Early Childhood Home Visiting and Home-Based Child Care Providers

Expanding Participation

Heather Sandstrom and Kelly Dwyer

November 2021

More than five million child care providers across the United States regularly care for children in their homes (NSECE Project Team 2021). Although home-based child care (HBCC) is the most common form of child care—ranging from relatives and neighbors to licensed business owners—these caregivers are often not connected to available public programs and services. HBCC providers face unique challenges accessing resources that can promote the quality of care they provide and the health and development of children in their care. Home visiting services—traditionally designed to support new parents to promote positive parenting, home safety, and child health and development—could be used to support HBCC providers and improve child outcomes. Given that 5.3 million infants and toddlers and 3.4 million preschool-age children are in HBCC (NSECE Project Team 2016a), home visiting services adapted for HBCC could reach more children than services targeting only parents, offering benefits to providers, children, and their families.

This brief summarizes opportunities, challenges, and steps required to expand home visiting services to support HBCC providers. It is one brief in a series focusing on supporting HBCC provider participation in various federal programs and service systems.[1] Based on interviews with experts and a brief literature review, we first describe the HBCC context and what home visiting is. Then, we explain the benefits of home visiting for different types of HBCC providers, how home visiting is funded, key considerations for expanding home visiting to HBCC, recommended actions for states and the home visiting field, and future research directions. Box 1 highlights key points.

BOX 1

Key Takeaways

Home visiting is a service delivery approach that pairs a trained nurse, social worker, or parent educator with a new or expecting parent or primary caregiver of a young child not yet in kindergarten. Home visitors provide tailored support, education on child development, and links and referrals to community services and resources to meet caregivers' and children's unique needs. Evidence suggests home visiting could be a beneficial resource to HBCC providers, especially relative caregivers.

Key Considerations for Expanding Home Visiting to HBCC Providers

- Available home visiting services and funding for home visiting broadly are already limited.
- Program eligibility is narrowly defined with very few programs serving HBCC providers.
- Home visiting and early care and education systems typically operate in siloes.
- Home visiting should complement but not duplicate efforts of existing quality improvement initiatives.

Recommended State Policy Actions

- Take inventory of HBCC providers throughout the state and explore how available adaptations of home visiting models fit current needs.
- Identify which home visiting models, if any, are already offered in each local community and what would be required to expand services to HBCC.
- Leverage new federal funds available for rebuilding the child care system to connect HBCC providers with home visiting services.
- Leverage existing home visiting networks or build networks that can serve as a central hub for home visiting activities and group collaborations.
- Improve cross-program service coordination to identify gaps and avoid duplication of efforts and time burden on providers.

Recommended Federal Policy Actions

- Provide guidance to states about how to use CCDF funds for home visiting services.
- Review MIECHV program eligibility rules, clarify whether and how HBCC providers can be eligible, and consider expansion of eligibility definition.
- Gather federal agency leaders and staff to discuss ways to bring child care and home visiting systems together.

Recommended Policy Actions for the Home Visiting Field

- Support cross-model collaboration to adapt model curricula when appropriate and tailor services to reach HBCC providers.
- When adapting home visiting models, be mindful of the unique realities of HBCC and differences among providers.
- Consider the needs of a wide range of age groups, including school-age children.
- Raise awareness of the value of home visiting services for HBCC providers.

Future Research Directions

- Which home visiting models work best with which types of providers, and for which outcomes?
- What special training do home visitors need to understand the HBCC context?
- What services do HBCC providers really want?
- What lessons can be learned from sites that have extended home visiting to HBCC?

Understanding the HBCC Context

HBCC is the most prevalent form of nonparental child care in the United States, especially for children younger than age 3 and children from families with low incomes. In 2019, nearly 5.2 million HBCC providers (including about 1.1 million paid and 4 million unpaid) served about 12.3 million children younger than age 13 across the US (NSECE Project Team 2021). HBCC arrangements are varied and include relatives caring for a single child or small group, licensed and unlicensed providers caring for small groups of unrelated children, and providers operating a home business with a larger group of children and support staff.

BOX 2

Understanding the Terminology Used to Describe HBCC

The HBCC field has many terms, often poorly defined, that are used to refer to HBCC, including "family child care," "family friend and neighbor (FFN) care," "informal care," and "relative care." In this brief, we use

- licensed HBCC, which is any home-based provider who meets their state or local licensing requirements; and
- license-exempt HBCC, which is any home-based provider legally exempt from state or local licensing, which can include care by individuals who are related or not related to the child.

We differentiate between licensed and unlicensed care because licensing status is a common criterion in many states for accessing publicly funded services available to child care providers. However, states vary widely in which HBCC providers they require to be licensed, with some states requiring HBCC providers to be licensed as soon as they care for even one unrelated child and others not requiring HBCC providers to be licensed until they are serving many children.

These early educators and caregivers often experience long work hours, few breaks to address personal needs, and feelings of isolation when working alone (Gerstenblatt et al. 2014; Porter et al. 2010). Specifically, 83 percent of listed providers ("listed" meaning they are licensed or registered with their states as child care providers) work more than 40 hours a week—57 hours on average (NSECE Project Team 2016b). Attending training and networking opportunities outside the home is challenging

given schedules and logistics. Though virtual meetings are more convenient, finding time to commit to virtual meetings when children are not present is also challenging.

