** We included measures with internal consistency reliability (coefficient alpha) of 0.70 and above in our analyses.

We analyzed the CCAT-R time sampling data using an approach consistent with analysis of the Child-Caregiver Observation System (C-COS), a similar time sampling measure for assessing the quality of child-caregiver interaction (Boller et al. 1998; Administration for Children and Families 2004). We summed the number of instances observed for each action/communication (such as instances of "caregiver responds to focus child's language or communication" or "caregiver does not attend to focus child") and then created variables to reflect the percentage of observation periods in which the action/communication occurred at least once. When appropriate, we also created composite variables of some actions/communications, such as "any caregiver talk to child." Cronbach's alphas for these measures ranged from 0.80 to 0.89. We dropped two composite variables, "child engaged" and "child upset or withdrawn," because the alphas (0.64 and 0.66) were below our threshold of 0.70. For each individual item or scale, we report the average percentage of time, standard deviation, range, and number of observations. We computed frequencies, means, and ranges for items on the health and safety and materials checklists and the caregiver interview.

Factor analysis on the Arnett conducted for previous studies has identified four subscales: (1) positive interaction, (2) punitiveness, (3) permissiveness, and (4) detachment (Arnett 1989; Peisner-Feinberg and Burchinal 1997). Cronbach's alpha for the overall scale was 0.86. The permissiveness subscale had an alpha of 0.58; because it was below our threshold of 0.70, we excluded the subscale from further analyses. Alphas for the remaining subscales ranged from 0.84 to 0.92. We constructed subscales and a total caregiver quality score using standard scoring procedures for this instrument. For the full scale and each subscale, we report the average score, standard deviation, ranges, and number of observations.

ROAD MAP TO THE REPORT

We now turn to presenting our findings from the evaluation. In Chapter II, we provide an overview of the pilot sites and the program models they developed. The chapter also

describes the children and families who participated, staff who worked on the pilot, and other community service providers that partnered with the grantees to provide pilot services. In Chapter III, we examine enrollment levels and the types and intensity of services provided to kith and kin caregivers. In Chapter IV, we report the characteristics of caregivers enrolled in the pilot, as well as the amount and quality of care they provided to Early Head Start children. Chapter V presents findings from the evaluation about the potential sustainability of the pilot after grant funding ends, as well as the potential for replication by other Early Head Start or family support programs. Finally, Chapter VI presents implementation lessons from the pilot project, including programs' implementation successes and challenges, and a synthesis of lessons learned that may be useful for future replication of the pilot.

CHAPTER II

PILOT OVERVIEW: DESIGN, STAFFING, AND TARGET POPULATION

Relatively little is known about the training and support needs of kith and kin caregivers or about how best to design and deliver services that will strengthen the quality of care they provide to young children. Because of this limited knowledge base, Early Head Start grantees were given broad latitude in designing their pilot programs. The only requirements were that they (1) "provide training, resources, and services" to relatives and neighbors who were providing care to Early Head Start children; and (2) partner with another community agency to deliver the services. The Office of Head Start encouraged grantees to design programs tailored to the unique needs of the families they serve and build on the resources already available in their communities. Above all else, the Enhanced Home Visiting Pilot was intended to generate innovation in design and implementation, with the pilot sites serving as laboratories for developing promising models that could be expanded to other Early Head Start and early childhood programs.

This chapter presents important background information about the Enhanced Home Visiting Pilot that sets the stage for examining service delivery, child care settings, and the potential for replication in subsequent chapters. It describes (1) the design process, (2) the staffing models that the pilot sites developed, (3) the characteristics and child care needs of enrolled families, and (4) community partnerships that were formed to serve kith and kin caregivers. The chapter draws heavily from staff and community partner interviews conducted during the first round of site visits and follow-up telephone interviews with program directors approximately six months later. More detailed information on staff training, supervision, and community partnerships is taken from staff and community partner interviews conducted during the second round of site visits with the selected subset of pilot sites. Information on the characteristics of enrolled children and families comes from the program record-keeping system.

DEVELOPMENT OF PROGRAM MODELS

The 23 Early Head Start programs participating in the pilot are located in all 10 ACF regions; 17 served families and caregivers living in relatively rural areas with limited community resources for low-income families. In this context, the pilot had the potential to

offer much-needed services to kith and kin caregivers, many of whom were geographically isolated and had little or no access to other community programs. In this section, we provide an overview of the process Early Head Start programs used to design the pilot, the goals they set, and the populations they targeted for services.

Design Process

Program directors in half the pilot sites said they viewed the Enhanced Home Visiting Pilot as a natural extension of services they were already providing or wanted to provide. For these directors, this was a primary reason for applying for the grant. Three-quarters of the pilot sites used some combination of a needs assessment and consultation with community partners, Early Head Start staff, and Policy Council members to design their Enhanced Home Visiting Pilot. The remaining sites relied on family surveys, input from home visiting staff, or discussions with community partners to determine whom to target for enrollment and what services to provide. Only one pilot site did not begin a formal design process until after funding was received. Sites that based their Enhanced Home Visiting Pilot on a prior or ongoing initiative were no less likely than other sites to follow a formal design process of community needs assessment, community partner involvement, and informal input from Early Head Start staff and families.

Fourteen of the sites had some difficulty in designing their pilot programs and getting them launched. For the most part, this was because program staff initially misinterpreted the federal grant announcement. For example, some thought they could use the grant to serve more Early Head Start families, some thought they could reduce the number of home visits to families by doing some visits with caregivers instead, and others thought they could serve caregivers of children enrolled in a community partner's home visiting program. During the grant review and award process, the Office of Head Start clarified the grant requirements and requested that these sites redesign their pilots accordingly.[1] Most were able to adapt quickly, but a few struggled to redesign their pilot to fit the grant requirements and awarded budget.

Setting Program Goals

During the first round of site visit interviews, program directors described four main goals of the Enhanced Home Visiting Pilot: (1) improving the quality of care provided by kith and kin caregivers, (2) increasing the consistency of caregiving practices across home and child care settings, (3) improving parent-caregiver relationships, and (4) supporting caregiver needs (see box next page). The first three of these goals focus on improving the quality of care for children, while the fourth directly addresses the caregivers' needs.

[1] As stated in Chapter I, the pilot sites were required to continue to provide all services to children and parents that the Head Start Program Performance Standards for home-based programs require. In addition, through the pilot they were to provide support services to kith and kin caregivers of enrolled Early Head Start children.

Goals of the Pilot Sites

	Number of Programs
Improve quality of care	23
Increase consistency of care	10
Improve parent-caregiver relationships	5
Support caregiver needs	12

N = 23 pilot programs.

The overarching goal of the pilot, noted by all sites, was to improve the quality of care provided by kith and kin caregivers to support young children's development. In most sites, addressing this goal involved efforts to improve caregiving practices by sharing child development information and demonstrating play activities designed to stimulate the child's growth. Many sites also planned to address this goal by providing health and safety equipment and age-appropriate furnishings to caregivers to improve the child care environment.

Nearly half the sites identified increasing the consistency of care between parent and caregiver as a goal. Programs planned to pursue this goal by encouraging parents and caregivers to adopt similar caregiving practices to create more consistency in the child's daily routines. In some cases, program staff also aimed to encourage Early Head Start parents to adopt certain caregiving practices by reinforcing them among all the child's caregivers. Sites differed in how they proposed to accomplish this goal, but all involved efforts to provide consistent child development information to parents and caregivers.

Five sites specifically aimed to improve communication and relationships between parents and caregivers as a primary goal of their pilot. For example, one site serving incarcerated teenage parents whose child was in the care of a relative believed that fostering positive family communication would facilitate successful reunification after the parent was released from prison. Through group socialization activities during the parent's incarceration and home visits afterward, the program created opportunities for parents and caregivers to communicate and rebuild their relationship for the welfare of the child.

More than half the sites set a goal of providing emotional support to caregivers and helping them access needed social services. Program directors noted that relative caregivers often are socially isolated and go unrecognized for the contributions they make to the child's well-being. From the directors' perspective, attention to caregivers' emotional and social service needs was a critical component in supporting their efforts to provide the best care possible for the child.

The pilot sites varied in their emphasis on improving caregiving practices and addressing caregivers' emotional support and self-sufficiency needs more generally. Twelve of the sites focused on the dual goals of (1) improving the quality of care, and (2) providing emotional support and referrals to address caregiver needs. The remaining sites, in contrast, placed most of their emphasis on improving the quality of care, and one site focused exclusively on this goal. The decision to focus on improving the quality of care was often prompted by program directors' concerns that asking home visitors to help caregivers with personal needs would divert attention away from the pilot's stated primary goal of improving caregiving knowledge and skills.

Target Population

According to the federal grant announcement, families were eligible to enroll in the pilot if they (1) received services through the home-based option of Early Head Start, and (2) were using kith and kin child care for their Early Head Start child. Most of the pilot sites enrolled all families who met these criteria and agreed to participate in the pilot. Therefore, the characteristics of the families they served were similar to those of all families enrolled in their Early Head Start programs. Some sites, however, targeted specific types of families. These sites were already serving a specific target population and saw the pilot as an opportunity to expand the scope of services (see box). For example, six sites targeted immigrant families using kith and kin care, and five targeted families in which parents were working or in school. Five sites targeted families with teenage parents. Two of these sites worked almost exclusively with this population, and another targeted teenage mothers and fathers incarcerated in the state juvenile corrections facility and the relative caring for the child during the parent's incarceration and probation period. Five sites targeted families involved with the child welfare system; one of these sites focused exclusively on foster parents and relatives assigned as kinship caregivers by the child welfare agency.

Types of Families Targeted for Enrollment

	Number of Programs
Immigrant families	6
Parents working or in School	5
Teenage parents	5
Families involved with child welfare system	5

N = 23 pilot programs.

The federal grant announcement stated that "relatives and neighbors who are caring for Early Head Start/Migrant infants and toddlers" were eligible to enroll in the pilot, but did not specify further what types of caregivers could be enrolled. Thus, sites had some latitude in how they chose to define kith and kin caregivers for pilot eligibility. Most sites chose to limit eligibility to unregulated family, friends, or neighbor caregivers. In most cases, this meant enrolling grandmothers or other female relatives who cared for the Early Head Start child (see box). Three sites chose to define kith and kin care more broadly, however, and targeted a mix of relative caregivers and regulated family child care providers. In addition, two sites targeted specific types of caregivers. One site planned to work exclusively with foster parents and relatives assigned as kinship caregivers by the child welfare agency. The other site planned to work almost exclusively with residential and nonresidential fathers.

Types of Caregivers Targeted for Enrollment

	Number of Programs
Mostly grandmothers/relatives	18
Mix of relatives and regulated family child care providers	3
Mostly foster parents and kinship caregivers	1
Mostly fathers	1

N = 23 pilot programs.

STAFFING FOR THE ENHANCED HOME VISITING PILOT

In many ways, smooth implementation of the Enhanced Home Visiting Pilot depended on the programs' ability to attract and retain home visitors whom caregivers would trust, confide in, and look to for knowledge and expertise. Finding the right staff to fill this role was not always a simple task. As one program director said, "It's not for everyone. It takes a certain kind of person who can deliver the message in a nonthreatening way, a person who believes in the mission …." This section describes the staffing models that the pilot sites developed. We begin with an overview of the staffing and supervision approaches used, then describe the training that pilot home visitors received. We end the section with a discussion of staff turnover during the first two years of implementation.

Approaches to Pilot Staffing

All the sites assigned one or two management staff, either from Early Head Start or a community partner, to serve as pilot coordinators to oversee recruitment and service delivery and to supervise the pilot home visitors. The sites also took one of three approaches to assigning home visitors to caregivers: (1) a dual home visitor approach, in which a pilot home visitor worked with the caregiver, and an Early Head Start home visitor worked with the parent; (2) a single home visitor approach, in which the Early Head Start home visitor worked with both the caregiver and parent; and (3) a community partner approach, in which community partner staff worked with the caregiver, and an Early Head Start home visitor worked with the parent.

Approaches to Staffing of Home Visitors

	Number of Programs
Dual home visitor	13
Single home visitor	8
Community partner	2

N = 23 pilot programs.

Dual Home Visitor Approach. More than half the sites used the dual home visitor approach (see box). Programs typically chose this staffing model because of concerns that home visitors would be overburdened if they were expected to provide home visits to both caregivers and parents. In some programs, such as the one that targeted foster parents as caregivers, it was essential that different staff be assigned to the caregiver and biological parent to keep the foster parents' and biological parents' situations confidential. One site began implementation using the same home visitor for caregivers and families, but it quickly found that the increased caseload was too difficult for staff to manage and hired a full-time home visitor to work exclusively with pilot caregivers.

Overall, the dual home visitor approach worked well for the sites that adopted it. Home visitors reported that they were better able to focus all their attention on serving caregivers without the added pressure of having to meet the home-based option performance standards for Early Head Start families as well. Having separate staff for caregivers and parents also reduced the risk that home visitors would be pulled into family

conflicts. During the initial months of implementation, tensions arose in some sites about coordinating services when more than one staff member began working with the same child and family. Some Early Head Start home visitors were resistant to involving the pilot home visitors in service delivery for "their" families. These tensions, however, were generally resolved within a few months of startup.

Most sites implementing the dual home visitor model planned for caseloads of about 10 caregivers per home visitor. Because enrollment was lower than expected, some home visitors had caseloads of six or fewer caregivers. One site using the dual home visitor model had a substantially larger caseload of 40 caregivers per home visitor, but the planned intensity of "consistent contact" with a minimum of three required home visits per year was lower than that of the other dual home visitor sites.

Single Home Visitor Approach. Eight sites used a single home visitor approach, in which the Early Head Start home visitor worked with both parents and caregivers, either in a joint home visit (if the parent and caregiver lived in the same home) or as separate home visits. Programs chose this staffing model based on the belief that families and caregivers would be more receptive to enrolling in the pilot if they already had a relationship with the home visitor assigned to them. Staff also believed this approach would make coordination of services easier and increase consistency in caregiving between parent and caregiver. All but one site had implemented this approach from the start, and that program adopted this approach in the beginning of the second year. This latter site had used separate home visitors for parents and caregivers throughout the first year, but it was unable to overcome resistance from some of the Early Head Start home visitors who were concerned about pilot home visitors working with their families. Changing to a single home visitor model allowed this program to increase caregiver recruitment and coordination of services by capitalizing on the trust and personal relationships Early Head Start home visitors had established with their families.

In general, Early Head Start home visitors in these sites were receptive to adding caregivers to their caseloads. Distributing the caseload of caregivers across multiple home visitors reduced the burden of additional work, and some sites weighted pilot families as two cases when assigning caseloads to ensure a more equitable workload for all staff. Some sites also used pilot funds to hire an additional Early Head Start home visitor to accommodate the increased caseload. Typically, home visitors in these sites were responsible for two to four caregivers, in addition to their caseload of 7 to 10 Early Head Start families.

Community Partner Approach. Two sites relied solely on their community partners to provide home visitors for the pilot, with mixed results. In both cases, the community partners were programs operating under the larger umbrella organization that served as the Early Head Start grantee. One site chose to collaborate with the Parents as Teachers program administered through its grantee. This program had been providing home visiting and other services to families in the community for more than a decade and was well suited to play a key role in the pilot. This site experienced challenges in coordinating the work of home visiting staff across the two agencies during the first year of implementation, but, by the second year, the staffing model was working well. The other site chose to collaborate

with the child care resource and referral agency administered through its grantee to provide home visits to caregivers. Despite the joint efforts of Early Head Start and community partner staff to coordinate caregiver recruitment, this site was only able to enroll and provide services to a few caregivers during the first two years of implementation.

Approaches to Supervising Pilot Home Visitors

In 17 of the 23 pilot sites, pilot home visitors received supervision at a level of intensity comparable to that provided to Early Head Start home visitors. The mix of supervision activities was also similar—individual meetings with supervisors, staff meetings, in-field observations of home visits, and, to a lesser extent, case reviews and reflective supervision sessions (Table II.1).[2] In general, the pilot sites took two approaches to supervising the work of pilot staff, with the approach largely defined by whether sites assigned the same or different home visitors to work with parents and caregivers.

In all but one of the sites using the single home visitor approach, supervision of home visitors' work with caregivers was integrated into the supervision they received for their work with Early Head Start families. None of the pilot home visitors in these sites received supervision specifically for pilot activities, other than through individual meetings with supervisors monthly (or as needed). Instead, discussion of pilot activities was folded into the discussion of Early Head Start activities during Early Head Start staff meetings. In these sites, the supervisor for pilot home visitors was the person who supervised the Early Head Start home visitors.

Table II.1. Types of Supervision of Enhanced Home Visiting Pilot Staff

	Approach to Pilot Staffing			
Supervision Activity	Dual Home Visitor (13 sites)	Single Home Visitor (8 sites)	Community Partner (2 sites)	Total
Individual Meetings with Supervisor	13	5	2	18
Pilot Staff Meetings	4	1	1	6
EHS Staff Meetings	11	8	1	20
Case Reviews	4	5	0	9
Reflective Supervision	5	3	0	8
In-Field Supervision	7	5	0	12

Source: Site visits and telephone interviews with pilot staff.

N = 23 pilot programs.

[2] Reflective supervision sessions were individual or group meetings between home visitors and supervisors or mental health consultants to talk about job stress related to working with caregivers and families.

All the sites using the dual home visitor or community partner approach to staffing, as well as one site using the single home visitor approach, provided some supervision that focused on pilot activities. For example, home visitors in these sites had individual meetings with pilot supervisors to discuss services they were providing to pilot caregivers. Five of these sites also held regular pilot staff meetings to discuss recruitment issues, coordinate services, and plan group events specifically for the pilot. Pilot home visitors in seven of the sites also received in-field supervision, in which the pilot supervisor observed a caregiver home visit and provided feedback. In half of these sites, the supervisor for the pilot home visitors was the person who supervised the Early Head Start home visitors. In the other half, the supervisor was the staff person assigned to coordinating the pilot, the Early Head Start director, or a community partner supervisor.

In six sites, pilot home visitors received minimal direct supervision. In four of these sites, the pilot home visitors had from 7 to 18 years' experience in early education or home visiting, and they were essentially operating the pilot on their own. In one site, the Early Head Start home visitor supervisors served as home visitors for the pilot. Program directors in these sites placed a lot of trust in the home visitors' ability to manage the pilot independently, and, in all but one site, this approach seemed to work well. Moreover, directors felt that supervision of pilot home visitors could be less intensive than for Early Head Start home visitors because pilot home visitors had few formal requirements (for example, there are no performance standards for the number of home visits that must be provided to caregivers), and the caseload was a smaller.

Only three sites changed their approach to supervising pilot staff during the first two years of implementation. In one site, a pilot supervisor had initially been assigned to the pilot home visitors. When this person left the agency after the first year, the position was eliminated, and the Early Head Start supervisors assumed responsibility for overseeing the work of the pilot home visitors. This staffing change allowed the program to better coordinate services provided to pilot caregivers and Early Head Start families. Another site assigned supervisory staff to serve as mentors for pilot home visitors. The third site substantially increased the amount of supervision the pilot home visitor received in the second year.

Approaches to Coordinating the Work of Pilot and Early Head Start Staff

A primary goal of the pilot was to increase consistency in caregiving between parents and caregivers through coordination of services provided by home visitors. To accomplish this goal, pilot sites took different approaches to facilitating consistent communication and service delivery for parents and caregivers. As described earlier, eight sites used Early Head Start home visitors to serve both parents and caregivers, making coordination unnecessary in those sites.

Staff Coordination Strategies in Sites Using Separate Home Visitors for Parents and Caregivers

	Number of Programs
Individual meetings with EHS home visitors	15
Attendance at EHS staff meetings	13
Conduct joint home visits with EHS staff	2

N = 15 programs using dual or community partner approach to pilot staffing.

In sites using separate home visitors for parents and caregivers (dual approach or community partner approach), coordination between pilot and Early Head Start staff was accomplished in three main ways: (1) one-on-one meetings between home visitors, (2) coordination during Early Head Start staff meetings, and (3) periodic home visits conducted jointly by both home visitors (see box). Pilot and Early Head Start home visitors in dual approach and community partner approach sites met individually to share information (such as family and child goal sheets, service plans, and child assessment results) and coordinate home visit activities. Housing Early Head Start and pilot home visitors in common office space often made it easier to share information. In all but 3 of the 15 sites using different home visitors for families and caregivers, pilot home visitors also participated in the weekly or monthly Early Head Start staff meetings to share information about family and caregiver needs and goals and coordinate strategies to address child and family issues. In two sites, pilot and Early Head Start staff conducted periodic joint home visits with the family or caregiver to share information and encourage consistency in caregiving routines.

Nearly two-thirds of the sites that used separate home visitors experienced initial challenges coordinating their work. In some sites, Early Head Start home visitors were initially unclear about the pilot's purpose and how it complemented their work with families. In addition, as mentioned earlier, some Early Head Start home visitors did not feel comfortable having a new staff person working with "their families." Maintaining confidentiality of family and child information was also a concern in at least two sites, and housing pilot and Early Head Start staff in separate buildings was a barrier to coordination in a few others. Nevertheless, most sites were able to address these issues and improve staff communication and coordination during the early months of implementation, and all sites resolved these issues by the end of the second year.

Pilot Staff Qualifications

The pilot sites drew on a highly qualified pool of people to provide services to caregivers. Most had little difficulty initially identifying and hiring qualified staff for the pilot or finding qualified replacements for home visitors who left the program during the first two years. In some cases, experienced staff in the agency chose to transfer positions to work with caregivers; in others, qualified candidates from outside the agency applied and were hired as pilot home visitors.

The pilot sites used highly qualified staff to provide services to caregivers. Most pilot staff had an associate's or bachelor's degree in early childhood education, elementary

education, child development, social work, or nursing (see box). Staff in five sites were pursuing a bachelor's or master's degree part-time while working on the pilot.[3] Home visitors without a two-year or four-year degree had a Child Development Associate credential. Most home visitors had prior work experience in early childhood or home visiting programs when they were hired for the pilot; they had 1 to 18 years of experience in early childhood education and 1 to 16 years of experience in home visiting programs. Levels of education and prior work experience of pilot home visitors did not differ significantly across sites using a single, dual, or community partner staffing approach.

Qualifications of Pilot Home Visitors

	Percentage of Home Visitors
Highest Degree Obtained or in Process:	
Associate's degree	32
Bachelor's degree	58
Master's degree	4
Years Experience in ECE/ Home Visiting:	
Less than 5 years	62
5 to 10 years	23
More than 10 years	14

N = 69 home visitors.

In two of the three sites serving a mix of relative caregivers and regulated family child care providers, at least one home visitor had experience as a regulated child care provider herself. Only two home visitors, however, reported having prior experiencing working with kith and kin caregivers. Because few programs to support kith and kin caregivers exist, this is not surprising.

Based on their experience with the pilot, program directors noted several characteristics that are important for home visitors working with kith and kin caregivers to have. Prior experience as a home visitor and the ability to build rapport and gain caregivers' trust were viewed as very important. Program directors recommended looking for staff who can be flexible, persistent, and not easily flustered by what they might encounter in caregivers' homes. The ability to work independently and the ability to promote the value of the program—to families, caregivers, community partners, and other Early Head Start staff—were also considered important. Some directors also stressed the importance of hiring someone caregivers would consider a peer—a grandmother or someone with life experiences similar to theirs.

[3] Information on pilot staff qualifications is based on program director and pilot home visitor reports for the 69 pilot home visitors with available data. Information on educational degrees was missing for 14 home visitors; information on prior experience was missing for 25 home visitors.

Staff Training for the Pilot

The pilot home visitors received pre- and in-service training during the first two years of pilot implementation to support their work with caregivers (see box). Pilot staff in six sites, especially those who did not have prior home visiting experience, shadowed the Early Head Start home visitors before beginning their work with caregivers. In nine sites, the pilot coordinator provided preservice orientation on the Enhanced Home Visiting Pilot. In more than half the sites, home visitors participated in training for certification on the Parents as Teachers' "Born to Learn" or "Supporting Care Providers Through Personal Visits" curricula, WestEd's "Program for Infant/Toddler Caregivers," or other curricula, either before or during the first year of implementation. Home visitors in three sites received curricula training during the second year as well. Home visitors in more than half the sites also attended state and national conferences. In addition, home visitors in most sites participated in monthly in-service training workshops provided to Early Head Start staff.