Moreover, many HBCC providers struggle with low earnings and lack of access to employee benefits. In 2012, when data were last published, median annual earnings for paid, listed providers were approximately $23,000 (NSECE Project Team 2016b). In 2019, 11 percent of all HBCC providers (licensed and not) had no health insurance coverage and 28 percent self-reported having fair or poor health.[2] The COVID-19 pandemic has further exacerbated health inequities in the US and placed greater demands and stress on the HBCC workforce, many of whom continued operating throughout the pandemic (Porter et al. 2020). The health and well-being of HBCC providers is concerning. Physical exhaustion and stress can result without proper access to supports and resources, keeping providers from offering the best care they can.

Available resources to support child care providers more broadly, especially those targeting quality improvement and promotion of child health and school readiness, are often limited to licensed providers and designed with center-based providers in mind. For example, nearly all states have child care quality rating and improvement systems (QRIS) that offer training and resources to support providers in their quality improvement efforts (Tout et al. 2017). Most states include licensed HBCC in their QRIS; however, many of these systems were designed for centers and then modified for licensed homes, and they typically do not include license-exempt HBCC providers. A QRIS is also a consumer education tool designed to provide quality ratings to parents to help them make informed child care decisions. However, QRIS focus on program-level quality and do not traditionally collect data on individual children to track their health and development.

As an alternative approach, home visiting programs focus on individual children and families while promoting caregivers' wellness, confidence, and competence. Coming into the home and working with caregivers and children directly is a seamless way to offer support to providers in their typical setting and routine.

How Home Visiting Programs Can Support HBCC Providers

What Is Home Visiting?

One promising strategy to support HBCC providers is providing access to early childhood home visiting services (Lloyd et al. 2019). Home visiting is a service delivery approach whereby a designated support person—typically a trained nurse, social worker, or early childhood specialist—goes into a family's home to work directly with an adult caregiver and child to provide education, support, and connections to local community services. Home visiting has a strong body of evidence of effectiveness in improving outcomes for pregnant women and parents with young children (Duffee et al. 2017; NHVRC 2020). Home visitors support caregivers to make homes safer, promote safe sleep practices, and promote healthy child development. They screen for postpartum depression, substance abuse, domestic

violence, child developmental delays, and family needs, and they refer families to local services so they have stable housing, food security, medical care, and other necessities.

Currently, 21 home visiting models meet criteria for being evidence-based by the US Department of Health and Human Services, and dozens of other models with various levels of published research evidence exist.[3] Although all models are designed to support child and family outcomes, some focus more heavily on maternal and child health and others target parenting practices and school readiness or prevention of child maltreatment. Timing of enrollment varies with multiple models targeting pregnant women to help improve birth outcomes, several enrolling newborns or young infants to support new parents, and others enrolling families with toddlers or preschool-age children to promote school readiness.

Home Visiting Model Adaptations for HBCC

Although home visiting models are designed to serve current and expectant parents, several models, including Home Instruction for Parents of Youngsters (HIPPY), ParentChild+, and Parents as Teachers, have adapted their curricula to fit HBCC providers' needs.[4] These model developers recognized that some parent participants in their programs are regular caregivers for children other than their own, including nieces, nephews, and other young relatives, as well as unrelated children of friends and neighbors. When home visitors go into the home, they see and learn about these other children. Model developers saw this as an opportunity; what parents learn through home visiting services can have a positive impact on other children in their care and those children's families.

Additionally, the home visiting field has recognized that a significant number of young children spend their days with home-based caregivers other than their parents, and these caregivers (related or unrelated; licensed or exempt) may also benefit from the support of a home visitor. Home visiting is also an innovative approach for offering individualized coaching and professional development to HBCC providers. Existing professional development models, especially those designed with center-based care in mind, may fall short of meeting HBCC providers' unique needs and fail to address their personal well-being.[5]

Providing services through child care providers is another way to reach children to support their development, particularly in settings where they routinely spend their days. Experts suggest home visiting may improve health equity and reduce disparities in child health and developmental outcomes. Home visiting can also reduce disparities in access to services and supports among providers disconnected from the child care system (i.e., unlicensed providers and those not participating in any quality improvement initiative or provider network).

Though HBCC providers vary in terms of licensing, payment, and number of children in their care, most are license-exempt, not paid, and related to at least one child in their care (NSECE Project Team 2021). In other words, these caregivers are extensions of the child's family. In this way, HBCC is different from center-based care and offers a setting well aligned with home visiting services: a home setting, existing relationships between caregivers and children (in most cases), and integration of family

and work life for the provider, with children regularly present in the home. Although home visiting traditionally focuses on parents and their children, multiple home visiting curricula are well suited for HBCC providers given the in-home service delivery method and focus on child development (Lloyd et al. 2019).