Training Received by Pilot Home Visitors

	Number of Programs
Preservice:	
Shadowing home visitors	6
Pilot orientation	9
Preservice or In-Service:	
Formal curricula training	12
National and state conferences	12
Pilot-specific training	11
Early Head Start training only	10

N = 23 pilot programs.

In nearly half the sites, the training for pilot staff consisted exclusively of the preservice and in-service training provided for all Early Head Start home visitors. This was especially true for the sites that used a single home visitor approach to staffing, although three of the dual approach sites took this approach as well. However, 12 sites, including 3 that used a single home visitor approach, sponsored trainings specifically for pilot staff during the first two years of implementation, and at least 3 sites planned to offer pilot-specific trainings in the third year as well. Training topics intended specifically for pilot staff included working with grandparents as caregivers, working with fathers, facilitating parent-caregiver communication, kinship foster care regulations, and child care licensing requirements. Sites that targeted specific populations of caregivers—foster parents, fathers, relatives of incarcerated teenage parents—sponsored trainings targeted specifically for that population.

The types of training that home visitors found most useful depended on their levels of prior home visiting experience and the specific needs of their site's target population. For example, for staff with little or no prior home visiting experience, shadowing Early Head Start home visitors and having discussions with them was the most useful part of their training. In other sites, home visitors found the curricula training especially useful for solidifying their knowledge about infant/toddler development so they could more effectively share this information with caregivers. Home visitors working with foster parents said that training on kinship foster care regulations was the most useful, and home visitors working with drug-exposed infants found training on the effects of methamphetamines on child development to be most useful.

At the end of the pilot's first year, home visitors identified several areas in which more training would have been helpful. Across all sites, the most common areas mentioned were more training on how to work effectively with grandparents and how to facilitate communication and mediate conflicts between parents and caregivers. In the subset of sites visited at the end of the second year, most of the home visitors felt that their training needs for the pilot had been met.

Turnover in Pilot Staff

Fifteen of the sites experienced turnover in pilot home visitors during the first two years of implementation, with more sites experiencing this during the first year than the second (see box). Turnover occurred when pilot home visitors left the agency or were reassigned to other positions in the same agency (for example, to work in an Early Head Start center). For the most part, pilot sites were able to identify qualified replacements with little disruption in caregiver enrollment and services. When there was a delay in hiring a new pilot home visitor, in some sites, the Early Head Start home visitors picked up the caregiver caseload temporarily. This strategy was also used in the few sites where a pilot home visitor went on maternity or medical leave. Of the 15 programs that had a change in pilot home visitors, only three had declines in enrollment and disruptions in services. In two of these sites, caregiver enrollment declined significantly after the pilot home visitor left the agency. In the third site, pilot services were disrupted for two months until a new home visitor was identified and hired.

Turnover in Pilot Staff

	Number of Programs
Any Home Visitor Turnover	15
Turnover in year 1	11
Turnover in year 2	7
Turnover in both years	5
Any Turnover in Management Staff	9
Turnover in pilot coordinator	5

N = 23 pilot programs.

Nine of the pilot sites also experienced turnover in management-level staff during the first two years of implementation, with changes in pilot coordinators occurring in five sites. None of these reported disruptions in enrollment or services as a result of the changes. For example, in one site, a consultant was brought in to manage the pilot until a permanent pilot coordinator could be identified and hired. Two other sites chose to eliminate the position entirely after the pilot coordinator left and assigned responsibility for pilot management to the Early Head Start supervisors during the second year of implementation.

CHARACTERISTICS OF CHILDREN AND FAMILIES

To be eligible for the pilot, families needed to be enrolled in the home-based option of Early Head Start and be using kith and kin child care. Consequently, all the pilot families had a child under age 3, and most had incomes below the federal poverty level. This section

describes the characteristics of the pilot families, including demographic characteristics of the children and parents and their reasons for using kith and kin care.

Demographic Characteristics of Children and Families

Early Head Start children were 17 months old, on average, when their families enrolled in the pilot; children were fairly equally divided between infants under 12 months of age, toddlers 12 to 23 months old, and toddlers over 23 months old (Table II.2). Nearly two-thirds of the children were white, a proportion considerably higher than the 33 percent enrolled in Early Head Start nationally (Hamm and Ewen 2006). Differences in racial composition between pilot children and the Early Head Start population as a whole may have been due to demographic characteristics of the communities in which the pilot sites were located. Indeed, interviews with program directors suggested that pilot children were demographically similar to the larger population of children served in each site's Early Head Start program.

All Head Start and Early Head Start programs must reserve at least 10 percent of their enrollment slots for children with disabilities. Sixteen percent of children enrolled in the pilot had a suspected or identified disability or delay, which is somewhat higher than the national average of 13 percent of Early Head Start children enrolled in 2003–2004 (Hamm and Ewen 2006). This difference could be due to families' difficulties finding regulated child care for children with disabilities or their desire to place these especially vulnerable children in the care of a trusted relative or friend. This finding is consistent with other research findings on kith and kin child care arrangements suggesting that nearly one in five kith and kin caregivers report caring for a child with special needs (Brandon et al. 2002).

In most pilot families, the Early Head Start child's primary caregiver (and recipient of Early Head Start services) was a parent or stepparent (Table II.3). Another eight percent were grandparents or other relatives. Five percent were unrelated to the child (they were either foster parents or legal guardians). The parents/primary caregivers were 27 years old, on average, when they enrolled in Early Head Start; one-quarter were teenage parents. Nearly half were married or living with a significant other at the time of enrollment. Similar to the pilot children, approximately 70 percent of the primary caregivers were white. Ten percent spoke Spanish as their primary language, and one percent spoke a language other than English or Spanish.

At the time of enrollment in Early Head Start, half the parents were employed full- or part-time; another 11 percent were looking for work. In addition, 16 percent were in school or some type of training program. These rates of employment and school attendance are somewhat lower than the population of Early Head Start families nationally.[4] This may

[4] Based on 2003–2004 Program Information Report data for Early Head Start, 53 percent of single-parent families and 84 percent of two-parent families included at least one employed parent. Twenty-nine percent of single parents were in school or job training, and 23 percent of two-parent families had at least one parent in school or job training (Hamm and Ewen 2006).

Table II.2. Demographic Characteristics of Children Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Children
Child's Age at Enrollment in Early Head Start	
Prenatal	15
Birth to 11 months	46
12 to 23 months	22
24 months or older	17
Child's Age at Enrollment in the Enhanced Home Visiting Pilot	
Prenatal	6
0 to 11 months	33
12 to 23 months	30
24 months or older	30
Child's Gender	
Female	48
Male	52
Child's Race	
American Indian or Alaskan Native	3
Asian	1
Black or African American	6
Hispanic or Latino	16
Native Hawaiian or Other Pacific Islander	< 1
White	64
Multiracial	10
Child Has a Suspected or Identified Disability or Delay	16
Of Those with a Disability, Category of Disability or Developmental Delay[a]	
Visual Impairment	2
Hearing Impairment	2
Orthopedic	9
Speech	47
Health Impairment	4
Mental Retardation	1
Emotional-behavioral	2
Learning disability	11
Autism	2
Other disability	35
Child Has Been Referred to Early Intervention Services	90
Child Is Enrolled in Early Intervention Services	65

Source: Enhanced Home Visiting Record-Keeping System. Missing data range from 0 to 16 across items.

Note: N = 570.

[a]Some families reported that their child had more than one disability or delay.

Table II.3. Demographic Characteristics of Primary Caregivers (Parents) of Children Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Primary Caregivers
Primary Caregiver's Age at Enrollment in Early Head Start	
Younger than 20	25
20 to 29	49
30 to 39	16
40 or older	10
Primary Caregiver's Relationship to the Child	
Parent or stepparent	86
Grandparent	6
Other relative	2
Other nonrelative	5
Primary Caregiver's Gender	
Female	96
Male	4
Primary Caregiver's Marital Status	
Single	43
Married	36
Living with significant other	13
Separated	4
Divorced	4
Widowed	1
Primary Caregiver's Race	
American Indian or Alaskan Native	3
Asian	2
Black or African American	5
Hispanic or Latino	16
Native Hawaiian or Other Pacific Islander	< 1
White	71
Multiracial	3
Primary Language Spoken at Home	
English	88
Spanish	10
Other	1
Primary Caregiver's Occupational Status[a]	
Employed full-time	28
Employed part-time	22
Trade or business school	2
In school, high school or GED	8
In college	6
In graduate school	< 1
Looking for work	11
Retired	1

Table II.3 *(continued)*

	Percentage of Primary Caregivers
Homemaker	22
Disabled	2
Other	5
Primary Caregiver's Highest Level of Education	
Less than high school	9
Some high school	23
High school diploma/GED	41
Some college	21
Two-year college degree	5
Four-year college degree	2
Number of Siblings Living in Focus Child's Home	
0	35
1	36
2	18
3	6
4	4
More than 4	1
Primary Caregiver's Reason for Accessing Child Care	
Employment	40
Training/Education	13
Both employment and training/education	9
Respite	13
Other	25

Source: Enhanced Home Visiting Record-Keeping System. Missing data range from 6 to 73 across items.

Note: N = 570.

[a]Some primary caregivers reported more than one occupation.

reflect the fact that pilot families were enrolled in the home-based option, while national data for Early Head Start include families enrolled in all program options.

More than 70 percent of the parents had not completed formal schooling beyond high school. Nearly one-third had not graduated from high school, while 41 percent had a high school diploma or GED. Only 26 percent had attended college or received a two- or four-year degree. The rates of educational attainment among primary caregivers in the pilot are nearly identical to the national average for Early Head Start parents in 2003–2004 (Hamm and Ewen 2006).

Families' Reasons for Using Kith and Kin Care

According to the program record-keeping system data, nearly two-thirds of families enrolled in the pilot were using kith and kin care so parents could work, attend school, or both (Table II.3). Another 13 percent cited respite as their primary reason for using kith and kin care. During focus groups conducted at the end of the first pilot year, a sample of pilot parents were asked why they decided to use kith and kin child care and whether they had considered other arrangements. Across pilot sites, parents described a variety of reasons—including availability, trust, low cost, convenience, and shared culture and values—that are consistent with prior research on parents' child care decisions (Emlen 1999; Larner and Phillips 1994; Mitchell et al. 1992; Porter 1991). Few parents said they had considered arrangements other than kith and kin care for their infant or toddler.

Parents' Reasons for Using Kith and Kin Care

	Percent of Arrangements
Caregiver is a relative	57
Trust in the caregiver	53
Flexible hours	42
Affordability	41
Shared language/cultural values	30
Individual attention	28

N = 593 kith and kin arrangements.

Record-keeping system data on parents' reasons for using particular kith and kin arrangements are consistent with focus group findings (see box). For more than half of the arrangements, parents cited their familial relationship with the caregiver and trust in the caregiver as their main reasons for using the arrangement. During focus groups, some parents expressed general distrust of care provided by strangers and child care centers; for this reason, they preferred relatives, especially their own mothers, to care for their child. Convenience of flexible hours and affordability were also identified as important reasons for using kith and kin arrangements in both the focus groups and the record-keeping system data.

During focus groups, pilot parents rarely mentioned the possibility of using regulated child care, perhaps because the limited supply and high cost of infant-toddler care in their communities precluded these options. During year one site visits, staff in all but two of the pilot sites described a scarce supply of regulated infant/toddler child care in their communities, especially for low-income families. In some rural sites, staff reported that only one child care center in the entire county accepted infants and toddlers; many other sites

reported waiting lists as long as two years for infant-toddler care. The supply of center-based care during evening and weekend hours was also limited in most sites, and transportation posed an additional barrier for families in the rural sites.

Pilot and community partner staff also reported that the high cost of regulated infant/toddler child care and limited access to child care subsidies posed barriers to accessing regulated child care. For example, staff said that the cost of regulated infant-toddler care in one rural site averaged $100 to $125 per week; in another site, staff reported costs of nearly $700 a month. In addition, pilot parents often were ineligible to receive a child care subsidy because they did not meet the state's requirements for citizenship or participation in work or school activities. In other cases, staff reported that parents could not maintain their eligibility for child care subsidies because of illness, erratic job attendance, reductions in work hours, or job loss. In addition to parents' difficulties obtaining and keeping child care subsidies, staff in some sites reported that the required co-payment was unaffordable for low-income families.

COMMUNITY PARTNERSHIPS

The Office of Head Start required the Enhanced Home Visiting Pilot sites to partner with at least one community service provider for their pilot program, acknowledging that fully meeting the needs of kith and kin caregivers required building on existing expertise and resources from other community agencies. In this section, we describe the types of community partners involved in the pilot and the services they provided. We then summarize the process Early Head Start programs used in selecting community partners and end with a discussion of how the partnerships evolved over the first two years of the pilot.

Types of Community Partners and Services Provided

By the end of the second year of implementation, all pilot sites had selected at least one community partner to provide training, materials, or referrals for the pilot. In six sites, the community partner or partners were part of the larger umbrella agency that served as the Early Head Start grantee. As described earlier in the chapter, the community partner in two of these intra-agency partnership sites was responsible for providing all the home visits and other pilot services for caregivers.

The most common type of community partner was a local child care resource and referral agency (CCR&R; see box next page). In most sites partnering with CCR&Rs, the agency was the pilot's sole or primary community partner; in one site, the CCR&R provided all staff and services for the pilot. Typically, CCR&Rs collaborated by offering training activities for caregivers—group trainings sponsored specifically for pilot caregivers or invitations to attend the agency's regular trainings for child care providers. In two sites, CCR&Rs provided toys, books, and safety equipment for pilot home visitors to distribute to caregivers; in another, the CCR&R operated a mobile lending library. A few sites planned to have the CCR&Rs provide referrals for pilot recruitment. However, as discussed later in this chapter and in Chapter III, these referral arrangements proved unworkable because of

the requirement that children's families be enrolled in Early Head Start before their caregiver could be enrolled in the pilot.

Types of Community Partners

	Number of Programs
Child care resource and referral	12
Family support and home visiting	8
Health care providers	4
Child welfare agency	3
Mental health care providers	3
Part C providers	2
Even Start	2
State and local child care initiatives	2
Cooperative extension service	2
Public school district	2
Public library	1
Literacy Council	1
Department of Juvenile Corrections	1

N = 23 pilot programs.

Family support and home visiting programs were the second most common type of community partner. These programs already provided services to families with young children in the community, such as home visits, parenting classes, playgroups, and grandparent support groups. In four sites, the family support program was the pilot's sole or primary partner. These programs typically collaborated with the pilot to provide playgroups or cosponsor group socialization events for pilot caregivers, children, and their parents. Family support programs in three sites also collaborated to cosponsor grandparent support groups. In one site, the family support program provided all staff and services for the pilot.

Pilot sites chose a variety of other agencies to serve as community partners. Three sites, for example, developed partnerships with child welfare agencies because of the nature of their target population for the pilot—families with incarcerated teenage parents, foster parents, and kinship foster parents. In these sites, the child welfare agency's primary role was to provide referrals for pilot enrollment and coordinate child protective services with services provided by Early Head Start. The site working with incarcerated teenage parents also developed a strong partnership with the state's department of juvenile corrections, which provided access to incarcerated parents, referrals for enrollment, and space at the correctional facility for pilot activities. Even Start programs cosponsored group socialization events for the pilot. Other types of partners, including health care providers, child care initiatives, and cooperative extension agencies, provided trainings for caregivers. Some partners, such as Part C providers, mental health care providers, and the literacy council, accepted referrals.

Selecting Community Partners

Identifying appropriate community partners that share a similar vision and commitment to collaboration is crucial for any program's success. This may be especially true for an initiative like the Enhanced Home Visiting Pilot because so little is known about how to

deliver services effectively to kith and kin caregivers. Developing clearly defined roles for each member of the partnership and accommodating differences in organizational rules and procedures to provide services takes time and energy, but it is essential for building strong partnerships.

Given these challenges, it is not surprising that all but one site selected at least one community partner with whom they already had a relationship, either because they were part of the same grantee umbrella organization or had a history of successful collaboration. For example, one site looked to their umbrella organization's CCR&R to supervise pilot activities and provide group trainings for caregivers, recognizing its greater expertise in this area. Similarly, more than half the pilot sites drew on established partnerships outside their agency, such as CCR&Rs, Part C providers, Even Start, and health care providers that already provided services or accepted referrals from Early Head Start. Overall, 74 percent of the 43 partner agencies recruited for the pilot had collaborated previously with the Early Head Start program.

To recruit partners, in most cases, the Early Head Start director contacted potential community partners about the pilot, discussed what their agencies might provide, and then included them in the grant application. Often, the community partner provided a letter of commitment but was not involved in writing the grant application. In some cases, formal partnership agreements were drawn up specifically for the pilot. In others, the sites relied on formal partnership agreements already in place with the Early Head Start or Head Start program. None of the sites used a formal process for identifying and inviting community partners to be involved in the pilot.

Early Head Start programs identified most of their partners for the pilot before the grant application was submitted or shortly after funding was awarded. Seven sites, however, forged new partnerships with CCR&Rs, health or mental health care providers, or family support programs during the second year of implementation to better meet the needs of pilot caregivers. For example, two sites developed partnerships with health care agencies to provide training on nutrition and dental care to caregivers. Another site developed a partnership with a program for disabled adults to cosponsor a bimonthly grandparent support group for pilot caregivers and other grandparents in the community.

Evolution of Community Partnerships Over Time

The Enhanced Home Visiting Pilot sites had to forge new partnerships or rework prior partnerships in a short period of time to provide services to kith and kin caregivers. By the second year of implementation, all sites had selected a community partner and tried to involve the partner in pilot recruitment or services. In some sites, the partnerships were vital for implementation of the pilot, while in others, the partnerships enriched the services

Importance of Partners' Role in the Pilot

	Number of Programs
Essential	6
Enriching	10
Minimal	7

N = 23 pilot programs.

provided to caregivers by Early Head Start. In some sites, however, the partner's planned role in the pilot was never realized (see box previous page).

The community partnerships described as essential shared one common element—they all provided some combination of key staff, space, and access to the target population that the Early Head Start grantee would not have had on its own. For example, the pilot site that targeted kinship caregivers and foster parents relied heavily on its partnership with the child welfare agency for pilot referrals and worked closely with child welfare staff to coordinate pilot services. In two sites, the community partner agency recruited caregivers and provided all pilot services to them. Neither of the Early Head Start directors in these site felt they had the staff necessary to provide services to both parents and caregivers.

Quote from a Community Partner About the Value of the Partnership

"For the foster parents, the more well-adjusted the child is, the fewer behavioral problems there are. For us, we know there's an entity out there doing something for children and foster parents we don't have time to do. Foster parents are getting up-to-date child development information that we don't have time to give them …EHS can do this for us."

Most of these essential community partnerships grew stronger over time, often because of concerted efforts by pilot staff to communicate with partner leadership and work through challenges. For example, the sites that partnered with the child welfare agency and department of juvenile corrections faced ongoing challenges in communication and coordination because of frequent turnover in partner staff. In both sites, Early Head Start managers played key roles in educating new partner staff on the pilot's purpose and reminding them of what they had agreed to provide for the pilot. These extra efforts paid off in that both partner agencies grew to value the partnership and services provided by the pilot and Early Head Start (see box).

Nearly half the sites described at least one community partner whose services enriched what was provided to caregivers through Early Head Start. These partners were a diverse group— CCR&Rs, cooperative extension agencies, family support programs, local child care initiatives, health care and mental health care providers, and a public school district. Some of these partners provided toys, books, and home safety materials to caregivers; one operated a mobile lending library that delivered materials directly to caregivers' homes and conducted home safety checks. Others provided caregiver trainings on key topics such as behavior management, CPR and first aid, and nutrition; some cosponsored support groups for grandparents. One cosponsored a two-day retreat for pilot caregivers and families at a state 4-H camp. While these partners were not essential to the success of the pilot, Early Head Start programs valued them because they filled service gaps by offering caregiver training in areas in which Early Head Start staff did not have sufficient expertise. In addition, by cosponsoring events, partners split costs and shared resources with the pilot.

During the first two years of implementation, pilot sites faced some challenges in implementing the partnerships as planned or in identifying partner services that pilot caregivers would find attractive. For example, some CCR&Rs planned to provide help with licensing, until pilot staff discovered that most caregivers were not interested in becoming

regulated providers. In other cases, partnership activities were planned, but then put on hold until pilot enrollment increased. In at least two sites, pilot sites had initial difficulty communicating and coordinating activities with partner staff. These issues took time to resolve, but, by the second year of implementation, all the essential and enhancing partners were actively involved in providing pilot services.

In seven sites, however, partnerships were never implemented as planned. As noted earlier, some sites planned to partner with CCR&Rs as sources of referrals of caregivers to the pilot. This strategy did not work because of the requirement that the child's family enroll in Early Head Start before the caregiver could enroll in the pilot. The Early Head Start programs were almost always fully enrolled, and many had long waiting lists. In other sites, plans to offer caregiver training through CCR&Rs did not work well because caregivers did not want to attend general trainings offered by CCR&Rs. In some cases, other trainings and playgroups cosponsored by partners were not well attended. Over time, these community partners became less involved with the pilot, although, in some cases, they continued ongoing partnerships with the Early Head Start program.

SUMMARY

Programs established four main goals for the Enhanced Home Visiting Pilot: (1) improving the quality of care provided by kith and kin caregivers, (2) increasing the consistency of caregiving practices across home and child care settings, (3) improving parent-caregiver relationships, and (4) supporting caregiver needs. Programs targeted primarily unrelated family, friend, or neighbor caregivers of Early Head Start children for enrollment in the pilot. Three programs, however, included some regulated family child care providers, one targeted foster parents and relatives assigned as kinship caregivers by the child welfare agency, and one targeted residential and nonresidential fathers.

The pilot sites took three main approaches to staffing: (1) a dual home visitor approach, in which a pilot home visitor worked with the caregiver, and an Early Head Start home visitor worked with the parent; (2) a single home visitor approach, in which the Early Head Start home visitor worked with both the caregiver and parent; and (3) a community partner approach, in which community partner staff worked with the caregiver and an Early Head Start home visitor worked with the parent. Pilot staff were highly qualified; most had education and experience in early childhood education and home visiting. Staff turnover, however, was fairly high; 15 of the 23 pilot sites experienced turnover in home visitors during the first two years of implementation.

Overall, the demographic characteristics of children and families enrolled in the pilot were similar to those of the larger population of children and families served in each site's Early Head Start program. Early Head Start children were 17 months old, on average, when they enrolled in the pilot. Sixteen percent had a disability or developmental delay. Parents were 27 year old, on average, at enrollment; 20 percent were teen parents. Most were white, and nearly half were married or living with a significant other. Eleven percent did not speak English as a first language. Two-third of parents were working or in school when they enrolled.

All of the pilot sites recruited at least one community partner to provide training, materials, or referrals for the pilot. The most common type of partner was the local CCR&R, followed by family support and home visiting programs such as Parents As Teachers. In six sites, these partnerships were essential to the pilot because they provided key staff, space, or access to the target population that the pilot site would not have had on its own. In 10 sites, the partnerships enriched pilot serves by contributing materials, training expertise and other resources. In seven sites, however, the partnerships were never implemented as planned.

CHAPTER III

DELIVERY OF SERVICES TO CAREGIVERS

A thorough analysis of the types and intensity of services that pilot programs delivered to kith and kin caregivers, along with a description of the implementation challenges these programs faced and promising strategies they developed, can provide useful information for improving the pilot and replicating it in other Early Head Start and community programs. In this chapter, we provide an in-depth description of the patterns of caregiver enrollment and service receipt during the first two years of implementation. We also describe service delivery strategies that the pilot sites developed, as well as parent and caregiver satisfaction with the services. The information in this chapter comes from two main sources: (1) the record-keeping system; and (2) interviews and focus groups conducted during two rounds of site visits, and one round of telephone interviews with key pilot staff.