Adjusting Adaptations Based on Context and Type of HBCC Provider

The experts we interviewed agreed home visiting services can benefit all types of HBCC providers—licensed or license-exempt and relative or nonrelative. A tailored curriculum delivered in the convenience, comfort, and safety of a provider's home can improve their knowledge of child health and development, support healthy relationships with children and families, and teach stress management and self-care practices to support positive mental health. Home visitors can refer providers to other services and community resources. Though certain adaptations would be necessary given the context:

- For licensed providers serving a group of children and larger license-exempt HBCC providers in states that exempt HBCC providers serving several unrelated children, home visiting services may be framed more as a professional development resource to support and coach providers in the care environment.
- For license-exempt caregivers who primarily care for children because of their relationship with the family, such as a grandmother or close family friend, home visiting services may be framed more as a family resource. Home visiting is especially appropriate for relative caregivers who are an extension of the family and likely to continue having a relationship with the child regardless of the caregiving arrangement. Relatives may act as a stand-in for parents. With an estimated 35 percent of infants and toddlers in a regular caregiving arrangement with a grandparent, and more children with other adult relatives (Laughlin 2013), home visiting offers an important opportunity to support secondary caregivers of the youngest children in our country.

Also, new HBCC providers, regardless of licensing, can gain from having a dedicated support person visit their home who can share information on caregiving practices and child development, answer questions, connect them to resources, and guide them in setting and achieving personal goals.

Home Visiting Offers Many Benefits for HBCC Providers and the Children in Their Care

HBCC providers can benefit from home visiting in several ways. Together, these benefits strengthen providers' personal well-being and the quality of their caregiving.

- **Reducing isolation**. Home visiting can reduce feelings of isolation as home visitors build trusted relationships with providers and offer their attention and support. As providers face challenges in their personal lives, with the children in their care, or with the families they work with, they can turn to their home visitor for guidance to work through their problems. Experts we interviewed

emphasized that providers cannot adequately offer safe and supportive care unless their own needs are met: the idea that "you can't pour from an empty cup."

- **Building on strengths**. Home visiting models are strengths- and relationship-based. Home visitors help their clients identify the things they already know and are doing well to build on those skills. The home visiting concept is built on the idea of meeting the family or provider where they are. Meeting in the home evens out power dynamics in the relationship. Home visitors are seen as supporters and not enforcers, which helps build providers' self-confidence and self-efficacy. In contrast, licensing monitors and QRIS specialists often come into the home to observe and assess quality and, as a default, take a deficit approach by focusing on areas in which providers need to improve to get a higher rating.
- **Tailored to meet individual needs**. Although a curriculum guides service delivery, home visits are tailored to participants' unique needs. Providers set goals for themselves and the children in their care and receive tailored support from home visitors to work toward those goals. This could include taking better care of one's physical or mental health or taking steps to get connected to local resources. Home visitors offer coaching to support adult behavior change.[6] Home visits offer providers time and space for reflection, rather than focusing on completing forms and checking documentation as other training and professional development programs often do.
- **Learning through modeling and coaching**. Home visitors educate providers on child health and development, home safety, and ways to encourage early learning and family engagement. Through modeling and coaching, they support positive caregiver-child interactions, which translates into higher-quality caregiving, secure attachments, and healthy child development. Providers build confidence in their skills engaging children, which can improve their emotional well-being and connection to their work.
- **Connections to community resources**. Providers learn about and get connected to community resources, which can be particularly powerful for relative and nonrelative license-exempt providers who are otherwise disconnected from and potentially unaware of available services. They learn to advocate for themselves and the children in their care and be more resourceful.
- **Group connections and networking**. Home visiting programs can connect participating providers to foster peer learning and sharing and informal networks. Group meetings, in addition to personal home visits, are a key component of the Parents as Teachers[7] and HIPPY model, to provide social experiences for children and adults. The ParentChild+ Family Child Care model includes a Community of Practice component to cultivate continuous quality improvement and build resilience through peer support.[8] Experts commented that peer networks may be especially important for unlicensed providers that otherwise are not connected to support services, and also for licensed providers living in areas with fewer professional development opportunities.
- **Convenience**. Home visiting may be more convenient for HBCC providers than other training models that require providers to attend meetings outside their homes. This means that they are more likely to be able to participate, as they do not need to deal with transportation, rearranging

schedules, and arranging for substitute caregivers if during the time they are caring for children. It is also convenient because children can (and should) be present during the visit.

As providers strengthen their knowledge and skills and achieve positive mental health, this has spillover effects for the families they serve. Providers often wish they could better support parents' needs, and home visiting may give them the skills and resources to do so (Lloyd et al. 2019).

Potential Impacts of Expanding Home Visiting to HBCC

If we assume the observed benefits for families are extended to HBCC providers, potential impacts on providers could include

- improvements in physical health (fewer providers self-reporting poor or fair health);
- fewer depressive symptoms;
- reductions in food insecurity;
- increases in health insurance coverage;
- improvements in the quality of their home environments; and
- more supportive interactions with children in their care.

Potential impacts on children could include

- improvements in receptive language skills; and
- reductions in behavior problems.

These outcomes were all found to be statistically significant in a national randomized controlled trial of the four largest home visiting models implemented in the US (Michalopoulos et al. 2019); though outcomes varied by home visiting model and dosage.[9]

A small-scale evaluation of home visiting services for registered and license-exempt HBCC providers in New York found significant improvements in the quality of the care environment, improvements in health and safety (e.g., handwashing, working smoke detectors), and an increase in providers' self-reported child development knowledge and skills (McCabe and Cochran 2008).