RECRUITMENT, ENROLLMENT, AND EXIT FROM THE PILOT

The greatest implementation challenge programs faced throughout the first two years of implementation was recruiting, enrolling, and retaining caregivers in the pilot. Few of the programs were fully enrolled at the time of our site visits in summer 2005, and many never reached full enrollment. We begin this section by describing the strategies programs used to recruit caregivers to participate in the pilot and the recruitment challenges they faced. We then examine the levels and duration of caregiver enrollment the pilot sites achieved. We end the section with an analysis of caregiver turnover in the pilots, the reasons caregivers reported for exiting the program, and how pilot staff handled these transitions.

Recruitment

Pilot staff reported using three steps to recruit families and kith and kin caregivers into the pilot: (1) identifying eligible families, (2) recruiting eligible families, and (3) recruiting kith and kin caregivers. The first step—identifying eligible families—was the greatest challenge for programs. Many sites did not have enough eligible families already enrolled in

Early Head Start to fill all their Enhanced Home Visiting Pilot enrollment slots.[1] If their Early Head Start program was already fully enrolled, they could not expand the pool of eligible families from which to recruit until some Early Head Start families left the program and new families enrolled. Long waiting lists in many programs complicated this situation, because families with the highest priority on the waiting list were not always using kith and kin child care. Next, we describe each step in the recruitment process and the strategies programs used to increase enrollment in the pilot's second year.

Identifying Eligible Families. To be eligible for the pilot, families had to be (1) enrolled in the Early Head Start home-based option, and (2) using a kith and kin child care arrangement for their Early Head Start child. The first step in recruitment, therefore, was to inform families enrolled in the home-based option about the pilot and identify those using kith and kin child care. Programs used five main strategies to identify eligible families: (1) soliciting referrals from Early Head Start staff, (2) developing outreach materials and advertising the pilot, (3) identifying families using kith and kin care when they enrolled in Early Head Start, (4) soliciting referrals from community partners, and (5) soliciting referrals from kith and kin caregivers (see box).

Strategies for Identifying Eligible Families Used in Year 1

	Number of Programs
Referrals from Early Head Start staff	21
Advertisement/outreach materials	10
Identification at Early Head Start enrollment	9
Referrals from community partners	7
Referrals from caregivers	3

N = 23 pilot programs.

Soliciting referrals from Early Head Start staff was the most successful strategy for identifying eligible families. Program directors, however, stressed the importance of making sure that all staff understood the goals of the pilot and its potential benefits for children and families. When this strategy did not yield enough eligible families, nine programs began screening families for use of kith and kin care during the Early Head Start application and enrollment process. They did this either by adding a new section about child care use to their application form or by asking families about their child care arrangements at enrollment. Some also contacted families on their waiting list to screen for use of kith and kin care and prioritize them for enrollment when an Early Head Start slot opened up.

Overall, soliciting referrals from community partners and kith and kin caregivers already participating in the pilot was not an effective strategy for identifying eligible families. Although this strategy often yielded referrals, these families usually had to be placed on a

[1] Early Head Start programs assessed their need for resources to support kith and kin caregivers before they applied for the pilot grant in 2003. Grant awards were made about a year after programs applied for the funds. During that year, the make-up of families in some programs changed, resulting in less need for the pilot than initially anticipated in some sites.

waiting list because the Early Head Start program was fully enrolled. Two programs that targeted special populations for enrollment, however, relied solely on community partner referrals and had enrollment slots available for referred families. One of these sites targeted families involved with the child welfare system, and the other targeted families involved in the juvenile justice system.

In the second year of implementation, some programs used additional strategies to identify eligible families and increase pilot enrollment levels. Two programs broadened their definition of which families were eligible for the pilot. For example, one site enrolled families who used kith and kin care while parents were working or in school; in the second year, they also enrolled families who used kith and kin care for respite. With approval from the Office of Head Start, two programs extended eligibility to families who enrolled in the center-based option, as long as they also used kith and kin care on a regular basis. Two additional programs that had not done so in the first year began screening families for pilot eligibility in the second year. Programs reported that these new strategies helped increase the pool of eligible families from which they could recruit, but not enough to achieve full enrollment.

Recruiting Eligible Families. Staff reported that, after eligible families had been identified, convincing them to enroll usually was not difficult. In programs that used a single home visitor approach (described in Chapter II), the home visitor simply presented the pilot to the family during a home visit. In programs that used a dual home visitor approach, the family's home visitor described the pilot during a home visit. If the family was interested, the pilot home visitor followed up, either by accompanying the family's home visitor on the next home visit or contacting the family on her own. In programs using the community partner approach, pilot home visitors usually contacted Early Head Start families on their own. During recruitment contacts, home visitors typically described how they would work with the caregiver; the types of toys, books, and equipment they could provide; the training opportunities that would be available to the caregiver; and in some sites, the types of incentives the caregiver could earn.

Recruiting Caregivers. After the family gave their approval, the pilot staff contacted the caregiver about enrolling in the pilot. If the home visitor already knew the caregiver, she usually would approach the caregiver directly. For example, some caregivers lived in the same household as the Early Head Start family and were sometimes present during Early Head Start home visits. If she did not know the caregiver, the home visitor would usually ask the parent to introduce her. In some cases, parents approached caregivers about enrolling in the pilot before introducing them to the home visitor. Parents often could vouch for the trustworthiness of the Early Head Start program and share their positive experiences with the caregivers.

When pilot staff contacted caregivers for the first time, they tried to schedule an initial home visit, because they found that in-person contact was the most successful means of convincing caregivers to enroll. If the caregiver expressed reluctance, home visitors reported that they sometimes suggested the caregiver agree to an initial visit or two, then decide whether or not to enroll. In addition, home visitors asked families to continue encouraging

reluctant caregivers to enroll; when caregivers did not agree to enroll, home visitors would sometimes contact them again later.

To attract caregivers to the pilot, home visitors said they highlighted the services and materials they would provide and how these could benefit both the caregiver and the child. Some home visitors also reported stressing that the services were flexible and would be tailored to the caregiver's needs and interests. In three programs, home visitors reported that they emphasized flexibility—even in the number of home visits they expected caregivers to participate in—more in the second year as a strategy for increasing enrollment. Staff in these sites reported that the increased emphasis on flexibility helped them recruit more caregivers in the second year.

Enrollment Levels and Duration

Most of the pilot sites struggled with recruiting enough caregivers throughout the first two years of implementation. As discussed earlier, enrollment was challenging primarily because of the limited pool of caregivers from which pilot sites could recruit (caregivers of children enrolled in Early Head Start), rather than because of caregivers' resistance to enrolling in the program. Although target enrollment numbers were relatively low (ranging from 10 to 50 across sites; see Table I.1), approximately one-quarter of the sites never enrolled the number targeted, and most did not maintain full enrollment on a continuous basis during the first two years of implementation. Some reported being fully enrolled for brief periods of time, but they were unable to maintain full enrollment because of turnover among caregivers. By the end of the second year, 16 programs had enrolled more than 75 percent of their targeted number of caregivers (Table III.1), but nearly half the caregivers had exited the program (discussed in more detail below). Taking into consideration those that had already left the program, only six programs were at or close to full enrollment at the end of the data collection period.

Table III.1. Levels of Enrollment, by Total and Active Caregivers

	Number of Programs in Each Category	
Percent of Enrollment Target	For Total Enrollment[a]	For Active Caseload[b]
25 Percent or Less of Target	2	5
26 to 50 Percent of Target	1	7
51 to 75 Percent of Target	3	4
76 to 100 Percent of Target	6	5
More than 100 Percent of Target	10	1
Total Number of Programs	**22**	**22**

Source: Enhanced Home Visiting Pilot Record-Keeping System.

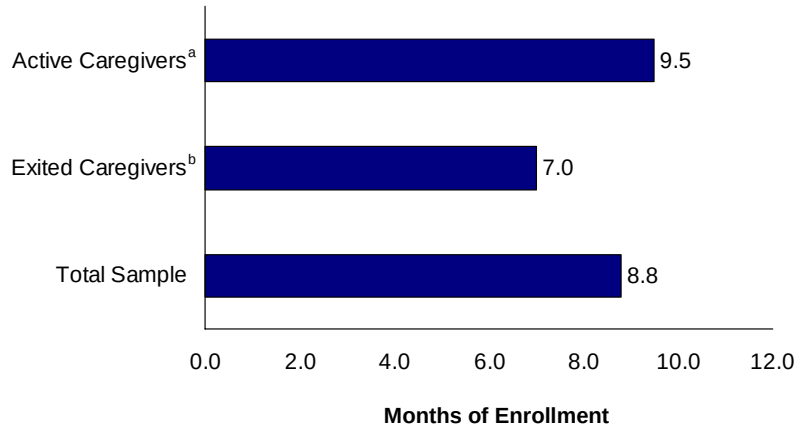
Note: One program was dropped from the analysis because of missing data.

[a]Total enrollment includes all caregivers ever enrolled in the pilot.

[b]The active caseload included only those caregivers actively enrolled at the end of the data collection period on May 31, 2006.

Caregivers were enrolled in the pilot for an average of 9 months; those who had enrolled and exited before the end of the data collection period were enrolled for an average of 7 months, and those who were still in the program had been enrolled for 10 months, on average (Figure III.1).[2] Nearly half were enrolled for six months or less; one-quarter were enrolled for more than a year (Figure III.2). On average, active caregivers (those still enrolled when data collection ended) had been enrolled in the pilot longer than caregivers who exited before the end of data collection. For example, 30 percent of active caregivers had been enrolled for more than a year when data collection ended, twice as many as caregivers who had exited. Thus, while nearly half the caregivers who enrolled in the pilot exited within less than six months, a small proportion continued to participate for a substantial period of time.

Figure III.1. Average Duration of Caregiver Enrollment in the Pilot



Source: Enhanced Home Visiting Pilot Record-Keeping System.

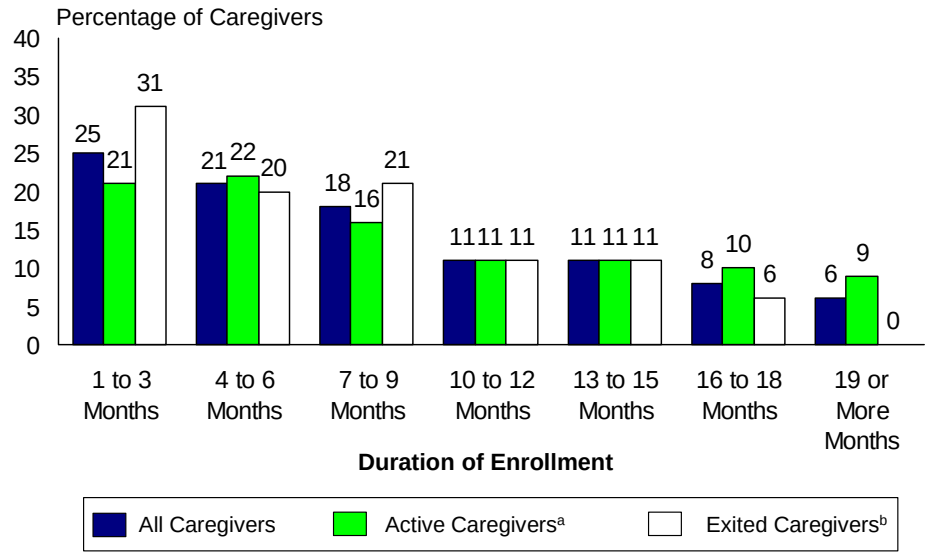
Note: N = 485 caregivers.

[a]Active caregivers are those still enrolled in the pilot at the end of the data collection period on May 31, 2006. The duration of enrollment for these caregivers is incomplete because they were still participating in the pilot program at the end of data collection.

[b]Exited caregivers are those who exited the pilot program before the end of the data collection period. The duration of enrollment for these caregivers is complete.

[2] The pilot continued to operate after the end of our data collection period on May 31, 2006, and more than 50 percent of the caregivers in our data set were still enrolled and receiving services. Throughout this chapter, when we discuss the duration of enrollment and the total amount of services caregivers received, we report on the total caseload of caregivers and the caseload of active caregivers. The total caseload includes all caregivers in our data set, including those who had already exited the program by May 31, 2006. Active caregivers are those who were still enrolled and receiving services when data collection ended.

Figure III.2. Duration of Caregiver Enrollment in the Enhanced Home Visiting Pilot



Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 474 caregivers.

[a]Active caregivers are those still enrolled in the pilot at the end of the data collection period on May 31, 2006. The duration of enrollment for these caregivers is incomplete because they were still participating in the pilot program at the end of data collection.

[b]Exited caregivers are those who exited the pilot program before the end of the data collection period. The duration of enrollment for these caregivers is complete.

Caregiver Turnover and Transition Out of the Pilot

Although nearly half the caregivers left the pilot within six months of enrollment, staff told us, during site visits and telephone interviews, that most caregivers did so because of changes in the families' circumstances, not because they no longer wanted to receive the services. For example, when families left the Early Head Start program, caregivers were no longer eligible to participate, even if they continued to care for the child. Indeed, record-keeping system data show that 45 percent of caregivers who left the program did so because the family left the Early Head Start program when the child aged out or dropped out for other reasons (see box). Another third of caregiver exits happened because the child care arrangement ended. Sometimes parents'

Reasons Caregivers Exited the Pilot

	Percentage of Caregivers
Child aged out of Early Head Start	20
Family dropped out of Early Head Start	25
Child care arrangement ended	35
Other reason	20

N= 219 caregivers who exited the pilot program before May 31, 2006.

child care needs changed because of changes in work or school schedules, and they either stopped using child care or needed to change arrangements to accommodate a new schedule. In about a third of the programs, staff reported that at least one arrangement ended when the family changed caregivers because of disagreements with the caregiver or concerns about the quality of care.

During the second round of site visits, pilot staff described how they handled transitions with caregivers when their participation in the pilot ended. They typically acknowledged caregivers' transitions out of the pilot with special activities that provided a sense of closure. For example, some planned final celebrations with the families and caregivers, and others gave photo albums to caregivers with pictures that home visitors took of caregivers and children while they were in the pilot. Some conducted exit interviews with the caregivers and talked with them about the positive things they had accomplished while they were enrolled.

Pilot staff in most sites reported that caregivers often did not want the services to end. As a result, some programs tried to maintain contact with caregivers who wanted it. For example, programs reported keeping the caregivers on the mailing list so that they continued to receive program newsletters with information about agency-sponsored and community activities. A few sites explored options to continue serving caregivers after children transitioned into Head Start; one site used other agency funds for this purpose. Other programs tried to keep caregivers enrolled in the pilot after the child in their care aged out of Early Head Start or was no longer in their care by encouraging caregivers to determine whether other children they cared for were eligible for Early Head Start. For example, one home visitor helped a caregiver print up business cards and had her come to group activities and Early Head Start trainings to see if other Early Head Start families needed a caregiver and were interested in the pilot.

SERVICES PROVIDED TO CAREGIVERS

Pilot programs reported that, overall, they did not provide additional services to families enrolled in the pilot beyond those that all Early Head Start families received. Instead, nearly all the services were directed to the kith and kin caregivers. In this section, we describe the types, frequency, and intensity of services that caregivers received during the first two years of implementation. We first look at overall levels of service receipt, and we then examine each type of service in more depth. We describe the home visits caregivers received, including programs' strategies for individualizing the visits to meet caregivers' specific needs and interests. We also discuss the content, structure, and levels of participation in group activities offered to caregivers. Next, we describe the types of materials and equipment distributed to the caregivers and the strategies programs used to help interested caregivers pursue child care licensing. Finally, we describe strategies programs used to strengthen relationships and improve communication between caregivers and parents.

Overall Levels of Service Receipt

The services that pilot sites provided to caregivers most frequently were (1) home visits; and (2) group events (such as training workshops, support groups, and playgroups). Therefore, our examination of overall service receipt focused on these two core services. Caregivers received the most intensive services in their first three months after enrollment. On average, they received nearly six hours of a combination of home visits and group events (Table III.2). In subsequent quarters, they received between three and a half to four and a half hours of services. As we describe in more detail later in the chapter, levels of service receipt varied substantially across sites. This is due in part to variation in planned levels of service intensity and in part to sites' varied success in implementing different aspects of the program.

Table III.2. Levels of Service Receipt per Caregiver, by Quarter Since Enrollment

Services	Quarter Since Enrollment			
	1 to 3 Months	4 to 6 Months	7 to 9 Months	10 to 12 Months
Number of Service Contacts				
Number of Home Visits Received	3.1	2.5	2.9	2.2
Number of Group Events Attended	0.5	0.5	0.6	0.3
Number of Home Visits and Group Events	3.8	3.2	3.5	2.8
Amount Of Services, In Hours				
Hours Spent in Home Visits	3.9	4.0	3.1	2.4
Hours Spent in Group Events	1.2	0.9	0.4	0.3
Hours Spent in Home Visits or Group Events	5.6	4.3	4.5	3.5

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 513 caregivers.

Home Visits

In this section, we examine home visiting services in detail. We begin by describing the intensity of home visiting services for caregivers. We then describe typical activities conducted during the first home visit and subsequent visits.

Intensity. Although the intensity of home visiting varied, all the pilot sites provided home visits to caregivers. More than 90 percent of caregivers received at least one home visit, with most receiving more than one (not shown). Across all sites, caregivers received 9

Table III.3. Levels of Home Visiting Receipt per Caregiver, by Total, Active, and Exited Caregivers

Levels of Home Visiting Service Receipt	Total Caregivers	Active Caregivers[a]	Exited Caregivers[b]
Average Number of Home Visits	8.5	9.2	6.7
Amount of Time Spent in Home Visits, in Hours	10.1	10.9	7.6
Number of Home Visits Received per Month (Percentage of Caregivers)			
Less than 1	49.4	43.9	49.2
1 to 1.99	38.1	42.1	30.0
2 to 2.99	9.6	8.3	8.8
3 to 3.99	1.6	0.6	2.2
4 or more	1.4	0.6	1.7

Source: Enhanced Home Visiting Pilot Record-Keeping System. Data from one site, 13 caregivers, dropped from the analysis because data were incomplete. Missing data ranged from to 43 across items.

Note: N = 513 caregivers.

[a]Active caregivers are those still enrolled in the pilot at the end of the data collection period on May 31, 2006. The duration of enrollment for these caregivers is incomplete because they were still participating in the pilot program at the end of data collection.

[b]Exited caregivers are those who exited the pilot program before the end of the data collection period. The duration of enrollment for these caregivers is complete.

home visits on average, ranging from 2 to 13 visits across the sites (Table III.3). Active caregivers received more home visits than exited caregivers (9.2, compared to 6.7). Nearly half the caregivers received less than one visit a month on average, and more than a third received between one and two visits per month.

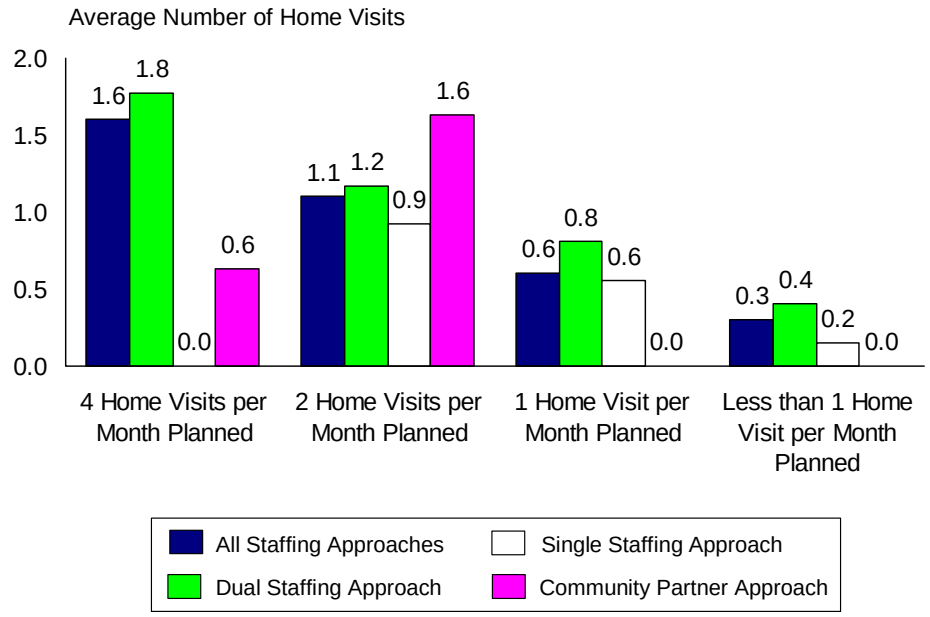
Most programs planned to conduct home visits with caregivers weekly or monthly (see box). On average, programs completed about half the number of home visits per caregiver they intended to provide each month (Figure III.3). Programs that used the dual home visitor and the community partner staffing approaches (described in Chapter II) completed more visits, on average, than programs that used a single home visitor approach. Perhaps staff in sites using the single home visitor approach had more difficulty completing caregiver visits because they had to divide their time between families and caregivers. Moreover, because the Head Start Program Performance Standards require weekly visits to families, and the pilot

Planned Intensity of Home Visits

	Number of Programs
Weekly	7
Biweekly	11
Monthly	3
Three times a year	1
Initial visit only	1

N = 23 pilot programs.

Figure III.3. Average Number of Home Visits Caregivers Received per Month, by Staffing Model and Planned Service Intensity



Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 513 caregivers.

had no minimum requirement for the number of visits, home visitors prioritized meeting the performance standard for visits to families.

Cancellations contributed to rates of home visit completion that were lower than planned. Although home visitors generally reported that caregivers canceled visits less frequently than Early Head Start families did, staff reported some difficulties completing visits with caregivers. According to the home visitors, the main reasons caregivers canceled home visits were conflicts with work schedules or appointments and illness. In some sites, home visitors did not conduct a scheduled visit if the pilot child was not in the caregiver's home when they arrived. In other sites, however, the home visitor would conduct the visit despite the absence of the child. In addition to cancellations by caregivers, home visitors reported canceling visits themselves because of weather, unexpected meetings, or illness. As described in Chapter II, more than half the sites experienced staff turnover during the first two years of implementation, which sometimes resulted in periods when pilot services were not delivered. At other sites, pilot

Home Visitor Quote on the Difficulties of Scheduling Home Visits

"One of my grandparents works until 2, so we can only do home visits after 2. Sometimes we have to cancel and reschedule. And my other grandparent, she had her other children in the home, they're 10 and 12. So after school was out, she was very busy with them and their appointments. So we had to reschedule two or three times. They want to do home visits, it's just hard."

services occasionally were interrupted while staff went on vacation, maternity leave, or other leave.

Initial Home Visits. Pilot home visitors reported the first home visit with kith and kin caregivers was primarily a chance to get to know the caregiver and child and to build trust and rapport. Staff from several programs reported taking the caregiver's lead during the first home visit. For example, if the caregiver seemed comfortable, the home visitor would begin asking questions about the caregiver's needs and goals. If a caregiver seemed uncomfortable, however, the visit would focus on the child, and the home visitor would spend less time in the home.

Home visitors also described pilot services in more detail and emphasized the pilot's benefits to the caregiver. Some home visitors described bringing educational materials for the children and safety equipment for the caregivers' homes during the first visit to demonstrate concretely how the pilot would benefit the caregiver (see box). Home visitors also described to caregivers the types of information they could bring to help them with the child's developmental goals or their own personal goals.

Home Visitor Quote About Building Rapport with Caregivers

"I focus on the material needs that they have for the child. It seems to break the ice if I say, 'I can help you get a car seat or clothing for the child.' If I can do something tangible, they know to trust you."