Experts also suggested that they would anticipate long-term benefits for providers when they participate in home visiting, such as reducing provider turnover and stabilizing the workforce.

Sources of Home Visiting Funding

The main source of funding for home visiting programs for *families* is the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program administered through formula grant funding to states and territories, with a total allocation of $400 million a year through fiscal year 2022. Federal aid in response to the COVID-19 pandemic included $150 million in one-time emergency funding for

MIECHV, expiring September 30, 2022, to support virtual and in-person visits. Other sources include Medicaid, Temporary Assistance to Needy Families (TANF), state general funds, state tobacco tax and lotteries, and philanthropic support. Programs generally target enrollment to the primary caregiver of the focal child—a parent or legal guardian.

Home visiting services for HBCC providers are less common. Without a dedicated funding source, states have been innovative with Child Care and Development Fund (CCDF) dollars and other existing funds to extend services to HBCC providers. Massachusetts is using infant-toddler set-aside funds from the Child Care and Development Block Grant to offer the ParentChild+ model to family child care providers serving toddlers. Colorado is using its Preschool Development Grant Birth to Five to add home visitors to its Parents as Teachers and HIPPY programs to specifically serve licensed HBCC providers and unlicensed family, friend, and neighbor caregivers. In Washington State, TANF child care dollars have been used, while local taxes from Seattle support ParentChild+ services in the city. Family First funding to prevent child maltreatment is another possible source that experts mentioned in our interviews. Additionally, the Early Head Start Home-Based Option targets services to parents of infants and toddlers but includes some visits and light-touch supports for FFN caregivers (Paulsell et al. 2006). Head Start Program Performance Standards articulate a goal to ensure all child care settings serving Head Start and Early Head Start children are high quality, but no precedent exists for targeting the bulk of services to the FFN provider (rather than the parent), so this would be a shift in the current model. Because initiatives to include HBCC have been small-scale and recent pilots, limited data are available on the enrollment of HBCC providers in home visiting.

With no clear funding stream, the experts we interviewed questioned whether MIECHV eligibility rules could be redefined to allow services to transfer from the parent as the *primary* caregiver to an HBCC provider as a *secondary* caregiver on record, thus following the focal child—or including the secondary provider from the start. This approach could promote greater program retention, because services could continue for children regardless of setting and their parents' ability to participate. For example, if a mother became employed or returned to work and did not have time to commit to home visiting, her child's provider could receive services in her place.

The influx of child care funding under the American Rescue Plan Act of 2021 as well as the increased funds available through the other pandemic relief initiatives give states a unique opportunity to invest in efforts to support HBCC providers.[10] Specifically, investing in home visiting for HBCC and strategies to support the mental health of HBCC providers can be a focus of the funds designed to stabilize the child care sector. For example, in the American Rescue Plan, stabilization funds can be used to support the workforce's mental health, at least for staff or providers in programs or settings that are licensed, registered, or regulated (Fortner 2021). Applying an equity lens, states can focus on HBCC providers needing the most support to weather the pandemic; rather than another form of monitoring, home visiting is nonpunitive and strengths- and relationship-based and can focus on provider well-being as the core to strengthening the HBCC sector's stability and quality.

Key Considerations and Challenges to Expanding Home Visiting to HBCC

Although expanding home visiting to HBCC has many potential benefits, our assessment identified several implementation challenges, including the following:

- limited service and funding availability for home visiting services generally
- constraints in program eligibility definitions, with few programs serving HBCC providers
- home visiting and early care and education operating in siloes
- perceived duplication of ongoing quality improvement initiatives

We discuss each issue below as an actionable area for policy improvement.

Limited Service and Funding Availability

Evidence-based home visiting services are available in all 50 states and US territories (NHVRC 2021). An estimated 53 percent of all US counties have at least one local home visiting agency implementing a model designated as evidence-based by the US Department of Health and Human Services (NHVRC 2021). Although services have expanded dramatically in the past decade since the 2010 rollout of the federal MIECHV program coupled with an increase in state investments, evidence-based home visiting programs reach only an estimated 1.7 percent of the approximately 17.6 million pregnant women and parenting families who could benefit from home visiting; this estimate includes all families with a child younger than age 6 and not yet in kindergarten and all pregnant women (NHVRC 2021). Other models not yet recognized as evidence-based serve additional families, but the reach is still low.

Constraints in Program Eligibility Definitions

Local programs follow the guidance specific to their program model to determine eligibility, such as serving only families with low incomes or children of a specific age group. Because home visiting models are designed to target pregnant women and parents of young children, local service organizations are built and funded specifically to recruit and work with parents and legal guardians and not HBCC providers broadly. Few home visiting models—ParentChild+, HIPPY, and Parents as Teachers—have adapted their curricula to target HBCC providers (not only parents). Existing examples of expanding home visiting services to HBCC are a result of state or local commitment to serve this population and innovative strategies on the ground to implement.

Home Visiting and Early Care and Education Operating in Siloes

Because home visiting is seen as a parent support model, the home visiting and early care and education fields have questioned how services can be offered without the parent there. These two service systems have traditionally operated in siloes with little cross-system coordination and service integration (Lloyd

et al. 2019). Some models may find it hard to adapt to integrate HBCC. The licensed child care sector may not see a role for home visiting, especially on top of existing quality improvement initiatives (though this would not be as much of an issue for license-exempt providers). It is also unclear how to structure services and advertise to parents of young children who are also informal caregivers of other children. How can home visiting serve a dual role and be both a parenting program and a program supporting a child care provider?