Home visitors also reported that they used the initial visit to collect information on caregivers' needs, interests, and expectations of the pilot to help plan future visits. They usually collected this information through interest surveys and needs assessments. Few programs reported conducting a formal needs assessment with caregivers; however, many reported informally assessing and recording caregivers' needs and interests. Several programs reported completing a partnership agreement with caregivers that outlined the responsibilities of caregivers and home visitors. For example, the caregiver would agree to participate in scheduled home visits and call to reschedule if she was not able to attend a visit. In many sites, home visitors and caregivers set goals for themselves and the Early Head Start child; some programs required the families to sign off on the goals that the caregivers identified. Home visitors reported that this was a way of keeping families informed about the topics that would be covered during the home visits and ensured that families approved of the goals that caregivers identified for the children.

Typical Home Visits. Home visits lasted about an hour, on average; three-quarters lasted between 30 and 90 minutes (Table III.4). The Early Head Start child enrolled in the pilot was present during three-fourths of home visits. In more than 40 percent of the visits, other children also were present. Most home visitors reported that they included other children present in the home visit activities and brought age-appropriate activities for them. Other adults, in addition to the caregiver and home visitor, were present during nearly half the visits. Parents were present in nearly a third of the visits, either because they lived in the same home as the caregiver or because they came to the caregiver's home during the visit. Others who participated included other professionals (such as other pilot staff or Part C providers), as well as other family members of the caregiver.

Table III.4. Content of Home Visits to Caregivers

Characteristics of Home Visit to Caregivers	Percentage of Home Visits
Length of the Home Visits	
0 to 29 minutes	9
30 to 59 minutes	22
60 to 89 minutes	54
90 or more minutes	15
Early Head Start Child Was Present During the Visit	74
Number of Children Present	
1	46
2	21
3 or 4	16
5 or more	7
Number of Other Adults Present	
1	31
2	10
3	4
4 or more	1
Types of Other Participants Present	
Parent or primary caregiver	32
Other pilot staff	1
Part C provider	1
Health professional	2
Translator	< 1
Other participant	14
Activities Conducted During Home Visits	
Provide education and/or information	84
Child assessment or observation	73
Carry out activity with child	57
Model/demonstrate interaction with child	56
Provide emotional support to caregiver	42
Goal setting and planning	34
Problem solving	21
Crisis intervention	3
Other activities	16
Topics Covered	
Literacy and language development	62
Cognitive development	60
Motor skills	58
Social and emotional development	54
Health and safety	47
Nutrition	34
Working/communicating with parents	20
Behavior issues	19
Referral to community services for caregiver	16
Special needs	8
Other	23

Source: Enhanced Home Visiting Recording System

Note: N = 4,261 home visits. Missing values ranged from 0 to 507 across items.

The home visitors' approaches to conducting home visits with caregivers often were modeled on the approach they used for conducting home visits with Early Head Start families. In most sites, home visitors tried to maintain a primary focus on the child and strategies for supporting his or her development, and they individualized services to the needs and interests of the caregivers and children. Most home visitors said their visits included (1) a discussion with the caregiver on a specific topic; (2) an activity with the child, caregiver, and home visitor; and (3) often, completion of a home visit record.

Curricula Reported by Programs

Creative Curriculum	Touchpoints
Parents as Teachers	H.E.L.P.
Healthy Babies	High/Scope
Father for Life	24/7 Dad
Born to Learn	PITC

Home visitors provided caregivers with information about child development and developmentally appropriate caregiving practices during more than 80 percent of the visits. Topics covered during more than half the visits included literacy and language, cognitive development, motor skills, and social-emotional development. During site visit interviews, home visitors said that they individualized the visits by bringing information the caregiver had requested on specific topics. When the pilot began, approximately two-thirds of programs adopted a curriculum for home visits with kith and kin caregivers (see box), with half these programs using Parents as Teachers. Frequently, this was the same curriculum the Early Head Start program used. Most home visitors described using the curriculum as a guide or resource for planning the visits, but not following it directly. Instead, they used curricula as sources for ideas about activities and information on child development topics, especially in response to caregiver questions and concerns. Home visitors reported that, while curricula were an important resource, they did not always meet the specific needs of the caregivers and children they worked with. Many said they preferred to choose activities and topics for the visits based on the specific interests and needs of the caregivers, rather than following the prescribed structure of the curriculum.

In more that half the visits, home visitors worked with caregivers to observe or assess the child, conduct an activity with the child, and model developmentally appropriate interaction with the child. Child-caregiver activities often were selected to address a specific goal defined for the child, such as learning colors or addressing a delay in speech or motor skills. Some sites used child development goals that the parents set as a guide for planning home visits with caregivers, and others used goals that the caregiver set. Nearly all home visitors, however, explained that they individualized the activities to fit the needs and developmental stage of the child. Often, they also used the activities as an opportunity to model developmentally appropriate practices for the caregivers and give them ideas for activities they could do with the child. For example, some home visitors worked with caregivers to make simple books, sorting games, and other toys from household items like formula cans.

Other home visit activities focused more on meeting the caregiver's needs. These activities included providing emotional support, goal setting and planning, and problem solving. The activities might focus on helping caregivers resolve difficulties they were having with a child, such as a behavior management issue or potty training. Home visitors also

helped caregivers with other issues in their lives by serving as a listening ear, giving advice, and providing referrals. Most referrals were for services in four categories: (1) health services, including mental health; (2) income supports, such as energy assistance, food stamps, and housing supports; (3) legal and financial assistance; and (4) employment services. Some of the most common referrals were to food banks, utility assistance, and mental and physical health services. Pilot home visitors interviewed during the second round of site visits reported that most caregivers followed through with referrals, especially when it was for a need they identified themselves. To encourage caregivers to follow through, home visitors from two sites often suggested that caregivers contact referral agencies during the home visit. More than half these programs provided caregivers with transportation to appointments, if needed.

Home visitors also worked with caregivers on improving the health and safety of the caregiving environments; this topic was discussed during nearly half the home visits. Nearly all programs reported working through health and safety checklists with caregivers, and some programs used the results of this checklist to determine the health and safety equipment to distribute to caregivers. Some programs used formal checklists, while others conducted informal checks during conversations with caregivers. Programs reported integrating health and safety topics into their lesson plans with caregivers and distributing safety equipment in response to needs identified by the health and safety checklist. For example, some home visitors designed a home visit around the topic of fire safety. The visit would include information on fire safety, a checklist of the types of fire safety equipment in the home, and distribution of equipment (such as fire extinguishers or smoke detectors) or referrals for caregivers to community organizations that had these items available for distribution. Of the programs visited during the second round of site visits, most reported waiting until at least the third home visit to use the checklist, and a few spread the checklist out over several visits. Home visitors explained that, before approaching sensitive topics, such as the cleanliness of caregivers' homes and personal habits like smoking, they waited until they had established a relationship with caregivers and gained their trust.

Home visitors reported that, while they made suggestions to caregivers about caregiving practices and other topics, they approached these issues carefully so they would not offend the caregiver. As with health and safety topics, most said that they did not make direct suggestions until they established a trusting relationship with the caregiver. Frequently, they approached a topic or concern by modeling appropriate behavior or sharing educational information on the topic. For example, home visitors frequently mentioned encouraging caregivers to turn off the television. Many initially asked caregivers to keep the television off during the home visits and later suggested limiting television viewing at other times. Home visitors also reported encouraging caregivers to maintain a smoke-free environment for the child. Some home visitors described often approaching the topic by sharing educational materials with caregiver on health topics, such as childhood asthma. Then they would suggest that caregivers smoke outdoors, or, if that was not successful, that caregivers not smoke in the same room as the child. Home visitors explained that suggestions were typically most successful when made in response to questions and concerns raised by caregivers. For example, if a caregiver raised a concern about temper tantrums, the home visitor would teach the caregiver behavior management strategies and encourage consistency with the discipline practices used by the family.

Group Activities

In addition to home visits, most programs offered group activities for caregivers. Programs described offering three main types of group activities: (1) training workshops, (2) group socialization activities for caregivers and children, and (3) caregiver support groups (see box). Some of these events were planned specifically for the caregivers enrolled in the pilot, while others were events offered by the Early Head Start programs or community partners that caregivers were invited to attend. During the first year of implementation, two-thirds of pilot sites reported that caregiver attendance at trainings, socializations, and support groups was lower than anticipated. Many programs reported that only one or two caregivers ever attended a group activity. During the second year of implementation, many of these sites reported (1) completely eliminating group activities for caregivers, or (2) continuing to invite caregivers to Early Head Start events but not planning group activities specifically for them. In the rest of this section, we describe the intensity of participation in group events, the types of events pilot sites planned, and strategies sites used to improve participation.

Group Activities Offered to Caregivers

	Number of Programs
Caregiver trainings	18
Socialization events	17
Support groups	4

N = 23 pilot programs.

Intensity. Caregivers in 17 of the 23 programs attended at least one group event. Across all programs, nearly one-third of caregivers attended at least one event, and 20 percent attended more than one (Table III.5). Programs reported that, although most caregivers never attended a group event, there was often a core group of caregivers who attended regularly. Record-keeping system data confirm this attendance pattern; while most caregivers never attended an event, 10 percent attended five or more events. Slightly more caregivers attended group trainings than socializations and playgroups (22 percent, compared to 18 percent).

Pilot sites reported that lack of transportation was the most common obstacle preventing caregivers from attending group events. Many caregivers lived in rural areas that lacked public transportation, and many caregivers did not have access to a car. To address this barrier, programs provided transportation to about one-third of caregivers who attended a group event. Some programs relied on home visitors to pick up caregivers in their personal vehicles and bring them to the events; others used agency vans and buses to transport the caregivers. One pilot site invested in a small bus and a driver to bring caregivers, families, and children to group events.

Other barriers to attending group events reported by staff included health problems that made caregivers reluctant to leave home, conflicts with work schedules, and shyness. Lack of child care was also a barrier for some, but pilot sites provided child care to more than 40 percent of caregivers who attended group events. Caregivers typically would bring the child to the Early Head Start program office, and child care would be provided on-site.

Table III.5. Group Events Attended by Caregivers

Type of Group Event	Percentage of Caregivers
Any Group Event	
Attended one	30.4
Attended more than one	20.2
Socialization (Playgroup/Support Group/Special Event)	
Attended one	17.8
Attended more than one	9.2
Training Workshop	
Attended one	22.2
Attended more than one	14.9
Number of Group Events Attended	
0	69.6
1	10.9
2	5.2
3 to 4	4.2
5 to 6	2.7
7 or more	7.4

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 513 caregivers.

Training Workshops. Initially, most programs planned to provide group training events for caregivers. Most offered trainings monthly, but a few offered weekly trainings. Sites often coordinated training events with a community partner, either by cosponsoring events with a community partner or inviting caregivers to attend trainings the partner already was offering. For example, many CCR&Rs that partnered with pilot sites invited the caregivers to attend their trainings free. The pilot or Early Head Start program sponsored approximately half the training events that caregivers attended, while a partner or other community agency sponsored the other events (Table III.6). Literacy and language was the most common training topic, followed by social-emotional development, nutrition, health and safety, and behavior management.

Some pilot sites offered training series based on a specific curriculum. For example, sites organized training series based on the *Touchpoints* curriculum, WestEd's Program for Infant/Toddler Caregivers (PITC), Love and Logic (a behavior management curriculum), and others. In some cases, participation in these training series counted toward credits needed for a child care license or a Child Development Associate credential. One site that served foster parents arranged for the trainings to count toward credit hours needed to maintain a foster care license.

Table III.6. Characteristics of Group Events

Characteristics	Percentage of Events
Training Workshops	
Topics Covered	
Literacy and language	17
Social-emotional development	12
Nutrition	12
Health and safety	11
Behavior management	11
Cognitive development	10
Motor skills	8
CPR/first aid	8
Working with parents	3
Special needs	3
Other	12
Training Event Sponsors	
Early Head Start	48
Community partner	30
Other agency	21
Socialization and Support Groups	
Type of Group/Socialization Activity	
Playgroup	38
Special event with children/families	30
Peer support group	12
Field trip	10
Other	10
Group Event Sponsors	
Early Head Start	85
Enhanced Home Visiting Pilot partner agency	14
Other agency	2
Supports Provided	
Child Care	43
Transportation	32

Note: N = 800 group events.

To encourage attendance, some sites provided incentives, such as door prizes and goody bags with items that related to topics presented at the event. For example, programs reported distributing books at literacy trainings and smoke detectors at trainings on fire safety. Most also provided meals or snacks at the group events. At one program, caregivers received $15 for every training they attended. Another program that conducted trainings gave caregivers who completed 18 hours of training $150 to spend on toys and materials to enhance the child care setting. Program staff differed in their opinions about whether providing incentives improved attendance. Some staff thought incentives made the group events more attractive for caregivers, while others thought incentives did not increase attendance. According to some home visitors, caregivers interested in training would come even if an incentive was not offered. One program initially gave $10 to caregivers who attended group activities. They discontinued this policy, however, because the home visitors found that it did not make a difference in attendance—the same caregivers came whether or not the incentive was offered.

Group Socializations and Playgroups. According to the Head Start Program Performance Standards, home-based Early Head Start programs must offer at least two group socialization events for parents and children every month. About half the pilot programs reported inviting caregivers to these events with the children in their care. Group socialization activities included playgroups, field trips, and other special events, such as picnics or family fun nights. The socialization events usually were organized around themes, such as outdoor play and summer safety, or a holiday, such as Mother's Day. Although attendance at group socializations was low overall, programs reported that grandmothers and other relative caregivers were more likely than nonrelative caregivers to attend these events.

Four programs offered playgroups, field trips, and special events specifically for caregivers and children enrolled in the pilot. One program offered these groups weekly, while the others offered the groups less frequently, such as four to five times a year. The socialization events included both playgroups and special events and field trips. For example, programs described planning events at community parks, zoos, and museums. Some programs planned special events such as trips to a pumpkin patch and apple orchard to celebrate fall.

More than 80 percent of the group socialization events were sponsored by the pilot program (Table III.6). In some cases, the pilot cosponsored group socialization events with community partners. For example, one program cosponsored a monthly First Books event with an Even Start program for pilot caregivers and Even Start participants. During the event, participants would read a book, do a caregiver-child activity based on the book, and receive a copy of the book to keep.

Support Groups. Four programs offered support groups for caregivers that were intended to give them an opportunity to share and learn from each other in a fun, relaxed environment. Unlike the playgroups, field trips, and other special events, which usually were open to caregivers and Early Head Start parents, the support groups typically were organized especially for the caregivers enrolled in the pilot, or for a combination of pilot caregivers and other caregivers in the community. For example, one program offered a "Grandparents as Caregivers" support group in collaboration with a family advocate from an elementary

school. A community partner provided the space for the meetings. The program initially offered the grandparent support group one day a month, but increased it to twice a month because it was so successful. The attendees were primarily the grandparents enrolled in the pilot, but a few other grandparents invited by the community partner also attended. Six to eight grandparents attended each meeting, and the program offered child care.

Strategies to Improve Participation in Group Events. Five programs had high rates of participation in group events. At these programs, nearly half the pilot caregivers attended more than one group activity, and many attended more than seven events (as many as 50 percent of caregivers in one site). All these programs offered group trainings and group socialization events. At all but one site, however, attendance was typically concentrated at one type of event. Four of these programs had highest attendance at trainings, while one had highest attendance at socialization events (specifically, peer support groups).

These programs reported offering a variety of incentives to encourage participation. Two offered trainings that counted toward child care and foster parent licensing requirements, one gave caregivers $15 for every training they attended, and all offered meals at events. In addition, they frequently offered door prizes and other materials. One program that served many Spanish speakers conducted trainings in both English and Spanish and offered English as a Second Language (ESL) classes at the request of caregivers. Most of the programs regularly offered transportation to events, and one program even invested in a bus and driver specifically for the pilot. Some of the programs also offered child care, if the event was for adults only.

Many of these programs reported low attendance initially; however, staffed worked on changing the format or timing of the events to better meet caregivers' needs. Many of these sites also offered group events at different times, such as in the afternoons and evenings, to accommodate caregivers' schedules. The pilot home visitors at these programs invested significant effort in these events and were typically instrumental in planning them. They relied on community partners only for occasional presentations or meeting space. For example, one home visitor organized trainings twice a month for caregivers. She conducted many of the trainings, but tried to have a presentation from a community partner once a month. At a program where the caregivers were invited to parent meetings for Early Head Start, the pilot home visitor was part of the planning committee and attended the meetings. In this way, she could select topics for the meetings that were of interest to the caregivers. Another home visitor provided a training series on PITC for family child care providers in the community and encouraged participation by caregivers enrolled in the pilot by using videotapes of some of the caregivers and children as footage for the series.

Materials and Equipment

Nearly all the pilot sites provided caregivers with materials and equipment to try to improve the quality of the caregiving environment. On average, caregivers received 10 items from the pilot (not shown). Two-thirds of caregivers received at least one item, and nearly 60 percent received more than one (Table III.7). The most commonly provided items were educational materials, toys, and books. Caregivers also received materials used to

Table III.7. Materials and Equipment Provided to Caregivers

Materials and Equipment	Percentage of Caregivers
Received at Least One Item	67
Received More than One Item	57
Types of Items Caregivers Received	
Educational materials	40
Toys	38
Books	36
Safety and home repair equipment	31
Art supplies	25
Educational materials for primary caregiver	15
Educational videos	9
Outdoor play equipment	8
Furniture	5
Car seats	3
Other	28

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 513 caregivers.

childproof homes—outlet plugs, safety gates, cabinet latches. As described earlier, safety items often were distributed to caregivers in response to findings from health and safety checks conducted during home visits. Art supplies were another common item programs gave caregivers. Home visitors reported bringing art supplies to home visits for craft activities, and commonly leaving extra supplies for caregivers and children to encourage them to engage in art projects. Other programs reported creating art boxes for caregivers, which included crayons, paint, paper, and child-sized scissors. The home visitors would refill the items as needed. Programs also reported giving caregivers a variety of other items, including household supplies, such as diapers, laundry detergent, and paper goods.

Although a number of pilot sites and community partners operated lending libraries, more than two-thirds of items were given to the caregiver (see box). The most commonly loaned items were educational videos, toys, and books. One community partner operated a mobile lending library that stopped at caregivers' homes at least three times a year. Nearly 80 percent of items were provided directly by the Enhanced Home Visiting Pilot. Many programs reported using pilot funding to purchase items to help caregivers address health and safety concerns and to enhance the

Distribution of Materials and Equipment

	Percentage of Items
Given	68
Loaned	32
Provided by:	
Pilot site	76
Community partner	23

N = 4,938 items.

care environment. About 20 percent of the items were given to caregivers as incentives at enrollment or for attending group activities (not shown).

Help with Child Care Licensing

As described in Chapter II, few caregivers enrolled in the pilot expressed interest in becoming licensed or registered child care providers. However, if a caregiver was interested, every program reported that they would help caregivers obtain a license. After the first year of implementation, approximately half the sites reported that one or two caregivers expressed interest. These caregivers were referred to other agencies, using CCR&Rs for help with the process. In addition, home visitors described providing transportation for caregivers to attend required trainings and assisting them throughout the licensing process by helping them complete paperwork. At some sites, group training events were designed to help caregivers meet credit requirements for licensing. For example, programs offered first aid and CPR training, as well as training in child development topics. Some home visitors also reported helping caregivers connect with agencies that could help them pay for home improvements and other changes caregivers needed to make to meet licensing requirements.

Strengthening Relationships Between Caregivers and Parents

While only four pilot sites explicitly defined strengthening relationships between kith and kin caregivers and families as a goal of their pilot programs, home visitors from nearly all programs reported that they worked on this topic with caregivers and families. During the second round of site visits, staff from most programs reported working with some caregivers and families when conflicts and issues arose. In addition, staff reported supporting communication between caregivers and families to help improve the consistency of caregiving practices. Staff in only one program reported that they did not focus on promoting communication and consistency in caregiving practices across caregivers and parents. In this site, however, many parents and caregivers lived in the same household, and parents often were present during the caregiver home visits. Therefore, the home visitor shared information about caregiving practices with both parties.

Disagreements that occurred between families and caregivers ranged from differences in opinion about child-rearing practices, such as discipline and toilet training, to more serious conflicts about drug abuse and guardianship. In general, home visitors reported that they most frequently addressed issues about child-rearing practices, and were much less likely to get involved when the issue focused on guardianship and parental behaviors not related to child rearing. Program staff reported using five main strategies to help

Strategies for Facilitating Communication Between Parents and Caregivers

	Number of Programs
Sharing home visit records	3
Joint home visits	2
Joint group events	2
Sharing educational materials	3
Encouraging direct communication	4

N= 12 pilot programs visited in spring 2006.

communication between caregivers and families: (1) sharing information about the caregiver visits with parents; (2) conducting joint visits; (3) inviting both caregivers and parents to socializations and other group events; (4) sharing educational information about child care topics with both caregivers and parents; and (5) facilitating and/or encouraging direct communication (see box previous page).

Caregiver Quote About How the Pilot Changed Her Relationship with the Parent

"I think it enhances my relationship with her, because we talk about what the baby did. Not only does [the enhanced home visitor] come to my house, but [the parent educator] also goes down to see her. So sometimes we'll talk about the difference between the two sessions. Sometimes [the mother] gives me ideas and sometimes I give her ideas. So I think that's really enhanced our relationship from me being in the program."

Some programs formally shared information about caregiver visits with families by providing families with a home visit record or other documentation. This documentation typically involved information on the time and length of the visit, the main activities and topics covered during the visit, caregiver concerns and questions, and goals for the next home visit. Programs that used a single home visitor approach reported informally sharing information with families about the activities and topics covered during the home visit with caregivers. Joint home visits were seen as an opportunity to share information with caregivers and families. At one program, the joint visits were with the family, Early Head Start home visitor, and pilot home visitor. These visits were an opportunity for the family to hear about the types of activities the pilot home visitor conducted with the caregiver and child and about the child's activities in the child care setting. Other programs conducted joint home visits, trainings, or socializations with families and caregivers. During these joint events, the home visitors planned activities and addressed issues based on family and/or caregiver concerns and disagreements. Home visitors also reported addressing communication issues more directly by mediating conversations between caregivers and families, encouraging families and caregivers to share information about routines and ask each other questions about the child's day, and sharing information with families and caregivers about communication skills.

Programs considered facilitating communication between families and caregivers as an important way to encourage consistency of child care practices and to improve the quality of care the children received. Nevertheless, home visitors across programs described "walking a fine line" between keeping the family informed and maintaining confidentiality with the caregiver. Home visitors from programs that shared documentation about home visits to caregivers with families reported censoring some of the information they included in the record. For example, when caregivers expressed concerns about parents' behaviors or relationships, home visitors explained that they often did not include this information in the documentation. Home visitors wanted the caregivers to be able to share information with them, without concerns about confidentiality. Home visitors also reported that they typically deferred families' questions about the caregivers. This practice was particularly stressed in cases where the caregivers were foster parents or legal guardians of the children. In these instances, the home visitors tried to encourage direct communication between the family and caregiver.

Parent Quote About Addressing Disagreements with Caregiver

"We had a hard time with bottle-breaking. Well not a hard time, but I would come and she [the caregiver] would forget to put it away and I would come back and she would have given him a bottle. But if I have [the home visitor] bring her stuff, to educate her, it kinda helps me and backs me up because like, she thinks 'Somebody else thinks that too and maybe I should do that.'"

Staff from programs that used the same home visitor for families and caregivers described another challenge they faced: "not becoming the middle man." Staff at one program had resources available to help them navigate these relationships. For example, the home visitors attended training on relationships and facilitating communication. In addition, they were able to meet with a mental health consultant to discuss handling disagreements between caregivers and families. While home visitors described these resources as helpful, they explained that, at times, they struggled to remain an impartial third party. Staff from programs using a dual home visitor model expressed concerns about sending families and caregivers consistent messages and advice about issues and concerns. The pilot home visitor described working closely with Early Head Start home visitors to develop strategies and consistent approaches to responding to families and caregivers.

During focus groups with families and interviews with caregivers in the second round of sites visits, most participants said that the pilot had little effect on their relationship with their caregiver because they already had a good relationship with them. Some families, however, shared examples of ways in which the pilot improved their relationship or helped them resolve situations with their child's caregiver. Families and caregivers described the pilot as affecting the type of information they discussed with their child's caregiver. For example, families and caregivers reported talking more about the child's routines and development since participating in the pilot. Other families and caregivers described participation in the pilot as improving their overall relationship by encouraging them to communicate more and to trust each other more. Other participants described how the programs helped them resolve issues with their child's caregiver. Families reported sharing concerns about the caregivers with their Early Head Start home visitors or directly with the pilot home visitor. For example, families described concerns about caregivers giving their children unhealthy foods, watching too much television while caring for the children, and undermining families' attempts at potty training and stopping use of bottles. When families voiced these concerns to home visitors, families reported that the home visitors helped educate the caregivers about the topics in an attempt to make the caregivers' practices consistent with the care provided by families.

PARENT AND CAREGIVER SATISFACTION WITH PILOT SERVICES

Families and caregivers participating in focus groups and interviews overwhelmingly reported that they would recommend the pilot to other families; many reported that they already had told friends and family members about the pilot.[3] Families typically described

[3] The participants' responses may not be representative of all participating families, because the families who attended the focus groups were most likely to have liked the pilot. The caregivers interviewed in spring

the pilot as benefiting their child's caregiver more than themselves. However, some families explained that they felt more secure leaving their child with the caregiver because the caregiving environment was safer and the caregiver was interacting more with the child. For example, some parents described the caregivers as playing more with the child and getting on the floor with the children and engaging them. Parents reported that participation in the pilot gave the caregivers new activities and ideas of things to do with the children. Parents also appreciated that caregivers learned updated or additional information about child development and how children learn. In addition, parents mentioned that the pilot provided support for caregivers and increased opportunities for adult interaction during home visits and group events. Some parents described the pilot as helping caregivers recognize and be proud of the role they play in the child's life. Finally, parents were grateful for the free equipment and materials, which enhanced the care environment and made the environment safer and healthier for the child. Parents also reported that the pilot not only benefited the child who was enrolled in the pilot, but also benefited the other children in the caregivers' care. In some cases, these were siblings or relatives of the enrolled child; in other cases, they were unrelated children.

Parent Quote About How the Program Has Changed the Quality of Care Provided by Caregiver

"My mom questions things now. Like we were worried about serving sizes of food because my son eats all the time, and they were telling us that two tablespoons should be enough for his age… so now she is always asking me, 'Is this enough?' I think before the program she would have just let him eat whatever."

The aspects of the pilot that caregivers described as being most beneficial and positive mirrored the aspects that the families identified. Caregivers also identified learning new ideas and activities to do with the children, learning about child development, receiving free materials and equipment, and having support from the home visitors as aspects of the pilot they liked most. In addition, caregivers mentioned as highlights of the program their own and the children's connection with the home visitors. They described home visitors as friends and like part of the family, and emphasized their kindness, understanding, and patience. Many emphasized how much the children looked forward to the home visitor's arrival and discussed how positively the children reacted to the home visitors. Caregivers described the children waiting by the door for their home visitor's arrival. Caregivers who cared for more than one child described a similar reaction from all the children in their care. Caregivers overwhelmingly reported that they would recommend the pilot to others because of the benefits for the children and their

Caregiver Quote About Satisfaction with the Pilot

"The people here go beyond their jobs. They find ways to help you. If there's resources out there, they'll get them for you. And they back you up too, for your family…They back you up in ways that have nothing to do with the program, which is really cool...[be]cause a lot of us have stress in our lives with the grandkids, and we need a shoulder to cry on."

(*continued*)
2006 were randomly selected to participate in in-home observations; however, the caregivers who consented to the observations may also have been more likely to have enjoyed participating in the pilot.

own positive experiences in the pilot. Some caregivers reported that they had, in fact, told relatives and friends about the program and encouraged them to join.

SUMMARY

Recruiting, enrolling, and retaining caregivers in the pilot was challenging throughout the first two years of implementation. At the end of the data collection period, most of the sites were serving 75 percent or fewer of the caregivers they planned to enroll. Staff in most sites reported, however, that enrollment was low primarily because of the narrow eligibility criteria for the program, rather than because of a lack of interest among kith and kin caregivers. To be eligible, caregivers had to be caring for a child already enrolled in Early Head Start. Many sites did not have enough enrolled families already using kith and kin care and could not easily enroll more because they were already at full enrollment and had long waiting lists.

The average duration of caregiver enrollment was nine months; nearly half the caregivers left the program after about six months. In addition, staff reported that, to some extent, turnover was more the result of families' tumultuous lives than of caregivers' lack of interest. For example, nearly half the caregivers left the program because the child and family left Early Head Start. In many cases, however, the caregiver continued to care for the child and wanted to continue participating in the pilot. About a third of the caregivers left the program because the child care arrangement ended. According to pilot staff, parents' child care needs often changed because of changes in work or school schedules.

More than 90 percent of caregivers received at least one home visit; across all sites, they received an average of nine visits. Most programs planned to conduct home visits with caregivers weekly, biweekly, or monthly. On average, programs completed about half the number of home visits per caregiver they intended to provide each month. Overall, programs that used the dual home visitor or community partner staffing approaches completed more of their planned visits that those using a single home visitor for parents and caregivers. Most caregiver home visits included a discussion with the caregiver on a child development topic and an activity with the child, caregiver, and home visitor. Nearly half the visits also included activities that focused on meeting the caregivers' needs, such as providing emotional support, problem solving, and making referrals for social services.

Across all programs, one-third of the caregivers attended at least one training workshop, support group, or group socialization event. According to pilot staff, lack of transportation was the most common obstacle that prevented caregivers from attending. Five programs, however, had high levels of attendance. These programs tailored group activities to the interests of the caregivers, and they provided transportation, child care, and participation incentives.

Nearly all the pilot sites provided caregivers with materials and equipment to improve the quality of the caregiving environment. Two-thirds of caregivers received at least one item, and nearly 60 percent received more than one. The most commonly provided items were educational materials, toys, books, and safety equipment.

Nearly all programs implemented strategies to improve communication and increase consistency in caregiving practices between parents and caregivers. They did this by sharing information about the caregiver visits with parents, conducting periodic joint visits, encouraging both parties to attend group events, sharing consistent educational information about child care and development with both parties, and encouraging direct communication.

CHAPTER IV

CHARACTERISTICS OF CAREGIVING ARRANGEMENTS

Knowledge of the characteristics and needs of kith and kin caregivers is an important precursor to developing effective outreach strategies for this population and identifying the mix of services they need to provide good-quality child care. This information can be useful to Early Head Start programs and others who are developing initiatives for supporting kith and kin caregivers. In this chapter, we provide a detailed portrait of the kith and kin caregivers enrolled in the Enhanced Home Visiting Pilot and the child care they provide to Early Head Start children. We begin by describing the caregivers' (1) demographic characteristics; (2) their child care experience, training, and support; (3) their interest in becoming licensed providers; (4) their attitudes toward child care; and (5) their relationships with the children's parents or guardians. Next, we describe the child care arrangements, including the duration, intensity, schedule, number of children in care, and compensation the caregivers received for the care they provided. We also explore the extent to which families used multiple arrangements for their Early Head Start children in kith and kin care.

We then look more closely at the quality of a selected subsample of kith and kin care arrangements that were the subject of the Enhanced Home Visiting pilot. As described in Chapter I, we conducted in-home observations of a random subset of kith and kin arrangements in the 12 pilot sites we visited in spring 2006. We first describe the health and safety features of the arrangements and the materials available to the children and caregivers in the child care setting. We then examine the quality of child-caregiver interactions as measured by the Child Care Assessment Tool for Relatives (CCAT-R) and the Arnett Caregiver Interaction Scale.

The information in this chapter comes from several sources. We rely primarily on the record-keeping system to describe the kith and kin caregivers and child care arrangements.[1]

[1] Our sample includes 526 kith and kin child care providers enrolled in the pilot and 593 child care arrangements. There are more arrangements than caregivers in the sample because some caregivers cared for more than one Early Head Start child.

To explore caregivers' attitudes toward child care and relationships with parents, we also draw on responses to a brief caregiver interview conducted at the end of the in-home observation and focus group data from the first round of site visits.[2] Information about the quality of the arrangements is based on 74 in-home observations.

As noted in Chapter I, this evaluation was designed to be descriptive, and as a result we cannot provide estimates of the pilot's impact on the quality or other characteristics of the kith and kin child care arrangements that were the target of the pilot. In addition, the kith and kin child care settings observed as part of the evaluation were not selected to be representative of the caregivers enrolled in the Enhanced Home Visiting Pilot. It is possible that our assessments of quality overestimate the quality of care that caregivers enrolled in the pilot provide, because those who provide lower-quality care may have been more likely to refuse participation in the observation. However, we include the observation findings here because they provide an important window into the daily experiences of Early Head Start children in kith and kin care.

CHARACTERISTICS OF KITH AND KIN CAREGIVERS

To be eligible for the pilot, kith and kin caregivers had to be providing care for at least one child enrolled in Early Head Start; there were no other requirements. Across the pilot sites, the caregivers enrolled in the pilot were diverse in their demographic characteristics and their relationships to the children. In this section, we describe the caregivers in detail, including their demographic characteristics, years of experience and training for providing child care, interest in becoming licensed or registered providers, attitudes toward child care, and relationships with the children's parents.

Demographic Characteristics

More than two-thirds of caregivers enrolled in the pilot were related to the children in their care. Nearly half were the children's grandparents; another 14 percent were aunts, uncles, or other relatives (Table IV.1). A small proportion of the caregivers were parents; two percent were nonresidential fathers who cared for the child on a regular basis, and five percent were nonresidential fathers.[3] Ten percent were family friends or neighbors. Fourteen percent had no prior relationship with the child; these caregivers were a mix of licensed or registered providers, unregulated providers, and foster parents.[4]

During site visit interviews, pilot staff noted that many kith and kin caregivers provided a sense of stability to the Early Head Start family; they were often viewed as people who

[2] We conducted 78 caregiver interviews, and 107 caregivers participated in focus groups in year 1.

[3] One of the pilot sites focused on enrolling and serving fathers as caregivers.

[4] One of the pilot sites focused on enrolling and serving kinship foster parents related to the child and unrelated foster parents.

Table IV.1. Demographic Characteristics of Caregivers Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Caregivers
Caregiver's Relationship to the Early Head Start Child	
Nonresidential parent	2
Residential father[a]	5
Grandparent	48
Aunt/uncle	10
Other relative	4
Family friend	9
Neighbor	2
Other relationship	6
No prior relationship	14
Caregiver Is Child's Primary Caregiver[b]	9
Caregiver's Age at Enrollment in Enhanced Home Visiting	
Under age 20	7
20 to 29	18
30 to 39	21
40 to 49	29
50 to 59	17
60 to 69	7
70 or older	1
Caregiver's Gender	
Female	84
Male	16
Caregiver's Marital Status	
Single	24
Married	56
Living with significant other	8
Separated	2
Divorced	7
Widowed	4
Caregiver's Race	
American Indian or Alaskan Native	2
Asian	1
Black or African American	6
Hispanic or Latino	15
Native Hawaiian or Other Pacific Islander	0
White	73
Multiracial	2

Table IV.1 *(continued)*

	Percentage of Caregivers
Primary Language Spoken at Caregiver's Home	
English	87
Spanish	11
Other	2
Primary Caregiver's Highest Level of Education	
Less than high school	10
Some high school	23
High school diploma/GED	38
Some college	18
Two-year college degree	6
Four-year college degree	4
Some graduate school	1

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 526. Missing data range from 7 to 115 across items.

[a]One pilot site enrolled both nonresidential and residential fathers. The caregivers in this category represent the *residential* fathers served by this program.

[b]Pilot caregivers included some foster parents and some grandparents who were serving as the child's primary caregiver on a temporary or permanent basis.

"held things together" for other family members. Indeed, caregivers were often more mature and settled than the Early Head Start parents. The average age of caregivers at enrollment in the pilot was 41—two-thirds were between 30 and 59 years old. Eight percent were 60 or older; one percent was 70 or older. More than 80 percent of the caregivers were women, and almost two-thirds were married or living with a "significant other." Unlike the Early Head Start families, not all caregivers lived in poverty. Nevertheless, many had low incomes. Among those we observed in spring 2006, half reported annual household incomes of $20,000 or less (see box).

Annual Household Income Reported by Caregivers

	Percent of Caregivers
$10,000 or less	28
$10,001 to $20,000	23
$20,001 to $30,000	22
$30,001 to $50,000	14
More than $50,000	13

N = 69 caregivers interviewed during the second round of site visits.

Other demographic characteristics of the caregivers parallel those of the Early Head Start parents. Like the parents, more than 70 percent of the caregivers were white; another 15 percent were Hispanic or Latino. Thirteen percent spoke a first language other than English at home. Ten percent did not speak English well or at all (not shown). Educational attainment varied widely across caregivers; about one-third had not completed high school, nearly 40 percent had completed high school or obtained a GED, and nearly 30 percent had at least some college.

Child Care Experience, Training, and Support

At enrollment, most caregivers had some prior experience caring for children other than their own; nearly one-quarter had between one and three years' experience, and nearly a third had more than 10 years' experience (Table IV.2). More than a quarter had experience working in a child care program, such as a Head Start classroom, a child care center, or a family child care home. Nearly one-third of the caregivers had participated in training on child development, such as a child care or parenting workshop, training toward a certificate, or college courses. This level of training is consistent with levels found in other studies of kith and kin child care (Brandon 2005).

Most caregivers reported providing 10 or more hours of child care in a typical week; nearly 30 percent reported providing more than 40 hours of care per week. These caregivers cared for an average of two children; one-third cared for four or more children. Nearly 40 percent reported that they had a regular assistant who helped them care for the children. More than 90 percent of these assistants were family members of the caregiver; half were the caregiver's spouse, and 16 percent were her own children (but not the parent of the focus child).

Table IV.2. Child Care Experience, Training, and Support for Caregivers Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Caregivers
Caregiver's Years of Experience Caring for Other People's Children	
Less than 1	19
1 to 3	23
4 to 6	17
7 to 10	11
More than 10	31
Caregiver Has Experience Working in a Child Care Program	26
Caregiver Has Education or Training in Child Development	31
Total Hours of Care Provided in a Typical Week	
1 to 10	25
11 to 20	19
21 to 30	13
31 to 40	14
More than 40	29
Number of Children Cared for in the Caregiver's Home	
1	31
2 to 3	35
4 to 5	21
6 to 8	9
More than 8	4
Caregiver Has a Regular Assistant	39
Assistant's Gender	
Female	51
Male	49
Assistant's Age	
17 or younger	11
18 to 60	81
Older than 60	8
Assistant's Relationship to Caregiver	
Spouse or significant other	51
Own child	16
Paid assistant	4
Other relative	27
Other nonrelative	2
Caregiver's Licensing Status	
Licensed family child care home	6
Registered home child care provider	5
Exempt from licensing or registration	39
Other licensing status[a]	7
Licensing status unknown	42

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 526. Missing data range from 32 to 54 across items.

[a]This category includes licensed foster care providers.

Interest in Licensing

Approximately one-tenth of the caregivers in our sample were already licensed or registered family child care providers when they enrolled in the pilot (Table IV.2). Another seven percent reported another type of licensing status, such a foster care license. Nearly 40 percent reported being exempt from licensing requirements because they cared for a small number of related children in their own homes, and the rest did not know whether or not they were exempt.

During caregiver focus groups and in-home interviews, few of the caregivers who were not already licensed or registered expressed interest in becoming licensed or registered providers. Their reasons varied, but most did not view themselves as "child care providers," but as grandparents or other relatives who were helping their families. Many cared for only one or two children and were not interested in caring for children outside the family. Some caregivers had too many other commitments (such as work outside the home), in addition to caregiving duties, to work toward meeting licensing requirements. Others had health problems that precluded them from considering child care as a career option. Despite an overall lack of interest, at least one caregiver in more than half the sites expressed some interest in licensing. As described in Chapter III, pilot sites provided support and referrals to help these caregivers work toward meeting licensing standards.

In addition to lack of interest, many caregivers faced significant barriers to meeting licensing requirements. In some cases, caregivers or others living in the household had criminal records that would make the caregiver ineligible for licensing or registration. In other cases, caregivers' homes were too small or would need extensive repair work to meet health and safety requirements. For example, one caregiver initially expressed interest in licensing; however, her home was on a busy street and did not have a fence around the yard. The caregiver could not afford the cost of installing a fence on her property. Finally, immigration status prevented a few caregivers from pursuing licensing.

Attitudes Toward Child Care

Most unregulated caregivers did not express interest in pursuing regulation, but, during caregiver interviews, most expressed motivation to continue caring for children. Caregivers expressed genuine affection for the children, with most citing the need to help their families and their desire to spend time with the Early Head Start child and other children as their reasons for providing care (Table IV.3). Nearly half said they expected to continue caring for children as long as their health permitted it or as long as they were needed. For example, some said they would continue caring for the Early Head Start child until he or she began Head Start or kindergarten, although some mentioned other children in the family who would need ongoing care.

In response to open-ended questions, caregivers talked about what they enjoyed most about caring for the children. Caregivers said they enjoyed watching the children learn and seeing how rapidly they grow and develop. Many also said they enjoyed the children's

Table IV.3. Kith and Kin Caregivers' Attitudes Toward Child Care

Attitudes Toward Child Care	Percentage of Caregivers
Caregivers' Reasons for Caring for the Early Head Start Child	
I want to be part of the child's life	96
I love the child and want to spend as much time with him/her as I can	96
I want to help my family	85
I like being around children	71
I think I can do a better job than any other caregiver	66
My family asked me to do it	42
I need the money	18
Length of Time Caregiver Expects to Continue Caring for Other People's Children	
As long as I can	49
Until the children start school, preschool, or Head Start	25
As long as my family needs me	17
Not sure	9
What Caregiver Enjoys Most About Caring for the Early Head Start Child	
Watching the child grow and learn	35
Being with the child makes me feel good	29
The child's personality	18
Doing activities with the child	11
Everything	7
What Is Most Important About Taking Care of the Child	
Keeping the child healthy and safe	49
Making sure the child feels loved and happy	20
Helping the child develop social skills	10
Helping the child learn and develop	9
Helping the child learn to follow a schedule	4
Other	8
Aspects of Being with the Caregiver That Are Special for the Child	
Child receives attention and affection from the caregiver	38
Child does activities with the caregiver	16
Caregiver provides a safe, stable environment	14
Caregiver is not as strict/doesn't get as upset about the child's behavior as the parents	10
Child gets to play outside	9
Child gets more nutritious meals than at home	7
Child gets to play with other children	7

Source: In-home caregiver interviews conducted in spring 2006.

Note: N = 78. Missing values range from 0 to 10 across items.

affection, energy, and excitement. Others talked about how much they enjoyed playing with the children and reading to them.

When caregivers were asked their views on what is most important about taking care of the children, the most frequently mentioned issues were keeping children safe and healthy and supporting their social-emotional development. Caregivers also emphasized the importance of letting the children know they are loved and helping them feel secure. The emphasis on health and safety may reflect the high proportion of pilot home visits that included this topic and the fact that home visitors often did home safety checks with the caregivers (see Chapter III).

Caregivers also talked about their views on what was different or special for the child about being in their care, compared to being at home with the child's parents. Nearly 40 percent of caregivers, especially grandparents, said that they were able to give the child more attention and affection. They also talked about the activities they did with the child, the stability and safety of the environment in their homes, and opportunities to play outside and with other children.

Relationships with Parents

During site visits, pilot staff described efforts to promote positive relationships and communication between parents and caregivers as a key goal of the pilot (see Chapter III). Indeed, most caregivers who participated in the in-home interviews described their relationships with parents in positive terms. Nearly 90 percent said they valued their relationship with the parent and understood his or her schedule (Table IV.4). Three-fourths felt that parents listened to their advice about caring for the child, although more than a third acknowledged that their approach to raising children was different. In addition to providing child care for the parent, approximately 80 percent of the caregivers interviewed reported doing other things to help them, such as running errands and cooking meals (not shown). Despite these positive aspects of their relationships, however, 20 percent of caregivers reported feeling upset because the parent did not use the same behavior management strategies as the caregiver. A similar fraction also felt that the parent took advantage of their relationship.

Caregivers and parents communicated frequently. Nearly three-quarters said they talked about the child with the parent daily, and nearly 20 percent did so at least two to three times a week. Nearly 90 percent of caregivers reported talking most often to the child's mother about the child (not shown). The most frequently discussed topics included the child's routines, activities, and how the child felt during the day. More than half also reported talking often about what was going on in the parent's life, and nearly half talked about what was going on in the caregiver's life.

Table IV.4. Caregivers' Relationships with Parents

Statements About Caregivers' Relationships with Parents	Percentage of Caregivers Who Agree with Statement
I value our relationship	90
I understand what his/her schedule is like	89
I'm willing to be flexible about his/her schedule	89
Parent takes delight in how close I am to the child	84
Parent listens to my suggestions about how to care for the child	77
Parents gives me valuable suggestions about caring for the child	64
The parent's approach to raising children matches mine	59
I get upset because parent doesn't discipline the child the way I do	21
I think the parent takes advantage of our relationship	19
Topics Caregivers Talk About with Parents	**Percentage of Caregivers Who Talk About the Topic Often**
Child's routines, such as toileting, sleeping, and eating	75
What child ate during the day	74
What kind of activities the caregiver did with the child	71
How the child felt that day	71
What is happening with the child at home	67
How the child got along with other children that day	64
What is happening in the parent's life	57
What is happening in the caregiver's life	48

Source: In-home caregiver interviews conducted in spring 2006.

Note: N = 78. Missing range from 4 to 20 across items.

CHARACTERISTICS OF CHILD CARE ARRANGEMENTS

In this section, we describe the child care arrangements that were the subject of the Enhanced Home Visiting Pilot. We begin by examining the duration of the arrangements, the number of hours per week that children were in care, and the times of day care was provided. Next, we describe the locations where care was provided and caregivers' routines with the children. In addition, we examine the extent to which caregivers received compensation for care provided in these arrangements and reasons why most did not receive compensation. We end the section by examining the extent to which families enrolled in the pilot used more than one child care arrangement, either concurrently or sequentially, for their Early Head Start child.

Stability and Intensity of Child Care Arrangements

Most kith and kin child care arrangements in our sample were stable ones that lasted for more than a year. The average duration was 17 months; arrangements that had ended before our data collection period was over lasted 12 months on average, and those that were ongoing had lasted an average of 19 months by the end of data collection. Only 18 percent of the arrangements lasted 3 months or less, and nearly half lasted more than 12 months (Table IV.5). Among arrangements that were ongoing at the end of the study, 57 percent had lasted 12 months or longer (not shown).

The kith and kin arrangements in our sample were also fairly intensive, especially for young children under age 3. More than half the children were in care for 20 hours or more per week; 40 percent were in care for more than 30 hours a week. This level of intensity is comparable to that found in other studies. For example, the national evaluation of Early Head Start found that 37 percent of children in home-based programs were in care for 30 or more hours a week at 14 months of age, 32 percent at 24 months, and 51 percent at 36 months. Similarly, analysis of the National Household Education Survey found that infants and toddlers spent an average of 32 hours a week in paid kith and kin care and 25 hours a week if the caregiver was uncompensated (Brandon 2005).

In nearly three-quarters of the arrangements, care was provided during daytime weekday hours. However, substantial amounts of care were provided during nonstandard hours as well. For example, in more than half the arrangements, care was regularly provided on weekends.

Locations of Care and Child Care Routines

Nearly two-thirds of care was provided in the caregiver's home; caregivers came into the child's home to provide care in 19 percent of the arrangements (Table IV.5). Another 13 percent of these arrangements took place in a home that the caregiver and child shared. Caregivers in these arrangements were typically grandparents living in multigenerational households, kinship caregivers who cared for the child full-time (such as while a parent was incarcerated), foster parents, or fathers (in one site that targeted fathers as caregivers).