Perceived Duplication of Ongoing Quality Improvement Initiatives

HBCC providers may perceive duplication of efforts with existing training and professional development opportunities. HBCC providers that are licensed or participate in QRIS, the subsidy system, and/or the Child and Adult Care Food Program already have monitors and inspectors coming into their homes and participate in required trainings. They might not see the benefit of home visiting and view it as something extra on top of what they are already doing for quality improvement. Besides being perceived as potentially duplicative, providers may not have the time to dedicate to recurring home visits (often weekly). Providers may want to see the direct benefit for themselves before committing to services.

Experts explained that building a trusting relationship with the home visitor is foundational to active engagement. Providers must view home visitors as "on their side," nonintrusive, and not related to accountability efforts of the state or county child care agency. Duplication of efforts is less likely to be an issue for unlicensed providers not connected to any regulatory system, but they too must see the benefits and be willing to open their doors and trust home visitors.

Recommended Actions

Our assessment of the published literature and interviews with key experts identified several actions that, if followed, could bring home visiting into more HBCC settings. We divide these recommendations into three sections: (1) state policy actions, (2) federal policy actions, and (3) actions for the home visiting field, including models, technical assistance providers, and advocates.

Recommended State Policy Actions

- **Take inventory of HBCC providers throughout the state and how available adaptations of home visiting models fit current needs.** States should consider HBCC providers' diverse needs and how home visiting can support various types of HBCC providers in different ways. Home visiting may be particularly beneficial to small, licensed, or unlicensed HBCC providers and relative caregivers who are more similar to parents caring for a single child or small group. Whereas licensed providers may have different ambitions and needs for technical support to run their businesses well, which will ease work stress, unlicensed providers may benefit more from the tailored support and connections that home visiting offers. States may already provide training and supports to different types of

HBCC through licensing and QRIS, so taking inventory of those existing opportunities and who has access and who does not is important.

- **Identify which home visiting models, if any, are already offered in each local community and what would be required to expand services to HBCC.** Given the limited reach of current services, local home visiting agencies may not have the flexibility to expand without infrastructure supports and hiring new staff. With adequate staff and technology, virtual visits may be one option to help expand services in rural and hard-to-reach areas. During the COVID-19 pandemic, home visiting programs responded rapidly and shifted to a virtual platform to ensure services for families could continue (Thomson, Joraanstad, and Meisch 2021). State leaders should reflect on these experiences locally and consider the benefits and limitations of virtual visits within the context of HBCC.
- **Leverage new federal funds available for rebuilding the child care system to expand home visiting services to HBCC providers.** In the long term, this investment can support the workforce's mental health and well-being and the quality of care they provide, particularly for those hurt by the pandemic. Work with home visiting models to provide guidance and technical support to local service organizations, especially around hiring and training home visitors. Offer resources and supports to local home visiting programs to build their capacity, knowing that program expansion can take time and energy that programs may not currently have.
- **Leverage existing home visiting networks or build networks that can serve as a central hub for home visiting activities and group collaborations.** States might consider funding local organizations that work with HBCC providers to support home visiting implementation. This could include staffed family child care networks, with large networks even housing a home visiting program, or networks working more closely with family, friend, and neighbor caregivers. Networks have the benefit of being connected to providers and can find out what providers want and need (Adams and Dwyer 2021b). They can help determine when home visiting services would be beneficial to local providers. They can also be a trusted source to connect providers with home visiting services and coordinate with other services and monitoring activities to break down siloes and reduce duplication of efforts. States already implementing professional development for HBCC settings may consider how to integrate a home visiting component or apply lessons learned from home visiting.
- **Improve cross-program service coordination to identify gaps and avoid duplication of efforts and time burden on providers.** Providers may be engaged in other training and professional development initiatives, including QRIS. Home visitors working with HBCC should coordinate and communicate with QRIS specialists or other state quality-improvement experts about the work they are doing with providers and the information they are providing to support providers' goals. Information should be complementary and reinforcing and not conflicting or overly duplicative.

Recommended Federal Policy Actions

- **Provide guidance to states about how to use CCDF funds for home visiting services.** States might benefit from additional information from the Office of Child Care on approved uses of CCDF funds (e.g., quality set-aside) and pandemic relief funds for child care stabilization. In particular, can funds be directed to any type of home visiting model? Must services be limited to licensed or regulated providers, or could license-exempt providers—specifically license-exempt providers outside the subsidy system—be offered home visiting services?
- **Review MIECHV program eligibility rules, clarify whether and how HBCC providers can be eligible, and consider expansion of eligibility definition.** States and local implementing agencies receiving MIECHV funding would benefit from knowing how MIECHV funds could be used to serve HBCC providers. Are there certain circumstances, for example, where an active case could be transferred from a parent to a nonparental caregiver to promote family retention? Or could MIECHV funding be used to target and serve HBCC providers from the start? Documenting and sharing guidance for the field on these issues would be beneficial.
- **Gather federal agency leaders and staff to discuss ways to bring child care and home visiting systems together.** Without a dedicated funding stream, states and local communities are drawing on various sources to offer home visiting services to a very small subset of HBCC providers. However, more resources and coordinated guidance are needed at the federal level to support widespread service delivery. Given the pandemic's debilitating effects on the child care system and the workforce's health and well-being, a natural next step would be to explore health- and mental-health related services, like home visiting, that can support the workforce and children in their care.