During focus groups, caregivers described a variety of activities they did with the children. In general, most mentioned routine care activities, such as making meals and bathing and dressing the child. Other commonly discussed activities were playing, reading, and going outside to play or for walks. Caregivers also mentioned allowing the children to watch television. During in-home caregiver interviews, caregivers reported taking the children on outings. More than 70 percent had taken

Percentage of Caregivers Who Have Taken Children on Various Types of Outings

	Percentage of Caregivers
To the mall or shopping	84
To the park, movies, or zoo	73
To a regularly schedule doctor appointment	72
To buy books or toys	71
To visit related adults	64
To visit other unrelated children	55
To visit other related children	53
To the library or bookstore	40

N = 78 caregivers; missing data range from 1 to 5 across items.

Table IV.5. Characteristics of Child Care Arrangements Covered by the Enhanced Home Visiting Pilot

	Percentage of Arrangements
Duration of Child Care Arrangements	
Less than 1 month	2
1 to 3 months	16
4 to 6 months	11
7 to 9 months	14
10 to 12 months	9
More than 12 months	48
Number of Hours Child Is in Care During a Typical Week	
1 to 10	24
11 to 20	20
21 to 30	14
31 to 40	14
More than 40	27
Time When Caregiver Regularly Cares for the Child	
Weekday daytime	74
Early morning	43
Evenings	59
Weekends	54
Overnight	39
Location Where Care Is Provided	
Caregiver's home	64
Child's home	19
Both child's and caregiver's homes	13
Multiple locations	4
Primary Caregiver Receives Compensation for Providing Care	
Yes	29
No	61
Don't know	9
Type of Compensation (for Those Who Receive Compensation)	
Child care subsidy	69
Other cash payment	5
Trade child care	10
Other trade	2
Other compensation	14

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 593 child care arrangements. Missing data range from 54 to 128 across items.

the Early Head Start child to a regularly scheduled doctor's appointment. More than half the caregivers said they had taken the children to do household shopping, to the park, to shop for books or toys, to visit other children, and to visit other adult relatives (see box page 77).

In terms of schedules, unrelated family child care caregivers tended to describe set schedules of routine care and play activities they followed with the children every day. In contrast, relatives did not tend to schedule structured activities beyond sleeping and eating. They engaged the children in many of the same activities as family child care providers did, but their days were less structured (see box). Some caregivers who provided care on a more erratic basis said they could not describe a typical day, because it varied so much. Nevertheless, they also talked about providing routine care such as feeding, dressing, bathing, and generally "filling in" for the parent when needed. Finally, several caregivers described doing shifts of caregiving either before or after their own work shifts outside the home. For example, one grandmother described how her daughter and grandson meet her at work. She then takes her grandson back to her home, feeds him, plays outside, recites letters and numbers, and then gets him ready for bed.

Caregivers' Descriptions of a Typical Day

Family Child Care Provider

"I start at 6:30 a.m. We have free play until breakfast. After breakfast we do circle time and sing some songs. Then we have snack, more free time, lunch, and then nap. The children sleep for most of the afternoon since they get up so early in the morning. They don't usually wake up until 4:30 or 5:00 p.m. It is usually just a short time until we have dinner, and then we have free play until mom arrives at about 8:00 p.m."

Grandmother

"When she wakes up, the first thing she wants to do is eat. Then we go with washing up, getting clean clothes on, and all that. Just the normal things. Then, if it's nice outside, we go out and feed the birds, the dogs, and work in the garden. Then go in and take a nap. On Wednesdays, I bring her here [to the Early Head Start center for a group socialization] 'cause she enjoys being with the children, and we live out in the country. Her mom usually gets off at 5:00 p.m., and she comes and picks her up. But sometimes she works overnight, too."

Compensation

Nearly 30 percent of the caregivers reported receiving compensation for the care they provided to the Early Head Start child (Table IV.5). Of those who received compensation, 69 percent (or 16 percent of all caregivers in our sample) received a child care subsidy, and 5 percent received a cash payment from the parents. Other forms of compensation included trading child care or other kinds of trades. Of the caregivers who did not receive compensation, approximately half reported that they did not expect compensation because they were caring for a relative and/or did not view caring for the child as a "job" (not shown).

Use of Multiple Child Care Arrangements

At enrollment in the pilot, 21 percent of the Early Head Start families using kith and kin care were using at least one other concurrent child care arrangement (Table IV.6). Of these, more than a third were child care centers, and more than a quarter were regulated family child care homes. One potential explanation for the use of concurrent arrangements is that kith and kin caregivers were caring for the child when their regulated arrangements were not available, such as on weekends and evenings. This percentage is comparable to that found by the national evaluation of Early Head Start—that 15 percent of families used more than one concurrent arrangement when their child was 24 months old (Administration for Children and Families 2004).

As described earlier, most kith and kin care arrangements in our sample were stable, and more than half the arrangements were available during nonstandard hours. Perhaps for these reasons, the use of sequential multiple arrangements after enrollment in the pilot was relatively low. Only 13 percent of families used more than one kith and kin arrangement sequentially during the data collection period, and only 2 percent used more than two arrangements. It is possible that our analysis underestimates the use of sequential arrangements, because, when some families changed arrangements, the new caregiver might not have agreed to enroll in the pilot.

QUALITY OF THE CAREGIVING ENVIRONMENTS

Nearly all the pilot sites dedicated significant resources to improving the safety of the caregiving environments and providing developmentally appropriate toys and other materials to enrich the environments (see Chapter III). During in-home observations lasting about two hours, we used two checklists included in the CCAT-R—a health and safety checklist and a materials checklist—to assess health and safety and the availability of materials in the caregivers' homes. Overall, caregivers' homes met most of the health and safety criteria that the checklist measured. However, some critical safety features were not observed in a majority of homes, which, if not present, could pose an immediate danger to the child. Most caregivers had an ample variety of developmentally appropriate materials and toys in their homes.

Health and Safety

We observed most of the health and safety features on the checklist in more than half the caregivers' homes. Areas used for child care in most caregivers' homes were comfortable and clean, and they had adequate light and fresh air (Table IV.7). In more than 80 percent of homes, children were not left in playpens, swings, strollers, or other restraining equipment for a long time (defined as more than half of the observation period), and caregivers could see and hear children at all times during the observation. Areas used for child care were generally free of protruding nails and chipped paint, and two-thirds had smoke detectors installed.

Table IV.6. Use of More than One Child Care Arrangement by Families Enrolled in the Enhanced Home Visiting Pilot

	Percentage of Families
Families using more than one child care arrangement for focus child at enrollment	21
For families using more than one arrangement, number of other arrangements	
1	88
2	11
3	1
For families using more than one arrangement, type of other arrangement (secondary arrangement)	
Child care center	35
Licensed/registered family child care home	29
Nonresidential parent	3
Grandparent	20
Other relative	8
Other nonrelative	4
Families using more than one sequential kith and kin arrangement during enrollment in the Enhanced Home Visiting Pilot	
2	10
3	2
4	< 1

Source: Enhanced Home Visiting Pilot Record-Keeping System.

Note: N = 570 Early Head Start families. Missing data range from 6 to 68 across items.

The health and safety checklist includes several "red flag" items, which indicate conditions that could pose an immediate threat to the life of the child. Only 11 percent of the caregivers met all criteria for red flag items (in other words, no immediate threats to safety were observed), and the proportion of caregivers that met individual red flag item criteria was fairly low. For example, only 40 percent had electrical cords secured, only 30 percent had safety caps on electrical sockets , and only 23 percent had dangerous substances (such as cleaning supplies) in locked cabinets or out of reach. These three items were also the most frequently unmet red flag criteria in the CCAT-R field test conducted in 2004 (Porter et al. 2006a).

Materials

More than half of the caregivers' homes contained all of the materials on the checklist (Table IV.8). For example, nearly all caregivers had soft materials in the area used for child care, children's books, and soft cuddly toys for children under age 3. More than 80 percent

Table IV.7. Percentage of Caregivers Whose Homes Meet Health and Safety Standards

Health and Safety Standards	Percentage of Caregiver Homes
Temperature is comfortable	99
There is enough light to read by	96
There is good space for resting	96
Child care is provided in a clean, safe indoor space[a]	90
Children are not left in playpens, swings, jumpers, strollers, or other restraints for more than half of the observation period unless sleeping	88
Caregiver can see or hear children age 5 and under at all times[b]	83
Area used for child care has a source of fresh air	82
Toys and objects small enough to be swallowed are kept away from children[b]	80
No protruding nails on furniture or boards in area used for child care	79
Children do not use walker[a]	75
A quiet area for sick children is available	74
Extra clothes are available to change children	73
No peeling or chipped paint in area accessible to children	68
Smoke detectors installed	66
Diapers are checked and changed often (at least once during observation)	58
Radiators and pipes are covered in the area used for child care	45
Electrical cords are inaccessible or secured[b]	40
Safety caps on electrical sockets[b]	30
Dangerous substances are locked away or out of reach[b]	23
Accessible place for children to wash hands (such as a sink with step stool)	23

Source: In-home observations of caregivers conducted in spring 2006.

Note: N = 74 total in-home observations; 59 observations of children under age 3. Missing items range from 1 to 6 across items.

[a]This standard is only applicable to children under age 3.

[b]This is a “red flag” item that could pose an immediate threat to the child’s life.

Table IV.8. Percentage of Observed Homes with Developmentally Appropriate Materials

Materials Observed in the Child Care Setting	Percentage of Caregiver Homes
Materials for Children Ages Birth to 5	
Soft materials in area used for child care	99
Children's books[a]	96
Pretend play materials	88
Toys that talk, or make music or sounds	85
Space for children to be alone	83
Toys with wheels that children can ride on	71
Adult chairs with materials used to boost child to table level while eating or doing artwork, or child-sized table and chairs	68
Materials for Children Under Age 3	
Cuddly, soft, or pretend play toys like dolls or teddy bears	96
Toys that let child work his/her muscles	90
Toys that have pieces that fit together	90
Push or pull toys	88
Materials for Children Ages 3 to 5	
Toys that teach color, size, or shape	77
Toys that help learn numbers	71
Toys that require fine motor movements	60
Toys that permit free expression	58
Puzzles	57

Source: In-home observations conduced in spring 2006.

Note: N = 74 total observations, including 59 observations for children under age 3 and 15 observations for children over age 3. Missing = 1 to 15 across items for total sample; 4 to 9 across items for children under age 3; 0 to 2 across items for children age 3 or older.

[a]This item was coded if only one children's book was observed in the caregiver's home.

had pretend play materials, toys that talk or make sounds, and push or pull toys. The wide variety of materials present in caregivers' homes may reflect the pilot's emphasis on providing caregivers with access to lending libraries and giving them toys and books.

QUALITY OF CHILD-CAREGIVER INTERACTIONS

In this section, we report on assessments of the quality of child-caregiver interactions using two measures: (1) the CCAT-R (Porter et al. 2006b), and (2) the Arnett Caregiver Interaction Scale (Arnett 1989).[5] These assessments are based on data collected during in-

[5] See Chapter I for information on observer training and interrater reliability.

home observations of the child and caregiver in spring 2006. As described in Chapter I, the subsample of caregivers we observed is similar to the total sample of caregivers enrolled in the pilot, but was not selected to be representative. Caregivers in the observation sample are somewhat older on average (44 years old, compared to 41 in the total sample), and the proportion of caregivers who are relatives is higher than in the total sample (77 percent, compared to 69 percent in the total sample). In addition, the rate of refusal to participate in the observations was high—45 percent of caregivers selected to participate. It is possible that the care provided by caregivers who selected was of lower quality than that of those who agreed to participate, potentially resulting in an overestimation of the quality of the arrangements.

During caregiver interviews, conducted in conjunction with the in-home observation, we asked caregivers whether we had observed a typical day. Nearly three-quarters reported that the day had been typical. Reasons why the day was not typical included (1) having fewer or more children than usual in care, and (2) changes in the children's behavior (such as being quieter in the presence of the observer or watching the observer rather than doing other activities). Nearly all caregivers said that the observation did not disrupt their routine (75 percent) or disrupted it only a little (21 percent). Most said they did nothing different because the observer was there; a few caregivers reported cleaning up before the observation or changing the child's schedule (for example, changing nap time) to accommodate the observation.

Quality of Child-Caregiver Interactions Based on the CCAT-R

Because the CCAT-R is a new measure, and there is no clear consensus in the child care research field on how to assess the quality of kith and kin child care settings, we do not attempt to rate arrangements as being of good, adequate, or poor quality. Rather, we report our findings on the CCAT-R observation measures as a percentage of the total observation periods (up to 60 20-second observation periods) in which we observed the interaction. We scored an interaction as occurring if we observed it at least once during each 20-second period. Our analyses focus on incidents of child and caregiver language, caregiver engagement, child engagement, and caregivers' nurturing and harsh behaviors.

Overall, we observed incidents of caregiver and child language in a large proportion of the observation periods, as well as a high degree of engagement of caregivers and children. We observed a high degree of variation on most measures, perhaps due to the diverse range of caregivers in our sample and the wide age range of children (from infants to children over age 3).[6] Although the CCAT-R has not been used in other published child care studies, we compare our findings throughout this section to studies that have used a similar time sampling measure called the Child-Caregiver Observation System (C-COS; Boller et al. 1998)

[6] We also examined the CCAT-R measures separately for relatives and nonrelative caregivers. In general, we found a number of mean differences suggesting that relatives may have talked and interacted more with the children than nonrelatives. Perhaps due to our small sample size, however, few of these differences were statistically significant; therefore, we do not report them.

with samples of in-home child care providers—the national evaluation of Early Head Start (Administration for Children and Families 2004) and the Growing Up in Poverty Study (Fuller and Kagan 2000).[7]

Caregiver and Child Language. Caregivers talked to the children in nearly 70 percent of the observation periods, on average (Table IV.9). Nearly 30 percent of the time, this talk was in response to the child's use of language or vocalization for younger children. Caregivers requested language from the children, such as asking a question, in just over 30 percent of the observation periods. These findings compare favorably with studies that used comparable items on the C-COS. For example, the national evaluation of Early Head Start found that caregivers in home-based child care settings talked to children in about half the observation periods (Administration for Children and Families 2004). The Growing Up in Poverty Study found that kith and kin caregivers made requests for child language during about 22 percent of the observation period on average (Fuller and Kagan 2000).

We also coded several other kinds of caregiver talk directed to the Early Head Start child. Caregivers engaged in talk with the child aimed at promoting language development by repeating or building on what the child said or naming or labeling items, such as pictures of objects in a book. Language coded as "verbally directs child action," observed in 23 percent of the periods, on average, includes direct commands to the child to do something, such as "stop," "sit down," or "come here." "Other talk" includes all caregiver language directed to the child that did not fit in the other categories. This was often a request for child action phrased in a less direct and often more inviting manner. For example, "Go to the table and sit down" was coded as "verbally directs child action," while "Let's go sit at the table to have our lunch," would be coded as "other talk."

The Early Head Start child talked or made vocalizations during nearly 60 percent of the observation periods, most often to the caregiver. In 11 percent of the observation periods, children engaged in self-talk, which included babbling or talking to themselves or toys and other objects.

Caregiver Engagement. We observed a high level of caregiver engagement with the Early Head Start child during the observations. Caregivers were engaged with the child during more than 80 percent of the observation periods, on average (Table IV.10). In more than three-quarters of the periods, they were engaged in an activity with the child or a group of children. Although activities encouraged concept learning and experimentation with objects during a high proportion of the observations, levels of engagement in literacy-focused activities were lower. For example, caregivers read books to the children or did other activities involving print materials during only 15 percent of the observation periods.

[7] These caregivers observed in these studies have characteristics similar to those in our sample. The Early Head Start study included a mix of related and unrelated in-home child care providers, some of whom were licensed or registered child care providers (Administration for Children and Families 2004). We compare our findings to findings from The Growing Up in Poverty Study for a sample of kith and kin caregivers defined as relatives, friends, and baby-sitters who were not licensed (Fuller and Kagan 2000).

Table IV.9. Percentage of the CCAT-R Observation Periods with Incidents of Caregiver and Child Language

CCAT-R Measure	Percentage of the Observation Periods
Caregiver Language	
Any Caregiver Talk to Child	69.2 (23.5)
Range	8.3 – 100
Responds to Child Language or Vocalization	29.3 (21.8)
Range	0 – 93.3
Repeats or Builds on What Child Says	9.8 (8.7)
Range	0 – 33.3
Names or Labels	14.9 (13.0)
Range	0 – 65.0
Verbally Directs Child Action	22.9 (14.9)
Range	0 – 58.3
Other Talk	47.1 (23.8)
Range	3.3 – 96.7
Child Language	
Any Child Talk or Vocalization	59.5 (21.9)
Range	5.0 – 100
Talk or Vocalization to Caregiver	46.7 (25.2)
Range	0 – 91.7
Self-Talk	10.6 (9.2)
Range	0 – 38.3
Talk or Vocalization to Other Adults or Children	11.0 (12.6)
Range	0 – 53.3

Source: In-home observations conducted in spring 2006 using the CCAT-R.

Note: N = 74 observations. Missing data range from 0 to 3 across items. Standard deviations are displayed in parentheses.

Table IV.10. Percentage of the CCAT-R Observation Periods with Incidents of Caregiver Engagement or Lack of Engagement

CCAT-R Measure	Percentage of the Observation Periods
Caregiver Engagement	
Predominant Caregiver Tone Is Engaged	85.3 (22.7)
Range	16.7 – 100
Predominant Caregiver Tone Is Not Engaged	12.8 (21.6)
Range	0 – 83.3
Caregiver Does Activity with Child or Group of Children in Care	75.8 (23.7)
Range	8.3 – 100
Caregiver Does Not Attend to Child	18.4 (20.4)
Range	0 – 85
Caregiver Activities with Focus Child	
Encourages Concept Learning	40.6 (33.6)
Range	0 – 100
Encourages Experimentation with Object	34.4 (35.2)
Range	0 – 100
Encourages Independence or Autonomy	31.6 (29.6)
Range	0 – 100
Explains/Demonstrates How to Do Something	32.8 (29.4)
Range	0 – 100
Uses Routines As Learning Opportunities	9.6 (16.2)
Range	0 – 66.7
Tells Stories, Rhymes, Sings	11.6 (19.8)
Range	0 – 83.3
Interacts with Books or Print Materials	15.3 (19.9)
Range	0 – 83.3
Music or Rhythmic Activity	8.9 (17.2)
Range	0 – 100
Does Own Activities Excluding Focus Child	16.9 (25.7)
Range	0 – 100

Source: In-home observations conducted in spring 2006 using the CCAT-R.

Note: N = 74 observations. Missing data range from 0 to 3 across items. Standard deviations are displayed in parentheses.

Nevertheless, this finding compares favorably with the Growing Up in Poverty Study, which observed book reading during only two percent of the observation periods (Fuller and Kagan 2000).

Incidents of lack of engagement with the Early Head Start child were relatively low. We observed caregivers not attending to the child during 18 percent of the observation periods and doing their own activities that excluded the focus child during 17 percent of the periods. For example, caregivers could have been doing dishes, attending to another child, or talking on the telephone during these periods of inattention.

Child Engagement. Like caregivers, on average, children were engaged in activities during most of the observation periods. They were engaged with the caregiver during more than three-fourths of the periods and with safe materials or objects during more than 80 percent of the periods (Table IV.11). This is somewhat higher than levels reported for the Growing Up in Poverty Study, which found children engaged with materials during 63 percent of the periods (Fuller and Kagan 2000). Incidents of engagement with other children are comparable across the two studies—about 20 percent. Incidents of engagement with television or video were somewhat lower in the pilot sample—8 percent, compared to about 17 percent in Growing Up in Poverty. This may be the result of the higher levels of engagement with materials; children may have been more occupied with activities and thus less likely to attend to the television, even if it was on.

Caregiver Nurturing. During half the observation periods, on average, caregivers engaged the Early Head Start child in nurturing behaviors, such as kissing or hugging the child, touching or patting the child, or comforting the child (Table IV.12). We observed very few instances of any harsh behaviors, such as handling the child roughly, shaming the child, or ignoring the child; most of these observations were due to ignoring.

Quality of Child-Caregiver Interactions Based on the Arnett Caregiver Interaction Scale

As described in Chapter I, we calculated a total scale score for the Arnett Caregiver Interaction Scale and three subscales: (1) positive interaction, (2) punitive behavior, and (3) detachment.[8] Two studies have found that Arnett Scale scores predict caregivers' engagement with children and children's language development and security of attachment (Helburn 1995; Howes et al. 1992). The total Arnett score for our sample was 3.1 out of a possible 4 points (Table IV.13). This finding is comparable to both the national evaluation of Early Head Start and the Growing Up in Poverty Study, which found total scores of 3.3 and 2.9, respectively (Administration for Children and Families 2004; Fuller and Kagan 2000). Ratings of two negative behaviors—punitive behavior and caregiver detachment—are quite low, indicating that most caregivers in our sample did not engage in these behaviors. These findings are consistent with the CCAT-R findings, which show a fairly

[8] See Chapter I for information on training and interrater reliability.

Table IV.11. Percentage of the CCAT-R Observation Periods with Incidents of Child Engagement or Lack of Engagement

CCAT-R Measure	Percentage of the Observation Periods
Child Interacts with or Attends to	
Caregiver	75.1 (22.9)
Range	8.3 – 100
Safe Materials or Objects	84.4 (17.0)
Range	23.3 – 100
Television or Video[a]	8.4 (14.7)
Range	0 – 66.7
Other Children	19.2 (26.4)
Range	0 – 95
Other Adults	13.5 (21.2)
Range	0 – 91.7
Objects that Could Harm Child	0.4 (1.4)
Range	0 – 10.0
Types of Child Activities	
Gross Motor	91.5 (14.2)
Range	50 – 100
Fine Motor	90.8 (16.2)
Range	40 – 100
Self-Help Activities	18.5 (26.2)
Range	0 – 100
Eating/Drinking	28.9 (23.9)
Range	0 – 100
Unoccupied Wandering[b]	0.5 (3.1)
Range	0 – 20

Source: In-home observations conducted in spring 2006 using the CCAT-R.

Note: N = 74 in-home observations. Missing data range from 0 to 3 across items. Standard deviations are displayed in parentheses.

[a]Coded only if child attended to television or video. If the television was on during the observation, but the child did not attend to it during an observation period, then television or video was not coded.

[b]Coded only if unoccupied wandering occurred during more than half of a 6-minute, 40-second observation cycle.

Table IV.12. Percentage of the CCAT-R Observation Periods with Incidents of Nurturing or Harsh Caregiver Interaction with the Focus Child

CCAT-R Measure	Percentage of the Observation Periods
Nurturing Behavior	
Any Nurturing Behavior	50.5 (35.3)
Range	0 – 100
Caregiver Kisses or Hugs Child	12. 9 (20.3)
Range	0 – 83.3
Caregiver Holds, Pats, or Touches Child	49.7 (35.6)
Range	0 – 100
Caregiver Comforts Child	10.3 (21.6)
Range	0 – 100
Harsh Behavior	
Any Harsh Behavior	5.3 (13.9)
Range	0 – 66.7
Restrains Child	0.7 (4.3)
Range	0 – 33.3
Handles Child Roughly	0.7 (4.3)
Range	0 – 33.3
Criticizes, Shames, Teases, or Threatens Child	0.5 (3.9)
Range	0 –33.3
Ignores Child	4.1 (12.8)
Range	0-66.7

Source: In-home observations conducted in spring 2006 using the CCAT-R.

Note: N = 74 observations. Missing data range from 0 to 3 across items. Standard deviations are displayed in parentheses.

Table IV.13. Summary Table of Arnett Caregiver Interaction Scale

	Total
Total Scale	
Mean	3.1 (0.3)
Range	2.1 – 3.6
Positive Interaction	
Mean	2.9 (0.5)
Range	1.6 – 3.8
Punitive Behavior	
Mean	1.4 (0.4)
Range	1.0 – 3.2
Detachment	
Mean	1.4 (0.6)
Range	1.0 – 3.5

Source: In-home observations conducted in spring 2006 using the Arnett Caregiver Interaction Scale.

Note: N = 70 observations. Standard deviations are displayed in parentheses.

high level of caregiver engagement and few instances of harsh or ignoring behavior. While there is no standard convention in the literature to indicate the rating on the Arnett that is accepted as "good quality," a rating of 3 indicates that statements such as "speak warmly to the child" are "quite a bit" characteristic of the caregiver.

SUMMARY

More than two-thirds of the caregivers enrolled in the pilot were related to the children in their care. Nearly half were the children's grandparents. The average age of caregivers at enrollment in the pilot was 41. Two-thirds were married or living with a "significant other," and half had annual household incomes of $20,000 or less. More than 70 percent of the caregivers were white, and one-third had not completed high school. One-tenth of the caregivers were licensed or registered family child care providers. Most unregulated caregivers did not express interest in pursuing regulation, but most expressed motivation to continue caring for children.

Most kith and kin child care arrangements in our sample were stable ones that lasted for more than a year. The average duration of the arrangements was 17 months. More than half the children were in care for 20 hours or more a week; 40 percent were in care for more than 40 hours a week. Nearly 30 percent of the caregivers reported receiving compensation for these arrangements; 16 percent reported receiving a child care subsidy.

To assess the quality of the caregiving environment, we checked for the presence of health and safety features and developmentally appropriate materials and books. Overall, the caregivers' homes we observed met health and safety criteria, but some critical safety features were not observed, which, if not present, could pose an immediate danger to the child. For example, only 40 percent had electrical cords secured, only 30 percent had safety caps on electrical sockets, and only 23 percent had dangerous substances in locked cabinets or out of reach. Caregivers' homes contained a wide variety of developmentally appropriate materials; nearly all homes had at least one children's book.

To assess the quality of child-caregiver interaction, we conducted in-home observations using the Child Care Assessment Tool for Relatives (CCAT-R) and the Arnett Caregiver Interaction Scale. We observed incidents of caregiver and child language and engagement in a large proportion of the observation periods. Children interacted with the caregiver and with safe materials or objects during more than three-quarters of the observation periods. We observed incidents of nurturing behavior, such as kissing or patting the child, during half the observation periods, and we observed very few incidents of harsh or ignoring caregiver behavior. Findings from the Arnett Scale were consistent with those of the CCAT-R, showing a high level of caregiver engagement and few instances of harsh or ignoring behavior.

CHAPTER V

SUSTAINABILITY AND POTENTIAL REPLICATION OF PILOT MODELS

As noted in Chapters I and II, the overarching purpose of the Enhanced Home Visiting Pilot was to develop promising models for providing services to kith and kin caregivers—models that could be replicated in other Early Head Start and early childhood programs. Preceding chapters in this report have described the diversity of the program models and community partnerships developed by the pilot sites, as well as the diversity of outreach, recruitment, and service delivery strategies used to implement the pilot in different communities. This information can provide useful guidance on program design for other Early Head Start programs considering adding a kith and kin caregiver component to their existing home-based option. Information on the resources, both financial and in-kind, required for providing services to caregivers at specific levels of intensity is also vital for programs contemplating starting an initiative similar to the Enhanced Home Visiting Pilot.

The purpose of this chapter is to provide guidance on the resources needed to add a kith and kin caregiver component to an existing program. We will describe the package of resources programs used to implement their pilots and the resources they identified by the end of the second year to sustain services after pilot funding ends. A detailed analysis of costs, including itemized budget amounts and actual expenditures across the 23 pilot sites, is beyond the scope of this evaluation. However, as part of the in-depth study of 12 sites conducted in spring 2006, the evaluation team collected general information on the grantees' annual pilot grant award, other funding sources, and in-kind contributions from Early Head Start and community partners. We also obtained information on sufficiency of these resources for implementing pilot services, as well as recommended staffing levels for different caseload sizes. It is important to note that the 12 sites included in the in-depth study were selected, in part, because of caregiver enrollment and intensity of service provision at the end of the second implementation year. Thus, the analyses in this chapter reflect approaches to resource mobilization by program sites with higher levels of pilot recruitment and implementation, rather than all sites participating in the Enhanced Home Visiting Pilot.

The chapter begins with a discussion of the resource packages—including pilot grant awards, other funding sources, and in-kind contributions—used by the in-depth study sites.

The discussion also addresses how various resources were employed for pilot implementation. The chapter then describes staff perspectives on the sufficiency of pilot funding and staffing levels needed to provide services in the in-depth study sites. Next, the chapter moves to a discussion of preliminary plans in all 23 sites for sustaining services to kith and kin caregivers after pilot funding ends in spring 2007. The first two sections of the chapter draw on staff and community partner interviews conducted during the second round of site visits in spring 2006. The final section is based on telephone and site visit interviews conducted in 2006.

RESOURCE PACKAGES FOR PILOT IMPLEMENTATION

The federal grant announcement for the Enhanced Home Visiting Pilot did not specify the maximum amount of available funds, number of grants to be awarded, or recommended budget amounts for individual applications. Instead, all applicants were encouraged to submit proposed budgets that were "reasonable, appropriate, and cost-effective in view of the proposed services, strategies, and anticipated outcomes." Further, applicants were encouraged to submit budgets that demonstrated that "the applicant has mobilized significant additional resources to complement Head Start grant funds." This latter recommendation specified that the proposed budget include a nonfederal match equal to 20 percent of the federal budget. It also implied that applicants should mobilize in-kind resources from within and outside their agency to support pilot planning and implementation. In the remainder of this section, we examine the combination of resources sites used to implement the pilot.

Table V.1 summarizes the resource packages assembled to support pilot implementation in each of the 12 in-depth study sites, as reported by the program and community partner directors. Four categories of resources are listed for each grantee. First, we provide the range of each site's annual grant award from the Office of Head Start, along with the main pilot expenses covered by this budget. Second, we list the main in-kind contributions from the Early Head Start program and grantee agency. Third, we list the main in-kind contributions provided by community partners. Fourth, we provide information on other state and federal grants obtained by the grantee agency or community partner to support pilot implementation.

An understanding of the resource packages assembled by the pilot sites also requires some information on planned caseload size, as well as on the scope and intensity of services each site planned to provide. As discussed in Chapter III, the pilot sites varied tremendously in the scope and intensity of services planned and actually provided to caregivers, with some sites planning to provide weekly home visits, and others planning to provide visits to caregivers on a monthly or even more limited basis. Thus, we have organized the information on sites' resource packages according to three levels of planned service intensity:

Table V.1 Resource Packages of the In-Depth Study Sites in the Enhanced Home Visiting Pilot

Site	Planned Caseload	Annual Pilot Grant Range and Primary Budget Items	In-Kind Resources from Early Head Start	In-Kind Resources from Community Partners	Other Sources of Pilot Funding
Pilot Programs with Higher Service Intensity:					
Site A	20	$100,000 to $149,999 ▪ 2 full-time Home Visitors ▪ Supervisor's time ▪ Staff training ▪ Staff travel expenses and computers	▪ Staff training ▪ EHS lending library ▪ Child safety materials ▪ Materials and space for group activities ▪ Office space and administrative support	Even Start: ▪ Staff, materials, and space for group activities Part C: ▪ Staff training	None
Site B	14	$50,000 to $99,999 ▪ 1 full-time Home Visitor ▪ Supervisor's time	▪ Staff training ▪ EHS lending library ▪ Child safety materials ▪ Materials and space for group activities ▪ Office space and administrative support	None	None
Site C	20	$50,000 to $99,999 ▪ 1 full-time Home Visitor ▪ Lending library ▪ Child safety materials ▪ Caregiver stipends ▪ Leased vehicle for staff travel	▪ Staff training ▪ Supervisor's time ▪ Materials and space for group activities ▪ Office space and administrative support	CCR&R: ▪ Staff, materials, and space for group activities ▪ Lending library	None

Table V.1 *(continued)*

Site	Planned Caseload	Annual Pilot Grant and Budget Items	In-Kind Resources from Early Head Start	In-Kind Resources from Community Partners	Other Sources of Pilot Funding
Site D	14	Less than $50,000 ▪ 1 full-time Home Visitor ▪ Toys and books	▪ Staff training ▪ Supervisor's time ▪ EHS lending library ▪ Food and infant care items ▪ Materials and space for group activities ▪ Office space and administrative support	Dept. of Juvenile Justice: ▪ Staff training ▪ Space for group activities CCR&R: ▪ Staff training ▪ Staff and materials for group activities	Head Start Bureau grant for locally designed option for 1 full-time Home Visitor
Pilot Programs with Moderate Service Intensity:					
Site E	35	$100,000 to $149,999 ▪ 1 full-time Home Visitor ▪ Part-time mobile library staff ▪ Supervisor's time ▪ Community partner's time ▪ Mobile lending library ▪ Resource library ▪ Child safety materials	▪ Staff training ▪ Office space and administrative support	Mental Health Provider: ▪ Space for staff training	None
Site F	20	$100,000 to $149,999 ▪ 2 part-time Home Visitors ▪ Supervisor's time ▪ Child safety materials ▪ Materials for group activities ▪ Materials for community partner activities ▪ Caregiver handbook	▪ Staff training ▪ EHS lending library ▪ Space for group activities ▪ Office space and administrative support	Even Start: ▪ Staff for play groups Cooperative Extension: ▪ Staff for group activities	None

Table V.1 *(continued)*

Site	Planned Caseload	Annual Pilot Grant and Budget Items	In-Kind Resources from Early Head Start	In-Kind Resources from Community Partners	Other Sources of Pilot Funding
Site G	40	$100,000 to $149,999 ▪ 2 full-time Home Visitors ▪ Supervisor's time ▪ Administrative support ▪ Child safety materials ▪ Materials for group activities ▪ Leased vehicle for staff travel	▪ Staff training ▪ EHS consultant's time ▪ EHS mobile lending library ▪ Space for group activities ▪ Office space	Child Welfare Agency: ▪ Staff consultant's time	None
Site H	20	$50,000 to $99,999 ▪ Added salary for 10 EHS Home Visitors ▪ Part-time mobile library staff ▪ Child safety materials	▪ Staff training ▪ Supervisor's time ▪ Leased vehicle for staff travel ▪ Office space and administrative support	CCR&R: ▪ Van for mobile library ▪ Materials for mobile library	State grant for van for mobile lending library
Site I	11	Less than $50,000 ▪ 1 full-time Home Visitor ▪ Child safety materials	▪ Staff training ▪ Part of EHS Home Visitors' time ▪ Supervisor's time ▪ EHS lending library ▪ Office space and administrative support	CCR&R: ▪ Staff training ▪ Literacy kits and child safety materials	None
Site J	20	$50,000 to $99,999 ▪ 2 part-time Home Visitors ▪ Staff travel expenses	▪ Staff training ▪ Supervisor's time ▪ EHS lending library ▪ Child safety materials ▪ Household items ▪ Office space and administrative support	CCR&R: ▪ Staff, materials, and space for group activities	None

Table V.1 *(continued)*

Site	Planned Caseload	Annual Pilot Grant and Budget Items	In-Kind Resources from Early Head Start	In-Kind Resources from Community Partners	Other Sources of Pilot Funding
Pilot Programs with Lower Service Intensity:					
Site K	20	$150,000 or more ▪ 1 full-time Home Visitor ▪ 1 part-time assistant ▪ 1 part-time bus driver ▪ Small bus for transporting caregivers and children ▪ Toys and books ▪ Child safety materials ▪ Materials for group activities	▪ Staff training ▪ Supervisor's time ▪ EHS lending library ▪ Space for group activities ▪ Office space and administrative support	Family Support Program: ▪ Staff and materials for group activities Health Care Provider: ▪ Staff and materials for group activities Public Library: ▪ Lending library	None
Site L	50	$100,000 to $149,999 ▪ 1 full-time Home Visitor ▪ Supervisor's time ▪ Toys and books ▪ Child safety materials ▪ Materials for group activities	▪ Staff training ▪ EHS mobile lending library ▪ Space for group activities ▪ Office space and administrative support	Family Support Program: ▪ Staff and materials for group activities CCR&R: ▪ Staff and materials for group activities	None

Source: Program Director and Community Partner Interviews, Spring 2006 Site Visits

Note: Sites H and I are using a single home visitor staffing model. The remaining sites are using a dual home visitor staffing model.

(1) high—planned intensity of weekly visits, (2) moderate—planned intensity of biweekly visits, and (3) low—planned intensity of monthly or fewer visits.[1]

Looking across the various levels of service intensity, as well as across the four types of resources, several patterns emerge. One of the most striking is the wide range in the size of grant awards made to the 12 sites, irrespective of the planned caseload size and intensity of proposed services to caregivers. As will be discussed later in this section, sites took different approaches to funding the pilot, with some relying heavily on the federal grant to support planned services and others relying on a mixture of grant funds and in-kind contributions.

It is also noteworthy that only 2 of the 12 sites secured additional funding sources beyond the federal grant to support pilot implementation. In one instance, the site supplemented federal pilot funding with an existing grant from the Office of Head Start for their locally designed option to staff one of the two pilot home visitor positions. Another site collaborated with its community partner to obtain state funding to purchase and convert a van into a mobile lending library (with items such as toys, equipment, and children's books), which became an important recruitment tool and highly valued resource among the rural caregivers they served.

Another notable pattern across the 12 sites is the reliance on one resource over another to support specific aspects of the pilot, regardless of planned caseload size or level of service intensity. For example, all sites used the pilot grant—and in some cases, the entire grant—to fund pilot home visitors. A review of the original grant applications submitted by the 12 sites confirmed that home visitor salaries and benefits were by far the most costly items in pilot budgets. Given the relatively high proportion of programs' budgets dedicated to personnel, it is understandable that they would use the federal funding source for pilot staffing. Similarly, all grantees used Early Head Start program resources to support some or all of the pre-service and in-service training provided to pilot home visitors (especially if pilot home visitors received the same training as Early Head Start home visitors), and several drew on Early Head Start resources for pilot staff supervision and materials as well. For example, some sites assigned the task of supervising pilot home visitors to staff who were already supervising Early Head Start home visitors. Similarly, pilot home visitors could use children's books and toys already purchased for Early Head Start during their home visits with caregivers.

The final general pattern to note is that, for the most part, the relative reliance on pilot grant funding or in-kind contributions to support implementation did not vary by planned caseload size or service intensity. Sites that planned to provide lower intensity services were as likely as those who planned to provide higher intensity services to rely heavily on the pilot grant award to fund implementation. Similarly, grantees who planned to provide moderate intensity services were as likely as those who planned to provide high intensity services to

[1] We also analyzed pilot sites' resource packages according to levels of planned service intensity by combining the planned number of home visits and group events, but this did not change the relative differences in service intensity across the 12 pilot sites.

rely on a mixture of pilot funding and in-kind resources from Early Head Start and community partners to support the pilot. Below, we examine sites' use of resource packages in more depth, according to their degree of reliance on the federal pilot grant or other resources.

Resource Packages of Sites that Relied Primarily on the Federal Pilot Grant

Six of the in-depth study sites relied heavily on the pilot grant to fund program implementation. For example, site C, which planned to provide higher intensity services, relied heavily on the pilot grant for staffing, materials, and caregiver stipends. Similarly, sites E, F, and G, which planned to provide moderate intensity services, relied heavily on the pilot grant to cover the costs of pilot staff, supervision and administrative support, caregiver materials and equipment, and staff vehicles for conducting home visits, as well as to partially support the community partners' involvement in pilot activities. Sites K and L, which planned to provide lower intensity services, also relied heavily on the pilot grant to fund staffing, supervision, materials and equipment, and other expenses incurred by the pilot. In fact, one of these sites used a significant portion of the pilot grant to purchase and staff a small school bus to transport caregivers and children to and from various group events. This rural site, which emphasized field trips and group activities over home visiting, felt that investing in a vehicle was essential given their service delivery approach. This investment appears to have been a wise one in that the site was one of the few that had consistently high caregiver attendance at group activities during the first two years of implementation. In-kind resources in these sites consisted primarily of training for pilot staff, office space, and space for group activities.

Resource Packages of Sites that Relied on a Combination of the Federal Pilot Grant and In-Kind Contributions

Four of the 12 in-depth study sites relied on a combination of federal pilot funding and in-kind contributions. Sites A and B, both of which planned to provide higher intensity services, relied primarily on pilot funds to cover the cost of pilot staff and other resources from Early Head Start for staff training, pilot materials, equipment, and space. Sites H and I, both of which used a single home visitor approach for pilot staffing, used a combination of grant funds and in-kind contributions from Early Head Start and community partners to implement their pilot programs. In both sites, the Early Head Start program provided some staff time and all supervisory time for the pilot. Pilot grant funds were used to augment Early Head Start funding for home visiting staff, either as salary increases to compensate home visitors for adding caregivers to their caseload of Early Head Start families, or by hiring an additional Early Head Start home visitor and redistributing combined caseloads of families and caregivers over a greater number of home visitors. Pilot grant funds were also used to purchase safety materials for caregivers. The lending libraries of toys and books for caregivers were provided as in-kind resources in these two sites.

Resource Packages of Sites that Relied Heavily on In-Kind Contributions

Two sites relied almost entirely on other grants funds and in-kind contributions from Early Head Start to support pilot services. As noted previously, Site D was one of the few grantees that supplemented the pilot grant with an existing funding source. This site had been implementing an Early Head Start program for incarcerated teen parents and their children since 2001, and with the pilot grant was able to fund an additional home visitor to provide home visiting services to relatives who cared for the children while their parents were incarcerated. In this site, one of two pilot home visitors, staff training and supervision, space, and most of the pilot materials were funded by sources outside the federal grant. Site J relied heavily on Early Head Start resources to implement its pilot. As discussed in Chapter II, this site was one of the few that encountered difficulties redesigning its pilot after having misinterpreted the federal grant announcement. The budget submitted with the original application was sufficient for implementing the proposed services (four home visits a month split between parents and caregivers), but was not sufficient for providing weekly home visits to parents, as required by the Head Start Program Performance Standards, as well as regular home visits to caregivers. Because an increase in the proposed budget to accommodate a redesign of the pilot was not possible, the site drew, in part, on existing staff and resources within their agency to support services to caregivers.

STAFF VIEWS ON WHETHER RESOURCES WERE SUFFICIENT FOR PILOT IMPLEMENTATION

In all but 2 of the 12 in-depth study sites, program directors said that the combination of federal grant funds and resources from other sources was sufficient for providing services as planned. Moreover, because of lower-than-anticipated caregiver enrollment, as noted in Chapter III, some directors said that pilot funding was more than sufficient for providing services to their caseloads.

Program directors in the two sites that relied heavily on in-kind resources from Early Head Start, however, said that the pilot grant was not sufficient, and that they would not have been able to provide services at the current level of intensity and caseload size without substantial reliance on resources from their existing Early Head Start program. At the time of the second site visit, one site was attempting to provide weekly home visits to a caseload of 17 caregivers, but their pilot grant only covered the salary for one home visitor. Other resources required for implementing the pilot, including a second home visitor, materials and equipment, and staff training and supervision, came from their Early Head Start program and a separate Early Head Start grant for their locally designed option. Without these added resources, the program director estimated they would only be able to serve 7 to 10 caregivers.

In the other site, pilot staff were providing bimonthly home visits to a caseload of 10 caregivers, but their pilot grant only covered half of the two home visitors' salaries and travel expenses. Other resources required for implementing the pilot, including the remaining portion of home visitors' salaries and materials and equipment for caregivers, were in-kind contributions from the Early Head Start program. As noted earlier, this site struggled to

redesign their pilot to fit the requirements of the federal grant, and as a result had to make compromises in staffing and service intensity. With substantial in-kind support from Early Head Start, this site was able to implement pilot services at a moderate level of intensity.

RECOMMENDED STAFFING LEVELS AND CASELOAD SIZES

An alternative way of quantifying resources needed to replicate the Enhanced Home Visiting Pilot is to examine the number of staff needed to provide services to a given number of caregivers at a given level of service intensity. As previously noted, salary and benefit packages for home visiting staff were by far the most costly budget item in the pilot grants, so focusing on staffing levels and caseload sizes can provide a useful yardstick for estimating the resources needed for replication.

During site visits interviews in 2006, we asked staff to estimate what they considered to be an ideal caseload size given the frequency of planned home visits to caregivers, as well as an estimate of how many home visits a single home visitor could complete in a week. Most pilot home visitors said they could reasonably complete nine to 12 home visits per week. In the two sites employing part-time staff for the pilot, home visitors estimated they could reasonably complete five home visits a week. Ten to 16 caregivers per full-time home visitor was considered an ideal caseload size in these sites, although one home visitor noted she could comfortably manage her caseload of 25 caregivers with bimonthly home visits. In the two sites using a single home visitor approach to pilot staffing, home visitors estimated an ideal caseload size of 10 to 12 cases overall, which allowed them to provide bimonthly home visits to two caregivers in addition to the weekly home visits to their caseload of 8 to 10 families. Home visitors in these two sites estimated they could reasonably complete nine to 10 home visits a week.

There were three exceptions to this general pattern. Because of other work obligations and substantial travel time involved in conducting home visits in rural areas, home visitors in three sites estimated they could reasonably complete five to eight home visits a week. Travel time was a significant factor in recommending caseload sizes in these sites, with home visitors traveling as much as two hours each way to conduct a home visit. Home visitors in one site also noted that all of their home visits had to be scheduled during a two and a half day period, because of required staff meetings and trainings scheduled during the remainder of the week. Given these added time constraints, ideal caseload sizes ranged from six caregivers in the site providing weekly home visits to 16 in the site providing monthly home visits to 28 in the site providing a few home visits per year.

PLANS FOR SUSTAINING SERVICES FOR KITH AND KIN CAREGIVERS

As the programs moved into their final year of pilot grant funding, finding ways of sustaining caregiver services within their Early Head Start programs became a growing focus of the pilot sites. Identifying funding sources and developing sustainability plans was the

primary topic of the annual grantee meeting held in May 2006, sponsored by Zero to Three.[2] However, as of spring 2006, only three of the 23 sites had identified potential funding sources for sustaining the pilot and only two had concrete sustainability plans in place. Program directors in most sites reported that they would not be able to continue providing services to caregivers after pilot funding ended, primarily because they would not be able to support the staff required for caregiver home visits without additional funding. This conclusion is not surprising given that the pilot grant was used primarily for supporting additional home visiting staff. Even sites that relied heavily on in-kind contributions from Early Head Start and sites that used a single home visitor approach to pilot staffing could not envision continuing the pilot without outside funding to support home visiting staff. However, most sites indicated that they would like to continue providing services to caregivers if funds were available.

Three sites had identified potential outside funding sources for sustaining the pilot, and as a result were more optimistic they would be able to continue providing services to caregivers in the future. For example, staff in one site were hoping to use funds from an existing agency grant focused on families in the child welfare system to provide home visits to the kith and kin caregivers of children in that system as well. In another site that was providing pilot services to foster parents and kinship caregivers, staff reported that they might be eligible for funding from a new state initiative to provide intensive in-home services to kinship foster parents. Staff in a third site reported the possibility of sustaining services to caregivers as part of their new involvement with a coalition of local funders and community agencies focused on services for children ages birth to 3.

By spring of 2006, two sites had developed concrete plans for sustaining pilot services at the same scope and level of service intensity. In one site, the pilot's community partner was in the process of applying for a three-year foundation grant to expand pilot services to all kith and kin caregivers of children under the age of 5 in their three-county service area, building the new initiative on the outreach and service delivery strategies developed for the pilot. If successful, staff at this CCR&R estimated they would be able to extend home visiting and support group services to up to 100 kith and kin caregivers beginning in September 2006. Sustainability in the second site will be accomplished through a reallocation of support staff positions from the site's Early Head Start to Head Start program in order to fund the home visitor position currently funded by the pilot grant. From the beginning, pilot implementation in this site was heavily reliant on other Early Head Start funding and in-kind contributions, which may have put the agency in a better position than most other sites to absorb pilot costs into their existing Early Head Start budget.