Recommended Policy Actions for the Home Visiting Field

- **Support cross-model collaboration to adapt model curricula when appropriate and tailor services to reach HBCC providers.** Adaptation may not be appropriate for all models, though several have already accomplished this and others could. As a first step, models must embrace the idea that home visiting has a role in HBCC. The experts we interviewed mentioned that the home visiting field has generally been reluctant to engage with HBCC, because of its long history of serving parents. Models are focused on the parent-child pair, often excluding other adult caregivers unless they are present with the parent at the time of visit. Models interested in adapting should reach out to formal and informal HBCC networks that understand and support providers to explore what elements would be useful to them and how to best adapt.
- **When adapting home visiting models, be mindful of the unique realities of HBCC and differences among providers.** Model developers often do not have an early childhood education background or strong knowledge of HBCC. When adapting curricula, models should be mindful of the unique features of HBCC and how they are different from center-based providers. This includes the presence of mixed-age groups, caregiving as a business for some portions of the HBCC sector though not for others, and long hours and parental need for nontraditional-hour care. HBCC arrangements are varied, with some providers caring for their own children and other parents'

children at the same time and some providers caring for only other people's children, related or unrelated. Group sizes range from caregiving for a single child (such as a grandmother caring for a grandchild) to large group homes with a dozen children, who may or may not require licensure depending on state licensing requirements. HBCC providers care for children for different reasons and in various contexts, with some caring for children with whom they have a relationship and some effectively running a small business. Model developers must consider the unique circumstances of HBCC providers and determine how they support different types of providers, or else clearly specify the target subgroup of HBCC providers. With any efforts, attending to caregiver well-being and quality of caregiving interactions needs to be front and center.

- **Consider the needs of a wide range of age groups, including school-age children.** Although home visitors typically take a whole-family approach and consider the needs of older children when visiting a family, home visitors are generally not trained to work with school-age children. With more than half of HBCC serving at least one school-age child, according to the 2012 NSECE,[11] home visitors may need additional training and supports to meet providers' needs if caring for school-age children. Experts discussed the challenge of the wide age range served in HBCC and how models may need to develop a base curriculum and then add on components to target needs of additional age groups.
- **Raise awareness of the value of home visiting services for HBCC providers.** Focus groups with HBCC providers in a past research study showed that available training opportunities are basic and offer little variety (Lloyd et al. 2019). QRIS are often too focused on assessments and ratings, often designed with child care centers in mind, and generally exclude unlicensed HBCC providers. Home visiting could offer a unique opportunity for change—to support home visitors' professional development and their personal wellness. Working with a trained professional who understands engagement with children and families in a home setting could be more useful than alternative approaches.

Areas for Further Investigation

Our assessment identified several gaps in knowledge and program limitations that could be addressed in future research and curriculum development. Areas needing to be addressed include the following.

- **Which home visiting models work best with which types of providers, and for which outcomes?** More than 20 home visiting models are evidence-based or show promise with emerging evidence (NHVRC 2020). However, each model's evidence base is different, and home visiting curriculum adaptations for HBCC are limited and at such different stages of development. Whereas home visiting for parents focuses on strengthening parent-child interactions for children not yet in kindergarten while attending holistically to family needs, any adaptations to home visiting curricula for HBCC providers must consider that child care providers may be caring for multiple children and possibly unrelated and school-age children. More research is needed to test home visiting curricula with different types of HBCC providers to identify evidence of effectiveness.

- **What special training do home visitors need to understand the HBCC context?** Home visitors receive extensive training on a range of topics but may need specialized training to work with HBCC providers. What topics should this training cover? What can be learned from Parents as Teachers, HIPPY, and ParentChild+ regarding their model adaptations for HBCC?
- **What services do HBCC providers really want?** Given concerns about possible duplication of efforts and burden for providers engaged in other initiatives and services, more work should be done to capture input from providers on their needs and whether there is a role for home visiting in supporting them.
- **What lessons can be learned from sites that have extended home visiting to HBCC?** Additional research is needed to identify promising strategies, lessons learned, and potential challenges of using home visiting for HBCC to inform service expansion. As states engage in further piloting or expand services, they should support implementation research in addition to studying outcomes, to help understand program barriers and facilitators and providers' program experiences.

Conclusion

The approach of early childhood home visiting services—in-person, in-home visits tailored to caregivers' and children's needs—could support HBCC providers who typically work long hours and are isolated and disconnected from local resources. Home visiting offers opportunities to deliver coaching, training, and relationship-based support that can improve caregivers' well-being and interactions with children and the safety and quality of the early learning environment. Because home visiting services are currently limited in reach, steps would need to be taken to ensure appropriate staffing and infrastructure are in place to expand services to meet HBCC providers' needs.

Notes

[1] Companion briefs published by the Urban Institute discuss HBCC providers' participation in the child care subsidy system (Adams and Dwyer 2021), the Child and Adult Care Food Program (Adams and Hernandez-Lepe 2021a), infant and early childhood mental health consultation (Sandstrom and Dwyer 2021), and the Small Business Administration (Adams and Hernandez-Lepe 2021b). See all briefs at "Expanding Participation of Home-Based Child Care Providers in Federal Programs and Services," Urban Institute, accessed November 9, 2021, https://www.urban.org/policy-centers/center-labor-human-services-and-population/projects/expanding-participation-home-based-child-care-providers-federal-programs-and-services.

[2] Weighted estimates based on authors' analysis of the National Survey of Early Care and Education, 2019, Home-Based Public-Use Data File, Child and Family Data Archive, https://www.childandfamilydataarchive.org/cfda/archives/cfda/studies/37941/.

[3] "Home Visiting Model Effects," Home Visiting Evidence of Effectiveness, US Department of Health and Human Services, accessed October 5, 2021, https://homvee.acf.hhs.gov/evidence-overview.

[4] As of May 2021, ParentChild+ was being delivered to 184 licensed and license-exempt HBCC providers across seven states: Massachusetts, New Jersey, New York, Ohio, Pennsylvania, South Carolina, and Washington. Services in an eighth state (Minnesota) were on hiatus this year. Parents as Teachers has adapted its curriculum

for HBCC providers but did not have data available on its use and implementation. HIPPY was unable to share counts of HBCC providers served for this publication.

[5] A scan of state and local initiatives to support HBCC professional development and quality improvement found multiple that include a home visiting component, but evidence of these models' effectiveness is limited (Porter et al. 2019). Home visiting in these programs is primarily geared toward home safety checks, providing technical assistance to support providers pursuing licensing or accreditation, and consultation or coaching to address low-quality elements observed in the home.

[6] Kelly Maxwell and Lauren Supplee, "Coaching to Change Adult Behavior: What Can Home Visiting and Early Care and Education Learn from Each Other?" *Child Trends* (blog), July 26, 2018, https://www.childtrends.org/blog/coaching-to-change-adult-behavior-what-can-home-visiting-and-early-care-and-education-learn-from-each-other.

[7] "Resources for Parents during COVID-19," Parents as Teachers, accessed October 5, 2021, https://parentsasteachers.org/.

[8] "Our Family Child Care Model," ParentChild+, accessed October 5, 2021, https://www.parentchildplus.org/family-child-care/.

[9] Parents as Teachers was one of the four models tested in that RCT, but HIPPY and ParentChild+ were not included.

[10] The Coronavirus Aid, Relief, and Economic Security Act from March 2020 allocated $2.5 billion for CCDF (see "Child Care and Development Fund [CCDF] Discretionary Funds Appropriated in the Coronavirus Aid, Relief, and Economic Security Act [CARES ACT] [Public Law 116-136] passed into law on March 27, 2020," memorandum to state, territory, and tribal Lead Agencies, April 29, 2020, https://www.acf.hhs.gov/sites/default/files/documents/occ/ccdf_acf_im_2020_01.pdf). The Coronavirus Response and Relief Supplemental Appropriations Act of 2021 from the US Department of Health and Human Services's (HHS) Administration for Children and Families (ACF) allocated $10 billion for CCDF for subsidies, virus mitigation policies and practices, and assistance to stabilize providers in and out of the subsidy system (see "Planned Use of Child Care and Development Fund [CCDF] Coronavirus Response and Relief Supplemental Appropriations Act, 2021 [CRRSA] Funds Report," memorandum to state, territory, and tribal Lead Agencies, February 12, 2021, (https://www.acf.hhs.gov/sites/default/files/documents/occ/CCDF-ACF-PI-2021-01.pdf). The American Rescue Plan allocated $39 billion to states, territories, and tribes to address the child care crisis caused by COVID-19. See press release: "Child Care Funding Released in American Rescue Plan," HHS, ACF, April 15, 2021, https://www.acf.hhs.gov/media/press/2021/child-care-funding-released-american-rescue-plan.

[11] Weighted estimates based on authors' analysis of the National Survey of Early Care and Education, 2012, Home-Based Public-Use Data File, Child and Family Data Archive, https://www.childandfamilydataarchive.org/cfda/cfda/studies/35519/datasets/9/sdaxml#.

References

Adams, Gina, and Kelly Dwyer. 2021a. "Child Care Subsidies and Home-Based Child Care Providers: Expanding Participation." Washington, DC: Urban Institute.

———. 2021b. "Home-Based Child Care Networks and Federal Programs: Supporting Home-Based Child Care Provider Participation." Washington, DC: Urban Institute.

Adams, Gina, and Fernando Hernandez-Lepe. 2021a. "The Child and Adult Care Food Program and Home-Based Child Care Providers: Expanding Participation." Washington, DC: Urban Institute.

———. 2021b. "Home-Based Child Care Providers and the Small Business Administration." Washington, DC: Urban Institute.

Duffee, James H., Alan L. Mendelsohn, Alice A. Kuo, Lori A. Legano, and Marian F. Earls. 2017. "Early Childhood Home Visiting." *Pediatrics* 140 (3): 1–14.