[2] The 2006 pre-institute meeting for pilot grantees was organized by the Early Head Start Resource Center at Zero to Three. Scheduled presenters at the one-day meeting included Toni Porter from Bank Street College, Paula Steinke from Child Care Resources, Inc. in Seattle, WA, and Heather Padgette from the Finance Project.

Although the most sites had not developed plans for sustainability by the end of the second year, program directors in nine sites reported plans to continue providing services to currently enrolled caregivers, and possibly to future caregivers as well (see box). The level of contact with caregivers, however, would have to be minimal without additional funds for home visitors. In all of these sites, staff cited the importance of continuing to provide educational materials to caregivers if at all possible, based on lessons learned during the course of the pilot on the vital role played by these caregivers in young children's development.

Proposed Strategies for Continuing Services to Caregivers After Pilot Funding Ends

	Number of Programs
Invitations to EHS socializations and group events	6
Mailings to caregivers	3
Lending library for caregivers	1
Joint home visits with parents and caregivers	6
Collaboration with community partners	2

N = 23 pilot programs.

Program directors in six of the sites planned to maintain contact with caregivers by encouraging them to attend socializations and other group events offered to Early Head Start families. Program directors in three sites also planned to maintain contact by keeping caregivers on their mailing list for newsletters and other materials. They also planned to add new caregivers to the list when a family using kith and kin care enrolled in Early Head Start. In addition, one of these sites was considering developing a lending library that caregivers could access as needed. Program directors in six of the sites were considering conducting joint home visits with parents and caregivers once or twice a month as part of the Early Head Start home visit, if this was allowable under the regulations for home-based programs. Staff in two sites noted that there were no resources within their agency to sustain the pilot, but said they were considering approaching other community agencies who might be interested in providing services to kith and kin caregivers.

SUMMARY

The information presented in this chapter provides some guidance on the resources needed to add a kith and kin caregiver component to an existing Early Head Start program, including levels of funding, potential packages of grant funds and in-kind contributions, and recommended staffing levels and caseload sizes. Moreover, the chapter illustrates that there are multiple ways of funding an initiative like the Enhanced Home Visiting Pilot at similar levels of service intensity, depending on an agency's staffing structure and capacity to leverage in-kind resources to support the initiative. Because the pilot was designed to be an enhancement to home visiting services already provided to Early Head Start families, there are few start-up costs involved in adding a caregiver component to an existing program. Moreover, many of the resources needed for implementation can be shared with the agency's Early Head Start program. However, based on experiences of two of the in-depth study sites, relying solely on resources from Early Head Start and community partners is not a feasible option for implementing services for a kith and kin caregiver component. Doing so limits service intensity and caseload size below what was planned in the Enhanced Home Visiting Pilot.

CHAPTER VI

IMPLEMENTATION PROGRESS, CHALLENGES, AND LESSONS FOR REPLICATION

A primary goal of the Enhanced Home Visiting Pilot evaluation was to identify and disseminate implementation lessons for program improvement and potential replication in other Early Head Start and early childhood programs. As noted in Chapter I, this evaluation was designed to be descriptive. Therefore, we cannot provide estimates of the pilot's impact on the quality of kith and kin care arrangements that were the target of the program or on the outcomes of Early Head Start children cared for in these settings. Nevertheless, an analysis of the factors that helped or hindered sites' implementation progress and the amount and types of services they were able to provide can give us important insights about how to replicate, and potentially strengthen, similar interventions in the future.

In this chapter, we examine the pilot sites' progress toward meeting their goals for the pilot and the implementation challenges they faced in the first two years of implementation. We then discuss lessons learned that could be applied to future replication efforts and suggest potential next steps for developing an effective intervention to improve the quality of kith and kin care provided to Early Head Start children. The information in this chapter is based primarily on telephone and on-site interviews with program staff and on our analysis of service use data from the record-keeping system.

PROGRESS TOWARD PILOT GOALS

During the first round of site visits, program directors described four main goals of the Enhanced Home Visiting Pilot: (1) improving the quality of care provided by kith and kin caregivers, (2) increasing the consistency of caregiving practices across home and child care settings, (3) improving parent-caregiver relationships, and (4) supporting caregiver needs. In the rest of this section, we describe the pilot sites' progress in achieving each of these goals by end of the pilot's second year.

Improving the Quality of Care

The overarching goal of the pilot was to improve the quality of care provided to Early Head Start children by kith and kin caregivers. Sites planned to address this goal by providing caregivers with information on child development and developmentally appropriate caregiving practices; engaging them with the child in activities designed to stimulate the child's growth; and providing safety equipment, toys, and materials to improve the child care environment. Although the evaluation design does not permit us to estimate the pilot's impact on the quality of care, we can describe programs' progress toward implementing services aimed at improving quality. Specifically, we describe progress in five areas: (1) increasing agency awareness and capacity to support kith and kin caregivers, (2) building trusting relationships with caregivers, (3) providing caregivers with information and materials, (4) providing individualized services, and (5) implementing caregiver support groups and training workshops.

Increasing Agency Awareness and Capacity to Support Kith and Kin Caregivers. Although home visitors were accustomed to providing home-based services to parents, staff often told us they had not focused on how much time some children were spending with other caregivers. After participating in the pilot, staff said they were much more aware of the importance of the caregivers' roles in the children's lives. While staff in most sites did not have previous experience providing services to kith and kin caregivers, they cited their increased capacity to do so as an important success of the pilot. During the first two years of implementation, pilot staff learned about the caregivers' needs and interests and about how to engage them. Moreover, six sites reported that they had developed important new partnerships with other community agencies that further strengthened their efforts. As they entered the third and final year of the pilot, many programs were seeking ways to build on this new capacity to continue working with the caregivers.

Building Trusting Relationships with Caregivers. Staff in more than half the pilot sites reported that establishing trusting relationships with kith and kin caregivers was one of their most significant accomplishments. According to home visitors, trust was essential for getting into caregivers' homes regularly to conduct home visits. Trust also enabled home visitors to address safety issues in the caregivers' homes or suggest changes in caregiving practices without offending them.

Providing Information and Materials. Home visitors provided information on child development and developmentally appropriate caregiving practices in more than 80 percent of their home visits. Some home visitors described how caregivers have learned to observe the children and identify developmental milestones. In addition, two-thirds of the caregivers received at least one educational or safety item from the pilot, and nearly 60 percent received more than one. As described in Chapter III, home visitors in most sites reported performing a home safety check or conducting at least one home visit that focused on home safety.

Providing Individualized Services. Most pilot sites modeled their approach to conducting caregiver visits on their approach to conducting home visits with parents by individualizing the services to the needs and interests of the caregivers and children. To do

this, they planned home visit activities in response to caregivers' questions and concerns about the Early Head Start child's development and behavior, and they were flexible about scheduling the visits. They typically individualized the visits for children by planning child-caregiver activities based on the developmental stage of the child and, often, on developmental goals for the child set by the parents or caregivers.

Implementing Support Groups and Training Workshops. Although most pilot sites struggled with low attendance at support groups and training workshops for caregivers, five sites had high attendance rates. They achieved these high rates by tailoring the events to the interests and needs of the caregivers; providing transportation, child care, and participation incentives; and scheduling the events at convenient times.

Increasing Consistency of Caregiving Practices Between Parents and Caregivers

In a quarter of the pilot sites, staff identified increased consistency in caregiving across parents and caregivers as an important success of the pilot. Whether parents and caregivers had the same or different home visitors, these programs sought to (1) present similar information during visits with parents and caregivers, (2) select child-caregiver activities conducted during caregiver visits based on the developmental goals for the child set by the parents, and (3) encourage the parents and caregivers to use consistent behavior management strategies across the two settings. Some programs reported that these efforts made it easier for the children to move from one setting to the other.

Improving Parent-Caregiver Relationships

In half the pilot sites, staff reported that they have been able to improve communication and help resolve conflicts between parents and caregivers. For example, staff in these sites reported that parents and caregivers sometimes disagreed about such issues as behavior management techniques or the timing of toilet training. Home visitors' primary strategy for helping the parties resolve their differences was to encourage them to focus on the needs of the child—to work things out "for the child's sake." Home visitors helped both parties work on communication by encouraging them to talk openly and respectfully about disagreements, listening to their concerns, strategizing with them about how to approach different issues, and not taking sides. In addition, home visitors said they tried to point out the positive role that each party played in the child's life.

Supporting Caregiver Needs

Staff in half the pilot sites reported that they viewed supporting caregivers' needs as an important success. Specifically, they reported successes in helping the caregiver recognize her important role in the child's life, reducing caregivers' social isolation, and linking caregivers with other community services.

Recognition of the Caregiver's Important Role in the Child's Life. Staff reported that including the caregiver more formally in Early Head Start services helped parents and

caregivers recognize the important role caregivers play in supporting the children's healthy development. According to staff, this recognition boosted the self-esteem of many caregivers and motivated them to learn more about child development and how they could work with the child on developmental goals. Moreover, this acknowledgment helped foster more positive working relationships between parents and caregivers.

Reducing Caregivers' Social Isolation. Pilot staff reported that many caregivers were socially isolated. Some lived in rural areas and lacked transportation. Some were new immigrants who did not speak English and were not familiar with the community. Others were elderly, and some had difficulty getting out of the house because of their responsibilities as caregivers. Staff reported that participation in the pilot, especially regular visits from home visitors, reduced the caregivers' sense of isolation. They had someone to talk to about their concerns and questions about the children, and they received emotional support and encouragement from the home visitors. Although attendance at group events was low in most sites, a few sites reported that caregivers formed support networks and enjoyed meeting regularly. Likewise, some relative caregivers regularly attended group socialization events at the Early Head Start programs.

Improved Knowledge of Community Services. Home visitors described several other ways they helped caregivers connect to community resources—a goal established by half the pilot sites. For example, staff reported referring caregivers to other social service providers, such as home heating assistance programs, food banks, support groups, mental health services, health care providers, and GED and ESL courses. Other home visitors introduced caregivers to child-friendly places in the community by taking caregivers and children on field trips to local playgrounds, libraries, and nature centers.

IMPLEMENTATION CHALLENGES

Although pilot sites made substantial progress toward their goals, they also encountered significant implementation challenges. In this section, we highlight seven challenges the pilot sites faced during their first two years of implementation: (1) caregiver recruitment, (2) caregiver turnover, (3) difficulties completing home visits, (4) low attendance at group events, (5) overcoming resistance to changing caregiving practices, (6) parent-caregiver conflicts, and (7) obstacles related to implementing the pilot in rural communities.

Caregiver Recruitment

During interviews in year 2, 15 program directors cited caregiver recruitment as a significant implementation challenge. At the end of the data collection period, most of the sites were serving 75 percent or fewer of the caregivers they planned to enroll. Staff in most sites reported, however, that enrollment was low primarily because of the narrow eligibility criteria for the program, rather than because of a lack of interest among kith and kin caregivers. To be eligible, caregivers had to be caring for a child already enrolled in Early Head Start. Many sites did not have enough enrolled families using kith and kin care and

could not easily enroll more because they were already at full enrollment and had long waiting lists.

Caregiver Turnover

Nearly half the caregivers left the program within six months of enrollment, adding to programs' difficulties maintaining a full caseload of caregivers. As with recruitment, however, much of the turnover was due to the limited eligibility criteria for the program. In addition, staff reported that, to some extent, turnover was more the result of families' tumultuous lives than of caregivers' lack of interest. For example, nearly half the caregivers left the program because the child and family left Early Head Start. In many cases, however, the caregiver continued to care for the child and wanted to continue participating in the pilot. About a third of the caregivers left the program because the child care arrangement ended. According to pilot staff, parents' child care needs often changed because of changes in work or school schedules.

Difficulties Completing Home Visits

On average, home visitors were only able to complete about half the home visits to caregivers that they intended to provide each month. Several factors contributed to difficulties completing the visits. Home visitors in sites using a single home visitor approach completed fewer of their planned visits, perhaps because they were dividing their time between visits to caregivers and parents. Caregivers sometimes cancelled visits because of conflicts with work schedules and appointments or because the child was not in care that day. In addition, most sites experienced staff turnover, which sometimes resulted in periods when services were not delivered to caregivers. Gaps in service delivery also occurred when home visitors went on vacation, maternity leave, or other types of leave. In six sites, home visitors reported difficulty scheduling visits to caregivers who provided care primarily during nonstandard work hours.

Low Attendance at Group Events

Most sites struggled with low caregiver attendance at training workshops, support groups, and group socialization events throughout the first two years of implementation. According to pilot staff, lack of transportation was the most common obstacle preventing caregivers from attending group events. Other barriers were caregivers' health problems, conflicts with work schedules, and reluctance to participate in a group.

Overcoming Caregiver Resistance to Changing Caregiving Practices

Staff in one-quarter of the sites also mentioned caregiver resistance to changing some caregiver practices as an obstacle to improving the quality of care they provided. Home visitors in these sites had difficulty figuring out how to motivate some caregivers to make positive changes and how to make suggestions without offending them. For example, home

visitors mentioned some caregivers' reluctance to turn off the television, even during home visits. A related challenge was how to encourage the caregivers to interact more with the children and to get down on the floor with them. One home visitor said, "[E]very time I go to that home I go straight to the floor and say, 'Look what we are doing!' Getting them motivated to do it can be difficult." Home visitors reported that they began by trying to change patterns of interaction during the home visits themselves—for example, suggesting that the caregiver turn off the television while the home visitor was present and participate in the activity. They also modeled age-appropriate interaction during the visits, pointed out developmental milestones, encouraged caregivers to observe the children, praised caregivers when they exhibited a positive behavior (such as talking to the child), and left toys and activities for the caregiver and child to use together. Many said they tried to avoid making direct suggestions unless they observed a serious safety issue in the home.

Parent-Caregiver Conflicts

Half the sites mentioned improving parent-caregiver relationships as a success of the pilot. However, parent-caregiver conflicts also were challenging for home visitors at times, especially for those using a single home visitor approach. Talking with caregivers about these conflicts took valuable time during home visits, distracted home visitors and caregivers from their work with the child, and led to increased turnover when parents or caregivers ended care arrangements due to conflicts. Conflicts arose over behavior management, toilet training, and children's schedules. Sometimes they were related to long-standing disagreements within families or intergenerational conflicts between parents and their children. As described in Chapter III, home visitors encouraged both parties to talk openly and respectfully about their concerns and to try to resolve the conflicts for the child's well-being.

Rural Issues

Staff in nearly half the pilot sites reported that implementing the pilot in a rural area created some challenges. For example, in some sites, caregivers lived far from the Early Head Start office and lacked transportation to come to group events. In sites that covered a large geographic service area, travel time to caregivers' homes limited the number of home visits that could be completed. In addition, the availability of other community services was limited in some rural communities; as a result, home visitors could not make referrals or draw on the resources of other agencies to address caregivers' needs.

LESSONS FOR REPLICATION

Before implementation of the pilot, few Head Start or Early Head Start programs had undertaken systematic efforts to improve quality in kith and kin child care settings. Thus, the Enhanced Home Visiting Pilot sites have broken new ground in their efforts to reach out to and support kith and kin caregivers of Early Head Start children. Because of their expertise in home visiting, relationship building, and child development, these agencies (and, possibly, other early childhood and family support programs) seem well suited for this new

role. Although the 23 sites worked toward a common set of goals, each site is unique in its design, target population, service delivery strategies, and community partnerships. Nevertheless, some common themes have emerged from programs' implementation experiences that may be useful for ongoing improvement of the pilot initiatives and for future replication in Early Head Start or other early childhood programs. In the rest of this section, we highlight lessons learned in four areas: (1) staffing, (2) partnerships, (3) recruitment and enrollment, and (4) service delivery.

Staffing

Based on the pilot sites' experiences during the first two years of implementation, we present lessons learned about three aspects of pilot staffing: (1) the qualifications and training needed by pilot home visitors, (2) the staffing structure that yielded the highest level of service intensity, and (3) the importance of coordination between Early Head Start and pilot staff.

- ***Qualifications and Training.*** Programs should seek staff to provide home visits who have the skills needed to build rapport with caregivers and gain their trust, and who can be flexible and not easily flustered by what they might encounter during home visits. Moreover, home visitors should be able to support caregivers and parents in resolving conflicts and improving communication without getting drawn in as the "go between." Program directors suggested that staff with prior experience as home visitors or training in social work may be good candidates. In addition, home visitors reported that prior experience as home visitors, shadowing home visitors as part of pre-service training, and training on how to work effectively with grandparents and how to mediate conflict and encourage communication were be especially helpful.

- ***Staffing Structure.*** Based on the experience of the pilot sites, programs should consider implementing a dual home visitor approach, with at least one home visitor dedicated full-time to serving kith and kin caregivers. Home visitors who split their time between parents and caregivers were not able to complete as many of their planned caregiver visits as those who dedicated all their time to the caregivers.

- ***Coordination.*** To help increase consistency in caregiving practices between parents and caregivers, programs should promote coordination between staff working with each party. Promising strategies for doing so include integrating supervision of caregiver and parent home visitors, co-locating caregiver and parent home visitors, encouraging regular communication between home visitors, and communicating to all staff the benefits to the child of coordinating the work among all parties.

Partnerships

The pilot sites identified two main implementation lessons from their experiences working with community partners to delivery pilot services. These lessons concern: (1) the types of partners that can be most helpful to kith and kin initiatives housed within Early Head Start programs, and (2) the importance of maintaining frequent communication with community partners.

- ***Types of Community Partners.*** Programs should consider partnering with CCR&Rs because of the resources they often have available to caregivers and the help they can offer with licensing for caregivers who are interested. In addition, programs should consider developing partnerships with other community service agencies willing to receive referrals and provide help to address caregivers' social service needs.

- ***Communication.*** Especially when programs depend on partners to generate referrals for program enrollment, they need to continually educate partner staff about the benefits of the program for children and caregivers and maintain frequent communication to ensure a steady flow of referrals.

Recruitment and Enrollment

The pilot sites' experiences recruiting and enrolling caregivers yielded two primary lessons about (1) the types of host agencies that can successfully attract kith and kin caregivers to enroll in a quality-improvement initiative, and (2) considerations related to eligibility criteria for caregivers.

- ***Host Agency.*** Housing programs for kith and kin caregivers within programs for families with young children, such as Head Start and Early Head Start, Parents as Teachers, and other family support and early childhood education programs, can make recruiting caregivers easier. Pilot sites found that, because they had already established positive, trusting relationships with families, parents wanted their children's caregivers to enroll and often helped program staff recruit them.

- ***Eligibility Criteria.*** Programs should carefully consider how their eligibility criteria might limit their ability to recruit and retain caregivers. For example, programs might consider enrolling caregivers of Early Head Start-eligible children who are on programs' waiting lists, or retaining caregivers who want to continue receiving services after the child leaves Early Head Start, as long as the child is still in care. Another option might be to set aside some regular program enrollment slots for children in kith and kin care, to ensure that slots are available for families with children in care who wish to enroll in the program.

Service Delivery

Based on the recommendations of pilot staff and levels of service delivery achieved by the pilot sites, we have identified eights lessons related to delivering services to kith and kin caregivers. These lessons concern: (1) the planned level of service intensity, (2) individualization of services for caregivers, (3) conducting child-focused home visits, (4) encouraging changes in caregiving practices, (5) emphasizing the safety of the caregiving environment, (6) planning group events, (7) providing caregivers with materials, and (8) accessing community resources.

- ***Intensity of Services.*** Based on the pilot sites' experience, planning to do two home visits a month seems feasible. Several obstacles hindered home visitors' ability to complete more than two visits, and some caregivers were reluctant to commit to more frequent visits. These visits could be supplemented by training workshops and other group events.

- ***Individualization.*** Services should be individualized to the needs of the caregivers and children. Caregivers responded well to child-focused activities during the visits and to receiving information on topics of interest or concern to them. Likewise, well-attended group events were targeted to meet the needs and interests expressed by caregivers and scheduled at convenient times.

- ***Child-Focused Home Visits.*** Caregivers responded well to child-focused visits in which the home visitor, child, and caregiver did an activity together. These activities provided opportunities for home visitors to model positive interaction with the child, teach the caregiver to observe the child, and provide information on typical behavior and developmental milestones for children of different ages.

- ***Encouraging Changes in Caregiving Practices.*** Home visitors stressed the importance of building rapport and trust with caregivers before making suggestions about changing their caregiving practices. They also emphasized the importance of expressing respect for caregivers' experiences as parents, grandparents, and caregivers. Home visitors should make suggestions gently and indirectly, rather than "telling" caregivers how to take care of the children. Likewise, home visitors should be respectful of caregivers' cultural norms about childrearing and seek to fully understand them before suggesting changes.

- ***Safety.*** Based on findings from the in-home observations, more attention to improving the safety of the child care setting seems warranted. Home visitors should plan to bring information on home safety and childproofing as soon as caregivers are enrolled in the program, provide materials needed for basic childproofing, and perhaps set aside a visit to help the caregiver install outlet plugs, safety latches, and other safety devices in the area where care is provided.

- ***Planning Group Events.*** Group events for caregivers can provide important opportunities for learning and for much-needed social interaction. To encourage participation, programs should tailor training workshops and support groups to the interests and needs of caregivers and provide transportation, child care, and participation incentives.

- ***Materials.*** Programs should plan to give or loan toys and books to kith and kin caregivers. Caregivers responded positively to the toys, children's books, and educational materials provided through the pilot. Parents also viewed access to these materials as an important incentive for caregivers. Moreover, caregivers who participated in the in-home observations had a range of developmentally appropriate materials in their homes, some of which might have been supplied by the pilot.

- ***Community Resources.*** Programs should seek resources and help from other community agencies to meet kith and kin caregivers' social service needs. Many had social service needs similar to those of Early Head Start families. Moreover, some social service needs and health conditions interfered with home visitors' ability to deliver child development information and conduct child-caregiver activities during home visits.

POTENTIAL NEXT STEPS

Early Head Start children enrolled in the Enhanced Home Visiting Pilot spent large amounts of time with their kith and kin caregivers, in child care arrangements that lasted for 17 months, on average. Because children spend so much time in kith and kin child care during their critical first three years of life, developing an intervention within Early Head Start to improve the quality of care provided in these settings seems warranted.

The Enhanced Home Visiting Pilot represents the first step in developing such an intervention. Through their experiences implementing the pilot, sites have demonstrated the feasibility of recruiting kith and kin caregivers, the levels of need for and interest in these services among Early Head Start families (particularly those enrolled in the home-based option), the levels of service delivery that can be achieved, and the staffing patterns that seem most promising. They have also identified a number of lessons related to implementation and service delivery that could be applied to future attempts at replication.

Experiences of the pilot sites also suggest that initiatives for improving the quality of kith and kin child care settings can be implemented in Early Head Start programs with fairly modest amounts of additional resources. Additional funding is needed primarily to cover the cost of hiring home visitors to work with caregivers, and for purchasing safety and educational materials. Early Head Start programs already have expertise in early childhood development and home visiting, along with well-developed systems for staff training and supervision, that can be drawn on to support a kith and kin initiative.

As a next step in developing an effective initiative to improve the quality of kith and kin child care used by Early Head Start families, the Office of Head Start could consider launching another intervention in selected programs that builds on lessons learned from the Enhanced Home Visiting Pilot, and potentially testing the effectiveness of the intervention with a more rigorously-designed evaluation. For example, the Office of Head Start might consider developing a set of standards for the intervention based on the findings from this study—such as requiring programs to hire at least one full-time home visitor to work with 10 to 12 caregivers and provide biweekly home visits and monthly group training or socialization events. The effectiveness of such an intervention could be tested by assessing its impact on the quality of care provided by kith and kin caregivers and children's outcomes to determine if the intervention produced the desired results. If the intervention is found to be beneficial for Early Head Start children, the Office of Head Start could consider options for supporting broader implementation.

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