Fortner, Alyssa. 2021. "State's Plans to Use the CRRSA's $10B in Child Care Relief Funds. Washington, DC: CLASP.

Gerstenblatt, Paula, Monica Faulkner, Ahyoung Lee, Linh Thy Doan, and Dnika Travis. 2014. "Not Babysitting: Work Stress and Well-Being for Family Child Care Providers." *Early Childhood Education Journal* 42 (1): 67–75. https://doi.org/10.1007/s10643-012-0571-4.

Laughlin, Lynda. 2013. "Who's Minding the Kids? Child Care Arrangements: Spring 2011." Current Population Reports, P70-135. Washington, DC: US Census Bureau.

Lloyd, Chrishana, Maggie Kane, Deborah Seok, and Claudia Vega. 2019. *Examining the Feasibility of Using Home Visiting Models to Support Home-Based Child Care Providers*. Bethesda, MD: Child Trends.

McCabe, Lisa A., and Moncrieff Cochran. *Can Home Visiting Increase the Quality of Home-based Child Care? Findings from the Caring for Quality Project*. The Cornell Early Childhood Project. Ithaca, NY: Cornell University.

Michalopoulos, Charles, Kristen Faucetta, Carolyn J. Hill, Ximena A. Portilla, Lori Burrell, Helen Lee, Anne Duggan, and Virginia Knox. 2019. *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*. OPRE Report #2019-07. Washington, DC: US Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Planning, Research and Evaluation (OPRE).

NHVRC (National Home Visiting Resource Center). 2021. *National Home Visiting Yearbook*. Arlington, VA; Washington, DC: James Bell Associates; Urban Institute.

NSECE (National Survey of Early Care and Education) Project Team. 2016a. *Early Care and Education Usage and Households' Out-of-pocket Costs: Tabulations from the National Survey of Early Care and Education (NSECE).* OPRE Report #2016-09, Washington DC: HHS, ACF, OPRE.

———. 2016b. *Characteristics of Home-based Early Care and Education Providers: Initial Findings from the National Survey of Early Care and Education*. OPRE Report #2016-13, Washington, DC: HHS, ACF, OPRE.

NSECE Project Team. 2021. *Home-based Early Care and Education Providers in 2012 and 2019: Counts and Characteristics.* OPRE Report #2021-85, Washington, DC: HHS, ACF, OPRE.

Paulsell, Diane, Debra Mekos, Patricia Del Grosso, Patti Banghart, and Renee Nogales. 2006. *The Enhanced Home Visiting Pilot Project: How Early Head Start Programs Are Reaching Out to Kith and Kin Caregivers Final Interim Report*. Washington, DC: HHS, ACF, OPRE.

Porter, Toni, Juliet Bromer, Samantha Melvin, Marina Ragonese-Barnes, and Patricia Molloy. 2020. *Family Child Care Providers: Unsung Heroes in the COVID-19 Crisis*. Chicago: Herr Research Center, Erikson Institute.

Porter, Toni, Diane Paulsell, Tahra Nichols, Carol Begnoche, and Patricia Del Grosso. 2010. *Supporting Quality in Home-Based Child Care: A Compendium of 23 Initiatives*. Washington, DC: Mathematica Policy Research.

Sandstrom, Heather, Sarah Benatar, Rebecca Peters, Devon Genua, Amelia Coffey, Cary Lou, Shirley Adelstein, and Erica Greenberg. 2020. *Home Visiting Career Trajectories: Final Report*. Washington, DC: Urban Institute.

Sandstrom, Heather, and Kelly Dwyer. 2021. "Mental Health Consultation and Home-Based Child Care Providers: Expanding Participation." Washington, DC: Urban Institute.

Thomson, Amanda, Alexandra Joraanstad, and Allison D. Meisch. 2021. *How Do Home Visiting Models Define and Operationalize Virtual Home Visits?* Arlington, VA: James Bell Associates.

Tout, Kathryn, Katherine Magnuson, Shannon Lipscomb, Lynn Karoly, Rebecca Starr, Heather Quick…Jennifer Wenner. 2017. *Validation of the Quality Ratings Used in Quality Rating and Improvement Systems (QRIS): A Synthesis of State Studies*. OPRE Report 2017-92. Washington, DC: HHS, ACF, OPRE.

About the Authors

Heather Sandstrom is a principal research associate in the Center on Labor, Human Services, and Population, where she leads studies on early childhood home visiting and child care access and quality.

Kelly Dwyer is a research analyst in the Income and Benefits Policy Center. She tracks state child care subsidy policies through the CCDF Policies Database and works on Urban's microsimulation modeling of safety net programs for children and families.

Acknowledgments

This brief was funded by the HomeGrown Funders Collaborative, and specifically the Buffett Early Childhood Fund, Imaginable Futures, Klingenstein Philanthropies, and the Pritzker Children's Initiative. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors gratefully acknowledge Chrishana Lloyd and Maggie Kane from Child Trends, Jon Korfmacher from the Erikson Institute, Tiffany Lee from ParentChild+, Staci Croom-Raley from the Children's Equity Coalition, and Rena Hallam from the University of Delaware for providing information through interviews for this brief. We would also like to thank Gina Adams for providing comments on an earlier version of this brief and Liza Hagerman and Casey Simmons for editorial support.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.